

“Oh God, what do I do with this patient?!”: Countertransference Reactions of Psychoanalytically Informed Psychotherapists Working With Religious Patients.

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Declaration

I declare that this thesis is my own unaided work. It is being submitted for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in another university.

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_____ Day of _____, 2012.

Acknowledgments

With gratitude, I dedicate this thesis to my supervisor, Dr Yael Kadish, and to my family.

Abstract

This study aimed to explore the countertransference responses of psychoanalytically informed psychotherapists working with religious patients. By elucidating the various responses that devout patients may provoke in psychoanalytically oriented psychotherapists, it also sought to investigate how differences in religious orientation - which referred to atheistic, agnostic, theistic, or a combination of these metaphysical views – between patient and therapist may influence the nature of psychoanalytically informed psychotherapists' countertransference responses to their religious patients. Thirdly, it endeavored to understand how psychoanalytically informed psychotherapists manage religiously influenced countertransference responses. A sample of six psychoanalytically informed psychotherapists participated in a self developed, semi-structured interview. A thematic content analysis of the psychotherapists' interview transcripts revealed that the therapists' countertransference responses to their religious patients were broadly negative, and primarily took the form of feelings of paralysis and frustration. Concerning the extent to which the therapists perceived that differences in religious orientation between themselves and their patients influenced the nature of their countertransference reactions, a key finding was that, while the theistic therapists generally noted these responses, the agnostic therapists seemed to give more attention to them during the interviews, while reflecting on the extent to which their agnosticism may partially account for the intensity of their countertransference paralysis and frustration. Most of the agnostic therapists, moreover, were able to identify early personal experiences that may have contributed to these responses. Thirdly, regarding the management of these countertransference responses, all the therapists alluded to the significance of supervision, colleagues and their own therapy. It was also found that the therapists' countertransference reactions to their religious patients were partly a consequence of the therapists' perspectives on what constitutes healthy and pathological religion, and perceived similarities between certain religio-mystical concepts and aspects of psychoanalytic thought. The study elucidates the complex interaction between various factors that conceivably influence the nature of psychoanalytic psychotherapists' countertransference reactions to religious patients, as well as the necessity for therapist self-awareness when working with religious patients, with the broader aim of offering an example of an increasingly applied and relevant form of psychoanalytic praxis in a country with a diverse and inherently religious population.

Table of Contents	Page
Chapter One: Introductory Chapter	8
1.1 Aims	10
1.2 Research questions	12
Chapter Two: Literature Review	13
Note on the Use of Terms	14
2.1 Freud	15
2.2 Jung	21
2.3 Contemporary Views: Object Relations Approaches	24
2.3.1 Religion as Transitional	26
2.3.2 'Adaptive and 'Maladaptive' Religiosity: Existential Psychoanalytic Perspectives	28
2.4 Working With Religious Patients Within a Psychoanalytic Context: Countertransference and Other Considerations	32
2.4.1 Countertransference	40
2.5 Psychoanalysis, Religion and Mysticism: Theoretical and Practical Continuities and its Implications for Countertransference	44
2.6 Summary	44
Chapter Three: Research Methodology	46
3.1 Research Design	46
3.2 Research Objectives and Research Questions	46
3.3 Reflexivity Comment	47
3.4 Sampling Strategy	48
3.5 Data Collection	49
3.6 Instrument	50
3.7 The Qualitative Research Interview: An Introduction	50
3.8 Advantages of the Semi-Structured Interview Questionnaire	50
3.9 Data Analysis	51
3.9.1 Thematic Content Analysis	51
3.9.2 Thematic Content Analysis Steps	53
3.10 Ethical Considerations	54
Chapter Four: Results	56
4.1 Introduction	56
4.2 Themes	56
4.2.1 Theme One: Countertransference Paralysis	56
4.2.1.1 Anxiety Due to Paralysis	59

4.2.2 Theme Two: Countertransference Frustration	60
4.2.3 Theme Three: Other Countertransference Reactions	63
4.2.4 Theme Four: The Influence of Therapists' Own Religious Beliefs On Their Countertransference Reactions	65
4.2.4.1 Agnostic Therapists' Countertransference Explorations of Their Religious Patients	66
4.2.4.2 Theistic Therapists' Countertransference Reactions to Patients of the Same Religious Orientation.	67
4.2.4.3 Theistic and Agnostic Therapists' Countertransference Reactions to Patients of Different Religious Orientations	69
4.2.5 Management of Countertransference Reactions	70
4.2.6 Religion as Defense	73
4.2.6.1 Religion as a Healthy or Adaptive Defense	74
4.2.6.2 Religion as an Unhealthy or Maladaptive Defense	76
4.2.7 Healthy and Pathological Religion	78
4.2.7.1 Healthy Religious Practice as the Capacity to Think, Explore, Be Curious Be Flexible	79
4.2.7.2 Religious Communities as Nurturing	82
4.2.7.3 The Necessity of Religion for Well-Being	82
4.2.7.4 Religion and Psychosis	83
4.2.8 Religious Material in Psychotherapy: Advantages and Disadvantages	84
4.2.8.1 The Advantages of Religion in the Context of Bereavement And Suicidal Ideation	84
4.2.8.2 The 'Inappropriateness of Challenging Religious Beliefs.	86
4.2.9 Commonalities Between Psychoanalysis and Religion/Mysticism.	87
4.2.9.1 Psychoanalysis and Religion/Mysticism as Dealing with the 'Non-Scientific'	88
4.2.9.2 Other Commonalities Between Psychoanalysis and Religion/Mysticism.	90
 Chapter Five: Discussion	 92
5.1 Introduction	92
5.2 Synopsis of the Findings	92
5.3 Discussion	95
 Chapter Six: Conclusions	 118
6.1 Central Findings	118
6.2 Limitations of the Study and Directions for Future Research	121
 Reference List	 123
 Appendices	 134
Appendix A: Interview Schedule	134
Appendix B: Participant Information Sheet	135

Appendix C: Participant Consent Form	136
Appendix D: Participant Consent Form (Tape Recorded Interview)	137
Appendix E: Interview with ‘Lisa.’	138
Appendix F: Interview with ‘Sue.’	146
Appendix G: Interview with ‘Teri.’	158
Appendix H: Interview with ‘Nancy.’	167
Appendix I: Interview with ‘Alice.’	179
Appendix J: Interview with ‘Andrea.’	193

Chapter One: Introductory Chapter

Some questions are timeless: ‘what exists, what happens to us ‘after’ we die, where were we ‘before’ birth, why is there something rather than nothing, is there a ‘higher meaning’ or ‘reason’ for everything that happens in our lives, if there is a God, what does he want us to do? What is moral and good?’ Indeed, pointing out that these questions have not aged has become a commonplace. Religion – those “institution[s] consisting of culturally patterned interactions with culturally postulated superhuman beings” (Spiro, 1966 in Rizzuto, 1979, p.3) - has ever sought to provide answers. Yet these are not strictly academic or theoretical issue. They matter to us in our contemporary world as much as they did to philosophers thousands of years ago. Popular culture has never been more interested in religion, and with 95% of all people on earth believing in some kind of higher power, its effects are precipitate in our daily living (Frame, 2003).

The therapy room is no exception. Psychotherapy, originally considered a “treatment of the soul” (Freud, 1926/1947, p.8), cannot, by definition, be exempt from addressing religious material. The existential-psychoanalytic psychotherapist James Bugental (1987) defined psychoanalytic therapy as “therapy which inquires into the bases on which one identifies who and what one is and the way one believes the world to be” (Bugental, 1987, p.212). Therapy involves discovering what matters most to people. And for most people, it is their religious beliefs that do. The inquiry into the meaning of things in our lives is a key task of psychoanalysis. Yet while religions purport to provide us with an objective account of reality, psychoanalytic psychotherapy aims to get to our subjectivity – what is our experience, or what is it like, to believe and practice these things? The philosophical truth or falsity of religion’s claims, despite Freud’s (1927/1949; 1929/1949) interest in them, is thus beyond the scope of psychoanalysis. Its province is rather with what Jung (1938) called the “psychic truth” (p.38) of religion, namely, the reality it occupies in the mind of the believer. In some religions, a defining characteristic of the divine is ‘omnipresence.’ This is not an empty term – God appears to be in the

therapy room as much as the lecture hall, the synagogue, the church, the courtroom and our homes.

Nevertheless, it has been said that religion, not sex, is the most taboo topic in psychotherapy (West, 2000). Popular reference is sometimes made to a Christian scientist who is a priest on Sunday and an atheist on Monday. The bifurcation between our personal religious beliefs and our professional, ‘public’ lives is born of the idea that one’s religious beliefs are private and impervious to critique. This presents a distinctive set of challenges to psychotherapists. For example: a patient’s religious beliefs may be inextricably linked to their pathology. How does the deeply religious therapist, for example, take on the patient’s personal religion, and in so doing, critique that which he holds true as well? On the other hand, a patient’s religious beliefs may be intimately tied to their well-being. How does an irreligious therapist make sense of this, and in turn, subject his own beliefs to scrutiny? For an atheistic therapist to be as effective as possible, is it necessary for the therapist to grant that the religious patient’s beliefs are *not* merely irrational, defensive, or delusional? Is this really possible? These and many other scenarios illustrate the inevitability of particular countertransference responses when working with religious patients. Today, analysts take the view that religion is neither healthy nor pathological by definition (Spero, 1995). The point is how it works for the individual: what does it mean to him/her? This says nothing of its truth value, as per Freud’s (1927/1949; 1929/1949) critique, but endorses a post-modern, ‘true for me/true for you’ epistemology. Religion *may* be ‘bad science,’ but is it potentially ‘good psychology?’

Countertransference was originally considered a distortion and a hindrance to therapy (Freud, 1926/1947) but is now viewed as a tool for gaining insight into the patient’s transference (Heinman, 1950, 1960; Spero, 1985). The cultivation of self-awareness in the training of therapists is paramount to a psychoanalytic approach (Sahlein, 2002). Religious beliefs are often fraught with associations to our early family life and may be vulnerable to defensive reactions (Rizzuto, 1979). For this reason, religious beliefs are potentially the site par excellence for psychoanalytic psychotherapy, whose business includes trying to elucidate not only what we believe, but *why* we believe what we do.

This kind of insight into the self and the patient is invaluable. In this regard, it may be said that religion is indispensable to therapy, for a patient's and therapist's religious views, as Jung (1938) suggested, and which is supported by an abundance of research (Rizzuto, 1979; Frame, 2003, Sahlein, 2002), are a looking glass into their psychic world - a map of what reality is for them, what exists, what they believe about what exists, their skepticism, realism and fantasies. It may provide the ideal medium through which to dramatize their neuroses. Religion, like the dream or the work of art (Freud, 1900/1999) may be a gateway into our subjectivity. Yet contemporary psychoanalytic theory holds that we cannot glimpse it until we have first turned these questions on ourselves, and the relative success or failure of this self-analysis determines the potential usefulness or harm of our countertransference responses. Therapists' lack of insight into their own religiosity is injurious to effective therapy with religious patients (Bartoli, 2003). This study therefore hopes to contribute to the cultivation of this awareness.

1.1 Aims

In this regard, the study's primary aim is to investigate countertransference responses of psychoanalytically informed psychotherapists working with religious patients. By elucidating the various responses that devout patients may provoke in psychoanalytically oriented psychotherapists, it seeks to illustrate the ways in which these therapists manage their countertransference reactions to such patients. The study thus endeavors to qualitatively explore the unique challenges that therapists may encounter through working with religious patients which contribute to the formation of countertransference reactions. This includes possible tensions between the therapist's and the patient's religious beliefs; the therapist's potentially unresolved conflicts regarding their own religiosity and how this is evoked by the religious patient; potential discontinuities between aspects of psychoanalytic theory and the patient's religious beliefs; the ability to discern whether the patient's religiosity takes an adaptive or maladaptive form, and if maladaptive, how to manage this therapeutically without disrupting the therapeutic alliance.

The study intends to provide a starting point for therapists to make sense of their own countertransference reactions specific to their work with religious patients. The research intends to unfold the dialogue between religion and psychoanalytic theory by exploring potential latent continuities between these two areas of inquiry, despite the early psychoanalytic antipathy to religion fostered by Freud (1907/1966;1927/1949; 1929/1949).

There is, in addition, a possible deficit of religious literacy among psychotherapists, partly a consequence of the neglect of religious orientation during the training of therapists (Frame, 2003). In as much as self-awareness is crucial for coping with countertransference reactions, therapists would struggle to treat their religious patients effectively unless they know something about their patients' religious traditions. Without a basic acquaintance with religious doctrines, it is possible that the answers to what constitutes normative, excessive or irrational religious behavior in a given therapeutic context are ambiguous, since the answers are relative. Religious illiteracy amongst psychotherapists is thus potentially harmful. This study argues against it by offering examples of how familiarity with patients' religious beliefs, coupled with self-awareness, is the best means towards informed and empathic interventions. This is not, however, to emphasize the importance of content-based religious knowledge over and above what that content means to a particular individual – as Rizzuto's (1979,2009) work shows, everyone has a 'personal God.'

Finally, this research aims to contribute to psychoanalytically informed literature on the relationship between context and the manner in which it resonates with experiences within the therapeutic encounter. Berg (2009) argues that the cultural diversity of a country like South Africa necessitates the need for psychoanalytic psychotherapists to continuously rethink how practice could and should be influenced by contextual issues, whether race, gender, social class, or religion. The current project's significance thus lies in its attempt to offer an example of a more applied and relevant form of psychoanalytic praxis in a country with a diverse religious population, where the greater majority of its citizens purport to believe in some kind of 'higher power' (Berg, 2009).

1.2 Research Questions

Hence, the three research questions being explored are:

- 1) What particular countertransference responses do deeply religious patients provoke in psychoanalytically informed psychotherapists?
- 2) How do differences in personal religious orientation between therapist and patient influence the nature of the therapist's countertransference?
- 3) How do psychoanalytically informed therapists manage religiously influenced countertransference responses?

Chapter Two: Literature Review

This review of the literature begins by offering a brief survey of the seminal works within the field of psychoanalysis and religion. Freud's early essay, "Obsessive Actions and Religious Practices" (1907/1966), was the first to address religion from a psychoanalytic perspective. Freud then developed these themes in papers throughout his career, of which "Totem and Taboo" (1913/1946), "The Future of an Illusion," (1927/1949) and "Moses and Monotheism" (1937/1951) are key contributions. Freud's 'scientific' or 'reductionistic' approach to religion is then contrasted by an exposition of Jung's (1938) radical 'mystical' or 'elevationist' perspective (Wilber, 1995). Then, it elucidates how contemporary psychoanalytic approaches in the form of Object Relations theories advance on the scientific reductionism of Freud and the transcendental-elevationism of Jung by proposing a more nuanced psychoanalytic account of religion. Theorists such as (Winnicott 1971a; 1971b; Rizzuto 1979; 2009; Meissner 1984; 2009; Spero 1981a; 1985; 1995; 2009a; 2009b; 2009c) are considered, each of whom acknowledge the essential place of religion in human life, as well as distinguish between healthy and unhealthy religiosity – an important distinction neglected by Freud, for whom religion was pathological by definition, and Jung, for whom religion was our greatest source of well-being (Berman, 2006). In this regard, particular attention will be given to Winnicott's (1971a) notion of 'illusion' as an experience based neither exclusively in fantasy nor reality, which challenged Freud's (1927/1949) view of illusion as defensive wish fulfillment. Studies which deal with countertransference reactions to religious patients in the form of excerpts from clinical cases in the literature are then considered (Cohen, 2009; Meissner, 2009), highlighting the unique complexities of working with religious patients. It concludes by proposing a rapprochement between religious and mystical ideas and aspects of psychoanalytic theory. Knowledge of common theoretical ground and experiential goals between religion and psychoanalytically informed therapy is beneficial to therapists working with religious patients, notwithstanding the need for constant awareness of harmful or collusive countertransference responses.

A Note on The Use of Terms

It is necessary to establish, at the outset, how this study defines ‘religion’ and ‘mysticism.’ By ‘religion,’ it refers to “the external expression of those internal beliefs and values which relate one to the transcendent or ultimate reality, comprising beliefs, ethical codes, and worship and uniting one to a moral community” (Joseph, 1987 p.382), or, as Spiro (1966 in Rizzuto, 1979, p.3) put it: “institution[s] consisting of culturally patterned interactions with culturally postulated superhuman beings.” In both senses, religion is a constellation of behaviors or rituals that express an internal belief in the transcendent or mystical. By ‘mysticism,’ it refers to a singular idea which is sufficiently captured by Blackburn (1996) in ‘The Oxford Dictionary of Philosophy’: “Belief in union with the divine nature by means of ecstatic contemplation and in the power of spiritual access to domains of knowledge closed off to ordinary thought” (p.253). The first aspect of this definition denotes the goal of the mystic – union with the divine and access to divine knowledge – and the second points to the means by which this is to be achieved, that is, by way of a ‘spiritual’ mode of cognition, which is taken to refer to a state of consciousness purportedly beyond that which is identifiable by material science. The above definition of ‘religion’ therefore encompasses ‘mysticism.’ For clarity, throughout this study, ‘atheism’ is defined as the absence of belief in the supernatural, ‘agnosticism’ is defined as ‘not-knowing’ whether one believes in the supernatural or not, and ‘theism’ is defined as belief in the supernatural. It is understood that these ‘positions’ occupy a continuum rather than distinctive categories.

A key area of concern in this research is an exploration into whether differences in ‘religious orientation’ between psychoanalytic psychotherapists and their patients influence the nature of the therapist’s countertransference. For the limited purposes of this study, ‘religious orientation’ refers to the therapist’s or patient’s set of metaphysical beliefs, that is, whether they consider themselves to be atheistic (lacking belief in the supernatural), agnostic (uncertain as to whether or not they believe in the supernatural) or theistic (belief in the supernatural) (Blackburn, 1996). Thus, religious orientation does not refer to affiliation to a particular ‘religious tradition,’ namely, Judaism, Islam or

Christianity etc, although it does not necessarily exclude these, and the interview schedule (Appendix A) does not exclude the participants from exploring how affiliation to their own religious traditions may influence their countertransference reactions to their religious patients of similar or dissimilar religious traditions. It should also be noted that the term 'religio-mystical' denotes ideas germane to both religion and mysticism, as they are defined here.

2.1. Freud

In "Obsessive Actions and Religious Practices" (1907/1966), Freud discerns certain resemblances between the rituals of an individual suffering from an obsessive neurosis and the ceremonials carried out by a religious person. These include: the fastidious attention to detail, the tendency towards increasing esoteric implications and complexity of the acts, the pangs of guilt when the ritual is neglected and the defensive safeguarding of the ritual from being interrupted. Freud argues that since the resemblance is uncanny, obsessive neuroses are analogous to a private religion, and religion is a public form of obsessive neurosis. Indeed, he wanted to identify the two as variations of a single pathology: "In view of these similarities and analogies one might venture to regard obsessional neurosis as a counterpart of the formation of religion, and to describe that neurosis as an individual religiosity and religion as a universal neurosis" (p.680). Similarly, "An obsessional neurosis presents a travesty, half comic, half tragic, of a private religion" (p.681). Freud offers an intriguing case example of this kind of degenerative functioning in "The Wolf Man" (1918/1953), whereby his patient's sado-masochism, nightmares, anxiety and irritability were abated by the performance of religious rituals. If 'The Wolf Man' kissed all the holy pictures in his room, traced the sign of the cross a given amount of times while in bed and repeated specific prayers, his nightmares and anxiety would disappear. By trading his anxiety for obsessions, Freud (1918/1953) remarks that, as a child, 'The Wolf Man' became "social, well-behaved and amenable to education" (p.46).

Contemporary analysts (Kernberg, 2000; Spero, 2009b) acknowledge that religious practices have the potential to function in this way and that some of their religious patients would become dysfunctional without their rituals. That this, however, is not a rule as Freud would have it, is demonstrated by patients whose religious rituals are integrated and non-defensive (Spero, 2009a). Healthy religious individuals illustrate a key point: religious practices only begin to resemble obsessive actions when the religious individual is already neurotic. It is not religious practices that inevitably *make* him/her neurotic, though they may exacerbate an existing neurosis. For an obsessive neurotic, religious ceremonies may provide the ideal set of rituals through which to sublimate anxiety (Meissner, 1984). Freud, therefore, leveled his critique at a ‘straw man.’

Furthermore, in “Totem and Taboo” (1913/1946), Freud employs anthropological and evolutionary theories to arrive at an account of the origins of religious belief. These ideas were then expanded on in his final essay, “Moses and Monotheism” (1937/1951). “Totem and Taboo” (1913/1946) argues that during primeval times, our early ancestors lived in small bands dominated by a single, fearful male. At one point, the brothers of the horde united, murdered and ate the patriarchal tyrant. As a consequence of the guilt and remorse provoked by this crime of ‘parricide,’ an animal or ‘totem’ was worshipped as a symbol of the slain primal father. The crime was then commemorated by the ritual eating of the totem. The worshipping and subsequent devouring of the totem symbolized the ambivalence felt towards the primal father. At once hated and loved, the totem acted as the original father substitute or surrogate, a symbol of the longing for the original father.

Freud (1913/1946) argues that later, Gods were created to serve the same function as the totem, namely, to act as father ‘surrogates.’ Implicit in Freud’s (1913/1946) account is thus the first reference to the idea of God as an object relation, a ‘Father,’ the representation of which is formed during the Oedipal phase (Freud, 1924). Every member of the human species, he claims, carries this repressed, phylogenetic inheritance or “memory trace” of the exalted primal father within them. One’s personal relationship with God “depends on his relation to his father in the flesh.” (p.22). He goes on to assert that:

Psychoanalysis has made us familiar with the intimate connexion between the father complex and belief in God; it has shown us that a personal God is, psychologically, nothing other than an exalted father....the roots of the need for religion are in the parental complex...[the Gods] are...revivals and restorations of the young child's ideas of [father and mother] (p.22).

Thus, Freud (1913/1946) implies that object representations may be genetically inherited and that these phylogenetic memories may remain latent without manifesting themselves to the individual. Certain significant external events, however, may reactivate the repressed object representation. The central thesis of "Moses and Monotheism" (1937/1951) is that historically, it was precisely during Moses' time in the desert with the Jews that this reactivation occurred: "When Moses brought the people the idea of a single God, it was not a novelty but signified the revival of an experience in the primeval ages of the human family which had long vanished from man's conscious memory" (p.31). The "return of the repressed" object representation that was so deeply missed and longed for, according to Freud, was initially met with gratitude, awe and submission to the divine will as prophesied through Moses. Moses was the catalyst for bringing this evolutionary imprinted memory to the consciousness of the human race, and monotheistic religion begins by way of regression to an earlier object representation and the associated feelings of longing and remorse.

Freud (1913/1946) thus extrapolates from an evolutionary account of early man's collective object relations, to modern man's individual relationship with his parents during the Oedipal phase. A common critique is that the theory of the primal horde is speculative at best, and that the move from an assumption about the early family life of our ancestors to the family life of modern people is tenuous (Spinks, 1983). However, implicit within this account are the first adumbrations of how object relations and object representations may influence one's conception of God. This is the essential premise of the 'Object Relations' approaches to religion, and there is an abundance of evidence to substantiate Freud's (1913/1946) initial theory that one's image of God is profoundly influenced by one's early image of their parents (Rizzuto, 1979, Hall, Brokaw, Edwards

and Pike, 1998; Sahlein, 2002; Hall, 2007a,2007b, Hewitt, 2008). Some of these studies will be discussed further in section 3.1 of this literature review.

Turning away from evolutionary, anthropological, historical and object relational arguments for the genesis of religious belief, Freud advances an ‘existential’ critique of religion in “The Future of an Illusion” (1927/1949), which is often considered to be his intellectual masterpiece on the subject (Meissner, 1984). In this essay, Freud (1927/1949) accounts for the strength and pervasiveness of religious belief by alluding to humankind’s deepest fear – the fear of death. The possibility of the supernatural offers respite from the doom of mortality. Belief in God, the after life and other supernatural ideas, are, according to Freud (1927/1949), examples of wish-thinking: we believe in such things because they comfort us by gratifying our deepest wishes. Here, Freud draws on his initial (1900/1999) account of the function of fantasy, namely, to provide partial gratification to a wish. The idea of an after-life is comforting because it satisfies two crucial needs, namely, immortality and accountability. The first gives us a reason to no longer fear the non-existence of the self at death and the second offers believers the possibility of justice - ultimately, good people will be rewarded and bad people will be punished. For most, nothing is more frightening than the prospect that a Hitler or a Pol Pot will not have to account for their crimes against humanity and that they are resting blissfully in a state of non-being. And few things are more comforting to a parent who has lost a child than the conviction that their child is ‘in a better place’ and that they will one day be united again. Hence, Freud (1927/1949) described these kinds of beliefs as “fulfillments of the oldest, strongest and most insistent wishes of mankind” (p.52).

For Freud (1927/1949), the power of these beliefs is undeniable, for they give purpose and meaning to the apparent injustices of this world. They offer reconciliation and the guarantee that the madness of reality will one day make sense. They epitomize the commonplace sentiment that ‘there is a reason for everything.’ Yet Freud (1927/1949) proposes that these are merely defensive fantasies or ‘illusions’ which are constructed in order to provide an escape from an intolerable reality. Freud (1927/1949) speculated that the evolution of human consciousness would guarantee that mankind would out-grow this

infantile, regressive need to retreat into defensive fantasies about the nature of reality and embrace a psychologically mature, sophisticated world view grounded in reason and scientific evidence.

Freud (1927/1949) observes, further, that the cost of the renunciation of religious belief may be severe: “the true believer is in a high degree protected against the danger of certain neurotic afflictions. By accepting the universal neurosis he is spared the task of forming a personal neurosis” (p.77). He suggests that the protective power of these beliefs is such that many would decompensate psychologically without them. Here, Freud (1927/1949) revisits the analogy between public religion and private neurosis as discerned in “Obsessive Actions and Religious Practices” (1907/1966) and later echoes this idea in a key passage in “Civilization and Its Discontents” (1929/1949). He notes that one may respond to an intolerable reality by withdrawing from it and protecting oneself from it. However, “...one can do more than that,” (p.30) namely, detach from it completely. If a sufficient number of people begin performing the same actions and professing the same beliefs as a means towards this escape or detachment, the behavior becomes normative, and we get organized religion:

...one can try to recreate the world, to build up in its stead another world in which its most unbearable features are eliminated and replaced by others that are in conformity with one's own wishes...each one of us...corrects some aspect of the world which is unbearable to him by the construction of a wish and introduces this delusion into reality...a special importance attaches to the case in which this attempt...is made by a considerable number of people in common. The religions of mankind must be classed among the mass-delusion of this kind. (p.68)

Thus we arrive at Freud's (1929/1949) conception of religion as a culturally acceptable form of delusion.

Yet Freud's theory of religion as defensive wish fulfillment is vulnerable to the following objection: he offers no account for non-belief other than to elevate it to the status of 'adult,' progressive and rational thinking. Yet the very same charge of wish-fulfillment can be leveled at atheism. It is conceivable that the belief in non-existence after death

may similarly protect the individual who is afraid to have to account for his life's actions. With no God to answer to, such an individual escapes divine justice. The wish to go to heaven has its counterpart in the wish to avoid going to hell. Both belief and non-belief in the supernatural can therefore be exploited as defense mechanisms. But that these beliefs serve this function by definition is rendered false by the existence of both believers and non-believers who employ their beliefs in an 'adaptive' way (Spero, 1995, 2009a) – an idea that will be expanded on in section 3.1 of this review.

Nonetheless, it is apparent that Freud's work on religious belief cautions us to be aware of a crucial distinction regarding the psychology of belief more broadly, namely, the difference between believing in something because, via a process of open, honest and rational scrutiny, it appears to us to be true, and believing in something because it makes us 'feel better.' It seems we must be careful, moreover, not to misread Freud and conclude that for him, the consoling power of religion necessarily invalidates its truth value – he said unequivocally that “the fact that [the acceptance of] a theory is psychologically determined does not in the least invalidate its scientific truth”(Freud, 1913/1953, p. 179). That something makes us feel better does not make it true, but that something is painful does not, conversely, make it false. How we personally feel about an idea has no affiliation with the idea's objective truth. To ignore this is to slip into solipsism. His work is thus an important contribution to the psychology of belief.

Evidently, Freud aimed to facilitate an irreconcilable antagonism between psychoanalytic and religious world views. Yet his approach, in spite of his personal atheism, was never reactionary or abrasive. His essays demonstrate a nuanced and carefully argued critique, irrespective of whether or not we accept his conclusions. His views on religion as obsessional neurosis, projection of the Father and as wish-fulfilling illusion offer a useful starting point. However, his iconoclasm allowed no room for the possibility that religion may function in ways other than in these caricatured forms, which renders his theory liable to the charges of reductionism and pathologism. These critiques are expanded on through exposition of Jung's (1938) views and by contemporary Object Relations

approaches. As we shall see, the latter approach is indebted to Freud's implicit object relational ideas as originally posited in "Totem and Taboo" (1913/1946).

2.2 Jung

Jung's view is contrary to but as extreme as Freud's - madness is a sign of an *absence* of religion in our lives (Zinnbauer and Pargament, 2000; Berman, 2006). Mankind, for Jung, is essentially religious, which is proven anthropologically by the fact that almost every culture is furnished with its own set of Gods or a God. The reason, according to Jung's theory, is that the idea of God is a perennial archetype in the collective unconscious – that phylogenetically inherited repository of human experience accumulated by our ancestors over millions of years, transcending differences of culture and individual character (Jung, 1938). It is modern man, for Jung, who has become overly urbanized and aberrant in his relinquishment of the Gods. The psychological consequences of this renunciation take the form of various disorders and existential crises. Jung (1953) intimates that it is "only suprahuman, revealed truth" (p.24) that elevates man out of his despair.

Jung (1938) distinguished between 'formal religion' and 'religious experience.' He refers pejoratively to the former as "codified," "dogmatized," "congealed" and "rigid" versions of original mystical experience (p.6). As examined, Freud attacked both: organized religion is culturally valorized mass psychosis and mystical experiences, which Freud (1927/1949) called "oceanic" (p.11), are regressions to primary infantile narcissism. While Jung (1938) acknowledged that organized religion has the potential to function as Freud believed, evident by his claim that "There are any amount of creeds and ceremonies that exist for the sole purpose of forming a defense against...the unconscious" (p.21), he argues for the possibility of genuine transcendental or 'higher' states of consciousness. These "other peculiar conditions of consciousness" (p.45) are, for Jung, the epitome of psychological health. Where the Freudian (1915/1953) psyche is said, metaphorically, to have 'depth,' we might conceive of the Jungian psyche as the corollary by attributing to it the property of 'height.'

However, both Jung and Freud believed that their approaches to religion were ‘scientific.’ Greenwood and Loewenthal (2005), however, allude to the distinction between ‘what can be experienced’ and ‘what exists’ with regards to Freud’s (1985/1953) ‘case study’ method, rendering problematic the epistemological positioning by Freud of his case studies within the domain of ‘science.’ Similarly, Jung (1938) asserted in various places that his method was ‘empirical,’ since he relied on the incorrigible truth of his own and his patients’ subjective experiences of the supernatural. This, essentially, is the foundation of mysticism, which holds that its truths are independent of philosophical analysis or reasoning, for they are based on the phenomenal experience of the individual (Blackburn, 1996). If one has ‘experienced’ the supernatural, that is, come to know it phenomenologically, one is exempt from arguing for its reality – its existence is as indubitable as other objects of sense perception. Jung (1938) uses the phrase “psychic truth” (p.38) to denote the infallibility of our subjective experiences.

However, while the mystical experiences that Jung refers to are in fact private and subjective in the sense that dreams and fantasies are, (and therefore lack the ‘objectivity’ he wished confer upon them) psychotherapists employ a key tenet of Jung’s when working with religious patients, namely, that the religious experiences they describe are real *for them*. Spero’s (1981a, 1981b, 1985,1995, 2009a;2009b;2009c) clinical work illustrates that in order to work with a religious individual who claims to have perceived supernatural phenomena, the analyst must acknowledge the reality of the experience for the individual. His work suggests that there can be no healthy therapeutic alliance without this kind of empathy for the patient’s experiences. Moreover, he argues that, excluding obvious cases of hallucination, one cannot work with a religious patient without allowing for the possibility that what he/she has experienced is objectively real, in addition to merely being ‘true for them.’ Jung’s (1953) claim that “in physics we can do without a God-image, but in psychology it is a definite fact that has got to be reckoned with, just as we reckon with ‘affect, instinct, mother etc’” (p.48) speaks to this point. However, the God-*image* as an ineradicable element of the human psyche is a different concept to the idea of God Him/Herself, for the God-image refers to God as He/She is experienced in our minds. Indeed, as will be illustrated with reference to the Object Relations school, no

therapist working with religious patients can neglect its significance. While the move from the psychic reality of the God-image to the objective reality of God is fallacious, and it is a move against which Jung (1938) warned, what we take from Jung is a sensitivity to the power of the God-image in the mind of the believer. This study will also therefore explore how this kind of empathy influences the nature of the therapist's countertransference reactions.

In short, the ramification of adopting either Freud's or Jung's opposing but equally extreme views on religion is that both theists and atheists, while they may be fully functioning people, are delusional. As Berman (2006) puts it, if we accept either of them, we will "have a great deal more madness on our hands" (p.362) For if Freud the reductionist is right, then individuals who even mildly believe and practice religion will be at least neurotic, whereas the devout will probably be psychotic. However, if Jung the elevationist is right, then it is the indifferent or non-believers who are ill to some extent, for they deny their perennial God archetype. For Freud, religion makes us sick. For Jung, we are sick without it. In fact, as Barteimer (1965) observes, Jung went as far as to claim that he had never had a patient whose neurosis was not due to his lack of religion, nor had a patient whose cure was not due to a return to religion. Wilbur (1995) deftly notes the problem with both these positions: Freud's mistake was that all sincere feelings of the numinous, the mystical or at-one-ness are primitive and autistic by definition - mere throwbacks to infantile states of narcissism and oceanic a-dualism. Jung's error was to confer transcendental significance to genuinely dissociated, pathological states. "Anything nonrational," cautions Wilbur (1995), "gets swept up and indiscriminately glorified as a direct route to the Divine" (p.82). A more nuanced account in the form of Object Relations perspectives on religion is offered, which claims that it is not belief or non-belief that determines one's well-being. Health or sickness, on the other hand, is something the individual brings *to* religion.

2.3. Contemporary Views: Object Relations Approaches

Winnicott's (1971a; 1971b) notions of 'illusion' and 'transitional experience' have been applied to the area of religion by contemporary psychoanalytic thinkers such as Meissner (1984; 2009), Rizzuto (1979; 2009) and Spero (1981a; 1981b; 1985; 1995; 2009a; 2009b; 2009c) The Winnicottian approach to the psychoanalytic study of religion challenges the Freudian view in two key respects: it redefines the concept of 'illusion' in a healthy, non-pathological way and it advocates the essential role of the mother in the formation of religious beliefs (Winnicott, 1971a; 1971b; Rizzuto; 1979; 2009; Spero 1981a; 1981b; 1985; 1995; 2009a; 2009b; 2009c).

If the critique of both Freud and Jung's theories on the supernatural has been one of reductionism and elevationism respectively, the application of Winnicottian ideas evades these charges by an approach that reconciles the materialism of Freud and the transcendentalism of Jung. Central to this resolution is the idea of 'transitional experience,' which Winnicott (1971a) defines as experiences which are neither objective nor subjective, but situated 'between' the two. This elusive experiential space is explained with reference to certain objects to which infants typically become attached, such as blankets and teddy bears. These objects, Winnicott (1971a) explains, act as substitutes for the mother's comfort, and represent the beginnings of a process of separation from the maternal matrix. They are a placating means of protecting the infant against the anxiety associated with separation.

Among other characteristics of these objects, Winnicott (1971a) notes that "[they come] from without from our point of view, but not so from the point of view of the baby. Neither does it come from within; it is not a hallucination."(p.166). Winnicott thus identifies a liminal space between the reality of external objects and the inner world of fantasy, which he calls "illusion,"(p.167) He elucidates this as follows: a responsive, 'good enough' mother provides comfort at the appropriate moments of discomfort. Since the mother's breast appears when the infant desires it, the infant believes that it has created the breast. The mother's responsiveness facilitates the illusion in the child that it

has magical control over a world of objects. This “primary illusion” (p.167) is essential for the child’s enjoyment and love of reality. As the child learns to tolerate frustration, the mother’s task is to gradually ‘disillusion’ the child, aiding in the transition from the pleasure principle to the reality principle. Transitional objects, therefore, are vehicles of continuity between these two principles.

Winnicott argues that this dialectic between illusion and reality dramatizes itself throughout our lives, for we never fully complete the task of accepting reality, and that the tension between our fantasies and objective reality is tempered in areas of life where our fantasies need not be challenged, such as in the arts and in religion (Jones, 1991). Yet, as Winnicott (1971a) observes, we consider someone mad if they expect others to accept their own subjective phenomena objectively. On the other hand, if we can enjoy our subjective phenomena without this expectation, then our illusions are healthy, and we may even notice similarities between our own and other’s illusions. Such are the rudiments of organized religion. This contrasting picture to Freud’s (1927/1949) gives illusion an adaptive and necessary place in reality. Our illusions are the means by which we creatively manage our subjectivity while at the same time living in the world with other objects.

This creative capacity is initially established in the nature of the child’s playing with his transitional objects: organized, shared playing demonstrates the ability to integrate one’s illusions into a world occupied by other objects, in turn characterized by their own subjectivity. Illusion, therefore, in so far as it helps the child to ground itself in reality, is a developmental achievement. Where psychic health for Freud (1900/1999) depended on a bifurcation between fantasy and reality, Winnicott (1971a, 1971b) fosters a subtle exchange between the two, whereby we creatively adapt to the harshness of reality by our illusions, while accepting that others do the same with their illusions. This ‘playing’ with reality is inevitable – we project, distort and transfer our subjectivity onto the world around us. Winnicott (1971a) acknowledges, however, that should these processes be exploited for absolute escape, pathology ensues.

2.3.1 Religion as Transitional

Rizzuto (1979,2009) and Meissner (1984,2009) apply Winnicott's (1971a,1971b) views to religion by suggesting that religious beliefs, rituals and ideas of God function like transitional experiences. To illustrate, Meissner (1984) analyses the experience of faith. Religious faith, he explains, is not a purely subjective phenomenon, for it consists largely of shared views concerning the nature of reality, the existence of a creator and one's relationship to the creator. However, faith alone cannot empirically demonstrate the existence of the supernatural and so lacks objectivity. Faith is thus a coalescence of the subjective and the objective. This 'third,' transitional experiential space is also evident in relation to communities of faith. Despite that communities offer the individual an objective set of religious tenets, one inevitably fashions his own, private beliefs, using the culturally given system as a guide. The believer therefore situates himself between the objectivity of the public religious environment and the privacy of his psychic experiences within the environment. The faithful move along the continuum between submission and devotion to culture, and alienation through privacy and rebellion. The experience of faith is therefore an amalgam of what is received and what is created.

It is in this sense that God is both given and made. Rizzuto's (1979) series of clinical studies of God representations in five adults illustrates that in spite of scriptural definitions telling the believer what God is like, we all have a personal God, whose image is primarily fashioned by our relationships with our earliest objects, and which has to contend with the God of the scriptures. There is no God concept independent of the way we relate to other objects. Freud's (1915/1953) early observations were the foundation of such object relational approaches:

The individuals emotional attitudes to other people...are already established at an unexpectedly early age...[they] have already been laid down in the first six years of his life...The people to whom he is in this way fixed are his parents and his brothers and his sisters...All of his later choices of friendship and love follow upon the basis of the memory traces left behind by these first prototypes (p. 207).

The reasons why one experiences God as loving, punitive, jealous, wrathful, sadistic, indifferent, callous, giving or withholding are explicable by thorough psychoanalytic investigation into one's early life. How an individual prays to God, that is, whether the temperament of prayer is primarily fearful, grateful or one of passive dependence is a mirror into the nature of the individual's object relations, elucidating the nature of our transferences and projections onto God. Atheism, furthermore, also constitutes a God-concept and is subject to similar analysis (Rizzuto, 1979). To wit, Nietzsche said 'God is dead,' Freud, 'God is Dad' and Winnicott implied that 'God is Mom.' Object Relations approaches have established a vast catalogue of empirical and qualitative data to show that there is an indisputable association between one's God representation and one's object relationships (Kirkpatrick and Shaver, 1990; Hall et al, 1998; Sahlein, 2002; Hall, 2007a,2007b; Hewitt, 2008). Moreover, our God representations may reflect our self-representations in that our view of God is also our latent view of ourselves and the world (Hall, 2007a). We project onto and re-introject aspects of ourselves via God. He is in our image and we are in His.

A further key area of religion explicable as a transitional phenomenon is what anthropologists refer to as 'material culture,' namely, the sacred objects, such as the crucifix, the 'Star of David,' the 'Menorah' and blessed foods employed during religious rituals (Meissner, 1984). For the believer, these material objects are invested with powerful subjective meaning, which renders them symbolic. Since the cross is neither perceived in 'objective' terms as two opposing pieces of wood, nor merely created by subjective interpretation, it and other devotional objects occupy a transitional space. As transitional objects, they act as tangible reminders of the practitioner's beliefs. We may think of these reminders as 'God substitutes,' analogous to the way in which the child's blanket and teddy bear act as 'mother substitutes.' However, Meissner (1984) cautions that the employment of transitional substitutes can degenerate into totalitarian idolatry by a fetishistic over indulgence in the object's power. Use of religious objects can regress into infantile dependency, whereby objects and rituals, believed to have magical omnipotence, become a site for obsession, corrupting sincere faith into bigoted ideology. The departure from Freud (1907/1966) is particularly apparent in this regard, for whom

this kind of idolatry constitutes normative religious practice - all religious objects function in this talismanic way and so are regressive by definition.

Despite the apparent antipathy between Freud's (1927/1949) and Winnicott's (1971a,1971b) conceptions of 'illusion,' the difference between them, upon closer scrutiny, is trivial rather than fundamental. Freud, as a profound scholar of literature, was not one to depreciate the importance of fiction and art in the growth of the human mind. He simply alerts us to the non-controversial claim that subjective fantasy falls within a different ontological category to empirical science. There is no suggestion from Winnicott's (1971a,1971b) theory that Winnicott believed in the existence of a third metaphysical category defined as a coalescence of the objective and the subjective. The emphasis, rather, is on how we experience certain objects of significance in our environment, and that the experience of these things is *something like* a fusion of fantasy and reality. This, however, denotes a state of consciousness, a phenomenal experience of reality, not an actual space in reality on the border between the real and the imaginary, and therefore, references to "blends" between the objective and subjective are metaphorical at best. Freud's emphasis on the bifurcation between fantasy and reality seems useful, and our psychological health still depends on this distinction (APA, 2000). Winnicott seemed right, however, in stressing the necessity of fantasy in fostering a love for and adaptation to reality. But this in no way suggests that the realm of illusion should be taken more 'objectively.' The above views emphasize how we accept that fantasy and illusion are subjective, while at the same time appreciating how 'real' our own subjectivity seems to us.

