Struggles with God: Transference and Religious Countertransference in the Treatment of a Trauma Survivor

John R. Peteet

Abstract: Transference and countertransference in treatment situations where the patient and the therapist share religious faith can be complex. This article discusses the course of therapy of a Christian woman with a history of trauma and depression by a therapist who shared her religious orientation. Countertransference reactions shaped the therapist's responses to the patient's struggles, and eventually contributed to a new level of trust in their shared God.

The growing literature on religious countertransference describes common types of negative countertransference (Griffith, 2006), nuanced relationships between the patient's religious transference and the therapist's countertransference (Abernathy & Lancia, 1998; Kehoe & Gutheil, 1984; Peteet, 1981; Spero, 1995), complexity added by dual roles such as pastor and therapist (Kahn, 1985; Spero, 1981), and potential therapeutic richness offered by shared religious imagery (Spero, 1994, 2004). No reports have traced changes in religious countertransference with changes in the patient's transference and god representation over time. In the case described below, my own religious identity and countertransference were important in the way I engaged a depressed survivor of childhood physical and verbal abuse, who showed some symptoms of PTSD, and who shared my faith. Subsequent modifications in her conception of herself and of God challenged my conception of my role, altering both my approach and countertransference.

John R. Peteet, M.D., Associate Professor of Psychiatry, Harvard Medical School; Department of Psychiatry, Brigham and Women's Hospital, Boston, MA.

Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry, 37(1) 165–174, 2009

CASE HISTORY

A therapist at a Christian counseling center referred Clara (a pseudonym), a 60-year-old divorced former seminarian who had completed a hospitalization following a suicide attempt.[1] Her overdose seemed to have been a reaction to the loss of her job, a move away from the seminary where she had completed a degree, and the loss of a church's worship team where she had felt "protected from my demons." During Clara's hospitalization, one of her children who lived elsewhere declined to be involved and seemed afraid to have her visit for the holidays afterwards. Clara's therapist had requested a psychiatric evaluation for antidepressant medication, which the patient was reluctant to consider, and in order to support her application for psychiatric disability. I agreed to write a letter supporting her application and to take on for her the role of prescribing psychiatrist.

Clara reported childhood physical and verbal abuse from her immigrant, nominally Catholic parents, who belittled her efforts to be more like children from the "other side of the tracks" and pushed her to pursue an education. Fortunately, her teachers told her that she was bright, and she determinedly put herself through college. In an attempt to escape the family, she married in her early 20s a man who turned out to be physically abusive and became paranoid and eventually psychotic and unable to work. After a separation, Clara took him back, then a few years later divorced him when she saw no other options. Working as a special-needs attendant, she struggled to provide her own children with a good education and other options that she did not have, yet was terribly disappointed that they seemed to want little contact with her after they left home. Essentially alone and lonely, following a conversion experience to a Protestant church that offered her an experience of grace she had not known before, Clara had become interested in theology, thrived in one of their academic seminaries, and for a while considered pursuing a doctorate with a concentration in theology and the arts.

Over the course of years before her hospitalization, Clara had seen therapists and psychiatrists for the treatment of depression but found the customary modalities—cognitive-behavioral therapy, non-directive therapy, and trials of multiple antidepressant medications—unhelpful with her chronic feelings of depression, shame, and low self-esteem. At

1. Names have been changed and personal clinical material in this article has been disguised.

our initial visit, Clara presented as a bright, direct, somewhat cautious, and provocative woman who was also capable of warmth and of taking an interest in me. I have conceptualized her subsequent treatment in four phases and summarize below her experience, the transference, her god representation, and my own "religious" countertransference during each phase.

SURVIVAL AND TRUST

In the first several months, I saw Clara monthly for medication monitoring, adding the antidepressants bupropion and duloxetine to the list she had tried before without success (which included tricyclics, MAO inhibitors, fluoxetine, venlafaxine, and lithium) while continuing low-dose clonazepam, which she found helpful for sleep and anxiety. She struggled with suicidal ideation when her children did not invite her to see them for Christmas, especially since she had considered declaring bankruptcy (in the literal sense but not without its metaphorical meanings). Having felt betrayed by her children and her old church, she looked at new ones, including a Pentecostal congregation. At some point, Clara asked me straight out where I attended church and wondered if I knew "what God was doing?"

I attempted to help stabilize her, to bolster her sense of boundaries and emphasize her capacities, to foster trust by showing consistent interest, and to encourage the formation of helpful connections. Once, feeling overwhelmed during a session, Clara asked what I thought she could do, and I suggested looking at the guilt she felt about her children. Given our progress to date, I was surprised when she responded sharply, "That's none of your business." As suggested by this exchange, Clara's transference was ambivalent, cautious, and even expressed in caustic terms at some times, while also unrealistic about what I, as a prescribing psychiatrist, and sometimes others could do for her.

