Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE TWENTY-SECOND ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Enhancing the Skills of Mental Health Practioners: Treating Mind and Body and Spirit

We have been through an age of clinical specialization, which results in fragmentation of health and mental health care. This violates the essence of community mental health. As society rebels against dehumanization there is increasing interest in reintegrating people and community life. The speakers will offer their expert perspectives in a case conference format addressing trauma, with the goal of expanding and integrating competence in caring for mind, body, and spirit in clinical practice. We then are better able to meet the needs of whole people.

Case Conference Participants

Stanley J. Berman, PhD, Visiting Associate Professor, Department of Psychology, Wellesley College; Director, Institute for Clinical Health Psychology, Massachusetts School of Professional Psychology.

John T. Chirban, PhD, ThD, Clinical Instructor in Psychology, Harvard Medical School; Professor of Psychology and Chairman Department of Human Development, Hellenic College/Holy Cross School of Theology; Adjunct Instructor in Psychology, Massachusetts School of Professional Psychology; Co-Director, Carlisle Counseling Associates; Director, Cambridge Counseling Associates.

Martha Stark, MD, Faculty, Boston Psychoanalytic Institute; Faculty and Supervising Analyst, Massachusetts Institute for Psychoanalysis; Instructor in Psychiatry, Harvard Medical School; Author, Working with Resistance and A Primer on Working with Resistance (Jason Aronson, 1994), and Models of Therapeutic Action (Jason Aronson, in press).

Moderator

David G. Satin, MD, LFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School; Chairman, Erich Lindemann Memorial Lecture Committee

Friday, May 14, 1999, 2:30 – 5:00 pm

Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132

Introduction by David G. Satin, MD

There is abroad a lively interest in integrated views of life and health, and treatment approaches. Perhaps this is a healthy reaction to the disintegration of society and lives as a consequence of long-term trends in industrialization, population mobility, and family cohesion. The Lindemann Lectures have addressed current pressures toward the depersonalization and dehumanization of health care policies, economics, and practice.

Today we have prepared an exercise in a multifaceted and integrated approach to mental health practice. The presenters are familiar with the broad perspective on clinical practice, and will try to demonstrate it for the consideration of and elaboration by those in the audience who give and/or receive health care.

The integration of physical, psychological, and spiritual healing has a long history. To take only one example, in the first decades of this century the Reverends Elwood Worcester and Samuel McComb at Boston's Emmanuel Episcopal Church reached out to work with internists like Richard Cabot and Joseph Pratt, and psychoanalysts like Isadore Coriat in the rehabilitation of those suffering from tuberculosis, alcoholism, and neuræsthenia, using medical, psychological, and spiritual means. They wrote the books *Religion and Medicine: The Moral Control of Nervous Disorders* [Worcester, E., McComb, S, Coriat, I. (New York: Moffatt, York, 1908)], and *Body, Mind and Spirit* [Worcester, E., McComb, S. (Boston: Marshall Jones, 1931)]. The "Emmanuel Movement" inspired professionals and laymen across the country, at the same time that it inflamed defenders of traditional professional boundaries. Eventually it was lost and forgotten. Is there a message in this about collaboration and change?

This issue was near to Erich Lindemann's heart. He himself was both a social psychologist and psychiatrist. He strongly advocated the inclusion of the social sciences in medical education and practice, working with anthropologists such as Clyde Kluckhohn, sociologists such as Talcott Parsons and Samuel Stauffer (and Louisa Howe), and psychologists such as Henry Murray and Marc Fried. Clergymen, too, were important collaborators in his ideas and practices: Joshua Loth Liebman, religious leader of Temple Shalom of Brookline and author of *Peace of Mind* was a respected colleague, and it was William Brooks Rice, pastor of the First Unitarian Church of Wellesley, who invited Lindemann to Wellesley to develop the Human Relations Service and became a colleague and friend. Lindemann, too, found criticism and resistance among those who wanted health care kept pure of "outsiders" and social entanglement.We hope addressing these issues will help you and that you will help us to explore them.

Dedication to Louisa Pinkham Howe, PhD by David G. Satin, MD

Louisa Howe was one of those great people of the past who stood out as landmark, and cannot be replaced. This is an appropriate place to take time to honor her memory.

1. Her mother was Wenona Osborne Pinkham, In the 1920's she was executive secretary of the Massachusetts Civic League (the precursor of the League of Women Voters), and state organizer for the Massachusetts Woman's Suffrage Association.
2. Louisa Howe graduated from Radcliffe College *Magna Cum Laude*, AM, and earned her Ph.D. in Sociology from Harvard University (with Talcott Parsons as her dissertation committee chairman).
3. She was the first woman Sigmund Freud Memorial Fellow at the Boston Psychoanalytic Society and Institute.
4. She was on the faculty of the Menninger Foundation, when, in 1951, she acted as expert witness in the case *Brown vs. Board of Education* (in the Kansas court). Her testimony included the following: "…The fact that segregation is enforced…gives legal and official sanction to a policy which is inevitably interpreted both by white people and by Negroes as denoting the inferiority of the Negro group…A sense of inferiority must always affect one's motivation for learning since it affects the feeling one has of oneself as a person…Attending a segregated school…is a trauma to the Negro child.…
5. Dr. Howe was interested in ociological practice—not isolated in academia. She practiced this in projects such as:
    - University of California-Berkeley School of Pub Health—Kauai Pregnancy Outcome Study
    - College Mental Health Center
    - From 1958 to 1967 she worked with Erich Lindemann and Gerald Caplan at the Harvard School of Public Health and Harvard Medical School
    - She was on the staff of the Boston City Hospital from 1967 to 1976 working in the rehabilitation of alcoholism and drug addiction, rising to the rank of Associate Clinical Professor of Psychiatry in Harvard University
    - (In 1990 she gave the 13th Erich Lindemann Memorial Lecture with the title "The Failure of the Moral Approach to Drug Abuse")

6. Since 1962 she practiced the Pesso-Boyden System of Psychomotor Therapy, in 1971 was an incorporator and then Secretary of the Psychomotor Institute, and Chairman of its Training Committee on the Pesso System

7. Since 1978 Dr. Howe was a member and then Secretary-Treasurer of the Sociological Practice Section of the American Sociology Association. In 1990 she was given the Distinguished Career in Sociological Practice Award. She was also Assistant Editor of the *Clinical Sociology Review*.
8. Louisa Howe was a member of the Boston Psychoanalytic Society and Institute, Past President of the Massachusetts Sociological Association, member of the Massachusetts Psychological Society, the Society for the Psychological Study of Social Issues, the Society for the Study of Social Problems, and Sociologists for Women in Society.
9. Louisa was a long-term member of the Lindemann Memorial Lecture Committee, always contributing with creativity, feeling, and enthusiasm. This came from her view of community:
10.

> "…The aspect which is distinctive of community is not simply territorial, but rather consists of a symbolically expressed sense of common destiny…a sense of interrelatedness in the face of this common destiny, and a knowledge of what community members can expect of one another…." (Howe, Louisa "Some implications for the Development of Community Psychiatry, Bellak (ed.), Handbook of Community Psychiatry and Community Mental Health (1964))

Stanley J. Berman, PhD

Director of the Institute for Clinical Health Psychology at the Massachusetts School of Professional Psychology, Visiting Associate Professor in the Department of Psychology at Wellesley

Introduction by David G. Satin, MD

Stanley J. Berman, Ph.D. is Director of the Institute for Clinical Health Psychology at the Massachusetts School of Professional Psychology and Visiting Associate Professor in the Department of Psychology at Wellesley

Dr. Berman received his bachelors degree in philosophy and history from the University of Rochester, and his doctorate in clinical psychology from Temple University. Among his publications in childhood and terminal illness is "Family Systems Medicine: Family Therapy's Next Frontier", written with B. Dym and published in *The Family Network*.

Stanley J. Berman, PhD—Body

Odessa, a 50 year old government worker, is the married mother of five daughters. She presents for individual psychotherapy with dysthymia, low self esteem, feelings of shame, guilt and passivity, and a significant abuse history in her childhood. In addition, she has diabetes and hypertension. Odessa was raised in the Roman Catholic church, but is now a convert to the Seventh Day Adventist faith. She takes her religious life seriously, is an active church member, and is married to the head elder in the church. She relates at the onset of treatment how conflicted she is about being a wife and mother, how confused she is about her religious tradition which asks her to be loving and respectful, when her own history makes this very trying, and how hard it is for her to be productive at her work or church.

Odessa has had a challenging, difficult life. It speaks to her own strength that she seeks psychotherapy and believes, in part anyway, that she can make changes in her life at age 50. There are of course many ways we could design a meaningful and effective intervention with Odessa. I would like to propose one approach, a Clinical Health Psychology model and explore with you how one would formulate the case and develop a treatment plan using this model.

Clinical Health Psychology: An Introduction

I would like to begin with a definition of Health Psychology. Health Psychology is a sub specialty in Psychology which addresses the applications of psychological theory and

research to illness, health and wellness, as well as disease prevention and health promotion. A more complete definition was proposed by Joseph Matarazzo:

> (Health Psychology is)...the aggregate of specific educational,scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness and related dysfunctions.(Matarazzo, 1980, p. 815).

We use the term Clinical Health Psychology to designate the applied field which draws from the research and theory base developed in Health Psychology. A closely related term, behavioral medicine is not synonymous. Behavioral medicine draws upon learning theory and cognitive behavioral models to design highly effective interventions across medical illnesses and psychophysiological disorders. Clinical Health Psychology includes behavioral medicine but also draws freely from other models including family systems; existential and psychodynamic approaches.

There are a few central fundamental distinctions in this field. Franz Alexander made a very important contribution with his discussion of psychosomatics (Alexander, 1950). His model however is a dualistic one in which there is a discrete psyche and soma which interact and influence one another. This model led to an unfortunate understanding in the general public that either one had a real disease or a disease that was "all in one's head", a psychosomatic disease. In Health Psychology, we posit that there is a unitary system and that mind and body might be more accurately thought of as a single word: mindbody.

A second assumption in this model is that there is a difference between disease and illness. As psychiatrist and anthropologist, Arthur Kleinman suggests, disease is the physiological process while illness is the psychosocial nest in which the disease occurs. Given the great diversity in human intrapsychic life, as well as in interpersonal and environmental circumstances, two individuals may have the same disease, but very different illnesses (Kleinman, 1988).

Yet a third fundamental is that the etiology of illness is multivariate. Koch, Pasteur and the great microbe hunters of the last century sought out, in a logical, linear path, the first cause of an illness like hoof and mouth disease. This search for a single microbe is largely responsible for the relative control of infectious illness in the industrialized world. This model however does not account well for modern illness. The Health psychology model explores illness in its ecology. Multiple factors including genetics, environmental exposure, stress, cognitive, affective, behavioral and social variables interact to account for illness. Illness then is examined with an integrative, contextual

approach. This approach is well captured by Engel's Biopsychosocial Hierarchy, a model which we will return to shortly (Engel, 1980).