2.3.2 'Adaptive' And 'Maladaptive' Religiosity: Some Existential Psychoanalytic Perspectives

Although Freud (1927/1949) asserted that religious belief is delusional and therefore unhealthy by definition, he clearly acknowledged that it is possible for sophisticated and highly functional people to be religious (1929/1949). This, primarily, is owing to one of religion's essential psychological functions: via its capacity to channel sexual and

aggressive instincts into culturally valorized forms, religion, along with art and academia, is a key sublimatory vessel (Freud, 1918 in Sahlein, 2002). To the extent that some do this more than others, there is, even for Freud, some distinction to be made between healthy and pathological religion. While a Winnicottian approach would naturally agree with this, it would tend to emphasize, to a greater extent than both Freud and Jung, that health or sickness is something one brings to religion, rather than the other way around. Habermas (2006 in Hewitt, 2008) notes that healthy religiosity is self-reflexive: it can be self-critical and through a pluralist, inclusive attitude, acknowledge the relativity of its doctrines in a world saturated by other traditions. For a religious individual to be able to assert with sincerity that their tradition's views on the nature of reality may be wrong is thus a mark of mature religiosity. A healthy atheism or agnosticism would necessitate the same capacity. In this sense, Klein's (1935/1986) concept of depressive functioning, characterized by a complex, integrated perception of reality, or 'whole object relating,' which includes tolerance for ambiguity and otherness, is applicable to Habermas's (2006 in Hewitt, 2008) notion of a pluralist, inclusive attitude towards other belief systems.

Alternatively, for Spero (in Cohen, 2008) unhealthy religiosity is characterized by the replacement of free will for compulsion, exactitude by obsession and intolerable guilt, irrevocable loss and a sense of failure and fear following an inability to adequately execute rituals. Joseph (1987), similarly, identifies the process of regression from healthy to unhealthy forms of religious ritual by noting that rituals which begin to appear mechanical and repetitious, and whose primary function is to ward off anxiety, deteriorate into symptoms.

Identifying pathological religion can be obvious enough when it takes the form of demonic possession, obsessive preoccupation with one's sinfulness, ecstasy or frenzy, spiritual depression, speaking in tongues in contexts where this practice is not valued, abrupt conversion, self-flagellation or masochism and violence against others in the name of religion (Frame, 2003). Conversely, a vast data-base of empirical evidence supports the theory that religious beliefs and practices can have profound psychological benefits (Gartner, Larson and Allen, 1991; Williams, Larson, Buckler and Heckmann, 1991;

Oxman, Freeman and Manheimer, 1995; George, Larson, Koenig and McCullough, 2000; Miller and Thoresen, 2003; Hill and Pargament, 2008). A key advocate of this view was the Existential Psychoanalyst Viktor Frankl (1975), who argued that the *sine qua non* of well-being is to feel as if one's existence is 'meaningful,' and religion provides 'meaning.' (Frankl, 1975) Frankl (1975) believes that we are ultimately driven towards finding meaning in our lives, and that 'meaning' is different to happiness, joy or love – these things may be the consequences of meaning, and should not be striven for in themselves. Only the pursuit of meaning – in the form of art, relationships, nature, a higher cause, as ends themselves - will allow us these positive feeling states. Yet it is within each human being's potential to make individual meanings out of objective circumstances. There is an irreducible human essence within every life situation that cannot be wholly explained by the nature of the situation itself. These meanings, Frankl (1975) holds, transcend the circumstances out of which they are made.

The ultimate meaning, however, is God, for God represents ultimate transcendence – a being beyond the world but which infuses it with meaning. The meaninglessness characteristic of our age, which Frankl (1975) calls the "existential vacuum" or "mass neurosis" (p.78) is a consequence of our self-centered interest in pursuing pleasure for ourselves rather than searching for meaning, which necessarily includes consideration for the pleasure of others. This forlorn condition is characterized by a "mass neurotic triad" (p.79) of depression, aggression and addiction. These are symptomatic of a lack of meaning in our lives, rather than aggressive internal drives. Religion, as the ultimate source of meaning, is capable of redeeming us from this "existential vacuum" since it represents a trust in the ultimate meaning of an apparently meaningless world. Frankl (1975) was fond, however, of quoting French philosopher Gabriel Marcel: "when we speak of God, it is not of God that we speak." (p.80), emphasizing that finite beings do not have the capacity to understand the infinite, and that ultimately we find meaning in life through our faith in something that transcends all of life. We may speak *to* this being, but not *of* it, who in our age is not 'dead,' but is silent and hidden. Importantly, Frankl (1975) does not agree with Jung that the transcendent forms the very basic structure of the psyche itself. Rather, God is wholly other and different to both the mental and the

material. Frankl (1975) believed that love for art, people and nature were repressed expressions of a love for the transcendent, and a search for God or ultimate meaning. A task, therefore, of existential psychoanalytic psychotherapy is to bring this repressed religiousness back into consciousness (Frankl, 1975).

Some of the aforementioned literature, therefore, is unambiguous in showing that religion may be exploited as a neurosis or integrated in an adaptive way, and that the difference depends, among other things, on the individual's psychological well being. Belzen (2010) elaborates by observing that religion is synonymous with life and how we live it. This would appear to be common-sense, since religion is typically considered to be a 'way of life.' Yet it is our subjective experience of religion which elucidates our individual psychology. If, for example, as Existential Psychoanalyst Erich Fromm (1950) intimates, we project the best of ourselves onto God, we impoverish ourselves. This reflects a masochistic, submissive way of relating that would be evident in our relationships with other people. Through depleting the self by conferring all that is good in us onto God, we necessarily feel like sinners and beg God, by his mercy or grace, to return to us what was originally ours. This self-humiliation disguised as humility constitutes what Fromm (1950) calls 'authoritarian religion' and is the basis for all forms of religious related pathology. Conversely, healthy religion for Fromm is premised on the capacity to love oneself and others. Yet this is psychoanalysis' general definition of healthy functioning, religious or secular. The purpose of psychoanalysis, for both Fromm and Freud, is to restore the patient's ability to love. To say, therefore, as Belzen (2010) does, that religion involves 'wish fulfillment,' 'fantasy,' 'projection,' 'repression' and other defense strategies, is not to say much at all, for it involves these things in so far as everyday life does. However, to suggest, as did Freud, that religion is *merely* these things, is to make a different claim.

2.4. Working With Religious Patients Within a Psychoanalytic Context: Countertransference and Other Considerations.

Some seminal psychoanalytic approaches to religion have been elucidated. The contrasting perspectives of Freud, Jung and Winnicott illustrate the dissention amongst psychoanalytic theorists around questions of faith. Inevitably, psychoanalytically oriented therapists' religious views will be influenced by a combination of their familial tradition, early object relations, personal philosophical thinking and greater or lesser degrees of the views of seminal thinkers in the field, some of whom have been alluded to above. The therapist is often challenged with reconciling potentially incompatible personal religious views with his/her psychoanalytic understanding of the mind. The result may yield a variety of religious 'positions' for the psychoanalytically oriented therapist, from theistic, to agnostic, to atheistic, with all the variations between. The above discussion of Freud, Jung, Winnicott and others demonstrates that any of these religious orientations can be made compatible with psychoanalytic theory. Yet these differences, along with innumerable other influences, some of which will be discussed, contribute to the nature of therapists' countertransference reactions to their religious patients.

2.4.1 Countertransference

That therapist self awareness is crucial to effective therapy is an incontrovertible principle of psychoanalytically informed therapy (Sahlein, 2002). The traditional model of the stone-neutral, objectively detached psychoanalytic therapist, bereft of "memory or desire" (Bion, 1967/1993, p.144), is defunct. Today, psychoanalytically informed therapists are trained to be aware of and utilize their emotional responses to their patients in productive ways. Drawing on Freud's (1910 in Spero, 1985) early definition of transference, countertransference may be defined as the re-emergence of infantile prototypes of interpersonal experience, displaced onto the patient, and experienced with a strong feeling of immediacy. Contrary to the initial view of countertransference as an interruption of the analysis, Heinman (1950, 1960) argued that a specific emotional response to a specific patient tells the analyst something important about the patient.

Ogden (1979) usefully summarizes the various definitions of countertransference within psychoanalytic psychotherapy. First, it may refer to the set of feelings the patient evokes within the therapist, which reflect the therapist's own neuroses. In this sense, it interferes with the therapist's ability to respond therapeutically to the patient. Second, it may be viewed as the therapist's 'total' response to the patient. This usage implies that the therapist's countertransference is a reflection of both the therapist's and the patient's pathologies. This second usage also refers to Ogden's (1994) later concept of the 'analytic third.' Ogden (1994) explains how, in addition to the subjectivity or transference of the patient, as well as the subjectivity or countertransference of the therapist, there is a 'third,' 'intersubjective' space, characterized by the coalescence of the patient's and therapist's intrapsychic world, ambiguously situated 'between' the transference and countertransference. Thus, Ogden (1994) suggests that within the analytic setting, the patient's subjectivity manifests in relation to the therapist's subjectivity, and the therapist's subjectivity manifests in relation to the patient's. In a sense, 'there is no such thing as the patient independent of the therapist' and vice versa, much like Winnicott's (1960) idea that 'there is no such thing as an infant independent of its mother' and vice-versa. While the interaction between three subjectivities, namely, the therapist's, the patient's and the 'analytic third,' is thus dramatized within the therapeutic space, the therapist's *experience* of the analytic third may be used to cultivate insight into the patient's transference (Ogden, 1994). Third, countertransference may refer to the therapist's empathic response to the patient's transference, which Winnicott (1949 in Ogden, 1979) called the 'objective counter-transference.' Here, the therapist openly receives the patient's projective identifications and allows himself, to an extent, to take on the role of an earlier object in the patient's life. This gives the therapist insight into the nature of the patient's object relations, and offers the patient a different way of responding from within this object relationship. The therapist, however, can become fully immersed in the role of the patient's earlier (or current) object, and become unconsciously compelled to feel the patient's feelings, or to 'be what the patient wants the therapist to be.' The therapeutic use of the patient's transference thus requires a balanced approach – therapists should strive to be situated between collusion and

absolute psychological distance. The ideal approach is to be openly receptive to the patient's transference without being overwhelmed by it (Ogden, 1979).

Spero (1985) notes that behavior patterns, feelings, fantasies, types and qualities of object relations and complete identifications may be transferred to the therapist. A powerful therapeutic tool, countertransference, along with transference, brings the past into the corrective influence of the present. They have, as Spero (1985) puts it, "a history" (p.11). The nature of these responses can be especially complex when working with religious patients, since, as noted in the introduction, our personal religious beliefs are often what we get most defensive about. The above account explains why this is so: our personal God-representations are so inextricably tied into our early object relations that our religious outlook on the world, when subjected to the scrutiny of analysis, is often indistinguishable from our deepest, unconscious feelings towards our primary caregivers and ourselves. Working with the devout thus has the potential to elicit powerful emotional responses in the therapist, compelled by the therapist's inevitable confrontation with his/her own latent feelings towards their early objects, via their personal God image.

A context characterized by therapy and religious material has the potential to foreground, at best, impasses between patient and therapist world views, notwithstanding tensions between the therapist's psychoanalytic and religious principles, and at worst, destructive therapist projections as a consequence of the therapist's own unresolved, unconscious conflicts around their personal religiosity. Sahlein (2002), Bartoli (2003), Cohen (2009), Charles (2009), Spero (1981a,1981b,1985,1995,2009a,2009,b,2009c), Fauteux (2009), Meissner (2009), Peteet (1981,2009) and Rizzuto (2009), through their intimate experience, document and analyze all manner of emotional responses to their religious patients. These include, among other feelings: envy for the peace and security that their patients' faith gives them; frustration at their patient's evasion of responsibility by the attribution of all success and well being to God; narcissistic injury at the patient's attribution of their psychological growth to their God rather than to therapy; anger at what might appear to be a morally aberrant deed or idea to the therapist, but which the patient swears by because it is consecrated in their holy book; and utter confusion in the

face of religious material that leaves the therapist confounded as to whether their patient is mad or enlightened.

Bergin (1980 in Lijtmaer, 2009), further, refers to trends of countertransference reactions that may occur with religious and non-religious therapists respectively. For instance, therapists who share their patients' religious beliefs are at risk of over-identifying with their patient's views which may potentially hinder them from gaining deeper understanding of their patients. Many religious patients also seek a co-religionist for psychotherapy, and religious therapists may find their patients' idealizations of them narcissistically gratifying. On the other hand, secular therapists are vulnerable to judging their religious patients as irrational, as well being liable to intense rescue fantasies wherein the therapist feels like they should 'free' the patient from their 'archaic' and 'fantastical' spiritual thinking (Cohen, 2008). Secular therapists may experience envy for the security, community closeness and peace of mind that their patients' religion may bring them. Such envy can be defended against by devaluation, avoidance and idealization (Spero, 1988 in Lijtmaer, 2009). Lijtmaer (2009) describes, moreover, how her envy for the comfort and joy that her patient's religious beliefs brought her was expressed primarily as sadness, and reminded her of feelings of awe, connection and transcendence when she, as a little girl, would go to synagogue with her grandmother. In this regard, we are reminded of Aristotle's (384BC-322BC/1926) dictum that envy is not only for what we do not have, but also for what we once had. Lijtamer (2009) admits that the loss of her grandmother was a catalyst for a loss of faith – her young mind could not understand how an all loving God could take away a relationship that was so precious to her. Analysis may therefore reveal that loss of belief may be a defense against one's anger with their God. Perhaps this may also be understood as a defensive derailment or depository for feelings of profound disappointment towards parents' fragility: if anger about the helplessness and mortality of parents can be deposited into God, God is 'destroyed' and the idea of the omnipotent parent is salvaged.

In considering a further case example, Cohen (2009) describes a case of psychodynamic psychotherapy with a middle aged Catholic woman, 'A,' who felt as if she had neglected

her true vocation in life, and began to express interest in becoming a nun. Cohen, herself a born Catholic, and a convert to Judaism thirty years previously, reflects on her struggle with powerful countertransference reactions which were symptomatic of her patient's provocation of her own unresolved religious longings, accompanied by the re-awakening of an old, adolescent God representation long since forgotten. 'A' was a single mother with grown up children, who Cohen describes as a 'self-subordinating character:' it appeared as if 'A' had always passively allowed her brothers and children to put their needs before her own, felt guilty doing things for herself and struggled making decisions related to her needs. Self-effacing and unassertive, 'A' simply tolerated being used as a means to others' ends. When 'A' expressed a desire to become more involved in the church by doing some volunteer work, Cohen interpreted this ambiguously – on the one hand, this appeared to be an autonomous and proactive choice to do something that was important to 'A' and so marked a turning point in 'A's' therapy. On the other, devoting oneself to volunteer work could be yet another vehicle for self-subjugation. A eventually became involved in this work, and did so with continued enjoyment. Shortly afterwards, Cohen asked 'A' whether she had ever considered a vocation in the church. Cohen explains that at this point, at first confused as to why she proposed this possibility to 'A,' it was as if a floodgate blocking her own repressed religious emotions was opened, and Cohen was reminded with profound nostalgia of her fascination with church-life as a teenager. For 'A,' the idea of joining the convent became increasingly appealing and therapy proceeded to explore what this would mean to her, as well as to work through her children's and her brothers' disapproval of such a life.

As 'A' struggled through her decision, Cohen struggled with her countertransference. Cohen was concerned that a cloistered, devotional life was yet another retreat into self-subordination, yet at the same time sensed an inexplicable and irrepressible urge for 'A' to go through with the decision. Cohen felt compelled to openly encourage 'A' to enter the nunnery, and feared that this wish would be indirectly communicated and complied with, as 'A' had passively complied with others' notions of how she should live her life. Cohen resisted disclosing this impulse, and 'A' slowly began to make her decision, unfettered by others' opinions. 'A's image of God began to change from a fearful and

authoritarian to a loving God representation. With reflection, Cohen realized that her counter-transference was rooted in her own adolescent wish to devote herself entirely to God, which she felt was gradually snuffed out by the professional and intellectual world she began to embrace as she grew older. Although Cohen felt that, overtly, she appeared neutral when ‘A’ asked for her views on the suitability of a devotional life, Cohen believes her encouragement was implicitly communicated by claims like “neither of us can know until you make the attempt” and “even if you discover it’s not for you, you would have learned something.” Cohen admits that “every time I spoke those sorts of words, I knew that I wanted her to go.” (p.42) This, in view of her countertransference, is clearly as much a reference to A as it is to Cohen’s adolescent self.

‘A’ had therefore ‘reawakened’ an old God representation within Cohen, long since replaced by a different God, but who, for Cohen, “apparently still slept in the recesses of my mind.” (p.40) – an allusion, further, to Freud’s (1937/1951) notion of the ‘return of the repressed’ object representation so deeply missed and longed for. It is plausible to assume that Cohen’s current God representation is in part an amalgamation of her old God, who she described as all loving and personally involved in her life, and the more detached, intellectual God she began to adopt with age. Her patient had reintroduced her to the former aspect of her God representation which she had, until now, temporarily discarded. This case illustrates, among other things, that one’s God image is protean and summoned to meet different needs at different points in one’s life.

Countertransference responses interact with other potential challenges, which may compound the difficulty of working with religious patients. One such area is in relation to patients’ ‘resistance,’ which Kohut (in Tietelbaum, 1991) defined as defensive operations which protect the patient against danger and pain - a term that, as Greenson (1967) notes, Freud used interchangeably with ‘defense.’ Spero (1981b) cautions that therapists must not be intimidated into ‘working around’ rather than ‘working through’ resistances disguised as invocations to the patient’s religion. Psychoanalytic therapy is premised, in part, on the understanding of resistance and religion has no privileged position within therapy. With empathy and basic trust, all beliefs are subject to analysis, and therapists

should be alert as to when religion is being exploited as a means of avoiding painful material.

Consider, for example, Spero's (1985) experience with a twenty-year-old, orthodox Jewish female patient, who had a conflicting relationship with her father. Spero explains that the following took place on the last session before *Yom Kippur*, or 'The Day of Atonement,' during which it is customary for Jews to ask forgiveness or *mehila* from others whom they may have wronged, during the weeks preceding this holy day – a custom which Spero, as a practicing orthodox Jew, would also be observing. Spero notes that during this session, the patient was in the throes of a negative transference reaction, whereby she attacked Spero and the orthodox rabbinate, accusing them of avarice, apathy and deception. Towards the end of the session, the patient apologized tearfully for the way she had been speaking, and with *Yom Kippur* approaching, asked Spero to grant her *mehila*. Spero responded to her request by asking her: "what comes to mind in asking me for *mehila*?" At this point, Spero says she became frustrated and angry once again, asking "...why does this have to be analysed? I have said some pretty rotten things in here and I simply want to enter *Yom Kippur* with a clean slate...You mean to tell me that you are going to hide behind your [therapist] mask and not even let go enough to fulfill a simple Jewish obligation?"(p.19). Spero gently noted to her that she wants her request for *mehila* to stand outside the analysis, and reminded her of the importance of trying to understand everything that is said from the perspective of their work together. He then asked her what associations she had to his not directly answering her request for *mehila*. She asserted:

that you're a dogmatic ass!" That you won't ever forgive me and that you'll draw satisfaction from knowing that God won't forgive me either. That my hate for my father is so intense that I will never be able to be forgiven!... When you take that cold, distant stand, I think of how he would just leave the room when I got angry at him and I would never, never know what he was thinking...if I leave today's session without your express *mehila*, I'll never know [what you're really thinking]...it would allow me to know if you cared...it would make up for all the times I was left without any idea of how my father felt about me...the *not* knowing was unbearable. Not knowing how *you* feel is unbearable to me now!" (p.19).

To this she added: “for that matter, who ever knows how God feels! It’s not like He sends you a clear cut message [laughs]. So we do the ritual, we run around like crazy people to get *mehilas* as if that’s our guarantee...”(p.19). Towards the end of this exchange and through Spero’s empathic response, the patient acknowledged that she did not necessarily need Spero’s *mehila* in order to feel cared for by him.

It is apparent that the patient’s request for her therapist’s *mehila* was a neurotic attempt towards reconciliation with her father. Spero recognized that the request for his *mehila* was a superficial means towards avoiding confronting her sadness and anger associated with her father, that is, it was an expression of transference, rather than a sincere and autonomous religious act. This “maneuver,” as Spero (1985) describes it, “was also a resistance in that it was unconsciously designed to hide a threatening object-relational agenda.”(p.21) Herein is also, therefore, another exemplar of Rizzuto’s (1979,2009)) theory of the God representation as a blueprint of our early relationships with significant others.

The ability to discern when religious concepts are invoked in therapy as a form of resistance, Spero (1985) argues, may uncover profound insights. However, the danger for the therapist who shares the same religious beliefs as the patient is the need to appear ‘religious enough’ to the patient. Had this been the case with Spero, he may have granted her request, and his patient would not have come to the awareness of her therapist’s genuine concern for her, nor her unresolved feelings towards her father, nor the adaptive belief that God would not punish her for her feelings towards her father. Spero notes that had his counter-transference been characterized by a need to appear ‘religious enough’ to his patient by granting his *mehila*, this would also have disguised a deeper need on his part to forgive others in order to be forgiven himself, or to gratify a latent narcissistic need to wield omnipotent power over the patient. Notwithstanding that Spero, by his knowledge of Judaism, fully appreciates the meaning of *mehila* for the religious Jew, nothing could demonstrate more unequivocally the necessity for therapist self awareness when working with the religious. While the patient’s request for *mehila* may have been the quintessential route into her transference dynamics, the way in which Spero handled

the request is equally revealing about the nature of his countertransference. Had he been possessed by unresolved issues around his own needs for human and divine forgiveness, he may have been manipulated, under the guise of a Jewish law associated with the holiest of Jewish days, to obviously grant his patient's request. Even though there is an apparent conflict here between Spero's religious views which state that one is ultimately obliged to grant *mehila* to another, and the psychoanalytic principle that all of the patient's behaviors, religious or secular, are multi-determined and need to be analysed in light of their psychological implications, his duty was first and foremost to the well-being of his patient. It was only by the latter principle that this was truly ensured.

As the above two case examples illustrate, the therapist's self-awareness is paramount: Why this response with this particular person? Anything short of this self-reflexivity may vitiate the therapeutic process. This general principle evidently has unique applications when working with religious patients.

2.5. Theoretical and Practical Continuities between Psychoanalysis, Religion and Mysticism and Its Implications for Countertransference

The relationship of psychoanalysis to religion is a puzzling but interesting one. Religion is frequently attacked by analysts as if it were a kind of rival dogma, and religious leaders have attacked "Freudian filth" as if it were a kind of devilish sedition . . .

The very fact that Freudians and religious spokesmen attack each other in a kind of sibling rivalry may be indicative of basic similarities between the two systems of belief, each of which has comparable unconscious goals which are threatened with discovery and disclosure by the other.

(Sherman, 1957, p 261-266)

An elucidation of some of the practical and conceptual similarities between religion and/or mysticism (the reader may wish to refer to the definitions of religion and mysticism in the introduction to the literature review) and aspects of psychoanalytic thought, is potentially a vast undertaking that may become tangential to this study's central concerns. However, discussion of a small sample of some perennial religio-mystical concepts and how these resemble certain core concepts within psychoanalytic

thought is useful for the purposes of this research since awareness of these may influence psychoanalytically informed therapists' countertransference responses to their patient's religious or mystical views. For example, a psychoanalytically informed therapist who is committed to the view that the concepts within religion and/or mysticism are utterly irreconcilable with any concepts within psychoanalytic thought, are bound to have more negative countertransference reactions to their religious or mystical patients who 'bring their religion into the room.' Notwithstanding that 90% of patients in South Africa are likely to hold some kind of religious and/or mystical belief (<http://countrystudies.us/south-africa/52.htm>), an awareness of potential continuities between the two fosters tolerance and acceptance. This affects therapists' capacity for empathy, which in turn makes for a more effective and contextually relevant psychoanalytically informed praxis (Berg, 2009).

Since this is a vast topic, which may be complicated further by considering concepts within particular religions or mystical traditions, commonalities between only a few perennial religio-mystical concepts and aspects of psychoanalytic thought will be suggested, namely, a) the idea that a transcendental aspect of the self exists; b) the notion of 'heightened awareness,' 'union' or 'merging' and c) the act of 'confession.' In psychoanalytic thought, these may loosely correspond to the following concepts respectively: a) the unconscious b) 'reverie,' 'primary maternal preoccupation' and 'evenly suspended attention.' c) the act of disclosure in psychotherapy. The reader may wish to consider further comparisons which won't be discussed here for the sake of brevity: exorcism and catharsis/abreaction; projective identification and possession; transference/countertransference and 'scapegoating.'

Point a) considers how the pan religio-mystical view that a transcendental aspects of the self exists may correspond to the (Freudian) 'unconscious' within psychoanalytic thought. While these are very different concepts by definition – the former refers to a divine aspect of the self and the latter, a repository for sexual and aggressive impulses within the mind that is beyond our awareness – it is proposed that these two concepts are situated within the same 'metaphysical' or 'ontological' category. Ontology is the branch

of philosophy which deals with what exists (Blackburn, 1996). Things may exist, however, in an objective or subjective sense (McGinn, 2004). Rocks and trees belong to the former, whereas dreams and hallucinations belong to the latter. As McGinn (2004) highlights, what makes something objective, therefore, is that is available to the five senses, accessible to another's five senses at the same time, is extended in space and could (in principle) exist without there being an individual observer. On the other hand, if something is unobservable by the five senses, immediately perceptible only by one individual at a time, un-extended in space and dependent for its existence on the individual perceiving it, it is 'subjective.' Both the transcendental self and the unconscious, therefore, denote something 'subjective' in the sense defined here. Ontologically, they belong to the same 'category.' At the most basic metaphysical level, therefore, psychoanalytic thought employs an abstract concept that cannot be proved or disproved scientifically, and that may arguably be as 'mystical' as the transcendental self, the soul, or the mystical 'super-conscious.' Ivey (2002) alludes to the same point by doubting whether the ontological status of the psychoanalytic 'internal world' is any different to the supernatural universe of spiritual forces and entities. This is congruent with the proposition made above regarding Jung's (1938, 1953) views, that where the Freudian psyche is said, metaphorically, to have 'depth,' we might conceive of the Jungian psyche as the corollary by attributing to it the property of 'height.'

Furthermore, Sherman (in Malone, 2007) notes that another similarity is that both concepts refer to an aspect of either reality or ourselves that we do not (not that we *cannot*) know¹. The former is *known* through meditation, whereas the latter is *known* through analytic techniques such as free association or dream analysis. Moreover, as Malone (2007) argues, both concepts render us partly at the mercy of unseen, unknown forces in spite of our conscious will. Furthermore, both the transcendental realm and the unconscious are said to have no sense of contradiction, to be beyond categories of space and time and disobey the laws of formal logic (Huxley, 1946; Freud, 1900/1999). Finally, Malone (2007) argues that *belief* is central to both areas of thought. Psychoanalysts must

¹ Interestingly, Grotstein (2009) proposes that the first historical reference to the unconscious was Jesus' prayer on the cross: 'Forgive them, for they know not what they do.'

believe in the unconscious to perceive unconscious motivation in their patients, and the religious or mystical must believe in God or the transcendental realm to perceive His will at work in the world.

Concerning point b), mystical traditions refer to states of ‘heightened awareness’ attainable through prayer or meditation, whereby the individual, to an extent, ‘brackets’ his own subjectivity or ego in order to ‘merge’ with something other than the self. This is often referred to as the ‘dissolution’ or ‘annihilation’ of the ego – a key ‘goal’ in mysticism (Huxley, 1946). Psychoanalytically, this may correspond to what Bion called ‘reverie’ (Wadell, 1998); Winnicott (1960), ‘primary maternal preoccupation’ and perhaps what for Freud (1923/1950) was ‘evenly suspended attention.’ Although these are distinct concepts, each broadly share the idea of being subtly receptive and attuned to things outside of the self - there is something about the relinquishment of aspects of the self in order to ‘receive’ the other, that is germane to all. The poet John Keats (1818/1975), whom Bion allegedly read², referred to the doctrine of ‘Negative Capability’ - “when a man is capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact and reason”(p.43). This capacity necessitates a negation of the ego – ‘becoming nothing in order to become everything’ - and it anticipates Freud’s (1929/1949) early notion of ‘primary narcissism,’ who appropriates this idea in the language of the child’s ego and its relationship to the world:

Originally the ego includes everything, later it detaches from itself the outside world. The ego feeling we are aware of now is thus only a shrunken vestige of a more extensive feeling – a feeling which embraced the universe and expressed an inseparable connection of the ego with the external world (p.133).

In the same essay, Freud (1929/1949) describes the state of ‘love’ in adulthood in terms reminiscent of the mystical notion of ‘union’ with the transcendental: “At the height of being in love the boundary between ego and object threatens to melt away. Against all the evidence of his senses, a man who is in love declares that 'I' and 'you' are one, and is prepared to behave as if it were a fact” (p.80). There is thus a perennial idea of rupture

² See Symington and Symington (1996) *The Clinical Thinking of Wilfred Bion*. London: Hogarth Press, p. 169

between the ego and the world or other, which, for other thinkers such as Bion and Winnicott, hinders an individual's capacity to be empathically attuned to another. It is also noteworthy, however, that for psychoanalytic thought, concepts such as 'merging' have pathological implications in the context of psychosis and narcissism.

Lastly, to consider the parallels between the religious act of confession, and the act of speaking in psychoanalytic psychotherapy, it is apparent that both acts designate a safe space within which to disclose feelings of shame, guilt, anger, envy and hostility as a consequence of our thoughts or actions (Worthen, 1974). Furthermore, although religious confession involves belief in an actual God who forgives, both are broadly intended to elicit some kind of psychic or emotional 'truth,' which results in a state of absolution for the soul or catharsis of the mind.

What do all these comparisons amount to? While many similarities between religion or mysticism and psychoanalytic thought could be argued for, perhaps, as Sherman (in Malone 2007) suggests, both disciplines derive from similar *emotional* needs, namely, to try and know something about a universe whose scale is unimaginable, and to help us feel safer in the midst of uncontrollable forces that threaten to annihilate us. Recognition of this, at least, may contribute to the prevention of vitiating countertransference reactions to deeply religious patients.

2.6. Summary

There is much dissention amongst seminal thinkers concerning psychoanalytic formulations of religion. Further, psychoanalytically informed psychotherapists may occupy any variety of religious orientations. This, coupled with the notion that one's God representations may unconsciously reflect one's early object representations, as well as various views around what makes for adaptive and maladaptive religiosity, contributes to the abundance of countertransference reactions psychoanalytic psychotherapists may have to their religious patients, which is often a product of both the therapist's and the patient's psychic content. Awareness of potential continuities derived from comparisons between

psychoanalytic and religio-mystical thought, furthermore, may enhance therapists' empathy towards religious or mystically minded patients, thereby tempering potentially vitiating countertransference reactions, and helping to facilitate a more applied and relevant form of psychoanalytic praxis in an inherently 'religious' country and world.

Chapter 3: Research Methodology

3.1 Research Design

The aim of qualitative research, which is to understand and represent the experiences and actions of people as they engage and live through situations (Elliot, Fischer & Rennie, 1999), makes a qualitative research design apposite for this particular study which aimed to understand the countertransference experiences of a group of psychoanalytically informed psychotherapists in their work with religious patients.

It did not seek to obtain empirical data from a large sample as a means towards generalizing its findings to a population. Its concern was with the experiential, subjective reflections of a small sample of psychotherapists on the nature of their countertransference experiences. A qualitative approach was employed since qualitative research is, further, premised on the in-depth exploration of individual experiences and the subjective meanings attached to experience (Denzin and Lincoln, 2005). The research instrument was a semi-structured interview (See Appendix A) with questions based on a reading of the relevant literature.

3.2 Research Objectives and Research Questions

This study is interested in the countertransference responses of psychoanalytically informed psychotherapists working with religious patients. Through exploring the various countertransference responses that devout patients may provoke in psychoanalytically oriented psychotherapists, it also seeks to understand the ways in which these therapists manage their countertransference reactions to such patients. The study thus endeavors, furthermore, to qualitatively explore the particular challenges that therapists may encounter through working with religious patients which contribute to the formation of countertransference reactions. This includes possible tensions between the therapist's and the patient's religious beliefs; potential discontinuities between aspects of psychoanalytic theory and the patient's religious beliefs; the ability to discern whether the patient's

religiosity takes an adaptive or maladaptive form, and if maladaptive, how to manage this therapeutically without disrupting the therapeutic alliance.

These objectives lead to the following research questions:

- 1) What particular countertransference responses do deeply religious patients provoke in psychoanalytically informed psychotherapists?
- 2) How do differences in personal religious orientation between therapist and patient influence the nature of the therapist's countertransference?
- 3) How do psychoanalytically informed therapists manage religiously influenced countertransference responses?

3.3 Reflexivity Comment

Hermeneutists³ must be alert to the fact that they are 'co-constructing' reality on the basis of their interpretations of data with the help of the participants who provided the data (Eichelberger, 1989). It is thus important for both researcher and reader to have knowledge of the perspective, situational context or praxis from which the researcher describes and interprets (Patton, 2002). Researchers are required to recognize that they are not entirely indifferent to the outcomes of the research and that some form of pre-understanding is brought to the research process (Terre Blanche and Durrheim, 2002). Indeed, it is critical for the hermeneutic researcher to self-reflexively consider his/her own impact on the research findings.

Since the researcher holds his own religious biases, it was necessary to be vigilant of how these biases influenced the interpretation of the data. It would appear inevitable that the researcher's biases would influence the analysis to some extent, and this was acknowledged where appropriate. In this regard, the idea that themes will passively 'emerge' or be 'discovered' within the data was not strictly tenable, since it is possible

³ Hermeneutics refers to a subjective method of interpretation of texts, as well as the social, historical and psychological world (Blackburn, 1997).

that the researcher's personal religious presuppositions did, consciously or unconsciously, influence the process of finding, highlighting, selecting and editing themes within the data to guide the argument. Themes, in this kind of research, were therefore 'co-constructed' as well as 'found.' The researcher was, however, to the best of his ability, self-reflexive in noting when this 'co-construction' of themes may have occurred.

Moreover, it is important to consider the extent to which my training as a psychotherapist, while interviewing psychoanalytic psychotherapists primarily from the same training institution (The University of the Witwatersrand) may have consciously or unconsciously influenced their responses. The fact that the researcher is not manifestly religious, that is, he does not wear religious clothing, may also have influenced the participants' responses. The researcher thus attempted to be constantly aware of how his subjectivity inevitably reacted with the subjectivity of the participants, with the aim of preventing such reactions from compromising any aspect of the research process.

3.4 Sampling Strategy

Six psychoanalytically informed psychotherapists took part in this research. The small sample size is accounted for by the in-depth and relatively open-ended nature of the interview questions, which aimed to elicit rich data. In order to render sufficiently rich, sophisticated material, and because the study focused on a particular context, namely psychoanalytically informed psychotherapists, purposive selection was employed (Miles and Huberman, 1994). Participants were required to meet the following criteria to take part in the research:

- 1) The therapists had to have a background in psychoanalysis. This was essential since psychoanalytically informed therapists are most likely to have thought about countertransference issues in therapy, given that countertransference is a distinctly psychoanalytic concept. 'A background in psychoanalysis' means, in this study, that the therapists are members of Johannesburg psychoanalytic groups.

2) A second criterion is that they have worked with religious patients. This was essential as the study aimed to investigate their countertransference reactions to their religious patients.

3) Participants had to have been in practice as psychoanalytic psychotherapists for at least five years. This was necessary as it was felt that greater experience would be more likely to yield richer, more informed and insightful responses.

Given these criteria, a non-probability, purposive sampling strategy was employed, which is described below.

3.5 Data Collection

In accordance with the method of analysis, namely thematic content analysis, the data set in this study consisted of a collection of texts, rather than individuals. The texts were derived from discussions facilitated by self developed, semi-structured interviews.

Regarding the inviting and sourcing of participants for the study, the following steps were taken: since the research supervisor is a practicing psychoanalytic psychotherapist and is a member of many psychoanalytic groups and organizations in Johannesburg, she sent emails to such groups and organizations explaining the nature of the research and inviting participation. The interview schedule was included in this email. It was also explained, in this email, that the identities of the participants would be protected from the supervisor. Interested participants were then asked to contact the researcher directly. This phase involved further clarification about the study and ethical issues around confidentiality and anonymity as outlined in the consent forms (Appendices B-D). Interviews were then arranged with participants at a time and place of their convenience. After signing the consent forms, participants were interviewed using the semi-structured interview schedule (Appendix A). Interviews lasted approximately 45 minutes. The participants' responses were audio recorded with their consent and the interviews were transcribed. The recordings were then deleted to protect the participants' confidentiality.

3.6 Instrument

The interview schedule consisted of a ten item, semi-structured questionnaire (Appendix A). Subjects had the freedom to offer as much information as they wished. The semi-structured format of the interview schedule allowed the researcher to explore material provided by the participants further.

3.7 The Qualitative Research Interview: An Introduction

The Qualitative Research Interview provides the opportunity for the researcher to understand the experiences and perceptions of the participants in their own language. This is the object of the qualitative research interview – to ascertain valuable data from the participant that reflects something about their experience (Kvale, 1996). The aim was to initiate a verbal exchange between the researcher and the participants which converge on the topic of the research (Rosenthal and Rosnow, 1991; Kvale, 1996).

Qualitative research interviews are centered around themes, the meanings of which are primarily generated by the participants' own experiences and perceptions. This approach allows the researcher to investigate topics that may be overly complex for a quantitative investigation (Banister, Burman, Parker, Taylor and Tindall, 1994; Kvale, 1996). Precision in the definitions of terms and in the interpretation of participants' responses constitutes the rigor of the approach.

3.8 Advantages of the Semi-Structured Interview Questionnaire

The approach to the qualitative research interview is non-directive (Kvale,1996). The advantages of such an approach are that it allows rapport to develop between the researcher and the participant, which is invaluable in gleaning richer responses from the participants (Rosenthal and Rosnow, 1991).

The ten item interview schedule employed in this research functioned as a basic outline of what material the researcher aimed to investigate, but also allowed for further exploration if the researcher wished to do so. The open-endedness of the questions potentially allowed participants to freely elaborate their responses and to discuss their experiences and perceptions without any constraints (Kvale, 1996). Dohrenwend, Richardson and Klein's (1965) meta-analysis of methodological studies found that semi-structured interviews elicited greater levels of disclosure for participants discussing their personal experiences. This interview format was thus well suited to this research project.

3.9 Data Analysis

3.9.1 Thematic Content Analysis

The core purpose of content analysis is the drawing of inferences from a given text, utilizing systematic procedures (Eagle, 1998). Since the aim of this research was to draw inferences and make interpretations regarding psychoanalytically informed psychotherapists experiences with their religious patients, a content analysis seemed a suitable approach. Thematic content analysis refers to a more interpretative application of the content analysis method and involves the identification of various themes which are subsequently categorized and then elaborated upon on the basis of systematic scrutiny (Bannister, Burman, Parker, Taylor, & Tindall, 1994).

Broadly, this method seeks to identify, analyze and report 'themes' within data (Braun and Clark, 2006). Themes are underlying patterns of meaning 'disguised' by the content of the interview (Kvale, 1996), and capture something important about the data in relation to the research question (Braun and Clark, 2006). The discernment of themes is a process that evolves as the analysis proceeds, in contrast to quantitative approaches which establish predetermined research concepts. The aim was to highlight the individual 'voice' of the interviewee, and to try connect citations of interviewee's observations to proposed themes. In this way, the researcher bears witness to the interviewee's personal narrative, and looks for areas of continuity and difference between the respective

narratives of the participants, organized and guided by the proposed themes (Kvale, 1996). The data was organized under the respective themes by way of codes, which included citations of long exchanges, phrases or sentences (Kvale, 1996). This is a subjective process wherein the researcher's own theoretical assumptions may influence the meanings attached to the data. Thus, the researcher was very careful to monitor his own biases upon ascribing meaning to the data.

Significant themes are illustrated by the researcher by the highlighting of direct quotations from transcripts and the linking of these quotations to a precise description of the themes. This allows the participant to expound his/her own experientially based responses, while the researcher acts as an 'editor' in choosing which citations to include for analysis (Breakwell, Hammond and Fife-Schaw, 1995; Kvale, 1996).

Neuman (1994) also refers to 'positive evidence' and 'negative evidence.' The former consists of material that may be analyzed which is manifest in the data, whereas the latter consists of data which, in light of the theory, the researcher may have expected to emerge. Such omissions may be important. Thus, while the researcher should be careful to maintain self-reflexivity, he should include commentary on omissions that may be significant to the research questions (Neuman, 1994).

The emphasis, in qualitative content analysis, is on establishing relationships between different aspects of the data, as the research question guides the process of discerning themes. The data is sorted into coded segments which may include paragraphs, sentences or specific phrases (Kvale, 1996). The process of coding is continuous, such that new codes may be discerned upon a closer and holistic examination of the data, with the aim of identifying citations from the participants that illustrate certain themes within the transcript (Neuman, 1994).

3.9.2 Thematic Content Analysis Steps

As Eagle (1998) notes, the essential purpose of content analysis is the reduction of data into coherent, manageable categories to allow for the identification and elucidation of central issues. To this end, the approach used in this study largely follows the steps adapted from Braun and Clark (2006):

1) Participants who met the sampling criteria were approached and interviewed. Interviews were audio recorded with an audio recording instrument with the participants' consent.

2) The researcher became familiar with the data through transcribing and by way of repetitive, close readings of the interview transcripts.

3) Interesting features of the data across the entire data set were initially coded. This involved indentifying potential themes and trends and assigning basic labels and codes to them. For example, material about the participants' countertransference responses was coded 'countertransferences.' This constituted the researchers initial attempt to condense the data, but the process of coding was still at a relatively low level of abstraction.

4) Codes were then collated into potential themes, gathering all data into relevant themes. For example, the initial code of 'countertransferences' was then refined into 'countertransference incapacitation' or 'countertransference frustration' – themes which were then coded 'Theme 1' and 'Theme 2' respectively.

5) Themes were then reviewed to ensure that they were appropriate in relation to both the coded extracts and the entire data set.

6) The analysis continued to refine themes and the overall 'story' the analysis began to tell was discerned, while further emergent themes were assigned with specific names and definitions.

7) The report was then written up by selecting vivid, compelling citations, relating these citations to one another, analyzing them further and connecting these analyses back to the research questions and literature.

This process was a recursive rather than a linear one, whereby the researcher went back and forth between these steps as the analysis proceeded. The goal was to provide a concise, coherent, logical, non-repetitive and interesting account of the emerging ‘story’ of the data. Moreover, the aim was to go beyond the level of description of the data, and construct an argument in relation to the research questions (Braun and Clark, 2006).

3.10 Ethical Considerations

Participants made themselves available voluntarily and they were not offered any compensation for their participation. A certificate of ethical clearance and approval from The School of Human and Community Development, Psychology Internal Ethics Clearance Committee of the University of the Witwatersrand was obtained.

Interviewing psychotherapists about the nature of countertransference responses had the potential to elicit material that, if known to their patients, would be potentially harmful. Names of therapists and patients were therefore kept confidential by the use of pseudonyms to signify both the name of the therapist and any patients referred to. If the therapists accidentally referred to their patients by name during the interviews, the mistakenly uttered name would not have been transcribed, but rather a letter of the alphabet would have been used, for example, ‘Patient A.’ No such patients name was uttered during the interviews, however. In turn, confidentiality was guaranteed in so far as the researcher did not disclose to any person, including the supervisor, the names represented by the pseudonyms. Absolute anonymity of the participants could not be guaranteed since the researcher was able to link a participant with a specific pseudonym. However this was never written down or disclosed in any way and remained in the researcher’s mind only.

Informed consent was obtained from the participants, in which a participation sheet outlined what participation entails, in addition to explaining the purpose of the study (Appendix B). It also stated that participation was voluntary, and that participants were free to withdraw their responses from the research at any point during the process. Permission to tape record the interview was also requested (Appendix D). Tape recordings and consent forms will be secured for a period of two years after completion of the study in the event that the study is published, and for six years if no publication arises, at which time they will be destroyed. Finally, it was explained to participants that their identities would be withheld from the supervisor, and they were requested at the outset not to refer to their patients using their patients' real names.

