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Commentary on The Persecuting God and the Crucified Self: The Case of Olav and the Transformation of His Pathological Self-Image

The Role of Religion and Spirituality in Olav's Treatment and Recovery: Commentary on an Exemplary Case Report

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ABSTRACT

The *Case of Olav* (Stålsett, Engedal, & Austad, 2010) offers in-depth insight from a spiritually and existentially informed psychodynamic perspective of how religious and spiritual issues may be intertwined with psychopathology. This case report also shows how psychological and spiritual interventions can be used in an integrative manner to help patients with severe long-term psychopathology. Ultimately the case provides convincing quantitative and qualitative evidence that an in-depth working through of Olav's pathological inner representations of self and God were instrumental in his psycho-spiritual healing and recovery.

Keywords: spirituality; existential; psychodynamic; case study; evidence-based treatment; God image

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The *Case of Olav* (Stålsett, Engedal, & Austad, 2010) is exemplary in many ways. I will mention and briefly discuss what I regard as three of its major contributions to the scholarly literature. First, in the context of the long-standing divide between research and practice, the *Case of Olav* provides an excellent example of how a methodologically well-designed case study can help bridge that gap by providing (a) clinically relevant, rich insight into the processes of treatment, and (b) convincing empirical support concerning the positive outcomes of treatment. Second, in the context of the evidence-based treatment movement (APA, 2006), the *Case of Olav* makes it clear why methodologically rigorous case studies should be more widely regarded as a valuable type of outcome and efficacy evidence. Third, in the context of the growing trend to integrate spirituality into psychological treatment and to develop an evidence-base supporting spiritual approaches (Richards & Bergin, 2005; Richards & Worthington, in press; Sperry & Shafranske, 2005), the *Case of Olav* provides much insight into how this can be done in an ethical and effective manner.

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BRIDGING THE RESEARCH-PRACTICE GAP: METHODOLOGICALLY RIGOROUS CASE STUDIES

Case studies have a long history in psychology and psychotherapy (Stake, 1994). Although case studies provide rich insight into therapeutic processes and interventions relevant to practitioners, they are frequently ignored by researchers because of concerns about limited generalizability and questionable internal validity (Kazdin, 2003). Although an individual case study by itself cannot fully escape these limitations, the accumulation of many methodologically rigorous case studies with many different clients in a variety of settings can contribute to a data base that provides convincing empirical evidence. In my view, the *Case of Olav* is an excellent example of a methodologically rigorous and clinically rich case study that contributes to both research and practice.

The *Case of Olav* has a number of methodological strengths. Process and outcome data were drawn from multiple sources including transcripts of group sessions, therapists' notes, patient interviews, patient art work, video tapes, diagnostic testing, and standardized assessment measures. A variety of professionals, including accomplished outside consultants, provided input into the theoretical case conceptualization and qualitative data analysis. The qualitative sources of data and rigorous case conceptualization resulted in comprehensive and clinically detailed insights that were grounded in theory and clinical data.

In addition to the rigorous qualitative procedures, the researchers also collected pre-treatment, post-treatment, and one-year follow-up quantitative outcome data about Olav using the Beck Depression Inventory (BDI), Symptom Checklist-90 Revised (SCL-90-R), and the Inventory of Interpersonal Problems (IIP). The quantitative data provided valuable additional support for the psychological and interpersonal improvements the researchers and clinicians observed through their clinical observations and judgment. Collectively, the qualitative and quantitative data provided detailed information about the processes and interventions of the treatment model and convincing empirical evidence concerning its effectiveness. I am optimistic that if more studies such as the *Case of Olav* were conducted and published the research-practice gap would shrink.

CONTRIBUTING TO EVIDENCE-BASED PRACTICE

During the past two decades there has developed a widespread movement promoting evidence-based practice in health care (APA, 2006). Although most healthcare professionals agree that medical and psychological practice should be based on the best available evidence, considerable controversy exists over what constitutes such evidence (e.g., Messer, 2004; Slife, Wiggins, & Graham, 2005). An important aspect of this debate has focused on the question of whether randomized clinical trials (RCTs), also known as true experimental designs, and single-N experimental designs truly represent gold standard designs for obtaining best empirical evidence (Chambless et al., 1996, 1998; Rapkin & Trikkett, 2005; Slife et al., 2005). Numerous limitations of RCTs and single-N experiments have been described, including for example, (a) limited external (real life) validity and generalizability, (b) difficulty in ruling out threats to internal validity, (c) limitations in ability to isolate which components of treatment are effective,

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(d) difficulties in implementing such designs in real clinical settings, and (f) challenges with avoiding ethical violations (e.g., withholding or withdrawing treatment from patients in immediate need of help) (Kazdin, 2003; Rapkin & Trikkett, 2005; Slife et al., 2005).