If we adopt an ecological or contextual model, we then must revisit whether the physician-patient or mental health professional-patient dyad is the most effective nexus of intervention. If indeed multiple variables account for an illness presentation, and the patient's experience of illness is within a complex social environment then a better treatment model would be a patient and their family, (biological family or the social support network the patient considers family), and the multidisciplinary medical team. Now, I have not, like Rip Van Winkle, been asleep throughout managed care's intrusion into our lives. This model sounds likely to be less economically efficient. It is beyond the purview of today's talks to address this issue at length. I would say however that the family and team are not routinely brought together, but rather strategically brought together, and that innovative and cost effective models of collaborative care are being explored currently (Seaburn et. al. 1996 ; Blount, 1998, Dym and Berman, 1986).

The Lens of the Clinical Health Psychologist: Eight Key Variables

In this section, we explore eight important constructs in health psychology and make preliminary suggestions for how to shape an effective assessment and intervention.

Physiological Variables

The Health Psychologist must have a sophisticated understanding of the body and its functioning. After one is conversant with the subsystems of the body, one next attends to the physiological pathways of stress (Selye, 1956), the relationships of cognition, affect and behavior studied in the field of psychoneuroimmunology (Solomon, 1974 ; Ader, 1993), and new developments in the neurosciences.

Odessa presents with diabetes mellitus. The case report does not specify whether she has Type I or Type II, (although I am assuming this an adult onset Type II disease), or what self-management is necessary. We do know however, that of all women, African American women have the highest prevalence rates of diabetes, and are at higher risk to develop diabetes-related complications. We further know that dietary adherence and weight control are particularly important in daily self-care of diabetes. Given Odessa's feelings of depression and low-self esteem and passivity, it is reasonable to assume that she experiences compromised self-efficacy, and may find dietary restrictions to be difficult to adhere to (Ruggiero, 1998).

We also know that there is a complex, yet not well understood relationship between stress, distress, and glycemic control. We do have enough evidence to know that stress can affect glucose regulation indirectly through interfering with self-management or with less clear data, directly through psychophysiological pathways (Polonsky, 1993).

Intervention strategies for Odessa's diabetes will be addressed in the more detail in the final section of this essay.

Odessa also has hypertension, an illness which is a major risk factor for heart disease and stroke. African Americans of both sexes have a higher incidence of hypertension than whites (Wassertheil-Smoller, 1998). While hypertension can often be well controlled with daily medication, one must remember to take one's medication each day. Hypertension is a silent illness in which one has little awareness or distress from the disease. Adherence is a major issue for chronic illnesses which cause little daily distress. Odessa could be at higher risk to be medication non-compliant. Hypertension is also a stress-sensitive illness. Odessa feels under-employed and uncomfortable and unhappy with her life. She is hard working but feels under-appreciated at her church. She feels very little social support. There is intriguing work on the possible correlation between racism, stress, and hypertension (James, 1983; Anderson, N.B., 1986). We can appreciate that the combination of Odessa's low confidence and low self-efficacy could lead to poor adherence with her medication regime. We can further anticipate that we will want to develop interventions which help her modulate stress and build social support. Finally we know that the Type A coronary risk theory has evolved to a focus on hostility as a primary risk factor. Odessa is understandly a very angry person. We will also want to address issues of hostility in our intervention (Williams, 1988).

Learning Theory and Cognitive Behavioral Models

The theory base of behavioral medicine will be a rich resource for developing intervention strategies for Odesssa. Odessa clearly has major existential issues, issues about the self and her relationship to others. Ideally, she would benefit from a psychotherapy focused on healthier resolutions of these life long issues including most prominently coming to terms with her abuse experience and her feeling unprotected and abandoned emotionally by both parents. One would then in an ideal world offer her a health psychology intervention to aid her in living successfully with two chronic illnesses. It is entirely possible however that she could have a significant problem with regulating her hypertension and diabetes mellitus due to problems with medication adherence, stress management, dietary regulation, insufficient exercise or inadequate weight control. The internist (or cardiologist or endocrinologist) might refer Odessa for a behavioral medicine consultation prior to an in-depth psychotherapy having taken hold due to her elevated concern about Odessa's medical symptoms. In this event, learning theory and cognitive behavioral models would be very helpful.

Psychoeducation about nutrition, exercise and stress management might be indicated. Obtaining a behavioral baseline on one of several health related behaviors for

a seven day period, followed by a behavioral contract and specific interventions to meet a goal agreed upon collaboratively might also be offered. The use of cognitive behavior models developed by Ellis (1962) and Beck (1972) in which Odessa would be invited to examine schemas she has about her health, could lead to the development of a more accurate, realistic cognitive map with more on target behavior to follow.

Learned Helplessness and Self-Efficacy

Martin Seligman's impressive line of research on learned helplessness clearly indicates that when we believe that our behavior, any behavior we initiate, will not lead to the desired outcome, we are likely to feel helpless and to not voluntarily initiate new behaviors. We become helpless and immobilized. Seligman has specified the very close relationship between learned helplessness and depression (Peterson, Seligman, 1993). Odessa has every reason to feel ineffectual. While she was able to protect herself from sexual assault, she was unable to protect her sisters. She felt unprotected by both parents. She is very intelligent, but does not experience herself as intellectually capable. She is under-employed, feels unappreciated at work and home and feels unable to rectify her situation. These feelings of helplessness and depression have prevented her from mounting steps to change her life. She has taken a first step by seeking psychotherapy. Any effective psychotherapy will have to provide a method for her to develop a sense that she can reach her objectives, to believe that her behavior does yield desired outcomes. Albert Bandura's closely related construct of self-efficacy, a belief that one has the resources and skills to reach a specified goal is indeed one of the treatment objectives (Bandura, 1997). A growing sense of self -efficacy would be sought out not only related to diabetes and hypertension, but to being more assertive at work, at the church and in her marriage.

Stress and Coping

From the pioneering work of Walter Cannon (1932) and Hans Selye(1956), we have a model of the physiological pathways of the stress response. Solomon (1974) and Ader (1993) and Kiecolt-Glaser and Glaser (1984; 1991) have documented the relationship between cognition, affect, behavior, and immunocompetence in the relatively new field of psychoneuroimmunology. We know that stress can exacerbate both of Odessa's medical conditions and can cause a deleterious wear and tear on her daily psychic life. We also know that she has felt very little self-efficacy to manage the challenges of her life whether they be daily hassles or major stressors.

Lazarus and Folkman (1984) have developed a well respected cognitive model of coping in which the individual first evaluates whether an intrapsychic or environmental

event is a threat to their well-being. If the answer is yes, the individual then assesses what resources they have to mount to respond to the challenge. A set of coping responses is then initiated, and a second round of appraisal then transpires to ascertain whether the threat has been managed. Odessa repeatedly assesses challenge, but then most often concludes that she lacks the resources, both internal and in the environment, to successfully respond. A successful treatment plan will include helping her to build new skills and tools, to rehearse these skills and tools and try them out in her world.

Ethnocultural Variables

Odessa is an African American woman in a culture which she experiences as misogynistic and exploitative of woman, and as racist. She is painfully sensitive to the fact of being an individual with little power. One cannot mount a successful intervention without clearly understanding how her ethnicity, religion, social class, and gender shape her construction of her world (Young and Zane, 1995). One can learn this in part by reading, but it is best apprehended by interviewing Odessa about her own beliefs about the meaning of her difficulties and her illnesses. Young and Zane describe how culture will shape the meaning of symptoms and their expression, personal coping, help seeking, the use of social support and the interface with medical providers.

Meaning Making and Existential Issues

Kleinman (1988), Frank (1995), Rolland (1994) and Jacobs (1992) all argue persuasively that each patient constructs her own narrative about why she became ill, what will happen, who has the power to impact upon the illness, and what meaning the illness has to her and her family. We cannot build a successful alliance and collaborate with Odessa on her treatment without a rich understanding of her illness narrative. This central concept intersects most dramatically with questions of God and spirituality, as we can be certain that Odessa's faith and her participation in the Seventh Day Adventist will be a key organizer of her narrative. Her family's past history with coping with illness and adversity and their methods of coping will also inform her narrative. The construct of meaning making should be a familiar theme in psychodynamically informed psychotherapy.

The Transtheoretical Model

Prochaska, DiClemente and Norcross (1992) were interested in the question of when substance abusers are ready to address their drinking problem. They constructed a spiral model of readiness for change in which individuals move from a precontemplation phase, in which they are not truly considering change, to a contemplation phase in which

the individual is aware that change is needed and they are beginning to consider it, to a preparation phase in which they are gathering information, resource sand resolve, then an action phase in which they initiate new behavior, and finally to a maintenance stage in which they attempt to hold on to the new behavioral cluster. There is of course the possibility of relapse and then a recycling of the stages. This model has been increasingly applied to many other health related behavioral change processes like cigarette cessation or diet initiation. The key issue with this useful model is that an assessment of an individual's ambivalence about change (see William Miller's Motivational Interviewing model, 1993), and readiness for change is a vital step in an assessment. Odessa should seek to increase exercise and monitor her caloric intake, for example, because she is ready and committed, and not because the physician has become more anxious about her weight and is consequently ready for Odessa to change.

The Biopsychosocial Hierarchy

Engel developed a model to account for how illness occurs at multiple inter-related levels concurrently. An illness is not a cellular change with subsequent psychosocial sequellae. Rather an illness occurs on several levels at once. If we consider Odessa's diabetes, we will find frank differences on the cellular level in measures of blood glucose and in pancreatic beta cells, the body's primary source of insulin. We will see differences on the tissue and organ level as insufficient insulin entails an inability of tissues to absorb glucose, and certainly differences in pancreatic functioning. On the level of the person, we may see increases in fatigue or dizziness. We may find a depressive response to the cumbersome nature of regular testing, injections if Odessa is insulin dependent, and strict balancing of diet and activity level. On the two person system, we may find stress related to considerably greater risk and complications with diabetic women who are pregnant; and with sexual functioning, as there is some evidence suggesting that while diabetic men have much greater impairment in sexual functioning, diabetic women may have some difficulties including lowered levels of arousal (Ruggiero, 1998; Polonsky, 1993).

On the family system level, we may find that family stress exacerbates Odessa's diabetic regulation. This relationship was suggested in an early study by Minuchin and Rossman (1978). In the community, we may find that Odessa has modest social support as she feels disconnected from close relationships within the church community, and her depression impedes her seeking out support. Social support is a key salutary variable in many chronic illness presentations (Berkman, 1985). On the cultural level, we will want to consider the variables we discussed previously as to how ethnicity, social class, gender and family history create a lens through which Odessa perceives her illness. Engel's

model allows us to see how these phenomenon are on-going and continuously influencing one another. As so much of the action can also be on the family level, family systems interventions often are important components in living adaptively with a chronic illness.

With these eight inter-related constructs in mind, we can finally turn to crafting a successful health psychology intervention in collaboration with Odessa.

