CAN A RELIGIOUS BELIEF BE A PATHOLOGICAL DEFENCE?

A Modified Systematic Literature Review Concerning an Issue Related to the Psychotherapeutic Relationship Interspersed with Case Illustrations from Clinical Practice.

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ATTESTATION OF AUTHORSHIP

I hearby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed…….

Date……

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ABSTRACT

This dissertation is concerned with how psychotherapists appraise the health of their clients' religious beliefs when pathology is suspected to be interwoven with client's belief systems. While the study has a specific clinical focus it has wider implications concerning the confluence between psychotherapists and psychotherapy with religious clients (client's who espouse religious beliefs) and religion within the therapeutic relationship. Freud's dismissal of religion as exclusively a neurotic expression representing individuals' need for Oedipal protection from existential anxiety is found to be an unsatisfactory explanation for the numerous psychological functions of religious beliefs in clients' lives. This study is inclusive of the differing perspectives and forms, both healthy and pathological, regarding religious involvement.

This study uses a modified systematic literature review to search primarily theoretical and clinical literature but also includes two empirical studies looking at the correlation between individuals' religious investment and mental health. From a review of related material it is observed that there are significant deficiencies within the literature about clinical issues related to working with clients' religious beliefs. It is argued that this gap in the literature may be representative of Freud's legacy and felt to have contributed to an avoidant and uninformed 'culture' to be promoted within psychodynamic psychotherapy with respect to religion and the religious beliefs of clients.

Conclusions are drawn with regard to the influence of this 'culture' on the ability for psychotherapist to work in an informed way with their religious clients. Due to the lack of guidance within the field, suggestions are made about the need for psychotherapists to become cognisant of specific therapeutic dynamics when working with clients' religious beliefs. Future directions in research within this area are considered.

CHAPTER ONE

INTRODUCTION

Can a Religious Belief be a Pathological Defence?

This chapter presents an overview of the research topic by combining personal and theoretical approaches to the literature review as well as describing a clinical case that gave rise to the research question. I shall also briefly discuss why a study of religious beliefs within the context of the therapeutic relationship is important to the practice of psychotherapy. I will also describe the content of the chapters within this literature review.

On reflection, I became interested in religion from an early age. I remember when I was seven asking my father: What happens to the 'me' after my body dies? My elderly father's explanation included talk of a "grand design" at work in the universe and that we should live life like a one act play - once the lights go up and the curtain falls "there are no second chances, kiddo". As I got older I realised how different our views of these things were, with my need to conceptualise the 'life force' inside me being an attempt to make sense of the death of my mother when I was four years old. Struggling to comprehend the finality of this event I believe I unconsciously sought to find a way in which to remain in relationship with her.

As a psychodynamic psychotherapist, I practise within an object relations framework and regard myself as a relationalist (Ghent, 2002), which refers to a therapeutic 'position' that privileges the client-therapist relationship. I regard the therapeutic relationship as the catalyst for client growth and change, and use countertransference as a tool, amongst others, to understand clients' psychodynamics. I am an agnostic but have studied and gained a degree in Religious Studies. I became interested in religion[1] within the context of psychotherapy as I became more aware of clients bringing issues related to their religious lives. I was fascinated by my responses to working with their religious issues but felt perplexed by the difficulty I had in identifying with clients' religious experiences and beliefs, on a personal level. I wondered whether other

[1] A definition of religion will be provided in the 'Discussion' section, at the beginning of Chapter Three.

psychotherapists had similar difficulties in relating to religion in the consulting room, and reflected on how little religion had been spoken of, as opposed to spirituality[2], within my psychotherapy training. I was interested in whether this signified an unspoken position psychotherapy took with regards to religion.

The research question evolved from a specific clinical issue (described below) that seemed to encapsulate some of the clinical difficulties I had experienced when working with clients' religious beliefs. While the research question is specific, its implications for clinical practice are broad and this is reflected within the literature review. The question considers whether secular psychotherapists can determine the health of religious beliefs. This study will focus on literature that has attempted to understand the complex role that religious beliefs have in the lives of psychotherapy clients. From this, we may be able to determine when a religious belief is an important area of enquiry during the course of a client's psychotherapy.

A Clinical Example

I would like to present a clinical case that will explain in more detail the conception of the research question and my specific area of interest. I will give a brief description of the client's background, his presenting issue and how it relates to his religious beliefs. I will refer to the client as Simon, which is not his real name.

Simon is a man in his late fifties who presented to my practice having recently received an e-mail from his 18-year old son asking for an explanation about why he had left him and his brother after the separation from their mother. Ten years previously, Simon's wife had decided to leave him and return to the United States with the two boys. This began a drawn-out custody battle that Simon eventually lost. Simon told me he was particularly affronted by his son's "accusation" in the e-mail that he had left his children as he firmly believed that his children had left him. Simon felt that his children's "decision" to leave him indicated their disinterest in him as their father. He felt rejected and betrayed as well as angry that he had allowed himself to become vulnerable by trusting in their relationship. In response Simon unconsciously punished the children by emotionally withdrawing from them.

[2] A definition of spirituality will be provided in the 'Discussion' section.

Accompanying these difficulties, Simon complained that he suffered from "melancholy" particularly around his birthday and Christmas.

Simon had been brought up in a Christian family but as an adult never felt affiliated with the religion and became involved with Buddhism soon after the break-up of his marriage. Simon explained that Buddhism "made a lot of sense" to him and helped him come to terms with what had happened during this time. However, while these beliefs invariably helped Simon to cope during a very difficult period in his life, he also seemed to be using them to justify his emotional withdrawal from his children. He claimed not to need his children, which, he said, was in line with the Buddhist principle of nonattachment. This principle encourages the dissolving of the innate human desire to possess things (e.g. people, possessions etc.) in a way that puts us in conflict with the natural order of attachments being finite. This is different from the developmental usage normally associated with psychotherapy. Buddhism suggests that our unhappiness or suffering comes from the clinging quality within our desire and, in terms of our relationships, that "we [should] no longer believe that our happiness depends on [others'] love for us, or their not leaving, not dying. We're able to surrender to the rhythm of life and death, to the natural law" (Medhanandi, 2003, p. 15).

Mark Epstein (2005), a practising Buddhist and psychotherapist, provides an alternative interpretation to Simon's view of nonattachment. He argues that to deny our desire for the love object only produces further suffering. Instead, Epstein describes nonattachment as needing to be interpreted as a realisation of the limitations of what we have a desire for –our ideals– rather than denying it completely. Religious interpretation of this kind is an inevitable part of religious involvement, however, whether Simon's religious beliefs are theologically right or wrong, true or false, is not what this study is concerned with. Where my interest lies is with how the religious belief is organised within the psychic structure of the individual believer, and what function is 'allocated' to the religious belief.

Some months into our work it became apparent that Simon could not consider the possibility that his decision to adopt Buddhism may be linked to feelings associated with his sense of hurt and loss. Simon's insight would not extend to wondering about

his reasons for being drawn to Buddhism or how well nonattachment suited his underlying emotional conflict. Although I was aware of not wanting to dissuade Simon from his religious beliefs, I felt that we were becoming more embroiled in debates about the rights and wrongs of Buddhism. Consequently, I noticed feeling a tension between my ethical responsibility to uphold Simon's right to his religious beliefs and my professional conviction that religion should be analysable within the therapeutic encounter. However, perhaps I was wrong. Was religion a sacrosanct area within psychotherapy? And, if so, how do therapists determine the boundary between the analysable and the sacrosanct?

After six months Simon decided to end our work, and although he told me it was because the year was ending, it was hard not to feel as if we had experienced a 'stalemate' within the therapy. My efforts to invite Simon to wonder about his melancholy as a possible symptom of needing to defend himself against feelings of intimacy had been rebuffed by justifications that his relational distance was not based upon his past experiences but in accordance with his Buddhist beliefs. The Buddhist principle of nonattachment seemed to fit Simon's unconscious need for an explanation about why he had been hurt (i.e. he had become too attached to his wife and children); it also protected him from the vulnerability of intimacy and allowed him to punish his estranged family without remorse. Simon and I ended our therapeutic relationship in a position that was 'oppositional' rather than 'alongside', indicating that I had not been able to achieve a therapeutic level of empathy with him. What compelled me to understand this in more detail were my continuing doubts about the 'healthy' functioning of Simon's religious beliefs in his life.

It should be noted that I viewed Simon's religious beliefs as part of his overall clinical presentation. Simon exhibited narcissistic personality traits at a borderline level of functioning (McWilliams, 1994). This may have influenced his overall functioning, but, as I am versed in working therapeutically with narcissistically defended clients, it seems peripheral as a therapeutic issue because his personality traits and functioning are not out of the ordinary. I would normally work with this personality type in line with Kohut's (1971) theory on treating narcissistic clients. This would mean avoiding confronting Simon's narcissistic defences by working to build a strong therapeutic alliance using empathy as the therapeutic intervention. The fact that I had confronted

Simon's defences made me wonder whether my unconscious reaction (countertransference) towards Simon's religious beliefs had influenced the way I would normally treat a narcissistically structured client. Narcissistic clients are generally considered notoriously difficult to engage with in long-term therapy (McWilliams, 1994), however, Simon's reason for leaving therapy would seem more credible on the basis that he felt his religious beliefs were being threatened by our work.

A Hypothesis

It is interesting to note that Simon sought the help of a psychotherapist rather than his Buddhist teacher for the issue he was struggling with. My thinking is that Simon knew on some level what he needed was not religious guidance but a way to separate out the sources of his internal conflict. The diagram below is part of my ongoing hypothesis about the relationship between religion and the individual's belief.

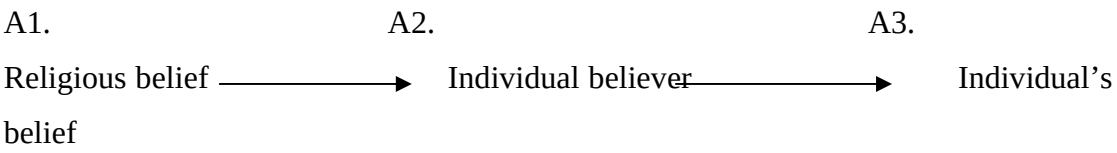

Figure 1.1 The internalisation of a religious belief.

