Tug-of-War: Domestic Abuse and the Misuse of Religion

Nada L. Stotland, M.D., M.P.H.

A major aim of psychiatric care, both psychotherapeutic and psychopharmacologic, is to foster patients' ability to make their own life choices. As psychiatrists, we try to learn our own biases and keep them out of the therapeutic process, although we never entirely succeed and remember that it is impossible. We ally ourselves with the patient's healthy ego, which is a distillation of temperament, experiences, feelings, desires, values, intentions, and coping styles, to help him or her discover internal conflicts that get in the way of functioning and happiness and find more adaptive ways to address them. But the conflicts we address are not only internal. Often there are forces—or people—in the patient's life who covertly or overtly thwart treatment. Families and other relational systems are always resistant to change, and family members use various techniques to discourage it. They complain of the expense, disparage the effectiveness, warn of the dangers of seduction and side effects, and support dependence. The fact that a family member is in psychiatric care can also be used to solidify the notion that the individual is defective, out of control, or incompetent, thus placing responsibility for the family's problems on the patient.

Domestic abuse presents a whole new dimension of conflict. In this situation a family member concentrates considerable time and energy on punishing the patient for an increasing and unpredictable array of alleged transgressions, humiliating him or her, devising means to keep him or her financially and otherwise dependent, and often presenting a real threat to the physical safety of the patient and any children in the home. These behaviors are defended as necessary or as temporary lapses in a loving and protective relationship. The patient experiences himself or herself not as abused but as bad. The process can be very similar to that of brainwashing or cult indoctrination, with interruptions of sleep and nutrition, isolation, restrictions on movement, and substitution of the abuser's world view for the patient's own. The patient must also cope with the symptoms of traumatic stresses that are both in the past and ongoing. This situation undermines the very affective and cognitive processes essential for the therapy the patient needs to extricate himself or herself from an abusive and physically and psychologically damaging situation. Since the patient about to be described is a woman, and because women predominate as the targets of domestic violence, the text refers to women, although men can also be abused.

Abusers sometimes find allies. Some traditions and families require women to stay with their husbands, regardless of circumstances, and even attribute fault in the abusive situation to the abused rather than the abuser. Even after the appearance of major national awareness campaigns and education initiatives for health care professionals, studies continue to demonstrate that women who are seen in emergency rooms, clinics, or doctor's offices with clear signs and symptoms of abuse are treated for the immediate injury or complaint and dismissed without inquiry, information, or follow-up for the life-threatening condition—abuse—that caused the immediate injury or complaint. This makes the health care system into an unwitting ally. This case illustrates a tug-of-war in which the abuser adduced the family's Christian faith, not only to support his abuse, but also—when threatened with the dissolution of his marriage—as a powerful tool to disrupt the therapeutic relationship. He declared that the psychiatrist was a liberal and a feminist sent by Satan to tempt the patient to repudiate her marital and maternal obligations and that she was going to go to Hell if she persisted with therapy. He initiated a tug-of-war in the patient's mind between her religion and her treatment.

It is extremely difficult for those of us who have not been abused, or who have not worked closely with others who have been, to empathize with the helplessness, both real and psychic, that abuse can engender and to comprehend the cognitive distortions it causes. Abusers shape reality for their victims just as parents shape reality for their children. Bolstered by fear, isolation, and occasional demonstrations of love and caring, they construct a reality in which the abused person is defective, incompetent, lazy, careless, ugly, undesirable, promiscuous, stupid, and bad and is repeatedly punished for these negative attributes. Psychiatry, despite its long history of focusing on the effects of trauma, has been slow to recognize and address this kind of trauma. It seems necessary to offer the extensive history of the patient and the treatment that followed because they chronicle a significant evolution in conception and therapeutic approach. This approach will help the reader understand how this patient and others come to think, feel, and behave as they do. It took me nearly 20 years to understand. Recently, it has become apparent that the signs and symptoms of chronic domestic trauma overlap considerably with the diagnostic descriptions of personality disorders. Perhaps this case conference will help shed light on the developing clarification of that overlap or confusion, which will in turn offer new possibilities for treatment.