Chapter Four: Results

4.1 Introduction

This chapter aims to present the reader with the findings of the research, including the main themes present in the interview transcripts. A discussion of these findings is provided in chapter five. Nine core themes and fourteen sub-themes, based on the research aims, questions and the data itself, were identified. This coding is reflected in the interview transcripts available in Appendices (E-J). The first five themes deal with the therapists' countertransference reactions to their religious patients. Themes six and seven are concerned with the therapists' perspectives on what characterizes healthy versus pathological religiosity, including the employment of religion as an adaptive or maladaptive defense. Theme eight deals with some of the general advantages and disadvantages of working with religious material in psychoanalytically informed psychotherapy. Lastly, theme nine illustrates the therapists' perceptions around comparisons between psychoanalytic and religio-mystical concepts. Core themes are denoted by full numbers (1;2;3), whereas fractional numbers are ascribed to sub-themes (1.1; 4.1; 4.2).

4.2 Themes

4.2.1. Countertransference Paralysis

The most prevalent countertransference response of the therapists to their religious patients was one of 'incapacitation.' All six participants, whose beliefs vary along the spectrum from non-belief, to agnostic, to belief, referred to various ways of feeling incapacitated, debilitated or 'stuck' at some point during their work with their patients, primarily as a consequence of their patients' religious beliefs. 'Sue's' broad reflection of this issue being "about something prohibitory and something that blocks off thinking," seems to précis all the participants' insights into this countertransference response. For

four of the participants, this feeling of paralysis was also associated with anxiety. This particular experience has been given its own sub-theme.

‘Lisa’ referred to her work with a young Catholic woman who was religious yet sexually active, and who engaged in extensive rationalizations, some of which took the form of employing Catholic doctrines to justify her sexual behavior. She described her difficulty with challenging these rationalizations thus:

... the mental gymnastics she does to explain how she’s both Catholic and sexually active leaves me going... ‘get real here,’ so, but its very hard to engage with, because if you try and question a belief, then you’re seen as doubting or undermining...

It is, however, the fact that her patient employs religiously inflected rationalizations, that makes Lisa feel as if it is “... hard to just do the therapy that I would normally do.” She goes on to describe the nature of her dilemma with this patient:

... I got frustrated in my task, which is to help her reflect on certain things and think about them. And it really makes me very aware of what words I choose and um, ya so it makes me feel quite cautious...how do we talk about this in a real way in whereby I can actually help this girl, um, but, you know, some very tough things have happened for her, so she also needs a defense. I think going to church and going to mass and all the youth programs also give her a safe place. So I guess I feel stymied: how do you take this therapy forward without stripping away something that she actually needs, but, this thing that she needs stops her from actually getting real, it stops her from talking about why she’s doing destructive things.

This dilemma, furthermore, makes Lisa feel as if the process of therapy is labored, as if she has just begun her career as a therapist and has to be overly, if not anxiously, mindful of what she is ‘doing’ at each particular moment during the sessions, contrary to the sense of organic spontaneity that develops with experience:

[I felt] stuck with her, walking on egg shells, trying to think of an intervention in a careful way, so it feels, you know when you learn to drive, you kind of aware of everything, where the clutch is etc, and then it kind of all comes together naturally, so it feels a bit like that, how do I do this...

For Nancy, the paralysis is a response to what she refers to as many of her religious patients' "fundamental black-white thinking" – a rigidity with regards to questions of ethics, or 'the right thing to do' in a given context. She often feels as if there is no place for ambiguity or divergent perspectives in these matters, which makes certain topics very difficult to open up and explore, rendering the therapist a helpless and powerless adversary in the shadow of the patient's God:

That for me is the hardest thing, they shutter you down – 'God wants it this way or Allah wants it this way.' What do I do with this? I can't compete against Allah, I can't compete against God, I'm stuck here, I'm gonna be struck down by lightning any second [laughs]... I have had moments when I think, 'Oh God, what do I do with this patient?!'

Alice illustrates how this feeling of inhibition is dramatized with patients of particular religious orientations. For example, her devout Jewish patients adhere to the law of *Lashan Hara*, which prohibits any Jew from speaking ill of another behind their back, which would naturally include parents and partners. This presents a profound challenge to their work, since it obstructs one of the essential purposes of therapy as, simply, a space to talk about one's relationships.

...they can't look squarely at what is going on realistically in their lives, and how they're being abused, or how they're being used, and the relationship issues, cos they daren't speak ill, even speak about the other person, be it their father, their mother, or their partner, their life partner.

Similarly, Alice's Catholic patients are compelled to forgive any person, irrespective of how enraged and hateful they are towards those who have wronged them: "... for them the difficulty comes in when you have to be a really good person and turn the other cheek" and that "no matter what people do to you, you have to forgive and be 'nice.'" This debilitates Alice's task of facilitating a space wherein those feelings of rage and hate may be felt and spoken about. She notes that the challenge in such instances is "to be able to pick up the projections of real rage and anger and be able to give it in a manageable thing that isn't anti-Christian." She notes how difficult this can be, however, as well as

questions around perceptions of therapy versus confession as a space to express ill feelings towards others:

... how do you say anything against a priest, how do you say anything against, you can go to confession and you can confess these things but you're not allowed to speak of them here. What is the difference?

4.2.1.1 Anxiety Due to Paralysis

For Sue, Teri, Alice and Andrea, there was an anxiety associated with feeling incapacitated. For example, Sue noted how the idea of consulting with a very religious client provokes anxiety around what she wears, how she speaks, and if the client is a male, how she carries her body and how close she sits to him:

...if I know I'm seeing a religious person I'll dress differently in the morning. I'm very aware that I need, I try to be respectful. And it's something like an internal dialogue that goes "well why? They've chosen to consult me, I don't need to." Unless when it's the mothers or the woman on their own, but if there's a father, I'm very careful about that kind of thing. And then how I sit and how much proximity...that's sort of my own countertransference anxiety. I feel a little inhibited about how I have to be.

Sue also spoke of how topics like sex with the children of very religious families are particularly anxiety provoking, given the necessity to confront the parents about them – an anxiety she does not seem to feel with non-religious families:

I had a little boy who told me that he had heard his parents making noises in the middle of the night, and there was an enormous amount of anxiety there, and I had to feed this back to the parents. Another child I saw who was trying to cope with a pregnancy, the mother was pregnant, and um, very anxious with lots of very, sort of persecutory fantasies about conception and how the baby's going to get out and how it got in, and I had to ask the parents to talk about sex to their child. So those kinds of things, I feel, when a family's more religious, I feel more inhibited, in saying, "you know what, a child does actually need to know."

Similarly, Sue highlights the difference between her countertransference response to a religious child patient disclosing material to her that would offend his/her parents from a

religious perspective, compared to a non-religious child patient disclosing material that may also offend the parents:

I've seen another child who, a little girl who was sort of mid latency, who hated the fact that she was growing up in a religious home, and had to cover up, and she would say "I'm not allowed to do this because its not *snius* [religiously appropriate] and I'm not allowed to do that because its not *snius*, and its so silly and the *first* thing I'm gonna do when I'm a teenager is I'm going to buy a bikini..." so that was quite tricky, that I had a sense that there might be something quite disloyal, but I mean, why would that be any more disloyal than a child, I mean one adolescent I'm seeing told me that she's smoking and her parents don't know... But it feels loaded.

Alternatively, Teri referred to an anxiety provoked by something more concrete – her patient's religious dress:

And one of the significant fears I had when I met this mom, when she came in with the *Burka* and the covered face, I said "I hope she's gonna take it off!" [laughs] "Cos how am I gonna work with her!?" And she's wears glasses, so for me to access her eyes...

Alice's anxiety was associated with a potential lack of knowledge around her patient's religious beliefs, which she managed by focusing on what is common to all systems of religious belief, in addition to what is unique about the patient's system:

I have some Greek and Italian very religious patients. I have found, in the beginning I was quite anxious about that, but I have found that if you see religion as spiritual and universal, even the cultural aspects of that can be applied. So it's about using what the patient brings with them, contextualizing it within their cultural framework. But the philosophies are the same...

4.2.2. Countertransference Frustration

The second most prevalent countertransference reaction of the therapists to their religious patients was one of frustration, alluded to by Lisa, Nancy, Andrea, Teri and Sue. For Lisa and Sue, however, this also took the form of anger and outrage in response to what they perceived to be religiously inspired 'hypocritical' behavior in their patients.

Lisa's Catholic child patient required psychiatric help given his numerous psychotic breaks. Lisa referred him to a psychiatrist that she trusted but who happened to be Jewish. The child's father refused to consult with this psychiatrist, allegedly owing to his being Jewish. Lisa's frustration is both a response to the father's bigotry, as well as his insistence that the son's psychosis may be religiously inspired:

I guess I was left thinking that religion got in the way of getting real help. The son had a number of psychotic breaks and I imagine he'll have another one, and he'll end up in hospital, and I hope that he gets a nice Catholic doctor and gets the help he needs. But I was annoyed that they had brought that in...and the father didn't want to know about a psychiatric illness, and he used religion as a way to avoid going to a psychiatrist I just wanted to scream at him and say "get real, your son needs some help!"

Nancy described her frustration in response to how religious beliefs, more broadly, may 'close-off' the possibility of deeper exploration, hindering the process of therapy:

...sometimes it feels like we need to move in a particular direction or going in a particular direction and then the religious view will come on and slam that door shut. You know, God wants that for me, or this is Allah's wish or whatever religion it is and it kind of just freezes the therapy and it's very difficult to challenge that. So it feels for me like a kind of frustration or irritation in the room.

Similarly, Lisa described how frustrated she gets with her religious patient who uses religious doctrines to distort the truth about the inconsistencies in her behavior, but who also feels as if it would be 'inappropriate' or 'taboo' to challenge these inconsistencies: "I'm feeling frustrated because she's fudging [the truth] in the room. It's hard to tackle her on it because [religion] is also, as I said, sacred ground literally." Lisa expanded on this response to this particular patient, noting how frustrating the contradictions in her sexual behavior can be, but how difficult it is to challenge this since the process of bringing these contradictions to awareness is truncated by the citation of a religious doctrine:

Ya. I mean she went into this long and detailed description about how the pill is not a contraceptive if you're using it for your skin. But she's not using it for her skin she's using because she's sexually active. So then it is a contraceptive. But "no no

no” she belongs to a more ‘reformed’ Catholic Church that says you can take the pill if it’s for your skin. But it’s not for her skin! ...it’s quite frustrating.

Andrea’s frustration was implicit in her disbelief with the extent to which her Catholic patient is self-punitive, such that “if she tells one lie, she’s a bad Christian and that’s it, it’s over. And to totally crumble her whole existence over that! ... but my feeling was, how can you ever live up to that?” Further, her frustration in response to her patient’s religious self-denigration also seems to be exacerbated by her own agnostic beliefs:

I wish I could say to somebody, “you know, its not that bad, or its not real even,” but it is real to them, but that’s how I sort of feel, I wanna say to them, “you know, even if you do tell one little white lie, does that mean the whole of you is a bad person now, and what do you have to do for the rest of your life to make up for that one little lie?”

She describes a more provocative version of this particular countertransference by alluding to aggressive fantasies:

...and I sometimes just think, you know, “as this intelligent person in the 21st century, can you be that narrow minded?” Cos sometimes it does feel narrow minded.... And so there is that in my countertransference as well where I want to like...punch a hole in that narrow mindedness and just say, “there are other perspectives in the world, there is something that might be different to this!”

Teri explained how angry she became bearing witness to the ways in which religious injunctions were imposed on her little child patient by the parents, which felt so unnecessary in view of the child’s other psychological difficulties. She describes “how the religious practice came though in a little boy of five or six, you know, “Jesus said I must do this and Jesus said I mustn’t be cross.” Teri found that her countertransference “was of annoyance – how can a parent impose such a judgmental way of upbringing when a child is struggling with so many things?!”

Finally, Sue reported becoming infuriated with what she perceives as a power differential between men and woman in very religious communities. She expressed the outrage she felt in response to her Jewish female client who had violated a law associated with

‘Kosher’ eating by asking the domestic servant to help cook the *Shabbat* meal due to time constraints. Sue described her patient’s distress at being verbally reprimanded by her Rabbi husband over this. However, this patient then noted how she catches her husband looking at pornography on the internet late at night, but didn’t feel as if she could confront her husband the way he confronted her. This double standard infuriates Sue:

and I remember feeling, even now when I say it, I just feel absolutely outraged, and she did not feel that she could...challenge that, because what he was doing I don’t suppose had any, you know, somebody hadn’t stood up in *shul* and said ‘don’t do that,’ its just a presumed don’t, whereas there were these very clear rules about...keeping kosher in the kitchen. So that kind of hypocrisy can really get me going too

Similarly, Sue’s very devout Muslim woman patient was distressed owing to her husbands numerous extramarital affairs. Her patient, however, although wishing to divorce him, felt powerless and afraid to do so owing to the allegedly complicated Muslim prescriptions and subsequent stigma associated with divorce. Sue struggled with her countertransference since she felt as if these religious prescriptions were impervious to critique in her patient’s mind, subjecting her patient to a form of emotional abuse:

so it was very very hard for me...I mean for three months, she was not allowed out of the home between sunset and sunrise, um and he was allowed to do...so that was, I remember her feeling outraged. And it’s not an anger that could really be thought or talked about because it’s an injunction in her mind, you know, she wouldn’t question it.

4.2.3. Other Countertransference Reactions (Envy, Respect, Seduction).

Only one of the participants, Nancy, described countertransference responses to her religious patients which were not limited to broader feelings of paralysis or frustration. These included positive reactions such as respect, admiration and fascination, as well as more ambivalent responses such as envy and feeling seduced by her patient’s religious material.

Nancy alluded to a mixed feeling of profound respect and at times, envy, that some of her deeply devout patients evoke in her:

The other feeling that I've funnily enough had with a few of them is enormous respect for being so devout, and this is revealing quite a lot, but it can be moments of envy that they have such faith. Faith provides a nice, neat, comfortable explanation.

She elaborates on a complex countertransference response she had with a deeply devout patient who had lost a child, which included feelings of respect, envy, incapacitation, inadequacy, frustration, fascination and disbelief:

Just absolute faith, that this is the answer and you will see your child again and this was meant to be and its God's will...I remember sitting with her at times and feeling quite baffled and quite envious of that wonderful, neat explanation, so, that's quite interesting... and a very difficult thing to admit in the room, because there's this thing of, 'I can't work freely with you because you have all the answers, so why are you here?' And this other part of me goes "I wish I had all the answers or the belief in the answers that you have.... I think it's with anybody who has a very powerful belief system, its there. That kind of like, Agh, you know they just have a nice explanation, and its all neatly packed, and sometimes it will even be with other, Muslim or Jewish people part of their community. You know the more devout they are they tend to be more part of a community, so, it can get elicited in other ways, but I think it is, sometimes in my own religion, a sense of 'what could have been had I been more devout?' So there's a knowing of what that person represents that I'm not... I don't know if envy is fully encompassing of the feelings sometimes, I think its more complicated than that, I think its envy and a frustration and an admiration and a kind of 'are you crazy?'

Nancy's intense fascination with aspects of her Muslim client's faith was also experienced as a feeling of being seduced and lulled into her patient's world, and which thus made her feel, at times, as if she was 'losing touch' with her role as therapist. Psychological questions about this patient seemed to recede into the background, as her clarity of thought almost felt clouded by the patient's religious material:

So I was incredibly curious and interested, so almost felt like the sessions were becoming about her just revealing all this inside information about kind of Muslim culture and going to Saudi and going to Mecca and all of this, and this complete fascinated enthrall and would gosh almost feel like an audience member and I'm

watching this documentary about you know a Muslim woman who goes to Mecca and all the stuff around being a woman and it was fascinating...it completely put me in an observers seat and a fascinator's seat rather than a therapist seat and I had to work with this quite a lot and saying 'what is this about and get out of that seat and back into your therapist role, and what is the meaning of this for her psychologically not spiritually.... But, with her I'm very conscious of a kind of fascination, she's a very intelligent woman she's a very articulate woman so I get quite seduced around her story telling and in those moments I feel more like I'm watching a documentary than I'm doing therapy and I can lose myself in that fascination, so it's quite important that I keep myself alert that, you not here to learn about her in that way, and constantly remind myself to think about her psychologically. So she's quite fascinating but she can be quite a seductive client that way.

4.2.4. The Influence of Therapists' Own Religious Beliefs on Their Countertransference Reactions.

This section illustrates the countertransference reactions of the agnostic therapists, namely, Lisa, Sue and Andrea, to their religious patients, as well as the countertransference reactions of the theistic therapist's (Nancy, Alice and Teri) to their religious (and irreligious) patients. The agnostic therapists had responses broadly characterized as more 'negative,' such as a tendency to view their patients' religiosity as defensive, as well as a tendency to feel less sympathetic towards their patient's religious beliefs. The theistic therapists' responses to their religious patients ranged from being especially evocative if the patient shared the therapist's faith, accompanied by a feeling of being unable to think about them 'objectively' during sessions, to a greater sense of openness and acceptance of the patient's views. Further, both the agnostic (Sue) and theistic therapist's (Nancy, Teri) alluded to certain advantages when their patients do not share their own religious beliefs, such as the capacity to think more 'objectively' about their patients and the safety of boundaries.

4.2.4.1. Agnostic Therapists' Countertransference Explorations of Their Religious Patients

Lisa spoke of how her agnostic views influence her countertransference response to her patient by compelling her to view religious material as defensive:

...when a patient brings a religious comment or religious explanation, I think I immediately look at it as a defense, rather than thinking, you know, this is a spiritual experience, so I do think [my agnostic beliefs] would color how I hear the material.

Lisa also notes how her countertransference frustration to a psychotic patient was exacerbated by her own agnostic views:

This was also this father who had, with the first guy, a father who had denied what was happening a lot. I think he was uneducated in this arena, and his son was clearly psychotic. I think he was saying things that we're absolutely bizarre and the dad was trying to rationalize them, and I'd say, you can't rationalize them, they're coming from madness, but his dad didn't want to hear it. I suppose if he had taken another tack and didn't go the religious route and said no no no, you know, I'm going to go homeopathic or something, I might have had a similar response, but I think, I think not being religious and also hating bigotry, coming from me my response was stronger.

Sue's agnostic views influence her countertransference response to what she perceives to be a disempowered woman: "I think I feel sorry for, particularly, Jewish and Muslim women, who are disempowered by religious practice." She also commented on how a combination of her own dislike for authority, present from her early history, combines with her agnostic views to evoke a negative countertransference reaction to her patients' subservience to religious authority:

I've made some rebellious decisions in my life about religion and I have issues with authority, and I guess that would be what would, that would be *my* stuff. I don't want anyone telling me what to do, least of all a rabbi or priest or Imam.

For Andrea, a combination of agnostic views, which are linked to perceptions of religion as potentially 'brain washing,' and unpleasant memories of staying with her 'Reborn Christian' Godmother, evoked a negative countertransference reaction to her 'Reborn Christian' patient who she describes as "happy clappy," which "annoys" her. During sessions, Andrea often has fantasies of this patient "jumping around and kind of

Halleluja, that sort of thing.” She often thinks to herself, “I don’t know, I just, I kind of feel like people are being brainwashed sometimes, and that frustrates me.”

4.2.4.2 Therapists’ Countertransference Reactions to Patients of the Same Religious Orientation.

Nancy, Alice and Teri reflected on how their countertransference reactions are influenced through working with patients who share their religious orientation. Nancy typically finds that her countertransference is more negative, whereas Alice and Teri describe more positive responses.

Nancy described how a patient of the same religion as her can often evoke a stronger countertransference reaction, characterized by confusion around what constitutes transference and countertransference, which she expressed by stating that “the closer it is to home, as with any patient, the more difficult it is to really ‘suss’ out what is mine and what is there’s.” She further described a relative lack of objectivity when thinking about the patient and a tendency to be more judgmental:

Its more difficult if its someone of a Christian persuasion, particularly of a Catholic background, because then I think its much more subtle in the room, and they’ll talk a language that I have some understanding of, and they’ll, you know, they’ll kind of evoke more in me than someone of a different religion. Its more curiosity for me if it’s a different religion, its more a mirror if it’s the same religion, which can then make it much more tricky, much more difficult to differentiate what is mine, what is there’s, what is envy what is...me thinking they crazy and this is why, you know, Catholics get a bad name because people like you do this kind of thing, it might be more judgmental, it might be far more than I think devout patients of a different religion..

For Nancy, this also manifests as a tendency to be less questioning or exploratory as she might be with a patient of a different religious orientation:

I think it’s, the closer the religion, I wonder how that plays itself out in the room, I’m less questioning of it. Cos I make assumptions that I understand that I know what they’re talking about which is also dangerous in the therapy. You know, just because we come from similar backgrounds, or a...it’s very dangerous to make the assumption, ‘Ok fine, I know what you mean.’ If you comment on this hymn that

was really moving to you, and I know the hymn, I'm making an assumption about that, and am I making the right assumption?

Alternatively, Alice reflected on some of the advantages of sharing the same religious views as her patients. Specifically, she describes how this helps her relate to her deeply religious Jewish patient who believes that she is 'channeling' the soul of an eminent, deceased spiritual leader known as *The Rebbe*: "she speaks about how *The Rebbe* 'works through her,' Ok, and I can relate to that in a way that doesn't upset me." Speaking more broadly, Alice notes how her spiritual views allow her to remain open but questioning to the possibility of a spiritual reality – a view that contributes to her more positive, accepting countertransference response to the patient mentioned above:

I have one foot in skepticism, which stays there all the time, and another foot in total and complete belief. It's an impossible thing to be able to prove or disprove. People are far more comfortable saying they believe in a God when there's no proof or disproof, than they are about believing in another life, and I don't impose that on anybody because you can't. It's either something you have got to accept, or, you don't. There is enough proof in the world if you are able to look on it as proof, because things happen to people that cannot be explained through other means, other than telepathy. And because telepathy is a proven science, it completely disproves all spirituality.

And furthermore:

... you have to reach a place of semi-belief, in order to do this, without total and complete knowing. And part of being a psychologist is being able to be in a not knowing space, and using that because it benefits people, as long as you're not going to do harm by it...So my philosophy is, I'm gonna plug it, not because I'm being deceitful but because I do believe in it. And if I land up dying and finding it was all 'a-croc-of-you-know-what,' so what will it, how bad will it have been?
[laughs]

Teri, finally, explained how the combination of her own eclectic religious background, including roots in Hinduism and Christianity, with a patient who is himself more eclectic in his religiosity, gives her more space to think about her countertransference reactions, especially if she finds herself feeling judgmental towards him:

I think there is more room for other things to be absorbed. I think those that are quite prescriptive and those that choose a very selective root might have a limited...I mean I might feel judgmental, but it feels as though the countertransference process will be limited to a particular experience, and that, um, having an eclectic view means that the judgment comes from many angles, and that there's a thoughtfulness for all areas.

4.2.4.3 Theistic and Agnostic Therapists' Countertransferential Reactions to Patients of Different Religious Orientations

Nancy, Sue, and Teri each spoke of particular advantages of being of a different orientation, whether they themselves are theistic or agnostic, to their patients. For Nancy, she values the 'otherness' of the patient in that this may allow her to be more aware and hence less overwhelmed by her countertransference reactions, as she believes she is less able to do with a patient of the same Catholic background as her:

I think the funny thing is, if its not, in any way related to my religious belief system, I think its easier for me to keep watch on my countertransference, because its almost like, the patient is enough 'other,' that I kind of see it as that, so it can be, say if they were from a different culture, it gives me the safety of distance, and it makes me more aware of my countertransference responses.

Sue explained how her religious Jewish patients are relieved to know that she is not herself Jewish, as this boundary seems to provide them with a sense of safety around disclosing personal issues. This, in turn, makes her feel less anxious:

most of the Jewish families I've seen are hugely relieved to know that I'm not Jewish, and because I'm not part of the community they feel safer. I think that's because the religious community is so small here, and I don't think the the boundaries and discretions are well kept, they are often very anxious if they have said anything to a rabbi or religious counselor, or if they've said anything to a rabbi or have had the *Chevra Kadisha* involved, they always feel exposed.

4.2.5. Management of Countertransference Reactions Through Supervision, Colleagues and Therapy.

Concerning the ways in which the participants manage their countertransference reactions, all referred to the necessity of supervision, the opportunity to confer with colleagues, and the benefits of their own therapies.

Teri felt that her particularly strong countertransference reactions tend to hinder her ability to think in the room and tend to divert her attention from her patient. For her, powerful countertransferences are to be endured in the session and thought about retrospectively, often with the help of colleagues, as “there will always be those ‘black spots,’ that the [counter] transference happens without the thinking, and then one has to go back and look at it.” She went on to say:

[I] wait for the time to go by [laughs], um, you tend to, ya you do tend to daydream a lot. It’s much harder to stay focused, I find it harder to stay focused, my mind wanders, I’m mindful of time suddenly, I notice things outside, I notice noises, and then you have to work hard to bring your mind back. So you feel more jumpy, and your thought is harder to bring together, the thinking happens more when they leave. And the debriefing happens in the corridor, in terms of, you know, I find my colleagues in the practice are very helpful in terms of saying this is what happens, what you can’t, this is what you can do, so that was like hands-on kind of learning. And in some cases it’s almost like you don’t want to remember that, in the space you survive it, and then you leave it. You know when I think of that young boy [upon whom she felt a punitive view of religion was imposed by his Christian parents], it felt like somebody was stuffing something into my throat. So it did feel harder to be available for that little boy, because he, I think there must have been something that evoked a memory in me. So it did make it hard to get past the dialogue, and wonder about what motivated that dialogue. But the thinking happened afterwards. It was more like surviving it, and then digesting it thereafter.

She also refers to the challenge of being aware of her countertransferences, the importance of reflecting on why the countertransference with a particular religious patient is so evocative, and the importance of considering whether this may be accounted

for by something within her own personal history, or her own feelings towards this patient's religion. These issues may be thought through in supervision and therapy:

I think that the first challenge in my personal opinion is to recognize that it's there, and then to ask myself what it is that's evoking a reaction – is it my own experience of anxiety, my own experience of religion, or is it another theme underlying that that's evoking a response. And I think for me it would be about filtering what's most evocative, taking it to therapy and thinking it through in supervision, because I think to not think it through is destructive. Particularly if you've had a strong reaction to something and it doesn't have commonalities with other things that are going on in the session. So if someone is anxious and their projection is this heightened sense of anxiety and you're reacting to the religious element, it suggests that something's going on – the projections and transferences and over-identifications are all bouncing around, and someone needs to own it, and I suppose the therapeutic alliance and supervision would allow that to develop.

Similarly, Andrea implied that 'the thinking happens afterwards' in supervision or therapy:

Ya, um [I wouldn't manage my countertransference] in the session...I suppose it's just to notice it in the session, and when you're writing up your notes afterwards, just to think about what it means, but I would generally take it to supervision and my supervisor, whether here or in the U.K would be like, you need to take it to therapy, um, so I think that's still something that I struggle with – that it's in the room, I notice it in the room, but, whether it's cos I'm anxious or, whatever, I don't address it there and then, I take it away, digest it, and it's 'Ok you need to address it.'

She also noted how, in her experience, religious patients are open to hearing about her countertransference reactions – an experience which seems to contradict what she considers to be a perception amongst therapists that such responses cannot be spoken about with very devout patients:

...And when you do people don't, I suppose it's, I don't know why religion is such a 'thing,' cos when you take it back into the room, people are fine with it... it's me bringing it up saying, you know, this is how I felt about what you talked about last week and what do you make of that? And most people are willing to engage in that.

Referring specifically to the ways in which she managed her countertransference reaction to a female patient, Lisa explained that her approach was to avoid disclosing her frustration with this patient:

Supervision, therapy [laughs], being aware of them, um, I think perhaps with the young girl [who used contraceptives to enable her to be sexually active rather than for the health of her skin, and with whom Lisa felt annoyed], I'm probably managing by being overly tentative...trying to set up a rapport], but ya, I think my response is probably to be to try quite hard not to show my irritation, so perhaps an overcompensation.

Nancy emphasized the value of colleagues in the event that her countertransference is one of intense fascination or curiosity with a particular patient's religion, especially if it's a religion she may be unfamiliar with, which helps her, in turn, think about what this fascination may mean for her patient psychologically:

...the importance of colleagues, of sometimes talking to colleagues who work with religious patients, or sometimes using a colleague to ask a question rather than sit with an intrigue and hold it in my mind for when that patient comes back, I find it quite helpful, you know if it's a question on a religion I don't know, just to ask one of my Jewish friends or one of my Muslim colleagues, and just to say, 'you know I don't understand this' so just tell me, give me an outline of what that means on a religious level, so I can then step back from the religion and go 'ok what does it mean psychologically?' Whereas if I don't have any understanding I find it puts me at a disadvantage. So I find colleagues are very good way of trying to manage just that curiosity stuff with me.

She also stressed the importance of self-awareness and being open to wondering about whether or not there is something in her personal life currently that may be provoking this response.

The personal stuff around envy or around kind of, you know, irritation, I think it really is for me to work on an individual basis with that client, and then, very much, management of countertransference is self awareness around it, and is there anything happening in my own life at that point that might be feeding it or triggering it in some way.

Alice alluded to the value of initially being unquestioningly accepting of her countertransference reactions to her very religious patients – a view which she suggests

may be partly attributed to her own spiritual beliefs, which may then be shared with a supervisor who offers Alice a sense of ‘objectivity’ on the matter:

I manage it by not questioning it, I know that’s against psychology practice. I decided a long time ago not to censor, because if I’m going to do what I believe is spiritual, I’m not going to question what comes through. And so I give it out and let the patient be the one who decides, whether its working for them or not working for them. And then I take it to supervision, every week and have been since I started practicing, because that’s the only thing that allows me to be this flexible, knowing that I have somebody outside of me whose going to be my objective observer.

Sue, finally, observed how her responses of rage and anger to some of her religious patients are more projective identifications than countertransference reactions, whereby she comes to embody the patient’s disowned rage and anger:

Sometimes its not the kind of countertransference that Freud was talking about it is about projective identification, about something that does get split off., so a woman like that Muslim woman who can’t actually think, or doesn’t want to acknowledge her own unjust feelings, cos that would put her in a very onerous position, in terms of where she would fit into her own family and the extended family, I think those probably do get projected into me, and then I’m the one left with the feeling of rage and anger and unfairness.

4.2.6 Religion as Defense

All six therapists alluded to the ways in which they understand some of their patients’ religious views, broadly, as defense mechanisms. In some cases, however, these were understood as healthy, adaptive or necessary defenses, as was discussed by Alice, Andrea, Lisa and Teri. Lisa, Sue, and Nancy, however, also discussed how their patients can employ religion as an unhealthy or maladaptive defense mechanism. Interestingly, both Lisa and Sue commented on how, when used in this unhealthy way, these defenses often seem to take the form of narcissistic defenses. This view was also implicit in Nancy’s comments.

4.2.6.1 Religion as a Healthy or Adaptive Defense

Alice felt that that the hallmark of a healthy defense is the extent to which it helps one function in one's world, which includes the capacity for healthy relationships:

...how do you decide what's healthy and what's not healthy. And I think the barometer has to be how functional your life is, and how well you interrelate in your world. And if having a belief helps you do that, then where's the problem?

Thus, no matter how strange or culturally deviant the belief system, Alice feels that if it is functional in this way, it should be considered a healthy defense, and while it is valuable to explore this defense, it may be detrimental to the patient to try disable the defense:

...psychology would call [a belief in unicorns or fairies] a defense mechanism. And a defense mechanism is serving a role, and if you take it away and the person crumbles, then what have you achieved?...Until you put something in its place, you have no right to tamper with that, that's how I feel....And that's why the particular religion makes no difference. It's what the person is doing with it, how functional it is in their world, and how it allows them to grow and develop, that is my criteria.

In another example, Alice applies the same criteria to her religious Jewish patient who believed she was 'channeling' the soul of a beloved friend who recently died:

Helping her to give them both a place, keeping them both in her heart, being able to move forward without having him in her life realistically and dealing with the day to day real life issues which I have to bring her back to, without taking him away, whether it's a defense or real spiritualism, I don't know and its not mine to question, but to take that away would be to take away something that keeps her sane, at my peril, so I have respect for those things, cos whatever they are, I can't explain them, I cant disprove or prove them, so I have to respect them.

Andrea also implied that the criterion for a healthy defense is the extent to which it allows her patients to function well, and alluded to the dangers of interfering with such defenses:

if the person's happy and functioning and everything else in their life is seemingly ok, it gives you the space to go into that kind of thing, whereas if they're in a

difficult place already, um, and religion is the only thing that kind of keeping them going, why would you wanna take that away from them?

Lisa's view expands on Alice's and Andrea's by implicitly including the concepts of 'meaning' and 'resilience' to the importance of functionality:

...if it gives them meaning, if it gives them hope, if it gives them a sense of 'this too will pass,' 'I'll understand eventually why this terrible thing happened because there's a greater meaning,' you know, then I think religious belief can be incredibly supportive and helpful and healing.

She expands on this view, suggesting that, despite her agnostic beliefs, she is open to the possibility that there may be a 'mystical' dimension to the universe, and that 'getting in touch' with whatever that is, rather than with the more dogmatic versions of this in the form of organized religion, may bring meaning and joy to one's life, especially when one considers how a pathology like depression can obliterate meaning, hope and joy:

I think, finding a meaning and having a happy, fulfilled life might involve having a relationship with a religious figure. I mean, I have some of my own views that might be, I don't know if I'd say spiritual, but often if someone makes a change, things fall into place quite easily, you finally get a sense that this is the right road...they leaving their husband, for example, they've got a friend whose roommate is moving out, the new job comes. I've often had that kind of experience. Someone struggles and struggles and struggles and they make the 'right' decision for them, then things 'flow.' I don't think I've ever seen that as a religious view, but would it be mystical? I don't know how you define mystic? But I do have a sense of a greater meaning, and I do think if someone can feel that, you don't feel quite as lonely, as desperate. You know, someone whose very depressed feels like there's no meaning, and it can be very hard to go on, so, do I think there's a place for it...If I really was to put my cards on the table, I think anything that's formalized and structured in terms of religion, that's when it usually starts becoming about people and pathologies. If it's something that gives someone meaning, warmth, comfort, then I believe there's absolutely a space for it.

For Teri, she understands the healthy employment of religious belief as a form of 'containment' – a safe space where one can feel more accepting of oneself - and notes the value of religious laws and prescriptions, as opposed to Lisa's less sympathetic view of organized religion noted above:

I think I understand religion also as, for a lot of people, being a container. So I do see, you know if a religion gives you containment, a sense of where you belong, a place of rules and um, allowing me to hold onto the bad and the good, and like myself more...

Nancy, finally, spoke of the ways in which the philosophies and practices of Buddhism were initially being used by her Bipolar patient to idealize others and to deny feelings of anger. Gradually, however, she describes how this belief system was employed in a healthier way, which allowed for a more ambiguous, integrated view of humanity, and which included feelings of anger and frustration with others:

...what's very interesting, and we spoke about it a lot, how humanity came through despite the Buddhism, so then she started to get irritated with some of the monks, she started to get irritated with her fellow Buddhists who were behaving badly at the retreat, and it was very interesting, cos then we spoke about how our humanness and the fact that we are flawed as humans, and even though the rules are really clear: you have to be accepting and tolerant and kind and loving, and there's no such thing as bad and treat the ants with kindness and blah blah blah, which is a phenomenal philosophy, but that humanness comes through, and when the humanness comes through, we then had to deal with these feelings, and it became more real for her. And we spoke about the fact that she was, again, starting to have a few depressive episodes and we spoke about how now its come out of that honeymoon, idealized phase and that this has saved her life, into now this is about human beings, and that no matter how sound the theory is, or in this case how sound the belief system or religion is, you're still dealing with human beings. The interesting thing is she's been able to maintain a relatively stable bipolarity, she's not gone back onto medication, so this patient has done extremely well, and she still practices, she's far more real in the world, she's much more real – she comes in irritated, she comes in moaning, she comes in frustrated with traffic, all the stuff – but what she does have now that she didn't have before is a structure that allows her to deal with things in constructive ways. So the meditation, the mindfulness, gives her a way to channel, to think about. And I think that is a way in which Buddhism is very different from other religions, that it is whatever thought comes into your head, think it, just think it. Whereas other religions are: 'that's a bad thought, that's an evil thought, is this the devil in my head?'

4.2.6.2 Religion as an Unhealthy or Maladaptive Defense, including as a Narcissistic Defense

Lisa noted how her patient used the Christian practice of confession to absolve herself of all responsibility for her sexual behavior. Once she had confessed her actions, she felt no

need to explore them in therapy, as if these actions had been “undone:” “It’s almost as though she can have sex with someone, go to confession, and it gets wiped out, it’s undone, so she doesn’t have to reflect on it.”

Sue noted how when religious belief is employed as an unhealthy defense, it seems to resemble a narcissistic defense: “It makes me think of how I work with narcissistic defenses which often evoke the same countertransference reaction, which is that you’ve got to walk on egg shells.” Lisa implies a similar perspective regarding her religious Jewish patient. She believed this patient used her religion to feel superior to others as a defense against a painful early history:

I think... the condescending patient was condescending in many things she did, ok, and it was absolutely a defense against this terrible background she came from. She used to receive brown paper packages, with people’s second hand clothes, and her defense against that was to get herself trained, she became a professional, and she earned a lot of money, and she would wear every kind of label, but very expensive, you know, she would wear *Manolo* shoes and *Lois Vuiton* bags, and everything was, ‘I’m better than you, I’m better than you.’ So, there’s a lot from her that was condescending anyway, so a lot of that comes from the patient. But I do think, seeing religion as a little bit of a defense, um, when someone tells me how special they are because they keep Kosher, I’m going to go ‘really?’

Lisa illustrates, further, how this patient’s Judaism was used as a medium through which to perpetuate her grandiosity:

And as my patient got older, and got married and had kids, she got more and more devout. So she kept Kosher and had the kitchen with the two sets of crockery and everything. And it also felt like a defense against her childhood, ok, she was going to be more Jewish than anybody else because she had grown up less Jewish, although she’d gone to a Jewish school and, she grew up in a poor family and had help from all the Jewish helping hand associations. So it also felt to me like the religion wasn’t something that...that it meant a lot to her. This wasn’t something that she loved or gave her meaning. It felt like it was a thing to do to make her more special. And there was also something very much in her engagement which was very much ‘holier than thou,’ you know.

Nancy also described how some of her religious patients have used the notion of ‘enlightenment’ to perpetuate their grandiosity over and above agnostic or atheistic

individuals. She further notes how her Buddhist patients tend to employ this defense to a lesser degree:

...many of these very religious patients of mine are quite judgmental of others that aren't. So it's not about what religion they are, it's about, 'they're not as enlightened as me.' You know, and when you find God, Allah, whatever, you will also come to this enlightened place. Funnily enough Buddhists tend to be less like that [laughs] which is quite interesting [laughs]

Connected to the use of their beliefs in a narcissistic way, Nancy also suggests that some of her orthodox religious patients have a tendency to be quite dogmatic in their thinking, which contributes to their potential intolerance of others, but which again, seems to be less applicable to her Buddhist patients:

So, I think, that's why I say, [Buddhism is] very much a philosophy rather than a religion, it's a philosophy of life, whereas others are, you know, very black and white, there is good and there is bad, there is right and there is wrong, you'll go to Heaven or you'll go to Hell, or wherever you believe you'll go to, and shame you the damned one. So they can be very judgmental and very critical of others.

4.2.7. Healthy and Pathological Religion

Some of the participants, namely, Nancy, Andrea and Sue, proposed that healthy religion in their patients is broadly associated with a capacity to think about, explore, question and choose their religiosity, whereas pathological religion is characterized by intolerance for these capacities. For Lisa, Nancy, Teri and Alice, healthy religiosity in their patients meant that religion constitutes an internal experience more than an outward show of behavior, and that healthy religion resembles other healthy forms of relationship to others and the self. Religious communities were also alluded to by Nancy and Andrea as potentially nurturing. Sue and Alice implied that religious or spiritual well-being is in some sense necessary for psychological well-being. Lisa and Alice, finally, associated some forms of religiosity with psychosis. Alice, however, implied that this does not necessarily render it unhealthy, even though some beliefs or practices appear both out of touch with reality and culturally deviant.

4.2.7.1 Healthy Religious Practice as a Capacity to Think, Question, Explore, Be Curious and Be Flexible.

Nancy emphasized the value of thought, choice, and the elements of a healthy relationship, including the freedom to feel, as essential for healthy religiosity in her patients:

... I think any adaptive behavior or healthy behavior allows for a questioning understanding. So I think the minute anybody comes in and just has this ‘don’t go there, don’t challenge me about that, I go about this without question’ I immediately see it as maladaptive on some level. So, if someone has chosen that, in their history I hear that, through their life they were raised in way, they were angry with it and moved away, and then by choice they came back to it, I often see them as more adaptive than someone whose never questioned, they’ve never, I often ask myself, ‘what does that mean about their psyche?’ In terms of the way they are in the world, And what they allow themselves to be, almost brain-washed with. I mean its quite a powerful word to use, its quite a judgmental word to use but I do sometimes feel with patients that have never questioned, have always grown up in a very devout home, followed that path, they do what their mothers did what their grandmothers did, I struggle more with them around it being : ‘how healthy is this, how adaptive is this behavior?’ and I tend to think its less healthy or maladaptive that they’ve just role modeled and replicated and, aping behavior rather than choosing, and I do feel that, and it’s a personal thought that, no matter what your belief system is, ‘where’s there space to question, where’s there space to wonder, where’s there space to feel, if its anger...cos it is a relationship at the end of the day, for me, that’s how I think of faith, as a relationship, whatever you believe the maker is, or creator, it’s a relationship, and relationships should by very definition go through variation – there are times of closeness and times of distance. So when it just never happens, I think, what is this really about? It feels two dimensional, it feels just like a cloak you’ve wrapped over yourself rather than something you grapple with. If it’s your belief it’s your belief, but question it and wonder about it and be willing to ask questions about it. So I think health and adaptability would be for me about an ability to think about, in an open way, about the religious belief, rather than just wearing it as a cloak, ya....

However, in her experience, she has often found very religious patients intolerant of questioning their religiosity non-defensively, as well as having a propensity to perceive ‘otherness’ as threatening:

whether it's a Jewish woman wearing a *shatil* or a Muslim woman wearing a head cover whatever it is, they wear their religion, it's out there in the world, and I think it's quite interesting cos they're almost quite adversarial in their relationship with others – 'so you're either for me or against me' – and its quite interesting because it doesn't allow the questioning.

Similarly, Teri felt that healthy religion has the elements of a healthy relationship, some of which include fluctuations in and flexibility around how one feels towards the other:

..for me healthy suggests, um, a relationship with religion rather than a, a rigid controlling response and living out of religious beliefs. That there can be ebbs and flows to a religious engagement, and that if the rules are what govern you to your own detriment, I would consider that unhealthy.

Like Nancy, Andrea also indicated the ability to question as fundamental to healthy religiosity:

And I suppose my understanding of a religion is that it is about questioning things, about questioning why this happened or where this happened, um, and to feel like you cant question, you know, if you challenge your God, and you get the answer you want, isn't that a positive aspect of it? But if you feel like you can't even challenge...

Similarly, Sue refers to necessity for choice and mindfulness in healthy religiosity:

They need to have chosen it rather than inherited it. And in some way chosen it mindfully, um...its got to do with mindfulness, or its got to do with reflective functioning, its gonna all come back to that, because its got to be, um, a capacity to think about the extent to which behavior may be informed by religious beliefs, or religious beliefs are used defensively to manage a situation...

She applies this to her adolescent Jewish patient who seemed to use her religion in a maladaptive way, partly as a consequence of the incapacity to apply freedom of choice to her personal identity while growing up. Therapy, as a context within which to think freely, became a space which provoked rebellious sentiments towards the religion of her parents:

I mean I can't not allow her to use this space in whatever way she wants to, and she's gonna have to sit down at some point and make a choice, and she may choose for and she may choose against. You know, her parents...so I think it's got to do with the adolescent talks of 'who am I?' 'who do I want to be?' I think that somewhere there has to be that. And I actually, when I think about it, when I think about the Christian woman that I saw, she was...I mean it was an adolescent issue that was delayed, she hadn't found who she was in terms of religion, it wasn't part of her evolution of self. That's what I think needs to be there for it to be healthy.

