

“May your God go with you!”

Spiritual Themes and Issues in a General Psychiatric Setting

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My title (as some will realise) comes from Dave Allen. It was his regular farewell to the public some years ago on his weekly show “Dave Allen at Large” in which he made intelligent fun of religion for the nation. He was arguably somewhat outrageous in this area, and yet I was not surprised to read in the preface of Rabbi Hugo Gryn’s autobiography¹ (posthumously prepared for publication by his daughter) a tribute to the rabbi’s enjoyment of Dave Allen and other irreverent comics. They speak of the human condition from a position of creative genius that in the case of Dave Allen and Billy Connolly is profoundly injured by perverse delivery of a traditional religious message. The tragedy behind this comedy relates to the observation made by Andrew Powell at one of these meetings some time ago, that religion is like a knife that can be used to kill or to cut bread. In the Irish literary tradition the wound of religious cruelty has brought forth great Art.

I was fortunate to see Dave Allen on stage and to hear him speak of his childhood. He was taken to school on his first day to a convent. The door was opened by a large and forbidding figure dressed in black: a nun. Behind her on the wall was a life-size statue of a man hanging, covered in blood on a cross.

“Who’s that?” said Allen in the voice of himself as a child.

“That’s God’s son,” replied the darkly dressed figure.

“What happened to him?” stammers the child.

“He was crucified, put to death...”

“Why?” says the curious child.

“Because of you and your wickedness” came the reply.

(But Allen has the last laugh on behalf of his child self);

“When did this happen?”

“2000 years ago”

“But I can’t have done it...I’m only four!”

Billy Connolly’s wife and biographer, Pamela Stephenson also recalls the child Billy, abandoned by mother and abused by father, starting school to be informed, “Jesus is dead, and it’s your fault!”²

What has this to do with the practice of Psychiatry? It tells of the pain of a distorted given image of God and the spiritual dimension often administered with those good intentions that pave the road to hell. Some people transcend and transform this injury but many don’t, and often these people become our patients, alienated from the ultimate archetypal source of help. This sort of experience may determine our own attitudes also and contributes to the schism between psychological and spiritual healing enterprises. Even if we have discovered, or re-discovered, a healthy and life-enhancing spiritual experience, how do we bridge that gap? I will speculate on this, and throw it open to reflection, because of course I have no definitive answer.

Here is a case history: Simon is in his twenties, the only son of parents who belong to a Protestant Evangelical Christian sect. Religion is extremely important in the home. His mother has a forceful personality, while father is more subdued and quiet. Their religion emphasises the literal truth of the Bible. My patient’s orientation is very evidently homosexual. His parents believe that people in gay relationships are spiritually damned.

Simon's condition and behaviour have presented a diagnostic challenge to various psychiatrists. At times he has stripped off his clothes in front of his parents and their friends. Mood swings have been an inconsistent feature. He has explored his homosexuality in a sordid context, and rendered himself very vulnerable, including getting raped. After this experience in London he took an overdose outside a church. He explained how he had thought that if God loved him, he would survive the overdose. He survived, but was unable to be reassured, as he immediately damned himself again for "putting the Lord to the test" a very serious sin by his account.

To balance this account, I have had many patients tell me that faith, prayer and devotional images have helped them in their illness. In one case an alcoholic with a mood disorder gets regularly averted from serious suicide attempts by a visual image of Christ that appears to him. He refuses all other forms of help but comes to outpatients occasionally to talk. I would like, however, to focus in this presentation mainly on the terrible guilt-inducing judgmental Gods that many carry and whether and how this can be helped. Does their particular God have to go with them, making life so difficult, or can we in some way aid a transformation?

I think that whether we approach this from a psychological or a spiritual perspective, key issues are the importance of acceptance and the concept of wholeness. This may include wholeness of the image of God incorporating a dark side as well as wholeness of the individual self. People's religious and moral education is often strongly focused on being good and recognising the good in others. In my experience, this can lead to impossible attempts to ignore one's own pain, reflecting as it does human limitations and the sort of random misfortune that insurance agents call "acts of God". It is a blinkered and sub-optimal way of living, which sits uncomfortably with a religious tradition in which God incarnated himself in order that people might have life more abundantly.

