NAZP

FORUM

Vol. 2
June 1996

THE JOURNAL of

The New Zealand Association of Psychotherapists (Inc.)

Te Roopuu Whakaora Hinengaro

NZAP

Forum

THE JOURNAL OF

The New Zealand Association of Psychotherapists (Inc.)

Te Roopuu Whakaora Hinengaro

Volume 2, June 1996

Cover motif *Hands* by Liam Davidson, Auckland

EDITORIAL

Since our inception we have had the concept of ourselves as an umbrella organisation of psychotherapists. In embracing different modalities, we look for our similarities, listen for our differences, and attempt to define the common core competencies of our profession.

The original practitioners came together for professional warmth – and we still do. We have been pioneering something special by resisting the tendency to factionalise and split that has characterised the profession elsewhere, and by maintaining this uniquely inclusive consciousness.

So it is with great pleasure that this year we have made formal connections with other professional psychotherapy bodies who are also constituted not upon adherence to a particular theoretical approach, but upon recognition of a broad commitment to psychotherapy practised in its various modalities. We are in contact with the United Kingdom Council for Psychotherapy which is attempting the bold task of drawing together the diverse strands of the profession in the UK. Similarly, the World Council for Psychotherapy held their inaugural conference this year in Vienna, where we were represented. The conference programme was remarkable for the diversity of presentations, attesting to the inclusive philosophy of the body.

This year our own conference hosted by Nelson invited us to contemplate the way in which as a profession we hold soul. This was an imaginative and not uncontroversial theme. Like the relatively recent naming of 'integrative' in psychotherapy, the theme will gradually develop philosophical underpinning, practical understanding, and clinical application, and I suspect that this year's conference will be seen subsequently as having recognised an important developmental context in our profession. A number of the papers in the *Forum* arise out of the conference and base their enquiry around its theme.

Current large scale change and initiatives in the health system require us to develop clarity of initial and continuing assessment processes, to involve ourselves with emerging demands for brief focused therapy, and to be active in fields of research and outcome analysis. These are positive trends that we should welcome as part of our continuing dialogue about the Association's admissions criteria and common core competencies in psychotherapy.

With all this we remember that central to our practice is relationship, the willingness to connect psychotherapeutically with others as they attempt to come to terms with their life paths. The view of ourselves and our clients we bring to this relationship is key. All professional enquiries need, therefore, to begin with our individual and collective consideration of the philosophical and clinical questions: Who or what is a human being; what is the activity of human being?

Peter Hubbard
Editor

CONTENTS

DREAMWORK AND SPIRITUALITY

Margaret Bowater

Abstract

Our dreams reveal many aspects of a spiritual process at work inside us, from simple metaphoric reflections of life-situations or inner roles, to dramatic confrontations with choices on our life-journeys; and from direct warnings of future events to vivid affirmations of a numinous reality beyond the material world we live in. Active dreamwork with the roles presented in our dreams can give the dreamer a deep sense of hearing spiritual truth from within.

I summarise my rationale, methods, and classifications, quoting (with permission) a few dream examples.

Introduction

To start with, I will give a little background about myself. I did my Master's degree long ago in English Language and Literature, which gave me a thorough grounding in the use of imagery and intuitive meaning. I consolidated this in my career as a high school teacher of English, and as a Playcentre Supervisor working with children's imaginations. In the 1980s and '90s, I have retrained in the field of Counselling and Psychotherapy, especially in TA and Psychodrama.

Since 1985, I have been a member of a dream group in Auckland, meeting fortnightly or monthly to work with one another's dreams. This group has been the primary matrix of my learning about dreamwork, along with extensive reading of Jungian books and the academic quarterly journal, *Dreaming*, of the American Association for the Study of Dreams. In the last nine years, I have led well over 100 dream workshops, as well as working constantly with my clients' dreams. I have also developed a growing interest in the ancient art of spiritual direction based on the voice of the spirit in dreams. My own spirituality has been shaped in dialogue with the Christian faith, science and mythology.

Since 1991, under the wing of the Human Development and Training Institute, I have developed a three stage Dreamwork Programme, combining basic Jungian theory with action methods and TA Redecision work, in the context of spiritual awareness. I aim to teach people enough skills and understanding to be responsive to their own dreams and to work in small ongoing groups through to more specific coaching for counsellors and spiritual directors.

I have come to perceive our dreams as windows into the universal realms of the Spirit that underlie and interweave the world of matter which we find ourselves inhabiting. Indigenous cultures have always known this. It is our Western culture

that has dismissed this view as 'superstitious', 'irrational' or 'unscientific'. To quote an old song: "'Tis we, with our estranged face, that miss the many-splendoured thing".

What is a dream

I like the definition given by Savary, Berne and Williams in their excellent book, *Dreams and Spiritual Growth*:[1]

> A night dream is a spontaneous symbolic experience lived out in the inner world during sleep. Such dreams are composed of a series of images, actions, thoughts, words and feelings over which we seem to have little or no conscious control.

You will note that a dream is not necessarily pictorial; it may have strong auditory or kinaesthetic elements, or even smell. The key factor is that it occurs spontaneously during sleep; to be more precise, during one of the cyclical periods of Rapid-Eye Movement that occur every one-and-a-half hours while we sleep. If such a vivid symbolic experience occurs while we are awake, it is called a vision. If, however, we believe the vision to be physically real, it is either a hallucination caused by mental illness, that is, an outward projection of disturbed subjective imagery; or a form of paranormal experience, that is, an objective extrasensory perception caught by means of a heightened psychic awareness. The distinction between these two may not be obvious, as our culture tends to dismiss visionaries as mad anyway. I have come to believe that some dream-events do belong to the objective category of paranormal, and happen to ordinary people far more frequently than our intellectual culture likes to believe. What is also clear, is that dreams are universal in human beings, from babyhood to old age, and that we all dream about five times every night, even if we never remember them.

Why do we dream

This does not have such a simple answer. Not only human beings dream. Rapid-Eye Movement is visible in the sleep of all the vertebrate animals. Dreaming may serve an important physiological function. Many theories have been put forward, ranging from dreams as direct messages from the gods, to dreaming as the random firing of neurons in the idling brain. Freud believed that dreams use symbolic language in order to disguise our unacceptable urges from us, whereas Jung saw the symbolic language of dreams and myths as simply the natural method of communication of the unconscious Self, which underlies and precedes the development of our conscious ego. Montagu Ullman, a major sleep-researcher, believes that all dreams are attempts at problem-solving[2], while recent trauma studies by Ernest Hartmann show that dreams have a function of

1. Savary, Berne & Williams (1984) *Dreams and Spiritual Growth.* Paulist Press.

2. Montagu Ullman & Nan Zimmerman (1979) *Working With Dreams.* Dell.

expressing traumatic memories until we come to terms with them[3].

Current consensus among dream psychologists seems to be that dreaming serves several psychological functions, such as seeking to solve problems, and integrating new emotional experiences into our being. Who has not gone to sleep with a difficult problem in mind, and wakened with a solution in the morning? Jung also proposed a theory of emotional compensation, in which the Psychic Centre, the Inner Self, seeks to regulate our emotional balance by expressing through our dreams the natural energies we have suppressed in conscious life, such as anger or grief, fear or desire. (I will use Jung's definition of the unconscious as the field of everything we do not know in our inner world.[4]

From my own experience now of working with over 2000 dreams, I believe that dreaming serves a variety of functions, which could be summarised under the general heading of continuous psychological feedback, not only about our daily life issues, but also about our whole spiritual journey through life. Some dreams have such a strong sense of spiritual guidance in them that there is no doubt in the dreamer's mind that they come from a spiritual source, by whatever name we choose to call it, such as God, angel, spirit guide, higher self, or the One Mind. I often have people come to me specifically to work with such a dream.

Marie-Louise von Franz, who has analysed some 65,000 dreams in her long life as a Jungian analyst, speaks in the Jungian film series, *The Way of the Dream*[5]:

> If you analyse dreams of artists or creative scientists, for example, very often you find that new ideas are revealed to them in their dreams. They don't figure them out in their computer. Rather they come from the unconscious as so-called *sudden ideas* ... So we must conclude that there is a psychic matrix which produces creative new insights ... this matrix seems to steer the ego consciousness into an adapted, wise attitude toward life. That matrix which makes the dreams in us has been called an inner spiritual guide, an inner centre of the psyche ... a divine inner centre.

What is spirituality

Spirituality is an ancient concept, familiar to mystical writers but scorned by rationalist theologians and scientists, and now being rediscovered in Western culture – ironically, partly in response to the new quantum theory of physics. Many in our culture seem to assume that if they have left the institution of the Church, they have no spirituality any more. Our word *religion* comes from the Latin root *religio*, to bind, carrying the sense of commitment or bonding to a system of beliefs. The word *spirituality*, however, comes from the Latin *spiritus*,

3. Ernest Hartmann (1995) The Dreams of Resolving Trauma. *Association for the Study of Dreams Newsletter* v 12 no 2, 1995.

4. Carl Jung (1963, 1983) Glossary. In *Memories, Dreams, Reflections*. Fontana.

5. Fraser Boa (1988) *The Way of the Dream*. Windrose Films, Toronto.

meaning breath, wind, something innate and much less definable. It is certainly not confinable to any religion. Thus our spirituality is our personal response to the sacred or ultimate dimensions of life, shaped as it will be of course by particular religious values, but nevertheless our own response.

Not only do religious leaders have difficulty with this concept; so do many scientists, including academic psychologists, who prefer to observe and measure tangible things. Yet the word *psychology* comes from the Greek root *psyche*, meaning the soul. Psychology means the study of the soul, not just the science of behaviour. We have been sold short by our universities, in the effort to fit the current scientific paradigm. Nevertheless, quantum physics has changed the old certainties of Newtonian science, in such a way that modern scientists now think of matter as interchangeable with energy. We are all part of a vast multiple energy field, that clusters itself into an infinity of different forms, with some form of consciousness possibly inherent even in the primordial stuff we are made of. Dana Zohar says in *The Quantum Self*:[6]

> Existence and relationship are inextricable in the quantum realm, as they are in everyday life ... and they are essentially what we mean by the wave/particle duality ... The wave/particle duality of quantum 'stuff' becomes the most primary mind/body relationship in the world, and the core of all that, at higher levels, we recognise as the mental and physical aspects of life ... We are able to trace the origin of our mental life right back to its roots in particle physics, just as has always been possible when seeking the origin of our physical being.

Using such language, we are very close to theologians like Tillich, who speak of God as "the ground of our being", or Teilhard de Chardin's concept of "withinness", or the mediaeval mystics who felt intuitively that God is all in all and everywhere.

The Jewish philosopher, Martin Buber, in his small though difficult book, *I and Thou*[7], first written in 1923, describes spiritual experience as found essentially in a certain quality of relationship: an open genuine mutual encounter between two beings – not only human – I being one and Thou the other, into which at any time the Eternal Thou may enter with a sense of transcendence. I–Thou encounters of the spirit have a totally different quality from the more mundane, objective I–It relationships we normally experience.

Buber initially summarised three 'spheres of dialogue' for spiritual encounter, which he later divided into four. We may encounter the spiritual Thou in the sphere of Nature "stretching from stones to stars", or in animals, which he calls "the threshold of mutuality"; or in another human being who "fills the heavens"

6. Danah Zohar (1990) *The Quantum Self*. Harper Collins.

7. Martin Buber (1958) *I and Thou, with Postscript*. 2nd edition. Scribner's Sons, NY

for a brief time; or in the sphere of spiritual beings, whom we meet in two major ways: through "the word and works" of great writers and artists, no longer living; or through the inner spiritual encounter that comes to us as 'inspiration', meaning an inner vision, seeking to be known and expressed.

Our archetypal dreams in particular may reflect I–Thou encounters in all of these spheres.

Berne and Savary have co-authored an excellent practical book, *Dream Symbol Work*[8], drawing on their backgrounds in Clinical Psychology, Sacred Theology and Jungian understandings. Their basic premise could be summarised thus: Dreams are spiritual gifts in symbolic language, given for our healing and wholeness, to bring us to consciousness, and to channel energy from our deepest self into our daily life.

I consider that if we could restore to our culture the art of understanding our dreams, there would be a dramatic rise in spiritual consciousness amongst us.

Meaning

The major key to dreamwork is quite simple: Metaphor. Apart from the small fraction of paranormal dreams, and another fraction of special archetypal dreams, the vast majority of our dreams speak to us through the age-old wisdom of using familiar objects as parallels to convey new insights. This is the same principle as in the parables that Jesus told, such as the story of the sower scattering the seed on different kinds of ground: "He who has ears to hear, let him hear", said Jesus, meaning that we have to do our own work to uncover the truth within the metaphor. Sometimes it is easy, sometimes a more complex process.

Let me quote a simple example of a recurring childhood dream from a man who grew up in a strict family where no emotions were allowed:

> *Secret Dolls*
>
> We were sitting in our dining-room on velvet chairs, Mum, Dad, myself and my two younger brothers. I was small and quiet, being very well behaved. We three children were each hiding our favourite doll behind us on our chairs. Mine was a black golliwog.

The scene is partly from literal memory, but adding a vivid metaphor, in a child's language, for the secret feeling selves the children had learned to hide from their parents. The dream uses a familiar image to convey a more abstract idea. The warm feeling conveyed by the words *favourite doll* contrasts with the formal setting, and reveals how the children are being affected by their parents' attitudes.

8. Patricia Berne & Louis Savary (1991) *Dream Symbol Work.* Paulist Press, NY.

Working with Dream

When I run a dream workshop I guide people to use an 8-step process, in two or three phases. In the first phase, the dreamer tells the dream, sketches it on the board, identifies the feelings, actions and associations, and describes the context from which it emerged, since every dream relates to a particular set of circumstances. Group members may ask 'naive' questions which help to bring out more connections. We play with words and phrases to discover double meanings. In the second phase, the dreamer moves one by one into the significant roles in the dream and responds spontaneously to simple questions, which often elicit new and surprising material. This may well be enough to reveal the underlying metaphors, and the dreamer is suddenly struck with new insight into a life-situation or relationship. If the dream is unfinished, we may have a third phase, in which we help the dreamer to find the resources they need to end it in a realistic place of safety or success. The dreamer is encouraged to act this out in solo psychodrama, taking all the roles, so that they actually *feel* the symbolic redecision, along with the support of the group to carry it out. Usually the dreamer needs little further help to see what step now needs to be taken in real life to honour the dream.

You will see from this summary that the process is intended to enable the dreamer to interpret their own dream by making the relevant connections. The dream was uniquely designed for the dreamer, who will usually know when an interpretation 'fits', in much the same way as we feel it when a piece of jigsaw puzzle clicks into place. Actually, it is more like catching the meanings of a poem, which may have multiple connections with our experience. Once we have some facility in working with metaphor, we can make sense of the majority of our dreams, leaving only a small proportion which need more expert assistance.

Types of dreams

For some time now I have been collecting examples of striking dreams, from clients, friends and workshop participants, which seem to have a strong spiritual significance for the dreamer, that is, conveying a potent depth of inspiration or challenge to respond to.

The Canadian psychologist Don Kuiken classifies dreams[9] into four categories, based on feelings: Mundane dreams (which he dismisses as unimportant); Anxiety dreams (mainly nightmares); Transcendent dreams (arousing awe or ecstasy); and Existential dreams (which he limits to pain and sadness). I think that these categories seem far too limited to cover the range of spiritual dreams and visions that people actually report.

I have identified three major types according to their dominant style and content.

9. Don Kuiken (1995) Dreams and Feeling Realization. In *Dreaming: Journal of the Association for the Study of Dreams* v 3 no 5, Human Sciences Press, NY.

A. Paranormal Dreams

These do not seem to arise out of the normal internally-generated process of dreaming, but are 'caught' from elsewhere, as if by some kind of 'angle-mirror', through some heightened receptivity to the future, to a pre-birth existence, or to unconscious contact with another's mind. The dream imagery is typically quite objective and literal, realistic and continuous, instead of symbolic and impressionistic (though it is sometimes a combination of both) – like the difference between a photograph and a painting. The dreamer feels a certainty that "It was real – not just a dream!" and may be quite shocked or amazed at the content. I include in this category precognitive dreams of the future, past-life dreams, clairvoyant and telepathic dreams, death-transition dreams, spirit visits from someone who has died, and out-of-body dreams. Ryback and Sweitzer's *Dreams That Come True,*[10] is a sober and useful analysis of many examples they have collected.

Here is one example of a paranormal dream, told to me by a psychologist, who had never had such an experience before:

> *Lost Child*
>
> I wakened at 4 am from a nightmare in which I was desperately searching a city street for my granddaughter 'Mary' aged 3. At the same time, my wife awoke beside me from a nightmare in which she was trying to pull Mary out of a bramble-bush.

They realised they had both dreamed vividly that their granddaughter was in danger, and considered over breakfast whether they should phone their daughter, who lived in another city. They decided not to worry her, as she always put reins on the child. But in the afternoon, he decided to ring her anyway, and asked how things were going. "Oh!" she replied, "I had a terrible time this morning! I went shopping downtown with 'Mary' without putting the reins on, and I lost her, and spent half an hour hunting before I found her again!"

