Emerging From the "Dark Night of the Soul": Healing the False Self in a Narcissistically Vulnerable Minister

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Predisposing narcissistic personality factors and the unique demands of the ministry may combine to create an emotional and spiritual crisis in some members of the clergy. This article examines (a) the concept of selective or inadequate mirroring that can contribute to the development of a false self in narcissistically vulnerable clergy, (b) the unique demands of the ministry that can reinforce the narcissistic minister's sense of falseness, and (c) the importance of the concept of empathic mirroring in the treatment of these patients. A case report describes psychotherapy with a minister whose underlying narcissistic disorder resulted from inadequate mirroring during childhood which set the stage for later disillusionment and despair. The patient's eventual response to empathic selfobjects led not only to a more integrated sense of self but also to a restoration of his faith in a more benign and accepting God. The humanizing effect of psychotherapy is poignantly reflected in his emergence from emotional desolation, his spiritual transformation, and his growing concern for others.

Clinicians have traditionally worked together with ministers to help them understand the special vulnerabilities faced by members of the clergy. In contrast to the popular press which sensationalized the emotional problems of well-known televangelists, clinical researchers have long been engaged in the serious study of the human struggles and patterns of conflict experienced by some ministers (Bowers, 1963; Bradshaw, 1977; Johnson, 1970; Meloy, 1986; Walker, 1960). An extensive review of this literature is beyond the scope of this article, which seeks instead to focus on predisposing narcissistic personality factors and unique demands of the ministry which may combine to create an emotional and spiritual crisis in some vulnerable ministers. An appreciation

of both of these factors can better prepare clinicians for work with such patients.

In order to understand the special kind of emotional vulnerability that may predispose some individuals to enter the ministry, it is useful to begin with a review of the concept of selective or conditional mirroring which can foster the development of a false self in early childhood. After a review of this developmental process, this article examines aspects of the ministry that may reinforce the minister's false self-experience and eventually contribute to a severe sense of disillusionment and despair. The theoretical underpinnings of the false self-phenomenon and its treatment implications is then elaborated in a case report of the psychotherapy process with a severely depressed minister. The case example describes the subtle interplay between psychotherapeutic factors and religious symbolism that led to transformation in both the patient's sense of self and his faith in God.

SELECTIVE MIRRORING AND THE FALSE SELF

Driven by less than optimal developmental experiences, the narcissistically vulnerable individual embarks on a lifelong task of seeking admiration and praise. This quest is fueled not only by the need for external regulation of self-esteem, but also by a yearning to feel real and connected to others. To better understand these core vulnerabilities and associated defensive and adaptive solutions, therapists must review key aspects of the maternal–infant relationship, especially the concept of mirroring and its relationship to the development of the self.

The process by which the mother mirrors and remains empathically attuned to the whole range of her child's needs, moods, and fears has been recognized as the sine qua non for the development of a healthy sense of self (Kohut, 1977; Laing, 1960; Southwood, 1973; Winnicott, 1967/1971). Parental mirroring, which is congruent with the child's uniqueness, promotes integration of what Winnicott called the "true self" (1960/1965), or what Kohut called the "nuclear self" (1977). Winnicott eloquently described how the mother's mirroring gaze is the foundation of the infant's experience of himself or herself as real Thus, by remaining empathic mirrors, parental caretakers reflect back and allow their children to perceive the totality of their own experience.

Kohut (1971) introduced the concept of the *selfobject* to describe how children experience their mother's mirroring presence as an integral part of themselves. Under optimal conditions, children eventually are able to internalize this mirroring function, and emotionally experience the whole range of their psychic life. However, unless all of the child's moods and needs are "seen" first by the parents, the child cannot feel completely real. In essence, what the parents fail to see remains invisible to the child as well. If the parents

ignore an important segment of their child's emotional life, the child will dissociate or split off this experience. When parents have not mirrored what is there, instead reflecting back their own desires and fantasies, then the child can only feel connected by burying a part of the self and responding in accordance with the parents' needs. Selective mirroring thus communicates to the child that there is something "bad" or unacceptable which must be hidden in order to feel connected to important figures. The resulting developmental distortion is best captured by Winnicott's concept of the "false self" (1960/ 1965).