Health Psychology Applied

This intervention is predicated on an assumption that Odessa has already made some substantial progress in an insight oriented, dynamic intervention with Dr. Stark or Dr. Chirban. A health psychology intervention can certainly be a first and primary intervention. This is the case, for example, when working with the cancer or HIV patient, the patient following his first myocardial infarction, or the individual with asthma or Reynaud's syndrome. In Odessa's case, I would suggest that the health psychologist provide an intervention after Odessa has a better understanding, and has made progress in addressing her history of abuse and abandonment. At this juncture Dr. Stark or Dr. Chirban has referred Odessa to a clinical health psychologist to specifically address her diabetes mellitus and her hypertension. These two illnesses have an undesirable synergy in increasing her risk for more serious coronary complications. Drawing on the eight constructs we have been discussing, we would begin with a thorough assessment examining Odessa's life in its fullest biopsychosocial context. We will be interested in her narrative about the meaning of her illnesses; her history of coping with adversity, her sense of both efficacy and readiness to address the illness issues and her own desired outcomes in addressing her diabetes and hypertension.

Needless to say, the intervention would be tailored to meet goals arrived at collaboratively. As we can only speculate on what her goals might be, I will make a few educated guesses. The goals we agree to pursue are: daily use of hypertension medication, daily glucose testing as per her physician's recommendation, anger and stress management, increased exercise and increasing social support. I would postulate that she irregularly takes her hypertension medication. With five daughters, a job, and a husband who does not share the house keeping responsibilities, she feels too tired and overwhelmed to carefully individualize her diet. She cooks one meal a night for the family and it may not meet her endocrinologist and nutritionist's recommendations. Her daily glucose testing is not regular enough. This is due to being overwhelmed, to believing her fate is in God's hands, and in being too depressed to be consistent with self-care. Both her cardiologist and endocrinologist are quite concerned by her inadequate self-care. Because she has felt some real success and improvement in her psychotherapy,

she is more open minded about this referral than she would have been two years ago, before her treatment commenced.

In our assessment, Odessa and I both recognize that her consistent feelings of low self-efficacy and of helplessness lead to her belief that she cannot effectively take better care of herself. We further recognize that her daily hostility may well place her at higher coronary health risk. Finally, she consistently reports feeling overwhelmed, which I understand to mean that she feels constant stressors she cannot manage. Our initial intervention will consequently include a program on anger management, likely delivered in a group therapy format. As her previous therapy has increased her understanding of her anger, she is likely to be able to utilize this more behavioral approach at this time. We will address self-efficacy by targeting one desired behavior change which is modest in scope and has a highly likelihood of success, perhaps her wish to move from a totally sedentary lifestyle to one which includes regular exercise. A half hour walk in the late afternoon at home with a friend would increase social contact and support and get Odessa exercising. This modest behavior change could be followed by more difficult targets like weight reduction. Relaxation training might be implemented. Several studies have shown that it increases glucose tolerance, although this approach may be more successful with Type II rather than Type I diabetes (Surwit and Feinglos, 1983). As Odessa makes progress on these fronts, she may be prepared for couples therapy to address long standing issues in her marriage, which must contribute to her feeling stressed and distressed. The above illustrations are just a few of the possibilities that the clinical health psychologist might implement. Individual, group, and family modalities are all drawn upon. Psychoeducation, stress and anger management, and cognitive behavioral contracting are all utilized. These interventions are always built in partnership with the patient and with sensitive attention to the patient's context and personal illness narrative.

Odessa has had a very arduous journey to age 50. At age 50, she now avails herself of the opportunity to confront old demons and to develop more adaptive models for living with herself, with her family and community, and with her chronic illnesses. Clinical health psychology can offer Odessa the opportunity to develop a new map to guide her in her journey, new tools, and if our efforts our truly successful, a new bounce in her walk.

Martha Stark, MD

Teaching Analyst at the Boston Psychoanalytic Institute and Massachusetts Institute for Psychoanalysis, Director of Three Ripley Street

Introduction by David G. Satin, MD

Martha Stark, M.D. is a Teaching Analyst at the Boston Psychoanalytic Institute and Massachusetts Institute for Psychoanalysis, and directs Three Ripley Street, a continuing education program for mental health professionals.

Dr. Stark is a graduate of the Harvard Medical School and the Boston Psychoanalytic Institute. She is on the faculty of the Center for Psychoanalytic Studies at the Massachusetts General Hospital and teaches in the Continuing Education Program of the Massachusetts School of Professional Psychology. Among the books she has written are *Working with Resistance, A :Primer on Working with Resistance,* and, scheduled for release this year, *Modes of Therapeutic Action: Enhancement of Knowledge, Provision of Experience, and Engagement in Relationship.*

Martha Stark, MD—Mind

The title for my talk is a quote from Archibald MacLeish, "We have no choice but to be guilty. God is unthinkable if we are innocent."

Odessa is a tormented soul with a broken heart. Her life has not turned out at all as she had hoped it would. None of her dreams has come true. She lives with chronic despair; there is no love in her life, no joy, no happiness, no sense of prideful accomplishment, and no good feelings about herself or others. Odessa's life is a bleak wasteland--it is a life that must, simply, be endured.

Odessa was raised in a family where the males were in a position of power and abused that power; the females were their victims. Father was a horrid man; he was himself abusive and gave his sons the message that they too were entitled to ravage the females in the family--physically, emotionally, and sexually. And mother was a weak, pathetically ineffectual woman who was ill-equipped to protect either herself or her daughters from the abuse the male members in the family meted out. Odessa is particularly resentful that neither parent encouraged her to develop her intellect; nor was she given any indication that she was a good, worthwhile human being who deserved to find love, fulfillment, and pleasure.

But despite this lack of support, Odessa, in an amazing show of strength, was able as a young adolescent, to fight back in such a fierce way (when her father and brothers attempted to force themselves on her sexually) that she "dissuaded them" from any attempts to assault her sexually. What an extraordinary feat. And we also learn that

Odessa, at the age of 18, left home, went out into the world on her own, moved into an apartment with another woman, and got herself a job--also an amazing accomplishment.

What a fiercely indomitable spirit Odessa must once have had--though tragically, somewhere along the line, she lost her way. And now she is a guilt-ridden, shame-filled, deeply (and angrily) depressed 50-year-old devout Seventh Day Adventist who regrets both having married and having had her five daughters and who, her entire life and despite her high normal intelligence, has been a chronic underachiever in the various low-level governmental positions she has held. She is chronically exhausted and has developed several medical problems because she works herself to the bone (asking nothing for herself but offering everyone else the world)--all in the interest of maintaining her image as a "sincere and loving Christian."

Odessa keeps up appearances but, inside, is raging, bitter, and resentful, is riddled with hatred and contempt (for both herself and others), feels ever persecuted, unappreciated, undervalued, and is racked with shame and guilt. She experiences herself as damaged goods, experiences others as woefully inadequate, and is consumed with outrage that life has dealt her such blows. Odessa can forgive neither herself (for having failed in the ways that she has) nor others (for having failed her in the ways that they have). Odessa has little "faith" in the goodness of others; nor does she appear to have much faith in a merciful, compassionate God--which must make her feel like such a hypocrite, particularly because church life (in fact, she is head deaconess at her church) and devoting herself to all manner of charitable Christian acts are such an integral part of her life. Ironically, it would seem that Odessa uses her religious orthodoxy to torment herself further and to reinforce her sense of herself as bad and as morally reprehensible.

Odessa's is an ascetic existence of "misery and punishment," interestingly characterized also by no smoking, no drinking, and no meat (which has earned her the reputation at work of being a saint, or, at least, a goodie two-shoes). Her strict adherence to such a regimen impressed me, although it did strike me that Odessa's abstinence may also speak to how self-punishing and self-depriving she can be.

People like Odessa, who have intensely critical superegos, often get caught up in harshly self-punitive behaviors, designed to appease their guilty consciences. In a vain attempt to absolve themselves completely of their guilt, such people continue to be self-abusive and self-destructive. As often happens for people burdened with excess guilt, they alternate between periods of self-deprivation and self-indulgence. Odessa's cycle would therefore go something like this: Because of her guilt, Odessa deprives herself of good things; but, after a while, she begins to feel angry, resentful, deprived, which prompts her to indulge herself; but then she feels guilty--and the cycle repeats itself, periods of self-deprivation alternating with periods of self-indulgence--which, of course, only reinforces her sense of herself as bad.

With respect to Odessa's guilt, her religious upbringing, which espouses "love and respect" for family and insists that one "not let the sun go down" on one's anger, must not have made it any easier for Odessa to come to terms with her particularly un-Christian feelings of outrage, hatred, and bitter resentment. We are told that Odessa, even as a child, was plagued with thoughts of seriously harming the male family members and harbored ambivalent feelings toward her mother for being so unprotective, passive, ineffectual--a terrible female role model whom Odessa wanted both to protect and physically to attack.

Odessa's guilt comes in many forms. Part of the price she pays for harboring murderously rageful feelings is guilt and an abiding sense of herself as a bad person, unworthy, undeserving. There is also the guilt Odessa experiences because of her inability to protect the other females in her family from the abusiveness of the males.

Then there is the guilt about which Arnold Modell (1965) speaks--separation guilt, which, I believe, figures prominently in Odessa's psychology. This is the guilt one feels about separating from the parental objects, becoming one's own person, carving out an identity of one's own. With respect to Odessa's differentiation of herself from her family and her efforts to establish her own autonomous existence, we are told that, as I had earlier mentioned, she moved out of the house at the age of 18 and that, at some point along the way, she converted from Roman Catholic to Seventh Day Adventist.

Modell (1965) suggests that the separation-individuation process (of the child from her family) is inevitably accompanied by guilt. In fact, Modell believes that such guilt represents a fundamental human conflict and is therefore present, to some extent, in everyone.

But, for some people, being separate is fraught with tremendous guilt and the (often unconscious) conviction that one does not, in fact, have the right to a life, the right to a separate existence.

This separation guilt is not the more classical oedipal guilt associated with libidinal feelings toward the opposite-sexed parent and aggressive feelings toward the same-sexed parent and nor is it Melanie Klein's (1933) depressive guilt (which arises from concern one has about having harmed with one's aggression an ambivalently held love object). Rather, it is the guilt that comes of feeling that, by way of separating and individuating from one's nuclear family, one has gained something at the expense of others, that to have something good for oneself means that others are being deprived or, even, destroyed. It is a zero-sum game. Modell (1965) suggests that there may even be the primal fantasy that in order to be born, someone else must die.

Hand in hand with guilt go feelings of shame--shame not about what one has done (or imagined doing) but about what one has not done or, even, shame about who one is. In fact, the relationship between guilt and shame is an intriguing one.

Guilt is often associated with a certain omnipotence of thought (often unconscious) that equates the thought with the deed; these illusions of omnipotence are often reinforced by religious orthodoxy.

If you have illusions of omnipotence, the bad news is that you feel guilty all the time, but the good news is that such illusions enable you to feel powerful. Yes, the price you pay is continuous guilt and the burden of feeling responsible for everything and everyone, but the payoff has to do with being able to feel really special, really important, and that you matter and can make a difference.

Often underlying this guilt is deep-seated shame--not about how powerful one imagines oneself to be but, rather, about how powerless one actually feels.

My patient whose mother had suicided on the eve of her daughter's graduation from college: For years she and I talked about how guilty she felt about her mother's suicide. But eventually we came to recognize that her feeling of having been responsible for her mother's suicide was a compensation for how utterly (and shamefully) powerless she had really felt in relation to her mother, an alcoholic, chronically suicidal woman who refused to stop drinking (despite her daughter's desperate pleas).