My overall impression was that Clara seemed to think of God as a transcendent savior, though one who might be too distant to know her or to help. My countertransference impulse was to admire her sharp intellect, direct manner, and hopeful faith and to identify with her as someone whose combined intellect and relationship with God had been important resources. I also found myself identifying somewhat with her personal path from a liturgically oriented, mainline religious practice toward an appreciation of more experiential, semicharismatic religious experience. As someone who takes a certain amount of healthy pride in my role as a consultant to the local Christian counseling com-

munity, my hope, apparently, was to rescue Clara from her intertwined religious and emotional distress.

CONFUSION AND FEAR

Clara gradually began to see her social worker therapist less and wanted to see me more. I agreed to meet with her weekly for psychoanalytically oriented psychotherapy. During this period, she bought a small dog, became involved in a local church within her denomination, and took an active role in an online theological forum. She also showed me a sermon she wrote and asked to read a book of mine. In turn, I invited her to be interviewed by a class I co-teach to psychiatry residents (entitled "Religion, Spirituality and Psychiatry") since I saw her as someone whose faith had been important to her emotional life. I was disappointed (likely a reflection of my countertransference admiration for her) to notice that she had made an impression on the residents as being more defensive and angry than I had expected.

After a period of relative stability, Clara began to experience memory difficulties (eventually diagnosed as due to small strokes) that frightened her greatly, adding to her feeling of being out of control. She was also rejected—she believed because she was seen as too needy—by a woman pastor who had her own personal history of trauma, who had at first seemed to invite a close relationship. Following these rejections, Clara again felt overwhelmed and suicidal and required admission to a psychiatric day program, where the female director's gentle expression of interest in her gave her hope. I continued to see her in regular therapy but did not prescribe for her while she attended the partial program.

During this new period in our working relationship, I tried to help Clara diversify her support resources, in particular her religious ones (e.g., by recommending regular meetings with another pastor, if not a small group), so that she would be able to face painful issues she had been so far unable to confront. Her transference during this period was marked by anger and growing skepticism about whether she could be helped ("I feel as though you're trying to get rid of me"—as someone too damaged to help, a position she adopted when feeling more hopeless). At the same time, her God seemed more distant and his influence indirect—deduced, as it were, from the care that others showed her—though she also wondered if *anyone* could truly understand or help.

My own clinical hope was in part a countertransference hope, since my aspirations for the patient and the sense that I might succeed in helping her derived to some degree from a personal sense of benev-

olent help that I had recently experienced within my newly found church, a more experientially oriented one than my previous ones. As that church was able to help my own adolescent daughter with her struggles, I hoped that a church and, if not, a spiritually sensitive group would help Clara to bring her faith to bear on her life concerns.

FACING DEMONS

Together with the encouragement of the psychiatric day program staff to deal more directly with her traumatic past, Clara agreed to supplement her work with me with a trial of outpatient group therapy. However, she found the abstinent psychoanalytic approach of the two female psychiatric residents who led the group simplistic and cold. Despite that mild setback, an unusually encouraging telephone conversation with her daughter enabled her to see both that she tended to discount her daughter's actual interest and the potential benefit of looking into her past for the origins of this reflexive hopelessness. For the first time in our work, emotionally charged memories emerged of experiencing a mixture of need and revulsion after being beaten by her mother. Clara wept and felt liberated after recognizing herself in descriptions of trauma survivors in Judith Herman's *Trauma and Recovery*, which she had been reading. As at other points of improvement in the therapy when she felt closer to me and more vulnerable, Clara, while moved by the new change, also expressed some anger and fear that I might try to distance myself from her by sending her to additional groups. However, she agreed to try a psychoeducational group program focused on helping individuals understand and live with trauma. I felt some relief, parallel to my hope that her church would "save" her.

Completing this series proved difficult because she felt overwhelmed; she dissociated once when the leaders reviewed effects that childhood trauma could (and she realized did) have on her. Specifically, she reported seeing herself as "limited," "twisted," and "manipulative," unable to love or make real friends. Over the next few months, she brought in distressing dreams, sometimes of herself as a 5-year-old girl. In one, she was able to send the child away "to a field to let the sun shine on her face" but was unable to communicate with her. Feeling suicidal, she again required a brief admission to the psychiatric day program. She expressed sadness that she could no longer believe in a God who could let someone become so damaged, "odd," "incapable of relationships," and too old to change. She also reported having called a pastor of my church to ask how one could continue to *believe* in the face of great personal suffering and was disappointed when he told her that, in the end,

she needed to choose whether to believe or to not believe. This call had transference implications and presaged further exploration of whether I would direct her, reject her, or encourage her to engage in the decision process.