Now this is not an ordinary dream. First, it is clearly precognitive, as it happened seven hours before the actual event. Second, two people dreamed of the event, one in literal form, the other symbolic, with similar feelings of great anxiety, caught as if by telepathy. One of them received the message in much more accurate detail than the other, showing how even a telepathic message has to come through our own reception system. Third, they dreamed not of their own future experience, but of their daughter's, as if through her eyes – a form of clairvoyance. Was this a warning? If so, from whom? There seems to be another level of intelligence or communication at work in such experiences, beyond the range of our normal sensory apparatus.

10. David Ryback and Letitia Sweitzer (1989) *Dreams That Come True*. Aquarian Press, UK.

B. Archetypal Dreams

These are just as vivid as the paranormal ones, but the imagery is mainly symbolic, and often numinous, with figures similar to those in mythology and religion. They seem to occur at times of spiritual crisis for the dreamer, providing inspiration, confrontation or encouragement, and are drawn from a deeper, more ancient layer of the psyche. The word *archetype* comes from Greek roots, meaning a *primordial imprint.* Carl Jung originated the concept of archetypes, based on his observation of the repeating similarity of certain dream figures to those in the myths and folk tales of world mythology. He considered that the archetypes are transcendent, belonging to the realm of soul, which underlies our physical existence.

This is an area of specialist training for Jungian analysts and mythologists, but it also includes many overtly religious dreams of I–The encounters, with a numinous quality of awe, often a sense of being in a parallel dimension of reality. The dreamer knows intuitively that these are spiritual figures or landscapes, different in quality from those in ordinary life, but equally real. Yet a dreamer with support can usually enter into an archetypal role, and let it speak for itself, knowing what is in its mind, which is not the case for paranormal dreams.

In this category I include dreams of numinous people, creatures, places and things, as well as certain vivid dreams about light, sound and movement. I also include visions of heaven in this category, on the assumption that the imagery is metaphorical rather than literal.

Here is a brief example from a time when the dreamer was beginning to work in the corporate sector:–

> *The Marvellous White Bull*
>
> I was in a wild bush setting, standing in a swift little stream, below a steep waterfall. I was in the curve of the stream beside a grassy meadow. I looked up and saw a huge, beautiful, white bull come rushing down the steep bank, straight for me. I couldn't run away anywhere – I was helpless and terrified. It was a magnificent bull, powerful, with horns – awesome. It stopped inches away from me, snorting. I could feel its breath on my face. I woke up crying and shaking.

When the dreamer did dreamwork, giving the bull a voice to express itself, she felt its primitive energy, and recognised it as a symbol of her own masculinity coming into consciousness. She said that after this she felt "fuller and stronger" in herself as she embarked on the tasks ahead of her. It became then an empowering dream to strengthen her spirit.

C. Life – Metaphor Dreams

My third major category of vivid dreams is actually by far the largest. Whereas paranormal dreams are mainly literal, dreams of this third type are based on metaphor. Whereas archetypal dreams draw on mythological or transcendent symbols, the dreams in this third category draw on symbols and metaphors from ordinary human experience – though they are sometimes collated into rather bizarre scenes and stories.

Here an example of my own, from a time when my life was overcommitted:

> *Feeding Six Babies*
>
> I am with a young mother of sextuplets – 6 babies – on a sort of commune-farm. She is a good mother, and quite overwhelmed with the task of nurturing 6 babies at once. She is breastfeeding them all, one after another all day, and getting worn out. I am helping by breastfeeding one myself – no problem re-inducing lactation as I've had children myself. (Maybe I'm her mother). The babies are all growing vigorously like little piglets or kittens, very active – in fact I have to go and catch them for feeding! They all snuggle around playfully together. I tell the young mother she must choose one of the babies to breastfeed, and let the rest go onto bottles now. But she wants them all to have the best, not choose one, it isn't fair on the others. I tell her she can't be fair to all of them, her health won't take it. She should choose the one that's different – there's one girl and five boys – she should choose one, and let her have the specialness.

Obviously, there's a warning about burnout here, but it's also interesting in that I was the eldest of 6 children, who were born in only 9 years; and it happened when I was getting interested in women's spirituality. So it touched many levels in me. It also expresses a continuing theme in my dreams about caring for a baby – or suddenly remembering to care for one – when I have neglected my own self-care. Such dreams do not come from my conscious ego, but from a deeper source of wisdom within me.

I have subdivided Life-Metaphor Dreams into traumatic memories, warning dreams, problem-solving, affirming, calling, wholeness and healing, learning, and life-journey dreams. There may well be more.

REFERENCES

1. **Savary, Berne & Williams** (1984) *Dreams and Spiritual Growth.* Paulist Press.
2. **Montagu Ullman & Nan Zimmerman** (1979) *Working With Dreams.* Dell.
3. **Ernest Hartmann** (1995) The Dreams of Resolving Trauma. *Association for the Study of Dreams Newsletter* v 12 no 2, 1995.
4. **Carl Jung** (1963, 1983) Glossary. In *Memories, Dreams, Reflections.* Fontana.
5. **Fraser Boa** (1988) *The Way of the Dream.* Windrose Films, Toronto.
6. **Danah Zohar** (1990) *The Quantum Self.* Harper Collins.
7. **Martin Buber** (1958) *I and Thou, with Postscript.* 2nd edition. Scribner's Sons, NY.
8. **Patricia Berne & Louis Savary** (1991) *Dream Symbol Work.* Paulist Press, NY.
9. **Don Kuiken** (1995) Dreams and Feeling Realization. In *Dreaming: Journal of the Association for the Study of Dreams* v 3 no 5, Human Sciences Press, NY.
10. **David Ryback and Letitia Sweitzer** (1989) *Dreams That Come True.* Aquarian Press, UK.

MIND, BODY, AND 'I'

Brian C Broom

Introduction

How compartmentalised are mind and body in personal and clinical experience? This question can be illustrated by an ancient story. The Old Testament tells of the prophet Nehemiah who is leading the Israelites in the rebuilding of the walls of Jerusalem. There is intense opposition from local non-Israelites who try several ways of stopping the work. In the end they resort to spreading a false report that the Jews are plotting a revolt and setting up a new kingdom, intending by this to activate surrounding forces against the Jews. Nehemiah's reported response is:–

> "They were trying to frighten us, thinking, 'Their hands will get too weak for the work, and it will not be completed'. But I prayed, 'Now strengthen my hands'."

It is very unlikely that a modern educated Westerner would express him/herself in this manner. The language shows that, for Nehemiah, being frightened and physically weak are two faces of the same thing. This is emphasised when he prays for his *hands to be strengthened.* A modern Western religious would almost certainly go the psychological route and pray that his fear be reduced, or his courage be increased. Nehemiah somatises the issue (whilst clearly acknowledging the fear), but our modern Westerner would psychologise it (very often to such an extent that any real awareness of the relationship of the fear to the physical concomitant is lost).

It is tempting for us to see Nehemiah's prayer as concrete and primitive, lacking understanding of the real psychological nature of his crisis. In fact it is quite clear that he knew he was frightened. He says: "they were trying to frighten us". He moves easily between his fear and his weakness.

Goldberg and Bridges have this to say about psychologisation and somatisation:–

> Indeed, 'psychologisation' appears to be the more recent phenomenon, and it still seems to be relatively rare in many parts of the world. To the extent that it occurs at all in developing countries, it tends to affect Westernised elites. Perhaps we should ask why people psychologise, instead of looking for explanations for somatisation.

And again: –

> In ancient Buddhist scriptures psychologisation was regarded as the original, most primitive, response to stress. It was regarded as primitive and maladaptive because it is difficult or impossible to mediate, and

> psychic pain is beyond the reach of medicines. In this formulation somatisation is regarded as an adaptive achievement of mankind, lessening psychic pain and exchanging it for physical pains for which there have always been treatments.[1]

Goldberg and Bridges are very aware of somatisation. They would have no problem with the notion of emotions being expressed in bodily language. But there is a difference between their approach and that of Nehemiah. In the case of Nehemiah there is an easy interchangeability between fear and physical weakness. He knows them both. There is a fluid connectedness, an interchangeability, a mirror-imaging of the two.

In Goldberg and Bridges' comments there is a much clearer either/or dilemma. In a typically Western fashion they immediately confront themselves with dualistic questions which must be resolved. Is the psychic pain (fear) prior to the physical pain (weakness)? Is somatisation a protective adaptation, a defence against psychic pain? I suspect Nehemiah would have no such problem – fear or weakness, both are there, either will do.

Most of us working in the somatisation field would in fact accept a linear and dualistic 'psychological-problem-leads-to-physical-problem' formulation as valid, at least in some clinical situations. This acceptance sits nicely with conventional dualistic taxonomies of disease. These taxonomies seem very tidy but how well do they represent the truth?

Person as Multidimensional Unity

A person is a cohesive unity, and it is this unified wholeness which needs to be continually emphasised. Gestalt psychology asserts that:–

> the whole, rather than being determined by its parts, determines the meaning of the parts.[2]

This statement acknowledges both the parts and the whole. But how we talk about the parts in the context of the whole raises many issues. We can so easily end up with a collection of compartments which then have to be integrated. As an alternative we could perhaps see the human person as a physical/psychological/spiritual/social/ecological gestalt. At any moment in time this complex unity could be seen as expressing itself, or potentially expressing itself, in all of these dimensions.

In an attempt to resolve a compartmentalising view we could perhaps say that there are multiple possibilities of connection or flow between various aspects of

1 Goldberg, D P and K Bridges. 1988. Somatic presentations of psychiatric illness in primary care setting. *Journal of Psychosomatic Research* v 32, p 137 – 44.

2 Strupp, H H and G L Blackwood. 1980. Recent methods of psychotherapy. In *Comprehensive Textbook of Psychiatry* 3rd edition.

the person within the unity. This suggests connections between separate *bits* of the person, implying therefore a linear and causal connectedness between various compartments. There probably is some usefulness in this conceptualisation. For instance, if a child has fractured a leg and cannot compete in the school athletics competition then he/she may feel depressed. The linear cause-effect conceptualisation (fracture – i.e. the physical – leads to depression – i.e. the psychological) is one description of the observed situation.

Recently one of New Zealand's most notable athletes stated on television that her injuries were not the reason that she was failing in some international events. She acknowledged that her most recent injury, occurring two days before an event, arose out of her ambivalence towards her sport. *In her view* her injuries were the somatic expression of her holistic response to her situation as an international athlete. She retired soon after to get on with the life she felt she had missed out on. Is it better to see the injury as a consequence of her emotional ambivalence (i.e. in a linear sense, and therefore suggesting that the mind disturbance precedes the body disturbance), or as just the *physical* expression of her ambivalence which is very naturally expressed in the whole, and therefore in both mind and body?

If we see the person as a unitary whole, we could conceptualise pathology in a general way as being some sort of intense condition or disturbance, *in the whole.* Apparent linearities and compartmentalisations may then be more a reflection of our observing capacities than truly reflective of fundamental reality.

Holism and Dualism

Attempts to develop holism whilst remaining steadfastly dualistic are less than satisfying. For example Brown in his article entitled *Cartesian Dualism and Psychosomatics*[3] quotes Grinker, who suggests that: –

> mind and body are two foci of an identical process,

This is a unitary and holistic emphasis. But Brown then quotes Reiser, who argues that we should be thinking in terms of a sophisticated organismic psychobiological theory which is circular rather than linear; in terms of somatopsychosomatic sequences rather than simplistic linear psychosomatic or somatopsychic sequences.

Brown is trying to encompass unity whilst retaining a fundamental dualism. In my view even the word *circular* implies a point-to-point microlinearity. A circle is a line with its ends joined. Holism is not achieved. It has to be decided whether mind or body comes first.

3 Brown, T M. 1988. Cartesian Dualism and Psychosomatics. *Psychosomatics* v 30, p 322 – 331.

Which *Bit* is Fundamental?

We do need to face the possibility that some dimension or other of our personhood *is in fact* prior, or ultimately more fundamental. This is clearly a dualist framework of thinking. It presupposes that categories of mind, body, and spirit are not just artefacts of human thinking but real compartmentalisations which we must wrestle with to integrate. A biological fundamentalist could practice something that leans towards holistic medicine whilst still holding that eventually when the biological collapses (dies) then the rest, the psychological, the spiritual, and the social, will also collapse. A spiritual fundamentalist could argue that when the spiritual is withdrawn then the other dimensions will collapse. Despite the ultimate disparity between these two positions both the biological and the spiritual fundamentalists could conceivably practice a functional and pragmatic semi-holism, which honours more than one dimension, in the here and now until such collapse occurs. In fact, in the here and now, the practices of both might even look rather similar. Such similarity or dissimilarity will depend on how strongly each conceives and perceives the various dimensions as both actually present and expressed.

But in a very real sense all elements are fundamental. The physical is clearly fundamental; collapse of the physical causes life as we know it to cease. A dead person appears to have no physical, psychological, social or spiritual vitality, at least as far as our ordinary perceptual faculties are concerned. The physical is in this sense fundamental. It gets more complicated though. A patient who is 'brain-dead' can have a living body but is not alive as we know living. The physical brain is still alive in a vegetative sense (albeit very damaged) but fundamental psychological abilities to think, feel, and relate are gone. The patient is not alive in the psychological sense. The psychological is indeed fundamental, and as fundamental as the physical.

More controversial in a secular and scientific age is the possibility that the spiritual is fundamental, and its associated question if what happens to the physical and the psychological when the spiritual is lost. Even if one is inclined to dismiss spirituality, the problem remains that *both* mind and body are fundamental to personhood. Which of these dimensions is ultimately prior?

In a materialist culture it is widely and implicitly accepted in medicine that the biological is fundamental. But if the psychological is fundamental too then we cannot legitimately look at disease and simply assume that mostly the psychological and the spiritual are to be disregarded, as is in practice the case in Western medicine. I take it further and assert that our *first* position with an illness should be that it is likely that this physical illness is a representation in the physical dimension of a 'story' which could be told in another dimension. This is perhaps most obviously seen in a simple somatic metaphor where a patient's mouth ulcers clearly reflect very accurately and aptly the patient's inability to express verbally painful affects of fear, guilt, and rage.

A particular illness may then be construed as a sort of appropriate crystallisation, or focal precipitation, or only available expression of what is happening to the person, within the person, between that person and other persons, between that person and the physical environment, and between that person and their divinity.

If we had a medical practice in which the physical and the psychological (and other dimensions) were attended to equally we would likely have no such sense that the psychological or physical was prior, and we would be left only with a pragmatic decision as to which dimensions we should expend our energies in to give the patient the best possible outcome.

Further, the urgent need in Western medicine to focus on the non-physical elements of the patient's story is not so much a reflection of psychological fundamentalism or *idealism*, but of a more urgent need to rediscover the person as an 'I', as a subject, somebody who gets lost in bricks and mortar of physicalism and biotechnology. This issue of the person as an 'I' is crucial (*vide infra*).

The Problem of the Observer

We are highly constrained by our abilities to observe. We are highly conditioned by our inevitably limited and inadequate presuppositions. To develop new ways of seeing we need to loosen up these presuppositions.

When an infant is comfortably feeding on the breast and is then torn away, the reaction to the violation seems to an observer to be instant and holistic, psychological and physical. Of course one cannot be sure that the reactions are truly concurrent. My Western psychologising presuppositional system tends to conclude that the child got angry and then yelled, kicked, and went red in the face. Nehemiah would probably see it differently. He would probably say: "My son is kicking mad!"

The frequent reality is that patients with illnesses present with *the same story in both the somatic and the psychological projections concurrently*. I am trying to emphasise that we are observing an integrated person who experiences, and who expresses themself constantly, and we observe that expression in one or another dimension, or all dimensions. And our observations are based on our presuppositions and are inevitably selective, and can create artefactual dualities, sequences, linearities, and even invisibilities (when we fail to observe). It may be that our tendency to structure reality into that which is first and that which is second is an inevitable consequence of our habitual and ordinary experience of time as linear.

As a psychotherapist and physician I am an advocate for the importance of the psychological both in personhood, and in its contribution to disease. Whilst I would see it as crucial I would not see it as fundamental. Non-physicalist approaches to illness may appear to require a presupposition of a putative

primary experience or substance which is itself dualistically antecedent to somatic and psychological expressions of the person. In considering this we come up against the various theoretical schools of psychotherapy, as well as the perennial questions of philosophy and spirituality.

Is the psychological fundamental?

In the last few decades, neo-Freudian psychoanalysis, the Object Relations schools of psychotherapy, the Interpersonal Psychologies (for example that of Harry Stack Sullivan), and, more recently, Self Psychology, have all contributed very powerfully to our understanding of the complex processes of the significant *relationships* of infancy and childhood, and the part they play in the development of the person and personhood.

There is a growing interest in how these processes *of relationship* might contribute to the development of disease. The relevance of early experience to adult experience is a 'given' for psychotherapists working in the psychodynamic tradition. A patient's *story* is full of relationship issues. It follows that illness is full of relationship issues. In fact the more I look at presenting illnesses and disease the more I can see them as representations of disturbance of relationship. So we might favour a concept of illness and disease arising from a *disturbance-in-the-whole* which is an expression of the *person-in-relationship*. In a sense this view defines persons as essentially persons-in-relationship, that is, that relationship is fundamental.