This article reveals my own struggles, as well as those of a vulnerable patient. There was another tug-of-war, then, between my duty to act only in my patient's interest and my desire to share, and allow her to share, her experiences in the hope of benefiting others. I offered my patient the manuscript to read. She was justifiably afraid that she

would overreact to some word or phrase and preferred instead to have me go over the contents with her in detail. She made corrections and additions and emphatically approved of the article's publication. She prefers to be called by her first name, so a first name is used in the article. But the problem of consent is inherently insoluble. It is extremely difficult for a patient to refuse a request from her physician, and it is equally difficult to advance our knowledge and practice without using data from real patients. Of course, I have disguised identifying information in the clinical material. I thank my patient for her generosity and courage in allowing her story to be shared with the psychiatric community.

Case Presentation

At the time of this emergency visit Violet had two babies: a 1-year-old and a 4-week-old. Her husband spent most of his waking hours at his office. The unusually severe winter weather had made it literally impossible for Violet to leave their small apartment with the two babies. She had few visitors, and she and her husband did not think it was acceptable to pay money for a baby-sitter or for Violet to be separated from her breast-feeding infant for any length of time. Her trip to the emergency room was the first time she had left the apartment since she brought the new baby home. She seemed to be suffering from old-fashioned cabin fever. She was tearful, sleepless, exhausted, and anxious.

History and Treatment

Violet's acute symptoms abated with the help of supportive psychotherapy and improvement in the weather. She did not report symptoms consistent with what now would be termed a mood, anxiety, or personality disorder, but she did have vague generalized anxiety. She seemed to expect ongoing psychiatric treatment, although neither she nor I made a clear diagnosis or articulated clear treatment goals. With open-ended psychodynamic psychotherapy as the expected and respected approach in the residency training program, and supported by Violet's health insurance, it was accepted that the diagnostic picture would take shape over time.

Violet demanded considerable reassurance, especially with respect to her maternal behavior, which was constantly questioned and criticized by her husband and older sister. She was very impressed by the fact that both of them had attended a prestigious university, whereas she had barely finished high school. Although the differences in levels of education undermined her confidence in her own decisions, Violet seemed to have perfectly normal intelligence. (At this point in the article, my patient corrected me: "above-average intelligence," she said.) The maternal behaviors she described always seemed appropriate.

Over several months of weekly visits a history of severe childhood abuse and trauma gradually emerged. Violet was the youngest daughter in a family of seven (with two older sisters, three older brothers, and one younger brother) in a small town. Her father was often drunk and violent. He threw Violet against a wall when she was 2 years old. She spent some weeks in the hospital, had a metal plate placed in her skull, and was ever after considered intellectually deficient by the family. They were desperately, humiliatingly poor. They had neither health insurance nor money to pay for medical care. Some of the children were delivered at home, on the kitchen table, by their father. One anecdote was particularly poignant. One day Violet's mother had no food for her children. She set the table and cut photographs of food from old magazines. After placing the photographs on the plates, she went to the river to drown herself. At the last moment she changed her mind.

Violet could not remember a single incident of positive parental attention or concern. When she was about 5 years old, she was befriended by an adult farm worker. She was full of loving feelings. But one day the family discovered her fondness and teased her unmercifully. The man withdrew from the relationship. She was shattered, convinced that she was not ever meant to have an affectionate relationship and that it was dangerous to trust anyone with her positive feelings. She was often expected to look after her brother, who was a year younger than she. When she was 5 years old, he ran into the street and was killed by a passing car. The family held her responsible. One of her older brothers was abusive—she could not bring herself to specify how—and was still frightening to her as an adult. Another brother was relatively kind; he was killed in Vietnam when Violet was a teenager.

Violet's academic performance was abysmal; she was completely "zoned out" in school, but she was passed along, finally receiving a high school diploma, to which she did not feel entitled. She thought she was stupid. She also felt completely vulnerable to virtually anyone who made sexual demands. It is likely that her brother and father sexually abused her; she shudders, cringes, and weeps if the subject is broached and has never been able to articulate specific memories. She is terrified of requests to attend events, such as family reunions, where her brother or father will be present.