Only when we recognized the compensatory nature of my patient's feelings of responsibility for her mother's suicide did we get to the heart of things. Easier for her to feel omnipotent (even if accompanied by terrible guilt) than for her to feel impotent (with its accompanying shame).

And so my patient and I had trouble getting to her feelings of impotence and shame because of her insistence that she was guilty, responsible, and therefore potent.

Later still we were to understand that the real guilt she felt had to do not so much with guilt about feeling responsible for her mother's death but, rather, with guilt about having felt so relieved once her mother was finally dead.

To return to Odessa: Closely related to her guilt and shame is her depression. Those who have never fully confronted the intolerably painful reality of the early-on privations, deprivations, and insults they suffered as children will be prone, as adults, to depression--chronic feelings of disappointment, frustration, and dissatisfaction.

From an object relations perspective, the internal world of the depressive can be conceptualized as populated by either one or both of the following two introjective pairs: victimizer and victim, superior and inferior pathogenic introjects (Meissner 1974). In fact, the depressive is torn apart inside by the conflict that rages between the two poles of these introjective pairs, intense conflict that ties up a lot of psychic energy, leaving the ego weakened, impoverished, and the patient exhausted, defeated.

As I will soon hope to show, the presence of highly charged victimizer/victim introjects gives rise to angry, guilt-ridden depressions and the presence of

superior/inferior introjects gives rise to empty, shame-ridden depressions. And I believe that Odessa suffers from both.

In order to understand angry depression, we must think in terms of the aggressive drive and the introjective pair of victimizer and victim. The victimizer introject resides in the superego; the victim introject resides in the ego.

Angry depressions are the result of excess aggression and are accompanied by excess guilt arising from conflict between superego and ego, conflict between victimizer and victim pathogenic introjects.

In order to understand empty depression, we must think in terms of the narcissistic need for perfection and the introjective pair of superior and inferior. The superior introject resides in the ego ideal; the inferior introject resides in the ego.

Where angry depressions are the result of excess aggression, empty depressions are the result of an excess need for perfection. Where angry depressions are accompanied by excess guilt, empty depressions (arising from conflict between ego ideal and ego, conflict between superior and inferior pathogenic introjects) are accompanied by feelings of intense shame.

On the one hand, then, are angry depressions, which speak to the presence of excess aggression and unconscious intrapsychic conflict between victimizer introject (in the superego) and victim introject (in the ego). Such depressions are characterized by anger, guilt, and a sense of the self as bad, as morally reprehensible. They are often accompanied by a wish to confess, to expose oneself as bad, and a wish to be punished in order to assuage the guilt.

And on the other hand are empty depressions, which speak to the presence of a desire for perfection and unconscious intrapsychic conflict between superior introject (in the ego ideal) and inferior introject (in the ego). Such depressions are characterized by emptiness, despair, shame, and a sense of the self as defective, inferior, worthless. They are often accompanied by a wish to conceal, to keep hidden, and a wish not to be exposed or found out.

Let us now think about the introjective pair of victimizer and victim. When the interactional dynamic between parent and child has been one of abuse, then the child deals with this betrayal by internalizing the bad parent. It is as if the child finds it so intolerably painful to be betrayed by her parent that she takes the burden of the parental badness upon herself (in the form of an internal bad object), thereby preserving the illusion of her parent as good and ultimately forthcoming if she (the child) could but get it right.

In essence, the child protects herself against the pain of her grief by deciding that it must be she (the child) who is bad, her parent who is good. Easier this, than to confront the reality that it is her parent who is bad. In order to go on living, the child must deny

the reality of what she really does know, in her heart of hearts, to be the horrid truth about the parent.

This horrid truth is registered internally (even if unconsciously) in the form of the introjective pair of victimizer and victim; and, if all goes well in the patient's therapy, three scenarios will eventually get played out in the transference. In fact, contemporary psychoanalytic theory (Mitchell 1988, Renik 1993) would have it that, if the patient's internalized traumas are ever to be reworked and mastered, then the patient must be able to recreate in the relationship with her therapist--in fact and not just in phantasy--some version of the negative interactional dynamic that had characterized the earlier traumatic relationship with the parent.

In the first situation, the conflict remains an internal one, between victimizer introject in the patient's superego and victim introject in her ego. The powerful, sadistic superego disapproves of, rages against, torments, and blames the powerless, masochistic ego--in response to which the ego experiences guilt. The net result is an angry, guilt-ridden depression.

In the second situation, the conflict is externalized by way of the patient's projecting the victimizer introject onto the therapist and identifying herself with the victim introject. Now the therapist is experienced as the perpetrator, while the patient experiences herself as the hapless, innocent victim--now made to suffer by her therapist as she had once been made to suffer by her parent. Such a stance is described as masochistic.

In the third situation, the conflict is this time externalized by way of the patient's projecting the victim introject onto the therapist and identifying herself with the victimizer introject. Now the patient is the perpetrator and the therapist her unfortunate victim--now the patient makes her therapist suffer much as her parent had once made her suffer. Such a stance is described as sadistic.

But let us now think about the introjective pair of superior and inferior. My hypothesis is that, because Odessa was raised a devout Roman Catholic, she was probably imbued with the belief that some people are morally superior to others, better than others, more deserving than others. These messages from the church may well have been reinforced at home--that there were the saints and then there were the sinners--and, Odessa, unfortunately, was in the latter group. The negative messages of which Odessa was a recipient would then have been internally registered in the form of a superior introject in her ego ideal and an inferior introject in her ego.

When a patient has internalized this dynamic, then here too, if all goes well in her therapy, eventually the following three scenarios will get played out.

In the first situation, the conflict remains an internal one--the perfectionistic ego ideal is contemptuous of the inferior ego, smugly superior, condescending, and

denigrating--in response to which the ego experiences shame and is plagued with self-doubt, feels like a failure, and believes itself to be hopelessly undeserving. The net result is an empty, shame-ridden depression.

In the second situation (of externalized conflict), here the patient will experience herself as shamefully inferior and a pathetic failure unable to live up to the expectations of the therapist, now experienced as superior, perfectionistic, and demanding. This situation manifests itself as an inferiority complex and is characterized by shame and feelings of inadequacy.

Finally, in the third situation (also of externalized conflict), the patient is contemptuous of, and smugly condescending toward, the therapist, who is experienced as inferior and lacking. This situation manifests itself as a superiority complex characterized by contempt for others.

In sum, I am suggesting that guilt and abuse are related, as are shame and contempt. So too, the angrily depressed patient can, in the next moment, become abusive; and the emptily depressed patient can, in the next moment, become contemptuous. By the same token, the abusive patient can, in the next moment, become racked with guilt; whereas the contemptuous patient can, in the next moment, become racked with shame.

Anticipated Course of Treatment

In fact, I believe that Odessa has not only an angry guilt-ridden depression and an empty shame-filled depression but also the potential to be abusive and contemptuous. Indeed, we read that Odessa had, at one point, been concerned that she might become physically abusive with her children; and, from what is presented, it would seem that she is contemptuous of her husband whom she experiences as miserably ineffectual.

In addition to the depression, Odessa also has, I believe, an underlying sadomasochistic character structure and demonstrates something to which I refer as "relentless hope," the hope speaking ultimately to an inability (perhaps unwillingness) to make her peace with the reality that things were as they were and are as they are.

As long as Odessa locates the responsibility for change within others (and not within herself), as long as she experiences the locus of control as external (and not internal), as long as she refuses to let go of the rage she has about all the abuse she has suffered, then she will remain desperately unhappy and forever unsatisfied.

More generally, patients who are relentlessly hopeful (and relentlessly outraged) have never really come to terms with their parents' failures of them; instead, they have spent their entire lives defending themselves against the pain of their grief by clinging to the hope that perhaps someday, somehow, someway, if they were good enough and

suffered long enough, they might yet be able to extract from their contemporary objects--perhaps, even, their parents in the here-and-now--the love they were denied as children.

As part of the grieving Odessa must do, she must let herself feel, to the very depths of her soul, her anguish and her outrage that her parents failed her in the ways that they did and that she is now scarred, deeply scarred, as a result of their failure of her. Again, the fact that Odessa is always disappointed and resentful speaks to her reluctance to confront (and grieve) the truth about her objects (both past and present)--so that she can let go of her need for things to be a certain way and can move forward in her life.

We are told that Odessa sees herself as a religious Cinderella whose accommodating nature and deep desire to please others so as to gain their approval have been taken advantage of by bad parents, abusive brothers, ineffectual sisters, a passive husband, unappreciative children, a denigrating boss, taunting coworkers, sexist religious leaders, and demanding congregants. It is Odessa's longing for these bad objects to be "good" and her hatred of them for being "bad" that fuel the relentlessness with which she demands of her objects that they change and the relentlessness of her outrage when they don't.

I believe that masochism (which is a story about the relentlessness of a patient's hope) and sadism (which is a story about the relentlessness of the patient's outrage and devastation in the face of being thwarted) always go hand in hand. I do not, by the way, limit sadomasochism to the sexual arena.

With respect to the masochistic piece: Masochism is about the patient's hope, her relentless hope--her hoping against hope that perhaps someday, somehow, someway, if she were but good enough, tried hard enough, or suffered deeply enough, she might eventually be able to get the objects of her desire to change. The investment is not so much in the suffering per se as it is in the hope that, perhaps, this time...With respect to the sadistic piece: Sadism is the sadomasochistic patient's response to the loss of that hope.

Ordinarily, a patient who has been told "no" must confront the pain of her disenchantment. She must come to terms with the reality that her objects may not always be able to satisfy her desire; she must mourn the loss of her illusions about what could be (and could have been).

Growing up (the task of the child) and getting better (the task of the patient) have to do with coming to terms with the disappointment, the outrage, and the pain that come with realizing just how imperfect the world really is (and was)--to which self psychology (Kohut 1966) refers as "optimal disillusionment."

But the patient with underlying sadomasochism, instead of confronting the reality of her disillusionment, coming to terms with it by way of grieving, and moving on, does something else. In those moments of dawning recognition that she may never be able to

get what she has spent a lifetime pursuing, the sadomasochistic patient responds with devastation and the unleashing of a torrent of abuse directed either toward herself (for having failed to get what she so desperately wanted) or toward the disappointing object (for having failed to give it to her).

The cycle is repeated if the object throws the patient a few crumbs. The sadomasochist, a real sucker for such crumbs, is once again hooked and reverts to her original stance of suffering, sacrifice, and surrender in a repeat attempt to get what she so desperately wants and feels she must have in order to go on.

In conclusion: If Odessa is ever to free herself of her compulsive need to extract from her objects in the here-and-now the love, kindness, and compassion that she was denied as a child, then she must be given the opportunity to do now what she was not able to do then--namely, to grieve--which, I believe, is the heart of the psychotherapeutic work that Odessa must do. Within the context of safety provided by the relationship with a therapist whom she comes to trust and by whom she can feel held, Odessa may finally be able to feel the pain against which she has spent a lifetime defending herself. Only as she grieves, doing now what she could not possibly do as a child, will she be able to get better and to move on to a deeper, richer enjoyment of her life and relationships. Perhaps sadder, yes, but wiser, more alive, and more at peace.