Any conceptualisation from one of the theoretical schools of psychotherapy of what can go wrong in the early relationships of infants with caregivers is of course a *psychological* description. Since Freud many elegant and helpful and often highly complex contributions have been made in this area. In a *relationship-is-fundamental* framework such psychological descriptions of early developmental mishaps are at risk of being invested with sole priority in the same manner that biologically-oriented clinicians invest the biophysical elements of our functioning. Thus the *psychological* trauma will be seen as fundamental, prior, and determinative, filling the stage, leaving little room for other emphases. But it is obvious that such reductionisms are as shallow as materialism.

For instance, a lonely immigrant mother with a workaholic materialistic husband becomes depressed and increasingly emotionally unavailable to her toddler. The child becomes irritable, sleeps poorly, and his eczema flares. He looks pale and pushes his food away. How should we select from this data? What is the best formulation? The physician, the psychotherapist, and the cleric will all select different elements of the story to respond to, and ask very different questions. Has the husband got his values wrong? What does belonging in a family and culture really mean? Is the mother suffering from despair in relationship, a form of object hopelessness? Is her brain biochemistry the problem? Is the child *just* allergic?

Is the child starting to carry the mother's depression? Is the child suffering an abandonment depression? There are in fact many selective descriptions of what has gone wrong but there is only one story, a multidimensional cohesive story. It is manifestly obvious that all the elements are important, all the questions are relevant, all dimensions are fundamental, and that anyone who wants to go the purely physical or psychological or spiritual way is clearly wearing blinkers.

The Unconscious and Somatisation

A psychotherapist wearing psychoanalytically-tinted spectacles might postulate the unconscious as fundamental in the somatisation drama. To suggest the unconscious is prior would be to take up a dualistic position with idealist overtones, a position which says that conflict in the mind is primary, and is then transformed dualistically into bodily form. That is, it construes the unconscious as prior to the physical, and determinative of physical reality, and there may be occasions when this is the best-fit conceptualisation.

Interestingly, the presuppositions of the notion of the unconscious were psycho-materialist rather than idealist. The origin of the concept of the unconscious as a territory of the psyche mainly belongs to Freud. Shalom has written a fascinating and rigorous analysis of the role of mind/body problem played in Freud's development of psychoanalytic theory.[4] He cogently argues that Freud was a physico-materialist who struggled during the 1890s, in the unpublished *Project*, to root mind processes firmly in bodily processes. In particular he struggled with the difficulty of explaining repression in neurophysical terms. What is interesting is that Freud appears to give up the overt struggle, as represented in the *Project*, to integrate mind into brain (though Shalom argues that the mind/body issue remained an underlying theme in all of Freud's work). In reaction Freud turns to a psychological focus, and psychoanalysis was born. Interestingly the terminology of Freudian psychoanalysis is characterised by *mechanisms, compartments, forces,* and *psychic structures*, and Shalom argues that the Freudian psychic structures are proffered in this way because he "molded *psychical* processes on the model of neurological processes".[5] The theory of psychic processes reflected Freud's previous preoccupation with the neurological processes. He turned to a psychological theory, a theory of psychic processes, mirroring in its structure the mechanisms of the physical. And, curiously, the unconscious became, for Freud, the psychic structure that was rooted in the biophysical:–

> As Freud himself pointed out in the *Outline of Psychoanalysis*, the specific hallmark of psychoanalysis is the doctrine of *the unconscious*

4 Shalom, A. 1985. *The body/mind conceptual framework and the problem of personal identity.* Humanities Press International, Inc. NJ, p 125 – 318.

5 Ibid, p 171.

as the *direct expression* of neural processes. [6]

Freud's position is fundamentally materialistic (the unconscious is seen as rooted in prior biological processes), and parallelistic (psychic processes and bodily processes exist in parallel), which is therefore dualistic.

There are some very important issues here. How should we construe somatisation in a psychoanalytic framework? Is the sequence of disease development as follows: brain processes – abnormal brain processes – disturbed unconscious – disturbed psychic processes – defensive manoeuvres including somatisation – disease? This is of course offensively simplistic, mechanistic, reductionist, linear, and probably not representative of many neo-psychoanalytic thinkers.

But I have other problems with an *undue* emphasis on the role of the unconscious in the development of illness. I think illness needs to be construed more often in sociological, relational and interpersonal terms. The focus of classical psychoanalysis firmly places the problem in the individual, and within his or her intrapsychic structure. There is this dimension of course. Disease then becomes, ultimately, an individual affair, downgrading the role of relationship (though of course it is recognised that intrapsychic structure arises or develops within relationship). It becomes a matter of emphasis. My preference would be to see many of the psychoanalytic emphases as valid, and yet to see the problem experience (ultimately manifesting as illness) as emerging in relationship (with other persons, and the environment), and *having unconscious elements*, rather than taking the further step of making the unconscious an entity, and then giving it primacy, thus moving to a dualistic and idealistic position (or conversely, in Freud's original analysis, to a materialist position).

It seems that mind, body, relationship, environment and spirit are all crucial but the difficulty is in how to talk about them in a way which is holistic, and gets us away from "the Mind/Body Problem". In order to do this I want to explore the issue of personal identity, the notion of the human subject as an 'I'.

Personal Identity and 'I'

I entered the mind/body conceptualisation 'jungle' by the route of clinical practice whilst wearing the hats of both physician and psychotherapist, but soon realised that certain types of clinical presentation nourished a belief in me that some illnesses were purely physical.

Hayfever is in many cases caused by seasonal exposure to grass pollens, in a person who is genetically predisposed to over-react immunologically to the grass pollen stimulus. The medical profession can manage the symptoms pharmacologically. We have then a precipitating cause, a genetic tendency, and a way of treating it. Seen this way it is a nicely closed system which appears not

6 Ibid, p 169.

to need any extra dimension. In fact virtually no one considers the possibility that other dimensions of personhood may play important roles in the pathogenesis of 'hayfever'. We encourage one another to see this purely physically. Any possible collateral "'story' is excluded. This illness *is* physical. There is no question about it.

On the other hand a muscle tension headache will commonly be construed as emotion-related and classed as psychosomatic, or non-organic. In this instance the mind is seen as influencing the body. This would not even be considered in the hayfever example. Thus in medicine we continue to appraise all physical conditions in a dualistic manner, and as long as we continue to exclude other person-dimensions from conditions like hayfever we appear to be justified in this approach.

The problem I faced was that increasingly in the supposedly *purely physical* illnesses I was discerning clear collateral 'stories' of apparently substantial significance to the predisposition, precipitation, and perpetuation of the illness. What should I do with this awareness? Once one had a substantial organic process underway it made pragmatic sense to treat the condition with whatever physical means there were available, but I was still left with the 'story', and how to integrate it into my understanding of the illness.

Gradually I began to conclude that we needed a paradigm or conceptualisation in which there *was* something prior to the concepts of mind and body, in which both were derivative. Eventually I came across Shalom's philosophical work on the notion of *personal identity* as more fundamental than either mind or body. This excited me because he was providing a rigorously argued conceptualisation which was very congruent with my own intuitions which had developed in the crucible of clinical experience without the benefit of philosophical training.

Shalom's thesis is developed in the context of careful analyses of the work of Wittgenstein, Feigl, Strawson, Smart, Armstrong, Place, Wiener, Sayre, Parfit, Nagel, Freud, Jaynes and Sperry. He argues that the person is not reducible to a *combination* of body and mind, and therefore the problem of mind/body integration is not soluble by working to relate mind and body categories as if they are the fundamentals. He sees the 'existing person', or 'subject', or the 'I', as the ultimate:–

> underlying the presuppositions of scientific reductionism there is a spontaneous and quite irreducible 'subject' who does not allow even the declared reductionist to identify his internal subjective structure with his external spatial structure.[7]

You and I *have* bodies, minds, souls, spirits, consciousness, or an unconscious. They are categories which describe important elements of our experience. All

7 Ibid, p 407.

have at various times been given priority and declared fundamental. They are real but none of them describe who 'I am'. I *have* them. The 'I' is there, not beyond body, mind, soul etc, but embracing them. Something that *has* something must be prior to that which it *has*. If we get rid of the *has*, and define the person as a mind or as a body or as a spirit or as a consciousness we end up with reductionisms which do not satisfy our whole experience of reality, and by many criteria do not stand up to logical analysis. So the 'subject' or personal identity, the subject as 'I', is postulated as fundamental:–

> I am in effect saying ... that the body/mind dualism considered as ultimate creates a false dilemma in which I, the 'I' which is trying to grasp its own situation, find myself trapped by virtue of the inadequacy of the conceptual framework used.

If then we situate personhood in a body/mind dualistic framework we will struggle forever, because it cannot contain what we experience as persons.

> If I put to myself the question: 'What or who am I?', my difficulty in answering stems from the fact that I know myself as both 'bodily' and 'conscious', and that I have an extreme difficulty in relating myself to what I mean by these two terms. And so I concentrate on these terms and thereby suppose that the problem can be expressed by saying that it is a problem of 'the relationship between body and mind'.

We succumb to the view that we must solve the problem of personhood between body and mind because these are prominent categories in our experience, and we then project the problem of personhood onto these categories.

> Since my experience of the external world teaches me that relationships have *relata*, I tend to assume that the present problem can be conceived in the same way, and that the *relata* concerned must naturally be precisely what are referred to as 'body' and 'mind'. But it is just exactly in that assumption that I have made my fundamental mistake. To borrow an expression from Wittgenstein: the conjuring trick has already occurred. For what I have failed to recognise is that in the very act of setting out the problem in this way, it is I the subject, who am formulating it in these terms, and this has implications of its own. The implications are that when I, the subject, formulate the problem in this way, I have projected myself into the referents of the terms which I have used in that formulation ... and I mistakenly assume that I, who am doing this, am absorbed within the framework of those referents themselves.

'I', the subject, experience mind and body but it is a mistake to absorb myself into a restricted system made up of these two categories.

> ... I assume that the compound of 'body' and 'mind' constitutes an adequate substitute for the 'I' that is performing both the projecting into the referents of these words, and the compounding of them into the theoretical entity which I, the same I, now call 'body and mind'. But this assumption is simply inaccurate, for there is no compound of 'body and mind' which is not thought so by an 'I' which continues to think so. And therefore the compound called 'body and mind' can only itself exist as a theoretical derivation of the continued intellectual activity of the 'I' which does not merely think itself as 'I' but which constantly expresses itself as 'I', thereby indicating in act its own priority relatively to the construct 'body and mind'.
>
> ... the problem is not 'the body/mind problem', but the problem of the person or the 'I'.[8]

Thus Shalom summarises the view that I had come to, that each day in my office I was dealing with whole persons, personal identities, 'I' after 'I', who, because their realities can be conceptualised and abstracted into categories covered by terms such as 'body' and 'mind', provide me with two sets of data which can be clustered together, in one case in terms of physical disease, and in the other in terms of 'story'. But they remain merely as focused-upon dimensions or derivatives of the reality of the prior 'I'.

Clinically this makes a huge difference. If now I look across to my psychotherapy client and he is battling with 'object hopelessness', and at the same time he and his doctor are battling with asthma, or rheumatoid arthritis, or irritable bowel syndrome, I do not have a sense that we have two rowing boats in a heaving sea, that somehow we have to tie them together, but rather we have one boat, and I and the doctor are trying to get onto it from different sides.

How might we apprehend this 'I'? Along with Shalom I would say that the 'I' is not an extra entity added to mind, body, soul, spirit, or what have you, but involves, embraces, subtends both matter and mind: –

> ... the fundamental reality of 'I am' is that I am 'an existent' that exists as body and that exists as mind, and that this implies neither a third reality nor the interpretation of 'I am' as body or as mind nor as an uneasy combination of both. [9]

This notion of 'existing' is important. 'I' am a sort of *permanent existing*. I remember myself going to school at five years of age. I know that boy to be the same person that I am now, I acknowledge all the changes in my body and my mind, which have occurred over the years, but there is something constant or

8 Ibid, p 411 – 412.

9 Ibid, p 420.

permanent which is 'me'. Ask an 85 year old. Is she the same person she was at age 10? At one level or pole she will say no, and at another pole she will say yes. Shalom calls these the pole of Change and the pole of Permanence.

Shalom is clear that this permanent existing, this personal identity, the 'I', underpins and expresses itself in 'how things are' in the modes we call body and mind. There is a distinction between the continuous process of 'how things are' in the modes of expression called body and mind (the arenas of investigation for scientists and psychologists) and something within all that referred to as 'permanent existing'.[10]

This is not dualistic. The 'permanent existing' is not a third reality separate in some way from mind and body. 'I', in my fundamental existing, am co-extensive with my physical functioning, which is accessible to scientific investigation, but *all* I am is not contained or able to be described by the conceptualisations of the scientists. My actual existing is not intelligible to the concepts of science. The conceptualisations of science must be supplemented with other conceptualisations. An understanding of existing must be grounded in some other reality.

How can we avoid a return to a problematic dualism? A way has to be found of relating this 'I', this permanent existing, to physical processes:–

> ... I have to suppose that I am a subject who has somehow emerged in the course of specific physical processes, so that when I use words like existing and permanence I am necessarily taking about a physical process of which I am myself an integral part. And since I have rejected the theory that the 'I' as subject can be directly derived from physical and chemical processes *per se*, I must assume that what I mean by 'physical processes' or 'physical reality' is not identical with what the scientist means by 'physical processes' or 'physical reality', though what I mean obviously cannot contradict what the scientist means.[11]

Instead of absorbing the 'I' into 'mind' and 'body' Shalom absorbs the latter two into the 'I' which must therefore have its ground elsewhere. He remains nevertheless thoroughly committed to the physical-ness of our 'I-ness'. Put in another way we can say that physical processes, in the widest sense, are carriers of our subjectivity: –

> ... the laws of physics are 'laws of physics and chemistry' by virtue of a more fundamental but inherent principle which determines them to be 'the laws of physics and chemistry'. Laws of this sort are shorthand expressions of concrete realities which they are unlikely to capture in their full existential complexity. But it is precisely in that existential complexity that physical processes can be *per se* the carriers of a

10 Ibid, p 426.

11 Ibid, p 426.

> subjectivity which will simply escape the generalisations that are the laws of science. In other words, subjectivity can in fact be a mode of organisation of those very physicochemical processes, of which the physicist and chemist know some of the 'laws', without that potential subjectivity having to appear in those 'laws'.[12]

We can all vouch for the 'reality' of our subjective experience. We do experience ourselves as having mind and body, and self-awareness, and consciousness, and something that many would concede can be described as spirit (even if we cannot agree on what it means). How does all this relate to the 'I'? Can we make sense of the categories of mind and body (at least) as a function of 'I–ness'?

In our experience of our reality we repeatedly observe physical and other processes. In the process of this observing we note *regularities* or patterns. We hold onto these observed regularities by naming them, and in so doing we make them into entities. In physics we call one regularity an atom, or another a black hole. In medicine we call a regular pattern a disease. Unfortunately we commonly go further and refit this disease pattern, and it becomes an entity which has too much finality. We assume we have it in our grasp; that now we know. The history of Newton and Einstein, as a major example outside medicine, shows how naive such assumptions can be. We believe that if we call something *clinical* depression, or obsessive – compulsive disorder, and particularly if we can describe some neurotransmitter abnormalities in the brain, then we have got a substantial hold upon it, and we make it into a substantial reality. From our *current* observer position these patterns *are* the patterns we see, and we get useful mileage out of inferring *laws* from these patterns. Laws are abstracted generalisations derived from our limited observations of patterns. It is dangerous to assume too much finality from the patterns we observe, or to allow ourselves to be too restricted by the laws we have derived from the patterns.[13]

What relevance does this have to our experience as 'I's' who know we have minds and bodies?[14] Mind and body categories are themselves categories or regularities in our experience as 'I's which we both perceive and name. They are important and dominant regularities in our subjective experience of ourselves as wholes. But they do not describe all of the whole. They must not be reified to entities which are then seen (when added together) as the best description of personhood. The perennial failure to resolve the mind/body problem by situating personhood as a composite of a dualistic pairing of mind and body is testimony to the failure of such reification.

There is also the matter of what we intuitively know. When I talk in seminars

12 Ibid, p 434.

13 Ibid, p 439.

14 Ibid, p 441.

about the 'I' as fundamental it seems that many people from very different backgrounds lean forward and say "Yes. Yes, that's right". We should assume that that which is fundamentally correct will have an intuitive feeling of congruence with reality. This seems to hold true in clinical practice. I find that when I talk to patients about mind/body issues, in a way which gets past their fears and acculturation, there is an inner hunger for seeing mind and body as *one*. Shalom makes the same point in respect of radical materialism, arguing that if the radical materialists were right in postulating matter as the ultimate fundamental (that is, reifying matter and giving it priority over all other aspects of personhood) then it would be easy for us all to accept this because at a deep level we would know this was in actual fact the real state of things:–

> the radical materialist (is in) something like an internally contradictory position. For he is holding the thesis that though, as subjectivities, we *should* be identifiable with purely material processes, yet in terms of actual experiencing, we are not identifiable in that manner: we, in fact, have to involve a *theory* in order to convince ourselves that we are to be identified in that manner. And it seems to me that this is quite an untenable position to hold for a subjectivity which is supposed to be a purely material process.[15]

Where we have got so far is to the position that the unity of the person is rooted in a reality of personal identity – which involves 'I', a subject, a permanence, an existing – of which the experience and expressions of mind and body are derivatives. But if we discard the dualistic mind/body conceptual framework for this more fundamental personal identity how can we understand "mind – as a real potentiality written into certain kinds of physical bodies?"[16]

Shalom calls on internalisation to help us understand our awareness of mind and body as separate. This is a term which psychotherapists understand very well, as a process which we use throughout life to develop our mental world. Schafer defines it in a way which would be acceptable to most psychotherapists: –

> Internalisation refers to all those processes by which the subject transforms real or imaginary regulatory interactions with his environment, and real or imaginary characteristics of his environment, into inner regulations and characteristics.[17]

Shalom puts it a little more philosophically when he remarks that internalisation is a potentiality, a capacity of the physical organism to "discern the scope of what exists".

