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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

Psychotherapeutic Change and Spiritual Transformation: The Interaction Effect

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Author's Note: I want to thank my friends and colleagues, Gry Stålsett and Arne Austad, and also my Rutgers colleague, Professor Daniel Fishman, for the opportunity to comment on this truly fascinating case.

ABSTRACT

Olav was an extremely difficult, regressed, and religiously preoccupied patient, with a long history of unsuccessful outpatient and inpatient treatment. His case study by Stålsett, Engedal, and Austad (2010) is used here to illustrate the VITA treatment program at the Modum Bad Hospital in Norway. This program uniquely combines contemporary psychoanalytic therapy and a focus on religious and spiritual concerns to produce a remarkably intense 12-week inpatient treatment process. My commentary concentrates on some of the theoretical and practical implications of Olav's case for the psychological study of religion and the clinical treatment of religious patients, and it argues in favor of the VITA approach to dealing with religious and spiritual concerns as opposed to other forms of “religious” or “spiritual” therapy. The case presentation implies that the VITA Program succeeded with Olav where others did not because it explicitly focused on religious and existential issues. I offer some suggestions based on self-psychology why that might be true but also suggest that other factors were at work as well.

Key words: psychotherapy and religion; psychoanalysis; affect-regulation theory; psychology and spirituality

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I have known two of the authors of the case of Olav—Gry Stålsett and Arne Austad—as friends and colleagues for decades. We have met on both sides of the Atlantic and discussed the development of their “VITA” treatment program as well as participating together in case presentations and theoretical explorations. I have watched the program’s evolution from Gry and Arne’s early theoretical investigations on the integration of psychodynamic approaches with religious and spiritual concerns, their development of an innovative and specifically relevant clinical outcome methodology, and finally the implementation of the full, broad-based and integrative, inpatient treatment model presented in Olav's case. It is thus personally gratifying to be able to comment on this complex and dramatic case study and to see the remarkable clinical fruits of their work.

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Before discussing the theoretical and clinical aspects of Olav's treatment and the VITA method, another personal comment is in order. In October of 2006 I was invited to be a keynote speaker at the opening of a new inpatient psychiatric center [the "Viken Center"] in the far north of Norway. I had plenty of opportunity to see this new facility up close and discuss the various intensive treatment programs that were soon to be deployed there. These were intended for patients from the full range of Norwegian social-economic groups, including the indigenous Sami people who populated that stark and beautiful glacial area north of the Artic Circle. Needless to say, I had not seen a clinical setting remotely like this for decades, if ever, in the United States. My sense is that intensive, psychodynamic inpatient treatment like this is a thing of the past in the United States where rapid medication stabilization and quick discharge are the rule. Apparently Olav experienced similar rapid medication stabilization attempts at treatment in the Norwegian context which led inevitably to brief symptomatic improvement followed by relapse. The case presented here argues powerfully for the effectiveness of intensive, inpatient *treatment*, not just medication stabilization—an option rarely available in the United States, except perhaps to the very wealthiest patients.

THEORETICAL CONSIDERATIONS

I use the term "psychodynamic" advisedly here. Not simply because the treatment involved so many modalities—narrative, group, art, existential—but more significantly because the psychodynamic component itself was very broad and inclusive. In developing the VITA Program, the authors and their colleagues drew extensively on the research of Alan Shore, Peter Fonagy, Daniel Siegel and others who rely heavily on neuropsychological and developmental research on affect regulation and attachment theory (Fonagy, Gergely, Jurist, & Target, 2002; Shore, 1994; Siegel, 1999). These contemporary psychodynamic models focus on the neurological underpinnings of the ways in which the individual develops (or fails to develop) the capacity to regulate affective experience. This capacity to regulate affect is theorized as the core of our mental states, directly influencing our cognitive functioning and indirectly influencing our behavior. This capacity develops through early attachment relationships with caretakers. Bringing together research from cognitive neuroscience, attachment studies, developmental psychology, as well as clinical psychoanalysis, affect regulation is understood as the center of our sense of self, our cognitive processing, and personality.