Lisa's took a less sympathetic view towards religious behavior. For her, healthy religiosity primarily constitutes an internal experience, without the necessity for specific religious practices, which can often be exhibitionistic:

I think when it becomes quite rigid, and it's more about behavior, so, for example, going to mass with the young girl and keeping your kitchen a certain way, um, that's when I start to think it's maladaptive. I don't know where the theory would be on that, but I guess for me, it's when it's more about an internal experience, I would say that's more adaptive. When it's more about behavior and other people seeing that behavior, that's when it's more maladaptive.

Finally, Alice described healthy religiosity as a vehicle towards joy, a celebration, and an expression of love rather than fear, with room for adaptability and change:

...there are people who practice their religion slavishly because they're scared not to, and then there are people who absolutely believe like the Rebbe, who can digress, because their practice is an expression of the love of their belief, and not a fear of not practicing... When you are strictly following laws to the detriment of the people around you and yourself. If you are ill and you cannot phone a doctor on Shabbos to save your life, that is absolutely self destructive.... And when it's used to make our life pleasant rather than unpleasant. There are people who have a vested interest in suffering, and they use the practices to entrench the suffering.... It's the vehicle they're using, there's no question about that.

She shared a poignant story about her religious, terminally ill female patient, whose father had reportedly been quite punishing in the way he practiced his religion. His almost sado-masochistic relationship to his religion was gradually 'softened' by his dying daughter:

But funnily enough this young girl who died of cancer, this young woman, she had such a father, a very self-punishing, rigid father who made religion a persecution and not a celebration – perhaps that’s a better way of describing it – but she broke him down, and when she was in the hospital, here at the xxx clinic, because she took two weeks to die, he broke all the rules, and it was just amazing to see him break all these rules, and he was just so completely able to be with her in those two weeks. Um, she wore no clothes, she couldn’t put any clothes on, they were so painful, and he would sit in the room with her, and he brought in a Rabbi to see his naked daughter to change her name...

4.2.7.2 Religious Communities as Nurturing

Nancy described the therapeutic value of being immersed within the Buddhist community for her Bipolar patient:

...she was practicing, she was going for retreats on week-ends, she was part of the *Lanwa* temple in Bronkospruit and she would go there. It was an incredibly containing, nurturing, safe environment, which she had never experienced before....And it was the thing of kind of, passivism and, equanimity towards everybody, and during that very kind of transformational period she would bring me Buddhist beads, and it was the first time she had brought me a gift, and we spent a long time talking about the meaning of these beads, and kind of, what is it replacing, and transitional objects, comforter, soother, all this kind of stuff.

Andrea also referred to the supportive nature of religious communities:

people do find a lot of comfort and support in religion, and community, I think going to church or being involved in community groups or whatever it might be can be hugely supportive to people.

4.2.7.3. The Necessity of Religion for Well-Being

Both Sue and Alice implied that spiritual or religious belief is necessary for psychological well-being. Sue stated: “I do think that spiritual well being is probably an important part of being healthy” and Alice reflected as follows:

...the truth is, it’s more useful to believe in it than to not, and I’ve seen that, with my scientists.... Psychologically, managing your life, living an effective life, dealing with adversity and tragedy, its far more functional, to actually believe.

4.2.7.4. Religion and Psychosis

Lisa and Alice associated certain forms of religiosity with psychosis. For Lisa, this constitutes religion at its most unhealthy, whereas for Alice, this is not necessarily the case.

Lisa observed:

...it is very interesting when you're in a psychiatric hospital, and those that are very mad, in the throes of an acute psychotic episode, how often the delusions are religious. And I've often questioned that and what is that about, and why when the frontal lobes and the thinking and reasoning is all stripped away, why does humanity go there? Is it to try find a meaning? Because if you're mad and the world's a scary place, you need to have some sense that there's a structure, that there's a meaning. The interesting thing is though, when they are religious, they are the messiah, and it's quite interesting to me, and it's interesting that you see that in psychosis. And maybe that shows my agnostic views again, but I guess what I'm implying is that when someone gets really sick they get religious.

She illustrated with an example whereby her young male patient was engaging in religious delusions. The patient's father, however, was resistant to the idea that his son was psychotic:

This was also this father who had, with the first guy, a father who had denied what was happening a lot. I think he was uneducated in this arena, and his son was clearly psychotic. I think he was saying things that we're absolutely bizarre and the dad was trying to rationalize them, and I'd say, you can't rationalize them, they're coming from madness, but his dad didn't want to hear it.

Alternatively, Alice expounded on an interesting case whereby her religious Jewish patient believed she was 'channeling' both the soul of a beloved friend who had recently passed away, and the soul of an eminent, deceased Jewish spiritual leader known as *The Rebbe*. While Alice is open to the possibility that this may be the case, she appreciates that this may appear "loony" to other people:

she's a woman whose husband is a rabbi and she, they run a seminary together. They're from xxxx, they're only three years in South Africa, they're struggling to

integrate into the communities here, um, and she believes that she was sent by the Rebbe – her and her husband – to do the work they do here. But in her loneliness, cos she has been quite lonely, she has, she found in a very religious Jewish doctor...she found in him a confidant, a father figure, because he's so religious, and because he's so kind and caring, he kind of became her real life sanctuary, while the Rebbe is her spiritual sanctuary. And with the passing over of this doctor she went into a really desperate state and didn't know what to do with his loss and didn't want to confuse his soul and whether he could be talking to her with the place that the Rebbe had held, it felt disrespectful to the Rebbe...This sounds loony, doesn't it? [laughs]

4.2.8. Religious Material in Psychotherapy: Advantages and Disadvantages

Implicit within participants' responses were references to various advantages and disadvantages of religious material in psychotherapy. Sue, Nancy and Alice referred to the benefits of religious belief within the context of bereavement and suicidal ideation, while Alice spoke of how the patient's religious beliefs may provide the opportunity to do deep analytic work in a different way, and she gives examples of these. A core disadvantage alluded to by both Nancy and Sue was the 'inappropriateness' of challenging their patient's religious beliefs.

4.2.8.1 The Advantages of Religion in the Context of Bereavement and Suicidal Ideation.

Sue spoke of how "when you come to things like bereavement that you know, working with more spiritual meaning-making" can be immensely beneficial for a patient. Nancy elaborated on this, and also noted how her countertransference was one of envy towards a patient who was able to find such clarity of meaning following the death of a child:

...and I'm thinking of one patient who went through the death of a child, and her religious belief gave her such enormous comfort, and her way of grieving and mourning was dictated by religion and I almost thought to myself, I remember thinking with her 'wow it would be so amazing to have that kind of... Just absolute faith, that this is the answer and you will see your child again and this was meant to be and its God's will...I remember sitting with her at times and feeling quite baffled and quite envious of that wonderful, neat explanation, so, that's quite interesting.

Alternatively, Alice discussed how, in her experience, atheistic patients, as well as herself as the therapist, are faced with profound challenges in finding meaning through the pain of loss or adversity, as opposed to her religious patients:

... *Very* difficult [to work with very atheistic patients]... Very difficult. I find it very difficult to find a way in to help them make sense of adversity. I had a couple who lost a child, and they have no way to make sense of that. They feel so terribly persecuted. And there isn't any way that you can help them come to terms with the fact that they're either to blame, or that they're being punished... Ya. And then your scientists who believe in randomized things happening, they don't know how to move on from it. They don't know how to really make some sort sense of it. They feel out of control, insecure, because it becomes an external locus of control rather than an internal locus of control...When you have some kind of belief system and make sense you can take charge of your healing, but when you believe that things are randomized and just science, then you're at the mercy of the universe.

In discussing her experience with religious patients with suicidal ideation, Andrea noted how religious belief acted as a protective factor. Even though, as she suggests, this may be 'maladaptive' since the only resistance to suicide is based in fear of punishment, it nonetheless protects them from committing suicide:

I suppose in another way, thinking about people who are, who have suicidal ideation and that sort of thing, a lot of [religious] people who are suicidal have said to me, you know, I would never do it, I would never commit suicide, so you know, that's quite a good thing [laughs] that they have that, and they do, as much as they want their life to end, they won't kill themselves, they will not do it because of the fear that will happen afterwards. Again it's a bit maladaptive I suppose if that's the only thing that's keeping them alive

Alluding to other benefits of the patient's religious beliefs in psychotherapy, Alice spoke interestingly of a religious Jewish, terminally ill patient who was deeply intuitive, and went into 'spiritual trance states' during the therapy. This gave Alice the opportunity to do deep analytic work in a different way, as opposed to taking a strictly psychoanalytically informed approach, as she initially undertook with this patient:

Another patient whose passed on. She was a deeply religious person who developed a rare form of cancer that had no treatment. And um, she was my patient for seven

years. And she initially came to me because she thought she had cancer and nobody believed her. She'd been to all the doctors, they had done all the tests and things and found nothing. So she was referred to me for some somatic illness. Um, very religious, and she said that she had this deep conviction that she had cancer and she was going to die. Very young, she had small children, she was only thirty. Well I did all the usual therapy, arrogantly, did all the psychosomatic stuff [laughs] only to find, lo and behold, that two years later, she was diagnosed with cancer. So we started to work differently. We started to work with how did she know, where did she know from? She was a very bright girl, exceptionally bright...and she continued to deteriorate. And our work became spiritual in that we did, I suppose you could call it hypnosis, but it really wasn't. She would go into trances and we would work in the trance space. She'd sit here, I'd sit there, as she got more ill she'd lie on the bed. And, she would speak about where she went to, her discussions with *Hashem*, and she started to teach – she was a teacher at *Yeshiva* – she started to teach these young woman the most amazing religious Jewish stuff, that was coming to her...

She describes, further, how some of her very religious patients who believe in the existence of past lives can be regressed through hypnosis into their past lives. This provides further opportunities for doing different work within a broader psychoanalytically oriented approach. Alice's own spiritual beliefs also contribute to the provision of these opportunities:

... very often you can hypnotize people and they go back to their other lives... So where do you put that into your psychoanalysis, you know? You're intending to do this, and you get that... [this constitutes] some of the evidence that makes me believe that there is this world of spirit. Not because I intend to do that, I don't do it as a party trick and I don't intend to do in therapy, it happens on its own.

4.2.8.2 The 'Inappropriateness' of Challenging Religious Beliefs

Sue referred to a need to be particularly cautious and tentative with regards to exploring her religious patients' beliefs, as if this would violate something sacrosanct, which she finds interesting, given her willingness to question patients about other aspects of themselves, such as their sexual orientation, parenting styles and their relationship with their spouse:

... why should I feel like I know a person's religion from the inside in order to think about it with them in the room, when I don't presume to know what it's like to be in any of another... I mean I don't know what its like to be in a lesbian relationship and I have a lesbian... I mean I don't know why I have that idea. But there's a bit of a, kind of a, like something's a bit sacred, to use a pun, it's almost like... you don't ask them to question that. But I would ask them, "why do you smack your child?" or you know, "why do you think its ok for your husband to have an affair?"

For Nancy, there is something anxiety provoking about the prospect of exploring religious beliefs in her devout patients as a therapist, as if this would transgress some kind of boundary – an anxiety which she feels is exacerbated by what she claims to be many of her religious patients' dogmatic adherence to their world views, as well as by feelings of inadequacy on Nancy's part associated with being unknowledgeable about a patients religion:

... generally speaking they quite a challenge in the room because they come in with such fixed beliefs about the world and how the world works and about the meaning of things, so whether it's a very devout Muslim or Catholic or a Jewish person they have a very particular world view and either they spend that time, it feels to me like educating me about that world view or expecting me to have an understanding of it, and it's difficult because they don't like to have that world view challenged, and who am I as a therapist to challenge a religious or spiritual world-view?

4.2. 9. Commonalities Between Psychoanalysis and Religion/Mysticism

Most of the participants, including Teri, Nancy, Alice and Andrea, suggested that what is common between psychoanalysis and religion or mysticism is that both essentially deal with non-scientific or 'abstract' explanations of human behavior. Sue and Andrea also referred to other possible commonalities between the two, such as the tendency for both to work on the 'charisma' of either the therapist or religious head, the 'goal' of both being the 'search for the true-self,' and the necessity for 'faith' in both areas.

4.2.9.1 Psychoanalysis and Religion/Mysticism as dealing with the ‘Non-Scientific,’ or ‘Abstract’ Explanations of Human Behavior

Teri suggested that both domains seem to implicate something ‘abstract’ – something that we do not necessarily know much about in a ‘scientific’ way:

I don’t know, maybe it is about just thinking that there are other things going on that contribute to something...the ah, the abstract is what makes it common rather than the concrete.

Nancy also felt that psychoanalysis is more akin to a philosophy of human behavior than a science, as is religion or mysticism:

...for me, the theory of psychoanalysis borders a little bit on a philosophy, more so than just a scientific fact. So it’s a philosophy of understanding what is human nature about – the unconscious mind, and the drive forces, or whatever the theory is, it’s an explanation of human behavior, and what is religion at the end of the day? An explanation of human behavior.

She further alludes to the fundamentally ‘unscientific’ nature of psychoanalytic thought by claiming: “as I say, its how you prove the existence of the unconscious” and moreover, suggests some interesting implications of considering that the unconscious is as abstract as a soul or a ‘higher power,’ and the kinds of parallels we may draw between psychoanalytic concepts like ‘projective identification’ and religious phenomena like ‘possession:’

But from a theory point of view, is there a place for mysticism in psychoanalysis? What would it mean for the unconscious mind if we say that there’s a higher power? ... [talking about projective identification]... you might as well talk about possession!

Alice takes up this theme by similarly querying the empirical status of concepts like projection, projective identification, countertransference and transference, by emphasizing that these are fundamentally abstract and unscientific concepts that almost require a mystical understanding to be meaningful:

I think [religion/mysticism] is seamlessly intertwined for me with [psychoanalysis]. I don't know how to separate it out. I don't know what you would do with projections, projective identification, transference, countertransference, if you don't think that they're intertwined, and I think that psychologists struggle with it...I mean I remember one of my lecturers at university when I said, "define projective, what do you mean when you say that people project?" She said "well I...?" And its psychology attempting to be a science when it isn't a science.

Alice elaborates by wondering how it is that a therapist may intuit, sometimes exactly, how another person is feeling, almost as if such intuitions are to be accounted for by an unknown mechanism beyond the realm of the senses, and which psychoanalysis gives the names 'projection' or 'projective identification.' She also refers to an area of overlap between certain branches of science such as 'quantum theory' and mystical sciences such as *Kabbalah*, where events became strange and abstract indeed, seemingly beyond the explanatory reach of science:

For me it isn't possible to separate out the two. I don't think it's possible to separate out the two having a general conversation with people. You walk into a room, you know when people are depressed. How do you know? What is it that's going on there?...What's going on?...Sometimes what you feel is desolation, sometimes what you feel is flatness, how do you know? But you know. And how you know that cannot be explained in science. It can be explained in quantum theory....So, we can't, do we have to give it a name, do we have to categorize it, and can we simply live in the 'not knowing' as Bion says? Go in with no preconceptions....it doesn't matter to me what religion the person brings into the room, I know we're all talking the same language..... And I have also delved into *Kabbalah*. And I don't see a difference there either.

Alice also makes this point with reference to dreams, and suggests that, ultimately, the question of whether psychoanalytic or religious concepts are 'real' is irrelevant in the field of psychotherapy. What matters is how these concepts are used to make meaning by the patient:

...if you have a look at dream interpretation, where those dreams come from, what they're for, what you're gonna do with them, can have so many different belief systems. You can either think they're coming from your unconscious, then it brings into question what is your unconscious, are you Jungian, is it a collective unconscious, what does it mean that there is collective unconscious, is it wishful thinking on your part, is it your brain categorizing the events of the day, or is it

your guide coming through to talk to you, or is it your mother? Or is it your ancestor? Or does it have to be any one of those?... It doesn't matter. It's what you do with the dream.

Andrea also gestured towards dreams as a potential point where Western 'scientific' concepts, in the form of the DSM, and religio-cultural concepts, converge: "Um, you know we all have, you have your internal dialogue, you have dreams, and if you talk about it, maybe we're all a bit crazy, according to the DSM!"

4.2.9.2 Other Commonalities Between Religion/Mysticism and Psychoanalysis

For Sue, psychoanalysis and religion potentially converge on the status of either the psychotherapist or spiritual leader, in that both can be invested with cult-like power, which may be the primary mechanism of healing in both areas of human behavior:

In my most cynical moments, I think that the reason why they can't really find a difference, in any of the efficacy studies, between the different [psychotherapeutic] modalities, is because I think a lot of them kind of work on the charisma of the practitioner...that at some level they're charismatic, and in that way I think that psychoanalysis can be a bit charismatic, like a charismatic religion. You change because you know, you're inspired to change. But that's quite cynical part of me, and when I practice I hope I don't practice using charismatic kinds of principles [laughs]

Sue, further, alludes to the potentially problematic perception that the aim of psychoanalysis is not merely the pursuit of self-knowledge, but the uncovering of a 'true-self' – a goal shared by mysticism, which seeks to know the 'true' or 'higher-self.'

I think that there may be something of a, of a similarity to or sort of, mystical practice in that it's a journey or a discovery, and the idea that there's a kind of a holy grail at the end of it, you'll 'know yourself'...and I think that's probably dangerous, actually, to set psychoanalysis up as...

Andrea, finally, implied that both the enterprise of psychotherapy, including psychoanalysis, and religion require the patient or religious practitioner to have 'faith:'

I guess when people come into therapy you ask them to trust in a certain belief about something, that this process is something that is done in a certain way, and you don't know about it, but you have to trust me in the long term...With religion you get taught something and you trust that that is how it is and that it is for your benefit. You know I think ultimately religions, you know people don't join a religion because it's a negative thing, you know they feel its going to benefit them. But I thought that was interesting that my immediate reaction was like "no ways, what we do is scientific somehow, and yet religion is not." And yet what we do somehow is about putting yourself into something and just 'knowing' somehow and that it will work.

Chapter Five: Discussion

5.1 Introduction

This chapter consists of a synopsis and a discussion of the findings. The synopsis will summarize the key findings, including similarities and differences across participants' responses, and the discussion will analyze these findings further with reference to the literature. The synopsis to follow will provide tentative responses to the three research questions being explored, namely:

- 1) What particular countertransference responses do deeply religious patients provoke in psychoanalytically informed psychotherapists?
- 2) How do differences in personal religious orientation between therapist and patient influence the nature of the therapist's countertransference?
- 3) How do psychoanalytically informed therapists manage religiously influenced countertransference responses?

It will also highlight interesting common findings across participants' responses that do not necessarily offer potential answers to the research questions, but which say something thought-provoking about psychoanalytically informed therapists' work with religious patients.

5.2 Synopsis of the Findings

The findings show that most of the psychoanalytically informed therapists' countertransference reactions to their religious patients were broadly therapeutically challenging and were associated with a feeling of being incapacitated or frustrated in various ways. Both of these responses suggest a feeling of being 'stuck' or 'hindered' from doing something in the therapy. This general response is captured by Sue's claim that "it is about something prohibitory and something that blocks off thinking." There was a common feeling amongst the therapists that the religious beliefs of their very

devout patients were often so ingrained and inflexible that the therapist felt unable to ‘go’ into particular material for exploration. This feeling of being ‘denied access’ into certain areas of thought, however, was also associated with anxiety for most of the therapists. It was not simply that the therapists often felt debilitated in their efforts to open up religious material for further exploration, but that they felt apprehensive to do so based on a deeper feeling of trespassing inappropriately onto something sacrosanct. Lisa captured this pervasive countertransference response by noting that “[religion] is also, as I said, sacred ground, literally.”

Religious material was thus generally, and rather anxiously, felt to have an impervious and privileged space within psychotherapy, and all the therapists suggested, in different ways, that they ‘tread extra carefully’ when exploring, interpreting, or challenging their patient’s on something associated with their religious beliefs, more so than when they explore other intimate material, such as a patient’s sexuality. Only one participant, Nancy, discussed countertransference reactions which were neither broadly associated with feelings of paralysis or frustration. She referred to more ambivalent reactions such as envy for the psychological security that her patient’s religion afforded her, as well as feeling fascinated and seduced by a patient’s religious material, but which was also, ultimately, rather incapacitating. The only example of a positive countertransference reaction, discussed by Nancy, was a feeling of respect for some of her religious patients’ love and devotion to their religion. Interestingly, however, the six psychoanalytically informed therapists interviewed here generally had therapeutically challenging countertransference reactions to their religious patients.

The second broad set of findings reflects the ways in which differences in religious orientations between therapist and patient may influence the therapists’ countertransference reactions. The therapists who described their religious orientations as ‘agnostic’ (Lisa, Sue and Andrea) generally focused on their more negative responses to their patients. This typically involved the tendency to view their patients’ religiosity as defensive. Therapists’ agnostic beliefs, moreover, seemed to exacerbate existing challenging countertransference reactions, such as frustration. The theistic therapists’

(Teri, Nancy and Alice) responses to their religious patient's were more ambivalent, and ranged from especially evocative responses if the patient shared the therapist's faith, accompanied by the feeling of being unable to think about them 'objectively' during sessions, to a greater sense of openness and acceptance of the patient's views. Further, both the agnostic and theistic therapists alluded to certain advantages when their patients were of a different faith. This allowed them the capacity to think more 'objectively' about them and the safety of boundaries. Nancy captured this by her claim that "the closer it is to home, as with any patient, the more difficult it is to really 'suss' out what is mine and what is there's." This corresponds to Bergin's (1980 in Lijtmaer, 2009) claim that therapists who share their patients' religious beliefs are at risk of over-identifying with their patient's, which may be experienced as a hindrance to deeper understanding.

Thirdly, concerning the issue of managing these countertransference reactions, all the therapists referred to the importance of supervision, having the opportunity to discuss their experiences with their colleagues, and the significance of their own therapy. The therapists also spoke of the importance of being open to the possibility that something 'going on' in their own lives at a given time may be evoking a particular countertransference reaction. Some, particularly Alice, spoke of how one often cannot know whether the countertransference is primarily being evoked by the patient's transference, or whether it 'belongs' more to the therapists. Most of the therapists suggested that countertransference reactions are an amalgamation of the therapist's and the patient's psychic content.

Finally, considering other findings, all six therapists discussed the ways in which they view their patient's religious beliefs or behaviors as defensive. In some cases, these were understood as healthy, adaptive or necessary defenses, and in others, as unhealthy or maladaptive defense mechanisms. Interestingly, both Lisa and Sue commented on how, when employed in this unhealthy way, these defenses resemble narcissistic defenses. In commenting on their views of healthy and pathological religion in their patients more broadly, most of the therapists considered healthy religion to be associated with a capacity to think about, explore, question and choose their religiosity, whereas

pathological religion was characterized by intolerance for these capacities. Healthy religion was also premised on being an ‘internal experience’ rather than a repertoire of external behaviors, and further, that it resembles other healthy forms of relationship to self and other. Religious communities were also alluded to as potentially nurturing. There were, moreover, associations made between some forms of religion and psychosis.

The therapists also implied that there are particular advantages and disadvantages to doing psychoanalytic psychotherapy with religious patients. Some of the advantages included the protection afforded by patients’ religious beliefs in the context of bereavement and suicidal ideation. Alice also spoke of how both her own religious beliefs and those of a particular patient give her the opportunity to do deep analytic work in a different way. For some of the therapists, a core disadvantage of doing psychotherapy with the very religious, however, was the difficulty of challenging patients’ religious beliefs, which often felt ‘inappropriate.’ In reflecting, lastly, on some of the potential commonalities between religion and/or mysticism and psychoanalytic thought, most of the therapists proposed that both essentially deal with non-scientific or ‘abstract’ explanations of human behavior. Other parallels alluded to were the tendency of both to work on the ‘charisma’ of either the therapist or religious head, that both share the aim of ‘self-knowledge’ or coming to know a ‘true-self,’ and the significance of ‘faith’ in both disciplines.

5.3 Discussion

This discussion will analyze the findings further with reference to some of the literature cited in the literature review, in addition to drawing on other extant primary and secondary literature. First, it will discuss the therapists’ countertransference responses to their religious patients. Then, it will discuss the findings concerning how differences in personal religious orientation between the therapists and their patients influence the nature of the therapists’ countertransferences. Third, the findings regarding how the therapists manage their countertransference reactions to their religious patients are discussed. Lastly, it refers to relevant literature in a discussion of the therapists’ views on

religion as a defense, on what, for them, constitutes healthy and pathological religion, on some of the advantages and disadvantages of doing psychoanalytic psychotherapy with religious patients and on the perceived similarities between religion and/or mysticism and aspects of psychoanalytic thought.

It is significant, firstly, that the six psychoanalytically informed therapists interviewed primarily had what may be considered to be negative countertransference reactions to their religious patients. These reactions, as noted, broadly took the form of a feeling of incapacitation, anxiety associated with incapacitation, and frustration. These particular responses of psychoanalytic psychotherapists to their religious patients do not appear uncommon, as they have been documented in the work of Sahlein (2002), Bartoli (2003), Cohen (2009), Charles (2009), Spero (1981a; 1981b; 1985; 1995; 2009a; 2009b; 2009c), Fauteux (2009), Meissner (2009), Peteet (1981; 2009) and Rizzuto (2009). Ogden (1979) proposed that countertransference reactions typically fall within three broad categories. First, they reflect the therapists' neuroses, which are provoked by a particular patient. This interferes with the therapist's ability to respond therapeutically to the patient. Second, they may reflect the interaction between the therapist's and the patient's pathologies. Finally, they may take the form of projective identifications, whereby the therapist empathically comes to embody a painful, split-off aspect of the patient's self, which the therapist can process for the patient and eventually return in a manageable form. All six therapists, however, attributed the greater part of their countertransference incapacitation, anxiety and frustration, to their patients' religious beliefs. Thus, these responses are initially considered in light of Ogden's (1979) first usage of countertransference. In addition, Straker's (2006) concept of the 'anti-analytic third' is highly applicable to these responses and will also be considered in accounting for the countertransference 'paralysis' experienced by the participants. For the participants, it was primarily something about the nature of their patient's religious beliefs, to wit, their omnipotence and rigid inflexibility that was perceived to account for these negative reactions. Nancy's exasperation aptly elucidates this:

That for me is the hardest thing, they shutter you down – ‘God wants it this way or Allah wants it this way.’ What do I do with this? I can’t compete against Allah, I can’t compete against God, I’m stuck here! ... I have had moments when I think, ‘Oh God, what do I do with this patient?!’

The intensity of the paralysis evokes the feeling that the therapist is almost vying with the patient’s God for access to the patient’s psyche. In this instance, Nancy may have experienced her patient’s religious beliefs as an ‘anti-analytic third’ (Straker, 2006), that is, as a pernicious discourse around her patient’s perceived relationship to God that undermines the essence of psychoanalytic psychotherapy as the cultivation of mindfulness, contrary to the fostering of healthy intersubjective reactions between patient and therapist, or ‘analytic thirds’ (Ogden, 1994). Further, Rizzuto’s (1979) research has shown, however, that the patient’s God, when theorized as an object relationship, is an unconscious amalgamation of the patient’s primitive feelings towards their early caregivers. This implies that we all have a personal God, such that there is no God concept independent of the nature of our other object relationships. For this reason, the psychoanalytic therapist may encounter defenses in their pursuit to explore their patients’ religious beliefs as unyielding as if the therapist were attempting to elicit the patient’s repressed unconscious associations towards their early caregivers. This scenario would understandably meet with formidable resistance. There may also be something here about the ‘mortality’ of parents, that their flaws subject them to being ‘deconstructed,’ whereas by definition, one’s God is ‘perfect’ and thus ‘off-limits,’ rendering religious defenses ever more resistant to being challenged therapeutically. Alice shared this feeling of paralysis and associated anxiety. Her question: “... how do you say anything against a priest !?...”, alludes to the difficulty of challenging an internal object that has been more than idealized, but almost *deified*, by the patient.

Yet interestingly, the therapists seemed to imply that there was something about their patients’ constellation of religious defenses that were more impervious to exploration than the defenses they might encounter in other material. There is something about religious content per se that, as Sue noted, “feels loaded,” and as Lisa claimed, makes the therapist “[feel] stuck...walking on eggshells.” In addition to invoking Rizzuto’s (1979) object relations perspective which may partly account for why the therapists may have

felt incapacitated and frustrated when trying to explore their patients' religious beliefs, Lisa's comments regarding her varsity aged Catholic female patient gesture towards another possible explanation:

the mental gymnastics she does to explain how she's both Catholic and sexually active leaves me going... 'get real here,' so, but its very hard to engage with, because if you try and question a belief, *then you're seen as doubting or undermining...* (italics added)

Lisa's usage in the italicized comment, especially the phrase "you're seen," alludes to a further issue concerning her feelings of incapacitation, anxiety and frustration, which is that she is aware of a meta-perception that the distinction between openly but respectfully exploring the psychological implications of a patient's religious beliefs, and the subversion of those beliefs, is experienced as extremely tenuous. Her phrasing almost suggests that for her, it feels prescriptive that the analysis of religious beliefs goes hand in hand with a kind of subversion, as if inappropriately violating something taboo - trespassing, as she suggests, onto "sacred ground, literally," or confronting, as Sue put it, "something prohibitory." Sue notes further:

...there's a bit of a, kind of a, like something's a bit sacred, to use a pun, it's almost like... you don't ask them to question [their religion]. But I would ask them, "why do you smack your child?" or you know, "why do you think its ok for your husband to have an affair?"

She also spoke of the enactment of the same prohibitory anxiety with reference to the ways in which she will dress more modestly if she is consulting with a very religious patient. She questions this, however: "... it's something like an internal dialogue that goes "well why? They've chosen to consult me, I don't need to." Similarly, she spoke of how her religious little boy patient "heard his mother and father making noises in the night," and how she had to "feed this back to the parents." However, it is, as she noted, "with those kinds of [sexual] things, I feel, when a family's more religious, I feel more inhibited." Sue may be referring to how, in anticipation of the confrontation with the child's religious parents, she 'holds' the parents' split-off, unwanted sexuality that the

child has been carrying in an unprocessed form, or as a ‘beta-element,’⁴ (Bion, 1959; 1962) which she, via her ‘alpha-function,’ then has to process and ‘return’ to the parents in a more tolerable form.

These comments suggest an implicit recognition of Spero’s (1985) dictum that everything the patient brings, religious or secular, is multi-determined, and that no material occupies a privileged, inaccessible space within the therapy. In short, nothing stands outside of an analysis. Despite this awareness, Sue seems to feel, like Lisa, almost morally prohibited from questioning religious beliefs. Nancy’s comments shed further light on this issue: “...it’s difficult because they don’t like to have that [religious] world view challenged, and who am I as a therapist to challenge a religious or spiritual world view? Indeed, Spero’s (1985) claims imply that it is *precisely* the responsibility of the psychoanalytic psychotherapist to challenge a patient’s world view, religious or secular, respectfully and timeously, if it poses a threat to the patient’s well-being. Neglecting to do so is analogous to colluding with a patient’s self destructive behavior in any form. Religion thus potentially presents further complications to therapists when it functions as a form of ‘resistance,’ which Kohut (in Tietelbaum, 1991) defined as defensive operations which protect the patient against danger and pain. Spero (1981b) cautions that therapists must not be intimidated into ‘working around’ rather than ‘working through’ resistances disguised as invocations to the patient’s religion. Psychoanalytic therapy is premised, in part, on the understanding of resistance. With empathy and basic trust, all beliefs are subject to analysis, and therapists should be alert as to when religion is being exploited as a means of avoiding painful material (Spero, 1981b)

There is, however, an additional question around why psychoanalytic psychotherapists might feel incapacitated or frustrated while working with religious patients. The above suggests that there was something about religion functioning as a resistance to the

⁴ Bion (1959; 1962) explains how the mother ‘lends’ her own mind to the infant’s experience – she uses her own thought-fullness (her ‘alpha-function’) to help the infant make sense of primitive, pre-verbal experiences (‘beta-elements’). These primitive experiences, often projected into the mother, there undergo a kind of psychic distillation, where her own thinking capacity makes sense of, or ‘mentalizes’ the infant’s experience. Should the mother then be able to communicate back to the infant a more processed, rarefied form of what was initially chaotic and ‘unthinkable,’ the infant is placated and may cope with experiences that were initially overwhelming.

therapy which may be associated to feelings of paralysis or frustration. Yet the therapists generally implied that the nature of religiously inflected resistance felt *more* incapacitating and frustrating than other potential aspects of their patients' psychic lives. What may account for this? That religion may function as 'anti-analytic third' (Straker, 2006) provides a starting point. Contextual issues such as religion, race, class and gender inevitably take the form, as Altman (2000) argues, of a 'third person in the room.' The effects of this 'third presence' may be subtly pernicious in vitiating the psychoanalytic ethos of mindfulness and the freedom to 'wonder.' Furthermore, psychoanalytic therapy is premised, in part, on the working through of resistances and defenses, rather than circumventing them, in order to access potentially painful, anxiety provoking unconscious material, as well as to help patients integrate unwanted aspects of the self, thereby becoming 'psychically larger' (Steiner, 1989). Given the object relations perspective that religious beliefs are so inextricably linked to primitive feelings towards early caregivers (Rizzuto, 1979, 2009), it seems plausible that the pursuit to 'uncover' or 'integrate' these primitive feelings or self contents may be met with resistance. A further hypothesis, however, is an existential one which invokes Freud's (1927/1949) views that the prospect of opening up religious beliefs in therapy for exploration is met with resistance since these beliefs are our most valuable and powerful defenses against our fear of mortality. According to Freud, religio-mystical ideas satisfy mankind's "oldest, strongest and most insistent wishes" (p.52), namely, that we are not alone in the universe and that our lives are meaningful. They eliminate 'randomness' which, existentially speaking, is terrifying. Hence Frankl's (1975) theory that 'meaning' is the *sine qua non* of psychological well being, and religion offers a profound sense of meaning.

It is significant that only one of the therapists, Nancy, referred to countertransference reactions that were more ambivalent, as well as positive. Concerning the former, Nancy described feeling envious of her patient's religious beliefs regarding her patient's response to the loss of her child. It was this patient's "...absolute faith, that this is the answer and you will see your child again and this was meant to be and its God's will..." that compelled Nancy to ask herself: "What could have been had I been more devout?" So there's a knowing of what that person represents that I'm not..." It is possible,

however, that Nancy was on the receiving end of a projective identification, in that the patient may have been feeling omnipotent, and used Nancy as a container within which to evacuate her own, un-digested feelings of pain, dejection and hopelessness. In this sense it is possible that the patient, in fact, envied Nancy, who had not lost a child. Lijtmaer (2009), similarly, describes how her envy for the comfort and joy that her patient's religious beliefs brought her was expressed primarily as sadness, and reminded her of feelings of awe, connection and transcendence from her religious youth. Although Nancy did not elaborate on the nature of this envy, Lijtmaer (2009) argues that in this context it is primarily associated with a nostalgic yearning for things past. Linked to her envy was a feeling of profound respect for the nature of her patient's love and devotion to her religion. In considering the above countertransference reactions, Sahlein's (2002) observation that therapist self-awareness is paramount, and that it is not so much the nature of the countertransference response as the awareness of it, has been exemplified by the psychoanalytic psychotherapists interviewed here, as they have evidently illustrated a sensitivity to their countertransference reactions to their religious patients.

The second core theme regarding the therapists' countertransference reactions to their religious patients elucidated the ways in which differences or similarities between the therapists' and patients' religious orientations contributed to the therapists' countertransferences. This, therefore, draws on Ogden's (1978) second definition of countertransference, namely, an emotional response that is constituted by both the therapist's and patient's psychic content. Since it may be argued that this is almost always the case, it is proposed that Ogden's (1978) taxonomy should be conceived of as a continuum. It is noteworthy that the belief systems of the psychoanalytic therapists who participated were evenly varied between agnostic (Lisa, Sue and Andrea) and theistic (Nancy, Teri and Alice). None of the agnostic therapists considered themselves strictly atheistic. This variation implies that almost any set of metaphysical beliefs can be made compatible with psychoanalytic theory and practice, as suggested in the literature review. This was illustrated with reference to the ways in which an object relations approach (Rizzuto, 1979; 2009; Meisner, 1982; 2009), especially applying Winnicott's (1971a; 1971b) views on transitional experience, reconcile the 'reductionism' of Freud and the

‘elevationism’ of Jung. Such an approach renders the metaphysical questions around what exists less important than the psychological questions around how the patient experiences what they think exists. Interestingly, therapists such as Alice, who believes in a spiritual reality, proclaimed herself to be a Freudian and a Winnicottian. Allegiance to a seminal psychoanalytic thinker evidently does not require the therapist to adhere to any one thinkers’ metaphysical beliefs in order to apply their theory in practice.

Yet the therapists who considered themselves agnostic generally focused more on their negative countertransference reactions to their religious patients. Lisa illustrated how her countertransference responses to her religious patients, which generally take the form of a tendency to view their beliefs as defensive, is partly a consequence of her own world view:

...when a patient brings a religious comment or religious explanation, I think I immediately look at it as a defense, rather than thinking, you know, this is a spiritual experience, so I do think [my agnostic beliefs] would color how I hear the material.

Sue explained how aversive feelings towards ‘authority’ cultivated during her adolescence, combined with her agnostic views, contribute to her negative countertransference reactions towards religious authority:

I’ve made some rebellious decisions in my life about religion and I have issues with authority, and I guess that would be what would, that would be *my* stuff. I don’t want anyone telling me what to do, least of all a rabbi or priest or imam.

Moreover, implicit in some of the therapist’s remarks were allusions to the ways in which their own early experiences with religion and caregivers contributed to such responses. Consider, for example, Andrea’s response to her ‘Reborn Christian’ patient who she describes as “happy clappy,” which “annoys” her. Andrea related how during sessions, she often has deprecatory fantasies of this patient “jumping around and kind of Halleluja, that sort of thing.” Yet Andrea noted, further, how when she and her sister were young, they had to spend one holiday with their ‘Reborn Christian’ aunt, who “forced [us] to pray before bed... So...I have an aversion to – if somebody’s a

Reborn Christian and they try push their beliefs onto you...” Andreas’s countertransference annoyance, as well as her deprecatory fantasies about her Reborn Christian patient is possibly, therefore, a coalescence of her own, early anger towards her aunt’s intrusive forcing of her religion onto her nieces, and her patient’s dogmatic religious beliefs, apropos Ogden’s (1979) second definition of countertransference. Andrea’s awareness of the ways in which this early personal material colors her countertransference response to this particular patient suggests that this response takes the form of a ‘creative,’ rather than ‘anti,’ ‘analytic third’ (Ogden, 1994; Straker, 2006). In light of her generally negative countertransference reactions to her religious patients, Andrea’s agnosticism, moreover, may be understood as a coalescence of her primitive feelings towards her early caregivers, as per Rizzuto’s (1979) hypothesis.

Alice’s positive countertransference reaction to a very religious Jewish patient who proclaimed, interestingly, that she was channeling and receiving insights from the soul of a deceased, eminent Jewish spiritual leader known as *The Rebbe*, is similarly partly accounted for by the fact that she shares this patient’s religious beliefs (although she does not herself feel that she is channeling spiritual beings): “[my patient] speaks about how *The Rebbe* ‘works through her,’ Ok, and I can relate to that in a way that doesn’t upset me.” She elaborates on her personal metaphysical views that shaped this accepting response to such novel material – a view that reminds us of Winnicott’s (1971a, 1971b) ambiguous ‘transitional space:’ “I have one foot in skepticism, which stays there all the time, and another foot in total and complete belief. It’s an impossible thing to be able to prove or disprove.” In reflecting on the potential origins of this world view, Alice notes how she “had the choice to either follow [her] mother or [her] father, and [she] chose something that married the two...” Alice’s capacity for empathic countertransference reactions to her religious patients, especially those who bring novel material as noted above, has evidently been influenced by her own history, and thus constitutes a further instance of Ogden’s (1979) second definition of countertransference as the coincidence of both the therapist’s and patient’s psychic content. Teri illustrates the same point with reference to the ways in which the combination of her Hindu upbringing and her marriage to a Christian man has evolved

into an “eclectic” religious world view, which endows her with a sense of “thoughtfulness” in response to her very religious patients, whereby there is “more room for other things to be absorbed.”

Thirdly, concerning the ways in which the therapists managed their countertransference reactions, all six therapists alluded to the significance of supervision, the opportunity to confer with colleagues, and their own therapy. The context of supervision, colleagues or their own therapies may function as ‘transitional spaces’ (Winnicott, 1971a) whereby a process of ‘meta-containment’ or ‘meta-processing’ may occur. Alice spoke of how one often cannot know whether the countertransference is being evoked by the patient or whether it “belongs” more to the therapist. In these instances, the supervisor or colleague opens up the ‘stuck’ therapeutic dyad, allowing for the emergence of triangular space, enabling the therapist to access her ‘thinking’ mind once again (Ogden, 1994; Straker; 2006). Sue and Alice also referred to instances of projective identification in the Bionian sense, whereby they would come to embody unwanted, disowned aspects of the patient’s self (Ogden, 1979; Hinshelwood, 1991). The therapists were thus referring to Ogden’s (1979) third usage of the term ‘countertransference.’ Sue relates how she came to embody her Muslim patient’s projected anger associated with her husband’s infidelity, but which she felt she could not challenge owing to complications around divorce in the Muslim faith:

Sometimes its not the kind of countertransference that Freud was talking about it is about projective identification, about something that does get split off., so a woman like that Muslim woman who cant actually think, or doesn’t want to acknowledge her own unjust feelings, cos that would put her in a very onerous position, in terms of where she would fit into her own family and the extended family, I think those probably do get projected into me, and then I’m the one left with the feeling of rage and anger and unfairness.

Alice referred to the second step in Bion’s projective identification, which involves the employment of the ‘alpha-function’ in the processing and subsequent returning of the patient’s projections or ‘beta-elements’ in a more manageable form, along with the understanding part of the therapist’s self (Hinshelwood, 1991). She refers to this with regards to some of her very religious Jewish patients who repress their anger towards

people who may have offended them, in adherence to the Jewish law of *Loshen Hora*, which prohibits any Jew from speaking badly about another behind their back. Alice finds that, since their anger is too anxiety provoking for them to integrate within themselves, they project it into her and remain safely detached from it. Alice is then challenged with using her alpha-function to process this anger for them, and further, help them re-introject and integrate these split-off aspects of themselves. She notes how carefully she has to go about this, however, since she is aware of how serious the injunction against and speaking ill of another is in the Jewish religion:

It is very hard for my religious Jewish people, to deal with the issue of *Loshen Hora*. And so it interferes with their therapy in that they can't look squarely at what is going on realistically in their lives, and how they're being abused, or how they're being used, and the relationship issues, cos they daren't speak ill even speak about the other person, be it their father, their mother, or their partner, their life partner. So a lot of the time I have to feel that, and I have to verbalize it for them, in order for them to even get an understanding that its in the room, and that its in their minds, and it takes quite a lot of trust to be able to build up before you finally will get them, and I got to say it in a very non blaming way. And it's a huge struggle. So I have to feel it, and I have to verbalize for them and give it back to them in manageable bits.

Alice also notes, implicitly alluding to Ogden's (1979) second definition of countertransference as a synthesis of both the therapists and patient's material, that:

... its hard for me – am I sitting here being prejudiced? Am I, is it really coming from them or is it me reading into something that isn't their? And because you don't get an instant recognition and acceptance of what you're saying you're still working in the dark.

This illustrates how the distinction between countertransference as a synthesis of the patient's and therapist's material, and countertransference as a projective identification, that is, Ogden's (1979) second and third usages respectively, is often blurred, and that the notion of 'categories' of different kinds of countertransference reactions is misleading. In practice, it may be more appropriate to conceive of a spectrum of countertransference types.