In discussing the etiology of narcissistic disorders, Rinsley (1984) explained how these individuals appear to "go through the motion of acquiring the psychosocial trappings of growing up but only if everything that is apparently accomplished remains in relation to the [symbiotic] maternal object" (p. 5). Although he did not elaborate on the concept of mirroring or the false self per se, Rinsley was referring to selective or conditional mirroring which reflects the selfobject's needs and not those of the child. Furthermore, he pointed out that narcissistic individuals deal ambivalently with the maternal selfobject: They invoke it to feel sustained and connected but hate it because it prevents genuine growth.

Subjected to a pattern of selective mirroring, the narcissistically vulnerable false self becomes susceptible to bouts of depression that may alternate with periods of grandiosity. These individuals may thrive in the reflection of excessive conditional mirroring only to feel deflated when external sources of praise and admiration disappear. Thus, although depression may appear quite the opposite of grandiosity, these states may be complementary conditions rooted in an underlying narcissistic disturbance. Both grandiose and depressed individuals are compelled to fulfill the introjected mother's expectations. Miller explained that "whereas the grandiose person is her successful child, the depressive sees himself as a failure" (Miller, 1981, p. 45).

NARCISSISTIC VULNERABILITY AND THE DEMANDS OF THE MINISTRY

Various authors have noted that narcissistically vulnerable individuals often gravitate toward the fields of entertainment, politics, and religion (Gabbard, 1983; Kernberg, 1975; Rinsley, 1985). Bradshaw (1977) described the characteristics of a large sample of ministers evaluated at the Menninger Foundation and found that over one fourth were considered narcissistic personalities. Meloy (1986) hypothesized that narcissistic disorders may be common among ministers because the inherent nature of the ministry attracts and selectively reinforces individuals who need admiration from their parishioners to sustain them.

Other explorations of the human problems of ministers have focused on aspects of the ministry that may place a special burden on the minister's self-image (Bowers, 1963; Walker, 1960). Although not studying narcissism per se, Bowers (1963) identified the great demands that an adoring, venerating congregation of worshipers can place on the minister's self-image. The image of the clergy as "shepherds of the sheep" connotes not only a superior relationship to parishioners but it may also foster in the parishioners unrealistically high expectations of the minister (Walker, 1960). By wanting their minister or priest to be an exalted figure, the congregation may resemble a parent who lavishes praise as long as the child functions according to the parent's own needs and wishes. Like the egocentric parent whose selective responsiveness chokes the development of the child's true feelings, parishioners' spiritual needs for a transcendent "chosen" representative of God can make it difficult for narcissistically vulnerable ministers to experience fully their humanity, including their fallibility, envy, competitiveness, rage, and mortality.

Such lofty expectations from the congregation and society at large may encourage these ministers to adopt a veneer that ultimately results in their feeling like imposters who must continue to disavow human weakness. In addition, competitiveness among ministers may inhibit them from acknowledging personal faults and weaknesses to each other (Walker, 1960). Seized by a growing sense of the imposter within, the narcissistic minister finds it increasingly difficult to turn to others for help. Like their counterparts in health-related fields, ministers may be plagued by a belief that if they are sick, they should be able to heal themselves. They may avoid asking for help because they experience it as an assault on their facade of perfection and divinity.

As these ministers wrestle with their personal crises, they may have difficulty finding solace and direction in prayer. Thus, many charismatic ministers throughout history have experienced a "dark night of the soul"—a spiritual crisis entailing an erosion of their faith, a belief that they have been abandoned by God, and an inability to pray (Bowers, 1963, p. 12). Sevensky (1984) described this experience as a feeling of spiritual emptiness, anhedonia, and boredom frequently found in those who, despite their apparent social stability and church affiliation, lead empty lives, lacking in joy and warmth. This inner emptiness, sense of falseness, and failure (and the resulting loss of interest in living) bear a striking resemblance to clinical depression.

PROCESS OF PSYCHOTHERAPY

The concept of *mirroring* occupies a prominent place not only in the study of mother–infant interaction, but in the psychotherapy literature as well (Kohut, 1971, 1977, 1984; Wolf, 1983, 1985). Kohut's emphasis on listening and responding in the empathic mode led to the discovery that for those patients who

have suffered serious problems in narcissistic development, the sense of empathic synchrony with a therapist may constitute a significant resource for developing self-cohesion and regulation of self-esteem. Such a process of empathic attunement echoes the special bond of "intercommunicatedness" between the primary caretaker and the infant which lays the foundation for the growing child's capacity for self-regulation and associated development of an integrated self-experience. Lichtenberg (1981) indicated that the psychoanalytic treatment of such patients must be guided by an "empathic vantage point": "The empathic vantage point in psychoanalysis is a means employed by the analyst to gain information in which he orients his listening stance to be from within the perspective, the state of the analysand" (Lichtenberg, 1981, p. 352). Listening from this experience-near perspective implies that the therapist perceives and conceptualizes the whole context of how patients are sensing themselves, their relationships with others, and the whole range of their cognitive and affective experiences.