The growing recognition of the limitations of RCTs and single-N experimental designs has led many healthcare professionals and researchers to argue for a more comprehensive and inclusive view of what constitutes best available evidence. The American Psychological Association's Task Force on Evidence-Based Practice report (APA, 2006) reflects this growing consensus in the following definition:

> *Best research evidence* refers to scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields. APA endorses multiple types of research evidence (e.g., efficacy, effectiveness, cost-effectiveness, cost-benefit, epidemiological, treatment utilization) that contributes to effective psychological practice.
>
> Multiple research designs contribute to evidence-based practice, and different research designs are better suited to address different types of questions (APA, 2006, p. 274).

The APA report also lists and briefly describes various types of research designs and how they might contribute to evidence-based practice, including clinical observation (e.g., individual case studies), qualitative research, systematic case studies, single-case experimental designs, public health and ethnographic research, process-outcome studies, studies of interventions in naturalistic settings, randomized clinical trials (RCTs), and meta-analyses. The report encourages "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 284).

In my view the *Case of Olav* provides an outstanding example of how a rigorously conducted case study can provide researchers and clinicians with best available evidence by integrating clinical theory and expertise with qualitative and quantitative empirical observations—all in the context of giving careful attention to the patient's characteristics, culture, and preferences. I suspect that I learned more about effective clinical practice from the *Case of Olav* than I would have from reading about the quantitative findings of a large-scale RCT. I also felt more convinced by the qualitative and quantitative data presented in this case that the treatment approach was responsible for the positive patient outcomes than I would have by group means and effect sizes presented in an RTC study. It is in this sense, therefore, that the *Case of Olav* makes a valuable contribution to the development of evidence-based practice. The data from methodologically rigorous case studies can be as valuable as, and sometimes even more valuable for informing effective clinical practice than data from quantitative experimental studies (Rapkin & Trikkett, 2005).

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PROVIDING INSIGHT INTO THE ROLE OF RELIGION AND SPIRITUALITY IN TREATMENT AND RECOVERY

The *Case of Olav* makes an outstanding contribution to the literature regarding the integration of spiritual perspectives and interventions into psychological treatment because it describes in much detail (a) how various spiritual and existential interventions were used during treatment, (b) the theoretical basis for using them, and (c) qualitative and quantitative evidence supporting their effectiveness. Despite the proliferation of literature describing religious and spiritual interventions (Richards & Bergin, 2005), relatively few publications describe the application of such interventions with actual patients struggling with specific psychological problems. And even fewer have provided empirical evidence supporting their effectiveness (Richards & Worthington, in press). The *Case of Olav* is exemplary in this regard.

During the past two decades, the number of spiritually-oriented treatment approaches described in the mainstream psychological literature has increased dramatically. Several survey studies have provided evidence that 30% to 90% of practitioners, depending on the group surveyed, incorporate spiritual interventions into their practices (e.g., Raphel, 2001; Richards & Potts, 1995; Shafranske & Malony, 1990; Shafranske, 2000). Studies also indicate that most psychotherapists use spiritual interventions in an integrative manner with interventions from one or more of the mainstream secular therapeutic traditions (Richards & Bergin, 2004, 2005; Sperry & Shafranske, 2005; Worthington, Kurusu, McCullough, & Sandage, 1996). Higher percentages of psychotherapists who are personally religious use spiritual interventions, compared to therapists who are less religious, and they use a wider variety of such interventions (Raphel, 2001; Shafranske, 2000). Evidence also suggests that non-religious psychotherapists use some spiritual interventions (Shafranske, 2000), and that they use them as effectively as do religious psychotherapists (e.g., Propst, Watkins, Dean, & Mashburn, 1992).

Research to date has provided general support for the effectiveness and efficacy of spiritually-oriented treatment approaches. Three meta-analytic reviews obtained overall effect sizes ranging from .27 to .75, depending on which studies were included in the analyses (Richards & Worthington, in press). Christian and Muslim cognitive approaches for clients with depression and anxiety meet evidence-based standards of efficacy. There is also preliminary evidence supporting the probably efficacy of a variety of other types of spiritual psychotherapies, including a Taoist CBT approach for anxiety, a theistic spirituality group for eating disorders, and a Buddhist CBT approach for anger (Hook, Worthington, Davis, Jennings, Gartner, & Hook, 2010). Nevertheless, the data base is relatively small and has numerous methodological limitations.