Ambivalence about loved ones is a very prevalent psychological theme. Freud highlighted in *Mourning and Melancholia*³ how "the shadow of the object falls upon the ego" in states which we would now commonly call psychotic depression. I have often experienced, from a more Kleinian interpretative perspective, the wholesale exporting of murderous aggression in the countertransference into my team and myself. It is clearly often very difficult for people to contain and accept their negative feelings. I notice this particularly in first psychiatric interviews when I ask people what their parents were like. In the face of glaring deprivation and abuse I still find myself needing to ask, "did he/she have any faults?" or "what about the downside of Mum's character?"

D.W. Winnicott⁴ wrote in his paper 'Hate in the Countertransference' of the benefit at the end of analytical therapy of finally being able to share with the patient the difficulty and negative feeling experienced by the analyst during the treatment. This reclaiming of often unwanted baggage serves the purpose of wholeness and enhanced creativity. I am reminded of the story in the Christian tradition of the stone which the builders rejected becoming the corner stone of the building. I think that the injunction "Take up your bed and walk!" which nowadays can sound like an eviction order, may have referred in its original biblical context to that aspect of healing which requires a person to take on board or own their personal contribution to ongoing suffering, in order to aid future liberation.

In general psychiatry, unlike formal psychotherapeutic settings, we commonly see people who are without insight, or even overtly reluctant to engage with us at all, and so this aspect of healing is generally more difficult or perhaps even impossible for us. Yet as a theme it appears and needs to be born in mind.

Harriet was a very ill woman in her 50s who was referred privately by a psychotherapist colleague because her condition was not treatable psychotherapeutically. Her treatment was funded by her former employer from whom she had been on sick leave for years and with whom she was in conflict. She

suffered from a somatisation disorder and was in constant pain. She had had numerous surgical investigative procedures, which did not help and led to pain from adhesions.

My role with her was relatively brief. It included various attempts to understand and alleviate her symptoms. Most importantly I had to challenge the defensive aspect of her illness by severing her connection with the employing authority and, with this, the role of victim. I had to write a report that would allow her a medical retirement, hopefully the opportunity to abandon her dispute with the employer, and to get on with her life. She had asked to see the report and I had a strange experience while showing it to her. An image came to me from the film "Shindler's List",⁵ where Stein, the accountant, shows the typed list to Shindler of those who can go with him and possibly avoid the death camps. There is light shining on the paper from a desk lamp. Stein says, "the list is life, around the edges is the darkness". I suppose in my fantasy/reverie, my patient was saved or damned, depending on whether she could accept the pain about herself contained in my report and thereby be enabled to move on.

In considering the interaction between mental health and the spiritual or religious realm, I am influenced by several sorts of writers. There is a vast amount of relevant good literature. If I could prescribe a poem for many of my patients, I think it would be "Love" by George Herbert.⁶ The poem is a very direct evocation of acceptance, and the redeeming power of love, and addresses the guilt that can impede this. Herbert was an Anglican priest, and the poem exemplifies the best of the Christian religious tradition. Within other traditions I know there are also such inspirational works.

If I had to choose a second favourite poem relevant to my theme, the one that would accompany this would be W. H. Auden's "In Memory of Sigmund Freud".⁷ In its more secular context, it tells of the spiritual journey and recounts how "his [Freud's] technique of unsettlement" can be a revolutionary force, allowing us to "face the future as a friend". I first came on this poem when I saw it quoted in the introduction to Marion Milner's classic account of an analytic treatment entitled "The Hands of the Living God".⁸ The balance between challenge and containment in my opinion is critically important in working with very disturbed individuals. Both this poem and the one by George Herbert seem somehow to strike that balance for me.

The Jungian tradition has spirituality as a central theme. The work of Edward Edinger is an inspirational read and is most helpful in illuminating the psychology of religious experience in a way that is both immediate and grounded in clinical experience. Edinger writes of the relationship between the ego or self and the archetypal Self. The latter could possibly be conceptualised as "God" or "the God-within". He writes of the development in the process of psychological growth and individuation of an "ego-Self axis", which can come into consciousness to various degrees. This can allow the individual access to archetypal strength beyond ordinary self-reliance. The power of prayer and healthy religion can be seen in this light. He also stresses the awesome aspects and dangers of this encounter. Again, we are in the territory of "falling into the hands of the living God". There is a danger of inflation, and it is important to recognise the source of strength as Self, not self. I find it curbs my own therapeutic omnipotence to see the work as coming through me and not from me, and to consciously recall my limitations.