The idea of religion as a defense mechanism was alluded to by all six therapists. Alice, Andrea, Lisa and Teri spoke of how, in some of their patients, religion functioned as a

healthy, adaptive or necessary defense mechanism. Consider, for example Alice's comments regarding what constitutes a healthy or unhealthy belief system more broadly:

...how do you decide what's healthy and what's not healthy. And I think the barometer has to be how functional your life is, and how well you interrelate in your world. And if having a belief helps you do that, then where's the problem?

Thus, no matter how strange or culturally deviant the belief system, Alice feels that if it is functional in this way, it should be considered a healthy defense, and while it is valuable to explore this defense, it may be detrimental to the patient to try disable the defense:

...psychology would call [a belief in unicorns or fairies] a defense mechanism. And a defense mechanism is serving a role, and if you take it away and the person crumbles, then what have you achieved?...Until you put something in its place, you have no right to tamper with that, that's how I feel....And that's why the particular religion makes no difference. It's what the person is doing with it, how functional it is in their world, and how it allows them to grow and develop, that is my criteria.

Alice's perspective raises interesting questions regarding our 'Western/DSM' criteria for what constitutes healthy and pathological defense in the context of religious beliefs. The DSM-IV-TR defines a delusion as a firmly held belief in spite of evidence to the contrary and which deviates from the individual's cultural norms (APA, 2000). Alice argues that she would be less inclined to challenge a Euro-western adult patient's belief in unicorns or fairies – a belief which would be considered 'culturally deviant' in this context – if the belief is "functional." Alice's remarks have trenchant implications for psychotherapists who work with religious patients, notwithstanding their counter-transference reactions. A religious individual may be a paragon of well-being. He may be a compassionate, wise and industrious contributor to his community and his world. By his profound capacity for love, he may be an exemplar of Fromm's (1950) 'humanitarian' religion in the truest sense. And yet this says nothing of the truth value of his beliefs. They are 'true for him' in so far as they serve him and others in the best possible way. Yet he may still, strictly speaking, be 'out of touch' with reality. Should the psychotherapist care to invite him to question the truth value of his beliefs if they serve him so well? The immediate answer seems to be no: psychotherapy is concerned with the individual's *experience* of religion

(Jung, 1938). Not whether it is true, but whether it is useful and what it means to him, is what concerns psychotherapists today. Alice expressed this as follows:

...the truth is, it's more useful to believe in it than to not, and I've seen that, with my scientists.... Psychologically, managing your life, living an effective life, dealing with adversity and tragedy, its far more functional, to actually believe.

And yet this raises thoughts around whether there is a conflict here between Freudian (1927/1949) and Bionian perspectives on psychological well-being, which implores us to live in the truth, irrespective of how painful it might be (Ivey, 2009). And the 'truth,' in this context, as Alice suggests, is that there is no absolute evidence, in the strictest empirical sense, for the existence of the supernatural. It must be taken on faith. This is the challenge for the DSM alluded to by Alice: The DSM would have us accept that a healthy individual can hold improbable convictions – the Virgin Birth, The Eucharist, the Parting of the Red Sea – and *not* be delusional. If these beliefs serve a positive psychological function, that is, if they are not a source of anxiety, persecution, guilt or fear, then they are 'healthy,' psychologically speaking. They may not have 'scientific' truth, but they have 'psychological truth.' Yet should psychotherapists not endorse a vision of mental health that includes adhering to beliefs that are grounded in evidence? The issue is complicated further, however, when considering Alice's views on what counts as 'evidence:' "There is enough proof in the world if you are able to look on it as proof, because things happen to people that cannot be explained through other means," and "I think I'll say that, I've seen enough to say, this is a possibility." Alice thus gestures towards a further key principle of psychoanalytic psychotherapy – to be able to be, as she puts it, "in a not knowing space." Given that, as she claims "[the supernatural] is an impossible thing to be able to prove or disprove" with absolute certainty, and in light of Bionian principles on the capacity to tolerate ambiguity and paradox (Waddell, 1998; Ivey, 2009), it is conclusive that questions of the truth value of a belief are less significant than how functional that belief is for a patient. Thus Lisa can assert on the one hand, almost paraphrasing Freud, that "I guess what I'm implying is that when someone gets really sick they get religious" and furthermore, allude to an apparently tenuous distinction between psychosis and religion by wondering how -

when you're in a psychiatric hospital, and those that are very mad, in the throes of an acute psychotic episode, how often the delusions are religious. And I've often questioned that and what is that about, and why when the frontal lobes and the thinking and reasoning is all stripped away, why does humanity go there? -

she can *also* assert:

...if it gives them meaning, if it gives them hope, if it gives them a sense of 'this too will pass,' 'I'll understand eventually why this terrible thing happened because there's a greater meaning,' you know, then I think religious belief can be incredibly supportive and helpful and healing.

This view also resonates with the existential psychoanalytic perspectives of Frankl (1975), who argues that the *sine qua non* of well-being is to feel as if one's existence is 'meaningful,' and religion provides 'meaning.' Yet, again, there seems to be, as was apparent with reference to the ways in which differences in religious orientation may influence therapists' countertransference reactions, some value for psychotherapists in adopting a more ambiguous, 'Winnicottian metaphysics' situated in the liminal space between 'fantasy' and 'reality,' where questions of *experience* become more important than question of 'fact,' for the only kinds of facts that matter in psychotherapy, which both the therapists interviewed and the literature (Jung, 1938; Rizzuto, 1979; 2009; Meissner 1984; 2009; Spero, 1981a; 1981b; 1985; 1995; 2009a; 2009b; 2009c) suggest, are 'psychological facts.' Freud and Jung allowed for no such ambiguity – for the former, religion was pathological by definition, and for the latter, religion was our greatest source of well-being. This is why, as Berman (2006) notes with acuity, a consequence of accepting either of their views is that we shall "have a great deal more madness on our hands" (p.362). The fact that both the agnostic and theistic therapists interviewed here identified when their religious patient's were employing religion as an adaptive or maladaptive defense, testifies to their awareness of this fact.

Nancy, moreover, spoke of how her Bipolar patient initially used the Buddhist principle of 'magnanimity to all' to repress and deny feelings of anger or frustration with others. From a Kleinian (1935/1986) perspective, she thus seemed to employ her Buddhism as a manic defense, idealizing the Buddhist monks and her fellow

practitioners. However, through therapy, she came to perceive the Buddhist community as a ‘whole object,’ integrating their humanity with their transcendentalism, which allowed for recognition of their flaws, as well as feelings of anger and frustration. Interestingly, Nancy notes how she began having more depressive episodes. She appeared to shift from a more paranoid-schizoid to a more depressive-position way of relating to her Buddhism, or her ‘object.’ The patient thus shifted from perceiving her Buddhism as a concrete, idealized ‘part-object,’ to something psychically alive and nuanced – a ‘whole-object’ (Klein, 1935/1986). Nancy explains how this patient has been able to:

...maintain a relatively stable bipolarity, she’s not gone back onto medication, so this patient has done extremely well, and she still practices, she’s far more real in the world, she’s much more real – she comes in irritated, she comes in moaning, she comes in frustrated with traffic...

The difference, however, is that now she has “a structure that allows her to deal with things in constructive ways. So the meditation, the mindfulness, gives her a way to channel, to think about.” In using Nancy’s case example to think about religion as an adaptive and maladaptive defense mechanism in terms of Kleinian paranoid-schizoid and depressive position functioning we are reminded of Etezady’s (2008) claim that “Faith can be...dominated by splitting. Or it may, by contrast, arise out of a depressive position, and be therefore reflective...morally integrated” (p.562). Nancy illustrates how she finds some of her very religious patients relate to others in a more ‘paranoid-schizoid’ than depressive way, ‘dominated by splitting:’ “...others are, you know, very black and white, there is good and there is bad, there is right and there is wrong, you’ll go to Heaven or you’ll go to Hell.” She thus identifies an intolerance for otherness and complexity in some of her ultra religious patients, which is characteristic of paranoid-schizoid ways of object relating (Klein, 1946/1986)

Yet for some of the therapists, there were obvious instances where their religious patients were employing their beliefs in a maladaptive way. For example, Lisa spoke of how her Christian patient compulsively used the act of confession to divest herself of all

accountability for her sexual behavior. Confession seemed to ‘undo’ her behavior, which absolved her of the need to explore it in therapy: “It’s almost as though she can have sex with someone, go to confession, and it gets wiped out, it’s undone, so she doesn’t have to reflect on it.” It seems as if confession was more than a vehicle for splitting-off or disowning the promiscuous aspect of herself – it almost functioned as a means of obliterating parts of herself. Freud (1907/1966) proposed a relationship between the ceremonials of a religious person and the rituals of an individual suffering from an obsessive neurosis. Where Freud (1918/1953) illustrated how religious ceremonials reduced anxiety in the case of ‘The Wolf Man,’ Lisa’s patient seems to use the confession ritual to mobilize a powerful defense against her anxiety. It is necessary for the defense to be examined ‘in the room’ to help the patient integrate the disavowed aspects of herself. In this regard, we are also reminded of Joseph’s (1987) claim concerning a process of regression from healthy to unhealthy forms of religious behavior: rituals that become mechanical and repetitious and whose primary function is to ward off anxiety, deteriorate into symptoms.

Further instances of the use of religion as a maladaptive defense were alluded to by Lisa, Nancy and Sue. Interestingly they each illustrated how these particular instances of pathological religious defense took the form of narcissistic defenses, in that their patients used their religion in various ways both to perpetuate their own grandiosity and to implicitly denigrate individuals of different faiths, or individuals of the same faith who were perceived as ‘less enlightened’ (Kohut and Wolf, 1978). Lisa made the connection to narcissistic defenses via her countertransference: “It makes me think of how I work with narcissistic defenses which often evoke the same countertransference reaction, which is that you’ve got to walk on egg shells.” She thus indicates the need to be hypersensitive and cautious, as she would with a narcissist, so as not to offend their grandiosity, since a challenge to their religion is experienced as a challenge to their very fragile sense of self (Kohut and Wolf, 1978). Self-worth is defended against, in these instances, by a “holier than thou” attitude, as Lisa put it. In speculating further about the tendency for maladaptive religious beliefs to resemble narcissistic defenses, Freud’s (1913/1946) early account of God as an object relation, a ‘Father,’ the representation of

which is formed during the Oedipal phase, may be useful. Freud (1913/1946) argued that one's personal relationship with God "depends on his relation to his father in the flesh:" (p.22). He goes on to assert that:

Psychoanalysis has made us familiar with the intimate connexion between the father complex and belief in God; it has shown us that a personal God is, psychologically, nothing other than an exalted father....the roots of the need for religion are in the parental complex...[the Gods] are...revivals and restorations of the young child's ideas of [father and mother] (p.22).

Narcissistic comparisons of one's own faith or God to another's, therefore, may be analogous to unconsciously proclaiming: 'my daddy's better than yours, therefore I'm better than you.'

The therapist's perspectives on when their patients may be employing their religious beliefs or practices as an adaptive or maladaptive defense is constitutive of a broader issue, namely, what characterizes psychological health or pathology, and by implication, healthy or pathological religious beliefs and practices? The therapists emphasized the capacity to think, explore, question and choose, as characteristic of healthy religiosity - "where there's space to question, where there's space to wonder, where there's space to feel...", as Nancy aptly captures it - whereas pathological religiosity is marked by intolerance for these capacities. The "space" to "feel," "wonder" and "question," as Nancy puts it, alludes to the creative, 'third' (Ogden, 1994) or 'transitional' (Winnicott, 1971a) spaces within which we "create one another anew," as Straker (2006, p.751) suggests is one of the goals of psychoanalytic psychotherapy. This also resonates with Habermas's (2006 in Hewitt, 2008) view that healthy religiosity is self-reflexive: it can be self-critical and through a pluralist, inclusive attitude, acknowledge the relativity of its doctrines in a world saturated by other traditions. "The space to feel," as Nancy put it, resembles healthy object relating more broadly. Nancy and Teri proposed that healthy religiosity looks very much like a healthy relationship. Nancy put it as follows:

...cos it is a relationship at the end of the day, for me, that's how I think of faith, as a relationship, whatever you believe the maker is, or creator, it's a relationship, and

relationships should by very definition go through variation – there are times of closeness and times of distance

Similarly, Teri noted:

..for me healthy suggests, um, a relationship with religion rather than a, a rigid controlling response and living out of religious beliefs. That there can be ebbs and flows to a religious engagement

Both perspectives are congruent with Rizzuto's (1979, 2009) theory of faith as an object relationship, the nature of which, like all object relationships, is largely determined by one's internalized early object relationships. Nancy and Teri both speak of the need for space to feel a variety of emotions towards one's religion or God, rather than defend against painful feelings states out of fear. In this sense, there is a capacity for movement, change and hence growth. It is something about being able to work through painful feeling states in relation to one's religion, analogous to the ways in which healthy relationships require partners to survive feelings of disillusionment, guilt, fear, anger and love for one another. The notion of trusting that our faith or our God can 'survive' us, makes Rizzuto's (1979, 2009) notion of God as a 'transitional object' meaningful. In short, we need to have 'faith in our faith.' Moreover, as Rizzuto's (1979, 2009) theory suggests, 'we all have a personal God,' since our conception of God is a construct of our feelings towards ourselves and others, which in turn is largely a construct of our most primitive feelings towards our earliest objects. Nancy and Teri's perspectives imply that there will be times when we experience our God, or the extensions of Him in the form of our religious community or spiritual leaders, as loving, wise, punitive, jealous, wrathful, sadistic, indifferent, callous, giving or withholding – in short, everything we felt or can feel towards our most significant objects. The extent to which we can feel abundantly while claiming responsibility for those feelings thus speaks to the relative health or pathology of the relationship. It includes the awareness that, as the case of Cohen (2009) and her patient 'A' illustrated in the literature review, one's God image is protean and summoned to meet different needs at different points in one's life. Healthy religion, therefore, involves both a capacity to think and the freedom to feel.

Alice's perspectives on healthy religiosity contrast fittingly with Spero's (1984 in Cohen, 2008) views on unhealthy religiosity. Alice proposed that healthy religiosity is a vehicle towards joy, a celebration, and an expression of love rather than fear, with room for adaptability and change:

...there are people who practice their religion slavishly because they're scared not to, and then there are people who absolutely believe like *The Rebbe*, who can digress, because their practice is an expression of the love of their belief, and not a fear of not practicing... When you are strictly following laws to the detriment of the people around you and yourself. If you are ill and you cannot phone a doctor on *Shabbos* to save your life, that is absolutely self-destructive.... And when it's used to make our life pleasant rather than unpleasant. There are people who have a vested interest in suffering, and they use the practices to entrench the suffering.... It's the vehicle they're using, there's no question about that.

This 'positive definition' of healthy religion suggests that religion is a medium through which joy and love are cultivated, in contrast to Spero's (1984 in Cohen, 2008) views on what characterizes unhealthy religiosity, namely, the replacement of free will for compulsion, exactitude by obsession and intolerable guilt, irrevocable loss and a sense of failure and fear. This 'negative definition' of unhealthy religiosity suggests that its purpose is defensive in that religion is necessary to ward off something painful, rather than foster something pleasurable. Implicit in Alice's response is also a critique of Freud's (1907/1966) view that religious behaviors and obsessional neuroses are variations of a single pathology, whereby obsessive neuroses are analogous to a private religion, and religion is a public form of obsessive neurosis. On the contrary, Alice suggests that religion is merely one of many 'vehicles' for impaired functioning, wherein a constellation of maladaptive defenses or defective patterns of object relating may be dramatized. Moreover, as the above has illustrated, it is a vehicle for our entire personal psychology, including, for example, our joy, love, sado-masochism, narcissism or dependency. It may be approached from a depressive-position type functioning, such that it is reflective and concerned, or a paranoid-schizoid way of being, where it is the site for excessive splitting, projection and anxiety. Although religion may throw an existing pathology into relief, implicit within the participants' responses was the idea that health or sickness is primarily something the individual brings to religion. Interestingly, the

general perception that pathological religion or religion had to do with an incapacity to question, explore, think and feel is congruent with the core finding regarding therapists' countertransference reactions to their patients as a feeling of paralysis and frustration.

The participants also made implicit reference to some general advantages of religious material in psychotherapy. Sue, Nancy and Alice, for example, referred to the benefits of religious belief within the context of bereavement. They each suggested that belief in God gives 'meaning' to loss – a view compatible with Frankl's (1975) emphasis on the finding of 'meaning' as the most profound means of coping with severe adversity. Nancy, further, spoke of

.... one patient who went through the death of a child, and her religious belief gave her such enormous comfort, and her way of grieving and mourning was dictated by religion and I almost thought to myself, I remember thinking with her 'wow it would be so amazing to have that kind of.... Just absolute faith, that this is the answer and you will see your child again and this was meant to be and it's God's will

In addition to suggesting that her countertransference response to this patient was one of envy (without the need to denigrate the patient to defend against her envy, that is), she cites one of Freud's (1927/1949) key critiques of religious belief, namely, that the believer adheres to spiritual beliefs, not because they are true but because unconsciously, they fulfill "the oldest, strongest and most insistent wishes of mankind."(p.52) – in this instance, the wish for a parent to be reunited with their child after death, as well as the wish for 'method in the madness' associated with unbearable pain through loss. ' This might imply, however, a therapeutic dilemma of sorts, since it suggests that such patients may never fully mourn the loss, calling into question the psychoanalytic view that losses must be mourned for mental health to be reached once again. Andrea's point regarding the protective power of religious belief in patients with suicidal ideation may also be elucidated with reference to Freud's (1927/1949) argument: since many religions consider suicide to be a severe transgression punishable by damnation (Spiro 1966 in Rizutto 1979), the wish to avoid going to 'Hell' is conceivably as potent as the wish to go to 'Heaven.'

Interestingly, Alice spoke of how her use of hypnosis with certain patients spontaneously began to take the form of ‘past life regression’ work:

... very often you can hypnotize people and they go back to their other lives... So where do you put that into your psychoanalysis, you know? You’re intending to do this, and you get that... [this constitutes] some of the evidence that makes me believe that there is this world of spirit. Not because I intend to do that, I don’t do it as a party trick and I don’t intend to do in therapy, it happens on its own.

The veracity of the material seems less relevant than the richness of it, analogous to the ways in which analysts do not bring questions of ‘fantasy versus reality’ when working with dreams. We are reminded of a principle implied by Spero (1985), namely, that ‘nothing stands outside of an analysis.’ Moreover, it was their religious beliefs, first and foremost, that offered Alice the opportunity to do deep analytic work in a different way. Regarding Alice’s work, it should be noted, moreover, that at the inception of psychoanalysis, hypnosis was the primary psychoanalytic technique, but which was abandoned, partly owing its tendency to ‘bypass the defenses’ of the patient (Greenson, 1967).

Finally, in discerning some of the commonalities between religion and/or mysticism and psychoanalysis, most of the therapists claimed that both ‘disciplines’ ultimately deal with explanations of human behavior that are ‘abstract’ or ‘non-scientific.’ For example, Nancy noted, “as I say, its how you prove the existence of the unconscious,” alluding to the equally unfalsifiable (Blackburn, 1996) nature of both the unconscious and mystical concepts like the soul, spirit or spiritual realm. While the literature review preempted this potential commonality, and despite that it recognized that these are very different concepts by definition, since the former denotes a ‘higher’ non-material realm of existence and the latter, a ‘lower’ repository for sexual and aggressive impulses within the mind beyond conscious awareness, it argued that what these concepts have in common are similar ontological or metaphysical ‘statuses.’ Both, it was suggested, are ‘subjective’ in McGinn’s (2004) sense, since both are unobservable by the five senses, are immediately perceptible only by one individual at a time, are un-extended in space

and are dependent for their 'existence' on the individual perceiving them. Alice takes up this theme by querying the metaphysical status of concepts like projection, projective identification, countertransference and transference, by emphasizing that these are fundamentally abstract and 'unscientific' concepts that almost require a mystical understanding to be meaningful:

I think [religion/mysticism] is seamlessly intertwined for me with [psychoanalysis]. I don't know how to separate it out. I don't know what you would do with projections, projective identification, transference, countertransference, if you don't think that they're intertwined, and I think that psychologists struggle with it...I mean I remember one of my lecturers at university when I said, "define projective, what do you mean when you say that people project?" She said "well I...?" And its psychology attempting to be a science when it isn't a science.

Religion and mysticism were similarly, 'seamlessly intertwined' with psychoanalysis for Jung (1938) who alluded to transcendental, "other peculiar conditions of consciousness" (p.45), conceivably conferring the property of 'height' to the psyche where Freud (1915/1953) metaphorically gave it 'depth.' Similarly, Nancy spoke of the kinds of parallels we may draw between psychoanalytic concepts like 'projective identification' and religious phenomena like 'possession:'

But from a theory point of view, is there a place for mysticism in psychoanalysis? What would it mean for the unconscious mind if we say that there's a higher power? ... [talking about projective identification]... you might as well talk about possession!

Bion's (1959 in Hinshelwood, 1991) notion of projective identification does seem to be one of the concepts that make psychoanalytic thought strange indeed, since it suggests that without any verbal communication between two people, one person can begin to behave or think in ways that are *very* unusual for them, as a consequence of the other person's unconscious phantasy. Interestingly, Ivey (2002) expounds a case of a man who ingested psilocybin and began to believe that his dog was Satan, and that he was 'possessed' by the dog. He argues that through projection, this man, wracked by paranoid anxiety, had located the evil and destructive aspects of himself in the family pet. As a defensive strategy against being persecuted by evil parts of himself, he externalized them,

and the intrusive return of these projections gave rise to the experience of being possessed by a foreign, demonic entity (Ivey, 2002). In the therapeutic context, the resonance between the concept of 'projective identification' and 'possession' becomes meaningful when considering what distinguishes projective identification and countertransference, which Ivey (2004) suggests is as follows: In projective identification, the recipient feels uncontrollably possessed by their countertransference feelings in a manner that feels both unfamiliar and overwhelming. Or, as Bion (1967/1993) put it, being the recipient of a potent projective identification is akin to having 'thoughts without a thinker' - to have the sense that one is thinking thoughts that do not belong to them. It is in this sense, that, as Alice wonders:

So...do we have to give it a name, do we have to categorize it, and can we simply live in the 'not knowing' as Bion says? Go in with no preconceptions....it doesn't matter to me what religion the person brings into the room, I know we're all talking the same language..... And I have also delved into *Kabbalah*. And I don't see a difference there either.

There is apparently an 'area,' whether described in the language of psychoanalysis, mysticism, or even "quantum theory," which Alice also alluded to, where things become strange indeed, and where we find ourselves looking 'through a glass, darkly.'⁵

⁵ 1 Corinthians 13:12

Chapter Six: Conclusions

Current literature on psychoanalytic psychotherapists' countertransference reactions to their religious patients has alluded to a wide variety of emotional responses that may be elicited through work with the religious (Sahlein, 2002; Bartoli, 2003; Cohen, 2009; Charles, 2009; Spero, 1981a; 1981b; 1985; 1995; 2009a; 2009b; 2009c; Fauteux, 2009; Meissner, 2009; Peteet, 1981; 2009; Rizzuto, 2009). Although these responses were typically the product of both the therapist's and the patient's psychic content, the literature also identifies broad 'trends' of countertransference reactions germane to differences in religious orientation between therapist and patient. There are, further, a plethora of additional elements which may contribute to countertransference reactions to the religious, including the therapists' views on what characterizes healthy and pathological religion and awareness of potential similarities between religio-mystical concepts and aspects of psychoanalytic thought.

6.1 Central Findings

Despite that the literature documents all manner of emotional reactions of psychoanalytic psychotherapist's to their religious patients, a key, unanimous finding amongst the therapists who participated in the current study was that their emotional responses to their religious patients were primarily negative. Moreover, there was consensus amongst the therapists that the nature of these negative responses primarily took the form of feeling either incapacitated or frustrated. Other than being invited to consider whether or not they feel these responses were more a consequence of the patient's material, or rooted in their own history, the therapists were not specifically asked to try and 'formulate' these responses from a psychoanalytic perspective. In light of relevant literature, however, it was proposed in the discussion that the therapists' general feelings of paralysis and frustration in relation to their religious patients had something to do with the ways in which patients' religious beliefs functioned as a form of resistance to the therapy. Yet the therapists generally implied that the nature of religiously inflected resistance felt *more*

incapacitating and frustrating than other aspects of their patients' psychic lives that may be associated with resistance. How is this to be accounted for? The beginnings of an answer were proposed with reference to the core premise of object relations approaches, which have shown that since religious beliefs are so inextricably linked to primitive feelings towards early caregivers, it seems plausible that the pursuit to 'uncover' or 'integrate' these primitive feelings, as are some of the aims of psychoanalytically inflected therapy, may be met with a unique type of resistance. This may be a consequence of the patients' perceptions of religion and God as 'off-limits' in a way that parents would not be.

A further key issue of exploration was the extent to which the therapists perceived that differences in religious orientation between themselves and their patients influenced the nature of their countertransference reactions. While the feelings of paralysis and frustration in response to their religious patients were not limited to the agnostic or theistic therapists, a key finding in this regard was that, while the theistic therapists generally noted these responses, the agnostic therapists seemed to give more attention to them during the interviews, while wondering around the extent to which their agnosticism may partially account for the intensity of their countertransference paralysis and frustration. Most of the agnostic therapists were able to identify early personal experiences that may have contributed to these responses. It's as if the agnostic therapists carry some sort of implicit (social) guilt about not being theistic, which constitutes an additional countertransferential factor with religious patients. However, as the core theory suggests, there are unconscious, early patterns of object relating that are significantly implicated in the nature of countertransference reactions to religious material. The therapists often demonstrated an awareness of this during the interviews by alluding to 'black spots' or being in a position of 'not-knowing' concerning their understanding of their countertransference reactions, in addition to consciously being able to identify personal experiences that may have contributed to their countertransferences. Concerning the management of these responses, all the therapists referred to the significance of supervision, colleagues and their own therapy. This was not an unexpected finding given the emphasis placed on supervision and therapists' own psychotherapy apropos the

psychoanalytic approach, as well as understandings that countertransference responses may be a product of both the therapist's and patient's psychic life.

In light of these findings, it is possible that an object relations perspective is the most prudent approach for psychoanalytic psychotherapists to take when working with religious patients. This approach would appear to enrich the therapist's religious orientation by an understanding of how their own, early patterns of object relating are implicated in their religious beliefs. This may reduce unnecessary friction between the therapist's and patient's world views, in turn protecting the relationship from harmful countertransference reactions. The approach of therapists who are strictly Freudian or Jungian, on the other hand, is informed by an inflexible metaphysical stance, which thus has greater potential for destructive countertransference reactions when working with religious patients whose beliefs contradict those of the therapist. It would appear that the more widely read within psychoanalysis the therapist is, the better for the relationship with the religious patient.

A further key finding was that most of the therapists' perceptions around the employment of religion as an adaptive or maladaptive defense, as well as what constitutes healthy or pathologically religion more broadly, converged on the idea of openness to questioning, thinking and feeling, that is, on the notion of it functioning as a creative and true, analytic 'third' in the intersubjective or 'transitional' space (Winnicott, 1971a; Ogden, 1994). The perennial understanding was that the patient's relationship to religion was unhealthy if they were unable to do this. This perception, moreover, is congruent with the therapists' general countertransference response of paralysis and frustration, which was associated with a feeling of being 'blocked' by some of their religious patients' intolerance for thinking and feeling freely about their religion – when it functioned as an 'anti-analytic third' (Straker, 2006).

Finally, it was generally agreed upon that the core similarity between psychoanalysis and religion and/or mysticism was that both 'disciplines' deal with abstract or 'non-scientific' understandings of human behavior. This is congruent with the literature that explores

ontological similarities between psychoanalytic concepts such as ‘unconscious,’ ‘internal object,’ or ‘projective identification’ with religio-mystical concepts like ‘the transcendental self’ and ‘possession.’

6.2 Limitations of the Study and Directions for Future Research

As may be the case with exploratory qualitative research, the researcher is often called to make a decision in favor of scope or depth. It is evident that the researcher favored the former over the latter. In choosing to explore widely, it may be argued that significant detail or depth was not achieved. This may have been possible if the researcher had focused on the countertransference reactions of psychoanalytic psychotherapists of particular religious orientations, to their religious patients. Alternatively, the study might have focused on psychoanalytic psychotherapists countertransference reactions to *patients* of a particular religious orientation. As established at the outset of the literature review, ‘Religious Orientation’ in this study referred to either atheistic, agnostic, or theistic belief systems. Hence, studies such as this may be refined even further by exploring, for example, Jewish, Muslim or Christian psychoanalytic psychotherapists’ countertransference reactions to religious patients of a particular tradition, or vice-versa. There were evidently many ways in which to narrow the scope of the study in favor of a more refined treatment of the topic. The objective of this study was more modest: in looking at a variety of combinations of therapist-patient religious orientation, it proposes an exploratory introduction into a vast research domain, sacrificing a certain degree of rigor for wideness of scope. There are evidently opportunities for enhancing the exactitude of similar studies by making further specifications with regards to the sample and the research questions.

Concerning the potential refinement of the research questions, it was brought to the researchers attention, upon analyzing the data, that the therapists’ responses regarding the management of their countertransference reactions, namely, the value of supervision, colleagues and their own therapy - seemed relatively general and obvious, given that these are standard approaches to the management of countertransference within a

psychoanalytic model. The prospect of excluding this question on this basis, on the other hand, seemed undesirable given that this may have appeared negligent on the researcher's part in light of how crucial issues of countertransference management are within psychoanalytic psychotherapy. Thus, to circumvent the possibility of obtaining relatively 'thin' data in response to this question, while at the same time avoiding neglecting something crucial, in retrospect, the researcher could have asked the additional question of whether or not the therapists perceived any differences in their management of *religiously* influenced countertransference reactions relative to other countertransference reactions. In the interview schedule, this question could have followed on from the question, "How did you manage this/these countertransference reactions [to your religious patient/s]," thereby accentuating potential idiosyncrasies regarding the ways in which they managed their countertransferences to their religious patients, as opposed to inviting them to reflect on general principles of management.

Another possibility for future research follows from a key finding in this study regarding the therapists countertransference reactions: why the pervasive feeling of paralysis and why so much frustration on the part of the psychoanalytic therapists in response to their religious patients? Does this have something to do with the fact that psychoanalytic approaches to therapy are insight oriented, which aims to cultivate the patient's capacity to think, reflect, question and feel abundantly about the most meaningful aspects of their psychic lives – a endeavor premised, in part, on the working through of defenses and resistance? Or would this be the experience (they may not necessarily refer to 'countertransference') of therapists from other orientations to their religious patients? Furthermore, the current sample consisted of Johannesburg based psychoanalytic psychotherapists who belong to similar professional groups, which may well have influenced the findings. It might thus be valuable to replicate this research in other countries. These are potential avenues for future research, which would appear necessary given the need for an ever increasing form of applied and relevant psychoanalytic praxis in our inherently religious country and world.

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Appendix A: Interview Schedule

1. What psychoanalytic approach/es do you employ in your therapy?
2. Can you talk about whether or not you think your own religious beliefs influence your work as a therapist, and if so how?
3. Can you talk generally about the sorts of experiences you have had working with religiously devout patients?
4. What are some of the countertransference responses you have had with these religious patients?
 - a) To what extent do you feel your personal religious views contribute to your countertransference reactions?
 - b) Are these countertransference reactions evoked by the patient, or rooted in your own history?
5. Can you elaborate on a case/s that seem/s especially significant or interesting to you?
 - a) How did you manage this countertransference?
6. How would you understand healthy or adaptive versus unhealthy or maladaptive religious belief or practice in your patients?
7. What, for you, is/are potentially the most challenging aspect/s of working with the deeply devout? How do you/would you manage this/these challenges?
8. Do you think there is a relationship, in any form, between psychoanalysis and religion/mysticism? Do you see any commonalities or irreconcilable differences between the two?

Appendix B: Participant Information Sheet

Hi

My name is Brad Kallenbach. I am currently completing my Masters in Clinical Psychology at the University of the Witwatersrand. As a requirement to complete this degree, I am conducting research on countertransference responses of psychoanalytically informed psychotherapists working with religious patients. The study aims to explore the various emotional responses that religious patients may provoke in psychoanalytically informed psychotherapists, as well as inquire into how these responses are managed in a therapeutically productive way. I therefore invite you to participate in this study.

Participation in the study is completely voluntary and as such, no person shall be advantaged or disadvantaged on the basis of this decision. The research involves being interviewed by me, which should take approximately 30-45 minutes. There are no risks or benefits for participating. Should you decide to participate, the interview will be conducted at a time and place of your convenience. To ensure accuracy, it would be useful to tape record the interviews, and I therefore ask your permission to do so. I, as the interviewer, will be the only person who knows your name, which will not appear in the research report, although I may cite some of your words. Any information that might identify you or your patients will be excluded from the research report, and I will protect your identities from my supervisor. I will also request that, when discussing a patient, you do not use their real names. You may decline to answer any of the questions and you may withdraw your participation at any time. The tape recordings of the interviews will be destroyed upon completion of the research process. You may request a summary of the research report, which will be emailed or posted to you.

If you have any questions about the study, you are most welcome to contact me on (011) 804-3650 or 083960806. Or, you may write to me at bradkallenbach@hotmail.com.

Kind Regards

Brad Kallenbach.

Supervisor: Dr Yael Kadish.

Appendix C: Participant Consent Form

I understand that my participation in this research involves participating in an interview.

I understand that there are no risks or benefits to participating in the study.

I understand that I may decline to answer any questions I prefer not to.

I understand that I may withdraw from this research at any time.

I understand that all the responses that I have supplied will remain confidential and no identifying information will be included in the final research report.

I understand that direct quotes may be used in the final research report, and that these will remain confidential with no identifying information.

I.....(participants name) consent to participate in this study.

.....(signature).

.....(date).

Appendix D: Participant Consent From (Tape Recorded Interview)

I understand that this interview will be tape recorded and transcribed by the researcher.

I understand that no identifying information will be included in the transcripts or final research report.

I understand that access to tape recordings will be restricted to the researcher and the supervisor.

I understand that tapes will be kept safely in the possession of the researcher during and after the research process.

I understand that all tape recordings will be destroyed once the research is complete.

I.....(participants name) consent to have my interview recorded in this study.

.....(signature)

.....(date).

Appendix E: Interview With 'Lisa.'

I: Maybe we can start quite broadly with what...I know you're psychodynamically driven, but what particular orientations do you like to use in your practice?

Lisa: Um, ya definitely psychoanalytic. I see mainly adults, and if its trauma its kind of late adolescence, um, its long term, sometimes the frequency would be twice, three times a week. Most of the people I'm going to talk to you about would be once a week byut long term, umm, kind of wits trained, so probably object relations but a lot of my supervision and my thinking would be more Freudian than object relations, so I definitely wouldn't call myself a Kleinian...

I: Ok...

Lisa: And more and more intersubjective..

I: Ok great. Can you talk about whether or not you think your own religious beliefs influence your work as a therapist, and if so, how?

Lisa: I think absolutely they do. Um, I am quite, I suppose the term would be agnostic, which is saying Im not kind of an atheist saying I know what the truth is, but I'm kind of skeptical, so I do, I think that absolutely influences my therapy, because I have a skeptical view of religion, so when a patient brings a religious comment or religious explanation, I think I immediately look at it as a defense, rather than thinking, you know, this is a spiritual experience, so I do think that would color how I hear the material (4.1).

I: Mmm. Ok. I was going to ask a question related to what you've just said but I think we do get there, so I'll save it. If you could then just talk generally about the kinds of experiences you've had while working with religious patients...

Lisa: Ok. There were three particular experiences or patients that I wanted to share with you. The first was an experience...I had a young man, well, he seemed younger than me, I think he was in his late twenties, and his father had set up the appointment, and he only came for an assessment session, and it was clear that this guy was quite psychotic – delusions, hallucinations, highly anxious, internally distracted, and, you know the dad came in at the end and said what do you think, and I said I think you need to take your son to a psychiatrist. And I referred him to a psychiatrist I often work with, who I trust, who I'd send a member of my family to, um, and they said they would take him for an assessment and get back to me. About two days later the dad phoned, and he was kind of very cagey, and it took me a while to get through what he was trying to say. Eventually it became clear that they weren't going to go to the psychiatrist because the psychiatrist had a Jewish surname.

I :Mmm

Lisa: And he said to me, could I not help his son in a way that was more, um, in tune with their faith. So, I just, I said, I gave him a referral to someone else, I said the person I referred you to is who I think is best and I never heard from the family again. So they were gonna go for an assessment and I was gonna get feedback and they'd continue the process. So I think the thing that annoyed me, and perhaps it was their bigotry that was also showing...cos they said they were devout Catholics...

I: Yes...

Lisa: And that's why they didn't want to see someone who was Jewish. I'm not sure if it was because he wasn't Catholic or if it was because he was Jewish, if you know what I mean. It was the bigotry rather than their religious views. So I guess I was left thinking that religion got in the way of getting real help. The son had a number of psychotic breaks and I imagine he'll have another one, and he'll end up in hospital, and I hope that he gets a nice Catholic doctor and gets the help he needs. But I was annoyed that they had brought that in (2).

I: Yes

Lisa: The second one is a varsity aged girl who is Catholic and quite devoutly so and does church camps and that kind of thing. But she's also sexually active. And the mental gymnastics she does to explain how she's both Catholic and sexually active leaves me going... 'get real here,' (1) so, but its very hard to engage with, because if you try and question a belief, then you're seen as doubting or undermining, you know...

I: Mm, ya, I can imagine that poses a lot of challenges for the kind of alliance or rapport you're trying to establish...

Lisa Ya...ya, and it also, you know she'll, it also doesn't allow you to get to...she feels guilty about the sex, you know, she goes to confession after she has sex. But there's something about that whole process that gets hard to think about psychoanalytically, like what are you actually doing? You do this thing that you don't want to do, and then you go and get forgiven for it and then you go and do it again. Its hard to talk about that because then she'll go and quote the bible to you and say that a good Catholics allowed to do that and blah blah blah.

I: Mmm.mmm

Lisa So it also allows her not to take accountability. So that's a case that I've also been quite...I find it hard to just do the therapy that I would normally do.

I: Yes

Lisa: And then the third case is a woman who, she was born of a Jewish mother, and, a non Jewish father that her mom wasn't married to. So, she's never really been accepted in, well, se feels like she was never accepted the Jewish community. And when her mom

died she was buried in the not Jewish part of the Jewish cemetery, because she had had a child with a non Jewish man

I: Right

Lisa And as my patient got older, and got married and had kids, she got more and more devout. So she kept Kosher and had the kitchen with the two sets of crockery and everything. And it also felt like a defense against her childhood, ok, she was going to be more Jewish than anybody else because she had grown up less Jewish, although she'd gone to a Jewish school and, she grew up in a poor family and had help from all the Jewish helping hand associations. So it also felt to me like the religion wasn't something that...that it meant a lot to her. This wasn't something that she loved or gave her meaning. It felt like it was a thing to do to make her more special. And there was also something very much in her engagement which was very much 'holier than thou,' you know,

I: Mmm

Lisa..her husbands family was Jewish but didn't keep kosher, um, you know, would come to the house and she would say "don't touch that: and really emphasise just how Kosher she was and just how devout she was...

I: Mmm. Interesting. Ok, well I think the next, following on from your three examples and you can answer in relation to whatever example you want, whatever jumps out, some of the countertransference responses you've had...I know you've touched on them a little bit, but if you could elaborate on one of the cases you've mentioned.

Lisa: Well, lets talk about all three. The first one, the psychotic guy, I think I was just a little outraged, and I thought actually the father didn't want to know about a psychiatric illness, and he used religion as a way to avoid going to a psychiatrist, so it, you know I just wanted to scream at him and say 'get real, your son needs some help.' So, that was anger and annoyance. Um, with the Catholic girl and the sexual exploits... I suppose frustration in the literal definition of the word, which is that I got frustrated in my task, which is to help her reflect on certain things and think about them. And it really makes me very aware of what words I choose and um, ya so it makes me feel quite cautious...how do we talk about this in a real way in whereby I can actually help this girl, um, but, you know, some very tough things have happened for her, so she also needs a defense. I think going to church and going to mass and all the youth programs also give her a safe place. So I guess I feel stymied: how do you take this therapy forward without stripping away something that she actually needs, but, this thing that she needs stops her from actually getting real, it stops her from talking about why shes doing destructive things (1). It's almost as though she can have sex with someone, go to confession, and it gets wiped out, its 'undone,' so she doesn't have to reflect on it (6.2).

I: mmm.mmm

Lisa: Ya so stuck with her, walking on egg shells, trying to think of an intervention in a careful way, so it feels, you know when you learn to drive, you kind of aware of everything, where the clutch is etc, and then it kind of all comes together naturally, so it feels a bit like that, how do I do this and...(1)

I: mmmm

Lisa: Um, and with the other woman, the woman who was becoming very orthodox...ya kind of irritated and disinterested and...often spoken down to...I don't have a Jewish surname, so she'd 'teach' me about it, in a sort of condescending way. But again, it feels like its literally sacred ground. Its hard to talk about, to say, "really?" you know?

I: Mmm. I'm kind of, I'm making up one of my own questions here because it popped into my head in relation to the anger and frustration, um, its, this might be a difficult question to answer, but to what extent do you think you're religious, your feelings towards religion are implicated in your response – if you were more sympathetic towards religion do you imagine you might have been less frustrated?

Lisa: Ah absolutely, I think if I was a devout catholic and I indentify myself in that way and that was part of my view of the world and myself, then maybe I'd understand him. I suppose I also would have been referring to Catholic psychiatrists. I'd know Catholic psychiatrists, I would rank or rate a psychiatrist on different criteria. Id say 'ok you're Catholic so you see the world the same way, so I'll send my patients to him, so I think for sure.

I: Ok. Great. Um, I mean, its kind of related to that question, but all the countertransferences, all the responses you've mentioned – the anger the feeling of being stymied, the feeling that someone was condescending you...to what extent do you think they were evoked by the patient, as opposed to being rooted in your own history, and its kind of a similar question.

Lisa: Mmm. I think it's hard to tease those two things apart. I think the last patient, um, the condesecening patient was condescending in many things she did, ok, and it was absolutely a defense against this terrible background she came from. She used to receive brown paper packages, with people's second hand clothes, and her defense against that was to get herself trained, she became a professional, ad she earned a lot of money, and she would wear every kind of label, but very expensive, you know, she would wear Minolo shoes and Lois Vuiton bags, and everything was, 'I'm better than you, I'm better than you. So, there's a lot from her that was condescending anyway, so a lot of that comes from the patient. But I do think, seeing religion as a little bit of a defense, um, when someone tells me how special they are because they keep Kosher, I'm going go 'really?' (6.2). This was also this father who had, with the first guy, a father who had denied what was happening a lot. I think he was uneducated in this arena, and his son was clearly psychotic. I think he was saying things that we're absolutely bizarre and the dad was trying to rationalize them, and I'd say, you can't rationalize them, they're coming from madness, but his dad didn't want to hear it (7.4). I suppose if he had taken another

tack and didn't go the religious root and said no no no, you know, I'm going to go homeopathic or something, I might have had a similar response, but I think, I think not being religious and also hating bigotry, coming from me my response was stronger (4.1).

I: MMm

Lisa: Um, the young, girl, it's a fairly new therapy still, so that might be why I'm tentative, it might also be the context that its in, um, and she is, she is fragile, but you know her father was murdered and he's also very devout. So there's also something about going back to his church, attending the mass that he loved, that's also quite protected, so I think I'm trying to be gentle with her, but I do think she's being quite rebellious at home and stuff, but she's finding a way to fudge the truth, and I'm feeling frustrated because she's fudging it in the room (2). It's hard to tackle her on it because it is also, as I said, sacred ground literally.