The following case study describes the different phases of such a treatment process with a severely depressed minister who suffered from an underlying narcissistic disturbance. The case material illustrates how the combination of narcissistic vulnerability and the unique demands of the ministry perpetuated the patient's false self-structure and ultimately precipitated a major depression. An examination of his response to treatment, in particular the synergy between the emergence of a true self and the transformation in his faith, is elaborated in the Discussion section of the article.

REVEREND M: A CASE REPORT

Reverend M, a 40-year-old Protestant minister, had been married for 10 years and was the father of two sons. For several years, he had held a responsible position as the senior pastor of a church in a large New England community. A year prior to his hospitalization, Reverend M had experienced a progressively worsening depression, a marital separation, and a marked deterioration in his occupational functioning. Initially treated on a crisis unit, he was transferred to a long-term residential treatment program because of the extent of his depression and suicidal despair. Although he had previously seen at least two other psychotherapists, Reverend M was again referred for individual treatment in hope that an intensive psychoanalytic psychotherapy process (three sessions weekly) could help reverse his hopelessness and passive withdrawal.

Reverend M had functioned at a high level throughout much of his professional life. Two years before his hospitalization, he ran for local political office but suffered a narrow defeat. Although he minimized the disappointment, he acknowledged that his routine pastoral duties seemed mundane and colorless

after the excitement of running for public office. Reverend M found it increasingly difficult to sustain his interest in the multiple demands of his job. He began to question his calling as a minister and grew progressively more depressed and distant from his family.

Reverend M was the only child of an upper-middle class couple. His father, a prominent college professor, had frequently gone away on lecturing tours, leaving him alone with his strong and domineering mother. He had an extremely close relationship with his mother, who was his confidante until his late teens. So close was their relationship that he recalled that his mother would often "absentmindedly" introduce him as her "husband." During his youth, he listened to her praise his intelligence and tell him that someday he would enter the ministry and become a "savior" in his own right. The implicit message was clear: To retain this special relationship, he would need to pursue a course of development and vocational choice congruent with his mother's wishes. Whenever he deviated from her plan or behaved in ways contrary to her standards, he experienced a chilling withdrawal of her interest and affection.

Prior to the onset of his depression, Reverend M's career development had been impressive. Each year he accomplished more and was admired as a "rising star" (his words) within the local religious community. Highly competitive with his colleagues, Reverend M accepted new and larger posts with greater responsibility and prestige. Despite the appearance of marital stability, he began to grow restless and distant from his wife whom he had always viewed as a domineering and powerful woman. Eight years after his marriage, he began having brief sexual liaisons. Despite his episodic guilt, he continued to have occasional affairs until he became severely depressed and his wife filed for divorce.

Phase 1: Despair and Hopeless Resignation

When he entered treatment, Reverend M was a deeply despondent and bitter man whose depressive appearance belied an undercurrent of seething rage. His pessimistic outlook reflected not only his doubts about the value of treatment, but also his sense that the prospects for recovery were bleak. Equal, however, to his cynicism and passive resignation was his angry, devaluative stance toward mental health professionals and the hospital. Reverend M approached me with a distant and mechanical politeness. Although he denied animosity toward me, his bitter and contemptuous attitude clearly extended to our relationship. He rarely looked at me and only begrudgingly acknowledged my comments. However, he resonated to my observation of how discouraged and disappointed he felt about psychotherapy after having received so much treatment over the last 2 years and yet continuing to feel so miserable. To this, Reverend M complained how his wife, the church, and God had all turned

away from him. I echoed how his sense of having been treated unjustly had apparently led him to question his faith, as well as his ties to the people around him. Reverend M answered by bitterly acknowledging his loss of faith, his social alienation, and his wish to die.