A1. The religious belief is a construct of the religion. The belief may be intended to function in a certain way for the believer (e.g. promoting a reliance on God) or it may have a default function that is not necessarily intended by the religion, such as surrendering agency.

A2. The religious belief is internalised by the believer.

A3. The belief becomes the individual's and is unconsciously allocated a psychological function, which can be determined by a mixture of the religion's intention for the belief, the believer's interpretation of the belief, and the psychological make up of the believer.

I will be examining the theoretical and clinical viability of this hypothesis and will be adding to it (in the 'Discussion' section) as my understanding of the relationship between psychopathology and the unconscious use of religious beliefs develops. Once completed this hypothesis could be tested in a future quantitative study.

To reiterate, I am interested in looking at how the belief functions in the mind of the believer rather than whether the religious belief *per se* is right or wrong, true or false. The clinical dilemma I had encountered with Simon seemed to involve my own beliefs regarding religion as much as determining the clients' relationship to their religious beliefs.

Religion and Psychotherapy

Pruyser (1974) suggests that 'unbelief' has the same psychological value to an individual as a belief; in other words, the state of 'unbelief' is a 'belief'. Potentially, the secular psychotherapist holds their unbelief with as much value as the client holds their religious belief. This diametrically opposed position between therapist and client can have implications for emergent countertransferential reactions in the therapist. Spero and Mester and (1988) consider envy as one possible response: "the therapist's [countertransferential] envy….may further elucidate conflicts or dissatisfactions relevant to religious expression in both the therapist and patient" (p. 47). When working with Simon, I wondered whether my countertransferential envy towards his religious conviction drew attention to a religious longing or repression (Kung, 1990) in myself as much as to a possible unconscious dissatisfaction in Simon that his beliefs were not ameliorating his feelings of melancholy.

Psychotherapists' difficulties relating to or identifying with clients' religious beliefs may stem from a lack of knowledge of what it is to be religious. This position is reflected to some degree in the 'culture' of psychotherapy, which has been described as religiously atheistic. Sorenson (2004) notes that psychotherapists in America are more often than not atheists, with this being the largest percentage of non-religious affiliated mental health workers. This is supported by Bergin and Jensen's (1990) research on psychotherapists' religious involvement, which suggests that psychotherapists are more likely to have spiritual as opposed to religious beliefs.

Sorenson (2004) points out that psychotherapists lack knowledge when it comes to religious issues and are inclined to reproduce the religious cognisance of their own therapists, which, he argues, has created a tradition of religious avoidance within psychotherapy.

Anecdotal evidence suggests that religious issues have the potential to take on a taboo or 'hands-off' quality for psychotherapists. Jones (1996) suggests that psychotherapists' neutral stance is often adopted not out of any hostility towards religion, but rather that this seems "the most respectful position one can take toward that which does not personally endorse or understand" (p. 114). While Brooke (2000) suggests this is based on psychotherapists' well-meaning attempt to be non-judgemental. It would seem that a fear may exist with regards to not wanting to insult the client's sense of propriety, which works to protect the therapist's lack of religious knowledge, possibly leading to an avoidance of the topic altogether. Sorenson (2000) adds, however, that psychotherapists would be doing a disservice to avoid the analysis of religious beliefs as all human experience should be of equal value to the analysis.

Interestingly, these contemporary ideas about psychotherapy and religion seem to reflect to some degree Sigmund Freud's (the founder of psychoanalysis) difficulty with religion. Freud (1927) asserted that all religion is a neurotic defence against individuals' feelings of existential anxiety. The influence of Freud's argument will be discussed in more detail in the 'Historical and Contemporary Perspectives' section in Chapter Three. It follows then that psychotherapists need to equip themselves with a greater understanding and consciousness of issues relating to religion in the lives of their clients.

Description of Chapters

Chapter One has given some background to why I have been drawn to the topic of this study. I have described a case illustration to show how the research question evolved and summarised my thinking using a diagrammatical hypothesis about the relationship between religion and the individual believer. I also provided evidence for why this study is important for psychotherapy and psychotherapists who work with religious clients. Chapter Two describes the methodology used for this study, how it

was applied to the research question and details the strengths and limitations of its use.

Chapter Three begins the literature review with definitions for some key words that help to define the parameters of the study. The sub-heading 'Religion and Mental Health' considers quantitative research looking at whether there are correlations between religious involvement and mental health. Some difficulties are noted in researching religion and in particular finding an applicable measurement of religiosity. Turning to the psychotherapeutic literature, 'Historical and Contemporary Perspectives' considers the opposing arguments relating to religion and psychopathology and shapes the direction of the proceeding inquiry.

Chapter Four begins with 'Religion: Merely An Existential Defence?' and considers whether religion can only be seen as an existential defence and an 'immature' belief or whether it can be motivated by more 'mature' psychological or religious needs. The sub-heading 'Pathology and Religious Beliefs' considers how a psychotherapist might consider the aetiology of psychopathology within a religious belief system from a practical and theoretical perspective. The use of criteria to assess the health of religious beliefs is also discussed. 'Interpreting Religion' considers how interpreting religious beliefs through a psychotherapeutic modality has both strengths and limitations. This is exemplified through the use of a clinical illustration. Finally, 'Ethical Considerations' describes the ethical issues inherent to psychotherapists assessing the health of religion using a psychotherapeutic lens. Personal and professional values and beliefs are considered as possible factors influencing therapists' appraisal of religious beliefs.

Chapter Five is the 'Discussion' section and focuses on what has been brought to light through the information drawn from the literature review. Comments are made about how the 'culture' of psychotherapy views religion within the therapeutic encounter. Inferences are made about the scarcity of material regarding this research topic. Some suggestions are provided to help psychotherapists become informed of the lack of guidance offered from literature and the need to educate themselves with regards to working with religious clients. Reference is made to the first case illustration and the

initial hypothesis is added to, as a reference for future research. Finally ‘Limitations of the Study’ are considered and suggestions for ‘Future Research’ are described.

CHAPTER TWO

METHODOLOGY

This study uses a modified systematic literature review to collate and synthesise material pertaining to the research question: can a religious belief be a pathological defence? The study incorporates case illustrations to emphasise certain aspects of the literature. A systematic literature review is a specific research tool which attempts to locate and then synthesise as much of the literature about a specific clinical question. Ordinarily, a systematic literature review is used by medical practitioners to review quantitative research studies about a medical intervention. The modification to this systematic review implies that this study is not solely focused on quantitative research but instead allows for a broader collection of different types of literature pertinent to the topic, including some quantitative studies.

Using this methodology, a question is formulated from the clinician's practice and is researched through a systematic process of reviewing the literature regarding the specific topic. Once the review has been completed, the research will not only help to inform the individual practitioner's clinical work but more importantly will further the profession's understanding of a specific clinical issue. An important outcome of conducting a systematic literature review is that it stimulates additional research questions about related topics for future studies.

Systematic literature reviews have become a standardised research tool for evidence-based practice. This is a model for health care created by the medical establishment to make the conversion of research into clinical practice more accessible to clinicians. It has been noted that clinical research is both costly and time consuming for practitioners (Parry, 2000) with systematic literature reviews providing a cost effective and time saving alternative. A systematic literature review is advantageous in terms of the breadth of knowledge it gathers about a particular topic, as compared with results from a single quantitative research study.

However, psychotherapists have noted some problems with evidence-based practice due to it being a medical model of health care that is accustomed to measuring

intervention outcomes, which are expected to capture empirical evidence for practice e.g. Randomised Controlled Trials (Hinchelwood, 2002). Measuring the outcome of psychotherapeutic interventions, such as empathy, on the therapeutic relationship is noted to be more diffuse, with clinicians being aware of the inherently subjective nature of appraising therapeutic changes. This tension has caused some to argue that, in order for psychotherapy to successfully utilise the strengths of evidence-based practice, it needs to be adapted to account for the unique qualities inherent to the practice of psychotherapy. Starcevic (2003) suggests that psychotherapy needs to formulate "its own criteria on the basis of which usefulness of psychotherapy can be assessed" (p. 280), while Sanderson (2002) concludes that this "is paramount to the survival of psychotherapy as a viable treatment" (p. 3). These assertions are based on the need for psychotherapy to be considered an ethical, legitimate and credible form of health care. Systematic literature reviews provide psychotherapy researchers with an excellent platform from which to research specific clinical questions as well as identify areas within the literature that require further research.

The Literature Search

The question for this modified systematic literature review was born out of my experience of working with a specific client but encapsulated a number of difficulties that were apparent from working with other religious clients in my practice. A brief search of the literature for my initial research proposal suggested that there was a very small amount of literature specifically relating to the research question. Consequently, I widened the scope of the question to be more inclusive of the literature that considers the relationship between religion and mental health - the material specifically relating to the research question was a subset of this larger pool of literature.

The following describes the exclusion criteria for this literature review. This study has excluded the literature that relates to spirituality and psychotherapy. Due to this being an important parameter of the study it has been explained in detail within the following chapter ('Definitions'). This study also excludes literature that considers the involvement of religion and religious beliefs with psychosis or psychotic illnesses such as schizophrenia. The reason for this exclusion is due to my clinical caseload; this comprises of clients who espouse religious beliefs but who do not suffering from

psychotic illnesses and hence my experience of working with this client population is limited. It is also noticeable within the literature that there is a division between what is written about neurotic[3] clients with religious beliefs and psychotic clients who are religious. This apparent difference has led me to believe that a separate literature review about the topic would need to be done to do justice to the specific peculiarities of this client population and for this reason I have decided to exclude this literature from the present study. The study will also exclude material written in languages other than English.

I used the following databases for my searches: PEP, EBSCO MegaFile Premier, ProQuest International 5000 and PsychINFO. I began by using key words specific to the research question and then widened the search by using words that included literature pertaining to religion, psychopathology and neurosis. The two variations in spelling of defence (defense) were used in order to obtain full coverage of the literature.