I: Mmm. Mmm. Thank you. Ok, we've discussed cases... Some of the countertransference responses that were particularly strong, I don't know if they we're all as strong, um, how did you manage them?

Lisa: Supervision, therapy [laughs], being aware of them, um, I think perhaps with the young girl, I'm probably managing by being overly tentative (5), but its also a new therapy, and she did set it up by telling me I'm her third therapist and that she thinks therapists suck, so...

I: No pressure

Lisa: [laughs] no pressure! So, trying to set up a rapport], but ya, I think my response is probably to be to try quite hard not to show my irritation, so perhaps an overcompensation (5).

I: Mmm. Ya. Its not directly related to my study, but you know, questions of is it projective identification or is it a countertransference, that kind of controversy...

Lisa: Mmm

I: it sounds maybe with this example, that that could be meaningful.

Lisa: Mmm. Mmm. Ya

I: The pressure she seems to be putting on you

Lisa: Ya. I mean she went into this long and detailed description about how the pil is not a contraceptive if you're using it for your skin. But she's not using it for her skin she's using because she's sexually active. So then it is a contraceptive. But no no no she belongs to a more 'reformed' Catholic Church that says you can take the pill if it's for

your skin. But it's not for her skin! So ya, there's a whole construct there of...but ya it's a newer therapy and we'll have to see where it goes. But it's quite frustrating (2).

I: Yes. Ok, now this is a slightly more theoretical question but feel free to draw on your patients, um, and you have touched on it in places, you've mentioned defenses, but how would you define healthy or adaptive versus unhealthy or maladaptive religious belief or practice in your patients.

Lisa: Mmm. I think...its probably not very theoretical what I'm saying, its probably more personal opinion, but, if it gives them meaning, if it gives them hope, if it gives them a sense of 'this too will pass,' 'I'll understand eventually why this terrible thing happened because there's a greater meaning,' you know, then I think religious belief can be incredibly supportive and helpful and healing (6.1). I think when it becomes quite rigid, and its more about behavior, so, for example, going to mass with the young girl and keeping your kitchen a certain way, um, that's when I start to think its maladaptive. I don't know where the theory would be on that, but I guess for me, its when its more about an internal experience, I would say that's more adaptive. When its more adaptive about behavior and other people seeing that behavior, that's when its more maladaptive (7.1)

I: Mmm. Alright. For you, what are some of the most challenging aspects of working with religious people? Other than, I know you mentioned the frustration and feeling incapacitated? I was going to also say, how would you manage these challenges but you have discussed that a bit...

Lisa: Ya, ya, I guess its about being able to challenge beliefs, but in a way that's respectful. So if someone comes and says, 'no one's ever gonna love me,' its in a realm that therapy's in, so you can say, you know, lets see where that comes from, what evidence is there for it, what do you do to reinforce it? You know you can work with it. But there's something about religion that is, I've used the word sacred ground, sacrosanct, that if you try and question it, you immediately a-religious, you are bad, because being religious is good and pure, and it's a desirable thing, its something people should...so if you question it you, you're bad, you're what are the words I'm looking for....

I: You're almost violating a taboo, you're being controversial, you're kind of inappropriate

Lisa: Absolutely, but then you know, you haven't, whatever, if you take the Christian...if you dint have a good relationship with Jesus, its just...you then become the one who has the pathology, or you're disrespectful...so, its hard.

I: mmm. Indeed. Ok, how we doing for time?

Lisa: We got lots of time..

I: Ok, then I'll save the last question. Just to, I mean because you mentioned you're agnostic, what do you make of the DSM's criteria, for, when it comes to things like delusions, what do you make of the fact that...

Lisa: When people go mad they think they're Jesus? [laughs]

I: Well, yes, yes, not only that but, so long as a critical mass of people do that, then they're not delusional. Do you know what I'm driving at? I mean, some of the criteria for delusions is that so long as there's, so long as a 'culture' believes these things, I mean, I can believe something bizarre, I can believe the sun hatched out of an egg. If I'm alone in that belief then I'm crazy. But if that belief forms a culture, then we have 'cultural relativism,' then I'm not crazy. What do you make of that?

Lisa: I don't think I would agree, I mean, I think 'don't drink the kool aid' came from, I think it was the 'moonies' but whatever, I think, I think, they were all crazy, maybe in a different way, I think, some, the leader thought he was the savior, and they may have had their own pathologies, but I think, it didn't make it more right simply because there were lots of them. It's a bit tangential to what you're asking but it is very interesting when you're in a psychiatric hospital, and those that are very mad, in the throes of an acute psychotic episode, how often the delusions are religious. And I've often questioned that and what is that about, and why when the frontal lobes and the thinking and reasoning is all stripped away, why does humanity go there? Is it to try find a meaning? Because if you're mad and the world's a scary place, you need to have some sense that there's a structure, that there's a meaning. The interesting thing is though, when they are religious, they are the messiah, and it's quite interesting to me, and it's interesting that you see that in psychosis. And maybe that shows my agnostic views again, but I guess what I'm implying is that when someone gets really sick they get religious (7.4).

I: Mmm

Lisa: Um, so, I don't think I would agree. My reading would be that if there's a group of people, it gets less mad. But I think often it gets, it gets more cultural than religious. I mean if you're in the middle east...Islamic law doesn't say that women need to wear burkas. It's the culture that says that, not the religion. Um, so when there's a group involved I think it brings different dynamics.

I: Mmm. Would you be in a sense saying that you disagree with the fact that the DSM wouldn't consider, so long as there's a group who believes something it's not mad, would you say you disagree then with the DSM's criteria?

Lisa: Ya I would say I disagree with that. You know they talk about folie-a-deux, where's there's three people that have it so why can't four?

I: Yes, and at what point, what's the number that makes it non-delusional, seventeen? Eighteen?

Lisa: Yes, and again the difference between religion and cultural makes it difficult to tease out. You know, if people start off by saying that we want to live off the land and be hippies, there's a cultural element whereby people get together in the evenings and play guitar and sing kumbaya, what's religious and what's cultural.

I: Absolutely. So this is our last question, maybe also more theoretical. Do you think there's a relationship between psychoanalysis and religion or psychoanalysis and mysticism for that matter. For example, do you see any commonalities or irreconcilable differences between the two?

Lisa: I think I'd go back to my answer about feelings and behaviors. I think, finding a meaning and having a happy, fulfilled life might involve having a relationship with a religious figure. I mean, I have some of my own views that might be, I don't know if I'd say spiritual, but often if someone makes a change, things fall into place quite easily, you finally get a sense that this is the right road...they leaving their husband, for example, they've got a friend whose roommate is moving out, the new job comes. I've often had that kind of experience. Someone struggles and struggles and struggles and they make the 'right' decision for them, then things 'flow.' I don't think I've ever seen that as a religious view, but would it be mystic? I don't know how you define mystic? But I do have a sense of a greater meaning, and I do think if someone can feel that, you don't feel quite as lonely, as desperate. You know, someone whose very depressed feels like there's no meaning, and it can be very hard to go on, so, do I think there's a place for it...If I really was to put my cards on the table, I think anything that's formalized and structured in terms of religion, that's when it usually starts becoming about people and pathologies. If it's something that gives someone meaning, warmth, comfort, then I believe there's absolutely a space for it **(6.1)**.

I: Great, thank you.

Lisa: You're welcome, I hope you can use that.

Appendix F: Interview With 'Sue'

I: If we can start broadly, maybe you can tell me what approached you employ in your therapy, I know you're psychodynamically oriented...

Sue: Ya, pretty much psychodynamic, psychoanalytically oriented, although often one has to be more supportive, depending on the patient and their needs, but it's psychoanalytic.

I: Ok. Right. Then also quite a broad question but maybe you can tell me about whether or not you think your own religious beliefs influence your work as a therapist...

Sue: Ah, that I don't have strong religious beliefs probably influences my beliefs as a psychotherapist. I probably have a more existential understanding of the world, and so I hope and expect my patients to do the work themselves, to see themselves as agents in their lives, to reflect on their own contributions in terms of things that are happening in their lives, so its an absence of strong religious beliefs that would be influential...

I: So, more an agnostic kind of approach?

Sue: Mmm. Id like to think that I have an idea that there is a spiritual realm, and I do think that spiritual well being is probably an important part of being healthy (7.3), but I cant pretend to be helping my patients with spiritual matters. I don't offer any kind of spiritual counseling. Although having said that it's when you come to things like bereavement that you know, working with more spiritual meaning making I guess (8.1).

I: Mmm.

Sue: I might come back to something if I think of something.

I: Sure. Ok, then if you can talk quite generally about the experience you've had while working with religiously devout patients.

Sue: Ok. I have had a few, and I was thinking about that since I got your interview schedule. I have seen, um, a very religious Christian woman on the couch, and um, her, while it wasn't so much that here religion created difficulties doing therapy, it was her difficulties with religion that became a topic in therapy. It was very hard for her to find a church that gave her a sense of who she was, finding a way of practicing Christianity, it was, created quite a lot of conflict with her parents who had different views to her own...I think she would have preferred me to have been a Christian helping her to grapple with Christian things, but saw it as a sort of medium through which she was resolving interpersonal issues. Likewise with her partner, um, how to negotiate their different religious view points, in terms of her children, what kind of schooling decisions they should make for them, whether or not they should or shouldn't be baptized or, there were points of conflicts with her partner, but I think it was about her sense of self. I think

she was trying to find out who she was in the world, and it was all taking place around religion. And she would get frustrated. She didn't know what I was or wasn't, but I think she presumed that in not saying, declaring myself to be a Christian, I probably wasn't, or as devout as she is. So that was difficult. I mean eventually the therapy shifted into other areas, but, um, that's an example that comes to mind.

Then I've seen quite a few, ah, I work in an area that's got, like many of my colleagues who work in this area, a high percentage of our patients are Jewish, so I might have seen, I've seen rabbi's, I've seen children of rabbi's and rebbetzins, I've seen quite orthodox woman, and there are a couple of things that come into that. Um, one of the things that's quite, sort of a countertransference anxiety of mine, is that if I know I'm seeing a religious person I'll dress differently in the morning. I'm very aware that I need, I try to be respectful. And it's something like an internal dialogue that goes "well why? They've chosen to consult me, I don't need to." Unless when it's the mothers or the woman on their own, but if it's a father, I'm very careful about that kind of thing. And then how I sit and how much proximity...that's sort of my own countertransference anxiety. I feel a little inhibited about how I have to be (1.1) Then other things, these are some examples, um, this has come up several times, I work with children and with adults, so, a very common theme will be sexual stuff, and in a religious Jewish family...I mean I've got a child whose playing out the mother and father kissing...I had a little boy who told me that he had heard his parents making noises in the middle of the night, and there was an enormous amount of anxiety there, and I had to feed this back to the parents. Another child I saw who was trying to cope with a pregnancy, the mother was pregnant, and um, very anxious with lots of very, sort of persecutory fantasies about conception and how the baby's going to get out and how it got in, and I had to ask the parents to talk about sex to their child. So those kinds of things, I feel, when a family's more religious, I feel more inhibited, in saying, you know what, a child does actually need to know..(1.1).and, in fact what I was surprised by was that I had prejudices. The one family I'm thinking of particularly I was very anxious, and I phoned a male friend of mine whose also a therapist and whose very religious, and he said that you must just say, speak from your professional position, that this is what I think is going on and I don't know how they'd handle that from a religious position, but that was the deal. And in fact the parents were open to it. They said 'I didn't know that children knew or were interested or had those thoughts' and so I described the play and we were OK with that.

I've seen another child who, a little girl who was sort of mid latency, who hated the fact that she was growing up in a religious home, and had to cover up, and she would say "I'm not allowed to do this because it's not snius [religiously appropriate], and I'm not allowed to do that because it's not snius, and it's so silly and the *first* thing I'm gonna do when I'm a teenager is I'm going to buy a bakini..." so that was quite tricky, that I had a sense that there might be something quite disloyal, but I mean, why would that be any more disloyal than a child, I mean one adolescent I'm seeing told me that she's smoking and her parents don't know...(1.1)

I: Mmm.Mmm

Sue: But it feels loaded, (1.1) um, so I had those kinds of issues. I've also worked with one particular very religious Jewish woman, who influenced me and my thinking in a

way, because her religion seemed so profoundly spiritual and not about the kind of dogma and rules and I had a very different kind of....

I: Response...

Sue: Ya. It kind of shaped my own thinking in a way. I mean when you say “how do my own religious views influence my work?” I think I feel sorry for, particularly, Jewish and Muslim woman, who are disempowered by religious practice (4.1), but she, I had a different sense with her. She was an intelligent woman and I think she made me feel that in fact it’s not simply that woman aren’t consciously and mindfully choosing. So that helped a bit too. Um, I think it just feels more prohibited.

Another religious woman that I saw quite a long time ago who was quite persecuted in her experience of the world, and it is true that she had quite a lot of dreadful things happen to her, and it was very hard to be both empathic and compassionate, and for her to have compassion for herself, and it was very hard to get her to think about where there was repetition, what role she was playing, because she could only see it as, Hashem, she was being punished for something. So it was very hard to shift that. I think eventually we were able to a little but by, I talked about, when she would talk about Hashem I would talk about parental or even paternal...

I: Mmm I was gonna ask you about that...

Sue: Ya I would try and make that link you know, so there’s always somebody bigger, stronger, more powerful telling her what to do. So trying to talk about it in terms of psychodiagnostically thinking about a critical superego. But it was hard because, you know the level of dialogue, was hard to get past that. But I think over time we were able to shift that a bit and then she relocated, and so that therapy never really ran its course. Um, I see a muslim woman who has been through a terrible marriage where he has had numerous affairs, and what has been hard for me, is that a lot of the time she’s had to explain that there’ve been quite complicated cultural, um, rules, prescriptions in terms of getting married and getting divorced, in terms of who you go to if you’re in trouble...so it was very very hard for me...I mean for three months, she was not allowed out of the home between sunset and sunrise, um and he was allowed to do...so that was, I remember her feeling outraged. And its not an anger that could really be thought or talked about because its an injunction in her mind, you know, she wouldn’t question it (2).

I: Mmm.mmm

Sue: So I keep saying its about something prohibitory and something that blocks off thinking, that’s how I have experienced it. Um, she had a child in the room, and in the dolls house. I’ve tried quite carefully to have mixed families – some black families and some Hispanic family dolls, and some Caucasian families, but this little girl, whenever she played she had to wrap a tissue around the mother’s head, because the mother always had to have her head covered, so she would turn the dolls into something that...I guess otherwise it didn’t feel like a mommy person to her. So sometimes I feel a bit, as hard as I try to embrace the cultural diversity, I do fall short a little bit...

I: Mmm. I mean you've, my next question was going to be about countertransference responses but you've mentioned a lot, um, I wanted to ask you...well, I'll get back to that so let me ask this first...the question I was going to ask is related to the outrage you felt towards those injunctions, and the question is related to how you actually managed that with her, but we can come back to that maybe...

Sue: Well, I can think about that a bit

I: Ok...to what extent do you feel that your personal religious views contribute to your countertransference reactions, and you have touched on it a bit...

Sue: No I would have to say they are very influential, because I would like to think about, and its not even so much religious views, its also political views about equality and about human rights and a whole lot of things, you know, if I was in a philosophical argument with somebody or a religious argument with somebody, I could get quite heated about it. But there are, its not only religion that one has to get one's head around when you're doing therapy...there can be particular value systems, or parenting ideas, I often have to deal with parents who have a world view that doesn't accord with my own, I am a parent myself. And I think that's just grist for the mill in terms of this kind of work. So we can come back to how you actually do it. Sometimes you have to just put your own countertransference aside. Sometimes its not the kind of countertransference that Freud was talking about it is about projective identification, about something that does get split off..

I: Mmm,. I was gonna ask you that...

Sue: Ya, so a woman like that Muslim woman who cant actually think, or doesn't want to acknowledge her own unjust feelings, cos that would put her in a very onerous position, in terms of where she would fit into her own family and the extended family, I think those probably do get projected into me, and then I'm the one left with the feeling of rage and anger and unfairness (5).

I: And she's not even aware of these things, she's safe

Sue: Ya, ya, she can just feel a bit, you know, that this is the way it is, a bit resigned and helpless and impotent...ya, I mean that therapy is ongoing, so we might get back to it at another point, but the focus has shifted now that the marriage is over. I guess it will be a similar issue with something else, but she's not even there.

I: And it sounds like its relatively early in the therapy, in terms of giving that back to her...

Sue: Ya, no she's not ready to hear that yet. I mean I guess if I was asking myself harder questions, would I say that I avoid things? It might be and that might also be that I feel out of my depth. And I don't know why I say that, because why should I feel like I know

a person's religion from the inside in order to think about it with them in the room, when I don't presume to know what its like to know what its like to be in any of another...

I: Any cultural...

Sue: I mean I don't know what its like to be in a lesbian relationship and I have a lesbian...I mean I don't know why I have that idea. But there's a bit of a, kind of a, like something's a bit sacred, to use a pun, its almost like a...(8.2)

I: Taboo,

Sue: Ya

I: That's sacrosanct,

Sue: Ya

I: You don't go there...

Sue: No, you don't ask them to question that. But I would ask them, "why do you smack your child?" or you know, "why do you think its ok for your husband to have an affair?" (8.2).

I: Mmmm. It seems in a lot of ways this is the crux of what seems difficult about doing work with these people, because you're not, you feel like you're almost trespassing, by going into their religious views, but if their religious views are so implicated in what problems they're having in living, in life, if its affecting them, it seems really tough.

Sue: Mmmm.mmm, I do think, maybe the other thing, that's why it seems different, but I think of people that Ive worked with who are sort of devoutly Christian and the Muslim families who are religious, is that they 'wear' there religion, quite literally, I mean you could be sitting here and a be a, a...

I: A Buddhist monk or something

Sue: Exactly, and I wouldn't know. But when someone comes in with a shatel on, or her head covered wearing, particularly Muslim-type clothing, its not so, it's in the room.

I: Absolutely.

Sue: I'll tell you one other thing that's just come to mind, another woman that I also saw for a very long time in quite an abusive marriage, she was married to a very religious orthodox Jewish man, and she, um, I remember her coming in here the one day sobbing because she had bought a packet of lettuce from Woolworths, and her husband had said, 'how dare you?' And then round about the same time she was very distressed in a session because she'd been struggling to get the dinner ready on time and she's allowed the

domestic worker to cook, which was a rule she broke in their home. And then some months later she told me that her husband surfs the internet late at night looking at porn, um, and I remember feeling, even now when I say it, I just feel absolutely outraged, and she did not feel that she could...(2).

I: Challenge...

Sue: Challenge that, because what he was doing I don't suppose had any, you know, somebody hadn't stood up in shul and said 'don't do that,' its just a presumed don't, whereas there were these very clear rules about...

I: Buying lettuce

Sue: Ya keeping kosher in the kitchen. So that kind of hypocrisy can really get me going too. But maybe its just the way the abuse manifests.

I: Ya, ya

Sue: Cos maybe there are other families where, you know, um, the husbands having an affair and the wife's getting shouted at about, how much money she's spending.

I: Mmm.Mmm, its almost like its not about the religious rules...

Sue: No, but that's where it played out

I: Mmm, like it was the medium within which it was dramatized.

Sue: Ya.

I: Sorry there might be a bit of repetition here, because you probably have touched on this, whether or not your countertransference reactions, whether it is the outrage or hypocrisy, or feeling of being kind of prohibited, walking on egg shells, those kinds of things, whether or not these are primarily provoked by the patient or rooted not just in your current religious beliefs but your religious history, your religious upbringing...and you have touched on this...

Sue: Ok but let me see if I can answer it more directly. I think its going to always be both, and maybe one of the, why its quite hard to answer it, because I have probably not done as much work as I could/should around my own spiritual beliefs. So, I guess, you know, I'm probably not always absolutely clear whether its my stuff or there stuff. I mean I've grown up in a Christian family but not a Church going family, an I've you know, I did do some rebelling of my own. I've never been confirmed, which would have been a typical thing to have done as a teenager, um, even though at the time the thing was that if you didn't get confirmed you couldn't get married in the church. So I've made some rebellious decisions in my life about religion and I have issues with authority, and I guess

that would be what would, that would be *my* stuff. I don't want anyone telling me what to do, least of all a rabbi or priest or Imam (4.1).

I: Or a book...

Sue: Or a book. So I would be much less inclined to you know, perhaps more, eastern religions, more Buddhism if you include it as a religion. Ya.

I: Mmm

Sue: I'm not sure if that's answering the question

I: Yes

Sue: I do think that, I probably can't say for sure, but this is probably an area of therapeutic grayness.

I: Ya, it really, it does really seem to be a matter of both-and rather than either-or, but, ya, its nice to hear the way different people set it out like that, that's great. Ok, then my next question was going to ask you to elaborate on cases that seem especially significant to you but you've done that, um, but if we could maybe go back to the management of the countertransference...

Sue: How I deal with it in the room

I: In the room. You're sitting there, you're feeling this outrage, your bloods boiling. What happens? How do you...

Sue: Um, I can't remember exactly what I would have done, but let me give it to you as an as-if... I think the woman who told me that her husband was surfing the internet at night... um, I think I interpreted, you know, her anger at hypocrisy, but I would have also had to deal with, well, there certainly was a theme around helplessness – her helplessness around ever being able to challenge anything. So, I would probably have given it back to her at that level, um, what would I have done at the time...

I: Take your time...

Sue: I don't think I did it at the time, but if I think about it now a little more academically, and maybe its related to some supervision I've had on it recently, I have a greater sense now, when somebody comes into this room, and talks about people, and experiences in their lives, that it is useful to think about them not only as narratives that belong in the real world, but as narratives that belong in the psychic world. So it would probably take me much more away from the religious stuff and into her maybe her own conflict around sex for example. Ya, so I think, if I'm thinking about it, I won't get so hooked on the religious stuff, and I'll say, 'OK, let me think about it on another dynamic level...' Id like to think that that would be a way of managing it, but that wasn't quite

what you were asking, you were asking what I did. Ok, the woman, um, the Muslim woman, um, Ok you said something – anyway I’m thinking allowed now which I said I wouldn’t do, anyway you’ll have to just edit the transcript – um, when you used the word egg-shells, you planted an idea in my head. But its true actually, it makes me think of how I work with narcissistic defenses which often evoke the same countertransference reaction, which is that you’ve got to walk on egg shells (6.2). Um, so it may be in some way, that part of managing it is in some way about managing some sort of narcissistic defense. So, you cant challenge it outright, you gotta work very carefully, there’s got to be a lot of trust before you can gently question something, so that it isn’t felt as a sort of blow to the self. Um, and that’s not to say I would think of that woman, the Muslim woman as being narcissistic, but maybe there is somewhere a narcissistic defense of some kind.

I: That’s really interesting.

Sue: Um, let me think about the. Ok one of the ways I do it is I do enact something myself by sure that I dress differently, talk differently, approach things less bluntly, more respectfully. I think at some level its maybe about respect, trying to be more respectful. I like to think I’m respectful anyway, but...

I: [Laughs }

Sue: Um, um...I mean the question you haven’t asked, but I suppose is really big, is, can someone really do deep psychoanalytic work with someone who is very religious?

I:Mmmm. That kind of touches on something I was going to ask later but that’s actually a better way of putting it than I had it here...

Sue: How did you have it there?

I: I had it as ‘what for you are potentially the most challenging aspects of working with the deeply devout.’

Sue: Well it might be that I wonder what you gonna do. How you gonna fit a God into that psychic world? And I’m not sure, I haven’t, I’ve never had anyone on the couch whose deeply religious. Is that a co-incidence? Or is that [laughs]

I: Interesting

Sue: I mean are you less likely to get on the couch if you’re deeply religious, I don’t know. But I must say that I do wanna say that in my definition of religion I would include Buddhism, because I think Buddhism allows for much more self reflection and much more thinking. So I’m really thinking in my experience about devoutly Christian and devoutly Muslim and devoutly Jewish woman. I’ve had a few new patients, but is hasn’t felt like there’s been religion in the room.

I: Ok, great.

Sue: I'll tell you one other thing that I've found quite interesting. There are a couple families that have been in the room who have been very religious, and, um, if the session falls on a religious holiday, they don't come, and others do. And I've never asked why. I think for some this may be seen as 'work,' and for others may be seen in a different way.

I: Which is so telling...

Sue: Ya. So I've never questioned it, but I don't presume it either, so I'll usually say 'I believe it's a Jewish holiday on this date and what does that mean?' and they'll say "means I definitely won't be seeing you" or "It means my husband can come"

I: Interesting

Sue: Ya. Or "we can bring the other child" or...um, but I mean that's not, when I say religious home, it would be in the middle of the Pesach week. On Yom Kippur I don't think anyone would come. I have one Jewish man I see whose not particularly religious by his own admission, but he would never come on Yom Kippur, so...

I: It would be really interesting to see, if you get the chance, to...

Sue: Ask them why! Cos I think the guilt somewhere is there [laughs], I don't think he even goes to shul, but he won't come to therapy.

I: Ok. There really are, in terms of my questions, there's only two more questions, but both are actually more theoretical but feel free to draw on experiences with your patients and again you have mentioned a few of these things already, but how would you understand healthy or adaptive or unhealthy or maladaptive religious belief or practice in your patients?

Sue: Um, They need to have chosen it rather than inherited it. And in some way chosen it mindfully, um...its got to do with mindfulness, or its got to do with reflective functioning, its gonna all come back to that, because its got to be, um, a capacity to think about the extent to which behavior may be informed by religious beliefs, or religious beliefs are used defensively to manage a situation...(7.1) um, I have had a Jewish family not want to see me, because I'm not Jewish, but this is interesting – I mean its got nothing to do with this question – most of the Jewish families I've seen are hugely relieved to know that I'm not Jewish, and because I'm not part of the community they feel safer. I think that's because the religious community is so small here, and I don't think the the boundaries and discretions are well kept, they are often very anxious if they have said anything to a rabbi or religious counselor, or if they've said anything to a rabbi or have had the *Chevra Kadisha* involved, they always feel exposed (4.3). So there's something about, in fact they, you're not researching what someone who doesn't share their religious beliefs would say, but some kind of safety in it. But um, so, ah, we'll go back to what's healthy and what's unhealthy...

I: On the choice thing, can I ask you a question on that?

Sue: Ya

I: You said that in a situation when a child's grown up in a very orthodox Jewish family, when you say choice do you mean, would that include they've, even though they've been brought up in this way, they choose this way, even though they carry on with it...that sort of thing. So its not necessarily about, the family you're brought up in is almost secondary to...

Sue: to the choice...: Let me think that through, let me think of a case, I know you're asking theoretically...

I: whatever comes to mind ...

Sue: Ya if I'm just associating...you can grow up in a family of doctors and land up a doctor yourself, and it may very well be that that's, its an easy and obvious choice, you've grown up with people who love your work, you've been exposed to it, you may have the kind of temperament and intellect for it, um, and I don't, but I think that there's a point at which you have to say for yourself, how do I feel about this. 'It feels absolutely fine, I've been in this water all my life, and it fits, or it actually doesn't.' Um, I'll tell you something now, I don't know if you can use it, but, I cant disguise the information enough, if this patient even read it, I saw a little girl whose father is, not a rabbi but is very much part of the religious community, I mean he studies and whatever. And she has a mother, I mean, I think the mother's father might have been Jewish, I think there's some Jewish blood in the family but she didn't grow up as a Jew, she converted. When she met the father she was a swimsuit model, and this mother now, she's chosen to convert, and she covers her hair, she wears a shatel, she dresses very conservatively. The little girl is, obsessed with sex, absolutely obsessed with sex. She makes, she cuts out card boards of full sized dolls, so she makes paper dolls, so she will lie down on the floor and draw her outline and draw all kinds of clothes for them. So, the self she brings her is, all the time, is a, I mean I think the mother's projected the swim suit part of her, into the child, so the child is now left with this huge conflict. I think she carries that whole part, all of what her mother gave up. But I think that at the same time she is very, very concerned with impressing her father, and at the same she's very anxious, has a very critical superego, um, and she's a very conflicted little girl. Um, I do feel, I feel quite conflicted because I have a sense that her parents brought her here because she's anxious and the teacher thinks she needs help, but quite frankly, I think she may need this space to work something out that her parents are not going to approve of later. I mean I cant not allow her to use this space in whatever way she wants to, and she's gonna have to sit down at some point and make a choice, and she may choose for and she may choose against. You know, her parents...so I think it's got to do with the adolescent talks of 'who am I?' 'who do I want to be?' I think that somewhere there has to be that. And I actually, when I think about it, when I think about the Christian woman that I saw, she was...I mean it was an adolescent issue that was delayed, she hadn't found who she was

in terms of religion, it wasn't part of her evolution of self. That's what I think needs to be there for it to be healthy (7.1).

I: That's great, thank you. Ok, then the last question I have here, how much time do you have left?

Sue: Its Ok I have a patient at ten past...

I: Ok then you can give me a short answer to this, do you think there's any relationship, or rather, do you think there's a relationship in any form, between psychoanalysis and religion or psychoanalysis and mysticism? For example, do you see any commonalities between the two or any differences which are completely irreconcilable?

Sue: Ok, I've said to you why I wonder whether psychoanalysis will work with a very Orthodox believer...

I: Ya

Sue: But I do think sometimes psychoanalysis is like a religion, that it also has a kind of built in authority that is also has expectations of faith and of handing over something to someone, and I would imagine that that's quite a dangerous aspect of psychoanalysis, um, you know that there's also...

I: Something maybe dogmatic...

Sue: Mmm. So there's also, um, I would say that that might be there. I think that there may be something of a, of a similarity to or sort of, mystical practice in that it's a journey or a discovery, and the idea that there's a kind of a holy grail at the end of it, you'll 'know yourself'...(9.2) and I think that's probably dangerous, actually, to set psychoanalysis up as...and I'm not in psychoanalysis myself I practice as a psychoanalytically oriented therapist, mm, but, if you ask me theoretically, I do think there is space for those kinds of criticisms, I mean I don't think they're necessarily true. In my most cynical moments, I think that the reason why they can't really find a difference, in any of the efficacy studies, between the different modalities, is because I think a lot of them kind of work on the charisma of the practitioner...that at some level they're charismatic, and in that way I think that psychoanalysis can be a bit charismatic, like a charismatic religion. You change because you know, you're inspired to change. But that's quite cynical part of me, and when I practice I hope I don't practice using charismatic kind of principles [laughs] (9.2).

I: Sure

Sue: but ya., I'm sure I'm going to think of a million more things when you leave, is there anything else that you that I haven't....

I: No, I mean in terms of, that's all that I've got on paper, but I could ask you a million more questions cos what you're saying is fascinating but...

Sue: its what you're looking for? I mean I haven't not answered something that you...

I: No, we've covered everything. Thank you.

Sue: I've just thought, lastly, of a boy that I worked with, who goes to one of the more religious schools, and whenever he needed to tell me he was angry with me, he would say things like, "do you wanna go back to Egypt? Do you want to go be a slave in Egypt? Because if you want to then I can ask my Abba to send you back."

I: [laughs] Incredible

Sue: [laughs] so all of his ways of punishing me would be, he'd use kind of religious, the religious things he was getting at home. "That's not a mitzvah, do you know that? Because if you do that, then, whatever..."

I: That's so interesting

Sue: Ya I have to try and keep the smile off my face...

I: Can imagine that's hard !

Sue: [laughs].

Appendix G: Interview With ‘Teri’

I: Ok, maybe we can start quite broadly with you telling me – I think you’re psychoanalytically/psychodynamically oriented – maybe you can tell me about some of the approaches you employ in your therapy?

Teri:: The format in which I frame my thinking would be very psychodynamically based, so its rooted in the Winnicott perspective in terms of attachment and container/contained, and Bion and Bowlby and those kinds of approaches, but also using some of the psychoanalytic frames, um, to understand some of the internal worlds of the children, um, the Freudian and Melanie Klein’s perspective.

I: Ok. That’s great. Do you work mainly with children?

Teri: I mostly work with children, so a large component of my practice is children under the age of ten, starting from 3 upwards, and then I’ve got the odd teenager and adult.

I: Ok, then also quite a broad question, but maybe you talk a little bit about whether or not you think your own religious beliefs influence your work as a therapist?

Teri: Um, I think having a religious belief does allow for more thoughtfulness when someone comes in that is religiously, ah, focused In terms of how they live there lives and how they present concerns and problems, whereas I think if you’re not, ah, framed in any form of religious format it can be quite limiting in terms of the way you understand initially the person’s, ah, functioning. So from that perspective I do think it allows for a more thoughtful perspective. I don’t think my religious beliefs limit the way I engage with people of different religions...I also think that my religious beliefs mean that I pick up on innuendo’s when they present themselves. So there’s a different kind of sensitivity, ah, but it doesn’t influence the way I would engage with a client. I don’t think so.

I: Ok. Ah, I was wondering if you’re comfortable sharing what are your religious orientations?

Teri: Ok. I come from a Hindu background, and was raised to think quite eclectically, so it was more, um, the home in which I was raised in was rooted in religious practice, but was governed around the thought that, all religious practice leads to one, um, one end. My own choices as a teenager developed differently, in that I chose to become more focused in certain religious practices within the Hindu origin which I think was limiting, and then, ah, I married a Christian man and chose to move towards Christianity, to be less complicated in terms of our home environment...So I do feel like I have an eclectic experience of religion, and its rooted more in terms of practices that feel comfortable for me than, principles that are governing.

I: Ok, great, thanks. Um, this one’s also quite general but if you could just talk a little bit about the sorts of experiences you’ve had while working with religiously devout patients.

Teri: Um, you know when I got your questions the one point that stuck out in my mind was that, coming from Natal, um, my experience of the Jewish culture was very limited, actually, zero to none, um, knowing that its there but never really encountering it in any form or, anyway, and then becoming a psychologist and having to experience, um, Jewish culture quite differently, and, in the first two years of my practice, I had the opportunity to work with a very traditional, Orthodox, Jewish teenager and her mom, and it was a real challenge for me because it challenged a lot of

my, what I thought was, liberal views, in that the perception of contraception or perception of, Jewish practices, how our homes were governed, I think was challenging for me on my own personal level, as well as how I present myself as a therapist, and I do think that through the, the countertransference, which I couldn't label at the time, um, it might have worked to my detriment in my relationship with that client, particularly because perhaps my own inhibitions and my own prejudices came through unknowingly, because I hadn't worked through that, back then, and that relationship didn't last very long, um, also you know like, just the basic things of woman who wear wigs, that was like a complete different learning experience. So everything felt novel, and um, limiting in the sense that I didn't have a previous experience, in that even my own religious beliefs and thoughts couldn't transcend and create a bridge.

I: Right...

Teri: Um, so it felt like an isolating experience, however thereafter, I was a lot more thoughtful, I did research, I asked around, I inquired about the religious practices and all that, and in this area, I have worked with a lot of Jewish families of varying degrees of spiritual commitment, and that certainly prepared me for future clients. Um, I also have worked with some Orthodox clients in the Muslim faith and in the Hindu faith, and also some Christians had very very rigid perspectives on how things were done and what is acceptable, and um, I think in those instances the eclectic experiences of religion allowed me more tolerance and allowed me to let go of the religion aspect and focus on the client. Whereas I think in my first initial encounter with an Orthodox Jewish mom and her child, that was less evident.

I: Mmmm. Great, and I think later on Ill ask you to discuss one of those cases in more detail. Um, but ya, I'm glad you mentioned countertransference

Teri: Mmmm

I: cos it comes into the next question, um, I was gonna ask you what were some of the countertransference responses you had, with some of them...

Teri: Mmmm

I: and I know you've just touched on them a little bit, but ya, maybe if you could go into...

Teri: Ya well let me go back to that first client that seems to stick out so much

I: Ya

Teri: um, in this instance I was told that this mom had ten children and that she presented herself in such a, I don't even, in this, a Mormon kind of way, really demure, and really struggled, and the contrast with her teenager who was struggling to find her identity. Um, and I was very annoyed with this mum, and I had strong feelings about... 'look at this chaos that's happening,' and the judgment and all of this that was being bounced around by the three of us, and my sense it was partly the teenagers and me not being able to filter it out.

I: mmmm.

Teri: Um, also mixing up with my own, perhaps unprocessed issues around what is appropriate what isn't. The rigidity of religion and the, and the, lack of individual identity. Um, so I do think that the unprocessed, un-digestible countertransferences that were happening in that space,

ah, led to a more destructive therapeutic process than a helpful one. And with other, I mean, currently I have a client that's a very traditional Muslim woman, who also covers her face, and then removes the, the...the...

I: Burka or something?

Teri: Ya, when she comes into the room, and in that context the countertransference feels more around, it feels more theoretically aligned, so, instead of understanding it from: "I can't understand why you're doing this" – my mind is buzzing around: "what makes someone need a religion to be followed so rigidly?" "What motivates her to have all these boundaries that are created under the auspices of religion?" "And how does that then translate to what she does in her world, both in terms of a productive way and a destructive way. So I do feel that Orthodox Jewish mom and where I'm at at the moment, the experience of religion has allowed that journey to develop to a more theoretical understanding...

I: Mmm.Mmm

Teri: that feels a little more integrated, rather than...(inaudible).

I: Its interesting, I mean it seems like, someone who come into the room covered, its really in the room, its really...

Teri: Yes

I: Its like a statement...

Teri: Absolutely. And one of the significant fears I had when I met this mom, when she came in with the *Burka* and the covered face, I said "I hope she's gonna take it off!" [laughs] "Cos how am I gonna work with her!?" And she's wears glasses, so for me to access her eyes...(1.1)

I: mmm!

Teri: Um, and so there is that, that complete fear of being out of your comfort zone, because the work that we engage in is so personal, and also, the way I engage in the dynamic of the marital relationship is a lot more cautious. So when you have to ask more questions around intimacy and conflict, and that the way I word it, is, is more thoughtful, than had it been in another environment. And its hard to ascertain at this point how much of it is, a result of the transference or a result of expecting a traditional couple to be that cautious. So, it does have an ebb and flow to it...um, so, it does change.

I: Mmm. Ok, that's great, so ah, we might come to that, at the end there's some more questions around countertransference, so we might come back to that a bit later. Um, ya I mean the next one's also related to it, but to what extent do you feel that your personal religious views – your kind of eclectic upbringing, with a kind of broader roots in the Hindu faith - to what extent do you think that those views contribute to your countertransference reactions?

Teri: I think there is more room for other things to be absorbed. I think those that are quite prescriptive and those that choose a very selective root might have a limited...I mean I might feel judgmental, but it feels as though the countertransference process will be limited to a particular experience, and that, um, having an eclectic view means that the judgment comes from many angles, and that there's a thoughtfulness for all areas (4.2). However, there will always be those

'black spots,' that the transference happens without the thinking, and then one has to go back and look at it (5). Cos there was a client I had seen for short term work, um, and the mother had described, um, a religious faith – I think a Christiana religious faith, I think they were Jehovah witnesses or something to that effect – and how the religious practice came though in a little boy of five or six, you know “Jesus said I must do this and Jesus said I mustn't be cross,” and how I found that, that my countertransference was of annoyance – how can a parent impose a judgmental way of upbringing when a child is struggling with so many things?! (2). So I do think where the complication arises is more when, I have to work with the parent and the child, and, uh, there's no opportunity to just freely think. That the countertransference is just bouncing, ah, and its much harder to digest and process than just work through it, ah, it does seem to be more of a, of a feature.

I: Alright, ok, and then, I think you did touch on this already, you mentioned that sometimes its hard to say where it comes from

Teri: Ya...

I: Its there stuff or if its your stuff – maybe you can speak a little more about that, I don't know if you have any thoughts around that...

Teri: I do think there is something about my own history that is likely to evoke more of a reaction on certain themes than others, um, so an experience of, um, being prescriptive and being narrow minded is likely to evoke a reaction to me in a negative way, um, um, though I have my own boundaries about what's black and what's white, I struggle with things that are imposed without thoughtfulness, that it will be my Achilles heel, that I'm more likely to react to, ya...

I: Kind of, maybe anything dogmatic?

Teri: Yees. Yes. I think because, but I do think that its not necessarily always the case, because if I think of the Muslim, the traditional Muslim client that I'm working with, her experience of religion, um, though fundamentalist in the way its displayed, not how she might think, it doesn't, its not as evocative for me as someone who feels blindsided, and that its almost imposed. So, maybe its my own development as a human and the process of therapy, um, but I think it's a combination of things. That it's a combination of how the therapeutic alliance is developing, as well as the transference and the countertransference and how we both using it, but I think the difficult moments where I respond more evocatively is rooted in a sense of where the theory of the process gets lost, and the religion part dominates.

I: Mmm.Mm. I was also wondering with you being, you are Hindu by faith?

Teri: Hindu by birth

I: By birth, yes, how that, um, with different patients for example – Orthodox Jews, Orthodox Christians, does that, is there a pattern in, or do certain groups of people respond to you in a similar way or a different way, based on that, does it ever come up if they're very very religious?

Teri: Um, Oddly enough it's the one's who are less religious that ask about your religion...

I: Interesting

Teri: Um, the religious one's, my voice, ah, my name, my work, um, creates a neutrality , whereas if I presented myself or spoke in a more traditional Indian way, that perceptions might have been created, um, and being established in a community that's mostly non-brown, you tend to be a very neutral presence

I: mmmm

Teri: um, even with the, even with the brown skinned people that come in, because I'm less likely to bump into them. Um, so, ya, I do think that that, I think I've had two people in the entire five years I've been in practice that have asked me my religion.

I: Interesting. Ok, um, ya, you did in the beginning mention some cases that were interesting – the Orthodox Jewish teenager with the parent and the Muslim woman with the Burka – um, I'm just wondering about some of the countertransferences with those, how did you manage that? For example in the room, you're sitting there, you're perhaps getting annoyed with the parent, um, you kind of, all your things are being hooked that bug you about what they're doing...

Teri: Get lost in your head! [laughs]

I: [laughs]

Teri: Wait for the time to go by [laughs], um, you tend to, ya you do tend to daydream a lot. Its much harder to stay focused, I find it harder to stay focused, my mind wanders, I'm mindful of time suddenly, I notice things outside, I notice noises, and then you have to work hard to bring your mind back. So you feel more jumpy, and your thought is harder to bring together, the thinking happens more when they leave. And the debriefing happens in the corridor, in terms of, you know, I find my colleagues in the practice are very helpful in terms of saying this is what happens, what you cant, this is what you can do, so that was like hands on kind of learning. And in some cases it's almost like you don't want to remember that, in the space you survive it, and then you leave it. You know when I think of that young boy, it felt like somebody was stuffing something into my throat. So it did feel harder to be available for that little boy, because he, I think there must have been something that evoked a memory in me. So it did make it hard to get past the dialogue, and wonder about what motivated that dialogue. But the thinking happened afterwards. It was more like surviving it, and then digesting it thereafter (5).

I: Ok. Great. Um, I was wondering if the frustration or an y of the countertransference feelings you had in a session got really intense, if it was the kind of thing where, it happened so often where you thought, it must maybe be potentially some kind of projective identification, something about them that they're doing, I'm not sure if that's ever happened or if it did whether you would 'give it back to them' in that sense...

Teri: Mmm. Push it back...

I: Yeah.

Teri: I think lack of experience prevented me from doing that with the first Orthodox family, mm, and I think I was so thrown by this practice of having multiple children, and, I did need to talk about that a lot, ah, to digest it. Um, but in terms of the projective identification, I haven't had that experience in a direct way that I've observed or noticed. If I think about the, the traditional Muslim woman I'm thinking of, I think with her, the evocativeness comes in the need to protect something that's so unprotected. So I think in her instance, the Burka represents the need to

protect rather than the need to control, so I do think that its rather case related, and with the little boy that had this dialogue, its interesting cos I saw him fro a short time before he stopped, and then mom brought him back a year later, and in the second encounter, none of that surfaced, um, and in the first encounter I was perhaps happy for him to leave and not come back, so perhaps in that context the projective identification was, he pushed it all on me, and then it was easier for him to move on, but it was much harder to work with in the space.