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John T. Chirban, ThD, PhD—Spirit

In all too recent memory, mental health practitioners with concerns about spiritual and religious issues of their patients, and dare I say, about their own religious beliefs, felt the need to conceal such matters, lest they be shunned and marginalized by their colleagues. In sharp contrast, the last few years have been a time of liberation for the spirit in mental health. Scientific inquiries are confirming the importance of spirituality and religion: studies have shown the powerful impact of faith for emotional and physical health (Larson and Milano, 1995). Medical researchers literally have invited God into the laboratory, documenting the power of prayer for our overall well-being (Benson and Stark, 1996). Psychoneuroimmunologists have demonstrated how belief in God enhances our immune system (Merwick, 1995), showing that spirituality is critical for the quality of our life. Times have changed for the spirit in our discipline.

We are witnessing a renaissance of the holistic, psychosomatic view of the person in mental health that reintroduces or introduces ψυχη, the Greek for *psyche* or "soul" into the discipline of psychology and psychiatry. Psychology and psychiatry have now begun to accept the power of the spirit in terms of its psychological ramifications. Have we come full circle in terms of understanding this topic? Are we prepared to talk about the spiritual dimension of the person? How can we address the spirit in treatment? For mental health practitioners today, approaches to these topics are innovative, not to

mention complex and controversial. Because of the inherently personal nature of this material, I believe each clinician must answer these questions for himself or herself, as one's response dramatically affects treatment. In addressing matters of the spirit, we find a wide range of options to consider.

Because of a lack of cohesive models to guide our work with spiritual issues, I will discuss some basic questions that may help us to clarify our positions regarding the spirit in treatment. Then I will comment about how spiritual issues may be addressed in the case of Odessa.

I. What Is the Spirit?

By definition, spiritual issues appear subjective and often perplexing. Some view the spirit as intangible, supernatural, reflecting a wondrous nature, affecting the soul, pertaining to the divine, and often forming the sacred basis of religion. Webster defines the spirit as "an animated or vital principle held to give life" and "the activating or emotional principle influencing a person." Other languages capture the heart and action in their word for "spirit" itself: its Greek etymological root, ψυχω, means "to breathe." The "spirit" in Hebrew is *ruach* meaning a "wind" or "breath" (interestingly, you enact these words upon pronunciation -- as you say ψυχω, you breathe; as you say *ruach*, you make the sound of wind). The spirit is *élan vital* in French, the "vital force" by which God animates the world. For me, the spirit empowers the soul; it is passion, commitment, conviction, vision; it is the movement of life itself!

Because clinical psychology historically has aligned itself with the scientific method in its development as a discipline, in part out of a reaction to religious dogmatism, it is not surprising that matters of spirituality have fallen outside of its domain. However, as those whom we serve continue to value and continue to be affected by spiritual and religious dynamics, as we have begun to recognize the limitations of applying the scientific model to determine *all* that is significant to those whom we serve, and as socio-cultural changes are leading us to redefine the self in view of the sacred, clinicians are responding to the idea of the spirit as integral to the life of the person, and which should therefore be integrated into the world of mental health.

Current clinical interest in the spirit occurs in the context of a larger cultural phenomena. Statistics about the role of spirituality and religion in the lives of Americans are striking. National polls at the University of Connecticut's Roper Center report that the percentage of Americans who believe in God (however they understand this three letter word) has remained around *92%* to *96%* ever since polls have been conducted. And while the number of those who consider institutionalized religion important to their lives has declined over the last *twenty* years from 75% to *58%,* the number of those who place

importance on spirituality has risen from 58% to *76%* in the last *three* years. As support of institutional religion wanes, interest in the spiritual remains and grows. A recent MSNBC poll reports that the presence of the spiritual has become important to 83% of Americans. Accordingly, our culture is finding manifold ways to express how spiritual issues affect our lives. Participants in spiritual endeavors describe healing that not only alters blood pressure but, as a centering and integrating vehicle, leads to more *meaningful*, more *empowered*, more *loving*, and more *successful* lives. Can mental health professionals ignore these results? Argue that they don't exist? Or feel content to judge such experience as outside their expertise? I don't think so.

At this point, we may wish to distinguish between the terms religion and spirituality. These days, the term spirituality is often preferred over the term religion in two basic ways: First, spiritual usually refers to personal, affective, experiential experiences; where religion is defined as organizational, intellectual, ideological. Second, spiritual connotes meaning, connectiveness, transcendence, the highest form of human potential; where religion conjures the formalized creeds, rituals and practices of a given denomination and may be peripheral to the spirit. However, the connotations vary from different people. Essentially, religions exist to preserve the power of the spirit, what Kenneth Pargament (1997) calls the "sacred core," as he distinguishes these terms. When religions are functioning and alive, spirituality thrives. The disparaging connotation of religion occurs when spirituality is stifled and religion serves the interests of power structures and preserves religious forms alone.

At the same time that we as therapists have begun to admit that religious and spiritual topics often suffer from reductionism and pejorative characterizations in psychology and psychiatry, and as we start to open the door to the spirit, we recognize spirituality as often elusive and intricate to manage in therapy. Notions of the spirit vary considerably and may challenge reality as we know it. One woman whom I had seen in private practice left Reform Judaism and decided to pursue astro-projection and crystals in order to "meet her friends on different planets." She maintained that this medium permitted her to enjoy friendships as she never had before, even though she lived hundreds of miles away from these individuals with whom she related. Although psychological paradigms may swiftly access or dismiss this situation, can mental health professionals recognize this woman's spiritual yearnings? Might her spiritual dimension enhance her treatment? How might we incorporate this dimension into her therapy?

Although, at times, it may be difficult for mental health practitioners to explore spirituality, it remains essential for us to do so. Interest in the spirit is not a fad; it is a response to the need for human wholeness. To ignore the spirit is to miss an essential part of the person. As the field of mental health expands its purview to heal the whole person and embrace treatments that address preventive measures as well as positive

aspects of life, spirituality is finding a growing reception in treatment -- from discovering meaning in life to incorporating experiences of the "holy."

II. What Is the Impact of the Spirit on Our Theoretical Stance?

From a historical perspective, we have to recognize that to some extent the *denial* of the supernatural and the religious has supported, and even accelerated, progress in mental health and has increased the high esteem in which both medical and behavioral sciences are held today. A long tradition against addressing the spirit in mental health emphasizes, among other points, that the spiritual domain: 1) confuses treatment by introducing non-scientific phenomena, 2) creates conflicts between therapist and patient regardless of whether their beliefs are divergent, 3) introduces different goals and criteria that confound treatment, and 4) presents phenomena that are distinct from the goals of mental health driven by the scientific method.

Need we throw away the baby with the bath water? I think it's important not to. Mental health practitioners should engage the spiritual because: 1) it is honest, as each of us construes reality with an implicit philosophy, theory, or theological underpinning, 2) our understanding of a patient is incomplete without understanding how spiritual issues influence him or her, 3) mental health is surely affected by one's answers to questions of ontological meaning -- that is, Who am I? Why am I here? and Where am I going? and 4) the spiritual is often at the core of people's deepest concerns and passions (Jones, 1994). Whether or not mental health professionals believe that they *should* address the spiritual, the fact is that inevitably they do. Einstein informs us that our theory determines what we see. Our assumptions not only reflect our science of psychology but also inform our view of a person, our understanding of and perspective on the patient. How is our psychological perspective related to our philosophical, religious, or spiritual point of view? How does it focus our lens in professional care? To what extent is our approach in treatment guided by our philosophy or spirituality?

In my professional psychological development, B. F. Skinner provided the principle challenge to my beliefs and my approach to psychology. Our first discussions, which began in the early 1970s, reflected our very different histories and polarized understandings of human nature -- both psychologically and spiritually (Chirban, 1996). Skinner was the experimental scientist, the father of strict behaviorism; before studying psychology, I was a student of Greek Orthodox theology. Skinner had low expectations of religion; I had high expectations. He found no nurturance through faith or God; I found that faith and God were strengthening and sustaining.

In the mid 1980s, when Skinner was working on a book concerning ethics and behavior, we embarked on weekly conversations over several years, this time

collaboratively, to analyze and to understand the spirit from our different perspectives. Skinner previously had presented himself as anti-religious and even atheistic. Our discussions explored the origins of his psychology -- as well as his curious preoccupation as a utopian philosopher.

I learned that, in fact, Skinner's early religious experiences were powerful. In his autobiography, *Particulars of My Life*, he wrote:

The first religious teaching I can remember was at my grandmother Skinner's. It was her desire that I should never tell a lie, and she attempted to fortify me against it by vividly describing the punishment for it. I remember being shown the coal fire in the heating stove and told that little children who told lies were thrown in a place like that after they died . . . Some time later I went to a magician's show the final act of which concerned the appearance of a devil. I was terrified. I questioned my father as to whether a devil just like that threw little boys to Hell and he assured me it was so. I suppose I have never recovered from that spiritual torture. Not long afterward I did tell a real lie to avoid punishment and that bothered me for years. I remember lying awake at night sobbing, refusing to tell my mother the trouble, refusing to kiss her goodnight. I can still feel the remorse, the terror, the despair of my young heart at the time . . . (Skinner, 1976, p. 60).

His family's literalistic, punitive image of religion generated an aversive spirit. To what extent did such experiences affect his position that religion is negative?

As we spoke, it became more and more evident that our beliefs shaped our psychology. In his autobiography *A Matter of Consequences* (Skinner, 1983), Skinner openly acknowledged that much of his scientific position seemed to have begun as Presbyterian theology. His point of view in psychology that there is no choice and no freedom, along with the importance he placed on external control, found a conspicuous parallel with the theology of the Congregation of Jonathan Edwards.

In one of our conversations, Skinner shared the following:

There was always a certain element of fear. Not exactly that I might have the wrong religion . . . (such as) be a Presbyterian instead of Catholic. I went to Sunday school, but I never stayed on. I had a certain amount of fear of religion, I suppose. So that when I finally escaped, it would have been an element of relief, although it took me a long time. I remember when I was a freshman in college I was still somewhat bothered by . . . worried . . . about religion. I remember going to the professor of philosophy and telling him that I had lost my faith. The fact that the biologist, whom I liked and admired very much, taught Sunday school bothered me. These were problems. (Chirban, 1992)

As we spoke, I recognized that Skinner's argument was not against the spirit but against the abuses in religion that he personally felt. Moreover, his own yearnings fueled

his fervor to understand and to create the positive that he could not find. This hopeful wish asserted itself in his identity as a utopian visionary (Skinner, 1948). He told me (Chirban 1996 p. 82), ". . . what you say does not sound like religion . . . [it] seems to me very close to what I've been working on." His understanding of the term spirituality depended on callow images and of childhood association. In our discussions, he stated that he had not related the positive experiences that I reported as having anything to do with spirituality. Yet these positive experiences, which he called "feeling states," he judged as very significant for psychology. For example, he elaborated on his commitment to psychology's role in creating a better future for humanity and became interested in how spiritual paths might support that through cultural conditioning. In the end, we concurred that this definition of the spirit as a vital positive experience was critical for both faith and science.