Table 1: PEP

Search Words	Results	Useful
Religious belief	335	9
Religious belief and defence mechanism	105	2
Religious belief and defense mechanism	236	3
Religion and neurosis	143	5

Table 2: EBSCO MegaFile Premier

Search Words	Results	Useful
Religion and defense mechanism	152	7
Religion and defence mechanism	18	0
Religion and neurosis	49	2
Religion and psychopathology	251	3

[3] A definition of 'neurosis' will be given in the 'Discussion' section in Chapter Three.

Table 3: ProQuest International 5000

Search Words	Results	Useful
Religion and defence mechanism	30	3
Religion and defense mechanism	30	2
Religion and psychopathology	88	0

Table 4: PsychINFO

Search Words	Results	Useful
Religion and defense mechanism	50	3
Religion and defence mechanism	0	0
Religion and psychopathology	234	5

I used bibliographies and reference lists to source further material relevant to the topic. I was also recommended literature and authors by colleagues and tutors. While this is a modified systematic literature review, it included some non-systematic collection of data. For example, on one occasion I used the Google search engine on the internet to search for an out of print article and found a bibliography at www.freud.org.uk/biblio2.html, which contained an extensive list of relevant papers and books about Freud/psychoanalysis and religion.

Critique of the Methodology

Using a modified systematic literature review for this research question proved to be a good match for a number of reasons. It is noteworthy that to date no one has attempted to synthesis the literature about this topic under one umbrella. This meant that the methodology employed needed to allow for coverage of a wide area of sources and material. The methodology used, enabled this breadth of perspective and, as a result, applicable material could even be gathered from across disciplines. One example was an important paper written for the *Clinical Social Work Journal* (Northcut, 2000) specifically about psychodynamic psychotherapists working with religious issues. This highlights the benefit of having applied a systematic literature review to this research question. Using this methodology also helped to identify the

significant gaps in the current literature and brought about questions for future research that consider how psychotherapists work with the religious beliefs of their clients.

Some limitations of the methodology were also considered. While the methodology gained perspective in allowing for a broad search of the literature, the study may have relinquished some of the clinical focus of the research question. This is due in part to the question itself because it relates specifically to how therapists appraise and understand the way in which religious beliefs function for their clients. While the clinical illustrations provided a way in which to highlight points of discussion taken from the literature, they could not provide a comprehensive clinical perspective from which research conclusions could be drawn. Perhaps a methodology that enhanced this clinical focus, while providing less overall scope, could prove invaluable in addressing psychotherapists' experiences of working with clients' religious beliefs. Such a methodology may also have to be substantially longer in order to have the room to compile a sufficient number of case studies for conclusions to be drawn.

CHAPTER THREE

LITERATURE REVIEW

Definitions

In order to delineate the parameters of this study I will first provide definitions for some key terms relating to the research topic. This will include a working definition of 'religion' in contrast to a definition of 'spirituality' for exclusion purposes, and an explanation and definition of 'pathological defence'. I will also provide a definition of 'neurosis' due to the frequency with which it is used within the literature regarding the pathological aspects of religious beliefs.

Opinions vary widely about a 'true' definition of religion or whether this is even possible. My intention is to find a working definition as opposed to a philosophical definition of religion for the purpose of this study. The definition will include Buddhism as a religion (this will be qualified on the following page) rather than, as some have argued, a philosophy of living. I have chosen not to use 'spirituality' as part of this study because it is far more diffuse than religion and would incorporate a separate body of literature. This decision is influenced by the clients whom I have seen in my practice, who recognise themselves as having 'religious beliefs' and belonging to a formalised religion as opposed to holding spiritual beliefs and being spiritual. However, the following discussion shows the difficulty in trying to extract a working definition of religion without incorporating some component of spirituality.

Pargament (1997) defines religion as "a search for significance in ways related to the sacred" (p. 32). The 'sacred' refers to concepts "of God, the divine, the supernatural, the metaphysical, and the transcendent" (Pargament and Mahoney, 2004, p. 482). Pargament and Mahoney (2004) construe spirituality as the "most central function of religion - to facilitate the search for the sacred" (p. 482). Pargament (1999) argues that it is impossible to isolate a definition of religion from spirituality without erroneously representing the essence of what religion is, as all religions, he suggests, incorporate a spiritual component. This is a valid point. However, because of a growing group of individuals who claim not to have religious, only spiritual, beliefs (Hill, Pargament,

Hood, McCullough, Swyers, Larson and Zinnbauer, 2000), there needs to be a way of recognising a difference between them for this literature review.

Spirituality is a difficult concept to define as it relies less upon formal or institutional directives and principles and more on an individual system of belief, sourced from subjective experience. For the purpose of excluding spirituality from this study I will use the following definition of spirituality: Spirituality is an experience, concept, or aesthetic sense that is born out of the individual and their desire for connection with what is individually felt or understood to be the numinous. This is not limited by formalised principles or necessary beliefs but is uniquely created from the individual's experience of the external, internal and ethereal world. Lerner (2000) writes, "Spirituality is, first and foremost, a way of orienting to the world, a way of being and knowing, that emphasizes awe, wonder, and radical amazement at the glory of creation and the splendor [sic] of the universe" (p. 41).

In contrast, when I speak of religion I will be referring to a formalised "search for significance in ways relating to the sacred" (Pargament, 1997, p. 32) (sacred being a divine being, divine object, Ultimate Reality, or Ultimate Truth), with this search for the sacred being validated by an identifiable group of people or community (Hill et al., 2000). While attempting to segregate spirituality from religion for this study, I would concur with Pargament (1999) that religion can hold a component of spirituality. Buddhism is included in my definition of religion as I have used 'Ultimate Truth' as part of the definition. When referring to a religious belief I will be describing an individual's "propositional statement asserting the 'truth' about what is real or what matters" (Griffith and Griffith, 2003, p. 139) about their religion.

I will now provide an explanation and definition of 'pathological defence'. Within the context of this study pathology relates to unhealthy or maladaptive psychological functioning. However, determining what is pathological raises the question, how do psychotherapists assess the health of religious beliefs? This is a central question of this study and will be addressed in more detail within the 'Ethical Considerations' section. In the meantime, pathological will be more easily understood in conjunction with a definition of defence.

Within psychoanalytic theory a defence is a mechanism employed by the ego to protect itself when in conflict with "instinctual representatives and affects" (Freud, 1956). Object relations theory views defences as being less concerned with 'instinctual representatives' or structural conflicts (St. Clair, 1996) and more with the way in which an individual has adapted or maladapted to their relational environment while growing up. Defence mechanisms (withdrawal, denial, projection, repression, regression, isolation, intellectualisation, displacement, etc) (McWilliams, 1994) allow the individual to make sense of their environment while protecting themselves from any perceived threat to the self.

A healthy or adaptive defence mechanism is one that allows an individual to grow emotionally or to express themselves creatively. For instance, the ability to empathise with another's feelings means being able to "project [a defence mechanism] aspects of our own experiences into that person, and then take them back introspectively in a way which mirrors the other's wants or needs" (Schermer, 2003, p. 95). In contrast, an individual who is unable to be empathic might not be able to afford such a projection due to a lack of distinction between self and other, which would jeopardise a vulnerable sense of self. Instead, a defence such as devaluing the other might be used by this individual to defend against the possibility of feeling merged by the experience of another. A defence is a psychic compromise that is needed to maintain a satisfactory level of safety to the self. However, a defence becomes maladaptive when the psychological 'cost' of maintaining the psychic compromise begins to outweigh the benefits, impeding the individual's psychological functioning. Unhealthy, maladaptive and pathological defence mechanisms manifest rigidity, concreteness and lack resilience within the individual (Schermer, 2003).

Finally, many writers use the word 'neurosis' when referring to the pathological derivatives of religious beliefs. Psychiatric manuals such as the DSM IV (2000) have abandoned the use of 'neurosis' to describe a particular disorder, however the disorders neurosis used to describe still exist, albeit under different labels (Pfeifer, 1994). This has not lessened the use of neurosis as a term within psychodynamic psychotherapy. McWilliams (1994) describes neurotic personality structure as a level of psychic functioning that she considers as being more adaptive than borderline or

psychotic levels of functioning. Pfeifer (1994) provides a definition, which will be used for this study. He defines neurosis as

> "psychological disorders with certain symptoms – anxiety, obsessions and compulsions, depression, hysterical hypersensitivity- and with certain personality traits, such as inhibitions, insecurity, emotional instability, and scrupulosity. Reality testing is usually intact. Disorders of thoughts and emotions are often accompanied by functional somatic complaints" (p. 90).

For a more detailed analysis of neurosis, I would refer the reader to *Psychoanalytic Diagnosis* by Nancy McWilliams (1994).

Religion and Mental Health

The psychology of religion arguably began as a discipline with William James's *The Varieties of Religious Experience* (1902) at the turn of the 20th Century. There has been a renewed interest in this area of research in recent times, with particular emphasis upon understanding the relationship between religion and mental health (Pargament, 2002). Interestingly, writers and theorists from the psychotherapy tradition have written far less about this intersection. This makes me wonder whether Freud's influence has promulgated an attitude within psychotherapy of appreciating only the costs of religious involvement as opposed to a more balanced understanding of religious experience and mental health. Smith (1990) considers this and suggests that it would be dangerous for psychotherapists to hold preconceived ideas regarding the psychological costs of religious beliefs. Pfeifer and Waelty (1999) formulate from their overview of empirical research done since Freud that there have been numerous papers written "describing religion as a factor contributing to psychopathology" (p. 36), however, over the last 30 years there has been a move towards "showing far more beneficial associations between religion and mental health" (p. 36). This switch within the literature is considered by researchers such as Pargament (1997, 1999, 2000, 2001, 2002), who has written extensively on the relationship between religion and coping (and its effects on mental health) and provides an even-handed approach to the psychological costs and benefits of religiousness. He suggests that religion can be particularly

> "valuable to people when they are facing problems that push them to the limit of their own personal and social resources, exposing their basic vulnerability to the world. In response to situations that point to human finitude and insufficiency religion provides spiritual support, ultimate explanations, a sense of larger, benevolent forces at work in the universe, and a purpose in life that holds sacred significance" (1997, p. 170)

Pargament (2002) argues that the value of religious involvement is dependent on "the kind of religion, the criteria of well-being, the person, the situation, and social context, and the degree to which the various elements of religious life are well-integrated into the person's life" (p. 169). Researchers are often hampered by such variables, for example Maton (1989) looked at the influence of "spiritual support i.e. perceived support from God, to well-being for several high and low-stress samples" (p. 310). It was found that "individuals under high levels of life-event stress [i.e. bereaved parents] are likely to benefit from perceived spiritual support", however "no

significant relationship between spiritual support and well-being [was found] for the low-stress subsamples" (p. 319). I note that Maton did not consider the personality (e.g. emotional maturity, coping skills) of the individual believer within the relatively small sample size of 101, and nor were a variety of life-stressors used for wider analysis. The research also did not mention how therapists, pastors or congregation may have influenced the individual's perception of 'spiritual support'.