At the age of 17 Violet left home for a city where one of her older sisters was attending a university on a scholarship. She shared her sister's apartment and got a job on campus. She soon began dating a student named Luke. He took over her finances, made all her decisions, and abused her physically. Violet recently reported that it was when Luke first beat her that she felt comfortable, because this was the type of relationship she felt she was meant to have. When she became pregnant, he insisted that she have an abortion. It was many years into therapy before Violet was able to mention either the abortion or the abuse; earlier brief inquiries were met with denials.

When Luke graduated, he decided that they would marry. Violet did not love him and did not want to marry him, but she felt she had no choice. They married, Luke took a job, and Violet began having babies; eventually there were five. After their first apartment, they lived in a succession of fixer-upper houses, on which Violet performed nearly all the repairs. At Luke's insistence, she also did secretarial work at home. Nevertheless, according to Luke, she remained in his financial debt. He kept meticulous financial records. No one in the family was permitted to use a postage stamp unless Luke had agreed to the necessity of sending the piece of mail and had read it personally. Luke had to be told the content and the caller for every telephone call. If Luke gave Violet a $5 bill to go to a convenience store for a gallon of

milk for the children in the evening, Violet had to bring Luke the receipt and the change. Violet, after reading this article, added, "If there was a penny missing, I had to find a penny first." He hit her and berated her daily in front of the children and yelled loudly whenever they were together in public.

Violet tried hard to live up to Luke's expectations and blamed herself when he found fault, screamed at her, and hit her. The children were well behaved and successful at school and in after-school activities. Violet thought it was important for them to have a strong faith and religious affiliation. She was a "Christian," which I assumed meant fundamentalist, born-again, or evangelical; this was not a familiar area for me. Luke had grown up in a Christian denomination that he later rejected, and Violet gradually convinced him to join her church, where he became increasingly active.

Luke spent most of his time at work or going over his financial records. Although he had a good income and the family lived frugally, he worried aloud about expenses and the need to save money for the children's education. Violet was not allowed to go grocery shopping alone lest she purchase indulgences such as brand-name cereals, cartons of yogurt, or snacks of any kind. He made mealtimes a nightmare for everyone; he found fault and was so controlling that his adolescent son was not permitted to pour his own beverage into a drinking glass. Violet was unable to eat with the family; the very thought made her feel ill. She ate cold food out of cans when no one was around and, as she had in childhood, raw oatmeal. The children patched together school lunches or went without; there was nothing to feed their friends when they came to visit unless Violet paid for food from her own earnings. The house was a magnet for neighborhood children, who called her "Mommy Violet."

Luke also determined the family's political beliefs; he felt he had to help Violet cast her vote in government elections. Luke began to find rationales for all of his behaviors in the Bible and the teachings of their church. He banned most radio and television as a bad influence. Violet was not allowed to have opinions or preferences; she lived—and lives—in constant fear of "getting in trouble" and being punished, especially if she disagreed with Luke in any way. She had little idea of how other families functioned, and, anyway, she believed that God must have singled her out for suffering because there was something different or bad about her. She felt like a nonperson—as though she didn't exist at all. She was plagued by panic attacks with horrible dreams and terrors.

Development of Therapy

Violet seemed interested in talking, but for months and years the sessions consisted of Violet recounting her sister's criticisms and asking for reassurance that she was a good mother. In fact, over a period of 20 years, nearly every mother-child interaction Violet described indicated great patience, insight, empathy, and devotion. She drove the children to lessons and meetings and school events. She did craft projects with them. She insisted on politeness and honesty but seldom had to resort to punishment to obtain compliance. At the same time the children were exposed to repeated episodes in which she was abused and episodes during which she felt overwhelmed, shut herself in her room, or left home to stay in a motel for a day or so.

Her fondest fantasy was of becoming a registered nurse. In addition to her home secretarial, child care, and household duties, she began working as a nurse's aide on the midnight shift. She was beloved everywhere she worked. The incidents and concerns she described demonstrated that she had a sophisticated grasp of complex issues in patient care. Luke demanded that since she was in debt to him and unable to manage money, her paychecks be directly deposited into his personal bank account. She was not allowed to use Luke's credit cards, but she finally obtained one in her own name. Whenever she or the children needed money for something important such as school fees, medication, or shoes for which Luke refused to pay, she charged the cost to her credit card. Then Luke would "bail her out" by paying some of the bill, using each payment as an example of her incompetence and adding it to her arrears.