In "Ego and Archetype", Edinger has written a fascinating chapter on "Christ as Paradigm of the Individuating Ego".⁹ This contains a psychological analysis of the beatitudes. So often people's distorted religion mistakes "Love your neighbour as yourself" for "Love your neighbour [not] yourself". This is very unhealthy and flies in the face of the original, which accords with much later psychological work about the necessity of primary healthy self-love as a precursor to healthy object relations. Edinger writes of how loving the enemy could be considered perhaps to mean taking a kindly attitude towards one's own weaker shadow side. This could indeed be

liberating from the pathological judgmental deities - we might allow ourselves to be imperfect creatures.

The theme of omnipotence also comes up in the writing of Fr. Gerard Hughes, a prominent leader of retreats. He believes in the importance of "letting God be God".¹⁰ This is good advice in the persecutory climate of Inquiries that can make ourselves, and particularly our service managers, feel that we have to work miracles or else!

On the more overtly scientific front, Kate Loewenthal's book on the Psychology of Religion¹¹ provides the research evidence that there are more and less mature forms of religion, and that people may move in their lifetime to rediscover a more meaningful form of earlier religious faith. This rediscovered faith is more realistic, less literalist and may be associated with the capacity for appreciating the realm of symbols. We can, as it were, grow up in Faith. Critics of religion in general are often referring to an immature Faith, one that without adult thought may fail to realistically address adult concerns. I am reminded of St Paul: "When I was a child I thought as a child..."

I now intend to move on from these influences that I hope I carry with me, to the consideration of themes, which arise in ordinary clinical practice. I think it is Paul Tillich¹² who writes of "the courage to accept acceptance". This can be a challenge both in one's own psychotherapy and in the treatment, in particular, of borderline patients. People who have been abused and neglected in early life carry with them that particular template for human relationships and will often seem hell-bent on turning us bad and defeating every effort to help, often creating the self fulfilling prophecy of rejection. It is, of course, easier to live with that which is familiar than to view one's own contribution to ongoing pain against a gradient of envy, and to receive help and change.

One of my own most challenging patients is a woman with a very serious and damaging history of abuse and a long psychiatric history. She is herself a professional and when she came to our service, I was reminded by the paper "The Ailment" by Tom Main,¹³ of our limitations. Here was somebody with serious ongoing destructive tendencies who might ultimately not be treatable, and who might commit suicide regardless. This recognition and acceptance was very important for myself and a number of the professionals who continued to work with her. Initially we were pushed to a limit to prevent her self-destruction; on behalf of the inpatient team I had eventually to face her with the impossibility of this task. To my surprise and relief at the time, she experienced this as respectful and liberating, and so began a more active, albeit continually risky, beneficial psychotherapeutic treatment, one which has involved ongoing anxiety and complicated multi-agency networking.

This brings me to another term, that of "bearing the unbearable", which I believe is important in our work. The phrase has a somewhat religious/vocational ring to it (I think the source of the phrase may be the psychoanalyst W Bion). As psychiatrists, the substrate of our work is human misery. It is not surprising that sometimes a particular personality or personal circumstance is too much for us. Possible responses are rejection of some sort, which may fulfil the patient's prophecy, or excessive use of pharmacotherapy to a degree that becomes disabling rather than enabling. The latter may result from a venting of unconscious punitive desires or from a wish to medicate the misery that is evoked in us by that person.

Passive aggressive dependant personalities, for my own personal reasons, do it for me! I remember inheriting one such patient from a colleague owing to a change of catchment area. I can only describe being with this patient as like swimming through treacle. By sharing this within the team we have been able to hang on in there and again to see some change. This person held us to ransom for many months by a very real suicide risk. My experience was that I had to go with that for a time until we all felt safer, before moving on to the implicit acknowledgement that suicide is not something we can prevent and nor is it a beneficial bargaining tool.

Not only is she now less like treacle but also she can periodically reflect on the difficulty she experiences when others seek to make her responsible for them. Effectively she can empathise with us.