15 Ibid, p 439.

16 Ibid, p 441.

17 Schafer, R. 1968. *Aspects of Internalisation*. New York: International Universities Press, p 9.

Keeping Schafer's definition of internalisation in mind we can now summarise some of Shalom's postulates. Firstly, there is no mind-substance or separate mind. But living physical organisms do have a potential for subjectivity. A simple example may help. My eyes allow me to see RED (just as an animal might see red). There is something else besides. I can also say to myself "I am seeing red". I am self-aware. He is saying that humans (and, to a varying extent, other living organisms) have a potentiality for subjectivity, a potentiality which is inherent in physical processes. This subjectivity is actualised by means of processes such as internalisation. As an infant I experience my own physicalness which I fall over and get hurt. This (and many other physical events) is repeated many times and in varying circumstances. The physical pain, and the sight of the blood etc – the whole experience – gets internalised, and I end up able to say not only that "I have a body", but also that "I have pain", or that "I have a body in pain". There is still more. I can actually reflect upon the fact that I can think about myself as a body in pain. It appears then that I have gone on to internalise *my experience of my subjectivity*. In this way then I observe the many and varied processes of my internalisations, and I see a repetition of such processes, and I can therefore say "*I have* a mind". I have reified this recurrent experience, called it mind, and it becomes an entity. So certain sets of internalisations lead to the experience of *having* a body, and certain sets lead to the experience of having a mind. The apparent mind/body split is therefore based on internalised structuralisation of our experience.

The pot cannot hold the potter in its hand. We can look outward (so to speak) from ourselves, from our 'I–ness', to the physical expression of our personhood (and of course to other physical realities), and describe it, but we are always looking outwards from the integrated source of our existence. We try and explain that source by encompassing it within the dimensions we see as we look out (our physicality, our mind, or combinations of the two) but it never works because they are derivatives of the whole rather than, when put together, a full description of the source.

There is a requirement therefore to be tentative, aware of the fact that there are limits, and the need for humility. Nevertheless more can be said. There are the so-called poles of permanence and change, which have already been alluded to. These concepts illuminate the notion of the 'I'. Shalom helps us understand permanence and change by considering the newly conceived human embryo.

Permanence and Change

A new conceptus is an identity from the beginning. The conceptus is a self-realising subject involving processes of change and continuity which can be seen clearly in the dimensions of both body and mind. Or as Shalom puts it, the "locus of subjectivity subtends both body and mind". The crucial elements are beginning to emerge. The human subject from the beginning is characterised by *both*

continuity and change, the pole of permanence and the pole of change, the former reflecting the previously postulated notion of the 'I' as a permanent existing. The constant and rapid changes in the conceptus' subjectivity, as it develops, are "built on the permanence of that subjective locus of internalisation and actualisation".

The pole of change describes the constant and rapid changes in the body and mind of the infant, and the reality of growth and development over linear time. Internalisation plays a huge role in this actualisation. In the process the infant realises (internalises) his/her subjectivity and is able, eventually, to say in a self-conscious way "I have a body" and "I have a mind".

But the term pole of permanence describes our 'I–ness', and personal identity, our continuity, our sense of timelessness, and it is this pole, or this locus which gives me my 'me–ness'. In Shalom's words:–

> identity – is the conception of a permanent locus of all experience, a locus which gives structure, form, and content to a succession of changes which characterise that subject and no other.[18]

In our dualistic and scientistic way we tend to see physical processes as fundamentally inanimate. If then we follow Shalom it might seem that we must postulate some sort of vitalism which allows for a penetration of inanimate matter by some sort of new substance. Shalom asserts:–

> there is nothing lurking beneath these chemical processes: there is something involved in these chemical processes, something that necessarily escapes the chemist because it is not a matter of chemistry.

When he says that nothing lurks beneath the chemical processes I do not think he is precluding unseen complexity. Rather, he is emphasising that he is not allowing another reality dualistically separate from the physical processes, and hidden behind them. The unseen reality is unseen merely because scientific techniques, and probes of physical reality, are not capable of discerning the reality of the subjective 'I'. He is saying that life is more than that which is described by science, and that 'more than' element certainly includes a capacity for subjectivity, reaching its summit in the 'I–ness' of the human.

The issue of permanence needs expansion. The events or processes which seem to be best encompassed at the pole of *change* clearly fit in with conventional linear time. An infant weights seven pounds at birth and fifteen pounds weeks later. He talks at thirteen months. A girl menstruates at twelve, and a boy suddenly grows at fifteen. I retire at 65, and so on. It is all very linear, and comprehensible. But it appears that some of our functioning does not so easily

18 Ibid, p 450 – 452.

fit this sort of time. Paul Davies' book *About Time*[19] describes the current state of thinking in physics about concepts of time, thinking which certainly erodes confidence in our simplistic beliefs in a universal time, or just one sort of time existing everywhere. Day-to-day physical processes as seen by ordinary humans usually seem to fit within notions of linear time, but the things that cosmologists and physicists see with their new instruments cause them to struggle increasingly with linear and universal time concepts. But let's stay with the pole of permanence, the foetus, and personal identity.

The *physical* development of the foetus is rapid, involving aspects of mind and body encompassed by the pole of change, and the changes are easily accommodated within notions of linear time. But Shalom argues that identity with its pole of permanence must involve a different sort of time. As an aside it might be worth remembering Freud's notion that the unconscious is characterised by timelessness.

What Shalom is saying is that personal identity has something to do with nontemporality (or quasi-non-temporality), or is independent of linear time as we know it, whilst the processes *usually* observed by scientific methods have to do with linear time. This non-temporal aspect, my 'I–ness', gives rise to the aspects of myself characterised by the pole of change:–

> What this situation would mean for the chemical processes involved is that they are the processes that they are because of the particular kind of subtending quasi-nontemporality of that particular kind of subjectivity. [20]

He is saying here that the unique character of the 'I' gives rise to, or subtends, the unique manifestations at the pole of change, in the body and mind (as they are called once they are reified). Each living and conscious entity becomes by ennumerable internalisations the actualised entity expressive of its potential subjectivity.[21]

All of this helps us understand why we easily make the mind/body distinction. The human deploys two processes of internalisation:–

> the internalisation of physical processes in the locus of permanence, and the internalisation of the locus of permanence itself, together with all its internalised physical processes, to itself.[22]

Put very simply this seems to mean that my awareness of myself as body is a consequence of internalisation, to the pole of permanence, of my physical experience of myself. My awareness of myself as mind is a consequence of

19 Paul Davies. *About Time* Viking, Great Britain, 1995.

20 Ibid, p 456.

21 Ibid, p 460.

22 Ibid, p 462.

internalisation of the experience of one's self as a pole of permanence.

All living organisms are seen by Shalom as having some potential for subjectivity, and this potential comes in higher and higher forms. He acknowledges the mystery and obscurity of life, holding nevertheless to the view that we are better off with the mystery of personal identity than we are trying to unite mind and body out of a dualistic materialism:–

> The postulation of a potential subjectivity ... founded on quasi-nontemporality ... avoids the impossible problem of understanding how chemistry as such can become an instinct ... we situate these processes where they belong: in the obscurity of the temporal existing of the physical organisms which develop, by their means, into the specific animals that surround us, and of which we ourselves are exemplifications.[23]

An increasing capacity for internalisation allows for a finer and finer appreciation of the world and its physical processes. But it is the internalisation of the pole of permanence to itself which is the crucial issue of self-awareness:–

> ...what this ... implies ... is that the existential mystery of a potential subjectivity, the existential mystery of the quasi-temporality of the permanence polarity ... becomes partially intelligible by revealing itself to itself as that which becomes a 'self-conscious subject', an 'I', a human person ... it is an existential locus which not only internalises the processes of physical reality, but that is also itself internalisable, giving rise to its own self-realisations as a locus of quasi-nontemporality. We call the results of this further operation 'self-awareness'.[24]

Where we have got to is the notion of personhood which involves the priority of personal identity, the 'I' as existing, over any notions of mind or body. These latter terms are valid in the sense that they are concepts which describe our experience as 'I's. Put together in one way or another, in hierarchies, or in combinations, they never solve the problem of integration. But seen as understandable derivatives of our experience as 'I's which have self-awareness we find that much of the struggle around mind/body problems can drop away. The 'I' will actualise over linear time. Therefore physical and psychological development will have both a sense of continuity and change, and will seem underpinned by a permanence which is an essential characteristic of the 'I'.

In matters of disease and illness we should expect both physical elements and 'story', as nondualistic manifestations of the same 'I', in different dimensions. Nothing in all this excludes the possibility of complex derivative processes which would allow us to construe illnesses in terms of somatopsychosomatic

23 Ibid, p 457.

24 Ibid, p 460.

sequences, or the like. This is not an escape into dualism, but a recognition of derivative complexity beyond the holism achieved by seeing personhood as fundamentally rooted in personal identity, or the 'I'.

The work of Shalom provides a philosophical basis for a true nondualistic holism. Whilst embracing physicality he declines a physico-materialist fundamentalism. He argues for a more fundamental personal identity which *is* expressed in the physical, and yet is *not* fully described by the physical. He is not a vitalist in which the body is some sort of garment clothing the more genuine reality. The body is a vital dimension of the person. Matter is seen as having, in living organisms, a potential for subjectivity, seen in its ultimate form in human beings as the experience of 'I – ness', a potential not measurable with scientific instruments which only operate in the restricted dimension of physicality.

References

Brown, T M. (1988) Cartesian dualism and psychosomatics. *Psychosomatics* v 30, p 322 – 331.

Paul Davies. (1995) *About Time* Viking, Great Britain.

Goldberg, D P and K Bridges. (1988) Somatic presentations of psychiatric illness in primary care setting. *Journal of Psychosomatic Research* v 32, p 137 – 44.

Schafer, R. (1968) *Aspects of Internalisation.* New York: International Universities Press.

Shalom, A. (1985) *The body/mind conceptual framework and the problem of personal identity.* Humanities Press International, NJ.

Strupp, H H and G L Blackwood. (1980) Recent methods of psychotherapy. In *Comprehensive Textbook of Psychiatry* 3rd edition.

THE PLACE OF SOUL IN THERAPY, OR THE PLACE OF THERAPY IN SOUL

Helen Palmer and Peter Hubbard

Introduction

As modern psychotherapy looks beyond its rational and scientific antecedents, the spotlight is beginning to fall on the definition of soul and its relationship to psychotherapy. The questions that show up in this enquiry tend to focus on where soul might be acknowledged in psychotherapy, and then on how this particular aspect of therapy might be done. These are reasonable questions, yet put in this way, they underscore an assumption about this relationship. This assumption is predicted on the notion that soul is an aspect of therapy, that it is 'in' therapy.

When an enquiry into soul regards it as one aspect of therapy that can be separated off, a crucial conceptualising frame is unconsciously established. This frame relegates soul to the status of a subset of identity. Essentially what we are doing is protecting the primacy of egoic identity. Our sense of who we are remains defined by our egoic consciousness. In this we maintain that the characteristics of egoic consciousness are the ultimate coherence of personality. We affirm the egoic experience of individual separateness as the 'human condition'.

If on the other hand we hold that soul is not merely an aspect of therapy, but is the actual context of therapy, this notion of egoic identity is disturbed, disrupted. To hold soul as context for therapy requires that we be willing to engage the possibility of a psychological level shift. It intimates that hard-won egoic differentiation is but a stage of human development, rather than its sine qua non. Ego contemplates its own developmental 'death'.

Yet if we claim that we are not separate from soul in our therapy and in our lives, and that we are not separate from the ultimate context of spirit, a considerable reconceptualisation is required. This is because in our normal waking consciousness we do experience ourselves as separate.

Mental–egoic Consciousness

Our normal waking consciousness is essentially 'heroic' consciousness, which the transpersonal theorist, Ken Wilber calls mental-egoic consciousness. Wilber's term is quite specific. It suggests an experience of consciousness and of meaning-making that is centred in upper cognitive faculties, and is to do with embeddedness in, and maintenance of, ego. The parameters of this mental-egoic consciousness are characterised by:–

- an ability to separate and differentiate body/feelings from mind, and mind from the Divine.
- an ability to separate self from environment
- an ability to be self-reflexive, to develop rationality and formal operational thinking
- the experiential acknowledgement of individuality as a primary factor of identity, and a morality that reflects this
- linear temporal awareness, a grasp of historical time, and the ability to facilitate long-term planning.

While the fulfilling of this heroic potential stages a glorious epic of individual striving and affirmation, there is also a less comfortable or shadow side to the egoic structure. The self-conscious ego may be:–

- vulnerable in its separateness
- painfully aware of its mortality as the unity of life/death is severed
- guilty about its emergence and the shadow it thereby creates and projects
- open to anxiety, both neurotic and existential.

To withstand the terrors that may arise from these experiences, ego not only defends against basic levels of consciousness, initiating neurotic conflicts, but also defends against the more inclusive realms of consciousness, initiating existential crises.

In *Up From Eden*, Wilber says of the mental-egoic:–

> It sealed out subconsciousness and superconsciousness. There arose that peculiarly Western egoic mood: cool, rational, abstract, isolated, bravely over-individual, solid, shy of its emotions, shyer of God. ... And in this doubly defended consciousness (repressing the Below and denying the Above), the new ego, with its visions of cosmocentricity, proceeded to remake the Western world. (p 292)

The language forms that developed to express this egoic consciousness tend to nominalise events and then to describe the relationship between them. As the individual ego learnt to encapsulate its own experience and separate from its wider context, so language structure reflected a conceptual dualising. The basic subject-verb-object sequence of English structurally encodes this. We tend to nominalise events and processes, think in terms of polarities, of dualistic forms, and then make implicit assumptions that this is in fact how the world really is.

Our language then not only expresses, but also shapes our egoic meaning-making. Unconscious to the potential for hubris, we take the logical step of

assuming that an activity such as psychotherapy, which makes intensive use of the egoic skills of upper cognitive self-reflexiveness (nb the 'talking cure'), is able to subsume the far more inclusive and dynamic process of soul-making.

The context of soul-making

Egoic consciousness is experienced through these upper cognitive, self-reflexive faculties. How might awareness of soul-making as context for psychotherapy be built so that it includes and contains these egoic faculties, and also goes beyond them?

A basic practice of psychosynthesis monitors levels of being in order to develop this awareness. It involves identifying the physical, emotional and mental experiences, the personal centre of identity, and finally Self awareness, using a meditative focus. Roberto Assagioli originally formulated this: "I have, and I am not my body; I have, and I am not my feelings; I have, and I am not my mind; I am a centre of Self-Consciousness and Will."

While helping to differentiate levels, this formulation appeared to be quite dualistic and seemed to imply a disembodied psychology. The more inclusive wording: "I am, and I am more than my body, ... my feelings, ... my mind" avoids the separation implicit in: "I am not ..." with its egoic level overtones, and facilitates a sense of connectedness and relatedness. These qualities are preconditions for accepting one's humanity.

The reiteration of 'more than' acknowledges an increasingly inclusive experience of Self which is beyond the mental-egoic level of consciousness, while the awareness "I am my body and I am more than my body" grounds the heroic ego within a deeply immanent soul-making context.

Body is not then separate from spirit, but is spirit at its physical level. Physical experience is not essentially separate from what is divine, nor is emotional experience, nor mental experience. This has ramifications not only ontologically and philosophically, but also ecologically; not only for us as individuals, but also for the systems of which we are a part. These ramifications challenge heroic precepts that see individuals as separate from others and from the environment. They illustrate that the human experience can be both profoundly separate from, and interconnected with, all that there is. Mental egoic consciousness creates the individual experience of separateness from the system in which the individual lives. Soul-making consciousness creates the coexistent experience of separateness **and** connectedness in which our hard-won egoic consciousness is not 'lost'. This is the experience of immanence, grounded as form, as matter.

It is also important to acknowledge and include transcendent yearnings and experiences. These have been associated historically with denigration of body, and devaluing of matter and nature. Mental egoic consciousness has tended to see

the transcendence of form as the only true and valid spiritual truth. This is of course consistent with the way it conceptualises a split between body and mind, mind and the Divine, and body and the Divine. At best the body is regarded as a vehicle for soul, at worst an encumbrance to be scourged into submission.

Our mental-egoic consciousness may rebel at the apparent paradox implicit in attempting to hold both immanent and transcendent experience. Yet holding both helps connect us to the ultimate spiritual context which the Perennial Philosophy names as the ultimate ground, being the condition of all things and events. It also helps connect us to the context of soul-making, which may be understood as the personal ground, being and condition of all things and events. Here the same phenomenon manifests at different levels of being, appearing different, but in essence not.