Central to affect regulation is the capacity to reflect coherently on one's own mental/emotional states and to recognize others' mental/emotional states. Lacking this capacity, the individual is either totally engulfed by their experiences or dissociated from them, and the individual is also unable to empathize with others' mental/emotional states. This pathological state is often referred to in the literature as "embeddedness." Olav's early presentation certainly illustrates a person who is "embedded" in their experience most of the time. The opposite of "embeddedness," the capacity to stand back from one's mental/emotional states and reflect on them, is referred to as "mentalization" (Bateman & Fonagy, 2005). Mentalization confers cognitive and behavioral flexibility and empathic ability. It develops naturally in an empathically attuned attachment relationship, and it can be gained in adulthood through the therapeutic process of reflecting on and gaining insight into one's mental/emotional states in the context of a secure and empathic therapeutic alliance. Here the patient gains access to split off or overwhelming mental states and develops a reflective stance on them. This becomes the primary

treatment goal for intensive, dynamic therapy and is represented by the VITA Program's emphasis on developing a "culture of inquiry" in the treatment setting and eventually in the patient's life. This is primarily accomplished through individual and group psychodynamic therapy, and through intensive narrative work in which the patient writes about and reflects on their life story.

Alongside this rich and empirically grounded model of psychodynamic treatment, the VITA program is also fed by the research on the role of religious and spiritual concerns for human flourishing. While this research is not without its controversial elements, there is a general consensus that religious belief and practice is generally associated with improved mental and physical well-being. (For example, see the reviews in Jones, 2004 ; Miller & Thorsen, 2003; Pargament, 2002; Powell, Shahabi, & Thoresen, 2003). My impression from professional conferences and teaching in both Europe and the United States is that while these topics are most commonly denoted as "religious or spiritual" in the United States (for example the American Psychological Association's new journal is named *Psychology of Religion and Spirituality*), in Europe (and certainly in Scandinavia) similar topics are most commonly referred to as "existential" issues (DeMarinis, 2003). This nomenclature is clearly reflected in the VITA Program's inclusion of an "existential reflection group" in the treatment program in which the "ultimate concerns of life" are directly addressed in a reflective and non-judgmental (and non-coercive) milieu. In addition, a more overtly religious experience of pastoral counseling is available, but not required, as a regular part of the treatment. This direct focus on existential and religious concerns in the context of an intensive, multi-disciplinary inpatient treatment is unique in my experience. And to be accepted into the VITA Program, religious and existential concerns must be an important part of the patient's presentation, which was certainly the case of Olav. His severe depression and intense self-destructive cognitions and affects were heavy with religious content and were clearly and tightly connected to the punitive and moralistic religious milieu in which he had been raised

While emphasizing the importance of such religious, spiritual or existential concerns, the VITA Program clearly does not engage, even in its pastoral counseling component, in a religiously or spiritually oriented form of therapy. Religious beliefs and practices are not invoked as treatment modalities or psychotherapeutic interventions. Rather, in keeping with the psychodynamic orientation, these concerns too are subject to a "culture of inquiry" in which their developmental trajectory and psychological function are explored and analyzed. Here too the goal is a developing a reflective stance in relation to these issues.

We must recognize that this requires a particular cognitive shift on the part of patients, especially if they are religious devotees themselves. They must retain their commitments if their religious or spiritual commitments are to contribute to their healing. But, along side this stance of commitment and devotion, they must also develop an outsider's perspective on these commitments so as to reflect critically and analytically on the beliefs and practices to which they remain devoted. In terms of models of cognitive development this is a fairly high level of cognitive complexity and it may not be so widely distributed in the population (Day, 2008). But this is what would be required for the VITA Program's approach to existential/spiritual issues to work—that is, if the program is to draw upon the ability of religious and spiritual practices to contribute to human flourishing without either simply invoking religious beliefs or engaging in

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purely intellectual discussions of existential or religious philosophies and constructs, which is all that so many so-called religious, spiritual or existential therapies seem to do. In addition, I think that the ability to take a reflective and self-critical stance on one's own objects of devotion is a necessary psycho-spiritual skill if religion is to contribute to human well-being in this age of religious fanaticism and terrorism (Jones, 2002, 2008).