Violet began part-time training to become a nurse at a local community college but dropped out; Luke was concerned that she could not do justice to her parenting while in school. Then she started again at another school and after doing well failed an examination and was dropped from the program. She was accepted at a third school, completed the coursework, and began her clinical training. There she became so anxious that she failed a clinical requirement. Violet always had—and has—a generally overwhelming difficulty identifying the onset or trigger for episodes of despair, depression, and increased anxiety. Her reaction to my inquiries was to sob, put her hands over her ears, accuse me of deliberately making her suffer, and either curl herself into a ball or pace agitatedly around the office.

After one incident in which she performed poorly on an examination on material she had clearly mastered, I relentlessly insisted she retrace the incidents of the previous day. It turned out that Luke had found some cause for complaint as soon as he returned from work and had screamed at her, following her anywhere she went in the house all evening and all through the night. Violet was then able to recall that Luke had behaved similarly before each of her failures and decisions to drop out of school. He had torn up the final paper for a final course, setting her studies back an entire year. With tremendous trepidation, she was able to convince one of the schools to give her another chance. She decided to stay in a motel on the nights before examinations. She did so, graduated, and passed her licensing examination without further difficulty.

Over the course of the first several years Violet's behavior in treatment sessions evolved from pressured accounts of daily activities and requests for reassurance that her sister's criticisms of her parenting were unwarranted—without mention of the abuse it later appeared she had been undergoing—to virtually incoherent accusations, sobbing, and desperate demands for physical contact (hugs) from me. Although I often succumbed to the demands for reassurance, I otherwise left the sessions unstructured, as I had been taught, to allow Violet to set the agenda and for unconscious conflicts to emerge. Violet regressed; she seldom finished a sentence—much less a thought—without interrupting whatever she started to say with "it doesn't matter," "I'm just selfish," "I'm going to be punished," "You're trying to get rid of me," or "I guess this is the way you want it." She told me later that she had been extremely dubious

about seeing a psychiatrist and was very surprised to find herself loving me. The latter emotion filled her with unexpected hope and untold terror. After all, she was not "allowed" to love anyone, and she was certain to be punished for it, either directly by me or in some other way.

Violet is—and was—hypervigilant, scanning the office at each and every visit for signs of impending disaster. Any planned absence by me provoked terror that something would happen to me or convinced her that I was about to take a job in another part of the country. She was exquisitely sensitive to my every gesture, word, and action, easily interpreting one or the other as an indication of punishment. The punishment was to be rejection or expulsion from treatment. She required unceasing reassurance that I was not trying to get rid of her or trying to trick her into leaving treatment. She made and canceled appointments and left the office precipitously in the middle of sessions, but she always came for her appointments. Specific therapeutic issues are discussed in the following paragraphs.

Telephone Calls

Telephone calls were an issue between us. I believed—and believe—that psychiatrists, like all physicians, must be available to their patients in the event of emergency. Violet, however, experienced what she perceived to be emergencies daily if not, sometimes, hourly. She had no demonstrable capacity to rank order those experiences. For a while I increased her appointments to twice a week without perceptible effect except to provoke years of accusations that I had returned to a once-a-week schedule to punish her or drive her away. I was convinced that if I asked her to call only in the event of a life-and-death emergency, she would so define an ever-increasing range of experiences. I wanted Violet to work on remembering and using the content of her treatment sessions rather than calling me every time she felt overwhelmed. But I did not feel comfortable categorically refusing to take or answer all calls.

We are left with an uneasy compromise. Messages from Violet invariably indicate that she has a desperate and immediate need to talk to me. Sometimes I am aware that there is extra stress in Violet's always stressful life. Sometimes my secretary is away from her desk, and I answer my calls directly. When Violet gets through to me, she tells me that she is having an unbearably hard time. I ask her to reflect about the precipitant for her feelings and what she can do to feel better. It is not easy to end the call. Violet feels rejected when I announce I must leave. Having been confronted several times with the choice between saying good-bye and being hung up on, however, she has learned to respond to my good-bye with one of her own.