At Easter, Reverend M requested and obtained a pass to visit a friend and to investigate another treatment facility that he thought would have patients with a similar professional background and social status. Because I had grown increasingly concerned about his suicide potential, I considered it necessary to introduce a parameter and notify his inpatient treatment team of his heightened suicidal despair. He clearly felt frightened about leaving the hospital but was extremely reluctant to acknowledge these feelings. When I informed him of my recommendation that his pass not be approved, he became quite angry. While remaining attuned to his anger, I quietly told him that I had sensed his growing fear about leaving the hospital. Ultimately, Reverend M was allowed to leave, but only after his inpatient team tightened the structure of his pass to include a closer monitoring of his activities while he was away from the hospital.

Phase 2: Nascent Hope and Self-Examination

On returning from his pass, Reverend M was still angry over my recommendation against his leaving. Although he had enjoyed his pass, he said that the visit had neither alleviated his depression nor restored his hope. Continuing to question whether he should transfer to another treatment facility, he recounted all the possible advantages of doing so. He worried, however, that being near his well-adjusted friends might evoke intolerable feelings of envy. He further explained that he was both attracted and repulsed by the idea that he might eventually be taken care of by his friends.

Reverend M's ambivalence about his emotional neediness led to an exploration of his consciously eschewed dependency longings. For example, he recalled that he had always resented his wife's observation of his emotional dependency on his mother. Furthermore, he began to respond to my comments about his underlying anger toward his mother for her egocentric treatment of him. Although it was difficult for him to acknowledge his poorly tolerated rage and neediness, he saw these highly charged affects as prominent issues in his relationships with his mother and his wife. During one particularly intense session, Reverend M began to sob as I commented that it must be hard for a man who had needed to view himself as a savior and healer to accept his feelings of hate, helplessness, and neediness. For the first time, he seemed to agree that his difficulties were embedded in his complex relationships with the two key women in his life. He sadly expressed a dawning awareness of his highly ambivalent attachments to both women, whose emotional responsiveness, though bountiful, had always been contingent on his compliance with

their wishes. When I commented on his need for affirmation and praise, Reverend M bitterly acknowledged that his lifelong quest for achievement and glory had been in the service of securing his mother's love and admiration. Over the years, his ardent striving had left him feeling like an "imposter."

Following this session, Reverend M's appearance and attitude began to change. Gone were his sullen complaints about his treatment and his preoccupation with his bleak future. For the first time, he began to listen more intently and to look at me during our sessions. He also acknowledged his dependency feelings and his wish for more of my time. Reverend M spent less time in his room and gradually sought the company of other patients. Prior to this time, he had shunned contact with others because of his shame and humiliation at being a psychiatric patient.

Despite his ambivalence about going back to work within the next 5 months, Reverend M began to talk more confidently about returning to his church. One day he smiled and announced that he must be regaining his faith because he had discovered that he could once again sing hymns in church.

Phase 3: Flight From Dependency and Retreat to Grandiosity

In addition to speaking boldly about returning to take charge of his church, Reverend M spoke about taking charge of his wife when she arrived for their divorce mediation process. As he described the return of his "old self," he commented that he no longer felt dependent on either his wife or me. To the contrary, he shared a wish that he and I could "spar" with each other during our sessions, adding, "Now that would be enjoyable!" Likewise, he eagerly anticipated his wife's arrival so he could "do battle with her." At last he felt free of her control and able to assume a "superior" position in preparation for their impending financial negotiations. I wondered about his nascent competitiveness with me, his wish to assume a dominant position, and his desire to once again disavow his yearning for a close and comforting bond. He dismissed such comments and on occasion told dirty jokes. He began to smoke cigars, and with near swaggering self-assurance, described a growing sexual interest in women, a number of whom were staff members.

Gradually, Reverend M shifted his attention away from an examination of his painful relationships and underlying vulnerability and instead began to discuss self-help books and his plans to resume the leadership role in his parish. One afternoon he failed to show up for an appointment, later explaining that he had "simply forgotten." He imperiously complained about having to address the doctors by their titles, believing that perhaps he should be entitled to equal respect. When I asked how his missed session and demand for equal respect might apply to our relationship, he minimized any relevance, stating that he was thinking more about the other doctors on his treatment team.

Attempts to explore his movement away from therapy, his retreat from important relationships, and his disavowal of dependency feelings were usually met with denial or subtle contempt. On several occasions, he cordially thanked me for being "helpful" but added that it was now time to settle his divorce and get on with his life.