So, after seven years of hospitalizations and various trials of the usual therapies, Olav came into this VITA Program—a program which marries a rich and complex model of psychodynamic theorizing with an appreciation of the roles (positive and negative) that religious and spiritual matters can play in a person's life. There the VITA Program provided him an exceptionally intense and multi-disciplinary milieu therapy. The authors have courageously chosen a remarkably difficult case to illustrate their treatment program. Olav had a long history of severe, psychotic depression; suicide attempts; and additional Axis II diagnoses of Borderline and Paranoid Personality Disorders—all leading to a seven year history of unsuccessful psychiatric hospitalizations. He arrived socially isolated, heavily medicated, and on the verge of commitment to a closed ward for the severely schizophrenic. Such a patient would be a test for any treatment regimen. Still, at discharge Olav's scores on a depression inventory and a symptom distress measure were significantly improved , and on a measure of interpersonal functioning, moderately although still importantly improved. Also his drawings changed dramatically. His first drawings were basically stick-figures—concrete and impersonal. At discharge his drawings were non-representational and laden with affect. Profound personality and cognitive-developmental shifts had taken place.

At one year follow-up there was no sign of diagnosable depression, or evidence of psychosis, or other disorders nor was there any evidence of any Axis II Personality Disorders. His Global Functioning was in the normal range. A follow-up six years after discharge found Olav symptom free, off of all medication, re-married, and gainfully employed. A remarkable accomplishment for someone whose only future, when he arrived at Modum Bad, was a locked psychiatric ward.

ADDITIONAL CASE FORMULATIONS

There is no need to repeat the case history which is clearly described in the presentation here. But some additional factors might be noted from a self-psychological perspective. Neither parent was really available for an empathic and mirroring, secure attachment relationship for Olav. In addition, his parents divorced, which Olav must have been experienced, from a self-psychological perspective, as a terribly traumatic loss of an idealized object. His father both pulled for a high degree of idealization and yet fell from the moral high ground. In addition, we don't know how much Olav blamed himself for the series of losses that punctuated his childhood—his brother's death, his mother's depression, his parents' divorce. There was no environment here in which to develop a cohesive sense of self.

Olav had some internal resources to sustain himself and through which to gain some affirmation, especially his intelligence and professional ambitions. But he was left incredibly vulnerable. We don't know what, if any, social support network was available to help sustain him in his early adulthood. But he clearly lacked the internal resources to weather the loss

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subsequent to his divorce, which also recapitulated his earlier traumas. This loss and re-traumatization, plus a professional mistake, left him defenseless against the brutalizing internalized experience of his father and his father's "God," and so precipitated his decompensation.

It does not take any deep psychoanalytic insight to connect Olav's punitive and brutalizing God-representation to his punitive and brutalizing father. The further question concerns why Olav retained a tie to this tormenting and torturous "God" after he left his father's home and became a successful professional adult with his own wife and children. One obvious answer is that it maintained the tie to his father, but in the process continually recapitulated that relationship of fear and judgment. Did that recapitulation keep hope alive that he might find a way to finally please the insatiably sadistic father, now in the guise of an insatiability sadistic God? Or that he might remain attached to one on whom his vulnerable psyche remained dependent for a meager sense of connection and psychological nourishment? I don't know; but I wonder.

A self-psychological perspective might not only illuminate part of the cause and course of his illness; it would also suggest an additional reason why the VITA Program succeeded where others failed. Self-psychology suggests—to use the title of a famous essay by Heinz Kohut (1984)—that how analysis cures is by providing the patient with a new experience of an empathic and affirming relationship (and a context of interpretation) that the patient can then internalize and use to recreate a more cohesive and efficacious sense of self. By taking Olav's religious preoccupations seriously rather than either ignoring or pathologizing them, or pressuring him to abandon them, as previous treatments apparently did, the VITA program provided an empathic resonance to Olav's his own experience that issues of God, morality, and meaning were matters of ultimate concern.