More recently, Pfeifer and Waelty (1999) "explore the interrelationship of neuroticism and religiosity [Christian religion] in clinically diagnosed patients compared with a group of healthy controls" (p. 35). Pargament (2002) notes that studies looking for correlations between religiosity and mental health struggle to provide a distinct measurement of religiosity. Hood, Spilka, Hunsberger and Gorsuch (1996) critically observe that "virtually no study dealing with mental disorder goes beyond some vague breakdown of religiosity based on frequency of church attendance or a designation of individuals as Protestant, Catholic, Jewish and other" (p. 409). Pfeifer and Waelty's (1999) research also struggles to measure religious involvement to a degree that allows for "far-reaching conclusions" (p. 44) and they note this limitation within their findings. The results of the study do not "support a monocausal correlation of neurotic conflicts with the religiosity of an individual" (p. 44). However, interestingly, Pfeifer and Waelty (1999) conclude "that the primary factor in patients who display religious conflicts and anxieties seems not to be the degree of religious commitment itself but rather their underlying psychopathology" (p. 44).

Pargament's (2002) assessment of the research that considers whether religion is helpful or harmful to mental health concludes that "it depends" (p. 169) as there are both costs and benefits to religious involvement. The research examples above highlight some of the difficulties involved in finding a way of studying religion and mental health that does justice to the complexity of the topic. It seems that finding a satisfactory measurement of religiousness proves difficult to isolate. Pargament (2002) suggests, researchers may benefit from getting closer to the religious experience of subjects, which can help with creating a more "finely delineated measure of religion" (p. 178). For further research suggesting the positive influence of religious commitment on mental health and well-being, I would direct the reader to Bergin (1983) and Gartner, Larson and Allen (1991).

One attempt to define a measurement of religiosity was partially achieved by psychologist Gordon Allport (1950) who defined intrinsic (mature or internal) religiosity as a system of belief that is seen to be open, flexible, tolerant and compassionate (Lowenthal, 1995). He contrasted this with extrinsic (immature or external) religiosity, which is associated with a higher level of prejudice and is a form of religion motivated by "status, self-esteem and other gratifications" (Lowenthal, 1995, p. 116). Using these categories Allport and Ross (1967) devised the Religious Orientation Scale, which aimed to measure levels of prejudice felt to be indicative of the health of religious motivation within Christian populations. The limitation of the scale is that it is culturally and historically value based, which means that it is not transferable for research into other religious groups. Pargament (2002) critiques the scale by arguing that although high levels of prejudice have been noted in fundamentalist religious groups, research suggests that there are significant benefits to a fundamental mentality:

> "strict systems of religious belief and practice provide individuals with an unambiguous sense of right and wrong, clear rules for living, closeness with like minded believers, a distinctive identity and most important, the faith that their lives are sanctioned and supported by God" (p. 172)

Pargament (2002) notes a correlation between fundamental religion and optimism, religious and spiritual well-being, and marital happiness.

Allport and Ross's (1967) categories go some way to determining the health of religious beliefs (the scale is still used in research today). However, the scale's specificity has become its limitation, which has meant that it is often seen to be used in conjunction with other assessment criteria to create a more inclusive perspective of religious health. It should be noted that Allport and Ross used a psychological, as opposed to a psychodynamic, framework for their research and are concerned with conscious rather than unconscious religious motivations.

For the reasons I have mentioned, quantifying the effect of religion on mental health has proven to be difficult for researchers to substantiate and may account for the lack of research done in the area. This means that psychotherapists are perhaps less likely to use or rely on quantitative research for understanding the possible effects religion can have on their clients' mental health. The question of what psychotherapists use to

base their appraisal of the health of religious beliefs will be discussed in detail within the ‘Ethical Considerations’ section in Chapter Four.

I will now turn to the psychotherapy literature to view the question of religion and religious beliefs from a historical and contemporary psychotherapeutic perspective.

Historical and Contemporary Perspectives

A discussion involving psychotherapy and religion must include Sigmund Freud, not just as the founder of psychoanalysis on which modern psychodynamic psychotherapy is based, but because Freud was preoccupied with questions concerning religion. It is useful to juxtapose Freud's position to Carl Gustav Jung's (a psychoanalyst writing at the same time as Freud) as this highlights some of the opposing positions in the ongoing polemic within the psychotherapy literature about how to understand the function of religion in clients' lives. It must be noted that both Freud and Jung write within a white, Western, Judeo-Christian tradition and, although they use the word "religion" quite generally, they are referring specifically to their experience and knowledge within this tradition.

The Future of an Illusion (1927*)* was Freud's most comprehensive psychoanalytic theory for the creation of, and belief in religion. In anticipation that his critique of religious beliefs would be challenging to the religious establishment, Freud reminds the reader that his assertions are by no means new (Freud, 1927, p. 31). Rice (1999) notes that Freud's argument concerning the "seemingly irreconcilable frames of reference" (p. 397) of the rational and empirical versus the transcendent have been debated for centuries by philosophers. In *The Future of an Illusion* Freud (1927) asserts that religion is "the universal obsessional neurosis of humanity" (p. 39). He believed that religion "arose out of the conflictual relationship to the father" (Rice, 1999, p. 402) stating that man's

> "longing for a father is a motive identical with his need for protection against the consequence of his human weakness. The defence against childish helplessness is what lends its characteristic features to the adult's reaction to the helplessness which he has to acknowledge – a reaction which is precisely the formation of religion". (p. 20)

Freud suggests that without a 'religious illusion' "men will have to admit to themselves the full extent of their helplessness….no longer [being] the object of tender care on the part of a beneficent Providence…..men cannot remain children for ever; they must in the end go out into 'hostile life'. We may call this '*education to reality*'" (p. 45).

Freud believed that it is from our fear of death, the unpredictable forces of nature, and the deprivations that are inevitable in life that we are propelled to create institutions

such as religion that help us master our existential anxieties. Freud (1927) argued that those who invest in religion distance themselves from reality, allowing the faithful to inherit a universal neurosis, which, he argues, protects them from the more mature psychological "task of constructing a personal one" (p. 40). Freud's dictum on the neurotic nature of religious belief must be seen in terms of the post-Enlightenment (Quinodoz, 2005) milieu in which he was writing, as his argument relies heavily upon the belief that science is the only way in which to acquire true knowledge about the self (Rice, 1999). Freud (1927) writes in retort to an imagined critic, "No, our science is no illusion. But an illusion it would be to suppose that what science cannot give us we can get elsewhere" (p. 56).

In response, Black (1993) argues that Freud sought to denounce religion by qualifying it as a science, "essentially, he [Freud] sees religion as a science-like thing, making factual claims about the real world. Religion, therefore, can be refuted by pointing out the absence of observational evidence in its support" (p. 614). He also states that Freud made no effort in *The Future of an Illusion* to enquire "into the depths of actual religious experience" (p. 614). Meissner (1984) concurs by arguing that Freud's understanding of the function of religion is too simplistic and fails to recognise the complexity and variants of its function. He also challenges Freud's suggestion that a belief in religion is an exercise in "passivity, compliance, and dependence" (p. 58) on the basis that Freud allows for no consideration of a more mature religious position. Meissner is suggesting that religious beliefs can be categorised into 'healthy' and 'unhealthy' forms. Carveth (1998) notes the importance for psychotherapists to appreciate that "apparently similar religious beliefs and practices mean very different things and perform very different functions for different people" (p. 141). May (1997) considers the significance of viewing the religious belief within the context of a client's history, psychosocial development and psychological diagnosis. Guntrip (1969) suggests that Freud is being a reductionist to assert that all religion is a neurotic dependence. He states that just because religious beliefs have the potential to be a form of neurotic expression does not imply that all religious beliefs are pathological or neurotic.

Pruyser (1977) and Ellis (1986) provide contemporary support for Freud's position by highlighting the particular cost to the individual, which they argue is antithetical to the

goals of psychotherapy. Like Freud, Pruyser supports the idea that religion disposes people to sacrifice intellect, agency and freedom in the interest of regressive elements of the psyche (Leavy, 1993) by accepting as 'truth' the precepts of the religion. Pruyser suggests that there is a link between the 'psychological' health of the religion at an institutional level and the health of the individual and their beliefs. He argues that if the religion is unhealthy (neurotic) then the individual will inherit this dysfunction when internalising the religion's beliefs, motivation and dynamics. Pruyser's rather damning appraisal of formal religion must be seen as a response to the Evangelical movement in America during the seventies, which he mentions. He does concede, however, that if religion were to be 'healthy' it would have to promote freedom in order to facilitate positive growth. He comments, "I regard an enlarged sense of freedom as a sign of a psychological, moral and spiritual health" (p. 348).

Somewhat surprisingly perhaps, Pruyser also supports early object relations theorist Winnicott's (2001) concept of "transitional space" (p. 211) and its involvement in creating a mature form of religious belief. Winnicott's theory of transitional space has been used to locate religious concepts within the psyche by a number of prominent theorists (Meissner, 1984; Rizzutto, 1991). Winnicott proposed that transitional space was a third realm of human experience which bridged the split between the subjective and objective realities, the public and private spheres (St. Clair, 1994), describing it as existing "outside, inside, at the border" (Winnicott, 2001, p. 211). He asserted that the transitional space was created from the interpersonal interactions between parent and infant in the beginnings of life. Winnicott (1990) sought to show that a "child's capacity to transcend the dichotomies of inner and outer reality continues to grow" (Jones, 1996, p. 141) and "throughout life [this capacity] is retained in the intense experiencing that belongs to the arts and to religion and to imaginative living, and to creative scientific work" (Winnicott, 1958, p. 14). Winnicott (2001) challenges Freud's understanding that religion is an illusion by suggesting that illusion (imaginative living) is actually concordant with healthy psychological development. Pruyser (1977) concurs, arguing that throughout life a healthy fantasy world enables us to create, to play and find meaningful connection with the external world and is possible without jeopardising our perception of reality.

