Untwisting the Illusion

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Using the Positive Elements of Religion in Counseling Victims of Religious Dis-perceptions

This article is based on a lecture that was given in March of 1984 by Rev. Greer S. Imbrie for the parents of the patients at Earth House, a model residential treatment center for persons suffering from major mental disorders located near Princeton, New Jersey. Rev. Imbrie is an ordained Presbyterian clergyman serving a congregation in the coal mining area of central Pennsylvania. He is a graduate of Princeton Theological Seminary and is presently working on a Doctor of Ministry degree at Pittsburgh Theological Seminary. Rev. Imbrie studied Buddhism for four years in Thailand and is acquainted with teachings of other religions. He has been a member of the Earth House staff since 1982, serving as a religious and spiritual counselor for the Earth House patients. In December 1983, Rev. Imbrie was married to Rosalind La Roche, the director and founder of Earth House.

Responsible counseling of the schizophrenic is a difficult and challenging encounter. The schizophrenic with religious dysperceptions may present even more of a challenge to his counselor. In working with schizophrenics at Earth House who are religiously dysperceptive, I have become increasingly aware of how many persons act out the symptoms of this illness in the arena of religion. How can one work effectively with these patients? I hope that the remarks which follow will be of assistance to those who face the difficulty of counseling a religiously dysperceptive schizophrenic or to parents or others in a role of authority who are faced with the challenge of managing such a person.

The patients I have worked with at Earth House are victims of major mental disorders. They are chronically ill and most have been previously hospitalized, some for more than 15 years. I have come to learn that the other areas of the Earth House program are well run, that the patient gets proper exercise, rest and nutrition, and that the biochemical basis of his or her illness is being addressed, through nutrients and medication when needed. Because of this the students I work

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with are not experiencing visual or auditory hallucinations in an uncontrollable way. Within this framework I attempt to make religion a positive force in the patient's recovery rather than the siren which continuously lures the person back into insanity.

Let us examine the religious dysperceptive. Larry was caught in traffic in downtown Boston on the way to his brother's wedding at the time of his second psychotic break. His first psychotic episode had taken place soon after the divorce of his parents and after a bad experience with LSD. Larry's second episode occurred two years later. He hadn't been sleeping well because of the excitement connected with the wedding. He was feeling high in anticipation of the events that were to take place that afternoon. Suddenly as he was stuck in traffic with a nearing deadline to meet, he began to feel something transcendental come over him. It was extremely pleasant at first. Then he began to see the oppression of the people around him. He felt a deep, cosmic compassion for them because they didn't seem to realize that they were merely automatons, controlled by the system. Then Larry felt the weight of the sins of the world on his shoulders. He experienced himself as the Messiah. Jumping from his car, he began to run through the street shouting to people about the oppression of the system. Larry was wrestled to the ground by several policemen a while later, then stripped naked on the street and taken to a padded cell in a state hospital where his mother found him, still naked, three days later.

In Larry's illness there was a perceived religious experience which occurred at the time of his break. Larry felt that he had been chosen or set apart by this experience. This helped him explain to himself why he saw and heard what others didn't.

Jane's religiosity was different. Poor self-image, nurtured by several years on welfare was followed by a deep depression. Jane began to look toward religion as a source of hope. Jane did not feel any particular sense of being chosen. She seemed to feel, rather, that God was the only one who could possibly help her. He was also the only one who understood her pain. Jane claimed to be a "born-again" Christian while exhibiting none of the charitable qualities one would hope to see in such a person.

One can see both religious truth and falsehood in the perceptions of both of these individuals. Unfortunately, the "truths" we could point to have become so twisted in both cases that we can hardly recognize them as religious truths. Larry was correct in seeing that the world is oppressive. His compassion for the crowd would seem admirable if it had not come to him in such a compromising way. Larry needed to feel special, as do all individuals. A powerful experience and a need to be chosen, however, does not a Messiah make! Larry's overstimulated brain produced a twisted logic that made him feel like a savior. His racing mind caused him to obsessively make inappropriate connections between his thoughts and external reality. Everyday coincidences turned into events of earth shattering significance.