E-Mail

When I began using electronic mail, I had my e-mail address printed on my business cards. I did not anticipate receiving e-mail from patients who picked up my cards from my desk. But soon I was getting e-mail messages from Violet as often as several times a day. This posed the same dilemma as telephone messages. I am accustomed to reading and answering all my considerable e-mail, but, again, corresponding with Violet could become a full-time job that satisfies neither of us. There was no way to prevent her from sending messages, but neither was I willing to assume responsibility for answering them. I decided to inform her that I would read every message but that I would not respond. I have broken my own rule on a few occasions when Violet's messages conveyed the intention to do something self-destructive. I make my messages extremely brief and to the point. Despite the fact that behaviorist research demonstrates that intermittent rewards are the most reinforcing ones, this is working so far.

Gifts

I was taught to reject, or at the very least fully analyze the meaning of, gifts from patients. Violet has brought me handmade or painfully chosen and presented gifts, along with demands that they be displayed in the office. She dissolves into screams of self-recrimination at the slightest suggestion that the meaning of the gifts be explored. I have accepted gifts and insisted that the screaming stop. I have kept in my office items I would not otherwise have chosen to complement my decor—the most significant being a doll that Violet made and with which she identifies. The doll has suffered repeated injuries at Violet's hands but has survived. I have never refused a gift from Violet.

Medication

Violet has often demanded immediate pharmacological relief, but it has been difficult to get a clear picture of Violet's signs and symptoms. As described, Violet would complain of feeling "sick, very sick." But if she endorsed a sign or symptom, she would, in the next moment, deny it, seeming fearful of appearing self-centered or demanding. And there was significant cause for concern about how Violet would handle medication. She had been prescribed alprazolam by another physician and has been desperate to continue or increase it. However, it sometimes seemed that when especially stressed she took considerably more than she was prescribed to take at any one time. She would call, sounding oversedated. An uneasy compromise has been maintained: she has a prescription for alprazolam, 0.25 mg, 50 in number, to be dispensed no more frequently than every 7 days.

Even more worrisome was the fact that a neurologist had prescribed a tricyclic antidepressant for Violet's migraines. Several years ago I received an emergency page from the neurologist. Violet had called him and asked how much of the medication it would take to kill someone. I called the police in Violet's town and had her taken to the local hospital to be evaluated for suicidality. And I put an end to the tricyclic prescription. Until the selective serotonin reuptake inhibitors (SSRIs), with their more acceptable safety margins, became available, it did not seem possible to treat Violet pharmacologically for her depressive symptoms. When SSRI efficacy for the treatment of panic disorder was demonstrated, that was another reason to use an antidepressant. When they became available, I prescribed one for Violet. Paroxetine, 40 mg/day, was chosen because of its somewhat more calming, rather than agitating, side effects.

But despite her background in nursing and sophisticated grasp of the medications used in her area of specialization, Violet often takes extra doses of paroxetine when she feels bad or often fails to take it, either because she doesn't have the funds to pay for the prescription, because the medication has been misplaced

(whether this is a result of her disorganization or a deliberate act by Luke we do not know), or because she is convinced it causes her to gain weight. She has recently made a determined effort to take it on a regular basis. It is difficult to assess the effectiveness of the pharmacological treatment under these conditions, but at times the paroxetine seems to have somewhat ameliorated both the depressive and panic symptoms.

Hospitalizations

Violet has been hospitalized two times since I first saw her. These hospitalizations occurred when Violet took an unspecified amount of alprazolam, accompanied by a fifth of an alcoholic beverage (she does not drink alcohol otherwise), in an attempt to sedate herself to tolerate Luke's sexual advances. If she denied him, she knew he would become increasingly agitated and abusive.

She, a neighbor, or one of the children called to tell me she was incoherent and hysterical. I chose to allow the police or ambulance to take her to the closest hospital rather than to the hospital where I work. I believed that she should have a professional evaluation to make sure she was safe but that proximity to me, and the intensity of inpatient care, would exacerbate her dependency. On each occasion she immediately regretted the behavior that precipitated the hospitalization, disliked being in the hospital, pulled herself together, and was discharged within 1 to 2 days. My interventions have been precautionary. I do not see these episodes as serious suicide attempts, but suicidality has been a recurrent concern over the entire course of therapy. Violet frequently has thought that her life is unbearable and that the world would be better off without her.