So, our challenge as therapists is to understand and to discern how the spirit is understood and experienced. Much may be inferred when patients or therapists refer to the general constructs of "religion" and "spirituality." However, little is understood by these terms unless we take the time necessary to find out what such terms mean spiritually and serve psychologically for the specific person.

Additionally, it occurs to me that just as religion may become dogmatic and formalistic and lose its intrinsic value -- the essence of spirituality -- this same fate can befall psychological paradigms that lose their intrinsic objective of serving the person. Less we wed ourselves to models, treatment in mental health must not become doctrinaire in its own right but open to the whole person, attuned to the individual's experience as it supports his or her process and growth.

III. What Are Positive Resources of the Spirit for Treatment?

Empirical research has shown that religious devotion and commitment are positively correlated with healthy physical, emotional, and social functioning. Patients with mature spiritual lives demonstrate feelings of self worth, the capacity to internalize healthy values, the ability to integrate these values in healthy and productive ways, and the expression of contributions to their communities.

Attending to the spiritual point of view implies valuing the whole person -- who intrinsically holds special value. Through attuning to the spirit the individual is allowed to experience hope, vision, and security. Spiritual vitality enables one to gain courage and establish goals, which are essential for change. Spiritual connection permits reliance on a loving presence in the face of adversity, loss, and loneliness.

We find that spirituality is invaluable for personal growth. By including, exploring, understanding, and using spiritual feelings, we can more deeply examine a person's

commitments, character, and relationships. Erik Erikson (1968) observed that when we talk about faith, we move to the "psychology of ultimate concern." We are concerned about a person's existential health which explains where he or she may be going and why -- or, because of its absence or lack of clarity, the impact of not being able to get there. These constructs of meaning and purpose, whether the vocabulary is spiritual or not, correlate with emotional and physical health.

Spirituality nurtures virtues that enhance our lives -- Goodness, Truth, Justice, Faith, Hope, and Love -- the so-called "fruits of the spirit." Spirituality may well serve as an antidote to the technology and increasing time constraints that leave us isolated and exhausted, giving us much needed peace and connection.

As multicultural sensitivities have increased our understanding of the range of values that organize the person, and as we have recognized how many cultures fuse ethnicity and faith for the individual, we have learned how essential faith is to the identity of the person -- speaking to a central theme of the Lindemann Lectures -- how our communities shape us -- *from within*. Furthermore, people's relationship with the sacred, transcendent, and Otherness affects their -- indeed, our -- abilities to cope and to relate. Thus, we see how our faith and meaning are manifested in our actions.

IV. How Do We Approach Religion and Spiritual Concerns in Treatment?

Although it seems like the appropriate time for clinicians to address the spirit, each clinician must feel personally and professionally prepared to do that. So, before commenting on the applications of spiritual concerns in the case of Odessa, I would like to identify five goals for clinicians concerned with the spiritual dimension in treatment:

First, express openness to religious, spiritual, and existential concerns. During the initial consultation, regardless of the presenting problem, I typically inquire about the patient's religious identification and involvement. This question signals my openness to discussing such material, so that the patient may follow up as he or she determines. I often continue with another question concerning whether or not he or she participates in a spiritual life. The goal here is to clarify the role of spirituality in one's life. It is not unusual for a patient to respond, "Oh, you're asking about *that*. That's actually very important to me but I never thought we'd discuss it here." Our patients have learned to present themselves as fragmented in treatment before treatment that fragments them. The purpose is to convey that the spirit affects one's whole life and one's whole life is our concern.

Second, appreciate the spiritual, and do not reduce it with psychological interpretations. The anticipated lack of support for spiritual matter on the part of mental health professionals often dissuades patients from revealing their spiritual

concerns and disallows the opportunity to consider how it may provide a treatment resource. Assessing the patient's spiritual dimension may enable the clinician both to learn about the patient's traditions and to relate his or her faith and culture to this individual's psychological concerns.

Third, understand the value that the spirit holds, respecting the impact of spirituality in the person's life. Inviting a patient to discuss his or her spiritual interests provides a wellspring of information that informs the clinician of deep, personal experiences, influences, and ambitions. Here the task is to address the resources and impact offered by the patient's religious tradition as he or she functions in society in order to integrate the individual's spiritual and psychological dimensions.

Fourth, explore the spirit, recognizing how it affects the patient's life. As the patient is ready to examine the direction (as well as the costs and benefits) of his or her spiritual choices, the clinician may help the individual translate his or her spiritual tradition into life decisions and changes. By supporting this discussion, the clinician may explore positive and negative issues for understanding and integrating the patient's culture, history, and goals.

Fifth, attend to the impact of spirituality on the therapeutic relationship. Treatments that engage religious and spiritual concerns may accentuate our connection with patients and reduce the notion of the patient as pathological, affirming the individual in relationship. By recognizing how spiritual values enhance the patient's relationships with others, we can enhance our connection to our patients.

Applications in the Case of Odessa

Numerous religious and spiritual themes surface prominently in the case of Odessa. We are told she was of "more than moderate orthodoxy and devoutness" as a convert from Roman Catholicism to the Seventh Day Adventist faith. She "saw herself as a religious Cinderella" whose busyness, accommodating nature, and desire to please in order to gain approval "were taken advantage of by a bad parent, boss, or religious leader and bad sisters, co-workers, or congregants." Her religious traditions emphasized male dominance. She maintained an image of a "sincere and loving Christian" who, while responding positively, gave beyond her resources. "Humility and silence" and "suffering" were mottoes of her faith that provoked dissonance within her. Feelings of deep shame, guilt, depression, anger, self-hate, and ambivalence generated in her family relationships characterized her emotional disposition. Is this the scenario for one who devotedly espouses the spirit? How does a clinician with sensitivities to religious or spiritual concerns intervene?

First, we need to clarify our orientation in addressing spiritual and religious issues. Most mental health practitioners are not spiritual guides. In fact, we can observe that various postures exist for treatment: Some dominant personality theorists, who traditionally characterized the mental health stance, like Freud (1927) and Skinner (1948), maintained negative and suspicious interpretations of the spirit; others, like psychoanalysts Rizzuto (1979) and Meissner (1984), offer a descriptive approach for how individuals process religion, pointing out, on the one hand, the psychological usefulness of religious experience, and on the other, approaching the spirit as not unlike other phenomena; still others, like Jung (1948) and Frankl (1985), embraced the spirit as a positive, essential dimension in the treatment process. Richard and Bergin (1997), in their recent volume, A Spiritual Strategy for Counseling and Psychotherapy, published by the American Psychological Association, combine a clear theistic position for the therapist with respect for the scientific method.

Second, we need to have a basic knowledge of the patient's traditions, rituals, and symbols in order to interpret and understand the role of spirituality and religion in his or her life. Both of Odessa's faith traditions, Roman Catholicism and Seventh Day Adventism, emphasize conservative doctrine and traditions. Odessa converted to Seventh Day Adventism. Such information raises important questions for us: Did the rigorous Adventist world offer a safe, cohesive setting in contrast to her chaotic home? Did she convert to distinguish or distance herself from her Roman Catholic family? Was the community of her new faith nurturing, supporting, and caring -- thereby filling needs not met by her parents? Or was her conversion a function essentially of personal conviction?

In the context of Odessa's faith, we would like to understand the various conscious and unconscious needs that her spirituality and religion serves. We are not told why she converted but we are advised of her intensity and dedication. Both of these faiths offer expression of intense religious fervor. In particular, the Seventh Day Adventists require a more integrated commitment to faith in daily life as a fervent Protestant group that emphasizes life-style changes for its members, belief in the imminent return and reign of Jesus Christ, the primacy of the Saturday Sabbath, and an emphasis on a healthy life-style and healthcare (Kelly, 1995). Odessa's religion may have responded to both her psychological and spiritual needs for a strong, protective, enveloping structure, which is compatible with her rather dependent psychological organization. The fact of conversion, however, may also point to her character strength -- one of the few independent streaks noted in the synopsis of her life in contrast to the dependent style -- demonstrated by her ability to fight off the incestuous attacks in her family and resistance to identify with her mother -- who represented passivity. Any or all of these conjectures are worthy of

exploration. They may reveal her religious experience as a medium of emotional survival in addition to providing spiritual solace.

Given Odessa's devotion, it is important to remain especially sensitive to her religious investment in treatment. The significant value she places on her faith could make her unresponsive to psychological approaches that reduce or interpret her faith experiences or which use non-religious language. Therefore, the religious symbols and biblical images of her tradition could be incorporated valuably into treatment. In view of Odessa's struggles, metaphors of her religious tradition could serve as a source of hope in her world of vulnerability -- and free her from her emotional bondage. While faith offers several images that parallel and preserve her psychological pathos, a religion may also provide models that enhance a positive self -- for example, applying axioms and parables to her life such as, "love your neighbor as yourself." To love another, she needs first to know what it is to love herself. Examples from Jesus' life could also serve her well, e.g., where Jesus expresses anger in the temple because of abuse or confronts contemptible or unjust people. These provide metaphor and "inspiration" that enable Odessa to experience more readily the love and care that she seeks and needs. Another tool would be to explore Odessa's experience of prayer. We find that Odessa's punitive superego is internalized. By attending to how she perceives God, supporting her relationship with God as an available and caring parent figure rather than an all-powerful, potentially judgmental, and unaccepting authority figure, we can help Odessa begin to accept herself and understand her object relations.

Third, we need to differentiate between legitimate and illegitimate uses of religion. It is important to affirm Odessa's search for the spirit and for truth. Her faith offered her a viable community in which she could establish an identity. We recognize that Odessa's rigorous adherence to her faith provided her with control in her unbounded life. Once a therapeutic alliance is established, the task is to understand Odessa's idealizations and choices. As she develops her self concept, it would be valuable to explore the identifications and the motivation that led to her spiritual and religious choices. Following her lead, we could re-experience the positive aspects as well as the negative process in her pilgrimage. The task may be seen as helping her to understand the function of her ideal self and to accept her real self, as Horney (1955) describes it. This permits us to confront the negative self-image that her adaptation in religion fosters. While her rigid, literal focus of Scriptures supports, as she interprets it, psychological dependence in abusive relationships, we observe that she is selective about the Biblical passages to which she clings. Both home and religion locked her in situations of suffering. In the treatment process, we can identify the strictures of Odessa's religion that recapitulate the contingencies and dynamics of her home, where, in spite of abuse, she felt obligated to love her enemies. Like her home, her religion similarly maintains a

system of undefined boundaries that relegates her to second class citizenship, without rights, or privileges -- especially with men. Significantly, both settings required deference to male authorities and both settings left her without adequate approval.

When working with someone's religious beliefs we must be cautious not to destroy inadvertently what is deeply valued. At the same time, it is important not to support conflictual adaptations through faith. Odessa's interpretations of such statements as "do not let sun the go down on your anger" with regard to parents who abused her reflects distortions that may be confronted in therapy by considering interpretations of her faith and its impact on her self concept. By empathically attending to and understanding her personal struggle, building on her personal strengths and affirming her spirit by recognizing the elements of her tradition that serve her growth, we can help Odessa release herself from the guilt and harmful expectations implicit in her idealized self-image of a "sincere and loving Christian" so that she can begin to find, accept, and live her true self as Odessa.