Albert Ellis the founder of Rational Emotive Behavioural Therapy wrote *The Case against religion: A psychotherapist's view and the case against religiosity* (1986), which gives a candid appraisal of the psychological costs of religious involvement. Ellis (1986) complements Pruyser's position by suggesting that what religion sacrifices are the elements that psychotherapy tries to develop and maintain in the client. Ellis argues that religious beliefs do not alleviate existential or personal anxieties; to the contrary, religion creates further internal conflict by promoting a form of absolutism where the convert becomes consumed with anxiety and excessive guilt when trying to maintain permissible standards according to the religion's doctrine (Ellis, 1986). He adds that religion can be equated with a mental illness as it promotes irrational beliefs which keep people "dependent, anxious, hostile and thereby create and maintain their neuroses" (p. 34).

Like Freud, Ellis's argument relies heavily upon the certainty that religious expression is irrational and therefore unhealthy. For this reason, Ellis argues that the incongruent goals of religion and psychotherapy are reflected in psychotherapy's difficulty in accepting religious beliefs as a non-defensive expression (a mature expression) that supports mental health and self-awareness. In my view Ellis's argument lacks subtlety, which harks back to Freud's unilateral perspective on religion. The question of whether religion can only be conceived as an existential defence is considered in more detail in the following chapter. However, this constant return to Freud by the contrarians of religion is a pattern I have noticed within the literature.

In contrast, Jung differentiated himself from Freud through, among other things, his ideas on religion. Jung (1938a) postulated that 'religion' is an "instinctive attitude peculiar to man" (p. 361), which signifies "a consciousness which has been changed by experience of the numinosum." (1938b, p. 240) The function of this instinct is to maintain a psychic balance by retaining a relationship to the numinous through the manifestations of our unconscious. Jung believed 'religion' describes our capacity to believe and have particular forms of thought (MacKenna, 2000), and through a process of psychoanalysis this function is utilised, allowing us to 'listen' more adeptly to the symbols and archetypes represented within the unconscious. Jung suggests that by completing this task we are enabling access to the divine within ourselves (MacKenna, 2000). He saw the cultivation of this religious capacity as integral to

maintaining a healthy human psyche, which, if ignored or repressed, would place us at risk of developing mental illness (Ulanov, 2004).

For Jung, the place of religious realisation and growth was integral to a client's psychotherapy treatment and is attested to when he reflects on his practice: "Among all my patients in the second half of life – that is to say, over thirty-five – there has not been one whose problem in the last resort was not that of finding a religious outlook on life" (Jung, 1933, p. 226). Jung practiced psychotherapy in a way that privileged fostering religious growth in the client. He saw the psychotherapist's goal as being to reconnect the individual to their unconscious and to a divine collective mythology (MacKenna, 2000). However, Zinnbauer and Pargament (2000) critique Jung by arguing that he held an "elevationist" (p. 163) position with regards to religion by viewing "psychological problems [as] essentially religious problems" (p. 163).

There are similarities between Winnicott's argument that the use of imaginative processes from within the transitional space allows for an increased capacity for experience in external reality and Jung's argument that the psychic capacity to hold religious beliefs is fundamental to healthy mental functioning. Both agree that this capacity strengthens an individual's links with external reality, which opposes Freud's assertion that religion (an illusion) distances the individual from reality.

Freud's position on the role of religion is a reductionist one in my view and negates the possibility of a form of religious belief that is healthy. In contrast, Jung's view that religious involvement is central to mental health is arguably too exclusive (although he acknowledges religions potential for neurotic as well as constructive expression) (Wyatt, 2004). Both provide an extreme position regarding the role of religion in mental health, but in order for a psychotherapist to determine whether a religious belief can be a pathological defence there needs to be a way to determine a 'healthy' from an 'unhealthy' religious belief as Meissner (1984) has suggested.

The argument that a line can be drawn between the two forms - healthy and unhealthy -religious belief has been contested. Rempel (1997) challenges Meissner's (1984) argument that Freud failed "to distinguish between healthy and unhealthy forms of religious expression and belief" (p. 231). In retort, Rempel states that it would be

impossible to assess the health of a person's religious belief by categorising positive and negative aspects of these beliefs and their potential impact on the client. He argues that this would rely too heavily upon the therapist's subjective appraisal of the criteria, which would distort the accuracy of such an assessment. In response to Rempel's critique of Meissner (1984) and Kung (1990), who both attempt to define religious beliefs in this way, Carveth (1998) states:

> "if such distinctions are disallowed in the field of psychoanalysis of religion then they must be equally disallowed in clinical psychoanalysis and, therefore, we shall have to abandon efforts to distinguish the normal from the pathological, the authentic and the inauthentic, the mature and the immature, in every domain of mental life" (pp. 143-144).

I concur with Carveth's position but also suggest that there is an apparent incongruence between these two arguments. The distinction between them lies in the differing premise their arguments are built upon. Rempel follows Freud's assertion that religion is an illusion and therefore can not be considered rational on the basis that it is not grounded in principles of empirical truth. This argument is concerned with an epistemological assessment of the belief in religion. In contrast, Meissner and Carveth are not concerned with the truth or falsity of the religious belief but in the use and "meaning of the belief in the context of individual psychic reality" (Meissner, 1990, p.114). This difference is observed as Meissner and Carveth consider the need to define religious beliefs on a continuum of functionality within the context of the client's presentation. This consideration could not be possible without concluding that religious beliefs are a human phenomenon that are 'real' to those who believe in them (Spero, 1985). On this basis Carveth and others seek to understand how best to interpret this phenomenon within the context of psychotherapy. Recognising this distinction would seem to shift the focus away from the Freudian position on religion because the intention of the present study is not to quarrel with religion or religious beliefs. However, it is important to consider the psychoanalytic writers who have tried to account for a non-neurotic form of religious belief. This is an area which is discussed in detail in the following section ('Religion: Merely an Existential Defence?'). The focus will then shift to literature ('Pathology and Religious Beliefs') which looks at how to clinically interpret the function of religious beliefs, taking into account the complexity and multifarious expression of religion within the lives of psychotherapy clients.

Summary

In summary, a definition of religion (Hill et al., 2000; Pargament, 1997) and spirituality (Lerner, 2000) was juxtaposed in order to exclude the latter from the study. However, a tension was recognised in separating out religion from spirituality (Pargament, 1999). A combined definition of pathological defence was described (Freud, 1956; McWilliams, 1994; Schermer, 2003; St. Clair, 1996). Finally, a working definition of neurosis was explored (McWilliams, 1994; Pfeifer, 1994).

Two quantitative research studies were described (Maton, 1989; Pfeifer and Waelty, 1999) which focused on the costs and benefits to mental health of religious involvement. It was noted that no conclusive evidence supported a link between only costs or only benefits to mental health, which reflected a trend in research within the field (Pargament, 2002). It was suggested that one problem was finding a specific measure of religious involvement that was sufficient for producing unambiguous findings. One such attempt to measure religion and its link to health, using levels of prejudice, was examined (Allport, 1950; Allport and Ross, 1967). The strengths and limitations of this were described.

Finally, I reviewed psychotherapeutic historical and contemporary perspectives paying close attention to the literature that addressed how psychotherapy views religion and health. Described were the arguments both for (Black, 1993; Carveth, 1998; Guntrip, 1969; Jung, 1938a; Jung, 1938b; May, 1997; Meissner, 1984) and against (Freud, 1927; Ellis, 1986; Pruyser, 1977) the psychological health of religion. I supported the literature that argued that religion could function in different ways, and could be categorised as having healthy and pathological forms (Carveth, 1998; Kung, 1990; Meissner, 1984). I noted that this shifted the present study to literature that considers religion within these terms.

CHAPTER FOUR

Religion: Merely an Existential Defence?

The first person to consider healthy and unhealthy forms of religious beliefs from a psychological perspective was James (1902), who advocated that religion played an important role in maintaining mental health. James determined that there was more than one variety of religious believer and referred to the religion of "healthy-mindedness" (p. 132) versus the religion of the "sick soul" (p. 137). James understood the former group of believers to be constantly optimistic, looking "on all things and see[ing] that they are good" (p. 90). He argued that this form of religion functioned as a defence against existential reality, similar to the argument posited by Freud (1927). James describes the latter group of believers as those who are open to existential reality, acknowledging human frailty but as a consequence are beset by sadness and melancholy.

Beck (2004) offers a contemporary perspective to James's assertion by considering the dichotomy between an existentially defensive and non-defensive motivation for religious beliefs. It could be argued that these are not mutually exclusive forms and that there could be a mixture of motivation for religious involvement. However, Beck argues that defensive religion solves the problem of death by repressing existential anxiety and 'rewarding' the believer with an optimist outlook. He also adds that a "defensive world view must be believed absolutely and protected from threat" (p. 213), which can lead to dogmatic and fanatical forms of religious belief. Alternatively, Beck describes non-defensive religion as those who understand that their religious involvement is no protection from God's judgement and accept that their choices have to be made without "clear information, guidance, or guarantee of success/blessing" (p. 214). Underpinning the motivation for non-defensive religion is faith, which provides the believer with existential solace. This, Beck argues, leads to a more existentially anxious but tolerant and mature believer capable of contemplating new information or challenging dialogue without feeling threatened. I would agree and add that the meaning (and motivation) the client attributes to holding the religious belief (e.g. the reason for conversion) can also contribute to determining whether the belief functions on a healthy or unhealthy level.

From a psychoanalytic perspective, Symington (2004) challenges Freud's thinking that all religion is an existential defence by arguing that there are two forms of religious belief. Using Melanie Klein's (1997) developmental states, the depressive position and the paranoid-schizoid position, Symington describes a mature and primitive form of religious belief. He equates the depressive position with a "mature natural" (p. 197) form of religion, describing this state of mind as an inner spirituality where a person finds

> "meaning in the direction and quality of his emotional activity towards himself and others. The object upon which he places value and in relation to which he acts transcends his own interests, his own desires for power and aggrandizement." (1994, p. 20).