Countertransference

Working with Violet has provoked two major kinds of countertransference. First, her accusations, self-defeating behaviors, incessant demands for reassurance, inability or unwillingness to retain reassurances, difficulty completing thoughts and sentences, dissolving into sobs or shouting insistence that I not finish my own statements, tendency to change appointments, difficulty understanding what her treatment is about, and the chronic threat of self-destructive or suicidal behavior are frustrating and enraging. When Violet is overwhelmed by her own desperation, she is unable to realize what unreasonable and onerous demands she makes, and I am the one feeling like a nonperson or a primitive, withholding mother. When she is overwhelmed by her guilt and shame and does not feel entitled to speak, she deprives me of the verbal material I need to work with in treatment, so I am the one withheld from. When she is overwhelmed by her loving feelings, she goes into a panic over the expected rejection. She cannot register, much less accept, the evidence of my consistency over 20 years. I feel as if everything I have ever said or done has gone not only unappreciated but unnoticed, and there is no use doing anything with or for Violet.

Violet never ceases to demand, usually as she is leaving the session, that I assure her of my interest (she has learned not to demand my love). There is no feasible reply that satisfies either of us. I cannot give wholehearted reassurance without feeling resentful that it was extracted from me. I cannot refuse to give reassurance without provoking a traumatic reaction just as Violet is leaving for a long drive home and a week's wait before the next session. I cannot refuse to answer or turn the question back to Violet without the same outcome. I feel blackmailed.

But, second, Violet's survival of her abusive past and present, her persistence, intelligence, love, and empathy for her children, her patients, and others, and her unceasing attempts to be a good human being are awe inspiring. I harbor maternal feelings and rescue fantasies regarding her. I do care about what happens to her. And I don't want to fail.

Evolution of the Therapeutic Paradigm

This case spans a major evolution in psychiatric care and in the professional development of a therapist. Treatment began during a residency dominated by classic psychoanalysis, continued through formal psychoanalytic training, and persisted into an era dominated by new pharmacotherapies and manual-based psychotherapies. It spanned open-ended, undirected psychotherapy, an approach that probably exacerbated Violet's regression, and evolved into an eclectic, empirical mixture of pharmacotherapy, support, advocacy, cognitive therapy, and insight-oriented psychotherapy influenced by self-psychology. It has required ad hoc responses to situations not quite compassed by any one conceptual system. How many times can a patient change one appointment? (As many as my schedule and patience will allow.) Is it appropriate—even helpful—sometimes to tell a patient to stop crying and get back to the realities of the day? (It works.) I have been working to address Violet's need to develop self-soothing and coping skills, affording us a more adaptive way of coping with her telephone calls and e-mail messages. It has become easier to reply to Violet's insistent demands for judgment and direction with "What do you think?," "You know the answer to that," or "You will know what to do," even after she responds with "Yes, but," and repeats the question. And I have been known to order her to "Stop it. Let's talk about what happened and what you need to do" when she begins to cry, scream, cover her ears, or pace. There is always a danger of reacting to an abused patient with further abuse. But some firm direction helps us get on with the therapeutic work.

Diagnosis

A personality disorder, most likely borderline or mixed, with coexistent depressive and anxiety symptoms, seemed at first to describe Violet's signs and symptoms best. Over the course of this treatment domestic violence was not only recognized in the field as a cause of psychopathology but also specifically as a possible cause of misdiagnosis. Specifically, behaviors that are reasonable or inevitable responses to ongoing abuse have been attributed to personality disorders, which makes them character traits rather than responses to real external threats. An individual in an abusive situation behaves suspiciously. Her mood varies, sometimes abruptly. She feels isolated and different from other people, as though there is something wrong and bad about her. And she dissociates during particularly frightening episodes of abuse. A diagnosis of posttraumatic stress disorder (PTSD) applies as well to Violet's signs and symptoms as a diagnosis of borderline personality disorder. It encompasses suspicion, hypervigilance, mood swings, memory

difficulties, thought blocking, nightmares, and dissociation. So I entered a notation in Violet's chart indicating that recent findings support a need to change her diagnosis. PTSD is also less stigmatizing than borderline personality disorder in general and in terms of marital and custody disputes. In an episode in which the police and the law became involved in Violet's domestic situation, Luke and his lawyer were quick to humiliate Violet by throwing the "borderline" term around the courtroom.