Timing is all-important in achieving a balance between containment and challenge. In my experience the team has to bear the unbearable at times when the patient is unable to do so. For an individual professional to do this alone may not be possible or healthy. Here it is important to have access to help in the form of good team support and clinical supervision. Consideration of one's own health is also important, may involve attention to general, psychological and spiritual dimensions and may include personal therapy. I would also contend here that a sense of humour is a vital asset in our work!

Two young male inpatients faced our own team with the unbearable. Both had histories of terrible tragedy such that the nurses in particular found them painful to have around. Both suffered from bipolar affective disorder and were very immature adolescents.

John had lost his mother by suicide. In his own grief his father could not appropriately support John's grief and abandoned him to medical institutions in Germany, the country where they lived. There he was treated with pharmacotherapy and great diagnostic interest, but his grief seems to have been left unattended. On coming to the UK he seriously attacked his father as well as developing religious delusions. These seem to have arisen initially by his finding love in the setting of the Church. He went on to connect his name and that of his father with "the first and last" in a sort of apocalyptic vision. We were very indebted to the chaplain who helped in the treatment of this patient by his personal support and the message to the patient that "maybe you are taking religion a little too seriously". Psychologically there is a universal need to be both special and ordinary, and the chaplain, with his somewhat painful intervention, yet lovingly delivered, helped to balance these needs for this young man.

The other patient was a very immature teenager, a member of a large family with a strong family history of mental illness. He had already received his diagnosis from the Child Psychiatry services. He stopped his Lithium while on a family holiday in Ireland and became very manic indeed. He had a sad personal history and had been seriously abused at school. The combination of his adolescent limit-setting behaviour and the excesses of his illness proved well nigh impossible to contain despite pharmacotherapy. He managed to bring out the worst in our staff, who felt pushed beyond their limits while attempts were being made to transfer him to a more suitable place.

Just as a specialist placement was coming on stream, he appealed under the Mental Health Act for his discharge. Shortly before and during the hearing he was generally noted to be more contained and rational. Several factors may have contributed, including a second opinion leading to a change of medication. I noted however that he was wearing quite a prominent crucifix around his neck in front of his sweater. He was not by his own account religious and it may well have been given by a fellow patient. It struck me that this archetypal symbol of unbearable suffering had somehow coincided with him becoming more bearable to himself and others, where previously he had been the personal embodiment of awful pain. This came to the surface in a religious image, and with this came a real measure of recovery.

Lastly and most recently, I have been working with an outpatient who is very anxious, phobic and totally "stuck" in her life. Interestingly, she is a Jehovah's Witness. Her father died in her youth and she took a serious overdose after the failure of a second marriage in which she had seemed to invest everything. She couldn't look at the legal communications about divorce, such that her husband's lawyer had written saying he would proceed as if she was dead. (Indeed she has remained frozen most of the time since.)

Our explorations into the realm of her religious position come from her allusions to “The Truth”. It transpires that this is a one-sided truth that is unlikely to set her free and is associated with the Bible in her mind. Again, she links this with the notion of goodness and we have discussed the idea that there is violence and suffering as well as peace and love in the Bible.

This patient has a poor relationship with her mother, who she experiences as highly critical. She has spoken of “hiding” with the Witnesses, and of how recovery is painful and can reinforce a wish to “hibernate”. She talks often of “the Resurrection” when things will be better. By this she means that after the sleep of death “He will come down and put things right”. (I realised as I prepared this talk that it is likely that the Lord who will return to put things right may be linked with her father, loved, lost and longed for). I have asked her to consider a “resurrection” in the here and now, rather than waiting literally “till kingdom come”. What we have seen is an intermittent recovery of a wonderful and slightly wicked sense of humour, which we can enjoy together.

Sometimes I ask myself whether I am proselytising or trying in some way to convert her to my religion. It’s an interesting thought, and if I am, it is a sin against the prevalent social God of political correctness. I think we are really having some therapeutic fun, and that religion is a sort of transitional space for us. (Incidentally she has given me Jehovah’s Witness publications to read, and so any likely proselytising can be reciprocated).

I could go on recounting case vignettes where spiritual issues have had some sort of direct relevance to the psychiatric setting, since cases are legion and indirect relevance is always present. To draw this paper to a conclusion I would like to suggest that our work is always in some sense spiritual, and that some people for their own reasons are variously frightened, exited or consoled by this dimension. Explicit explorers of such territory need to be mindful of this. We can often, but not always, give patients a better experience that may even modify the God that goes with them.

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