Fourth, we need to attend to countertransference. Inevitably spiritual material intensifies transference, resistance, and countertransference and may complicate the therapeutic process. Just as with other complex themes, such as sexuality or politics, one must weigh the costs and proceed with vigilance. Spiritual issues provide manifold opportunities to confuse boundaries and roles. Whatever posture the clinician decides to adopt, when conducting psychotherapy that addresses spiritual concerns, we must avoid collusions that may come from validating a patient's assumptions and, rather, explore and examine them. Certainly advice giving on spiritual matters and moralizing is outside the bounds of treatment.

In therapy, the process of restoration begins when the therapist provides the opportunity for the patient to experience aspects of himself or herself through a relationship that is characterized by cohesion and trust. Through pursuing spirit-related issues in therapy, Odessa may feel enough confidence to deepen her spiritual quest. Her faith may have "saved" her in more ways than one. Moreover, when a religious patient experiences the therapist's assurance through respect for the values of faith, hope, and love in God, not only is the therapeutic process experienced as less threatening but the patient feels integrated more deeply.

By attending to the spirit in psychotherapy, we can support the patient's self-discovery of his or her inner motives, and dig beneath the forms of religion, to the heart. In this process we help people confront questions of truth about their life -- their intentions, meanings, and actions. By engaging the spirit in those who are willing, and tapping it in those in whom it has been silenced, personal freedom -- a shared goal of psychotherapy and of faith -- is within our grasp.

Discussion

David Satin:

Thank you, Dr. Chirban. In trying to fit one piece into the other as we go along I was wondering whether the spiritual perspective is just another language in which to discuss some of the same issues: emotional concerns like ego, health goals as meditation does, community issues in idealism, or is it another, completely different set of needs and goals that are transcendental to mundane life and the specifics, a realm of higher values? Or is it a set of resources for health in the service of health: belief, ceremony, liturgy, community? I guess you have to tell us. It's time now, I think, for the consultants on this case to integrate their perspectives, having heard one another, become synergistic in caring for Odessa and make a team, rather than a discontinuous set of experts. Would you tell us what you all think how you would respond to one another, and then perhaps we'll hear from the audience about their responses and their contributions to the consultation.

Stanley Berman:

If you really didn't have a depth of understanding, and I think part of the movement of the conversations this afternoon are that thoughtful, well-considered eclecticism might not be an intellectual?? violation but might be a high energy way to be really effective, and I think that the Engels model of this, I think if he was writing his model today it wouldn't be a hierarchy, it would be Russian nested dolls, rather than a ladder. Really gives us a way to have a frame to think about how legitimate it is to walk down several of these paths, depending on where the patient is at, the client is at, and where the treater, where the therapist. That would be my stab at it.

Martha Stark:

Well I was, I like that intro. Thank you. I was going to say that it is true, as I was thinking of it, but I really don't integrate the spiritual much. I'm actually probably more comfortable these days integrating the bodily aspects, partly because I've been getting some training in body therapy. The spiritual, about what I do, but I have to sort of think about this, I will either ask the patient what the nature is of their relationship to God, or what is their experience of God. That's been sort of interesting because I've found that often their experience of God, like they may say, 'Well, I'm not sure whether there is or isn't a God,' or 'Well, I think God is very punitive,' or 'Well, I think God is very compassionate.' It's very interesting how telling that can be about the nature of their relationship to a parent, or their wish for a parent, so it's sort of like a Rorschach. But I haven't really known, in all honesty, what to do with it, so I'll be thinking about that. And

when you ask, often, a schizophrenic or particularly a paranoid schizophrenic, you can ask them, 'Do you feel that you have a special relationship with God?' and inevitably the answer is indeed, yes, and then they go on, but that can really open things up, and they go on to talk at some length about that. And I know with respect to the body piece, at one point I don't even think I had even thought to ask what their diet was. I knew to ask about the alcohol, I got that part down, but I do ??? ask them about their diet, but as I've gotten more and more into it, and I, myself, am followed by a psychoneuroimmunologist, so I am very into that, I have found that affects very much my how I position myself in relation to the patient's body and ???

Stanley Berman:

John, I'll give you another moment to take a breath. John and I participated in a doctoral student's dissertation together, and she was very interested in how faith helped people who were coping with serious illness, and she opened her colloquium with a very interesting set of comments, which was to say that we've all been trained and feel highly comfortable in saying to a patient, 'Tell me about your sexual practices,' even in the first hour we know the individual, or 'Tell me about your sexual lifestyle,' or 'Tell me about your use of substances and your relationship to substances,' but many of us have felt that it's taboo to ask 'Do you have a spiritual belief set which is important to you?' or 'Do you participate in organized religion, or has there been a shift?' That encounter to what we do in polite interchanges in the park, that that is taboo…

Martha Stark:

Like asking them how much money they have.

Stanley Berman:

That's right—like asking them how much money they have, that's right. And I think that you really invite us this afternoon to recognize that this is such a key organizing issue for so many of us that to be sheepish about inquiring is to not have a complete encounter.

John Chirban:

Yes, and I would agree with that very much, and I find, strangely enough, even with couples, they may not discuss religious issues because they're in love, and then they have a child, and then they come to therapy, because those things which they didn't even identify, often, as significant—subtle traditions, values—are not only being orchestrated in dramatic ways by parents and all kinds of psychological interpretations of what that can be about, but they were even sheepish about that themselves, as you say, and now trying to decide what is deeply important to them in terms of constructing their home,

building their foundation for their new family is at risk. Will they be giving up something that's very valuable which they've taken for granted? Or maybe questions and doubts which are equally important. Oftentimes we speak about very deliberate traditions that may in fact affect a person's presentation and the whole organization of their daily life. But often it's much more subtle, or it's absence is also very significant, so having someone who says, 'It doesn't matter what your religious tradition is,' and then finding that there's a religious tradition that comes with this package that they're now pulled into. This is obviously the mixed marriage problem. It can be very significant and problematic in treatment, and interesting.

Martha Stark:

And the other thought I had as you were talking, Stan, is, to what extent are we then going to try to make of ourselves that would be a Jack of all trades, or Jane of all trades, so we kind of do it all ourselves, and to what extent to we then develop comfort with having adjunctive therapies: we do our own thing, and then have the adjunctive therapy as part of it all. But we all make sort of make decisions about how broad-based do we or don't we want to be in our work.

Stanley Berman:

I think the answer's pretty that we're not going to be very successful in being a Jack of all trades. When Engels was asked, 'What is the meaning of your model?' he suggested that the physician should really become super doctors, and that they should really be very sophisticated about mental health issues, and while that's a lofty goal, I think we recognize that the physician is going to feel, 'I have to understand the newest antibiotic that came out, and I have to understand this new diagnostic in cardiology,' and it's unlikely that's going to be successful. It's much more likely that this idea of tag-team consultation intervention is going to make the most sense, and then we're all doing what we love, and ???

Martha Stark:

And combined with a being open to.

John Chirban:

Right. I think that's what speaks to the value to a presentation or a seminar like this one where we're talking about an integration of perspectives, so that we don' think that we know it all because we've studied one section of it, because I think that can happen. Brave??? the fields. I think we've all had patients who've gone to a doctor who maybe was not sensitive to psychological parts or psychological elements and experiences and pains and feelings of the patient, and that's a real deficit, and as well, it has played out, I assure

you, for the religious that I have consulted, and just having, as you say, an openness, I think speaks to…

Martha Stark:

And to have an increased awareness of the impact of/on?? the body, of the spirit, of the mind.

John Chirban:

Right.

David Satin:

You start out from the point of view of the patient who is integrated: body, mind and spirit, then we are obliged to address that integration…

Martha Stark:

Ultimately, yes.

David Satin:

…and not to exclude some part of the person and essentially leave the person to suffer that part of alone. So it means that none of these is irrelevant. It's interesting that religion, or spirituality, become the odd man out that all of us has to get comfortable with. I guess we've had experience with patients coming to us and talking to us about a lot of things, but saying, 'I don't want to talk to you about that. It's too personal.' What are we doing here if we're not talking about personal things, and that the spiritual should be more personal than the physical, or more personal than the emotional. It's interesting. But we need to be aware that all these things are operating in the person. None of us can say, 'Don't talk to me about that. Go talk to somebody else.' because it affects what we are doing.

Martha Stark:

Well, the other thing, as you're talking, the other thing that sometimes I will do ?to start off, is sex, I mean I get the basics of that, but I mean it would be interesting to have a sex therapist up here. You couldn't have everything, or jokingly, when I said the thing about you don't tend to ask your patient, 'How much money do you have in the bank?' or 'What's your salary?' You know all sorts of stuff about them, but God forbid you should sort of know how much money they have in the bank, so too with couples. Many times they don't know ??? different parts of the person.

David Satin:

Again, let me ask, how do you put your insights together? You talked a lot about the internal struggles, the emotional struggles, that are choking and blocking the person…

Martha Stark:

And then that get externalized and delivered into relationships, yes, creating dysfunction in relationships, yes.

David Satin:

You talked about the person having to, Odessa, having to take herself in hand and address her physical ailments and change her behaviors. How does she do that when she is all choked up with this shame and guilt…

Martha Stark:

And self-sabotaging, self-destructive behavior.

David Satin:

…and self-sabotaging, and then how does the spiritual language, the spiritual issues that she articulates address her high blood pressure and her guilt, and her fear of being successful? How do these things talk to one another?

John Chirban:

I think what I was trying to suggest is that the religious and the spiritual can mean many things, and that we can't just, first of all, hear those words and run away, or think we know what's being said when we hear them, and that, in fact, they mean many things, and I think Skinner and Freud and Rizzuto??? and Meisner??? they're all right and they have a piece, and I think it's that appreciation, but I also think Frankl's??? right, and I also think Jung is right, so I think that all of these pieces seem quite valuable, and I think it's trying to understand what is being presented before us by the patient.

Stanley Berman:

I have a perspective that there's many health psychologists would not agree with ,which is that many health psychologists would feel that if Odessa had never had an hour of psychotherapeutic intervention, but the cardiologist referred her to you, that you can accomplish a substantial piece of work. I think that this particular woman's history is so striking in its difficulty for her that I would think that if that was my referral that I would have very modest goals, and that in many ways I'd be trying to offer her enough taste of success in her ability to take care of herself, that I would try to help her engage in a more depth-oriented piece of work to truly do this. As I said a few times, I really felt that

ideally I would see her accomplish the most if she had done a substantial piece of work before she came my way.

Martha Stark:

You know it's interesting that in this case write-up it doesn't really say why she came for treatment, which is a little bit hard…

John Chirban:

There's a presenting problem.

Martha Stark:

You know, she's sort of depressive, and shame-ridden, guilt-ridden.

John Chirban:

There's presenting problems and concerns. Right. That's what ???

Stanley Berman:

But what's not answered is what allows her, with this history ??? to seek this out now?

Martha Stark:

In part, right, but why now? What exactly is the precipitant? Right.

John Chirban:

Maybe we can alter that?