So, from a self-psychological standpoint, the VITA Program provided an ideal therapeutic matrix that combined an empathic and affirming approach to Olav's religious pre-occupations with a vigorous interpretative stance. Experiences of empathy and affirmation are the necessary supplies from which a more cohesive sense of self can be constructed. But simple expressions of support and understanding by themselves are rarely transformative, as the patient usually cannot internalize them. Interpretation and self-understanding are also necessary if the patient is to "put these experiences on the record" (as a former analyst of mine used to say). Without empathic and affirming relational experiences, interpretations easily become exercises in intellectualization. Without solid interpretation, supportive experiences have little lasting impact. The VITA Program provided Olav with both.

I am suggesting, in line with a self-psychological paradigm, that the primary function of psychotherapeutic interpretation is not to provide new intellectual information or enlarge the patient's capacity for rational understanding (as both Ellis and Skinner, from very different perspectives, claimed). Rather the primary function of therapeutic interpretation is to convey empathy and to facilitate the integration of new experiences (in and out of the treatment room) into the patient's developing sense of self. This also suggests that "mentalization" or "mindfulness" (the development of which is understood as the key to treatment success in the affect-regulation model of Shore and his group [Wallin, 2007)]) is necessary but may not be

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sufficient for major personality change. This may be why there is little empirical evidence that the practice of "mindfulness meditation" *by itself* produces lasting psychotherapeutic change. An empathic and supportive milieu and artful interpretation are necessary if the new experiences produced by these practices are to be relevant for psychological healing. (Of course mindfulness meditation may well produce other forms of spiritual, emotional, moral, and cognitive change, but my focus here is on the alleviation of psychological suffering.) The VITA Program rightly relied heavily on training in meditation and mentalization. But their success with Olav does not argue that these practices, *by themselves*, are so remarkably therapeutic. Rather it suggests that these practices need to be part of a larger psychotherapeutic treatment regime in order to be clinically effective.

IMPLICATIONS FOR THE PSYCHOLOGY OF RELIGION

An important claim made by the psychoanalytic psychology of religion is that religious beliefs and practices have very deep psychological roots in an individual's life history and personality. Many of us have argued for this claim based on psychoanalytic research into patients' life histories (Rizzuto, 1979), developmental theories (McDargh, 1983), and clinical experience (Jones, 1991; Meissner, 1984). Such research and theorizing has more often primarily involved the individual's image of God. But this literature is clear that the psychological concept of the "image of God" refers not simply to ideas about God but to a whole complex configuration of cognitions, affects, memories, bodily sensations, and motivations to action that are based in the relational experiences of early childhood and that develop and transform throughout the life cycle (Moriarty & Hoffman, 2008). The VITA program clearly presupposes such a claim as well. They quite deliberately integrate an exploration of the patient's religious ideas and experiences into the larger, dynamic exploration of the vicissitudes of the patient's development.

However, my impression from many years of working with religiously committed patients (and especially with clergy as patients) is that many think of religion as primarily a set of beliefs or behaviors that are entirely conscious and amenable to cognitive and volitional control. Religious people often seem to assume that purely verbal and instructional approaches and prescriptions can produce lasting change in a person's religious outlook, in their emotional set associated with religion, in their spontaneous moral behavior, or in their relationship to whatever is sacred or ultimate for them. From a psychodynamic standpoint, such assumptions are extremely naïve. And as a clinician who on occasion has had to pick up the pieces when it happens, I have seen how such naïve assumptions can also do much mischief. For it is too easy to blame the devotee when such psychologically and spiritually superficial practices do not, in fact, change a person's life, or the person's deepest spiritual predilections. Or too easy for a person to feel compelled to pretend to have undergone a profound and lasting psychological or spiritual transformation on the basis of a single intense emotional experience, or a passionate rhetorical display, or the adoption of a new moral code. For once the the pretense collapses and the split-off parts of the self return with a vengeance, the devotee becomes burdened with guilt that they have failed in their religious obligations--when, in fact, all that has happened is that denial and repression have masqueraded as spiritual transformation.