Cognition

Although the impact of treatment can be read in Violet's insights, behaviors, coping skills, and very survival, she seems to have great difficulty retaining the content of our interchanges. At times she has asked me to write down simple statements such as "I am your doctor." The pieces of paper on which these notes are written become talismans before becoming traumatically lost in the chaos and invasive surveillance instigated by Violet's husband, which include a methodical search of every bag of garbage removed from the family home. Her experience since early childhood has been that to have—much less to articulate—a positive affect or a confident thought poses mortal danger. It is impossible for her to contemplate an ordinary telephone call to ask her lawyer for straightforward information or to ask the hospital accounting department about a bill. In fact, she seldom makes or takes a telephone call, except to me or for her children. Questions about childhood or recent events can provoke cognitive shutdown. She immediately panics and dissociates.

It often feels to me as though Violet spends 24 hours a day, 7 days a week, in the suburban equivalent of a prisoner-of-war camp, while we have one session a week to counter the damage. My every utterance is filtered through a traumatic prism. It is possible that Violet suffered brain damage as a result of her father's brutality. But Violet is able to hear and respond to her children and not only to retain, but to use effectively, a wide array of highly technical information needed for her professional work. She is beginning to realize, and to very tentatively admit, that she is not stupid. I sometimes ask her to "use her nurse's mind" to address a discussion or a problem, and sometimes she can, but her level of anxiety and dissociation generally make insight-oriented psychotherapy very difficult. That does not mean, however, that she does not use our work to effect change.

Religion

Religion has increasingly dominated Luke's behavior at home. He often reads the Bible loudly at the dinner table. He attends Bible study classes and pores over the Bible at home. He has found Biblical injunctions to support his domination and control over the activities and beliefs of every member of the family. He is constantly on guard for any suggestion of thoughts and attitudes of which he disapproves. Should the children question any statement he makes, he accuses them of being "un-Christian" or heathens—an accusation that deeply wounds and terrifies them.

When Violet decided to seek legal advice about ending her marriage, Luke invoked Biblical passages about a wife's duty to submit—and stay married—to her husband: "God hates divorce." After he declared the therapeutic process evil, Violet had increasing difficulty coming to her therapy sessions, and she experienced an exacerbation of her difficulty thinking clearly and speaking once there. She often calls, asking for postponements to the following day, and arrives feeling dizzy, agitated, and generally unwell. Entire sessions have been consumed discovering that Violet has been thinking that she is violating God's law and will be thrust out of His protection and into Hell, not only for seeking a divorce but for continuing her treatment.

The invocation of Christianity took me out of my own tradition and sphere of knowledge. I consulted experts in Christian theology and ethics and was reassured that evangelistic Christianity did not compass physical abuse and destructive domination as intrinsic to marriage. I found an organization that specifically addresses dilemmas like Violet's. It publishes a paperback book citing each Biblical passage that has been interpreted to mean that women should tolerate domestic violence and counters them with other passages that clarify or reinterpret these passages (1). For example, the statement that a husband owns his wife's body is balanced by one stating that she owns his body as well. The message is one of commitment and dedication, not domination.

This organization has also produced two videos: "Wings Like a Dove: Healing for the Abused Christian Woman" and "Broken Vows: Religious Perspectives on Domestic Violence." (Both are available from the Center for the Prevention of Sexual and Domestic Violence, 936 North 34th St., Suite 200, Seattle, WA 98103-8869; telephone: 206-634-1903; fax: 206-634-0115; e-mail: cpsdv@cpsdv.org; http://www.cpsdv.org.) Each videotape comes with a study guide for facilitators. The videos present interviews with deeply religious Christian women who have wrestled with situations like Violet's, intercut with interviews with religious leaders from a variety of Christian denominations. Two copies of the book successively disappeared from among Violet's possessions at home. I was convinced that the same fate would befall a video and that watching it at home would subject Violet to abuse. We watched it together in my office.