Consistent with the APA Task Force on Evidence-Based Practice report discussed earlier (APA, 2006), Richards and Worthington (in press) encouraged a methodologically pluralistic research approach in this domain in order to develop a more adequate evidence-base for spiritually-oriented treatment approaches. They encouraged practitioners and researchers to collaborate using both quantitative and qualitative methods of inquiry, including case studies. The *Case of Olav* demonstrates that case studies can play an important role in developing an evidence-base for spiritually-oriented treatment approaches. It also illustrates the fruits of

collaboration between practitioners and researchers who draw upon theory, clinical experience, and research methodology in order to discover and document important insights about the role of psycho-spiritual interventions in working through serious psychopathology.

The *Case of Olav* also illustrates the value of a theory guided approach to treatment. The VITA treatment model described by the authors was grounded in four main theoretical orientations, including existential theory, narrative theory, object relations theory, and affect theory (Stålsett et al., 2010). At the heart of the treatment team's conceptualization of Olav was the idea that "patients' inner representations of God originate in the relationship with their parents" and that "in order to change an impaired sense of self, the affects and beliefs associated with inner representations of mother, father, and God must be transformed from rigidly held, harsh and punitive images to more differentiated images" (Stålsett et al., 2010, p. 52).

As I read the *Case of Olav* I was impressed with the creative and multidimensional manner that the treatment team intervened with Olav to help him work through his emotional and spiritual issues. I found it fascinating to read about Olav's emotional and spiritual working through of his inner representations of self, parents, "The Committee," and God and how the transformations in these internal object relations facilitated his emotional and spiritual healing and maturation. Dismissing "The Committee" (Olav's harsh God representation) to the "distant mountains" and developing "closeness and tenderness to a benevolent God" were in my view absolutely crucial to Olav's healing and recovery (Stålsett et al., 2010, p. 78).

In my own therapeutic approach, which is called *theistic integrative psychotherapy* (Richards, 2005; Richards & Bergin, 2005), I combine theistic spiritual perspectives and interventions with concepts and interventions from mainstream psychodynamic, humanistic, and cognitive traditions. In regards to God image development, I consider it a complex process that may include influences from genetics, trauma, family, peers, culture, society, and religious theology and tradition. In addition, according to my theistic perspective, God image development may also be influenced by individuals' actual relationship with God (O'Grady & Richards, 2007). As explained elsewhere:

> One of the most distinctive contributions of a theistic perspective to our understanding of God image development is the view that experiences with God can have a powerful influence on individuals' representations of God (Hall & Brokaw, 21995; Parker, 1998). According to this view, part of the change in people's perceptions of God over time may result from getting to know God better; analogous to the ways people's understanding of significant others in their lives develops over time and with added experiences (Hall & Brokaw, 1995; Levinas, 1981). God is not merely a representation to be perceived but also a reality to be experienced first hand. Individuals may experience God as a compensatory figure because God really did help fill in the gaps left by inadequate parenting (O'Grady & Richards, 2007, p. 190).

Stålsett et al. (2010) wrote that "Olav continually expressed the need for a God representation that could be available as an object of faith" (p. 78) and that Olav's "fear, guilt, and rage towards God were replaced by closeness and tenderness to a benevolent God whom

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Olav felt received by and who loved the real Olav" (p. 78). They concluded that "One could say that he learned to use God as a soothing object rather than a persecutory one" (p. 78).

Conceptualizing Olav's changes during treatment from my theistic perspective, I would be more inclined to conclude that Olav's treatment helped him learn to relate to God in an authentic way so that he was able to more fully experience the actual healing power of God's love and benevolence (Richards & Bergin, 2005). Such an interpretation seems more consistent with Olav's own understanding of his experience—which was that he had been "received by" a benevolent God and that this God "loved the real Olav" (Stålsett et al., in press, p. 78). This theistic interpretation of the case material, though no more or less empirically provable than a naturalistic interpretation, nevertheless remains open to the possibility that therapeutic change occurred in part because Olav experienced the reality of God's healing influence during the process of his treatment and recovery (O'Grady & Richards, 2007).

Conclusion

The *Case of Olav* is exemplary in illustrating how theory, practice, and clinically relevant research can work together synergistically to enhance one another. I thank the authors of the report, members of their treatment team, and Olav for their hard work and willingness to share this case study with the healthcare community. I plan to make the *Case of Olav* required reading in at least two of my doctoral level courses: Advanced Research Methodology and Spiritual Issues and Interventions in Psychotherapy. I congratulate the authors for this outstanding contribution to the literature.

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