During this phase, I tried to support her efforts to explore her painful past and identify its effects, without agreeing that change was either certain or impossible. When I responded to her despair by saying, "I don't think you're hopeless, and I believe you can change if you can let yourself feel your losses and put their effects into some perspective," Clara would say, "It's not enough, I can't do this!" Her loss of faith seemed to present a test of whether I would accept or try to change her, and I began to feel that I was being subtly invited to debate her fatalistic use of the doctrine of predestination. In fact, she said to me at one point during this period, "Calvin taught that God predestined some people to salvation and others not." I then asked her, "Do you find Scripture teaching this?"—with an intent to evoke some self-reflection on her part—but I held back from further engagement over theology. I could readily recall old mistakes made when I had fallen into unproductive discussion of similar issues with other patients. Once, when I questioned a provocative young patient's interpretation of some biblical passage, we became involved in a distracting and counterproductive argument. Another time, when I questioned a depressed pastor's self-condemnatory interpretation of some textual source, he assured me that *he* and not I was the expert. In general, my conclusion has been that this "technique" seems to have a very limited effect, interfering with the transference, coloring the patient's perception of the psychotherapist as "theologian" or "professional" in ways that cannot always be directly or immediately ascertained.

Clara's transference was marked by fear that I would reject her, both for how she now imagined I saw her in "reality," and for her lack of faith in God. At one point, her angry outburst at my suggestions of ways to reduce her isolation and correct her hopeless perspective made it clear that she felt I was expecting too much of her. Later, Clara reported an illuminating dream in which her mother threw her beloved childhood rag doll onto the trash heap, saying it was worn out, and that she must learn to do without it. As I comprehended this, I interpreted to her that she needed me to ask permission, in some sense, before asking her to explore (without benefit of comforting, if worn-out defenses) her painful past. I also admitted the limits of what I could do for her. When she said, "All the insight in the world isn't going to change me," I agreed, saying, "Only God can forgive, and provide a basis for ultimate hope." I feared that I would now be perceived as offering pious platitudes, but my response was truly heartfelt—that we needed to depend on God as

a partner in the work for her to get better. Making this type of direct allusion to God as a partner is not characteristic of my way of working with patients. I did so in this case because she seemed to need an honest response directed at the issue she was raising, rather than one that turned the question back to her in a way she would likely experience as evasive, after she had just emphasized the limits of psychological insight.

During this phase, Clara seemed to be struggling with the God of Job, who allowed (if not caused) suffering from a distance, and seems (in the text, as taken literally) to have felt obligated only to justify Himself by reasserting His sovereign authority. The image of Job, as an innocent sufferer trapped between God and Satan, had layered meanings for me. It revived memories of my father's orders to obey "because I said so," with the acquiescence of my mother, and represented my struggle to trust God's goodness in the face of the unexplained evidence to the contrary—in this case, represented by my patient's suffering as well as that of other individuals in the cancer institute where I practice.

But I also felt that I had adopted a role similar to Job's *friends,* who offered well-intentioned but ultimately unhelpful explanations of suffering rather than maintaining the focus upon how one *might* remain faithful, as Job had done, *despite* our inability to understand God. In my countertransference experience, I felt apprehensive about her stability and disappointed that my efforts to encourage her faith had failed. Any urge to help her spiritually was now being countered by memories of feeling crowded and embarrassed by the efforts of my father, who had graduated seminary but was never ordained, to foster belief in his children without understanding or to make an effort to grant our personal struggles any legitimacy. Conscious of wanting to avoid *repeating* this and of having by now gone too far myself in pointing toward solutions before sitting with her pain, I tried to hear Clara out and support her in facing her demons her own way.

MOVING ON

As Clara became somewhat satisfied that I was not intending to reject or control her, she asked for more direction and reported that she "might be forgiving myself." She also began to take practical steps and to assess their effects. Recognizing that she felt worse when isolated, she joined an exercise class and a book group. Recalling that she felt healthier when not smoking, she tried again to give up that habit. Noticing that she felt better when she remained involved in her church, she did so, admitting that her assertive contributions on the board of

elders were perceived as needed and were appreciated. When one of her children offered to see her while in the area on a business trip, Clara rehearsed with me ways to discuss the upcoming holidays and what might be standing in the way of her children inviting her to visit them, including envisioning how to offer to apologize for ways in which she might have been responsible for their pain growing up. In sessions, she explored in more detail the history of her estrangement from each of them.