I: Alright. This may be a slightly more theoretical question but feel free to apply it to your patients...

Teri: mm hmm

I: How would you understand healthy or adaptive versus unhealthy or maladaptive religious belief or practice in your patients?

Teri: I think, for me healthy suggests, um, a relationship with religion rather than a, a rigid controlling response and living out of religious beliefs. That there can be ebbs and flows to a religious engagement, and that if the rules are what govern you to your own detriment, I would consider that unhealthy (7.1). So if I think about the Muslim client, part of her challenge is her difficulty in asserting a role, being able to be angry beacsue its contradictory to the perception that shes creating or facilitating for others. So that feels fragile. But there's a sense that she's not dogmatic, which means that there might be some kind of flexibility around it. But I do know that if I had a very Orthodox somebody that walked in and was very : "you have to do it this way and you have to do it that way," that it would be very hard to work with and I know that it would evoke a more, a less thoughtful response perhaps before a more thoughtful response could be considered.

I: Mmm, ya, it also touches on what you were saying in the beginning that if there's room to think...

Teri: mmmm

I: Even though they practice these things, no matter how ah, religiously they practice these things, if there's room to think about these things, maybe if there's room for error...

Teri: :mmm

I: Or room for considering other points of view, that sort of thing.

Teri: mmm. But I suppose it also, that kind of adaptability also allows for a therapeutic alliance to develop, whereas the rigidity kind of excludes a therapeutic alliance because it's a one-way experience, rather than a dialogue that co-exists. Because there was another child I had where the child was the primary client, um, but the mom sat in on the sessions, and she was seeing a therapist, and then explored the idea of an alternate healer. And it did feel evocative, because here I am creating a therapeutic space and mom's saying, "well actually, your stuff is dodgy I'm going to an alternate person," but actually that with time, I could see the benefit it was giving her and so it created a flexibility around, 'this works for you, yay, but you allowing the space to still exist, that its not one or the other,' and I think she even took her little boy for these 'alternate experiences.' But she didn't stop this process. So I think in that kind of system, it feels pliable. And I think a religious Orthodox person has less pliable features to it.

I: Mmm. Do you think, just on that, that maybe an inability to be pliable, or inability to think, a dogmatic approach, do you think its more a complex of their personality generally, and perhaps religion is maybe just the medium through which its being dramatized or coming out, that you would see a similar way of being in other areas of life, in relationships, with you maybe...

Teri: Absolutely I think more and more I've been think about that, that there is a quality to it that does question what part of a person requires that kind of rigid practice, rule based and dong things in a step one to step five kind of way. And my sense is, and obviously there's no proof around this that I've read up on, but that it is rooted in a higher level of anxiety around needing order and structure and rules, and when one can consider that in that context its much easier to think. But when it evokes a reaction, you know, because the interpretation of anxiety being the other side, being the aggressive side, when that presents first, its much harder to find those anxious parts that need the rules and the structure to function.

I: Absolutely. Ok. Then, what for you are potentially the most challenging aspects of working with the deeply devout? Um, I know we have touched on this as well a bit

Teri: mmm

I: So maybe you can just think about that, and then, how would you manage these challenges, and we have discussed management with regards to your countertransference

Teri: mmm

I: but ya, whatever comes to mind...

Teri: I think the challenge is in recognizing it when it happens, that it can often be misaligned to other things, and , look its like something that can co-exist with other things anyway, so it is hard to create a black and white around it. But I think that the first challenge in my personal opinion is to recognize that its there, and then to ask myself what it is that's evoking a reaction – is it my own expense of anxiety, my own experience of religion, or is it another theme underlying that that's evoking a response. And I think for me it would be about filtering whats most evocative, taking it to therapy and thinking it through in supervision, because I think to not think it through is destructive. Particularaly if you've had a strong reaction to something and it doesn't have commonalities with other things that are going on in the session. So if someone is anxious and there projection is this heightened sense of anxiety and you're reacting to the religious element, it suggests that something's going on – the projections and transferences and over-identifications are all bouncing around, and someone needs to own it, and I suppose the therapeutic alliance and supervision would allow that to develop (5).

I: mmm. Yes. I know I framed the question mainly around countertransference, um, anything else, perhaps not related to countertransference, any other kind of challenges?

Teri: I think I understand religion also as, for a lot of people, being a container. So I do see, you know if a religion gives you containment, a sense of where you belong, a place of rules and um, allowing me to hold onto the bad and the good, and like myself more (6.1) it also allows me to try understand what makes this child or person feel confused outside this realm, so as much as the transference and countertransference is a form of communication, I do think that that the way the religion itself is interpreted um, be it imposed or created, um, I do think that there is an element from trying to understand what it represents. And I find it useful to think about the history of the

person, what are their attachment patterns, what are their life choices, and trying to understand how this person uses structures to allow them to function. And I think that's been relevant for all the cases I've mentioned.

I: Ok. Then just lastly, maybe also a little more theoretical, just your thoughts on whether you think there is a relationship, in any form, between psychoanalysis or psychodynamic psychotherapy and religion or between psychoanalysis and psychodynamic therapy and mysticism for that matter, for example, do you see any kinds of commonalities or irreconcilable differences between the two?

Teri: Um, I think it just depends on the kind of lens you put on. Um, If I had to reflect on clients that I, that come to my () in terms of religious groupings, I would say that I understand it more as I give it more thought over time, and that in the context, I don't feel I use any particular theoretical framework in the process, but as I reflect back on it now, I do think that the idea of anxiety and containment, and the kind of the, the depressive position, in terms of, what is a split, and where is the integration, and how does that formulate the way you engage with religion, that those theoretical principles can be very evocative in trying to think it through. Um, in terms of the similarities, I suppose religious practices has an element of being very prescriptive in terms of principles, but the way those principles are interpreted is based on the theory behind it. So if you're coming from a mystical perspective you're going to interpret it quite differently to someone that needs step one to step five. Ya, so I do think that the theory of psychoanalysis helps one to make sense of a religious practice or belief, but commonalities...I don't know, maybe it is about just thinking that there are other things going on that contribute to something...the ah, the abstract is what makes it common rather than the concrete (9.1).

I: Ok, well, that's really all I have hear so thank you.

Teri: Welcome

I: I was just wondering and maybe we can close with this...I'm not sure how we're doing for time...

Teri: Neither do I...we have all of four minutes [laughs]

I: Oh ok, alright I'll make it very quick. The kind of, speaking more psychiatrically, the kinds of things that count, in the DSM for example, as a delusion...the idea that certain beliefs, for example, I can believe something crazy, I can believe the sun hatched out of an egg, but if there's enough of me who believe that, and there's enough of me who can form a culture around that, that doesn't count anymore as a delusion...what do you make of that? Do you think its problematic that all it takes is a certain critical mass of people believe something, no matter how crazy it is, and the minute you have that mass, it doesn't count as a delusion....

Teri: I mean I, I don't even know if this is relevant but Ill just share it with you...when I was living at home, and my, I wouldn't describe my parents as being particularly religious, and this um, this moment where there was a whole lot of people who were, have you heard of Sai Baba?

I: Yes.

Teri: There were a whole lot of people that were saying "no if you do this, there'll be ashes coming out of this and that," and so my mom has this thing and things come out of it. And so like, on a very logical level, my brain is saying "you must be mad." On a psychic level there's a

need to believe that it exists. And yes I was a twenty somebody, I wasn't a young influential, but I think it is that mindset that if everybody believes, how can I not believe? So it is quite a powerful place, and yet logically you can think about it quite differently...If you think about, ah, the sangoma, I think its, U-twasa, is that right?

I: Yes I think so

Teri: um, its that same concept – I think I hear voices, in trances, and people who speak and say I cant remember what happened. So its all of these kinds of mystical things, um, I ya logically I question it, but ah, experientially with enough people believing in it, it does kind of diversify that opinion.

I: Yes. Ok great. A closing last question, I didn't ask you in the beginning? I think you do believe in something, in a higher something?

Teri: Yes. Yes [laughs] I'm practicing as a Christian, ah so I do believe in God, I do believe there's a good and a bad,

I: Right

Teri: um, but that my interpretation of things might be a bit more eclectic..

I: Ok, great, well thank you. I appreciate the time.

Appendix H: Interview With ‘Nancy’

I: Maybe we can start quite broadly and you can just tell me what psychoanalytic approaches you employ?

Nancy: So I generally work quite eclectically which is not a very popular word but it is the best word to describe the way I work within the psychoanalytic school of thought, probably my personal preference and where I tend to lean in most of my thinkings about and most of my interpretations are around object relations. So that would be kind of eh simplest way for me to describe my orientation.

I: Ok. And if you could just talk a bit about whether you think your own religious beliefs influence your work as a therapist? And if so, how?

Nancy: Mmm, here’s the difficult questions starting [laughs] I mean, very interesting question, I consciously try not to bring my religious beliefs into the room so...a very conscious thought I made right at the very beginning of my studies to separate out the two completely, and I don’t consciously find it a difficult thing to do, I mean I don’t use any kind of biblical or religious or spiritual language in my work, but if I think how much does it creep in unconsciously? I’m not so sure. And I mean certainly over the years patients have often put two and two together and figured things out. You know you take your Christian holidays and you take your Easter holidays and they kind of put things together and figure it out. So ya I’d say consciously I do try and keep it out of the therapy room but unconsciously, I, ya, who knows?

I: Ok, so you’re a practicing Christian?

Nancy: Yes I’m a Catholic by upbringing and that’s why I say patients will often with my Italian name ask a question like, ‘Oh do you com from an Italian background and they will automatically assume that I’m Catholic. I don’t confirm nor deny that, but it can often influence their perception of me, as much as I try not to bring it into the room.

I: Ok Great. Ya and then also a broad question, maybe you can talk about the kinds of experiences you’ve had working with very religious kinds of patients.

Nancy: Ya generally speaking they quite a challenge in the room because they come in with such fixed beliefs about the world and how the world works and about the meaning of things, so whether it’s a very devout Muslim or Catholic or a Jewish person they have a very particular world view and either they spend that time, it feels to me like educating me about that world view or expecting me to have an understanding of it, and its difficult because they don’t like to have that world view challenged, and who am I as a therapist to challenge a religious or spiritual world view? **(8.2)**. The problems is sometimes your interpretations don’t always stick with that kind of religious or narrow thinking, and often an interpretation can be challenging to a religious belief. So I do find the therapy be quite different when a person who comes in that is a very religious devout person, and I often wonder why they do choose to come into therapy as opposed to choose a religious counselor, whatever their religion is, but I often wonder why they coming into a therapy with someone whose not of the same religion, whose not a religious practitioner in the same way they are and what that is all about. It’s always a question in my mind.

I: Mmm, that’s interesting.

Nancy : Ya

I: Well maybe I'll ask you, actually the next question goes into your countertransference responses. Ya, the kinds of responses you've had to maybe some particular, or generally, the kinds of responses you've had.

Nancy: Mmm. I had to think a little bit about that when I saw the questions because its always nice not to think about your countertransference responses, rather just blame the patient [laughs]. I mean it's a very good question to ask. I think, I would say, broadly speaking they fall into two categories, my responses to my patients. The first is a kind of irritation or a frustration in the therapy that sometimes it feels like we need ot move in a particular direction or going in a particular direction and then the religious view will come on and slam that door shut. You know, God wants that for me, or this is Allah's wish or whatever religion it is and it kind of just freezes the therapy and its very difficult to challenge that. So it feels for me like a kind of frustration or irritation in the room **(2)**...that's when the thought will come that 'why are you here? Why are you not seeing a counselor at your church or your Imam, or your Rabbi, or , there other avenues for you to go if you want those kinds of inputs, you know, prey with somebody as opposed to come for interpretations, so I can feel frustrated. The other feeling that I've funnily enough had with a few of them is enormous respect for being so devout, and this is revealing quite a lot, but it can be moments of envy that they have such faith. Faith provides a nice, neat, comfortable explanation, **(3)** and I'm thinking of one patient who went through the death of a child, and her religious belief gave her such enormous comfort, and her way of grieving and mourning was dictated by religion and I almost thought to myself, I remember thinking with her 'wow it would be so amazing to have that kind of....**(8.1)**

I: Mmm, faith...

Nancy: Just absolute faith, that this is the answer and you will see your child again and this was meant to be and its God's will...**(8.1)** I remember sitting with her at times and feeling quite baffled and quite envious of that wonderful, neat explanation, so, that's quite interesting **(3)**.

I: Ya, that's very interesting. Its interesting cos some of the literature has looked at envy as a countertransference response, mainly with non-believing therapists, with atheistic therapists, um its interesting that you're a believer but you still have that, you can feel that with very very religious patients...

Nancy: Ya No it is definitely, very interesting and a very difficult thing to admit in the room, because there's this thing of, 'I cant work freely with you because you have all the answers, so why are you here?' And this other part of me goes "I wish I had all the answers or the belief in the answers that you have."

I: That is very interesting

Nancy: K so it is in the literature, cos I haven't read much literature at all on religion and psychoanalysis...

I: Ya its there, very interesting. This is probably also, maybe a bit tougher, but the extent to which you feel your personal religious views might contribute to your countertransference reaction?

Nancy: Ya that's a very interesting thing and I mean, certainly, if I think, I've been practicing long enough to have gone through the whole 9/11 thing in the States, and kind of the Muslims,

and working with Muslim patients and their reaction to the whole thing and my religious feelings at the time. So I've been around long enough to have felt some of that stuff...but a very interesting question around that, and I think the funny thing is, if its not, in any way related to my religious belief system, I think its easier for me to keep watch on my countertransference, because its almost like, the patient is enough 'other,' that I kind of see it as that, so it can be, say if they were from a different culture, it gives me the safety of distance, and it makes me more aware of my countertransference responses (4.3), particularly if, you know I work quite a lot with devout Muslims actually, and I'm very conscious and aware of thoughts and feelings and attitudes towards Muslim's in the media out there and so it makes me aware of my own feelings towards them. Its more difficult if its someone of a Christian persuasion, particularly of a Catholic background, because then I think its much more subtle in the room, and they'll talk a language that I have some understanding of, and they'll, you know, they'll kind of evoke more in me than someone of a different religion. Its more curiosity for me if it's a different religion, its more a mirror if it's the same religion, which can then make it much more tricky, much more difficult to differentiate what is mine, what is there's, what is envy what is...me thinking they crazy and this is why, you know, Catholics get a bad name because people like you do this kind of thing, it might be more judgmental, it might be far more than I think devout patients of a different religion..(4.2).

I: Mmm, ya. On the envy, do you find that more with patients who share your Catholic beliefs?

Nancy: Ya, a little bit more, but I think its with anybody who has a very powerful belief system, its there. That kind of like, Agh, you know they just have a nice explanation, and its all neatly packed, and sometimes it will even be with other, Muslim or Jewish people part of their community. You know the more devout they are they tend to be more part of a community, so, it can get elicited in other ways, but I think it is, sometimes in my own religion, a sense of 'what could have been had I been more devout?' So there's a knowing of what that person represents that I'm not...

I: Right

Nancy : So in that way I think, I don't know if envy is fully encompassing of the feelings sometimes, I think its more complicated than that, I think its envy and a frustration and an admiration and a kind of 'are you crazy? You're brain washed...' so its kind of a mixture of feelings (3) but the closer it is to home, as with any patient, the more difficult it is to really suss out what is mine and what is there's.

I: Right, right. Um, Ok then, if we, maybe if we can talk more specifically, if you can think of a case or cases that seem especially significant to you where you worked with a very religious person...

Nancy: Ya

I: Um, and you had, um a particular countertransference response, maybe you can tell me a bit about a case and then I was wondering how you managed your contetransference responses?

Nancy: Ya, there'll be two cases and Brad you can direct me, I mean as I say don't let me go off on tangents [laughs], I'm kind of just, you know, free associating my thinking with you [laughs]

I: Ok! Go for it...

Nancy: So rather, try and steer my thinking back if you need to. I mean both of them are current patients of mine, as opposed to past patients, so I'm aware of treading carefully in terms of how what I say to you and how it will influence me as a therapist in working with them, but the one patient I've seen for many many years, she's a very devout Muslim, um, and its very difficult with her, a lot of the time I feel like she's teaching me about her religion, so its quite interesting cos she has done the Haj, she has been to Mecca a couple of times and I saw her once before she went and when she came back, just how in love she was with her religion, there's no other way I can put it, and how frustrating it was for me to work with her at that time. So I was incredibly curious and interested, so almost felt like the sessions were becoming about her just revealing all this inside information about kind of Muslim culture and going to Saudi and going to Mecca and all of this, and this complete fascinated enthrall and would gosh almost feel like an audience member and I'm watching this documentary about you know a Muslim woman who goes to Mecca and all the stuff around being a woman and it was fascinating (3). it completely put me in an observers seat and a fascinator's seat rather than a therapist seat and I had to work with this quite a lot and saying 'what is this about and get out of that seat and back into your therapist role, and what is the meaning of this for her psychologically not spiritually.

I: Yes

Nancy: So, and it always, that feeling gets hooked often like around now, we're going into Ramadan and Eid and it influences the therapy in that she'll want to change times, you know she'll want to get home early and get the evening meal ready and, breaking of the fast and obviously Eid celebrations are often the week when Eid comes around so, I'm conscious of it and then it kind of becomes a, just a listening to it and accepting it as part of her world and not to make it about the religion and my curiosity about the religion, so I try very hard to kind of consciously catch myself and think more about, this is just an aspect of her world, you know she could be talking about hiphop culture, she could be talking, try and think about it in that way rather than a fascination, because I do have bit of a fascination around different cultures and religions and I do slip into, to that mode, so I got to be quite conscious around respecting her, you know, this is her world and her reality, how dies it impact in the therapy and because I've seen her for a long time we have been able to talk a little bit around how it affects her and how she feels and that I'm not a Muslim therapist and one of the most interesting things she said to me she would never see a Muslim therapist, cos it makes her feel quite safe in being able to see me outside of that culture and knowing that it's a safety net for her, and its fascinating why someone so devout would need that [laughs]

I: Yes

Nancy: But, that's a whole other question.

I: It is

Nancy: But, with her I'm very conscious of a kind of fascination, she's a very intelligent woman she's a very articulate woman so I get quite seduced around her story telling and in those moments I feel more like I'm watching a documentary than I'm doing therapy and I can loose myself in that fascination, so it's quite important that I keep myself alert that, you not here to learn about her in that way, and constantly remind myself to think about her psychologically. So she's quite fascinating but she can be quite a seductive client that way. (3)

I: Yes

Nancy: The other client I thought about is my Catholic client who's very very very devout, you know, in Church three times a week, you know, probably the perfect Catholic, kind of practitioner out there in the world, and it's really been a huge part of her identity her belief system, she doesn't question it at all, but she makes the assumption – she knows I'm from an Italian background – and she makes the assumption about my knowledge and I can get very frustrated with her in the room, cos I almost want to say to her, "don't make that assumption," obviously I don't go there, it's more interesting to know why she's making that assumption, but I can sometimes get quite, the combination of frustration and sometimes envy for her comes out, around, gosh imagine having such faith as her, imagine feeling the mass like she feels the mass, I mean I can go in there and sometimes, look down at my watch and kind of, this is my duty done tick it off [laughs], kind of thing, as opposed to her devout belief. So with her it's a very different feeling, I never feel like I'm an observer or fascinated. I more feel like, "don't make those assumptions about me, you're influencing our therapy." And sometimes she'll almost want to take me along in a religious language, and I can get frustrated a lot with her, it's like, "you're not here for that." And I think at one point I was quite direct with her in saying, "why do you need me to be your priest right now, not your therapist, when you're wanting me to give you a religious answer when I don't have that answer, what are you avoiding in the therapy." And that was quite a difficult time for her in that, "why can't I bring the religion into the room and it's a part of my identity and I can't leave it outside". So we had to work through it for a long time and I still don't think we've worked through it. For a long time it was a dialogue, and the conscious discourse between the two of us was around this whole thing of, 'where does her religion fit into therapy?'

I: Yes, yes,

Nancy: And what does it mean that she knows we both from the same religion, and the permission t gave her to ask quite personal questions, so like, "what Church are you going to for Christmas?" and almost wanting to know and then, "does she hope to see me there, does she hope not to see me there, is she almost checking if I am going to go, is she trying to suss out how religious I am, so we spent a long time kind of going through that. But it's almost difficult with her because it is such a huge part of her identity, and I think she's got a love-hate relationship with me around the fact that I do come from a similar background and that we're both Catholics, although somewhere she can sense that I'm nothing like her and I think that frustrates her. Although again, it's an assumption she's making, the fact that it happens to be an accurate assumption is not for her to know [laughs]

I: Yeah sure

Nancy: but it does make it very tricky for me around her, and kind of my feelings towards her, and clearly what I can sense is her ambivalence towards me

I: No that's really interesting. I had two questions that came up around both of them, and I don't know if resistance is the right word, I think it's more a Freudian kind of word

Nancy: Ya

I: but with the Muslim patient and how seductive she was, do you think it was a way of kind of keeping you at an arms length, kind of, I don't know if she felt safer if you were intrigued by her, as if you're watching this cultural documentary as you said. Do you think it was her way of keeping you out, or a defending against you...

Nancy: Ya it's a very interesting question you're asking Brad – was it a way of keeping me out so that I always remain an audience or was it a way of her bringing me into her world in a way that her world looks seductive to me as opposed to, looks limited, you know, it kind of, made me less critical of her world, the way she was describing it. And it doesn't always sit comfortably with my feminist tendencies, but very often you know, I would question with a lot of my woman patients, the funny thing is, I don't see many devout male patients, and I mean, that's a whole other, I don't know why that's is, but that is what it is, but with her particular...sometimes I'll sit with my very Muslim clients or my very Jewish clients, and I know woman have a very particular place in those cultures, and you know they have a very particular function and are often excluded from a lot of what men are allowed to do, and often I'll sit here and bristle and go, 'you really expect me to sit here and be ok with you saying I need to be more subservient with your husband, and I kind of find that really frustrating and I'll say, you know, are you even aware of what you're saying? So, I think with her it was more about her love of the religion and her being in love after those periods of heightened religious behavior, that she falls in love with her religion after she goes through one of these phases like Ramadan or, those kinds of things, and then she kind of pulls me in in that way, 'its so amazing, and we're so loved, and we're so protected by all these kinds of good deeds' so, that, is it just making me less critical or less questioning of her religious beliefs, so I don't know, it's a very interesting point, is it resistance or is it a way of making sure [laughs] I don't go to this uncomfortable place with her and not, question! [laughs]

I: Ya, sure!

Nancy: Cos I normally would just question as I would any person, you know if you come here and you say to me 'I believe in crystals,' I'm like 'fine, lets explore that, what does it mean to you, what is it about that that answers your questions?' And sometimes I'm a bit conscious or weary with my very devout patients not to offend them, not to step out of my role as a therapist and become a religious interrogator, that I don't want to be to them, because then what role am I performing, its not about them, then...

I: Ya, you feel like its kind of sacred ground

Nancy: Exactly

I: its kind of sacrosanct

Nancy: Exactly, that's a very good way of putting it. Ya.

I: Ok, that's really interesting. And then, I think you have touched on it already, but around the management of the countertransference, with the frustration or the envy, or the intrigue or, I suppose you manage different responses differently, but, I was wondering about that...

Nancy: Um, the importance of colleagues, of sometimes talking to colleagues who work with religious patients, or sometimes using a colleague to ask a question rather than sit with an intrigue and hold it in my mind for when that patient comes back, I find it quite helpful, you know if it's a question on a religion I don't know, just to ask one of Jewish friends or one of my Muslim colleagues, and just to say, 'you know I don't understand this' so just tell me, give me an outline of what that means on a religious level, so I can then step back from the religion and go 'ok what does it mean psychologically?' Whereas if I don't have any understanding I find it puts me at a disadvantage. So I find colleagues are very good way of trying to manage just that curiosity stuff with me (5). The personal stuff around envy or around kind of, you know, irritation, I think it really is for me to work on an individual basis with that client, and then, very much, management

of countertransference is self awareness around it, and is there anything happening in my own life at that point that might be feeding it or triggering it in some way (5).

I: Right, ya. You mentioned earlier, right at the beginning, that its sometimes hard to tease out, if its my stuff or there stuff, as far as countertransference goes. It kind of touches on the is it countertransference or projective identification, that sort of thing, um, so I was wondering if ever in a session, if you felt, you thought about it and you felt that this was more projective identification than all of your stuff. I was wondering if you ever 'gave it back to them' in that sense? The whole idea that they project something into you and you process it and give it back? I was wondering if you've ever done that kind of thing in a session?

Nancy: [laughs] its an interesting question, my immediate thought was that I can't think of an example of that, but it doesn't mean that, I mean it's a very interesting question, what is projective identification and what is countertransference, what is mine what is there's, so very very interesting point you're raising..I think it's, the closer the religion, I wonder how that plays itself out in the room, I'm less questioning of it. Cos I make assumptions that I understand that I know what they're talking about which is also dangerous in the therapy. You know, just because we come from similar backgrounds, or a...its very dangerous to make the assumption, 'Ok fine, I know what you mean.' If you comment on this hymn that was really moving to you, and I know the hymn, I'm making an assumption about that, and am I making the right assumption?...**(4.2)**, so its very, ya, I wish I could answer that question in a better way [laughs] I think it's a good question to ask, I haven't had a moment that automatically comes into my mind that I've been able to process it and give it back to them in that way, where I've understood it as P.I., so ya.

I: No, that's great. Um, Ok, then, maybe a slightly more theoretical question

Nancy: Ya

I: But feel free to apply it to your clients, how would understand healthy or adaptive

Nancy: Ya

I: Versus unhealthy or maladaptive religious belief in your patients?

Nancy: I think its interesting that you've put that question cos its made me have to think about it [laughs]

I: [laughs]

Nancy: I mean my personal answer to this and maybe more than a theoretical answer is, I think any adaptive behavior or healthy behavior allows for a questioning understanding. So I think the minute anybody comes in and just has this 'don't go there, don't challenge me about that, I go about this without question' I immediately see it as maladaptive on some level. So, if someone has chosen that, in their history I hear that, through their life they were raised in way, they were angry with it and moved away, and then by choice they came back to it, I often see them as more adaptive than someone whose never questioned, they've never, I often ask myself, 'what does that mean about their psyche?' In terms of the way they are in the world, And what they allow themselves to be, almost brain washed with. I mean its quite a powerful word to use, its quite a judgmental word to use but I do sometimes feel with patients that have never questioned, have always grown up in a very devout home, followed that path, they do what their mothers did what their grandmothers did, I struggle more with them around it being : 'how healthy is this, how

adaptive is this behavior?’ and I tend to think its less healthy or maladaptive that they’ve just role modeled and replicated and, aping behavior rather than choosing, and I do feel that, and it’s a personal thought that, no matter what your belief system is, ‘where’s there space to question, where’s there space to wonder, where’s there space to feel, if its anger...cos it is a relationship at the end of the day, for me, that’s how I think of faith, as a relationship, whatever you believe the maker is, or creator, it’s a relationship, and relationships should by very definition go through variation – there are times of closeness and times of distance. So when it just never happens, I think, what is this really about? It feels two dimensional, it feels just like a cloak you’ve wrapped over yourself rather than something you grapple with. If its your belief its your belief, but question it and wonder about it and be willing to ask questions about it. So I think health and adaptability would be for me about an ability to think about, in an open way, about the religious belief, rather than just wearing it as a cloak, ya (7.1).

I: Right, ok, I think its really interesting you talk about a relationship, because a lot of the theory driving this research is an object relations perspective, and I know you said you use object relations a lot, the idea of God as an object, even as a transitional object – that kind of perspective – um, do you think someone who cant think in this sense, who uses it more maladaptively, who uses it as a defense in that kind of way, do you think its part of a larger complex, that with other people, they would do a similar kind of thing, and the religion is just one area where it gets kind of played out, or?

Nancy: Ya That’s an interesting question to ask Brad, I mean if I think of the religious patients I’ve seen and how are they in their world, because they wear their religion so openly, that they are openly religious, others know they are, whether it’s a Jewish woman wearing a *shatil* or a Muslim woman wearing a head cover whatever it is, they wear their religion, its out there in the world, and I think its quite interesting cos they almost quite adversarial in their relationship with others – ‘so you’re either for me or against me’ – and its quite interesting because it doesn’t allow the questioning (7.1) to say but, you know I’m thinking in the work context where this one woman works in and its quite a very very open, kind of, quite a challenging, quite a harsh environment she works in, you know its male dominated, its fast paced, its quite a sexualized work environment, and how she feels quite odd in that environment, and yet she’s been part it for so long, and its very adversarial for her, in that she proudly is Muslim, and I often wonder if, ‘if you were in a different environment, if you were teaching, I don’t know, a nursery school in Lenasia, would you feel differently about your religion, than you do as almost wearing it as an armor, so is it defensive in the world, is it kind of, I do think there is an element of that, I think the minute there isn’t questioning, there’s just an acceptance of something, ya, its defensive it can be an antagonistic way of being in the world – a challenge to the other. And I do think this is a more general comment – and its dangerous to make general comments – but many of these very religious patients of mine are quite judgmental of others that aren’t. So its not about what religion they are, its about, ‘they’re not as enlightened as me.’ You know, and when you find God, Allah, whatever, you will also come to this enlightened place. Funnily enough Buddhists tend to be less like that [laughs] which is quite interesting [laughs] (6.2).

I: mmm.mmm.

Nancy: I have worked with a couple of devout Buddhists

I: Oh that’s very interesting

Nancy: And they’re far more...but its more of a philosophy than a religion, and it brings a different...

I: Yes, there seems to be such an emphasis on mindfulness and working through your own personal stuff, so maybe that has something to do with it

Nancy: Exactly, and a kind of acceptance of the other and tolerance of other, and being magnanimous in your approach to others

I: Yes

Nancy: So, I think, that's why I say, its very much a philosophy rather than a religion, it's a philosophy of life, whereas others are, you know, very black and white, there is good and there is bad, there is right and there is wrong, you'll go to Heaven or you'll go to Hell, or wherever you believe you'll go to, and shame you the damned one. So they can be very judgmental and very critical of others (6.2).

I: I'm going to take my opportunity to ask you this because you said you've worked with very devout Buddhist patients and I've always wondered, um, because it hasn't come up in other interviews where people have worked with devout Buddhists, so, Bion has this idea of being in 'negative H' where you cant hate, you cant feel aggression or violence...

Nancy: Yes

I: I've always wondered with very religious...or, do you call them religious Buddhists? Or monks, with your patients, did you experience their peace – because they're kind of all about peace and interconnectedness and no harm to anything – did you experience that as genuine, or did you feel like it might be defensive, like they were kind of repressing that?

Nancy: I mean, I'll tell you just briefly, and I'm, literally just kind of summing it up for you, the patient particularly whom I'm thinking about was diagnosed for many many years as a severe bipolar and was in and out of hospital, and then she found Buddhism and she started meditating and at first I thought "Oh my goodness, here we go its another bipolar episode in the making, and despite my skepticism and my reservation, it actually was, in front of my eyes, a life changing experience for her, and she actually did come off all her bipolar medication, and I thought, you know, this is an enactment, but the environment, and she was practicing, she was going for retreats on week-ends, she was part of the *Lanwa* temple in Bronkospruit and she would go there. It was an incredibly containing, nurturing, safe environment, which she had never experienced before. And it was the thing of kind of, passivism and, equanimity towards everybody, and during that very kind of transformational period she would bring me Buddhist beads, and it was the first time she had brought me a gift, and we spent a long time talking about the meaning of these beads, and kind of, what is it replacing, and transitional objects, comforter, soother, all this kind of stuff...(7.2) whats very interesting, and we spoke about it a lot, how humanity came through despite the Buddhism, so then she started to get irritated with some of the monks, she started to get irritated with her fellow Buddhists who were behaving badly at the retreat, and it was very interesting, cos then we spoke about how our human-ness and the fact that we are flawed as humans, and even though the rules are really clear: you have to be accepting and tolerant and kind and loving, and there's no such thing as bad and treat the ants with kindness and blah blah blah, which is a phenomenal philosoph, but that humanness comes through, and when the humanness comes through, we then had to deal with these feelings, and it became more real for her. And we spoke about the fact that she was, again, starting to have a few depressive episodes and we spoke about how now its come out of that honeymoon, idealized phase and that this has saved her life, into now this is about human beings, and that no matter how sound the theory is, or in this case

how sound the belief system or religion is, you're still dealing with human beings. The interesting thing is she's been able to maintain a relatively stable bipolarity, she's not gone back onto medication, so this patient has done extremely well, and she still practices, she's far more real in the world, she's much more real – she comes in irritated, she comes in moaning, she comes in frustrated with traffic, all the stuff – but she does have no that she didn't have before is a structure that allows her to deal with things in constructive ways. So the meditation, the mindfulness, gives her a way to channel, to think about. And I think that is a way in which Buddhism is very different from other religions, that it is whatever thought comes into your head, think it, just think it. Whereas other religions are: 'that's a bad thought, that's an evil thought, is this the devil in my head?' (6.1).

I: The judgment

Nancy: There's such a judgment and then how do you work with that? Whereas Buddhism actually allows that mindfulness.

I: That's fascinating

Nancy: Sorry, you see I can go off at tangents [laughs] I warned you ahead of time!!

I: No, this is good! Um, Ok, then again you've touched on this so you don't have to go into too much detail...for you, the most challenging aspects of working with very religious people, the hardest thing about it?

Nancy: Yeah, there fundamental black/white thinking. That for me is the hardest thing, they shutter you down – 'God wants it this way or Allah wants it this way.' What do I do with this? (1) I can't compete against Allah, I cant compete against God, Im stuck here, Im gonna be struck down by lightning any second [laughs]

I: [laughs] Sure. Um, Ok and then finally, do you think there's any kind of relationship between psychoanalysis and religion? Or psychoanalysis and mysticism for that matter? Do you see any commonalities or irreconcilable differences between the two.

Nancy: Sho

I: Also bit more theoretical but...

Nancy: I mean I'd love to hear your answer on this cos you've done far more reading on the subject than I have [laughs]

I: [laughs]

Nancy: I mean its such an interesting subject, psychoanalysis, for me, the theory of psychoanalysis borders a little bit on a philosophy, more so than just a scientific fact. So it's a philosophy of understanding what is human nature about – the unconscious mind, and the drive forces, or whatever the theory is, it's an explanation of human behavior, and what is religion at the end of the day? An explanation of human behavior (9.1). So I, its, I don't have the answer to that, but as a therapist I try and keep my own religious beliefs out of the room because I don't know how I can actually integrate them. So I can hold them in myself as two different parts of myself, I can practice comfortably as a Catholic within my role as a therapist, although I, you know, keep them separate. But from a theory point of view, is there a place for mysticism in

psychoanalysis? What would it mean for the unconscious mind if we say that there's a higher power? I mean I don't know, I don't know what the theory says, but...

I: Ya, I mean it does touch on everything you've just said, especially the idea of, you're dealing with, the two are so abstract, you're talking about the unconscious, you're talking about, even projective identification

Nancy: Yes!

I: Such a strange concept – you're unconscious putting bits of yourself into – you might as well talk about a soul and...

Nancy: Possession! **(9.1)**.

I: Exactly, ya so, it does touch on all that stuff. Another thing it says is that it talks about a more skeptical point of view which says that both kind of work on the charisma of the therapist, or rabbi, so you're feeling what you're feeling and you're changing because of the awe which you have for the therapist or rabbi, so that's a more skeptical kind of view...

Nancy: Very interesting though, I have, as I said earlier, I think my concept of religion or faith is a relationship, so I have had moments when I think, 'Oh God, what do I do with this patient?' **(1)**. And its so interesting that I had that thought. You know I didn't go and pray or...but I had that thought, 'Oh God what do I do with this patient?' and it was bizarre for me to think that, because I mean in my mind they're very separate so its quite interesting how subtly in comes in and then, what does it mean? Does it mean psychoanalysis fails us [laughs] – I cant think of a theory or a nice formulation that fits this patient, what am I going to do, break out in prayer with this patient? So ya, I'm sure its been very interesting., your readings around it...

I: Ya, definitely, I think I chose the topic just because I knew it would sustain my interest...

Nancy: Absolutely. I will end on a funny note. And I hadn't thought about it for years until I read your questions...when I was selected to go into masters, the pharmacist that we had all those many years ago that knew my mother quite well said to my mother, 'Oh no, she's going to become a psychologist, she's gonna become an atheist!' And I remember my mother coming in absolute horror: "why did he say this to me, what does this mean?" [laughs]. And when I read this I hadn't had that memory for years and I suddenly just got this, and I mean I did wonder cos I never got an answer cos I didn't ask him, but what made him think that its incompatible with religion and that you cant be a psychoanalyst and a religious person, you know that, you can be a doctor and pray, so why cant you be a psychologist and pray and that it doesn't necessarily influence your practice?

I: Ya, ya. We probably have Freud to thank for a lot of that...

Nancy: [laughs] and a few of the other guys! I mean Jung's stuff, Jungian theory *is* very mystical.

I: Very much so.

Nancy: I mean there's definitely a place for mysticism, it draws so much on that. But I think classical Jungian analysis is meant to be more scientific but, I don't know

I: Ya, its tricky

Nancy: It is, and as I say, it's how you prove the existence of the unconscious **(9.1)**.

I: Well thank you so much, I really appreciate it.

Appendix I: Interview With 'Alice'

Alice: Um, what approaches do I use?

I: Ya

Alice: I really do use a mixture of approaches, depending on what the client brings and what they need

I: Ok

Alice: Ok so it ranges from psychoanalytic, sometimes hypnotherapy, and sometimes behavior modification.

I: Ok, great, And within the psychoanalytic approach, are there any theorists that you're more oriented towards?

Alice: Definitely Freudian, Winnicottian Freudian

I: I thought as much when I saw the [points to a picture of Freud's room on the wall]

Alice: You saw Freud's room [laughs]

I: Ok. Thanks. Ok and then, if you can talk a bit about whether you think your own religious beliefs influence your work as a therapist, and if so, how?

Alice: Ok, so this is where the difficulty comes in...

I: Mmm

Alice: I am Jewish, and I come from both a mixed religious and not religious background. I had a religious mother and a not religious father. Ok. But I am, I like to think that I'm more spiritual than religious, I'm not sure you can separate the two, Ok. And so I think that my spiritual beliefs with my religious understanding, is what I bring into my practice. Ok, does that make sense?

I: Ya. So you do bring it in in some way, your spiritual...

Alice: Its in all the time. I don't believe that you can be a real therapist if you're not going to be open to the projections and the stuff that's going on in the room that isn't strictly verbal.

I: Mmm.Mmm. Ok

Alice: Ok. Doe that make sense?

I: Ya, so, perhaps it will come in in the form of, kind of a projection of your spiritual beliefs, even if you're not necessarily aware of it at the time, its there.

Alice: Its there. And its more a receiving of projections and an interpreting of those projections.

I: Right

Alice: We're calling it projections. It can be called anything.

I: Ok. If you can talk quite generally about the kinds of experiences you've had working with very religious patients...

Alice: Ok. I'm not quite sure what you would be wanting here...I deal with very religious patients but not just religious patients that are Jewish. I have some Greek and Italian very religious patients. I have found, in the beginning I was quite anxious about that, but I have found that if you see religion as spiritual and universal, even the cultural aspects of that can be applied. So its about using what the patient brings with them, contextualizing it within their cultural framework. But the philosophies are the same...(1.1)

I: Mmm.mmm. Do you find that a lot of your very religious patients agree in that way, that the underlying philosophies are actually the same?

Alice: Providing that you couch it in their language. So for instance my very religious – in fact when you leave you'll see a very religious woman coming – she speaks about how the *Rebbe* works through her, Ok, and I can relate to that in a way that doesn't upset me (4.2). Cos whether you call it a *Rebbe*, whether you call it a soul, whether...I don't know what's going on, I can't prove or disprove in any way. I know she's not having hallucinations. These are very real for her, and they inform how she lives her life, and so I keep that in the therapy.

I: Mmm. That's fascinating. Maybe I can ask you one or two more specific questions about that particular patient as we go on.

Alice: Ok

I: cos that's really interesting. Ok, um, so you seeing a woman who has that experience, any other kinds, I mean I know you said you have religious Greek patients...

Alice: Yes. I have a religious Greek patient who came in to therapy very distraught because she was pregnant and needed to have a termination. She had been excommunicated from her church they said, her priest said, if she goes through with the termination he cant bring her back into the church and he cant give her holy communion. So, we workj through what does it mean to have a termination? Is their a soul, do you believe in a soul, is there a life after life? And if you do, can you kill a soul, what are you doing when you have a termination? How are you going to feel about being excommunicated from your church and does your priest have a right to do this to you or do you have a direct hotline? [laughs]

I: Right. Have you by any chance worked with absolutely atheistic patients?

Alice: Yes. *Very* difficult.

I: I was wondering about that...

Alice: Very difficult. I find it very difficult to find a way in to help them make sense of adversity. I had a couple who lost a child, and they have no way to make sense of that. They feel; so terribly persecuted. And there isn't any way that you can help them come to terms with the fact that they're either to blame, or that they're being punished. (8.1)

I: Mmm.Mmm. Ya, there's no higher meaning or bigger picture

Alice: Ya. And then your scientists who believe in randomized things happening, they don't know how to move on from it. They don't know how to really make some sort sense of it. They feel out of control, insecure, because it becomes an external locus of control rather than an internal locus of control.

I: Mmm.

Alice: When you have some kind of belief system and make sense you can take charge of your healing, but when you believe that things are randomized and just science, then you're at the mercy of the universe **(8.1)**.

I: Mmm. Have you ever come across a completely atheistic patient who experienced a loss and perhaps, um, accepted the randomness or completely came to terms with the fact that some things just happen?

Alice: Yes, I did have such a person. And I eventually found my way in through string theory. [laughs]

I: Ok. So you grasped at some straw, or string!

Alice: [laughs]. Yes, I thought that Quantum theory is the only way I'm going to get in.

I: That's kind of their version of something that's abstract...

Alice: Ya, something that can be outside of the realms of see, touch, taste, feel.

I: That's very interesting

Alice: I knew you weren't gonna find this OK. [laughs]

I: [laughs] no this is great. Ok, then, if we can talk a bit more about your countertransferences, just if you could tell me some of the different responses with your religious patients...

Alice: Ok now this is my real difficulty, cos I'm not sure if I can separate what's transference and countertransference. It's something I think every therapist has to grapple with, because you know in theory it sounds really easy. But practically I'm not sure we ever know. Um, the only place that I can really make that kind of distinction is when I get a patient who has a father whose a sociopath, because I have a father whose a sociopath. Then I know what's my stuff, and I'm able to keep very clearly in my head, what is mine and what is there's. But, once I step out of that, then it becomes spiritual, religious, I'm not sure if I can make that separation.

I: Mmm. Even if you can't tell what's there stuff or your stuff, what are some of the emotions, whether it's transference or countertransference, some of the kind of emotional things going on, when you work with these very religious people?

Alice: I am really aware, well this I can separate. It is very hard for my religious Jewish people, to deal with the issue of *Loshen Hora*. And so it interferes with their therapy in that they can't look squarely at what is going on realistically in their lives, and how they're being abused, or how they're being used, and the relationship issues, cos they aren't speak ill even speak about the

other person, be it their father, their mother, or their partner, their life partner (1). So a lot of the time I have to feel that, and I have to verbalize it for them, in order for them to even get an understanding that its in the room, and that its in their minds, and it takes quite a lot of trust to be able to build up before you finally will get them, and I got to say it in a very non blaming way. And it's a huge struggle. So I have to feel it, and I have to verbalize for them and give it back to them in manageable bits. Then its hard for me – am I sitting here being prejudiced? Am I, is it really coming from them or is it me reading into something that isn't their? And because you don't get an instant recognition and acceptance of what you're saying you're still working in the dark.