He argues that a mature religious mind has the ability to debate themes such as truth, love, evil and goodness, and allows for authenticity through creative expression. Symington's argument is based on the premise that an individual possesses within them an innate capacity for altruism, which is the source of a mature religious position. It could be argued however, that Symington's idea of a mature religion resembles a spiritual belief rather than one created from a mixture of personal motivations and religious precepts.

Symington (1994) suggests that primitive religion can be equated to Klein's paranoid-schizoid position, which he argues is a type of magical thinking that takes the form of ritual, myth, sacrifice, external symbolism and belief in supernatural beings (Paul, 1995). Symington postulates that the ultimate concern of primitive religion is personal protection and survival; it is a "morality governed by the anxiety to please the one with power so as to ensure my own survival" (p. 15). This position is reminiscent of Freud's (1907, 1913) view on religious ritual as a neurotic appeasement of a deity to quell existential anxieties. While Symington (2004) appreciates that the religious divide between primitive and mature is not clear, he argues that the mentality between them is. However, I would argue that maturity also implies an ability to experience the primitive with an observing self rather than a splitting off of the primitive mind altogether. Like Jung (1938a, 1938b), who felt that rituals were an essential part of religion's ability to link our internal and external realities, and Winnicott's (2001) theory of transitional space, I would argue that the internal process of religion demands that it be anchored in external reality. Through the use of ritual and

symbolism the believer's internal (psychic) meaning can become realised in the external (physical) realm.

Symington argues for an 'evolved' way of religiously believing, which is based on insight, and an open, considered, psychological understanding of the self in relationship to the divine. From this position Symington (1994) concludes that "psychoanalysis is…a mature natural religion" (p. 197). However, I would agree with Paul (1995) who argues that Symington creates an "over-simplified dichotomy, according to which if something isn't a science, then it must be a religion, and the only question is whether it is a good, mature one – 'a spirituality' – or a bad, superstitious one" (p. 1061). Symington's view of religious expression is reliant upon the assumption that the individual has a capacity and appreciation for insight. He seems determined to make religion conform to a psychoanalytic framework and in doing so removes much of what seems to make a belief in religion 'religious'. I would argue that an essential component of religion is lost once you reduce religion and religious experience to insight and right moral action. Rizzuto (1991) concurs, arguing that to reduce religious beliefs to a mere mental conception or "analytic translation cannot be done without doing violence to it" (p. 577).

It should be noted that Symington's categories of primitive and mature religion might be used as a way to understand the client's level of religious functioning, but are less concerned with understanding mental health or psychopathology. This can be appreciated if we imagine an individual who is seen to have 'primitive religious beliefs' but who exhibits no unhealthy psychological symptoms or underlying psychopathology. Similarly if Simon, in the first case illustration, did not have symptoms of melancholy then it might be argued that his defences were working at a level that allowed him to function adaptively. However, his symptomatology signalled that his defences had become maladaptive.

Pathology and Religious Beliefs

William W. Meissner has a unique vantage point from which to consider religion and psychotherapy. Meissner, a Jesuit priest, psychiatrist and psychoanalyst, has written extensively on the creation of pathological religious beliefs and provides a useful framework to understand the theorists that follow.

Meissner (1996) suggests that there are multiple dimensions to the question of pathology in religious belief systems. He explains that "any belief can become a vehicle for expression of neurotic forces and conflicts in the person's psychic makeup, whether as symptoms or as character pathology" (p. 242). Similar to Pruyser's (1977) earlier assertion, Meissner differentiates between the possible dysfunction of the religious system and the health of the individual's system. He states that pathological beliefs can be "found in the belief system itself [the religion], regardless of the neurotic use any given patient might make of it" (p. 242). However, it has been noted that individuals will naturally be inclined towards religious systems that reflect their own belief systems (but not always; e.g. those who attend church to psychologically absolve themselves of guilt about immoral behaviour/acts). In terms of dysfunction, Meissner (1984) suggests individuals will seek out religious communities and beliefs that support their personal psychopathology. Paranoid personalities for instance, can be drawn towards fundamental or cult religious groups because of their tendency to be motivated by fear and distrust. Such religious communities will provide ways in which to cope with this world-view, often incorporating defences such as projection (onto a perceived enemy or scapegoat - the state, the devil, the unfaithful) and splitting (rigidly good and bad, us and them mentality) within the belief system. These group defences are similar to the defensive pattern of a paranoid personality style. Meissner (1991) uses the known defensive style of personality disorders (obsessive compulsive, narcissistic, hysterical and paranoid) to suggest these character types can incorporate religious beliefs to serve their particular style of defence system.

Preece (2005), a Buddhist psychotherapist, concurs with Meissner and argues that individuals can distort the meaning of the original belief to suit their underlying pathology. Preece states that

> "we can turn Buddhism into a reflection of our personal confusion and distort its essential principles. We can so easily place a veneer of spirituality over our

> personal neurosis and fail to recognise how our Buddhist life is flavoured by its pervasion" (p. 126).

In terms of working with clients whose religious beliefs seem pathological, I would agree with Meissner (1996) who suggests that "the [therapeutic] emphasis falls not on the belief system, on its truth or falsity, but on its pathogenicity and the degree to which it reflects the underlying pathogenicity of the patient's self-system" (p. 265). I also concur with Spero (1976) who suggests that the goal of therapy should not be to destroy the client's religion or to deny the possible usefulness of religion in the life of the client but to separate out the "intrapsychic conflict from its 'religious' defence system. Such a goal appears to be in the service of both psychotherapy and religion" (p. 365).

Rizzuto (1991) rightly qualifies Meissner and Spero's assertion by arguing that the perception of religion as part of a client's defensive matrix needs to be appreciated alongside the understanding that

> "all human actions are compromise formations resulting from complex defensive and non-defensive motivations and religion is no exception. However, the defensive components of any religious experience do not make them more or less pathological than any other human activity" (p. 577).

Meissner (1996) suggests that the therapist should be able "to discriminate those aspects of their patient's beliefs that are supportive, mature, reasonable, and psychologically adaptive, as opposed to those aspects that are destructive; misleading; misguided; and needlessly productive of guilt, anxiety, depression and despair" (p. 264). This is an idealistic perspective and Meissner allows his bias to show by assuming the therapist understands religion and is confident in determining the health of a religious belief. I would argue that for a secular psychotherapist, who has little experience or training with religious pathology, this may prove more difficult to decipher. However, Meissner (1996) recognises the tendency for therapists to leave religion out of the analysis by reiterating how important it is not to deny clients the opportunity to consider their religious beliefs within the therapeutic process.

Like Meissner and Spero, Pfeifer (1994) argues in his paper *Faith induced neurosis: Myth or reality?* that it is not "personal faith or a dysfunctional church that causes pathology, but it is the psychological disorder that tends to affect amongst other areas

of life, the religious perceptions, emotions and religious social life" (p. 92) of an individual. He argues that with individuals who are predisposed to neurotic functioning, it is not religion that is the reason for their neurosis, but that religion can exacerbate intrapsychic tension between inner experience and personal ideals. Pfeifer provides seven criteria to assess possible areas of conflict for Christian clients such as a general tendency towards conflictual functioning; conflicts between ideals and reality; a basic tendency towards increased anxiety; dependence on God versus taking personal responsibility.

Northcut (2000) extends this thinking to include other forms of religion. He uses ego strength rather than neurosis as a measure of client functioning and suggests the following questions as being helpful for assessing whether the client's beliefs are ego enhancing:

> "Are the beliefs representative of the client's religious group, community, and family? How does the client articulate the strengths and weaknesses of their belief system? How is their functioning affected following religious/spiritual experiences? And, what is the client's concept of God/truth etc.?" (pp. 164-165).

Northcut (2000) uses Saari (1999) to explain the goal of determining if the client's narrative is

> "sufficiently anchored in the broader meaning system of the client's cultural surround; if there are strengths that will help them grow in desired ways; if the meaning of these experiences is consonant with the best available understanding of human development and functioning and if [the] client's narrated identity enhances their capacity for intimacy with others" (Saari, 1999, pp. 9-10 quoted in Northcut, 2000, p. 165).

I believe that Northcut (2000) provides an inclusive description of criteria for assessing the uses of religious beliefs within the overall functioning of the individual.

Interpreting Religion

Kung (1990) questions whether psychotherapy can ever reduce religion into a form that can be truly understood within a psychotherapeutic context. I would argue that this is possible but that it relies as much on the psychotherapist's attitude towards religion as it does on the framework they practice within. However, therapists need to consider where the line is between the analysable and the theological, as there may be a tendency to either negate the analysis of religious issues completely believing that anything to do with religion belongs in a church or temple (which also serves to protect any lack of knowledge or insecurity the therapist may have about working with a religious client) or go beyond the boundary of their professional capacity and analyse strictly religious phenomena. Rizzuto (1996) recognises the limitations of psychotherapy to interpret all religious phenomena, for instance, she argues that psychotherapy is not able to explore such areas as religious transcendence. In contrast, Jungian psychotherapists amongst others (transpersonalists) consider all religious experience as material for the analysis. Psychotherapists who privilege the client-therapist relationship (relationalists) would argue that part of the therapy may be to discuss how the client feels about working with a therapist who has different or similar beliefs regarding religion. For further discussions about therapists' religious disclosure I would direct the reader to Rizzuto (1996) and Bergin (1991).

Object relations theory privileges human relationships as defining the development of our psychological lives, and in particular that our past interpersonal relationships shape our relationships in the present. However, St. Clair (1994) argues that this should include relationships to the sacred. I will describe a clinical example and use object relations theory to interpret the religious content of the client's issue.

Mary (not her real name) is a 48-year old woman who presented with anxiety related to feeling that God had abandoned her at a time in her life when she felt she needed "Him" most. Of significance was that Mary's mother died suddenly in a car accident when she was three years old and was subsequently brought up by her father. Mary had coped with the loss of her mother through the use of an elaborate fantasy world, and in particular the creation of an imaginary friend. While Mary had been brought up in a non-religious family she explained that her imaginary friend became God when she became old enough to conceptualise him. Mary told me that without God she

would not have been able to "survive" the loneliness of growing up an only child without her mother. As an adult Mary's relationship with God was intense, relational, and at times highly conflictual. She would often defer to God in her decision-making, seeking signs from him to assure her that she was "doing the right thing". However, when her good work was not being supported or recognised by God she would become depressed and then angry, explaining that she felt abandoned.