When accusations of evil made therapeutic dialogue not only difficult, but terrifying, for Violet, I found myself invoking Christianity to counter them. I asked her what Christ stood for, and when she answered "love," I asked whether Luke's accusations were loving. When she described episode after episode in which he had told her and the children that all the family's problems were her fault and that she was a bad and stupid person so that she questioned her very right to exist, I asked her whether Christ made people feel worthless and wicked. I repeatedly state that only God—not Luke—can sit in judgment of people's badness or goodness. I consult my religious experts to make sure I am not violating any tenets of Christianity. Violet has never inquired about my religious background or taken issue with my references to hers. My religious background is not obvious from my name, my office contains no "religious" items, and I take the usual public holidays. Violet is immersed and comfortable in her own religious frame of reference.

Violet is afraid to take up her religious dilemma with her minister; Luke has made a major effort to get close to him. I received the following e-mail from Violet: "dr stotland i cannot choose between you and God and that is what you are trying to make me do it is way too big." I responded, aware both of my presumptuousness and

her precariousness, with "God and I are on the same side." She answered, "is that true is it possible that you and God are on the same side and i do not have to leave you to be true to God." I have to confront the possibility that I am imposing my value system on Violet. Who is to know who is on God's side or if God has a "side"?

Violet gives me reason to believe that our benevolent and humanistic values, although arrived at from very different perspectives, are fundamentally the same. Is it I or Violet who wants Violet to be divorced? As I was going through this article with her, I told Violet that I was trying to be careful to help her do what she wants to do, rather than encouraging her to do what I want her to do. She immediately countered, "I have wanted to leave Luke since before I married him." Although severely torn, Violet maintains that she does not wish to live with or be married to Luke and that she can "never be a person" while married to him.

Orthodox members of several faiths remain dubious about subjecting themselves or their family members to the ministrations of psychiatrists, trusting only coreligionists. For evangelical Christians, a large "Christian therapy" movement has developed. Practitioners reinforce patients' attempts to think, feel, and live according to religious precepts and incorporate prayer into therapy. When freely chosen, this may be a workable synthesis. Sometimes guilt is the appropriate response to a behavior. At some point, even the most dedicatedly nonjudgmental psychoanalyst must differentiate right from wrong. Psychiatry, where it cuts close to the meanings and motivations of human life, must grapple with questions about responsibility, even if psychiatrists cannot answer them. Psychiatry, like medicine as a whole, has paid too little attention to the spiritual aspects of patients' being. It is not possible, or even desirable, to launder psychiatric practice of values, but it is possible to value the beliefs of patients.

Discussion

This patient, although first seen as a psychiatric emergency, initially showed no signs and symptoms of a DSM-IV disorder. It is unlikely that the third-party payers of today would be willing to underwrite the years of regular care that were necessary to establish a therapeutic relationship in which this patient could reveal her history, psychopathology, and extremely toxic life situation—much less work to change them. Absent psychotherapeutic support, this patient might have committed suicide.

This case is not resolved. It reveals my ignorance, ambivalence, ineptitude, struggles, and evolution, rather than my solution of a clinical conundrum, but it also illustrates the growth of knowledge about abuse and religion and their relationship to psychiatric practice. Although I haven't always known what I was doing in treating her, my patient successfully brought up children, forged a professional career, and recognized and took steps to leave a destructive situation. She now has fewer panic attacks. She can allow herself moments of self-esteem and pleasure. She has moments of crystal-clear insight. I look forward to what she will be able to do after her divorce, when she can sleep uninterrupted, eat meals at the table with her children, express an opinion without reprisal, and participate in therapy unencumbered by accusations of evil.

I recommend four publications for further reading (2–5).

Postscript

Violet just called to tell me that her divorce has been granted. She is incredulous, relieved, and happy. Her sense of humor can now show: she could not wait to declare "I don't," just as she had said "I do" at her wedding. She wanted to make sure I have noticed that she continues to work to make herself more mature, and she is confident that she can manage her money and her life.

Received Sept. 7, 1999; revision received Dec. 7, 1999; accepted Dec. 9, 1999. From the Department of Psychiatry, Illinois Masonic Medical Center. Address reprint requests to Dr. Stotland, Department of Psychiatry, Illinois Masonic Medical Center, 836 West Wellington Ave., Chicago, IL 60657; nadast@aol.com (e-mail).

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