I: Mmm.mmm. Its sounds like it can be quite confusing...is their anything else? Is sounds maybe a bit frustrating?

Alice: Well it requires that you sit it out for a very long time and in a place of not knowing, and you have to, sometimes you think 'Am I flogging a dead horse?' Or 'am I flogging my own horse?' But I keep going at it and then sometimes I get smacked cos I'm wrong and I'm going down the wrong road. But I Accept a very famous therapist Casement. I don't know if you know Casement? He said "the patient will correct you when you're wrong." They will eventually tell you very emphatically when you're wrong, and then you'll know, and you'll get lots of chances to get it right. So its very hard to know when to stop doing it.

I: Right, right.

Alice: So Loshen Hora is a problem.

I: A big issue, ya. I can imagine cos its, its supposed to be a space where they can talk freely, and let it come out, and there's this impediment to that then.

Alice: Ya. With my not, my other religious patients, my Catholic patients and Greek and Italian patients for them the difficulty comes in when you have to be a really good person and turn the other cheek. And so no matter what people do to you, you have to forgive and be 'nice' (1). And so again you have to pick up the projections of real rage and anger and be able to give it in a manageable thing that isn't anti-Christian.

I: It sounds difficult. Like you have to almost tread on eggshells, very kind of carefully?

Alice: And do you say, how do you say anything against a priest, how do you say anything against, you can go to confession and you can confess these things but you're not allowed to speak of them here. What is the difference? (1)

I: Mmm. Ya. It also reminds me a bit of, the theorist Bion came to my mind cos you started talking about manageable bits, and it reminds me of his thing about '-H' – not allowing yourself to feel anger or hate, is it that sort of thing?

Alice: Yes you cant, cos its anti Christian.

I: Yes

Alice: So the one is Losh, the other is, 'Im gonna be dammed, and I'm gonna be boiling in hell cos I couldn't find a place of grace.'

I: Mmm. Difficult, you're almost up against that?

Alice: Ya.

I: I also wondered, some of the literature also talks about a lot of different countertransference responses that therapists have when working with very religious people, whether they're religious therapists or atheistic therapists, they talk about for example, envy, sometimes actually envying the strength of the patient's faith, and the kind of security that it gives them in the face of difficulty or loss...I'm not sure if you've ever experienced anything like that?

Alice: No. No, I don't. I honestly, I don't think so. I think, because I had the choice to either follow my mother or follow my father, and I chose something that married the two, it was my choice, and I could have been there, and don't feel like I'm missing out on anything at all, I have no regrets about it. Maybe if you haven't gone through the choice...

I: Then you might experience something like...

Alice: Ya, ya. And funnily enough, one of my supervisors when I was studying, was a man whose mother was Jewish and whose father was, he owned the Boswell Wilkey circus.

I: Oh wow.

Alice: So his father was a circus master, I don't know what to actually call him. And he decided to explore all the different religions and what they meant, so he did Buddhism and Hinduism and the Islamic faith and Judaism and Catholicism. Cos you know he wanted to make up his mind after he understood and had lived each of them. He was a monk in the Himalyan mountains. An extraordinary man. And a Maoist. An amazing mind. And in the end he chose Catholicism. His brother chose Judaism [laughs]

I: Interesting! [laughs]

Alice: And he felt that through Catholicism he could marry all of them. And we had lots and lots of discussions cos I was choosing, um I wasn't going the route he did, I was just having to choose which way I would go, and ya, I think if you can arrive at a place after serious consideration you cant be envious anymore.

I: Mmm.Mmm. I think its, ya, the idea of choice and choosing might come up at the end, so maybe we'll get there again. Um, alright and then, I mean, I was gonna say to what extent do you feel you're personal religious views contribute towards your countertransference reactions, but I'm not sure if we've already...

Alice: Ya, massive. Massive.

I: Ya and you've answered this already – 'are these reactions evoked by the patient or rooted in your own history?' and I think you've said that you can hardly tell half the time, and that in practice you cant kind of carve the two up separately like that...

Alice: Mmmmm.

I: Ok, then if I can try and press you, if anything comes to mind, if you can elaborate on a specific case that seems significant or interesting to you regarding your countertransference response, if

you can, if there is a specific example where you felt a particularly strong response to a religious patient?

Alice: Phew, there lots...well there is this patient with the Rebbe, um, she's a woman whose husband is a rabbi and she, they run a seminary together. They're from xxxx, they're only three years in South Africa,, they're struggling to integrate into the communities here, um, and she believes that she was sent by the Rebbe – her and her husband – to do the work they do here. But in her loneliness, cos she has been quite lonely, she has, she found in a very religious Jewish doctor – I'm sure you know who I'm talking about - -she found in him a confidant, a father figure, because he's so religious, and because he's so kind and caring, he kind of became her real life sanctuary, while the Rebbe is her spiritual sanctuary. And with the passing over of this doctor she went into a really desperate state and didn't know what to do with his loss and didn't want to confuse his soul and whether he could be talking to her with the place that the Rebbe had held, it felt disrespectful to the Rebbe.

I: Mmm.

Alice: This sounds lunny, doesn't it? [laughs] (7.4).

I: [laughs] its fascinating.

Alice: And could she still keep him in her heart and find him their without being disrespectful to the Rebbe, and who took, who was in charge, and what was the hierarchy...

I: Mmm, mmm, its like a spiritual Oedipal problem [laughs]

Alice: Yes, I didn't think of it that way, you're right, I think you're absolutely right. I will hold onto that. So we had to work in that space, so that was particularly interesting. Helping her to give them both place, keeping them both in her heart, be able to move forward without having him in her life realistically and dealing with the day to day real life issues which I have to bring her back to, without taking him away, whether it's a defense or real spiritualism, I don't know and its not mine to question, but to take that away would be to take away something that keeps her sane, at my peril, so I have respect for those things, cos whatever they are, I cant explain them, I cant disprove or prove them, so I have to respect them (6.1).

I: So you're, you're feeling towards her is one of respect, obviously, is there any kind of raw emotional response you have to her?

Alice: Yes, cos she's lonely, she's bereft, she cries a lot and sometimes I cry for her because of the countertransference, or the transference, that's where you don't know, you really don't know, but I don't believe it's a countertrnsferenece, because I don't share the issues that she shares, so if I'm crying for her loneliness, and it really is a loneliness, it has to be hers, cos I'm not really in that kind of lonely space. If I was, like having a father whose a sociopath, I could then, I would have to go, whom I crying for here?

I: Yes, could it be more of a projective identification than a...

Alice: I think so. Ya. That's the one patient. Another patient whose passed on. She was a deeply religious person who developed a rare form of cancer that had no treatment. And um, she was my patient for seven years. And she initially came to me because she thought she had cancer and nobody believed her. She'd been to all the doctors, they had done all the tests and things and

found nothing. So she was referred to me for some somatic illness. Um, very religious, and she said that she had this deep conviction that she had cancer and she was going to die. Very young, she had small children, she was only thirty. Well I did all the usual therapy, arrogantly, did all the psychosomatic stuff [laughs] only to find, lo and behold, that two years later, she was diagnosed with cancer. So we started to work differently. We started to work with how did she know, where did she know from? She was a very bright girl, exceptionally bright...and she continued to deteriorate. And our work became spiritual in that we did, I suppose you could call it hypnosis, but it really wasn't. She would go into trances and we would work in the trance space. She'd sit here, I'd sit there, as she got more ill she'd lie on the bed. And, she would speak about where she went to, her discussions with Hashem, and she started to teach – she was a teacher at Yeshiva – she started to teach these young woman the most amazing religious Jewish stuff, that was coming to her...(8.1).

I: From this other...

Alice: From this other place, in these sessions, and I would just humbly sit and listen, quite frankly, the only work I did was to help her come to terms with leaving her children behind, the fact that she wouldn't be there for their Batmitzvahs, she had three girls, when they got married, when they had babies she wouldn't be there, and so then we decided for her to write a book. And the book, there was a different book for each girl, and all the kinds of answers to questions she thought they might ask as they were growing up. So the therapy was partly that and partly her trances, and, ah, until she got to ill to get up the stairs, and she would drive up and we would do therapy in the car in the driveway, and eventually I used to go to her house, so, that was...

I: That's an intriguing...

Alice: That was quite a mixture of things, ya...whether you can call that conventional, when you asked me what kind of therapy I do, I don't know [laughs]

I: [laughs]. Ya that doesn't really fit into any kind of...[laughs]

Alice: And I don't think I've done that with anybody else. So I think that it's important that your patient inform your therapy.

I: Right. I mean I'm, worried of going off topic, I know we don't have too much time left – how much time do we have?

Alice: I have until half past...

I: Half past eleven

Alice: Ya, my patient comes at half past eleven.

I: Ok, well I won't go on too much but I got a lot of questions coming through about the trance state experience...

Alice: Ok

I: The um, it sounds like when she went into these trances or altered states, it sounds like that was only here, that it happened? Was it just...

Alice: I think it was only here, but as she got worse, whether she was going into unconscious states or coming back again I don't know, but that started to happen at home, but she was very ill.

I: Yes, yes. Your, uh, feeling about the trance states, while they were happening, was it, I know I'm speaking for myself here, I would be intrigued, possibly a little, a little cautious, I'm wondering what your feelings were?

Alice: Well, I believe in spiritual philosophy and I have run spiritual groups for fifteen years. I have one foot in skepticism, which stays there all the time, and another foot in total and complete belief. Its an impossible thing to be able to prove or disprove. People are far more comfortable saying they believe in a God when there's no proof or disproof, than they are about believing in another life, and I don't impose that on anybody because you cant. Its either something you have got to accept, or, you don't. There is enough proof in the world if you are able to look on it as proof, because things happen to people that cannot be explained through other means, other than telepathy. And because telepathy is a proven science, it completely disproves all spirituality (4.2). Ok, am I making sense?

I: Mmm. Mmmm.

Alice: It will then also allow us to understand what we mean by projections, because then projections become telepathy, and there's nothing to say they aren't, there's nothing to say they are.

I: right

Alice: So you have to reach a place of semi-belief, in order to do this, without total and complete knowing. And part of being a psychologist is being able to be in a not knowing space, and using that because it benefits people, as long as you're not going to do harm by it. Because the truth is, its more useful to believe in it than to not, and I've seen that, with my scientists (7.3).

I: Mmmm, psychologically...

Alice: Psychologically, managing your life, living an effective life, dealing with adversity and tragedy, its far more functional, to actually believe.

I: Mmm.Mmm

Alice: So my philosophy is, I'm gonna plug it, not because I'm being deceitful but because I do believe in it. And if I land up dying and finding it was all a croc-of-you-know-what, so what will it, how bad will it have been? [laughs] (4.2).

I: So you'd rather take the chance and...

Alice: Its more useful to believe than not to believe. Its more useful to believe in a deity than not to believe in a deity.

I: Right. Does it, I mean, what you're saying is that you're well aware that there's such a strong psychological component to belief, in that many people may in fact believe because it makes them feel good, because it makes them feel better...

Alice: Yes, yes.

I: Not because they've weighed up the evidence if there is any, um...

Alice: Absolutely. And there's people who believe because they need to believe, because they don't believe. Does that make sense?

I: Yes.

Alice: So there are people who practice their religion slavishly because they're scared not to, and then there are people who absolutely believe like the Rebbe, who can digress, because there practice is an expression of the love of their belief, and not a fear of not practicing (7.1).

I: right, right. Ok, this, I'm gonna jump to the second last question because its so relevant here, and then maybe, go back a bit...at what point does belief become unuseful psychologically, at what point do you think it becomes unhealthy, maladaptive...what is unhealthy religiosity?

Alice: When you are strictly following laws to the detriment of the people around you and yourself. If you are ill and you cannot phone a doctor on Shabbos to save your life, that is absolutely self destructive.

I: So it's a kind of rigidity, an absolutely fixed, unfelexible approach to your beliefs?

Alice: And when its used to make our life pleasant rather than unpleasant. There are people who have a vested interest in suffering, and they use the practices to entrench the suffering (7.1).

I: Almost masochistically?

Alice: It is masochistic. But the whole family get drawn into it, because they have to.

I: I'm wondering, do you think such people, if they did use their beliefs masochistically like that, do you think the masochism or need to punish themselves or whatever it is, is part of a larger complex, that in fact they're using the area of religion to dramatize this 'something' about their personalities?

Alice: It's the vehicle they're using, there's no question about that. But funnily enough this young girl who died of cancer, this young woman, she had such a father, a very self-punishing, rigid father who made religion a persecution and not a celebration – perhaps that's a better way of describing it – but she broke him down, and when she was in the hospital, here at the xxx clinic, because she took two weeks to die, he broke all the rules, and it was just amazing to see him break all these rules, and he was just so completely able to be with her in those two weeks. Um, she wore no clothes, she couldn't put any clothes on, they were so painful, and he would sit in the room with her, and he brought in a Rabbi to see his naked daughter to change her name...(7.1).

I: That's the kind of flexibility...amazing...

Alice: [tears up]

I: Ya, I'm sure it's also emotional for you to go back into all this, having worked so closely with these people....

Alice: Mmmm.

I: Um, ok, I've skipped ahead because the one question was also on countertransference – and I'm using that the way you suggested at the outset, countertransference or transference, we don't really know – um, how do you manage, if you have an overwhelming countertransference to a very religious patient, whatever that feeling is, how do you manage that?

Alice: I manage it by not questioning it, I know that's against psychology practice. I decided a long time ago not to censor, because if I'm going to do what I believe is spiritual, I'm not going to question what comes through. And so I give it out and let the patient be the one who decides, whether it's working for them or not working for them. And then I take it to supervision, every week and have been since I started practicing, because that's the only thing that allows me to be this flexible, knowing that I have somebody outside of me whose going to be my objective observer **(5)**.

I: Ok, I'm just thinking, I've got the last question here but I'm just thinking about something that popped into my head while you were talking about healthy belief being flexible, sorry I'm going to see if it comes back to me....ya, a lot of, kind of, atheistic thinkers would say things like, the fact that your belief, whatever it is, makes you feel better, should not be grounds for holding onto a belief, and that one should always kind of strive for the...to get as close to the truth if there is such a thing, and that one should be hyper aware of whether you're believing something because it makes you feel good, or because given the evidence that you've looked at and weighed up, and you sincerely conclude in favor of one side or the other, that's a mature, healthy way to believe, as opposed to...

Alice: Well how do you decide what's healthy and what's not healthy. And I think the barometer has to be how functional your life is, and how well you interrelate in your world. And if having a belief helps you do that, then where's the problem? **(6.1)**.

I: Mmm, sure. I suppose, and I'm just playing Devil's advocate..

Alice: No play Devil's advocate because these things come up often...

I: Ya, I mean for example, I could believe in Unicorns or Fairies...

Alice: Yes..

I: And that belief could be very functional for me – I could be a sound person with a good job and happy loving relationships, an it,...

Alice: And worship the Unicorn...

I: And I could think Unicorn's are real and that belief gets me through, I hold onto that...

Alice: Then what's the problem?

I: You wouldn't want to challenge that in your patient....

Alice: Cos I, psychology would call that a defense mechanism. And a defense mechanism is serving a role, and if you take it away and the person crumbles, then what have you achieved? **(6.1)**.

I: Yes.

Alice: Until you put something in its place, you have no right to tamper with that, that's how I feel.

I: Sure.

Alice: And that's why the particular religion makes no difference. It's what the person is doing with it, how functional it is in their world, and how it allows them to grow and develop, that is my criteria **(6.1)**.

I: Yes, I suppose it ties into the stuff I've been reading in the literature for this research...most therapists, religious or a-religious, they say the same thing, that the province of therapy is not to try and philosophically prove or disprove, it's what it means to them, does it work for them, how does it manifest in their life, and I suppose the place to do that is in a philosophy class, as opposed to a psychotherapy room.

Alice: Yes, yes. And I do the same with spiritual philosophy. If you're going to go to a spiritual philosophy group and you sit in a circle and all go OM and everybody goes into a trance and you have a lovely evening and you go home, what is the purpose of that? I'm not saying it's real or unreal, I've done all that stuff, but how is it informing your life. And until you can bring that philosophy into the way you love your life, it's just a dilettante exercise, like going to the movies.

I: Sure. Like a faddish kind of thing.

Alice: Yes. So, if it can inform your life in a practical and functional way, so be it, and if you have a look at dream interpretation, where those dreams come from, what they're for, what you're gonna do with them, can have so many different belief systems. You can either think they're coming from your unconscious, then it brings into question what is your unconscious, are you Jungian, is it a collective unconscious, what does it mean that there is collective unconscious, is it wishful thinking on your part, is it your brain categorizing the events of the day, or is it your guide coming through to talk to you, or is it your mother? Or is it your ancestor? Or does it have to be any one of those? **(9.1)**.

I: Mmm, and it almost doesn't matter.

Alice: It doesn't matter. It's what you do with the dream.

I: Yes, yes. Alright then. Um, ya our last question, and this may be a slightly more theoretical question but feel free to draw on anything from your patients that's come up. Do you think there's a relationship in any form between psychoanalysis and religion or psychoanalysis and mysticism or what you were referring to as spirituality, for example do you see any commonalities or totally irreconcilable differences between the two?

Alice: I think the one is seamlessly intertwined for me with the other. I don't know how to separate it out. I don't know what you would do with projections, projective identification, transference, countertransference, if you don't think that they're intertwined, and I think that psychologists struggle with it...I mean I remember one of my lecturers at university when I said, "define projective, what do you mean when you say that people project?" She said "well I...?" And it's psychology attempting to be a science when it isn't a science **(9.1)**.

I: Ya, perhaps psychoanalysis...ya..

Alice: For me it isn't possible to separate out the two. I don't think its possible to separate out the two having a general conversation with people. You walk into a room, you know when people are depressed. How do you know? What is it that's going on there? **(9.1)**.

I: Mmm. Ya I suppose there's something more than looking at their behavior, which is more behavioristic – that's psychology as a science – you look at their external behavior, they're crying and their faces, their affect is 'blunted,' so you have the psychiatric terms but...

Alice: What's going on?

I: You feel something that...

Alice: Sometimes what you feel is desolation, sometimes what you feel is flatness, how do you know? But you know. And how you know that cannot be explained in science. It can be explained in quantum theory.

I: Yes I was thinking of that as well.

Alice: It can be explained in quantum theory. So, we can't, do we have to give it a name, do we have to categorize it, and can we simply live in the 'not knowing' as Bion says? Go in with no preconceptions.

I: Mmm. It does seem that there is a point where things get very strange, whether you approaching it as a scientist, psychoanalyst or a religious person, you get very very strange when you start talking about string theories and dark matter and, perhaps we are all speaking the same language but...

Alice: Different terminology. I do believe that. That's why it doesn't matter to me what religion the person brings into the room, I know were all talking the same language.

I: Ya, there's an abstract strangeness that we just don't know, just don't know about.

Alice: Mmm. And I have also delved into *Kabbalah*. And I don't see a difference there either, I really don't **(9.1)**.

I: Ya. Ok, well those are all my questions.

Alice: Ok, I hope this has been useful.

I: Its been fascinating, very very interesting, so thank you.

Alice: The only thing I haven't said here is that very often you can hypnotize people and they go back to their other lives **(8.1)**.

I: Oh, you done past life regression? Id love to hear about that..

Alice: Yes. So where do you put that into your psychoanalysis, you know? You're intending to do this, and you get that **(8.1)**.

I: Yes, ya, in your experience of doing that kind of stuff, have you seen that as, I don't want to say a confirmation but almost a confirmation of...

Alice: Some of the evidence that makes me believe that there is this world of spirit. Not because I intend to do that, I don't do it as a party trick and I don't intend to do in in therapy, it happens on its own. But I also did a course with Dr Michael Newton, I don't know if you know Michael Newton?

I: I don't.

Alice: Interesting reading if you're interested. He's a psychiatrist who, he's in his seventies now, he's in America, he hypnotizes people through this life, right down through into utero, then through their past life, then through their death, the death of their past life, and into that space between lives, and what happens, and its five to six hour sessions, he only does two a week, and he's written a book called the destiny of the souls, in which he gives you the tape recordings of these, and what happens to people when they die – where you go, and why you choose this life, and what you intend to do in this life, and what this whole process is about. Now, again, telepathy's powerful. I don't know of you know there was, there is a skeptic society, and the skeptic society has been operating for many years, and they're very skeptical about everything – that's their role.

I: Are you referring to the Richard Dawkins....

Alice: Yes, society. And there was a man who died and left the skeptic society money to investigate whether there really was life after death. And so they had a wonderful time [laughs], and one of the members wrote a book. I think his name was doctor Rogo. I read this book, and in it he said they went to various mediums, they went to Uri Gellar, who bends tea spoons, mediums, all kinds of things, to try to find a way to prove or disprove it, and they eventually, the problem with everything that they were trying to work out, kept being undone by telepathy. Because whatever experiences they had they said it was in your mind, and you telepathized it to my mind – what we're calling projections – so they made a pact that they learnt a particular passage of ancient Greek and they all learned the same passage, and of one of them died, they would go to a medium that they felt was more legitimate than others, and the person would come through that medium and relate that passage [laughs]

I: Amazing. Has it happened yet?

Alice: It happened. It actually happened. They sat there in the room, stunned, and then they said, but we were all sitting in the room with the passage in our heads waiting.

I: [laughs]

Alice: QED.

I: That's fascinating.

Alice: Ya. But the person who wrote the book, Dr Scott Rogo, he said, having gone through this whole process, he now believed, but he didn't know why, it was just a leap of faith rather than scientific evidence. He said he's seen enough to know, this is a possibility. And I think I'll say that, I've seen enough to say, this is a possibility

I: Thank you.

Alice: Ok.

I: It was fascinating, thank you. Different from my other interviews [laughs]

Alice: [laughs] was it?

I: In a good way [laughs].

Appendix J: Interview With Andrea

I: Ok, so ya, maybe we can just start quite broadly and you can just tell me what approaches you use – I'm not sure if you are strictly psychoanalytic?

Andrea: I'm not strictly psychoanalytic, um, I certainly don't practise more than once a week or on the couch or anything like that, I mean I trained psychodynamically, but I also trained in CBT and Person Centred, Ive done a lot of CBT and stuff as well, but I prefer to think psychodynamically. So that's how I think, that's how I formulate, its not necessarily how I work. But, um, I tend to work, I have worked longer term. When I was in the U.K. I worked with people for around two years. But here, then I worked in a hospital which was shorter term, and here, the work that we do here is short term interventions. SO you still sort of think psychodynamically but its not necessarily using the relationship or transference and that kind of thing. It's a lot more supportive, it's a lot more directive, solution focused type of work. So its difficult, because I like to think the way but in practice, to know how you put that in practice...

I: Ok, and within the psychoanalytic approach, are there any particular theorists that your driven to or like especially?

Andrea: Um, I suppose I like the sort of attachment theory stuff, um, I do get quite, Im not the person who remembers theories, so I must say I'm always impressed with people when they come up with theories (laughs), ya I suppose I probably rely on that kind of thing. You know we did a lot of Klein, um, but, because we trained in other models its actually quite difficult to stick with the one. I sometimes wish that Id only been trained by one model, because then you're much more defined by that. Um, ya, so I don't think there...ya.

I: Ok, that's great. K, um, and then maybe a gets a bit more tricky...if you could talk a bit about whether or not you think your beliefs influence your work as a therapist, and if they do, how?

Andrea: Mmm. Mmm. That was interesting actually, because I did have a read through this and I was trying to think about it. Um, I'm not religious, at all, I am Christian, born Christian, but went to schools that didn't have any sort of religious education cos they were all sort of multi-denominational, whatever you call it, my parents both went to schools where they had to attend Church, so they both erred on the side of not forcing it on us, and as a result we had no religious education at school, no religious education at home, so, basically I've been to Church for like weddings and funerals, so I don't have any religious beliefs, not that I'm an atheist or an agnostic or anything like that. I kind of believe in something, but I don't necessarily, whether its God or whatever you want to call it...so I think, I mean we might get into it a bit further, but I think, how it influences my work as a therapist, I think I have to be quite aware of that for myself when I see people who are quite religious. And it still sort of surprises me when I see people who are quite religious – I don't know why they're so religious, especially Christianity, I think, Ive worked a lot with Muslim people in the UK, and a lot with Jewish people, but

Christianity seems to be a bit, like, wishy washy, so when I come across people who are, except for Catholics – I worked a lot with Irish Catholics in the UK, but in South Africa I've found that people are quite religious, and I find it quite...

I: Surprising...

Andrea: Mmm, it still surprises me, so I need to kind of be aware of my own stuff, not that I think its, Oh why are you so religious or things like that, but just to keep in mind that this person might be religious. Um, there might be something else going on and, not to put my own views on them, so, its just another thing to bear in mind. Ya.

I: Ok, may be we'll get to, we'll expand a bit more on that as we go further. Ok, ya, if you can remember, some of the countertransference responses you've had while working with very religious Muslim or Jewish people?

Andrea: Well its interesting that, when I first emailed you back I hadn't really had many people here, and recently, maybe its cos its been brought up, I have had people here who have been very religious. Um, which is interesting in itself. But Ive got one client at the moment, um, I saw her Wednesday I think, and she's very very depressed. She hates herself, and she was talking about how she grew up very religious, her parents are Christian. And she talks about how If you're a good person, and God will protect you, and all of that kind of thing, and all these horrible things have happened to me, so what does that mean about me? And she basically lost her way, she said youknow, she started to loose – this was last year – loose the sense of feeling, there's something bigger than me, there's something protecting me, there's something giving my life meaning, and she totally fell apart, and was very very suicidal at that stage. And she's still quesitong that, questioning the meaning, and is there something out there, what does that mean? And I suppose for me, working with her, you know she's got a very punitive superego. On Wednesday, when she started talking about God I kind of imagined God as her supergo as well – this whole other dimension, you know, that she's never gonna live up to her expectations, she's never gonna be perfect, if she tells one lie, she's a bad Christian and that's it, its over. And to totally crumble her whole existence over that. And I mean we didn't sort of get into that, but my feeling was, how can you ever live up to that? (2) And I understand if you're brought up that way. But I suppose I think about that with, kind of, fundamental type of religious views. Certainly Catholics as well – there's a lot of kind of Catholic guilt and that sort of thing, the fact that Im not good enough, I cant do this, I cant do that. And I just think like, 'Its so much to add...on the flip side it can be so supportive, when people use it as a support, but with her, um, with her quite specifically I thought, you know, its just another thing...

I: An unnecessary...

Andrea: Ya, that she cant live up to. Um, and I think that seems to be, working with Muslim people, there isn't so much of that guilt, which is interesting. It seems to be a much moe supportive religion, if that makes sense. So that use it much more as a type of

supportive, 'community based' thing, whereas Catholics and Christians there's a lot more, sort of...

I: Punitive...

Andrea: Ya, ya, sort of not feeling good enough.

I: That's interesting.

Andrea: And I wish I could say to somebody, you know," its not that bad, or its not real even," but it is real to them, but that's how I sort of feel, I wanna say to them, "you know, even if you do tell one little white lie, does that mean the whole of you is a bad person now, and what do you have to do for the rest of your life to make up for that one little lie?" (2).

I: Ya, is it Kind of like a frustration but a disbelief as well?

Andrea: Ya, ya, ya. And I do struggle, because I'm not religious, can I challenge this? Or if I challenge this is this gonna result in them crumbling a whole lot more? Is it gonna be interpreted in a way that I don't get them, or don't understand, and I do struggle with that, and that is something I take to supervision, because I think its, beacsue I don't have the understanding of what it is liketo have this belief that you're totally invested in – what if that belief gets shaken about? So I do struggle with that in the sessions, so what I find myself doing is tending to not go into it so much. And what I have to do in supervision is I have to, I have to be challenged, to...

I: Go there...

Andrea: Ya, ya..

I: So its like a caution and a hesitancy, but also treading like a fine line...

Andrea: Exactly, cos I don't wanna go in all guns blazing ad then its too much, but I also don't want to avoid it, cos its something that's very meaningful for them.

I: Sure, sure. Ok well maybe we can go back to that a bit just now. Ya I think you've already touched on this – the extent to which your personal religious beliefs contribute to that response, the disbelief, frustration and caution...

Andrea: Mmm. I think there's also something about, you know you live in a society with intelligent people, its very science based, we research things, we test things out. And sometimes I do think, when people are totally blinkered to anything else, this is what my religion says this is what it is, and I sometimes just think, you know, "as this intelligent person in the 21st centurt, can you be that narrow minded?" Cos sometimes it does feel narrow minded.

I: Mmmm.

Andrea: And so there is that in my countertransference as well where I want to like...

I: Shake you...

Andrea: Ya, and to punch a hole in that narrow mindedness and just say, there are other perspectives in the world, there is something that might be different to this! (2).

I: Yes, yes.

Andrea: And then you start to think about, if this is the persons, whatever their presenting problem is, part of therapy is opening that problem up. So is part of therapy also opening up the religious aspect? And I do struggle with that. I think because of my own thing of not wanting to be 'led' by something.

I: Ya. Not to go too much off topic, I suppose we can get to it right at the end, but something about the psychological value that these beliefs have...

Andrea: Mmm.

I: It just shows you how potent it is. The kind of what would it mean not to believe in the kind of God I want to and the devastating consequences this could have, so the kind of comfort these beliefs have.

Andrea: Ya. But then also that these beliefs maybe keep the person in the place they are. So do we need to open it up a little so they'r enot just stuck in this space where they're guilty or negative or not worthy or whatever it may be. But ya, they're so invested in them, and yo cant just say "there's something else out there"

I: Sure.

Andrea: So it's difficult.

I: Ok, um, ya and then, I don't know if you have touched on this a little as well, but the extent to which they're evoked by the patient or rooted in your own history.

Andrea: Mmm.

I: I just realized that the questions kind of overlap, I don't know if you have anything more to add...

Andrea: Ya I think I would say that they're probably a bit more rooted in my own history, because I don't, if somebodies very religious, I don't have a a problem with their religion, what I have an issue with is, if we think about my own history – so my parents , no religious education and I was Christened and I have God parents and my one God mother

is a reborn Christian, and she took it upon herself to now educate myself and my sister, and I mean we hated it, hated it. And she looked after us once when my parents went away the one time. And we had to pray before bed, and we'd never done stuff like that. So that I have an aversion to – if somebodies a reborn Christian and they try push their beliefs onto you. So that I do have a problem with. But I think in therapy, beacsue I'm quite aware of that, and, those are their beliefs and that's fine, but this iswhere I find its quite a difficult line to tread, cos their I'm going, well, "don't bring your stuff to me" um, or is it the right place to question.

I: I suppose it's hard to know, what's my stuff and what's their stuff..

Andrea: Mmm. Ya.

I: I wondered when you were telling me the story if you'd ever had a reborn Christian in you therapy who kind of hooked you in that way?

Andrea: I haven't actually, no. I do have one client, I haven't seen her for a while, she's been away and whatever. And she goes to her particular church which is quite a fundamentalist church, and they are sort of happy clappy, I guess, um, and I, that does annoy me, so in the sessions I kind of have visions of her jumping around and kind of Halleluja, that sort of thing. And I just think, I don't know, I just, I kind of feel like people are being brainwashed sometimes, and that frustrates me (4.1).

I: Ya, I can imagine that must be frustrating. Ok, um, you have already, the next question I was going to ask you to elaborate on a specific case but you have already done that. I don't know if there are any other cases that pop into mind other than the one's you have mentioned, anything that comes to mind?

Andrea: I suppose, sort of, I think working with other religions is sometimes easier, so working with a lot of Muslims in the Uk, it was actually easier in a way because, you know, I don't know about the religion, I mean I know about the general stuff you hear but I don't know about the religion, so, in a way, it felt less threatening to sort of ask the question, ya, " I don't know what this is like, so you tell me," and in a way that was easier than working with someone of my own religion, um, because I kind of do know about it, so am I challenging it or am I just asking. So I think, even though there are the difficulties with Muslim men and woman communities, It did still feel like it was a lot less punitive of a religion, and I suppose it did sort of help me to understand Muslim people a lot more, you know you have stereotypes of how the woman have to dress, and when you would see someone in therapy and they would say this is what I believe and this is why I dress this way and you can ask the question is this something you want to do and yes this is something I want to do for whatever reasons, and I suppose it helped to educate me, helped to perhaps decrease any prejudices I did have, cos I was at least able to ask the questions.

I: mmm, it's so interesting some of the people I have interviewed have spoken about how they've struggled working with very religious Muslim woman because of the kind of

subjugation they experience with their husbands, and I don't know if You've ever felt frustrated at that aspect...

Andrea: See I didn't actually find, I can't think I've worked with anyone when I've felt that they're overly, that there's something, that they couldn't be a woman in their own right. I mean most the people I've worked with had arranged marriages and that sort of thing, so they were very devout. Maybe its something about how devout they were, that actually they did believe in it.

I: Ya, maybe, ya, it could be something about the therapist having a vested interest in feminist ideas..

Andrea: Mmm, ya.

I: which might have influenced their response..

Andrea: ya, ya. Cos I didn't, and I didn't, when you asked the question, and I'm thinking of somebody in particular, when I asked the question around the expectations of being a wife and what you're allowed to do and what you're not allowed to do. It didn't feel like she was held down in anyway, you know it was something that she believed in and wanted to be part of and live in this way, and I didn't sort of get a sense that, within myself, like "oh she has to break out of this" or anything like that.

I: Ok, um, ya and then with the kind of strongest countertransferences you've had, around the management, I know there are the usual things of take it to supervision

Andrea: Mmm

I: I don't know if you have any kind of specific way that you sort of handle the countertransference if its particularly strong?

Andrea: Ya, um, not in the session, I can't think of, I suppose it's just to notice it in the session, and when you're writing up your notes afterwards, just to think about what it means, but I would generally take it to supervision and my supervisor, whether here or in the U.K would be like, you need to take it to therapy, um, so I think that's still something that I struggle with – that its in the room, I notice its in the room, but, whether its cos I'm anxious or, whatever, I don't address it there and then, I take it away, digest it, and its 'Ok you need to address it' (5).

I: That its crunch time and you need to..

Andrea: Ya, ya. And when you do people don't, I suppose its, I don't know why religion is such a 'thing,' cos when you take it back into the room, people are fine with it (5).

B: Oh is that your sort of experience?

I: Ya I haven't freaked out or, you know, that there's been some negative reaction, but its me bringing it up saying, you know, this is how I felt about what you talked about last week and what do you make of that? And most people are willing to engage in that (5).

B: Ya, its interesting, what is it about religion that makes us more anxious to talk about it, to bring it in, its almost sacrosanct, like its taboo..

Andrea: Ya..

I: You don't go there

Andrea: Exactly, ya, ya. I mean its funny cos race is another thing, because race isn't something you can hide, its there, its out in the open but religion is kind of something that you might not know until quite long into therapy.

I: Yes sure, sure.

Andrea: And then it adds another aspect.

I: Sure, I mean unless they're coming in in a Burka or Yarmi..

Andrea: Yes, exactly.

I: Ok, um, ya,

Andrea: Sorry, something I was just thinking of... going to the schools I went to, as much as I didn't have any religious belief, I got exposed to everything else – the high school I went to was very Jewish, the primary school I went to was all, everything, so, that has opened my eyes to the world, and I suppose I'm always quite shocked when people don't know about certain types of religions, you know they only know about their own religion, so maybe that's helped and been a hindrance.

I: Yes, yes, well that's interesting, something important about your history which contributes to your approach..

Andrea: Mmm. Mmm.

I: Ya, and then, your take on what counts as healthy or unhealthy religious belief or practice.

Andrea: In your patients.

I: In your patients.

Andrea: Um, I think if its something they totally relying on for, validation, sense of self, self esteem, all of those types of things, I think that's quite difficult, um, whether its maladaptive or not I'm not sure, because it might be the only thing that keeps them going

but, I think to have it, cos people do find a lot of comfort and support in religion, and community, I think going to church or being involved in community groups or whatever it might be can be hugely supportive to people (7.2). But I think it's that feeling of, this is the only road to go down, and if you deviate at any point...

I: Lightning..

Andrea: Ya, your life is over, basically. I suppose in another way, thinking about people who are, who have suicidal ideation and that sort of thing, a lot of people who are suicidal have set to me, you know, I would never do it, I would never commit suicide, so you know, that's quite a good thing [laughs] that they have that, and they do, as much as they want their life to end, they won't kill themselves, they will not do it because of the fear that will happen afterwards. Again it's a bit maladaptive I suppose of that's the only thing that's keeping them alive (8.1).

I: Ya it seems quite tricky

Andrea: Mmmm.

I: Cos it can be unhealthy in the sense that they're dogmatic about it,

Andrea: Mmmmm

I: this is the only way, they can't think about it, there's no kind of space for being wrong or for questioning, for what if..

Andrea And I suppose my understanding of a religion is that it is about questioning things, about questioning why this happened or where this happened, um, and to feel like you can't question, you know, if you challenge your God, and you get the answer you want, isn't that a positive aspect of it? But if you feel like you can't even challenge...(7.1).

I: That's problematic...

Andrea: Ya.

I: Its um, its an interesting thing I mean what you were saying about, its hard to know at what point it becomes maladaptive..

Andrea: Mmmm.

I: It might not be strictly healthy but there's something about it that keeps you going or..

Andrea: Ya..

I: I'm just thinking you know, if you had a patient who came in, a rational person in the broadest sense of the word, highly functioning, good job, good relationships, and he came to you and he said "I genuinely believe in fairies, I really do, and it keeps me going"

Andrea: Ya

I: and he's got no problems in the rest of his life, would you feel like you need to challenge that belief..

Andrea: Mmmmm

I: Or get him to rethink it or suggest to him that like, look, as much as this helps you its crazy, cos there's no such thing as fairies..

Andrea: Ya,

I: I'm wondering what your...

Andrea: That's interesting, immediately I was thinking I would question, not question but, open it up

I: Explore it..

Andrea: But if that was a religious thing I probably wouldn't, not immediately, I would probably take it a bit slower..

I: If it was embedded within a religion it would be more..

Andrea: Ya

I: So there's something about if it's a kind of more idiosyncratic, its quite eccentric, its not something a group of people believes, or maybe there is I don't know [laughs]

Andrea:[laughs] Ya, but that's interesting, I mean immediately I was like "Ooh I would."

I: Ya, something about it doesn't feel right, but if the person's happy and they're functioning, it seems difficult, around what to do...

Andrea: But maybe also there if the person's happy and functioning and everything else in their life is seemingly ok, it gives you the space to go into that kind of thing, whereas if they're in a difficult place already, um, and religion is the only thing that kind of keeping them going, why would you wanna take that away from them? **(6.1)**.

I: Sure. I suppose maybe it's not a great example cos if they were happy, then...

Andrea: [laughs] why they in therapy?

I: in the first place! That's true. Ok, um, Ok and then for you the most challenging aspects of working with religious people?

Andrea: Um, I think what I've already talked about, I found it quite easy to ask the questions if it is something that I don't understand, that I don't have a good knowledge of, then, I don't mind asking questions. But it is that whole thing of do I open this up, or is that gonna challenge their whole system of belief.

I: Yes

Andrea: So to kind of go in softly...and I do but I tend to need to think about it first. It's not something I'm comfortable with in the room. I'm quite happy for them to talk about their religion, but to say, "this is what's going on for me, in regards to your religion," I find that quite hard to do in the moment.

I: Alright and then finally, this might be a little more theoretical, but feel free to draw on your experience with your patients, do you think there's any kind of relationship between psychoanalysis and religion, or psychoanalysis and mysticism for that matter, um, for example do you see any commonalities or irreconcilable differences...

Andrea: Mmm. When I first read this question I was like "no ways, there's no relationship" and then I thought about it and I was like "well, I guess when people come into therapy you ask them to trust in a certain belief about something, that this process is something that is done in a certain way, and you don't know about it, but you have to trust me in the long term...(9.2).

I: They have to have faith...

Andrea: Exactly, um, and I think that's probably quite a similar thing. With religion you get taught something and you trust that that is how it is and that it is for your benefit. You know I think ultimately religions, you know people don't join a religion because it's a negative thing, you know they feel it's going to benefit them. But I thought that was interesting that my immediate reaction was like "no ways, what we do is scientific somehow, and yet religion is not." And yet what we do somehow is about putting yourself into something and just 'knowing' somehow and that it will work (9.2).

I: No, sure. I mean just to change tracks a little bit, some people talk about, what do we mean when we're talking about an unconscious or projective identification, these things are so abstract and so strange in a way, could we, by the same token talk about a soul? Or a higher something, some people go there, so I don't know what you think of that...

Andrea: Mmm, ya, I haven't really thought about it to be honest. But it is interesting...I find it far easier to think about the unconscious than somebody's soul because it's not something that I am actively in a religious aspect, so it's not somewhere where my brain would tend to go. But ya, sort of thinking about it, there is that, there's some...

I: Ya, there's a level of abstraction, where, 'what are we really talking about here?' I mean like even in science, cognitive science, you talk about mind...

Andrea: Ya, what is that.. \

I: What is mind? We know what the brain is, and the brain generates the mind, but...some people will draw on that and say there's something a little mystical about projective identification, two people's kinds of unconsciousess 'talking to each other.' So there is that, but that's just one perspective...

Andrea: Ya, well something's just popped into my mind as well, um, is that I think sometimes [laughs], I think sometimes, religion is sort of thinking along the lines of, you know, lots of people believe in something, but analysts, can be very...cult-like

I: Cultish [laughs]

Andrea: As well, and that's why, not because I have an aversion to analysts – that would be interpreted in all sorts of ways – [laughs], I do feel like, you know, they need to just calm down, it's just too much, and maybe that is a similar thing to religion, that this is the belief and this is how you have to do it in order for this to work in this way, and that's kind of similar, as well.

I: Absolutely

Andrea: Whereas other therapists, I suppose are a bit you know dogmatic about their approach, but not in the way that analysts seems to be.

I: mmm, definitely I agree, there's also something about like the charisma of the kind of head analyst, there's almost a sort of reverence

Andrea: Ya, ya, interesting.

I: Ok, great, well that's all the questions I have. Maybe I can just close with one more thing. I mean I don't think, I imagine what you might say because of your beliefs, because you're more agnostic in your beliefs, but just, ah what you might think about the kind of, the DSM's criteria for...

Andrea: Mmm, Mmm

I: A delusion, a belief with no basis in reality, etc etc, but I think for me the interesting thing is that is doesn't count as a delusion if there's a large enough group of people who believe in it. And I always wonder to myself at what point, how many people do you need for it to become – I mean I can believe in a three headed monster – but if there's a group of people who believe that, then it doesn't count as a delusion according to the DSM, if its just my belief then I'm crazy, I don't know what you...

Andrea: Mmm, that's really interesting. We did, I remember in our training we did – I think our training in the U.K's very different – we did a whole thing on 'anti-psychiatry' and one of things that we did – they actually showed videos of it, it was horrible, - of someone from Africa but living in the U.k, and he was sectioned because he had all these beliefs. Um, and when you look at it, in the African culture, there are beliefs about people talking to you, the Gods talking to you and all those tyoes of things, and actually it wasn't, in any way, pathological, but because he was now in a Western society, it was. And I think that's, you know, I do find that really interesting, you know when you talk about Sangomas, and you come into different cultures, and I suppose in the sort of South MAeridcan cultures there's similar types of things, and because we live in a Western culture, who are we to dictate for the rest of the world.

I: Sure

Andrea: And certainly the DSM I don't, I find the DSM quite hard to follow, you know I don't like boxing people like that. Um, but I think its interesting, when you extend it out into the word, with different cultures and different experiences, does it fit? And I'm not sure it does. Um, you know we all have, you have your internal dialogue, you have dreams, and if you talk about it, maybe we're all a bit crazy, according to the DSM.

I: Mmm, Mmm, absolutely. Interesting, well thank you - that's all I've got.

Andrea: Ok, well thank you.