From the point of view of object relations, one might consider Mary's imaginary friend to be a direct response to the loss of her mother. Mary's replacement of her primary object created an unconscious continuation of the relationship, which was adaptive in order to defend her immature ego from the reality of her mother's death. Although the imaginary friend later became equated with God, I would argue that it seemed to be less of a transitional object (a bridge) and more an object created to substitute the care and security of her mother's presence. As an adult Mary seemed disconnected from the reality of her mother's death, almost as if the formation of God had suspended this possibility. It would seem that separating out her religious and human objects through grieving her mother's death would allow Mary to create a relationship with God and to her mother that was less entangled. Mary's adaptive defence (the creation of the imaginary friend) against the sudden loss of her mother had become maladaptive due to her merged relationship to God becoming an obstacle to grieving for the loss of her mother. Mary had not achieved individuation from her mother because she had not been able to grieve her death.

This example shows how psychotherapeutic understanding can help to separate out the pathology from the religious belief, without needing to challenge the client's religious faith. It also highlights the need for clinicians to know where the boundary lies between the analysable and the theological within the therapeutic encounter.

Genia (2000) suggests that the most important aspect of being witness to a client's personal image of God is that it provides the therapist with an appreciation of the quality of her "formative relationships and level of psychological development" (p. 215). Black (2000) suggests that the benefit or hindrance of a client's relationship towards their religious objects must be judged as other objects are by their long-term effects on the believer's life. Whether the therapist uses object relations theory or

another psychotherapeutic modality to view the religious beliefs of a client, psychotherapy remains a theoretical belief that looks to understand clients' beliefs in a particular way. Psychotherapists rely upon such theories to guide them. However, applying a psychotherapeutic understanding of health to religion invites both the influence of the therapist's personal values as well as the values imbedded within the psychotherapeutic modality. The ethical issue that this poses will be further explored in the following section ('Ethical Considerations').

Ethical Considerations

It is important to consider the ethical aspects inherent to the research question. What does a secular psychotherapist base their appraisal of mental health or pathology upon when assessing a religious client? In order to understand the clinical implications of this question we must first appreciate some of the different views relating to values and the therapeutic relationship. Freud perceived psychoanalysis as a "value-free scientific activity" (Holmes, 1996, p. 260), which is a viewpoint comparable to Bion's (1967) assertion that psychotherapists need to suspend "memory and desire" (p. 18) in order to prevent the therapist's values from influencing the therapy. Hanley (1999) argues that "critical realism" (p. 440), an objective therapeutic position, is possible by arguing that this position is an epistemology based on "common sense and science" (p. 440), which is the analytic position Freud adopted.

Conversely, there are those who recognise psychotherapy as a subjective and thus value-laden endeavour but who strive to work ethically alongside this understanding. Regardless of which perspective a therapist takes, determining what is psychologically healthy or pathological involves the therapist making a judgement. This has been commented on by a number of writers. Blass (2001) argues "[W]hat constitutes mental health and pathology is not a given fact to be simply observed but something that psychoanalysis through its theoretical foundations plays a part in determining" (p. 194). In other words, the theoretical orientation of the therapist has a role in determining how the therapist perceives mental health. Blass (2001) and Carnorchan (2001) both describe the differing views and goals pertaining to mental health within different modalities of psychotherapy. These can often be taken as fact by clinicians schooled within a specific orientation. Blass (2001) argues that these views are not factual suppositions but theoretical constructs based upon value judgements about what is deemed to be healthy.

Mental health can be recognised as a therapeutic goal, which is seen by many psychotherapeutic modalities as the attainment of certain developmental states. For instance, "superego development, the attainment of the depressive position, self-cohesion, the development of a true self, making the unconscious conscious, synthesis of the personality, integration of parts of the self, etc" (Blass, 2003, p. 929). Using the values inherent to their chosen modality, psychotherapists attend to their clients'

issues with a goal in mind that defines heath in a specific way. Blass (2001) argues the danger in this is that by facilitating the therapeutic environment for development of a true self for instance, a therapist is facilitating the actualising of a certain *kind* of development that is based on certain values relating to how a person should be. Carnochan (2001) argues along similar lines, posing the question "[A]re we suggesting that there is a single preferred structure for character?" (p. 335). Interestingly Blass (2003) asserts that the common link between different modalities' understanding of mental health is a focus on client self-determination. She describes this as a process involving the search for and discovery of the 'truth' of the self, which is enhanced by remaining within the value framework of the client's world (Bergin, Payne & Richards, 1996).

Alongside the values imbedded within theoretical modalities are the personal values psychotherapists bring to the therapy. These are often unconscious (Holmes, 1996) but are no less influential on the way a psychotherapist relates to religion and the religious issues of their clients. Spero (1985) challenges the psychotherapist's ability to be cognisant of religious biases, arguing that the "main source of bias in therapist's attitudes towards religious belief involves how we distinguish between pathological, dysfunctional religious beliefs and mature, autonomous religious beliefs (p. 76). If a secular psychotherapist is to rely upon their subjective appraisal of the health of a religious belief, what are they basing their appraisal upon?

Psychodynamic psychotherapy regards the self-analysis of the therapist as a cornerstone to ethical practice. This encourages an awareness of conscious and unconscious values that may influence working with clients who have similar or different beliefs and values. Coupled with clinical supervision, ideally the psychotherapist tries to ensure ethical practice through self-awareness and reflection upon unconscious processes that may be played out within the therapeutic relationship. Barnes (2001) argues that psychotherapists have a responsibility to be aware of their own character, values and beliefs, and the potential for these to influence the work with the client. It is worth considering how much value is placed upon therapist consideration of their relationship towards religion in this way.

Religion poses a unique conundrum for the secular psychotherapist. As has already been suggested, therapists can view religious phenomena as falling outside the therapeutic realm of enquiry. In order for therapists to see that religion is an important area for analysis, it would seem that there would need to be a shift in some therapists thinking about religion. This shift might be helped through a process of considering the personal attitudes or beliefs the therapist holds with regard to religion. Until therapists become more curious about religion for themselves they seem poorly positioned to regard their clients' religious beliefs. I will provide a clinical example to illustrate some of the difficulties that can arise from not having an awareness of one's own beliefs.

A Christian client called Tina (not her real name) whom I was seeing in my practice, made the assumption during the course of our work that she and I held the same religious beliefs and values. My countertransferential response was to feel incredibly uncomfortable with this assumption and, in order to relieve this, I felt considerable internal pressure to divulge my personal position on religion. While it is known that clients' transference can evoke strong reactions in therapists, I would argue that the level of therapists' self awareness regarding religion can determine the strength of their response to clients' religious material within therapy. Genia (2000) argues that without ample training, consideration and knowledge of religious issues, psychotherapists are prone to strong countertransferential reactions with religious clients. In this way, my countertransference towards this client was a reaction to feeling as if my personal beliefs about religion were sacrosanct and needed to be defended from the client's assumption. Perhaps the reason for psychotherapists' difficulties in approaching clients' religious beliefs is because they can identify at some level with their clients' beliefs being sacrosanct. Fortunately, I was able to take this issue to supervision and, having considered my initial reaction to the client, managed to refrain from disclosing my beliefs about religion. This was because I realised she was using me as a part-object in order to make me accessible and if I had revealed my position I would be gratifying my own need to feel separate from her.

Summary

In summary, the implications of interpreting religion within a psychotherapeutic context were considered (Kung, 1990). It was noted that there are limitations to interpretation of religious phenomena through a psychotherapeutic lens (Rizzuto, 1996). Religious pathology can be a reflection of pathology stemming from the religion itself, the individual, or a culmination of the two (Meissner, 1996). It was argued that the character style of an individual can influence the type of religious system the individual affiliates with. (Meissner, 1984, 1991). It was recognised that separating out the pathology from the religious defence could aid both the client's religious belief and determine the etiology of the client's psychopathology (Spero, 1976). Criteria for assessing the pathological derivatives of clients' religious beliefs was suggested as a practical way of determining the source of pathology (Northcut, 2000; Pfeifer, 1994).

It was identified from psychological (James, 1902) and psychoanalytic literature (Beck, 2004; Symington, 2004, 1994) that a mature form of religion can be conceived of. However, this was seen to be problematic due to it having to conform to certain psychoanalytic concepts of maturity and health (Symington, 2004, 1994). It was argued that in reducing religion in this way it could alter the definition of religion irrevocably (Rizzuto, 1991).

The ethical implication of applying psychotherapeutic paradigms of health to clients' religious beliefs was considered (Blass, 2001, 2003; Carnochan, 2001). It was suggested that the psychotherapist's awareness of personal beliefs regarding religion may help to ensure countertransference interpretations are not based on unconscious biases but on conscious personal and theoretical understandings of the client's relationship towards their religion (Barnes, 2001; Genia, 2000; Spero, 1985).

CHAPTER FIVE

DISCUSSION

To recapitulate, my initial interest in the topic for this modified systematic literature review stemmed from a clinical case that challenged my ability to work with a religious client whose beliefs, I suspected, were interwoven with his underlying pathology. Specifically, I was interested in finding out what had been written about how to determine the health of religious beliefs and whether a religious belief could function as a pathological defence. The wider implications to the research question included how the 'culture' of psychotherapy views religion and the religious beliefs of clients. I suggested that religion should be an analysable part of therapy but wondered how this might be achieved given my own experience of not being able to readily identify or empathise with the religious lives of my clients. This dissertation has essentially argued that religious issues can be considered in a similar way to other areas within psychotherapy so long as the psychotherapist is mindful of certain aspects unique to working with religious clients. Based on what I have gleaned from completing this literature review and from my own experiences I will now discuss why there are unique aspects inherent to working with religious issues in the therapeutic context.