During this phase, I tried to use our growing working alliance to help Clara to use her strengths in dealing more effectively with the challenges that continued to confront her. Her transference to me was at times as if she were my pupil (as an expert who had been down similar roads before) and at times as if she were my teacher (of me as a younger person, new to what she knew about the world, herself, and theology). At other times, the transference portrayed me as a man with whom she had begun to feel intimate. After I was away for a week, for instance, Clara volunteered, "I hate the way I depend on you and want so much to have someone care about me. It's complicated that you're a man—both because I've tended to trade sex for safety and because my father was not there, so I don't know what you're going to do."

God had seemed to transform into an image or a presence that was somewhat more benign, yet less powerful and less interested in her life. After reviewing the ways she had been doing better, she said, "but the God thing is still disappointing," explaining that she had been coming to feel perhaps less condemned by God and more aware of her impression that even He might be limited (as she explained a number of people believe). "Maybe He did the best he could." My countertransference experience, during these transformations, was to feel like a consultant on her forays into health and as a parent of an adolescent who had matured to the point where she was now more ready to make her own decisions (this, again, felt familiar, as I was simultaneously seeing our youngest child move away to college). It meant accepting Clara's relationship with God as her own, admiring her courage and insight, and trusting that God would continue to care for her, despite her struggles with him.

DISCUSSION

The case I have presented illustrates, I hope, some of the possible vicissitudes of the interaction among transference, god representation, and religious countertransference during several years of psychotherapeutic treatment of a religious patient with trauma-related depression.

My patient's initial admiration for me and my identification with her influenced me to take on the challenge of treating this bright, theologically adept woman who had found helpful a religious path from more liturgical to more experiential faith that was in certain ways similar to my own. As she continued to feel overwhelmed between weekly sessions, I came to see her as fragile and in need of more support, leading to discussion of religious supports, trials of group psychotherapy, and a trauma psychoeducation group, arranged with mixed results.

Eventually, Clara became more able to face the early origins of her mood and relational difficulties and to acknowledge their lasting effects on her sense of self and her relationships with others—in particular, her adult children. Facing these squarely shook her faith in the God who had previously comforted her in her isolation. Grieving these losses and deficits allowed Clara to forgive herself and to take realistic steps toward remaking a life that included greater honesty, intimacy, and a different relationship with God. Her movement through this process was accompanied by major shifts in her transference toward me, in her view of God, and, as a result, in my countertransference responses to her. As she moved to a deeper understanding of herself, I moved through disappointment at her loss of faith to a more realistic appreciation of my role in providing a safe space in which to confront her psychological demons. At the same time, as Clara eventually came to see God as more limited, I came to trust Him to do more with her capacity for spiritual growth, and to feel that I needed to do less of this work for Him.

REFERENCES

Abernathy, A. D., & Lancia, J. J. (1998). Religion and the psychotherapeutic relationship: Transferential and countertransferential dimensions. *Journal of Psychotherapy Research and Practice, 7,* 281-289.

Griffith, J. L. (2006). Managing religious countertransference in clinical settings. *Psychiatric Annals, 36*, 196-204.

Kahn, P. (1985). Religious values and the therapeutic alliance, or "Help me, psychologist; I hate you, rabbi." In M. H. Spero (Ed.), *Psychotherapy of the religious patient* (pp. 85-95). Springfield, IL: Charles C. Thomas.

Kehoe, N., & Gutheil, T. G. (1984). Shared religious belief as resistance in psychotherapy. *American Journal of Psychotherapy, 38*, 579-585.

Peteet, J.R. (1981). Issues in the treatment of religious patients. *American Journal of Psychotherapy, 35*, 559-563.

Spero, M. H. (1981). Countertransference in religious therapists of religious patients. *American Journal of Psychotherapy, 35*, 565-575.

Spero, M. H. (1994). Religious patients' metaphors in the light of transference and

countertransference considerations. *Israel Journal of Psychiatry & Related Disciplines, 31*, 306-307.

Spero, M. H. (1995). Countertransference-derived elaboration of religious conflicts and representational states. *American Journal of Psychotherapy, 49*, 68-94.

Spero, M. H. (2004). Hearing the faith in time: Countertransference and religious metaphor in an oncology patient's psychotherapy. *Psychoanalytic Quarterly, 73*, 971-1021.

Department of Psychiatry
Brigham and Women's Hospital
75 Francis Street
Boston, MA 02115
John_Peteet@dfci.harvard.edu