Placing our therapeutic work in such a context requires that our mental processes keep engaging with perspectives that go beyond the usual parameters and identifications of egoic meaning-making. These perspectives require us to both include and be more than our meaning-making identifications, to include and be more than our mental-egoic experience. The ego defends against this. It is being asked to 'die'. In fact this is its evolutionary challenge.

If we align with a context which takes us beyond the maps and models of psyche delineated and defined simply by mental-egoic consciousness, then we can engage in therapy as a way of participating in soul-making.

This does not mean that personality dysfunction is not diagnosed and addressed with clinical precision, that ego-strengthening work is not engaged in where appropriate, that developmental deficits are not engaged in the tranference, as some psychotherapists seem to fear.

Centering the therapeutic relationship in a context of soul-making requires that we eschew the possible mental-egoic hubris of thinking that we can fully diagnose, and conceptually encompass, what our clients' lives are about, in terms of pathology (and problems) alone. We attempt instead to be clearly and therapeutically in relationship with our clients in their soulmaking, knowing we can make useful hypotheses about pathology which contribute to understanding.

We also take care to keep open to the mystery at the heart of the psychotherapeutic encounter. Our psychotherapeutic skills include the ability to maintain a creative presence and the ability to live in the anxiety of the unknown. It is in the therapeutic moment of not knowing that we can open to the mystery of soul-making in ourselves and in our clients, if we are willing to recognise it as such. This perspective on soul-making, that includes pathology rather than focuses on pathology primarily, allows for healing insights and experiences other than those available to mental-egoic consciousness. It allows for grace, and profound connection. As psychotherapists, we know such moments.

The repression of the sublime in psychotherapy

Do clients want this soul-making context? Anderson and Hopkins, in *The Feminine Face of God* explore and collate women's spiritual experience and concerns through extensive interviews with women across America. This is what the authors say:–

> The women we spoke with had a deep desire to tell us what was meaningful and sacred in their lives.
>
> The warmth with which we were received and the openness and trust with which each woman related her story made us keenly aware that opportunities for this kind of sharing are virtually nonexistent.
>
> Even in the cloistered walls of a psychotherapist's office the dialogue usually focuses on what has gone wrong with one's life, rather than on *the deep purpose moving through it.* (p 13) [our emphasis].

Compare Michael Basch, a psychotherapist who has been engaged in attempting to provide a valid, unifying and useful explanatory theory for psychotherapy. From *Understanding Psychotherapy*:–

> It is a person's self-image, or self-concept, that furnishes both the potential and the limits of individual existence. Psychotherapy focuses on the aspect of a person's self-concept that is either frustrating that potential or is leading the patient into an inappropriate and counter-productive attempt to breach these limits and then tries to help the patient resolve these problems. (p 19)

This is a reasonably true and adequate description as far as it goes. But it tends to suggest that psychotherapy is simply a treatment option. It is obvious in his writing that Basch's practice of psychotherapy is empathic, respectful, and effective. Even so, can a theory underpinned by such an essentially pathologising mental-egoic focus truly be a unifying psychotherapeutic theory? If there is no clearly articulated spiritual context, can clients be assisted to engage consciously the soul-making, the deep purpose moving through their lives, as effectively as when there is such a context?

Theories that ignore, or do not formatively acknowledge soul-making may usefully unify knowledge of mental-egoic consciousness, but they will not serve as adequate evolutionary psychological frameworks which are inclusive of spiritual experiences because they do not map the egoic defence of repression of the sublime.

We are familiar with concepts around repression of the basic unconscious drives, instincts and developmental trauma that need to be defended against. Repression of the sublime, like the 'denying of the Above' that Wilber referred to earlier, involves 'sealing out' the superconscious and the experience of connectedness

beyond the egoic ceiling. It is a common phenomenon in our culture.

Psyche, which is etymologically derived from the Greek for breath, life, soul, has for Basch become information. He says:–

> Information is the psychical or psychological force, the motivation behind behaviour. (p 58)

It is important to include this concept. Yet it leaves unanswered speculation about the nature, process and experience of motivation. And there is no indication that Basch includes as information, input from levels of experience that contextualise, that are more than, the level of mental-egoic meaning-making.

> Thus is the once-mysterious psyche taken out of the realm of the supernatural to join science, the search for order in nature. (p 58)

This is a reasonable statement and it sounds suspiciously like an egoic motivation to repress the sublime. It implies psyche is to be 'reduced' to fit a 'scientific' notion of nature. There is enough debate about consciousness and the brain to know that attributing the capacity for will and volition to a biologically based, mental-egoic self-system does not eliminate the need to hypothesise the existence of levels beyond that. Mind as computer is not a sufficient metaphor, because it does not satisfy existentially or spiritually. We are still left with the questions: Who/what creates the self-system? Who maintains? Who dreams the dream? You still have the ghost in the machine.

We suggest that answering these questions takes us into realms of experience beyond mental-egoic consciousness, realms which cannot necessarily be adequately conceptualised with the faculties available to mental-egoic consciousness. Such experience must be validated without pathologising spiritual experiences as regressive fantasising, or, more subtly, patronised as mature self-soothing skills. Basch seems to be doing this in his account of a client reinstating himself as a practising Catholic. He says:–

> .... [the client] could now look to his religion – a more mature, abstract, internalized source of self-object experiences – for support in times of stress. (p 232)

He does not say his client could look to God as a context for living his life – whether stressed or not. He does not say that his client was willing to engage in the process of surrendering his egoic consciousness for a more inclusive and connected sense with all that there is. Yet these are other ways of naming the choices this client seems to have made.

When we take on this context of soul-making, we need to keep alive to all the ways that our language might betray a lapse into dualistic thinking. Thomas Moore's *Care of the Soul*, a book which describes the soul-making context for

his practice of psychotherapy, illustrates the difficulties of dualistic language structures. For instance, he says:–

> .... we can respond to our own soul as it winds its way through the maze of our life's unfolding. (p xiii)

This is evocative and poetic, yet by nominalizing 'soul' he implies a separation between soul, and 'life's unfolding'. If we consider soul-making as a process rather than just as a concept, then our soul-making is our life's unfolding and our responding to it.

Moore says:–

> We can cultivate, tend, enjoy and participate in things of the soul but we can't outwit it or manage it or shape it to the designs of a wilful ego. (p xvi)

This is conceptually unclear. It is true that we have a choice about whether or not we consciously cultivate, tend, enjoy and participate in soul-making, which engages the fascinating process of will. However, if the soul is still reified as a 'thing' which we have 'options' about, the relationship of the choosing consciousness and soul remains unmapped. Is that consciousness different from soul? We suggest that it is not helpful to consider soul as partial consciousness. This is the approach of mental-egoic consciousness creating separate classification and categorisation.

If we consider soul-making as a process of the personal ground unfolding, which includes all personal things and events, and all transpersonal things and events which are cohered by an individualised sense of self, then we begin to have a unifying sense of what a human being is in the fullest possible way.

When we surrender our individual sense of boundaries, not as psychotic regression, but because we are opening to the spiritual ground of the ultimate/ infinite/God, then we can go beyond the referents of individualised consciousness to an experience of profound connectedness charted by spiritual disciplines through the ages – an experience of the Divine. We differentiate psychosis from such a surrender by the ability of the mature ego to reassert itself, function in consensual reality, and begin the process of making meaning of the experience. It is worth remembering that these experiences of profound connection, called by Maslow "peak experiences", are more common than traditional psychology's silence on this might have us believe.

Repression of the sublime is the individual's or the culture's way of protecting itself from superconscious inflow that can devastate egoic boundaries, and so it serves as a primary defence of egoic integrity. This defence can also deny the transformative potential of such a psychological event if it is not recognised as such. Repression of the sublime needs, therefore, to be positively framed as a

psychological threshold, with possible developmental ramifications. It needs to be considered, like all thresholds, as a rite of passage available only to those developmentally ready to undergo it. In this case by those ready to undergo the process of surrender of the ego-centric world view to the more inclusive context of soul-making.

Conclusion

What then are some of the dangers of having therapeutic theories which do not formatively acknowledge soul-making and spirit?

1. Limited Diagnosis

Non-ordinary states of consciousness, or altered states of consciousness range from deeply spiritual and mystical experiences through to psychotic conditions characterised by lack of insight, paranoid delusions and hallucinations, and extravagant forms of behaviour. Obviously it is important not to romanticise severe personality dysfunction, but to treat it appropriately.

However, it is equally important to identify spiritual and existential issues and not treat them pathologically. Appropriately dealt with, they are potentially transformative.

We need to have psychotherapeutic models that help to differentiate clinically among spiritual, mystical, existential, neurotic, and psychotic states; that map aetiology and level of causation, and the phenomenology of each state; and that help structure the therapeutic relationship in terms of what may best support, contain and realise the healing potential in a non-ordinary state of consciousness.

2. Avoiding the I–Thou encounter in the dynamics of the therapeutic engagement

How comfortable are we with the I–Thou relationship which challenges us not just to tolerate the unknown, but to actively to seek it as the potential of the therapeutic encounter?

And if this potential does unfold, and there is that profound meeting, how do we name and hold it? Do we try to 'executively manage' the I–Thou relationship?

In the dynamics of the therapeutic relationship we are responsible for holding a point of tension with it as it unfolds, and helping the experience be known, named and validated. Our therapeutic model should structure such awareness and help give language to it.

3. Working with Transference

The exquisite process of decoding the dynamics of the therapeutic transferences is circumscribed by the failure to include awareness of the superconscious.

What can open up for a client if transferential material is not just associated with the biological, personal mother or father, but also with basic existential dilemmas

and spiritual yearnings?

What closes down if a therapist pathologises projection of the sublime?

What happens if the I–Thou meeting is reduced to notions of parental transference?

4. Pride

There is a potential danger that if we lack an intrinsic soul-making perspective in our therapeutic approach, we may have to graft on to this approach understanding from our own spiritual path or religion. The ideal that simply acknowledging this perspective in our current modality will serve to integrate the two is naive. Our perspective informs our approach.

If our client is not of the same religion or denomination, how do we keep the content from getting in the way of the process? If we bring in our own spiritual wisdom, how does this sit with a theory of practice which fails to articulate how the spiritual issues and dynamics we may be attempting to identify are best addressed and worked with? It could limit the client to whatever our own spiritual experience has been.

This demands a lot of us in terms of our knowledge and creative skill.

We need to stay alive to spiritual pride, the impulse to pronounce upon the life journey of another.

Having a transpersonal theory that is non-religious and non-denominational gives us the safe container of a knowledge base, a guiding context and process skills.

5. The mental-egoic ceiling

A danger of not having a model of therapeutic experience beyond the mental-egoic, is that it allows us to remain at the level of mental-egoic conceptualisation.

- There is no counterpoint to our mental identification. Nor to a world view predicated on duality and polarisation.
- Heroic mythology is elevated to an absolute truth.
- The psychological experience called Death of Ego is both overtly and covertly resisted.

Repression of the sublime goes unrecognised.

Maintenance of a mind/body split can all too easily lead to denial of body oriented techniques and strategies as suitable for the practice of psychotherapy. A 'disembodied' psychology may ensue.

Therapy is considered secular and scientific only – so that numinous experience in clients is given a reductionist gloss. Or we refer out of the province of psychotherapy, when in fact psychotherapeutic skills are called for to help a client integrate their experience.

6. Over-internalisation

The last danger we want to point out arises from an over-internalised examination of self that is not connected to vital engagement with social issues and the state of the world.

A context is needed which acknowledges the relatedness of all life, within which to encourage clients to consider the deep purpose moving through their lives.

This has profound implications for psychotherapy. James Hillman and Michael Ventura have published an iconaclastic dialogue entitled: *We've had a Hundred Years of Psychotherapy and the World's Getting Worse.* In it, Hillman says:–

> We've had a hundred years of analysis, and people are getting more and more sensitive, and the world is getting worse and worse.
>
> Maybe it's time to look at that. We still locate the psyche inside the skin. You go *inside* to locate the psyche, and you examine *your* feelings and *your* dreams, they belong to you. Or it's interrelations, interpsyche, between your psyche and mine. That's been extended a little bit into family systems and office groups – but the psyche, the soul, is still only *within* and *between* people. We're working on our relationships constantly, and our feelings and reflections, but look what's left out of that.
>
> [Hillman makes a wide gesture that includes the oil tanker on the horizon, the gang graffiti on a park sign, and the fat homeless woman with swollen ankles and cracked skin asleep on the grass about fifteen yards away].
>
> What's left out is a deteriorating world.
>
> So why hasn't therapy noticed that? Because psychotherapy is only working on that 'inside' soul. By removing the soul from the world and not recognizing that the soul is also *in* the world, psychotherapy can't do its job any more. (p 3 – 4)

We think it can – but it needs to be anchored in a soul-making context that acknowledges both immanent and transcendent experience.

So it is necessary to examine the place of therapy in soul, rather than the place of soul in therapy.

We need to welcome the engagement and pleasure afforded our mental egoic meaning-making – the consciousness out of which we write this paper and you engage with the ideas presented.

And to welcome the edges of this experience, that help us stretch to more of who we are, to encourage more of who our clients are.

It may not be so bad, to stretch in this way. We will survive.

Chogyam Trungpa Rinpoche puts it somewhat mischievously: Enlightenment is the ego's ultimate disappointment.

References

Anderson, S. and P. Hopkins. (1991) *The Feminine Face of God.* Bantam Books.

Assagioli, R. (1984) *The Act of Will.* Turnstone.

Basch, M F. (1988) *Understanding Psychotherapy.* Basic Books.

Grof, S. and C. Grof (eds). (1989) *Spiritual Emergency.* Tarcher.

Haronian, F. (1974) Repression of the Sublime. *Synthesis* v 1, no 1.

Hillman, J. and M. Ventura. (1992) *We've Had a Hundred Years of Psychotherapy and the World's Getting Worse.* Harper San Francisco.

Moore, T. (1994) *Care of the Soul.* Piatkus.

O'Regan, M. (1984) Reflections on the art of disidentification. *Yearbook* v 4, 4 Institute of Psychosynthesis, London.

Wilber, K. (1983) *Up From Eden.* Routledge and Kegan Paul.

DILEMMAS OF LOVE AND DISCIPLINE IN THERAPY WITH COUPLES AND PARENTS: THE CONSTRUCTION OF THE GENDERED SELF

Bruce Hart

Abstract

Feminist contributions to systemic approaches to human behaviour have led to gender being defined in interactional terms. Gender is seen not as a fixed quality or trait but as one socially constructed between men and women. This idea is discussed in relation to the gender debate in family therapy, attachment theory and feminist contributions to psychoanalytic thinking. Gender relationships are created as part of a person's internal working models of self and other. The ways that gender patterns are carried forward are examined, especially with respect to the contradictions between a person's gendered internal working models and their experience. These ideas will be examined through case examples.

Introduction – why is gender so hard to change?

This paper was developed from my research as part of my MSc in family therapy at Tavistock Clinic in England between 1992 and 1994. Primarily, this research considered how social context influences the individual's construction of gender. This was achieved through examining the gender constructions of men who are primary carers of children and focused on the lives of single parent fathers. In general, this research supported the idea that gender is substantially shaped by social context. Therefore, it suggests that masculinity and femininity are not inherent qualities applying to all men and women respectively. A more detailed examination of the results of this study is beyond the scope of this paper as I would like to focus on the thinking about gender that evolved out of this study and its implications for practice. Though the research focused specifically on single parent fathers, I have applied the issues more generally in order to understand how gender roles are constructed and maintained in the lives of families.

This leads us to consider the question: "Why are gender constructions so hard to change?" A more controversial question is: "Why do women seem to actively participate in their own oppression, even when given the opportunity to leave or change?" This last question was raised by Virginia Goldner and her associates

at the Gender and Violence Project at the Ackerman Institute in New York. They stated in their paper *Love and Violence: Gender Paradoxes in Volatile Relationships*:–

> ...we have attempted to co-construct with our women clients an explanation of how they were 'caught' in the battering situation. We wanted to understand why these women did not leave these relationships even when they had the material means to do so ... (Goldner et al, 1990, p 356)

I'd like to build on their work and explore particular dimensions of their thinking about gender. While it will not be possible to fully answer both questions in this paper, I will begin to outline some of the ideas that may help in understanding them.

Example One

A, who presented with bulimic symptoms, found herself repeatedly involving herself with men who would either physically or emotionally abuse her. She felt that she must have an invisible tattoo across her forehead saying "doormat". Every time she moved out of these relationships into a flat with others she felt anxious, empty and out of control inside herself. She would then quickly find another man similar to the one before. She found these relationships quite familiar to the one she had with her father, who repeatedly called her fat and ugly, with sexual undertones. On one hand, she wanted these men to take control of her and yet on the other she resented this. She needed to feel loved and wanted, but felt in order to get this she needed to be dependent and hopeless.

Exploring the nature of the gendered bond between men and women will enable us to begin to understand why men and women seem to 'mutually' participate in such relationships. This concerns the way that the external socio-political context becomes internalised in the patterns of family relationships and individual self concepts formed within these relationships. I will argue it is the nature of this gendered bond, as it is split between men and women in a polarised manner, that contributes to perpetuation of the oppression of women. Understanding this process in therapy with couples and parents enables alternatives to be considered and experienced, rather than being inevitable patterns of behaving and relating.