David Satin:

Do people have some ideas that they would like to address? If they do, we would like to hear them, and we would like to be able to include them in the discussion, so if you would raise your hand when you have something to say, we'd like to bring it to you.

Audience Member:

One thing that I thought about was that with some of the Buddhist studies that I've done, and other eastern studies, that some of them would say that maybe in Odessa's past life, maybe she did so many things that this is all to balance out, and I wondered if you could speak on that.

John Chirban:

I think that for traditions that, I don't know if that was Buddhist that you were referring to, but let's say she believed in kind of a reincarnation, is that what you were

saying? I think that it would be like with a patient with astroprojection. If there's a belief that you don't necessarily understand or believe yourself, I don't know that you can nurture that, so that your question is, what would your position be with this person who's holding? I think it would be to support and understand what the faith means to that individual, and how it's affecting their life. I think it would have the psychological stance and it would have a supportive stance, but it would also be, as I was trying to comment a few moments ago, looking at some of those, or being formed by some of those critiques which might offer a more critical consideration of what the function is in the life. For example, I believe that if a person, let's say, holds onto a value of reincarnation, this may really organize them quite well. I remember being once on an airplane with someone and there was heavy turbulence and he had particular spiritual position, he was a Hindu, that was extremely active and action-oriented to the moment, and it gave him total piece. So there was something that was very positive in this spiritual experience. I don't think that I would intervene in the faith, assessing one's spiritual values, but I think I would try to understand what those values or what is occurring through those values in one's lifestyle. Does that make sense? Is that clear? Was there something more specific that you wanted answered?

Audience Member:

I would like to approach this by saying that I'm all for an integrated approach to working with people because my training taught me that situations and people are much more complex. But in mind the constraints that managed care places on all different kinds of providers in terms of constructing and conducting intervention. I'm curious in your own realms how does this impact your ability to successfully integrate some of these ideas, because the first thing that comes to my mind is the long-term work, and how many clients really have the financial resources to commit to a long-term process?

Martha Stark:

Apart from the integration, how do we do it individually?

Stanley Berman:

I have long-term, ongoing patients who I'm seeing for health-related referrals. When I am seeing a patient for primarily a health-related referral, it's actually attractive to the third-party payer because it's a very discreet, concrete treatment plan that often can be offered in chapters or in episodes, so in my own work, that part of my practice is not that difficult, but the whole third-party payment world is trying to push us all into a mold of this basically a cognitive behavioral treatment plan and implementation, so it's much harder in the two models that John and Martha have been discussing.

Martha Stark:

One of the things that, I seem to be talking about money today—I guess that's on my mind—one of the things that I've become more comfortable doing is talking to people specifically about their financial situation, and what kind of financial investment they feel prepared to make with respect to their mental health and what their presenting complaint is and how ego-dystonic is it and what is their plan. So for me the impact of managed care has been that I've just gotten a little tighter and crisper about the specifics of treatment goals which can be much more sort of elusive. They don't have to be, 'I need to have spoken to my mother by June 5th.' It's not quite that specific, but to think more specifically about targeting specific goals and having the patient sort of put forth as being, so in the beginning session, at one point I would have said, I was taught then, anyway, I sort of actually learned to say, 'How are you?' I separated a little bit from my psychoanalytic training. But now I might be more inclined to say, 'How would you want to use your time in here today?' which is managed care's impact on me, so zeroing a little bit more specifically on that, and plus, then helping them financially to sort of getting a little more clearer and straighter about what kind of financial they want to make in their lives.

John Chirban:

And I would probably add sometimes the referral have often, whether it's to a physician or to one's religious tradition, having a person, who may be, let's say, one particular individual I'm thinking about at this point who was not active in his Jewish tradition suggesting the possibility that he would consider talking with a rabbi or looking in his temple for some support, and, in fact, that turned out to be an interesting and positive experience for him. So that there can be some kind of referral and supportive work that is done in collaboration. Generally, you're absolutely correct—to do the kind of work that we're describing is long-term work, and I don't think there's any short cut to it. You do a piece otherwise. I don't think you can do it—you really can't do it. It requires time, it requires care.

???:

Which they have???

John Chirban:

Right.

David Satin:

Do you have any experience or comment?

Martha Stark:

I just a thought. I know that I had been struck by the fact that she's abstemious in the way that she is: no smoking, no alcohol, ??? diet?? and noticed that you didn't emphasize that so much, and I was wondering how you felt about that, abstemiousness.

Stanley Berman:

It's a good point. In that trying to decide how to curb myself with the big map I drew. I didn't comment, and it's a very key detail, and it may suggest that I'm wrong in predicting that she is not taking good care of herself.

Martha Stark:

We don't know, in a way.

Stanley Berman:

Right. And it's quite possible she is. And to the extent that she follows the tenets of her religious tradition but still doesn't take as good care of herself, which is still where I put my money, I think that the fact that she's been so successful at being a vegetarian in the land of McDonalds makes it quite possible that she'll be more successful with some of these interventions.

Martha Stark:

Although it's also, I mean, talk about feeling betrayed by your body, that there she was: no alcohol, no smoking, strictly vegetarian, she gets high blood pressure and diabetes! Talk about a bummer!

David Satin:

What has her God done for her? Why is she being punished?

Martha Stark:

Yeah.

John Chirban:

Why are you asking me?

David Satin:

Because you are the spiritual consultant. Why is she being punished, although she did a good thing, she did all the right things, and now is getting sick in spite of it. Well might she ask: why me? What am I being punished for by my parents, by my body? What are my doctors doing for me? Who do I look to?

John Chirban:

I think it's a very helpful question psychologically to pursue, particularly for this woman because I think it might lead her to some of the edges of the religion in the way that she's constructed it, and permit her to come more deeply in touch with herself. I think it's the exact question that I would be interested in having her ask when she begins to begin to get in touch with her pain, which I think would lead her to looking at the way in which she's looked at her religion, and I believe that within the resources of her faith she will find the answer, but I also believe more significantly for the psychological process it is important for her to understand the way in which she's created a very small circle of awareness of her, if we can even say, psychology, and even of her religion, and I think that pursuing the question of why me and looking at herself and her pain would possibly open up herself to processing the losses and coming in touch with her experiences and maybe expanding her notions of her faith.

???:

First I want to say just how encouraging it is to hear the collaborative spirit of the three of you, and really the awareness of the comprehensive experience of the human being and the importance of being able to work together across different perspective. Stan, you made some allusion to family systems work, and I'm sitting here thinking there's five daughters in this family, there's a husband who is used to having his wife be a certain way and probably some way the system has supported her dysfunction, for lack of a better word, and I'm wondering what people's thoughts are about family intervention, about how you bring the spiritual life of the family into this in such a way that it bolsters her, and I see five at-risk kids in this family—I can't help it—and a system that is probably very precarious, and I just wonder if anyone could comment on that.

Martha Stark:

For one point of view, in answer to that, which is a very good question, relates a little bit to what she's identified as being problematic. I mean, if she's coming in and wanting to sort of do some of her own personal work, then my own style might well be to hold back a little bit before I would suddenly becoming concerned about these five daughters. I am concerned about these five daughters. But my hope actually, maybe that she's coming in and recognizing that she's done some bad stuff onto these kids and that they've suffered for that, and that she's really wanting to ??? the whole family, but I think my style might be to sort of list a little bit to where she's at with this, at least initially.

John Chirban:

I would probably be close in line with Martha in terms of the substantial amount of work that she has to do, but I certainly would see, also with concern for the expense, the

importance of having family work simultaneously going on as she is ready for that, but I would certainly see that as a decision that she would have to make, but I think that I would see it as my obligation to raise it and ask her what she's thinking about that. I've often observed that people are often very myopic when they're suffering, or even in a kind of religious perspective when they're locked in and they may not even recognize the effects on others and feel that somehow it's OK or that it's being taken care of, so I think as she becomes open to the perspective she might be able to share.

Stanley Berman:

It's an excellent point, at the most benign we can guess that these five young women are not growing up with much of a sense of women being able to navigate with authority in a world that's safe, that this has to be the message that she conveys to her daughters, and that the dad, we can guess, is conveying follow the tenets of our faith and that will be the only map you'll need, and that would be the most benign description of what might be going on. My guess is that she downplays the health issues to the girls, is my guess, and that if there was a dramatic presentation like a cancer diagnosis or a heart attack that it might be very easy to have a rationale that the parents could pull the kids in in terms of their response. I think engaging these parents as the gatekeepers to pull the girls in would probably be a bit of work, but I think that it would be a very valuable intervention. I imagine I saw it daunting enough that I'd talk about entering with the couple only, although ultimately that would be the comprehensive delivery, and that would be the delivery, I think about the work of Vorsinage???? and invisible loyalties and what happens from generation to generation, and so if you really wanted to have the train change tracks, this would be an intervention that you wouldn't be done until you did this and did it well.

Audience Member:

Again I really appreciate all that's been said today. I don't get a feeling other than what has been just discussed in describing Odessa that she is culturally connected to being Black, nor is the family in particular, and I wonder if that has been explored with her treaters. I wondered if they talked about that other than the richness of her religion.

Martha Stark:

That's a great question. It highlights a little bit how little we know about her really, because it's not addressed in the case, so I guess none of the three of us picked up on it, but that's a very interesting point. As I read the material it seems to me that she experienced herself as being so isolated on some level from any kind of connection, even with the others in the church, you just didn't get the sense of her as connected to anyone, nor to her

Audience Member:

??? seeing this woman ???

Martha Stark:

Oh, you didn't—I understand. No, this is just a case and we don't know this woman.

Stanley Berman:

It's a case from a textbook. And the four pages in the text don't really tell us much about that very key issue. But her very limited ability to feel pleasure and connection, or to feel that there's true connections would certainly suggest that if she is going to a hospital where a group of primarily mainstream, white treaters are offering service, that there's going to be three more rivers to cross in order to help her feel, I keep talking about collaboration as the ??? that holds the keys/peace???, and for her to feel that she can collaborate, a while male, and for me to assume that would just be easy because I'm soft spoken or I try to convey being compassion would be pretty Polly Annish, and that that's going to be quite a task in itself.

David Satin:

As usual, we haven't finished, but we just have to take a pause until next year. I think this was a very valuable exercise in addressing, through an individual, issues that are very familiar to the community mental healther: people functioning in their environments with their stresses, with their histories, with their resources, and how to bring the resources better to bear on this. Addressing the issue of how to bring these three different perspectives together, my own prejudice would be first of all have this lady tell us how she is multidimensional, what's important to her, how these things connect within her, and with what language are they expressed in her body, in her spirituality, in her emotions, and have us learn from her. The other thing I think I saw going on here was that her three consultants met one another and began to learn from one another, and began to integrate their different perspectives, and pick up the language, and pick up the flowing together of these different issues, and you do a better job with her when you have learned that. And it is one of the joys of interdisciplinary work. It is so enriching, it is such a growth for us as well as a benefit for our patients.

Thank you all for coming. Let me remind you to hand back your evaluations for your continuing education credits. Let me remind you, if you haven't already, to let us know who you are, and how to reach you to let you know about future Lindemann lectures, and let me invite you to the twenty-third Erich Lindemann Memorial Lecture next spring. Thanks for coming.