Phase 4: Expressions of Gratitude—from Humiliation to Humility

Two months before he left the hospital, Reverend M took a brief trip to renew his acquaintance with an old seminary friend, who had baptized his children many years before. When he returned, he exhibited another shift in his mood and interpersonal stance. Reverend M had initially been fearful about sharing his feelings with this close friend. He wondered how he could tell his friend and former competitor about his previous sexual liaisons and his struggles to accept his profound hatred and dependency needs. Surprisingly, however, sharing his "emotional wounds" had proven a deeply moving experience which brought new clarity to his sustaining relationships with therapist and hospital treatment team. As if to symbolize his experience of having been understood and accepted, Reverend M talked at length about the spiritual meaning of baptism as a symbol of the unconditional acceptance and love of Christ.

He also recounted a recurrent childhood dream which he had recently reexperienced. For years as a child, he had dreamed about encountering a deformed child in his backyard. In the dream, he would stand paralyzed with his gaze fixed on the child—wanting to flee out of repulsion but also curiously drawn to the figure. His intense gaze would always be interrupted by his mother's voice, telling him to go to the store to buy food for supper. This time, however, he found himself approaching and embracing the child. Tearfully describing this dream episode, Reverend M stated that the deformed child represented the hated and unaccepted parts of himself.

Along with the vivid illustration of this dream, Reverend M described religious symbols and experiences that reflected the restoration of his faith in a more benign and accepting God, a stronger therapeutic alliance, and a new kind of relatedness with others. For example, he made several visits to a nearby Catholic church and was reportedly quite moved while reflecting on a statue of the Pieta. He cried as he described the image of the Mother Mary holding the broken body of Jesus, safely and securely, "without judgment or expectation."

For Reverend M, his recognition of his own "wounds" marked a renaissance of his religious beliefs. Not only did he experience the return of his faith, but he also spoke of a new interest in Martin Luther's early teachings about grace and forgiveness. Similarly, he spoke about the desert way of spirituality,

passionately comparing his therapy experience to that of early Christians who were led into the desert only to discover a spiritual renewal and deeper sense of humanity. He was touched by the metaphor of his own desert-like journey, from which he had discovered new hope, stronger faith, and an appreciation for people. He told me about a book that described this desert way of spirituality and personal growth. Although he had been familiar with the book for many years, he had never been able to finish reading it. One day he arrived with the book and announced that he had finally finished it. In gratitude for our work together and as a token of the importance of our relationship, he asked that I accept the book.

He acknowledged that I, like the desert guides, had helped him "face his demons" and discover a new sense of humanity and vitality. Referring to the impending loss of his sustaining ties with his treaters, he said that he longed for a chance to establish closer, noncompetitive relationships with his friends and colleagues back home. During his last few weeks in the hospital, he scheduled time to thank numerous staff members with whom he had had contact during his treatment. Reverend M also brought in a letter from his son that described how much he had been missed during his illness. After reading this letter to me, he began to cry and exclaimed, "My God, what have I done!" He then spoke about wanting to establish a closer relationship with his children and to give something back to the many friends who had supported him through the years. Furthermore, he expressed his sadness over the plight of the homeless and shared his plan to build a shelter for them when he returned to his community.

In our final session, we discussed the agreed-upon plans for follow-up therapy in his hometown. As we reflected on our experience together, he said that he had changed following his return from his Easter pass. Although what exactly had happened remained a bit elusive to him, we both accepted the fact that something important had taken place. When asked to summarize the changes that had occurred, Reverend M recalled how humiliating and painful it had been for him to be a psychiatric patient. "What began to change," he added, "was that it gradually became less of a humiliating and more of a humbling experience for me."

DISCUSSION

This patient's childhood experience of selective mirroring fostered the development of a false self. He felt validated only by burying part of himself (like the deformed child in his dream) and by conforming to the needs and wishes of his introjected mother. Through his quest for glory, he acquired the psychosocial trappings of maturity but at the cost of genuine growth and self-acceptance. His disavowal of a segment of self-experience culminated not only in a

painful sense of falseness but also in an image of God as a conditionally available figure who eventually abandoned him.

A treatment process guided by empathic responsiveness and accurate mirroring enabled Reverend M to emerge from his dark journey with a heightened sense of gratitude, empathy, and a desire to make reparation. He remorsefully recognized the harmful effects of his narcissistic withdrawal and expressed an interest in forming closer ties with friends and family members. Of equal significance was the apparent transformation in his image of God. The rich religious symbolism to which he was drawn reflects the synergy between the development of a more integrated self-experience and the emergence of a new internal representation of God. At the core of these mutually enhancing processes was his experience of being held, empathically mirrored, and accepted by important figures around him.