Gender is a social construction created and maintained between men and women and not a fixed quantity that one is born with. The terms 'masculine' and 'feminine' are then seen, not as belonging to either men or women respectively, but as formed in the relationships between them. As Chodorow states:–

> To see men and women as qualitatively different kinds of people, rather than seeing gender as processual, reflexive, and constructed, is to reify and deny relations of gender, to see gender as permanent rather than created and situated. (1989, p 113)

The division of household labour between men and women within the family highlights many of these issues. The social construction of gender emphasizes the various stereotypical norms predominant in our western culture, that prescribe different roles to men and women which, in turn, reinforce the inequalities between them. In the division of household tasks, particular views of men and women are perpetuated, which contain not just the allocation of tasks but also the person's perceptions of themselves as a man or woman. These perceptions include the attitudes about what men and women should do and the characteristics ascribed to each gender. For example, men are said to be stronger and better at technical tasks and women more sensitive and to know instinctively how to care for children. Within the family context, self concept is constructed as 'internal working models' that guide and regulate behaviour. As they are carried forward to other contexts, they contain gendered aspects of self and other, that help recreate the patterns of gender relations and power inequalities in society.

I will consider social constructionist views of self, feminist contributions to systemic approaches and psychoanalytic thinking in relation to concepts of internal working models as developed by attachment theory. I will begin to link together some of the connecting points between quite divergent paradigms in order to examine internal working models as gendered social constructions. Some implications of these ideas will be explored in my struggles with the issues in practice. Feminist contributions have often been seen as women's perspectives. However, as a man I will attempt in this paper to begin to develop an inclusive both/and view of men and women in considering the gendered nature of human relationships. I hope to shift the responsibility for sexual politics from women, who have done the bulk of work in this area, to include men as well.

The social construction of self

Social constructionists consider the self as being constructed through and in language and narratives (Gergen, 1977). Our knowledges of ourselves can be viewed as social or intrepretive constructions which adapt to changing social situations, rather than being immutable characteristics or existing in some independent or objective sense (Gergen, 1977; Gergen and Kaye, 1992). Interestingly, this is Chodorow's contention as well, as quoted above, though she has been writing from a feminist psychoanalytic perspective. Knowledges of the self form a multiverse of meanings which are created through one's experiences in relation to others and social contexts. Through these self knowledges we punctuate and construct our views and experiences of ourselves and others.

Our experiences are much broader and richer than the narratives that form the constructions of the self (Bruner, 1986). We highlight aspects of our experiences as they fit with the view we have about ourselves. Our experiences are shaped by the social contexts in which we live. Our interpretations of these experiences are in turn shaped by the constructions we have about ourselves. In this way there is

an interactive process between the social constructions of ourselves and the variety of our experiences. This creates the possibilities of alternative construction of the self from the dominant models in society.

Hence, there is no real self that is waiting to be discovered by the objective other (e.g. scientist or therapist) but differing versions of the self. No one perspective is more right than the other but each exists embracing different aspects of experience. There can be more than one self as different versions of self may be perceived by the person or by others as the self evolves over time and across different contexts. Such versions may contain contradictory aspects, existing alongside each other as part of a double consciousness or alternative knowledges of self (Abrahams, 1986; White, 1991). These create alternative possibilities in what appear to be fixed roles that the self performs.

The self is a product of human exchanges, being created in relation to 'the other'. This process begins in the early formative years before the infant knows any language, then continues to be modified and reinforced in the patterns of relationships in the years to follow. This creates what could be called the 'relational self' (Benhabib, 1987) or 'intersubjective self' (Benjamin, 1988). The self, through its formation in relation to the significant other, maintains aspects of what the other does not have. The dominant presupposes the submissive, subject presupposes the object, victim presupposes the persecutor, the carer presupposes the cared for, masculine presupposes the feminine. The former of each of these qualities depends on the latter for its survival, each defined recursively with its opposite in the significant other. These views of self and other are then internalised as mental constructions or working models, which function to interpret, guide, regulate behaviour and affect in oneself and in relation to others. Thus, the idea of the socially constructed and intersubjective self is both an internal and interactional model.

The social construction of gender

The language of gender is constructed in polarised terms, such as 'masculine' and 'feminine' implying that these qualities belong inherently to either men or women respectively (Bem, 1974). Research on sex roles has found considerable variability from established norms of 'masculinity' and 'femininity' within each group of men and women (Bem, 1975; Russell, 1978). Lott (1990), in her review of the research on gender differences, acknowledges the differences found in many studies on the performance of men and women. However she argues, differences between men and women were found to be negligible when situational variables were accounted for; gender differences reflect the different social contexts and positions of men and women.

In moving away from objective views of gender traits, we can develop a social constructionist perspective of gender roles, particularly with respect to the concepts of masculinity and femininity. There is no real 'masculinity' or

'femininity' but rather multiple versions of the 'gendered self' that exist within the social and interpersonal context. The word 'gendered' is used here to describe something that is in the process of continually being created and maintained, as opposed to being a given quality in the individual. Gender becomes a fluid web of socially constructed meanings that form an interpretive guide to one's own beliefs, behaviour, relationships and expression of affect.

In our society certain versions of the gendered self, the stereotyped and polarised images of male and female, are given privilege. Our experience of ourselves as men or women is broader than the social definitions of masculine and feminine that have been created in Western society. For example, sex role research demonstrates that many men score high on femininity scores and women high on masculinity (Bem, 1975; Russell, 1978). Certain aspects of the gendered self are not given validity in the evolving constructions of ourselves, given our experience in the gender polarised society that we live in and within familial relationships that reflect it. The narratives of gender that we have internalised then serve to sift out the parts of our experience that fit within the socially dominant working models we have developed of men and women.

Even with formal commitments by society in various spheres reinforcing equality in law, employment and social conditions for men and women, there has not been a corresponding change, in personal relationships in the domestic sphere. (Coverman and Shelley, 1986; Brannen, 1988). The dominant models of gender relationships can seem inevitable and unchangeable as part of a person's 'core sense of identity', both individually and collectively (Frosh 1994, Chodorow, 1989). Frosh (1994) concludes that:–

> ... sexual difference 'is' [not] anything absolutely fixed; rather the organisation of the social world around difference produces people in relation to gender, so that what are in principle 'empty' categories (masculine, feminine) become filled with expectations, stereotypes and projections. This does not make their effects any less real: though gender distinctions may be constructed and in important senses 'arbitrary', they have a hold over us and are difficult, perhaps impossible to transcend. (p 41)

Gendered internal working models of self and other

Self concept is part of the way that individuals internally represent and carry forward patterns of relationships, particularly gender roles. The relationship between individual characteristics, which are internally represented, and family patterns has been studied by those interested in attachment theory. Building on the work of Bowlby, the idea of 'internal working models' has developed. These are:–

> a set of conscious and/or unconscious rules for the organisation of information relevant to the attachment and for obtaining or limiting

> access to ... information regarding attachment related experiences, feelings, and ideations. (Main *et al,* 1985, p 67)

Internal working models pay attention to the way that early relationships construct and transmit patterns of relationships and self concept. These are constructed out of diadic and triadic experiences (Bretherton, 1985) and view individual characteristics as being relational (Stevenson-Hinde, 1988). The way that relationship patterns have been internalised and represented as internal working models has been studied with particular reference to the way these are carried forward into behaviour and patterns of relationships in other contexts (Grossmann *et al,* 1988; Sroufe *et al,* 1988). Not only do individuals internally represent particular relationships (such as with their own mother), but also more generalised roles (such as the roles of mothers and women in general) from these specific experiences. Individuals not only internalise generalised roles, but sets of relationships, for which reciprocal behaviours are learnt.

Given that gender is a fundamental organiser of family life and relationships, then gender would also be a fundamental organiser of the internal working models. However, this idea seems to be underestimated in the development of attachment theory. Main *et al* (1985) pay little attention to gender as a variable. Radke-Yarrow *et al* (1988) relegate it to being a 'mediating factor'. The focus is primarily on the gender of the *child* in the mother[parent] – child relationship, with fathers being hardly mentioned. The influence of gender differences between the parents and the way children of different sexes internalise concepts of themselves, as male or female, are virtually ignored.

Patterns of relationships are gendered, and these are internalised or represented as 'gendered internal working models'. These then interpret, guide and regulate both behaviour and affect in relationships, particularly behaviour that men and women display in various contexts. The patterns of relationships that are internalised would reflect the gendered nature of relationships of which the individual is a part. This would include the way that gender qualities are ascribed to respective roles and relationships.

Feminist contributions to psychology have demonstrated that men and women have different ways of responding throughout the human life cycle. Men and women have developed, through their socialisation, different self perceptions, ways of relating and processes fundamental to the development of their identity and relationships, as outlined by the 'Self In Relation' theorists (Millar, 1991; Surrey, 1991) and feminist psychoanalytic theorists (Chodorow 1989). Chodorow asserts that men develop their 'core identity' primarily around the principles of separateness and autonomy, whereas women develop through attachment and relatedness.

Millar (1991) suggests that women develop 'an interacting sense of self', one which is more encompassing, in contrast to the more boundaried or limited self

concept of men. Differentiation or separation is then viewed as a particular way of being attached to others and in maintaining different and more complex ways of being in relation to others (Millar, 1991). Women in general develop stronger expressive (or what is denoted feminine) characteristics which emphasise connectedness and attachment. In a similar way, men develop stronger instrumentality (or what is denoted masculinity), which emphasises separateness and achievement (Gilligan, 1982). These characteristics develop in a polarised manner between the genders.

These dichotomies are reflected in the polarised self concepts of individuals in the way that they conceptualise themselves as either men or women. Traditionally, definitions of gender (and the gendered self) have been created in opposition to each other. Male means not being female, and female means not being male. Chodorow (1989) suggests that the process is different for men and women. She states that in the socialisation process men develop a negative identification, where they learn to be 'not female', that is, developing identity through separation from their mother. On the other hand, women develop gender identity through a positive identification, that is, in connection with the primary carer, the mother. In this relational context, the gendered self is constructed.

Aspects of what it means to be male or female are formed in these relationships and these are internalised into working models of self and other, male and female, which are continually reinforced by the environment in which they are formed and the person develops. These internal representations of self, as male and female, are understood in terms of an "active interchange with other selves" and the self as part of interchange between persons (Millar, 1991). Such models of self exist in a recursive manner with the 'other' (maintained within a social context of power and domination). The formation of these gendered self-concepts does not occur in isolation, but develops in interaction with others. This begins in the early relationships in life, as highlighted by psychoanalytic perspectives (Chodorow, 1989), and then continues to be enacted and reinforced in later relationships within the family and in wider social contexts (Goldner *et al*, 1990).

Gender as a relational quality

Gender roles of men and women often exist recursively, defining within the relationship who performs what role or maintains certain traits or personality characteristics (Sheinberg *et al,* 1991). This can be seen in the way that in marriage the man's need for emotional connection or dependency is maintained by his wife leaving him free to be more autonomous, such as in the context of work (Sheinberg *et al*, 1991). This, however, may mean that the wife is more constrained as she plays out the other side for him, such as through managing the domestic and nurturing spheres of his life. His independence or autonomy is created at the expense of her dependency, both emotionally and economically

(Stiver, 1991). Such characteristics are held in the 'other' and are therefore not developed or recognised in oneself. In this way, gender has been socially constructed to mean that being a man means not being a woman. Masculinity is sustained through defining itself as opposite to its 'other', that is femininity (Cornell *et al,* 1987). When such self definitions are created in this way masculine and feminine qualities become split and can not be contained in the one person.

If, for example, a man within the context of a relationship defines himself as being "a *man* that is not responsible for child care", then this by definition implies that *women* are responsible for childcare. Certain characteristics could also be held in 'the other' in complementary ways. In some families there is the classic divide between showing love and discipline, with the wife taking on caring and comforting and the husband taking on discipline and strength. One may contain feeling and intuition with the other containing thinking and logic. The more the other contains that quality the less one needs to develop it, or acknowledge the possibility that it may already exist within one's own repertoire of behaviours and capabilities (Sheinberg *et al,* 1991). Goodrich *et al,* (1988) state that:–

> There is no self without the other, and the challenge is to integrate autonomy and connection. One reason a man can look so enviably strong and separate is because women are playing the other side for him. (p 19)

This is describing a positive process in which the partner seems voluntarily to take on the specific gendered characteristics for the other. Simultaneously, there may also be a negative process through which the unwanted feelings are projected into the other person to contain on their behalf. One reason the man *has* to look so strong is that firstly, he may be projecting his unwanted feelings of dependency and vulnerability onto his wife and secondly, she may project her uncertain feelings about autonomy and strength onto him. The vice versa situation will exist for the women. These dynamics are among the processes through which the power relations between men and women are reinforced internally within the individual and in familial relationships.

Example two

Mr and Mrs S came to therapy concerned about the behaviour of their teenage daughter at home. The situation had become very tense which had led to Mr S and his daughter having physical fights, some seeming quite serious. Mr S said on one occasion that he felt he had gone too far and it was close to someone (i.e. his daughter) getting hurt. Mr S worked as a money broker in the city and had been working two jobs, following financial difficulties a few years previously. This was leaving him with only four hours sleep a night. The stresses on the family seemed intolerable.

Mr S said he felt very sad about the tensions with in the family. Sometimes he cried on his own about the way it had become. He felt that he had to be strong to carry his family through the difficulties they were facing, though felt that soon they would be over (i.e. with the finances). I commented that perhaps he was strong and able to carry this burden as the rest of the family was playing out the other side for him, that is the emotional, seemingly 'weaker' part. The dilemmas and costs of how the roles and tensions were managed within the family were raised with them. I considered with them the costs and benefits of investing in the different ways of managing the division of emotional roles with in the family.

Changing gendered internal working models

The research on internal working models focuses substantially on the way that continuity of the self is maintained over time, which, in turn, causes patterns of relationships to be perpetuated. Belsky (1988) and Caspi *et al,* (1988) have investigated the way that family patterns are reproduced, often leading to repetition of problem behaviour in the next generation. This research would then lead one to be pessimistic about the prospect of any change. Comparatively, less attention has been given to the ways that change, or discontinuity, in internal working models may occur.

Overall the types of events that create such discontinuities and redirect developmental trajectories are not well established. These events could then become a 'turning point' in their lives (Rutter, 1988) and a 'corrective emotional experience' (Belsky, 1988) that will change or modify their lifestyle trajectory enabling a corresponding alteration in their internal working model or gendered self concept. Working with such events in creating change is clearly the concern of therapy. Techniques such as focusing on the 'exceptions to the rule', as used by solution focused approaches, may be a way of using these discontinuities as a turning point for change.

Research might need to focus on the ways that various crises, transitions and events in a person's life expose potential for creating a 'discontinuity' of the gendered self. These are possibilities for aspects of the gendered self to be reorganised or reconstructed. The feminist movement over the last few decades has paid considerable attention to changing the gender inequalities and power relations in society, which are also enacted within the domestic roles in the family. While there has been progress, to some extent, on the rights of women in the workplace, very little appears to have changed in the domestic sphere, women on the whole working a double shift of paid work and home responsibilities, with men's participation in domestic work being secondary, voluntary and largely unaffected by their wife's employment status (Manke *et al,* 1994; Almeida *et al,* 1993). The question of change of gender roles is more vexed.

The concept of gendered internal working models of self and other brings up additional issues. Defining gender as a quality that is created and maintained

between persons, rather than as inherent traits, means that alternative constructions are possible. Using a recursive, or interactive, definition of gender means that these issues need to focus on women and men in relation to each other. Transformation of these roles requires multiple changes within the individual and wider network of significant others. Considering that qualities of the gendered self are maintained in the other, means that change in one person threatens the other's gendered sense of identity and cohesion.

In addition, the prospect of change in oneself may mean losing aspects of self held in the other. It is easy to simply label men as being more resistant and unwilling to change than women, rather than understand the broader nature of such change. In the light of this analysis, the idea that men are objecting mainly because they lose their privileged position is rather simplistic. They are losing, in the 'significant other' the ability to maintain the aspects of self which they have contained within these relationships (Benjamin, 1988). Loss of the 'feminine other' for men (through their partner changing) means losing the essential (feminine) parts of themselves. The irrational rage that sometimes emerges as this is threatened demonstrates the fundamental nature of this change for themselves and the ways these crucial aspects for the maintenance of the male gendered self are contained in these relationships.

The complementary position exists for women in relation to men. It may begin to explain why women who have been abused often repeatedly involve themselves with violent partners and refuse to leave them (Benjamin, 1988). One of the difficulties for the feminist movement is that women sometimes appear to participate actively in their own oppression, even when given the opportunity to leave or change. This is not to deny the oppression of women, but rather to begin to deconstruct the contradictions that maintain such oppression. This might provide a basis to enable us to find ways in our work with men and women in families for dealing with the problems and abuses of power that can characterise gender relations. It might help us to understand why it has been so difficult to change gender roles within families and society.