Religion may teach that ultimately God can help us. Jane has picked up on this "truth" and has, of course, neglected the intermediate steps of being responsible for her own life (which most religions would also require). God may be the only one who knows her pain. These "truths" have become twisted in a way that has allowed them to become a part of a delusional system that is self destructive.

In either case it was not therapeutic to deny the perception of these individuals. Their perceptions had taken on a significance in their lives which was a focal point for their existence. Rather than deny these perceptions, the religious counselor needs to enlist the strength of these perceptions in the sense that they are true. These "truths" then need to be untwisted before they can be of value in the recovery of the patient.

The counselor should not attempt to negate the experience of the patient. This is equivalent to denying his or her existence. The consequences of such a strategy may be to create a defensiveness in the patient about these perceptions. This will undoubtedly lead to a greater attachment on the part of the patient to these perceptions. A more wholesome strategy would be to help the patient understand the truth of his or her perceptions, again, in the sense in which it is true, that is, to help the patient untwist the illusions. In doing so there are three basic

rules to follow.

1. The person counseling the religious dysperceptive should attempt to learn about the religion this person is professing. This effort alone will show the patient in a nonverbal way that he or she has worth, that his or her views have value. The religious dysperceptive will almost always focus on a very narrow area of the religion in question, whether it be Buddhism, Christianity, Hinduism or whatever. If the person in authority can learn about the religion of the patient, he or she can supplement the belief system of the patient in such a way that the illusion may begin to untwist. The first rule is to know more about the patient's religion than the patient does. Jane claims to be a "born again" Christian and yet she lies, steals, is nasty to others and does not honor her father and mother. But Jane is committed to Christianity. The strength of this commitment can be enlisted to help her learn to tell the truth, not to steal, to be kind to others, to honor her father and mother, to be a responsible human being.

2. Religiously dysperceptive schizophrenics will often focus on a few issues of the religion they profess, to the exclusion of others. Hence, they may be convinced that they should fast, renounce material possessions, endure persecution for their beliefs, etc. There are, however, other sides to these issues which are given in all religions. It is advantageous for the counselor to know the other side of the issues which the patient probably has not addressed in the expression of the illness.

God may exact judgement on the evildoers, but he is also compassionate and forgiving. Religion may call for purity, and yet religion allows for fallibility. The schizophrenic patient especially needs to know that it is all right to be fallible. The religion of the patient may ask him or her to renounce the world but it also calls for responsible social action which includes work, provision for oneself, and care for others. The patient needs to hear this.

The religious counselor or person in authority needs to identify other dimensions of issues the patient has not addressed in his or her religious expression. Religion is not the enemy if it is wholesome religion. It can only be therapeutic when it is wholesome. It can only be wholesome when it leads to goodness, to responsibility, to health, wholeness and well-being. Because of the deep commitment of religiously dysperceptive schizophrenics to their religion and because of their interest in this area they may be much more willing to accept challenges which are presented to them in the language of their religion.

For example, one patient raised as a Christian had no menstrual period for many months and concluded that she was pregnant with the Christ child. Confronting her with her delusions wasn't helpful. In an attempt to rechannel her delusions I encouraged her to think of Christ as being in her heart rather than her womb.

3. A schizophrenic will frequently express many contradictory ideas and beliefs. More than one patient I have counseled has asked, "What is wrong, why has this happened to me?" and has at the same time espoused that "Nothing is wrong with me." Here is a basic contradiction. Either something is wrong or it isn't. One may point out the contradictions which the patient expresses, not in a malicious way, but for the purpose of self-exploration. These contradictions may be contradictions between what the patient professes to believe and what he or she actually does. They may be simple contradictions between what is said at one time or another. If these contradictions are pointed out and explored in a way that is not threatening to the patient, improvement may follow.

Conclusion

Schizophrenics are persons before they are schizophrenics. Their perceptions may be twisted, distorted or false, but they are their perceptions. The skilled counselor may aid the patient in his or her recovery by acknowledging these perceptions, by developing them, and by untwisting them so that they can become a positive force in recovery. The religiously dysperceptive schizophrenic already has an interest and commitment to something. This "something" can either be denied by others or enlisted as a positive force in conquering illness.