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The success of the VITA Program with Olav (and others like him who come with religious and existential concerns) supports the claim that religious phenomena can have deep psychological roots and connections. This case presentation charts a process of interaction between changes in Olav's personality structures and changes in his religious convictions and outlook, changes that other clinicians have also observed in their religious patients (Finn & Gartner, 1992; Jones 1991, 2002). I would argue that the shifts that took place in Olav's religious outlook would have been impossible without alterations in his personality dynamics and self-structure; and conversely that any changes in Olav's character and style necessarily ramified onto and reconfigured his religious beliefs and outlook.

This has obvious important clinical implications for work with religious patients. Change in dysfunctional religious cognitions, affects, and behaviors may well require attention to deeper personality dynamics. And in working with religious patients, even if their religion/spirituality/existential issues are not the direct focus of treatment, at termination the clinician might inquire as to whether the changes brought about by the therapy have also impacted on the patient's religious or spiritual concerns.

This clinical finding also has implications for research in the psychology of religion (a topic slightly tangential to the focus of this paper). Certain aspects of the religious life are clearly accessible to the questionnaire methods of research so common in contemporary psychology of religion. And the refinement of such measures has been exceptionally fruitful and added immensely to our psychological understanding of religion. However, this more clinical discussion suggests that there are other important aspects of the religious life that are not accessible to purely conscious and explicit research methods. This certainly argues for a mixed-method design in the study of religion which would utilize methods designed to tap more unconscious processes; for example projective tests modeled on the TAT or the use of drawings (as the VITA Program did). Such methods do not necessarily have to be psychodynamically based. Cognitive psychological paradigms utilize reaction time studies or subjective priming that also accesses unconscious processes. But these tend more to uncover implicit cognitive processing rather than the dynamic unconscious content referenced in clinical psychoanalysis.

DOES THE FOCUS ON EXISTENTIAL ISSUES EXPLAIN OLAV'S TREATMENT SUCCESS?

This case presentation implies that the VITA Program succeeded with this extremely difficult and regressed patient where others had failed because the VITA Program focused explicitly on religious and existential issues. Since I don't know what Olav's previous "treatments as usual" were, it is hard to evaluate this claim. Above I suggested some reasons, based in self-psychology, why that claim makes sense—by focusing on religious and existential issues, the VITA Program provided an empathic experience for Olav; and by combining empathic and supportive relationships with vigorous interpretations, the VITA Program made it possible for him to use these relationships in a structure-creating way.

On the other hand, the VITA Program's approach to dealing with religious and existential issues brought with it other extremely important therapeutic agents. For example, existential issues were dealt with by journaling and group therapy. So along with existential

concerns came a regular exercise in self-reflection and a group experience. I wonder if the VITA patients received more opportunities for self-reflection and the development of mentalization and more hours of interpersonal group therapy than patients in other inpatient programs. Certainly the milieu therapy processes in the VITA Program are extremely impressive—individual psychotherapy, dynamic group therapy, narrative group therapy, existential reflection group, as well as physical exercise, meditation group, and an art therapy group. While the focus of much of this may be on existential and religious themes (as well as on individual dynamics), along with this focus on existential and religious issues came a very affectively engaging, intense treatment milieu. These intense process factors, both individual and group, surely contributed much to Olav's remarkably successful outcome.

CONCLUSIONS

First, this case illustrates that intensive, relatively brief (12 week), psychodynamically oriented inpatient treatment can produce significant and lasting improvement, even in some severely disturbed individuals.

Second, this case suggests that focused and empathic interventions addressing a patient's religious and existential issues are an important dimension of treatment--at least for patients preoccupied with these issues, issues that existential philosophy claims are implicitly or explicitly the concern of all *Homo sapiens* unless they anaesthetize themselves against them.

Third, this case demonstrates that religious and spiritual beliefs and practices are not simply abstract concepts or emotional expressions but rather that they have deep psychological roots in an individual's history and personality. Thus the full range of the religious life cannot be understood at the purely conscious level. Also, simply affirming creedal concepts or following a code of behavior will not produce profound and lasting psychological and spiritual transformation.

Fourth, I have argued on the basis of this case (as well as other research, such as Day, 2008) that for religion to contribute to human well-being today, religious devotees, while remaining committed to their beliefs and practices, must develop a reflective and self-critical stance on the objects of their devotion.

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