Implications for practice

More positive and proactive responses from men in addressing the issues of gender inequality and men's roles in families, with a broad gender sensitive or feminist perspective, have recently been forthcoming (Allen *et al*, 1991; Reimers *et al*, 1990, Neal *et al*, 1991; Meth *et al*, 1990).

The crisis that brings families to therapy may be considered as a possible discontinuity or contradiction between a person's experience and their own internal working model of 'self and other'. This crisis may create a turning point in which the family may be more open to explore their own sexual politics as it relates to their difficulties. The assumptions that individuals within families hold about gender relationships and the way that the 'gendered self' is created in a

recursive manner between each other, become part of the family drama enacted before the therapist.

Families' difficulties frequently present at life-cycle transitions. These are times when established patterns of relationships may undergo change which involves a renegotiation of roles and relationships (Carter and McGoldrick, 1989). This challenges the old scripts or beliefs that have guided behaviour and the patterns of interaction (Byng-Hall, 1988), including those beliefs about gender roles (Burck and Daniels, 1990). Transitions and changes within the family structure will bring to the surface tensions through which these premises may be challenged by the therapist and renegotiated. Merely urging men to help out with more housework and childcare tasks would be too simplistic, though it is a useful start, and does not fully address the complexities of human relationships. All too often the performance of such tasks is within the framework of meaning that they are 'women's work'. In this way the assumptions and gender premises are not changed and inequalities in the relationship remain unchallenged.

Contributions from attachment theory, as discussed above, demonstrate the way these patterns are perpetuated across generations. Byng-Hall (1991) has used the concept of the family script as a way of applying attachment theory to family therapy. In the same way 'gender scripts' can be a way of applying the concept of 'gendered internal working models'. Exploring the patterns of gender relations in the family of origin can highlight the unspoken gender scripts, the ways these are enacted. Working with these tensions and incongruities between lifestyle and beliefs, lived experience and idealised images creates a potential for changing gendered self.

These gender scripts are not only patterns of acting, but qualities assigned to male and female roles within the family and ways of expressing affect. Fears of vulnerability, issues of intimacy and open expression of feelings are examples of such gendered qualities that are often assigned to one or other of the partners. Identifying the polarised manner in which these have been created and held in the other, enables the recursive nature of these qualities to be tracked in the family dialogue about their difficulties. Valuing the importance of each quality in each person, enables the dispute over who is right or wrong to be sidestepped, thus creating room for each to manoeuvre and consider. Creating greater flexibility in the gendered roles within the family gives them greater scope to resolve their difficulties. As Goldner *et al* (1990) state:–

> ...abuse and coercion exist with understanding and friendship in a unique and painful way. When the paradoxical terms of this gendered bond are clarified and critiqued, the freedom to change the terms of the relationship or to leave it behind becomes possible. (p 363)

Example three

Mr and Mrs C were referred for therapy by the local Community Medical Officer, because the parents were concerned about their fourteen year old son's bed wetting and behavioural problems. Simultaneously, the parents had contacted social services to have their son accommodated in foster care as they felt he was outside their control. Social services informed the clinic that there had been a long history of physical abuse by the husband on his wife and the older daughter. It was suspected that the son was also being abused. A couple of sessions after they started therapy, they admitted that Mr C would "go over top when things got tense". In the session I observed that the husband expressed the anger and the wife the sadness about what happened to their son. I identified a similar split in expressions of love and discipline at home. Here I was beginning to identify the recursive nature of the gender patterns in the family.

In Mr C's family his father had been an alcoholic. He was a very abusive man who had no time for his children, except for discipline in which he was punitive and violent. Mr C said that he did not want to repeat the patterns of his father and was extremely upset at himself when this occurred. He was scared that his son was beginning to be just like him in the way he would explode at times of stress. Like his father he found himself stepping in to make up for his wife's leniency in managing the children. The more punitive he was, the more lenient she would be. They felt trapped in this pattern of reciprocal behaviour. This highlights a three generational replication of the old family scripts or internal working models. From his early experiences Mr C had internalised a gendered model of himself as a man who guided the patterns of relationship and his self concept in the present time.

In their couple relationship they had created between them mutual and exclusive definitions of what it meant to be a man or woman along traditional gender lines. Each was maintaining in the other qualities that both recognised as being important for their family. Frequently they battled over this division: she would accuse him of being too harsh and he accuse her of spoiling their son. These polarised definitions of themselves and their gendered qualities (love versus discipline, or leniency versus harshness) became fixed so that both attributes could not be contained in the one person. The lack of flexibility in these definitions contributed to the family difficulties.

I connoted both sets of qualities positively. The dilemmas of the gender split between husband and wife and the reciprocal split of discipline and love were raised with the family. He identified occasions when he had been more loving and closer to his children and how much he enjoyed it. However, he and his wife then dismissed them as insignificant as he had not been able to follow them through. I (as a male therapist) challenged their view of the insignificance of these occasions. It may have been important, in this case, that it was a male therapist

who challenged the father and positively affirmed the new idea of himself as a father and a man. This appeared to assist Mr C to take responsibility for his violent behaviour. Mr C *wanted* to be a different kind of man from his father, one who was more loving and closer to his children. This may be described as a double consciousness or an alternative knowledge of himself as a father and a man. As this did not fit with the dominant view he had of himself it was then put aside as invalid information.

I suggested that Mr and Mrs C discuss the ways they might be able to share these roles rather than solely leave them with one or the other. Mr C would need to consider how he could share the discipline (and power) with his wife, so that he could be freer to find ways of discovering aspects of himself (as a loving father). For Mrs C, I suggested she consider how she could share with her husband the loving or nurturing aspects of the care of the children and begin to discover ways of taking on a stronger role. In this way Mr C would be able to continue to discover and validate these aspects of himself as a man, that had been seen on occasions. In this way, the recursive nature of the gender scripts were identified in the patterns of interaction that inscribed the particular qualities, often defined as 'masculine' and 'feminine', which were assigned in this family to the men and women respectively. Different formulations of these were re-labelled as being different ways of being a man or a woman.

Change with Mr C required a reciprocal change in his wife. They had to change the mutual definitions of self that they had maintained in the other person. Understandably, this was a delicate process and the potential was high for significant loss if the other person did not reciprocate. The risks and dilemmas were discussed with them, including the risks to their son if they continued in the same way. The dilemmas of change or not changing were weighed up with the family in the form of a debate going back and forth. This drew on the idea of the dilemma of change as highlighted by Papp (1983).

While at the foster care placement, the son's behaviour changed: the bed wetting and stealing stopped and his behaviour became more manageable. However, he reverted to being difficult to control on his weekend visits. The relationships within the family began to change soon after Mr C took his son out for the weekend – something he did not usually do. Mrs C found that she was more effective in following through in disciplining her son, as well as the two younger children. After further therapy their son returned home and follow up six months later indicated he was doing well. While the family may still be described as being traditional in their division of household labour, there appeared to be greater flexibility in the roles they ascribed to each other and in their ways of handling them.

Conclusion

In this paper I have tried to explore and link together ideas from quite different perspectives: attachment theory, social constructionist, and feminist contributions to systemic and analytic thinking. Despite areas of commonality there are numerous difficulties in bringing together such divergent paradigms, such as the incongruities in language and their modernist or postmodernist assumptions. Attempting to compare the similarities and differences between such divergent orientations is beyond the scope of this paper and further work is needed to deal with the inconsistencies between them.

I have suggested that it is essential to develop gender sensitive perspectives on men's issues, particularly regarding change for men. This is not to displace the focus on power and inequality that, quite rightly, has been brought to the forefront by feminist contributions, especially in the area of violence within the home; rather I have sought to integrate these views. In order to address the difficulties of changing gender stereotypes, further thinking needs to consider the ways that gender qualities or self concept are first constructed and internalised within the individual in their formative years from the influence of the early bonds, which is a different process for male and females. Secondly, it needs to consider the ways gender is maintained within the network of relationships in which they are imbedded in later life. This may begin to help us understand the seeming inevitability of the patterns of gender relations and inequalities in society and family relationships in order to begin working at ways of changing them.

This paper is an abridged version of a paper in the *Journal of Family Therapy* v 18 no 1, 1996, p 43 – 60) "The Construction of the Gendered Self". Reproduced with permission.

References

Abrahams, R D. (1986) Ordinary and extraordinary experience. In V W Turner and E M Bruner (eds) *The Anthropology of Experience.* Chicago, University of Illinois Press.

Allen, J and J Laird. (1991) Men and story constructing narratives in therapy. In M Bograd (ed) *Feminist Approaches for Men in Family Therapy.* New York, Hawthorn Press.

Almeida, D M, J L Maggs and N L Galambos. (1993) Wives employment hours and spousal participation in family work. *Journal of Family Psychology* v 7 p 233 – 249.

Belsky, J. (1988) Child maltreatment and the emergent family system. In K Brown, C Davies and P Stratton (eds) *Early Prediction and Prevention of Child Abuse.* Chichester, John Wiley and Sons.

Bem, S. (1974) The measurement of psychological androgyny. *Journal of Consulting and Clinical Psychology* v 42 p 153 – 162.

Bem, S. (1975) Sex role adaptability: one consequence of psychological androgyny. *Journal of Personality and Social Psychology* v 31, p 634 – 643.

Benhabib, S. (1987) The generalised and the concrete other. In S Benhabib and D Cornell (eds) *Feminism as Critique: Essays on the Politics of Gender in Late Capitalistic Societies.* Cambridge, Polity Press.

Benjamin, J. (1988) *The Bonds of Love: Psychoanalysis, Feminism and the Problem of Domination.* London, Virago.

Brannen, J. (1988) Dual earner households in Britain after the birth of the first child: some findings from a major research study. *International Journal for the Advancement of Counselling,* v 11, p 293 – 304.

Bretherton, I. (1985) Attachment theory: retrospect and prospect. In I Bretherton and E Waters (eds) *Growing Points of Attachment Theory and Research.* Monographs of the Society for Research in Child Development, Serial no 209, 50, p 3 – 35.

Bruner, E M. (1986) Ethnography as narrative. In V W Turner and E M Bruner (eds) *The Anthropology of Experience.* Chicago, University of Illinois Press.

Burck, C and G Daniels. (1990) Feminism and strategic family therapy: can mixed marriages work. In R J Perelberg, and A C Miller (eds) *Gender and Power in Families.* London, Routledge.

Byng-Hall, J. (1988) Scripts and legends in families and family therapy. *Family Process* v 27, p 167 – 179.

Byng-Hall, J. (1991) The application of attachment theory to understanding and treatment in family therapy. In C M Parkes, J Stevenson-Hinde and P Marris (eds) *Attachment Across the Life Cycle.* London, Routledge.

Carter, B and M McGoldrick. (1989) Overview: the changing family life cycle: a framework for family therapy. In B Carter and M McGoldrick (eds) *The Changing Family Life Cycle: A Framework For Family Therapy.* 2nd edition, Allyn and Bacon.

Caspi, A and G H Elder. (1988) Emergent family patterns: the intergenerational construction of problem behaviour and relationships. In R Hinde and J Stevenson-Hinde (eds) *Relationships Within Families: Mutual Influences.* Oxford, Clarendon Press.

Chodorow, N. (1989) *Feminism and Psychoanalytic Theory.* New Haven, Yale University Press.

Cornell, D and A Thurschwell. (1987) Feminism, negativity and intersubjectivity. In S Benhabib and D Cornell (eds) *Feminism as Critique: Essays on the Politics of Gender in Late Capitalistic Societies.* Cambridge, Polity Press.

Coverman, S and J F Shelley. (1986) Change in men's housework and child care time, 1965 – 1975. *Journal of Marriage and the Family* v 48, p 413 – 422.

Frosh, S. (1994) *Sexual Difference: Masculinity and Psychoanalysis.* London, Routledge.

Gergen, K. (1977) The social construction of self knowledge. In T Mischel (ed) *The Self: Psychological and Philosophical Issues.* Oxford, Basil Blackwell.

Gergen, K J and J Kaye. (1992) Beyond narrative in the negotiation of therapeutic meaning. In S McNamee and K J Gergen (eds) *Therapy as Social Construction.* London, Sage.

Gilligan, C. (1982) *In a Different Voice: Psychological Theory and Women's Development.* Mass, Harvard University Press.

Goldner, V, P Penn, M Sheinberg and G Walker. (1990), Love and violence: gender paradoxes in volatile attachments. *Family Process* v 29, p 343 – 364.

Goodrich, T J, C Rampage, B Ellman and K Halstead. (1988) *Feminist Family Therapy: A Casebook.* New York, W W Norton.

Grossmann, K, E Fremmer-Brombik, J Rudolph and K E Grossmann. (1991) Maternal representations as related to patterns of infant-mother attachment and maternal care during the first year. In R Hinde and J Stevenson-Hinde (eds) *Relationships Within Families: Mutual Influences.* Oxford, Clarendon Press.

Lott, B. (1990) Dual natures or learned behaviour: the challenge to feminist psychology. In R Hare-Mustin and J Marecek (eds) *Making a Difference: Psychology and the Construction of Gender.* New Haven, Yale University Press.

Main, M, N Kaplan and J Cassidy. (1985) Security in infancy and adulthood: a move towards the level of representation. In I Bretherton and E Waters (eds) *Growing Points of Attachment Theory and Research.* Monographs of the Society for Research in Child Development, Serial no 209, 50, p 66 – 104.

Manke, B, B L Seery, A C Crouter and S M McHale. (1994) The three corners of domestic labour: mothers, fathers and children, weekday and weekend housework. *Journal of Marriage and the Family* v 56, p 657 – 668.

Meth, R L and R S Pasick (eds). (1990) *Men In Therapy: The Challenge of Change.* New York, Guilford.

Millar, J B. (1991) The development of women's sense of self. In J V Jordan, G A Kaplan, J B Millar, I P Stiver and J L Surrey (eds) *Women's Growth in Connection: Writings From the Stone Centre.* New York, Guildford Press.

Neal, J H and A J Slobodnik. (1991) Reclaiming men's experience in couple's therapy. In M Bograd (ed) *Feminist Approaches for Men in Family Therapy.* New York, Hawthorn Press.

Papp, P. (1983) *The Process of Change.* New York, Guilford,.

Radke-Yarrow, M. (1988) Attachment patterns in children of depressed mothers. In CM Parkes, J Stevenson-Hinde and P Marris (eds) *Attachment Across the Life Cycle.* London, Routledge.

Reimers, S and B Dimmock. (1990) Mankind and kind men: an agenda for male therapists. *Journal of Family Therapy* v 12, p 167 – 181.

Russell, G. (1978) The father role and its relation to masculinity, femininity, and androgyny. *Child Development* v 49, p 1174 – 1181.

Rutter, M. (1988) Functions and consequences of relationships: some psychopathological considerations. In R Hinde and J Stevenson-Hinde (eds) *Relationships Within Families: Mutual Influences.* Oxford, Clarendon Press.

Sheinberg, M and P Penn. (1991) Gender dilemmas, gender questions and the gender mantra. *Journal of Marital and Family Therapy* v 17, p 33 – 44.

Sroufe, L A and J Fleeson. (1988) The coherence of family relationships. In R Hinde and J Stevenson-Hinde (eds) *Relationships Within Families: Mutual Influences.* Oxford, Clarendon Press.

Stevenson-Hinde, J. (1988) Individuals in relationships. In R Hinde and J Stevenson-Hinde (eds) *Relationships Within Families: Mutual Influences.* Oxford, Clarendon Press.

Stiver, I P. (1991) The meaning of dependency in female-male relationships. In J V Jordan, G A Kaplan, J B Millar, I P Stiver and J L Surrey (eds) *Women's Growth in Connection: Writings From the Stone Centre.* New York, Guildford Press.

Surrey, J I. (1991) The "self in relation": a theory of women's development. In J V Jordan, G A Kaplan, J B Millar, I P Stiver and J L Surrey (eds) *Women's Growth in Connection: Writings From the Stone Centre.* New York, Guildford Press.

White, M. (1991) Deconstruction and therapy. *Dulwich Centre Newsletter* no 3, p 21 – 40.

TURNING AWAY OR TOWARDS

Neal Brown

A recent visit to the centre of San Francisco has left its mark on me. To be confronted continually by requests for money from the homeless and hungry on almost every street corner was disturbing. Locals tended to ignore the problem. They turned away from it; I could not.

Moses was unable to turn away from the Burning Bush. He turned towards it, took off his shoes, and realised where he stood was holy ground. The integration of spirituality and psychotherapy is holy ground.

Introduction

The Hebrews had no word for religion; they spoke of life. For them God, people and the world are all one and any one aspect could not be addressed without all the others.[1]

The topic of the integration of psychotherapy and spirituality has been with me for a number of years. Somehow it will not go away, leave me alone. It keeps coming back to take my attention. It is as if there is something beyond my conscious self that has somehow engaged me in this process, something that is beyond me, but also very much part of me.

This paper begins with two questions that focus on the human condition. The first question is "where are you?"[2] (the question asked by God of Adam.) Where is humankind today? The second question is "what is Man?"[3] (from the Hebrew) a question asked by the psalmist long ago.

Spirituality is understood to mean "a surpassing of one's boundedness and relating to a larger framework of being"[4] which, when compared with the work of psychotherapy, is similar. Both seek the same goal of wholeness and wellbeing. The work of Buber helps give focus to what wholeness and fullness of being means when he talks of there being three spheres of relation: human beings, nature, and spiritual realities.[5] These will be discussed in the context of selfobjects.