Contemporary psychodynamic psychotherapy has a historically secular tradition which stems from Freud's theories regarding religion and religious beliefs. Freud's legacy has significantly dictated what has been written (and what has not been written) about religious beliefs within the context of the therapeutic relationship. Jungian psychotherapy provides an alternative perspective on religious beliefs but seems to be often regarded as non-mainstream, compared with more mainstream psychoanalytic modalities, such as psychodynamic psychotherapy. There are only a few writers who have differentiated themselves from Freud's legacy within contemporary psychoanalytic writing and the scarcity of this literature poses two important questions: the first is why there is so little literature written about the psychological functions and forms of religious beliefs; and the second, how then, do psychotherapists' think about clients' religious beliefs? For the psychotherapist who has evolved in their thinking from Freud's unilateral position on religion – how do

they inform their practice when the literature about how to work with or appraise religious beliefs in psychotherapy is simply not there. Clinical guidance from quantitative research in this area is also scarce with findings being largely inconclusive about correlations between religious investment and mental health.

This situation is made more pronounced by evidence from the United States suggesting that psychotherapists are significantly less likely to affiliate with a religion as compared with other mental health professionals. (Currently there is no research to date indicating the percentage of New Zealand psychotherapists who identify with a religion). They are more likely to identify as spiritual as opposed to religious. Without wanting to generalise, one might infer from this that a significant proportion of psychotherapists have some difficulties marrying psychotherapy with religious beliefs.

How do these factors contribute to the practice of psychotherapy with religious clients? There is a lack of guidance both from within the 'culture' of psychotherapy and from literature sources, which has attributed to there being insufficient guidance for the goal of 'best practice' to be achieved. So what are psychotherapists' doing when they work with issues of a religious nature? And what are they being guided by? It seems that individual therapists' are left to find their own ways of negotiating the work with religious clients. Invariably, this will leave room for any bias the therapist might have regarding religion to influence the work. This could be expressed through the therapist avoiding religious content or even a prejudicial bias giving the client an experience of being pressured to 'convert' to the therapists way of thinking.

Obviously, working with religious clients is not a prescriptive exercise, however there are certain things a psychotherapist can equip themselves with to help them work therapeutically with clients' who espouse religious beliefs. Firstly, psychotherapists can become more aware of their own beliefs about religion. This reduces the chance of the therapy being inadvertently influenced by therapists' bias, while contributing to the therapists' confidence in approaching religious topics due to their own (un)beliefs being accessible and conscious. This level of awareness is also important for psychotherapists who use countertransference responses to inform their work. Countertransferential reactions to the client's religious beliefs will be recognised

because of therapists' awareness of their beliefs, biases and assumptions regarding religion and can then be used to understand clients' intrapsychic world.

Secondly, psychotherapists need to educate themselves about their clients' religion and religious beliefs. This is so therapists can differentiate between possible healthy and unhealthy forms as well as be cognisant of the limitations of their knowledge and expertise. These boundaries need to be matched with clients' expectations about their treatment.

Finally, therapist would be helped to understand that while religious beliefs can seem antithetical or incompatible with psychotherapeutic theory that this does not necessarily equate to psychopathology. The therapists' acknowledgement of these differences promotes a 'working with' rather than a 'working against' therapeutic attitude. Despite there differences psychotherapy offers an invaluable perspective to religious clients, having the potential to enhance their understanding of themselves in relationship to their religious beliefs.

The case illustration at the beginning of this study provided a clear example of how unconscious material can detrimentally influence the therapeutic process. While I had some knowledge of Buddhism, my personal beliefs about religion remained unconscious, which hampered my ability to attain a therapeutic level of empathy towards Simon's connection to his Buddhist beliefs. In retrospect, my beliefs about religion were surprisingly defended and sacrosanct even to the inquisition of my own introspection. This was reflected in how uncomfortable I found approaching Simon's religious beliefs. It could be said that what remains hidden or sacrosanct about religion within the therapist will ultimately affect their ability to access the religious domain of clients' lives. My inability to consider my connection to religion paralleled Simon's inability to consider his own beliefs towards Buddhism with me. This diametrical position disallowed Simon the opportunity to use me in considering his connection to his religious beliefs. In terms of our therapeutic relationship, my inability to 'get-alongside' Simon, in a way that he could feel or recognise, ultimately stalled the therapeutic process. Simon could not trust me to honour the importance of his connection to his religious beliefs.

The diagram below builds upon my initial hypothesis and understanding about the interrelationship between the religion, the individual and their religious belief.

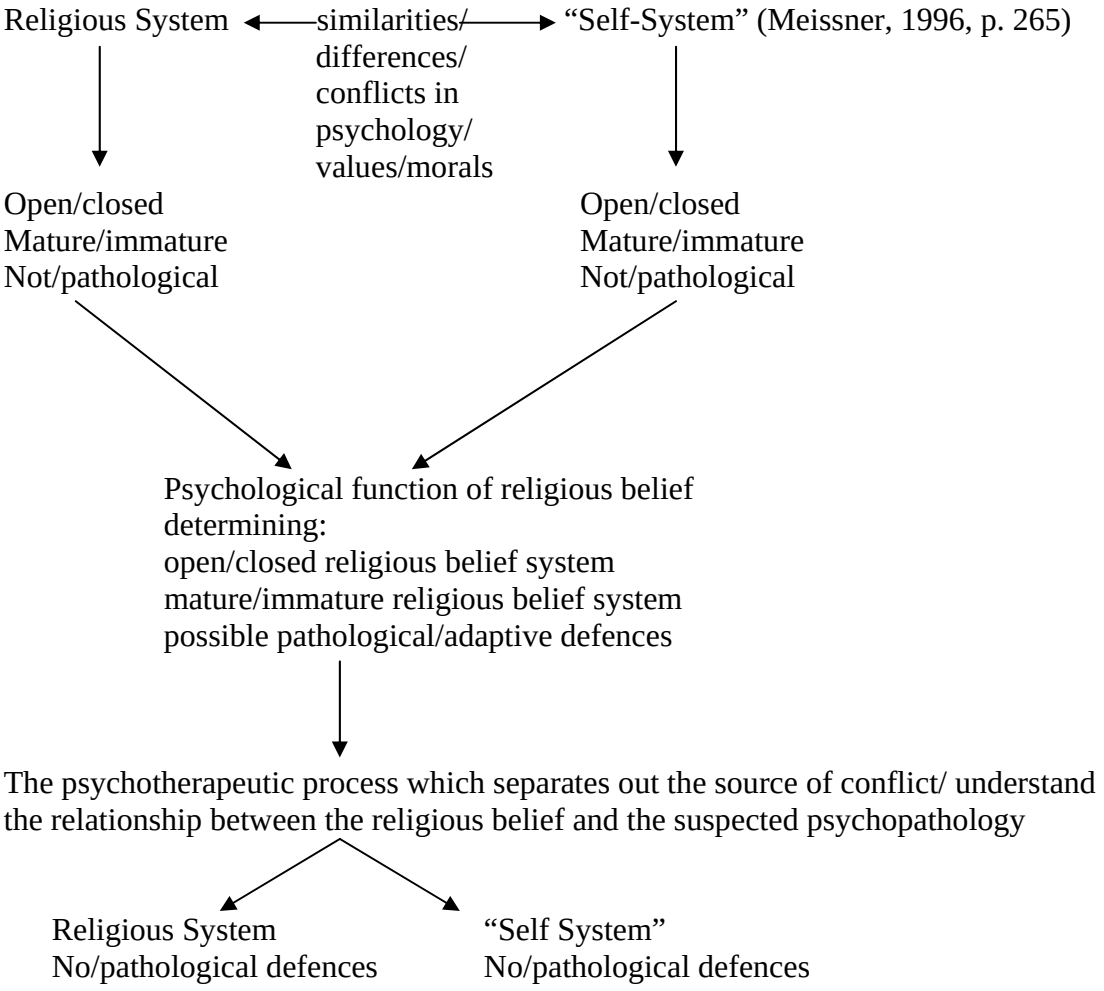

Figure1.2
A hypothesis describing the possible sources of pathology within a religious belief system.

My initial question, 'can a religious belief be a pathological defence?', is not easily answered given the lack of literature about the specific interplay of client's religious beliefs within the therapeutic relationship. Due to this, psychotherapists are largely responsible for their own education regarding the appraisal of the defensive (adaptive and maladaptive) functioning of religious beliefs. Psychotherapists' ability to decipher this will be determined to a significant degree on their awareness of the possible dynamics involved in working with religion and religious beliefs within their work. I would add however, that any belief, whether it is religious, spiritual, political or social

can function psychologically in a myriad of different ways that includes both the healthy and the pathological.

Limitations of the Study

A limitation of this study was the exclusion of literature relating to psychotherapy and spirituality. There has been an increased interest in this area in recent years and in order to do justice to both topics a comparison between them would help to fill the gaps left by the present systematic literature review. The difficulty in separating the two definitions at the beginning of this study identified the interrelatedness of the two topics, suggesting that the present study is left somewhat incomplete without a comparison of spirituality and religion within psychotherapy.

I think the interest in spirituality is significant and may either represent a growing number of clients attending psychotherapy who have spiritual beliefs or that spirituality can be seen as more psychotherapy 'friendly'. The latter may be because spirituality can be equated to a belief system that is more reliant upon an internal locus of control (which is generally regarded as optimal for health/maturity in psychotherapy thinking) as opposed to religion, which may be argued as having an external locus of control. The dogma of religion makes it less malleable to psychotherapeutic interpretation whereas spirituality is more nebulous in form, which, it could be argued, makes it more easily understood by psychotherapeutic models of health and maturity.

Future Research

The present study has identified an apparent lack of literature written about the clinical implications for psychotherapists of working with client's religious beliefs. Therefore an important area for future study would be a research proposal that focused specifically on the clinical experiences of therapists working with clients religious beliefs. This research would help to inform psychotherapists further about some of the issues that may arise from working with this client population.

A methodology for this research might be to interview therapists about their work that is supported by clinical case studies. It has been noted that the use of case studies within research has become more prevalent, Stiles (2006) argues that case studies are

an important form of data for psychotherapy research because of the "complex, nuanced, context-responsive aspects of psychotherapy and psychotherapy theories" (p. 57). If the reader is interested, a good example of research based on interviews with psychotherapists about their experiences of religious clients is Wyatt (2004).

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