In his sophisticated examination of the psychosocial influences on Martin Luther, Erikson (1958) described similar synergistic processes. Erikson emphasized how the selfobject tie with the priest Staupitz enabled Luther to experience for the first time stifled aspects of himself, which served to strengthen his ego initiative and to transform his spiritual beliefs. In his later life, Luther himself attributed much of his spiritual renaissance to his important relationship with Staupitz. Erikson also described how the Scriptures and the passion of Christ further symbolized for Luther a holding relationship, which contributed to a stronger sense of self and at the same time led to a perception of God as a more unconditionally accepting figure.

Some might argue that the turning point in treatment hinged on the psychotherapist's ability to weather Reverend M's bitter attacks against mental health professionals and against the therapist for opposing his Easter pass. Kleinian theory (Segal, 1973) would suggest that his stronger sense of self emerged as a result of his internalization of a repaired therapist whose "goodness" had survived his envious and destructive fantasies. Reverend M's heightened capacity for concern and his wish to express his gratitude by offering something of himself might be viewed as an attempt to make reparation for his destructive impulses. Although offering valuable insight into the process of change, this explanation does not address the transformation in Reverend M's belief in God. In discussing the syndrome of feeling abandoned by God, Sevensky (1984) pointed out that sufferers must learn that God does not reject them even if their pain and despair are expressed openly. Thus, similar to the therapist who survives bitter attacks and destructive fantasies, Reverend M had to learn that God too was strong enough to endure his rage and his hurt and still hear his prayers.

In examining the psychological underpinning of religious beliefs, Rizzuto (1979) described how an individual's mental image of God is a special kind of object relationship which is capable of evolving over the course of a lifetime. Just as important relationships in the external world affect our internalized

representations of self and other, these same influences may also transform one's mental image of God. Religious faith and internalized images of God can themselves become selfobjects that provide a stabilizing and regulating function for the individual. Reverend M's depiction of the baptism as a process of spiritual rebirth, his fascination with the Pieta and the "desert way of spirituality," echoed not only his experience of having been empathically mirrored and affirmed by his friend and his therapist but also the development of a more benign image of God as a holding selfobject. The intriguing discussion of the difference between traditional Calvinist and Lutheran theology further reflected the confluence of Reverend M's spiritual and psychological transformation. In the past, the more rationalistic teachings of Calvin had appealed to the patient's grandiose fantasies because he believed they taught that striving for Christian perfection was a way to achieve salvation. According to his interpretation, God's love was conditional, available only if Reverend M lived according to vaguely defined requirements to be "good." However, during the course of his therapy, he was gradually drawn to a theology that stressed, among other things, the values of humility, inherent human vulnerability, and justification by faith alone. In this respect, his shift toward the more emotional tone of Luther's theology was consistent with Reverend M's growing acceptance of the full range of his humanity, including his vulnerability or his emotional wounds.

Reverend M's psychological integration and spiritual transformation together reflected the process of having been empathically mirrored and affirmed by important selfobjects who had tolerated what had previously been unacceptable to him. However, this process, while necessary, may not provide a sufficient explanation for the dramatic changes in his psychological and spiritual experience. It is reasonable to assume that, just as Luther's emotional and spiritual growth was founded on a meaningful mirroring relationship with another member of the clergy, Reverend M's transformation also required such a relationship with a fellow minister. In the context of discussing the importance of cultural variables in psychotherapy, Frank (1961/1974) stressed that similar world views between patient and therapist enhance communication and contribute to a favorable outcome in treatment. Conversely, disparate cultures, such as those of the religious and the psychological man (Rieff, 1959), may at times reflect incompatible world views that can undermine the treatment. Thus, it may be that Reverend M could not have recovered without both the empathic acceptance and the "cultural sanctioning" provided by his friend and colleague. This premise underscores for psychotherapists the importance of remaining alert to cultural variables and potentially conflicting values in the psychotherapy of religious patients.

These explanations of the patient's emotional and spiritual recovery are by no means exhaustive. Regardless of the exact mechanisms of change, the

quality of the patient's relationships with his friend and his therapist clearly proved to be a humbling and humanizing experience for him. Through a relatively short-term intensive process, this minister established a sturdier foundation on which he could continue his odyssey of emotional growth and spiritual renewal.

ACKNOWLEDGMENT

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