1 B Reed. *The Dynamics of Religion* Darton, Longman and Todd, 1978, p 1.

2 Genesis 3 : 9 *Good News Bible*

3 Psalm 8 : 4 *Ibid*

4 J Kovel. The Meeting of Psychoanalysis and Religion. In *Is Psychoanalysis Another Religion?* I. Ward (ed.). Freud Museum Publications, London, 1993.

5 M Buber. *I and Thou.* C. Scribners Sons, New York, 1958.

Then the writings of Symington and Bragan are presented for they offer an integration of psychotherapy and spirituality. Finally with the work of Self Psychology and selfobject function in particular, there is an attempt to highlight the importance of the evocative function of symbolic selfobjects. We stand in relation to evoking selfobjects – what is our response – to turn away or to turn towards?

The human condition

"The true hallowing of man is the hallowing of the human in him."[6]

We begin with an understanding of the focus of our attention as psychotherapist – the human condition. What does it mean to be human and what contributes to the totality of human experience?

Firstly there is an ultimate question that needs to be asked about the human condition and that is the question that God asked Adam in the Garden of Eden: "where are you?" This question needs to be asked not only of our common humanity but also of individuals within it. Answers to this question reflect the cultural view of reality that we have of our world.

One answer given is by those who adopt a dualistic view of reality in which the human being is divided into a body belonging to this natural world and the soul or spirit belonging to an unseen transcendent world which is considered of a higher order. The human relationship with God/spirit is, therefore, moderated through a special process. God does not relate to persons through means of their personality, but by a special channel.

It is into this dualistic view that the interface of spirituality and psychotherapy fits, where they only make sense in the context of their own interpretive frameworks and varieties of experience. So there is a split of the human condition into such divisions as body/soul, heaven/earth, sacred/secular, good/evil, man/woman, God/human.

With such a view of reality, the question "where are you?" is answered: that humans belong to two different worlds, one controlled by God, who has special powers, and the other the world of the body which is of less importance ("I am only human"). With such a dualism it is impossible to integrate psychotherapy and spirituality. Rather, they travel along side by side occasionally acknowledging one another, but more often than not eyeing one another suspiciously.

There are, however, three other responses to the question "where are you?" that seek to provide an answer from within the human condition where experience is seen as a whole not divided into a dualism. Firstly there is a very marked tendency by human beings to turn away from experiences that unsettle and confront us,

6 M Buber. *Hasidism and Modern Man.* Harper and Row, New York, 1958, p 31.

whether they be within ourselves or our relationships. To turn towards the pain and hurt that arises in ourselves or in close personal relationships is often too difficult and an escape is sought by creating a dualistic view of life. When we turn away we become out of touch with that which speaks to us at the depths of our being, the stirrings within – the 'still small voice'.

A second response is suggested by Symington when he describes the habitat of contemporary people as the city, where they are divorced from nature and divested of their ancient heritage. Here in this concrete jungle they are dispossessed of natural satisfactions. With no sunset, no cows to milk, distracted from establishing a more mature emotional relationship where real satisfaction is to be found, human beings are in emotional crisis.[7]

A third answer is offered by Bragan when he refers to George Steiner, who has drawn attention to the fact that since the 17th century there has been a major shift from internal to external discourse. There has been over the centuries a marked reduction in those techniques of concentrated internality like religious meditation, introspection and learning by heart, with the emphasis now being on external communication, distraction and stimulation of all sorts.[8] Such activity, Bragan suggests could be responsible for the growing alienation that is present today in people's lives. He says much greater attention may need to be given to "the articulate means of the self, the internal discourse that grounds the self."[9]

Each of these answers to the question "where are you?" highlights the growing alienation of people from themselves, from one another and the world. Such alienation, the difficulties within and between people, and our relationships with nature and the world are not only psychotherapeutic concerns, but also spiritual and religious concerns.

Traditional religion has failed to understand the nature of the human condition from a psychotherapeutic understanding. By not starting with the human condition, but with God, religion is getting further away from the inner experience of the individual and an understanding of the spiritual.

There is the second ultimate question which is as important as the first, for it also helps us to focus on the human condition. This is the question posed by the psalmist long ago as "what is Man?" (Psalm 8:4). It is necessary that we have a psychological understanding of the answer to this question and this can come from the work of Kohut and Self Psychology.

The self is made up of many parts that either fit well together, as if glued, or fall apart easily. So there can be a self that is cohesive, or fragile.

7 N Symington. *Emotion and Spirit,* Cassell, London, 1994.

8 K Bragan, *Self and Spirit in the Therapeutic Relationship* Routledge, London, 1996.

9 Ibid p 13.

The cohesive self is a structure that gives a healthy sense of self, of self esteem and well being. The cohesive self is achieved by the development of the bipolar self, where the mirroring and idealising needs are appropriately responded to, the self then develops an inner directedness and strength, enhanced by the experience of essential alikeness of someone being alongside. To enable the self to function throughout life the presence of selfobjects is required. Selfobjects both evoke the structural self and maintain the continuity of the self.

There are four main selfobject needs that the individual has that require responses from selfobjects if he or she is to be able to function as a cohesive self.

- Mirroring needs: to feel affirmed, confirmed, recognised; to feel accepted and appreciated especially to show oneself.
- Idealising needs: to experience oneself as being part of an admired and respected selfobject, where the child can look up to and merge into a stable, calm, non-anxious and protective selfobject.
- Alter-ego needs: to experience an essential alikeness with the selfobject like someone being alongside, supportive and helpful in mobilising one's talents.
- Adversarial needs: to experience the selfobject as a benignly opposing force who continues to be supportive and responsive while allowing or even encouraging one to be in active opposition and thus confirming, and at least partial autonomy.[10]

Selfobjects are intrapsychic events that are not observable from the outside. They are subjectively experienced in the inner space and they also help to create that inner space. A healthy mature self needs a constant supply of selfobject experiences that help self-evoke and self-maintain throughout life. The form of these will change with the self's development: from the child who needs a self-evoking experience with a real live person who provides tuned-in empathetic responses; to the adolescent who needs self-sustaining experience with real objects or with symbols such as clothes, music, idols; to the adult who needs a self-sustaining experience with real objects or with symbols such as provided by art, literature, music, religion, sculpture and poetry.

According to Self Psychology, the human condition is made up of a self-structure that continues to require selfobject functions of mirroring, idealising, adversarial and twinning (alter-ego) throughout life if it is to maintain a coherent self. Important is the presence of the selfobject that evokes and maintains the self structure. It is my view that selfobjects evoke, and call the self into being more often than we realise, not only within the therapeutic setting but also in significant experiences with spiritual realities in relation to nature, and the world.

10 E Wolf. *Treating the Self* Astam Books, London, 1988.

Spirituality

> "Man cannot approach the divine by reaching beyond the human; he can approach him through becoming human."[11]

Spirituality today refers to a dimension of human consciousness which cannot find adequate expression in the physical, intellectual or material world. The human condition is such that humans in and of themselves feel incomplete in some way. There is a sense of being unfinished, unfulfilled, a longing for something extra, a search for the true self.

This yearning seeks expression in many areas of life, but particularly in religion, spirituality, and psychotherapy. Because such a yearning cannot be satisfied through the material world alone, we feel called to something higher and yet something deeper at the same time. We are called not only to the depths of ourselves but also out and beyond our normal level of functioning. This yearning is a central part of growth and development which lifts and motivates us to action, provided there is not a major deficiency of the self causing pathological behaviour to occur. Where there are minor deficiencies in the self this yearning provides the essential drive for growth.

Kovel defines spirituality as : " The practical creation of spirit where spirit is what transpires when the self experiences a surpassing of its own boundedness and relates itself to a larger framework of being."[12] This describes something of both the spiritual and psychotherapeutic processes. In order for there to be a surpassing of boundedness there is a requirement for the presence of a selfobject that helps create a relationship whether it be a person, a symbol in nature or the world. Buber says : "Relation is the key to personhood. All real living is meeting. The essence of what it means to be human is not found in the individual being, but in the personal relationship that exists between human beings."[13] He sees the world of relation taking place with people, with nature, that often is beneath the level of speech, and with spiritual realities. It is on these three spheres of relation that we will focus in seeking to understand the move from boundedness into a larger framework of being and how this brings about a spiritual experience of 'being in the spirit.'

Psychotherapy

The word psychotherapy is interesting when it is seen as psyche meaning soul or spirit, and therapist as servant, giving us "servant of the soul."[14] Soul means breath, the essential self, a sense of identity, wellbeing and wholeness. Described

11 M Buber. *Hasidism and Modern Man.* p 13.

12 Kovel. p 19.

13 Buber. *I and Thou,* p 11.

14 D Benner. *Psychotherapy and the Spiritual Quest.* Hodder and Stoughton, London, 1988.

in this way psychotherapy clearly has a close connection with the yearnings of the self for fulfilment. Psychotherapy thus has a wider view of the human condition than purely to do with psychopathology.

In the clinical setting there is a desire by the client to surpass their boundedness and relate to a larger framework of being. By entering into the hurt and pain, and the despair that occurred during the early stages of development such a process begins to take place.

A client in his mid 50s contacted a therapist in London as a result of pressure at work. A Christian counsellor had been asked for so that the client's faith would be respected. A's aim for the sessions was that he would have stopped biting his finger nails by the time therapy finished.

A's father had been a pacifist and as a result of his refusal to serve as a soldier during the War he was imprisoned in a camp some distance from his home. A was four at the time the separation occurred. The loss of his father was compounded for him by the abuse and punishment he received at school where everyday he had to run the gauntlet of verbal and physical violence.

The symptoms he developed as a result of such treatment were bedwetting, poor sleep patterns, nightmares and a withdrawal into himself. In his late teenage years A became a Christian and the church became an important container for him.

Over the years the repressed material would erupt in him causing him real concern for he felt it was most unlike him. He later prayed and was prayed over that the Holy Spirit might heal him – to no avail. He admitted that his "Christian overlay", as he described his faith, had not been able to touch the depths of his despair.

The Christian overlay is a good example of the horizontal split, in which the inaccessible repressed material, while influencing his behaviour, was not available to him. It began to express itself in the transference with him becoming annoyed with the therapist for wasting his time and money – "we are not getting anywhere". A was able to surpass a fraction of his own boundedness of behaviour to be open to a larger framework of his own being to include areas of the unconscious behaviour and thus become more integrated with some of his unconscious self. This could only be allowed to happen within a framework that included the recognition of his worldview plus also the worldview of psychotherapy. He became much more able to respond with how he felt and at the end of the therapy he had stopped biting his finger nails.

Each moment of integration in an individual's life, of the coming together of body, mind and soul, is an experience of moving towards wholeness. Buber has described it as: "the unification of the soul meaning the whole man, body and spirit and soul together. The soul is not really united unless all energies, all limbs

of the body are united."[15] Thus, as an individual becomes more integrated, and more united with themselves, the more present soul or spirit is. For soul/spirit arises out of the coming together of being.

It then becomes clear that there is a very close connection between psychotherapy and spirituality. For the greater the sense of self, of self confidence and identity, all very much part of the psychotherapeutic process, there spirit is. Such a view of spirituality is based upon the human condition. This is our starting point, not God. When beginning with the human condition it is possible to think about integrating psychotherapy and spirituality because both are seeking the same end – the development of the individual to his or her fullest potential, to wholeness of being.

Such wholeness of being does not happen to an individual in isolation. It happens in relation to self, other, nature and the world. As the individual interacts in the three spheres of relation acting as selfobjects, experiences occur that call forth from the self a response to a larger framework of being. But often people turn away from the 'call into being', they ignore the homeless even though there is an inner stirring. The holy ground on which they are standing becomes too uncomfortable and they prefer to stay within their own boundedness.

Spirituality and the human condition

> "People say that what they are seeking is meaning for life. I don't think that's what we're really seeking. What we're seeking is an experience of being alive."[16]

Much of the literature in the area of psychotherapy and spirituality attempts to adapt spirituality to a particular psychotherapeutic theory, or to tack it onto one without any real integration. There has been no real attempt to produce an adequate spirituality in either case.

Most writers have moved from the individual as a self-contained system to an interaction of the self with another, but usually their spirituality revolves around a view of God as a revealed deity that enters human experience from outside the human condition.

Symington and Bragan have different ways of integrating psychotherapy and spirituality. Symington[17] says that traditional religions fail to meet modern human beings where they are. They are struggling to make sense of the emotional space between people. It is this interpersonal interpsychic connection that is the focus of Symington's work. Crucial to his argument is the distinction he makes between revealed/primitive religion and mature or natural religion.

15 M Buber. *Hasidism and Modern Man.* p 151.

16 J Campbell. *The Power of Myth.* Doubleday, New York, 1991, p 4.

17 Symington.

Revealed religion is based on the belief that God revealed himself and his law to human beings and the essence of such a religion is worship of God by those human beings. God, not human beings, is the focus of such religion. Mature religion is concerned with how we should live and act towards our neighbour and towards ourselves: "the area where religion is required to exist ... is in the emotional space between people,"[18] particularly "in the emotional confrontations with the analyst"[19] which is the greatest spiritual encounter. Mature religion has as its foundation stone conscience. He says: "when I listen to my conscience I am attentive to a principle within me but which at the same time extends beyond me ... something has a claim on me which is at the same time greater than me."[20]

Here the words "extends beyond me" and "greater than me" fit well into the larger frame of reference of spirituality. However, when Symington wants to base his spirituality on the work of Socrates and reason, such a spirituality becomes very rational "my guiding star is the belief that there is a religious truth which can be established through reason."[21]

So for Symington mature religion becomes a mental discipline based on reason that seeks to focus on core values of compassion, truth and goodness, and seeks to answer the ultimate questions of "what is the purpose of human beings?", "what is the meaning of life?", and "how do men and women find fulfilment?" Symington's spirituality is intentional, with no place for revelation. Such a view of spirituality is based more on seeking meaning, rather than seeking an experience of being alive, of 'being in the spirit'. He does, however, seek to provide an integration of psychotherapy and spirituality in a very comprehensive way.

Bragan's *Self and Spirit in the Therapeutic Relationship* centres on the clinical relevance of the self with particular reference to Kohut and the place of Self Psychology, the role of inner experience, and the importance of empathy and how it relates to the spiritual. Buber is central to Bragan's thinking, for Buber's idea of the I–Thou allows relating to enter into the world of the spirit. In talking about the I–Thou relationship Bragan says "when man participates in an encounter of reciprocity he meets his Thou and lives in the spirit."[22] This I–Thou reciprocal relationship has within it the ingredients of living in the spirit, empathy and reciprocity, which then make it possible to meet the Thou and live in the spirit.

Bragan defines spirituality:–

18 Ibid p 26.

19 Ibid p 130.

20 Ibid p 155.

21 Ibid p 47.

22 Bragan. p 11.

> I start simply from the reality of transcending and include such concepts as awareness, timelessness, unknown, and this can only come about when there is an integration that unites all values and organises all experiences. Such freedom and integration is what makes personhood, and 'being in the spirit' is the open and free reaction of the whole person – body, mind and spirit – to reality as a whole.[23]

So there is an integration of the person. The unfulfilled, the longings, yearnings and hunger are for that moment fulfilled by a process of turning towards the dark or shadow side of the self and accepting all of what we are. At the same time this fulfilment is only possible within an encounter of reciprocity. Buber gives the example of the mother and child relationship which for Bragan illustrates a "real spiritual connectedness when the mother and child are with each other in open communion."[24] Such communion Bragan says "is a whole person relatedness which is completely natural and free of all contrivance, and it requires the term of mysticism to do it justice."[25]

It is into this relationship of reciprocity that an extra mystical dimension comes. Each participant senses and sees the reality of the other and speaks from the truth of the self. Bragan says that for such authentic relating to happen the transference at the time must be transcended, all prejudice and wishful thinking be shed.

> Such times of clarity can only be brief, but when they do happen, and to this is added an acknowledged mutual tenderness, then does the spiritual side of a relationship start to grow, and such growth tends to stabilise and strengthen the self so that the potential for reciprocity increases. The stronger the self, the greater is the possibility of reciprocity.[26]

It is clear that from these "moments of mutual tenderness" two results follow: the enabling of the spiritual side of the relationship, and strengthening the sense of self, resulting in the possibility of 'being in the spirit'. Such a view of spirituality certainly agrees with Campbell, who says that what we are seeking is an experience of being alive.

S is a 28 year old artist who occasionally brings paintings to the sessions. On one particular day she brought four paintings of herself. We talked about what they meant to her. The conversation drifted away from the paintings to life in her flat. On a number of occasions my attention was drawn to the painting of her as a four year old holding a doll. I brought the conversation back to this painting and to

23 Ibid p 93.

24 Ibid p 10.

25 Ibid p 82.

26 Ibid p 92.

the pleading, imploring eyes of the doll. The doll looked lonely and was pleading for someone to recognise and notice her. The painting was a wonderful expression of herself both as a child and as an adult. "People don't see me" she said.

My being able to mirror her need for acceptance and recognition, to see and hear her, resulted in a connection being made with her. There was a brief moment when in the meeting of our eyes, a significant encounter took place: our two beings were sufficiently free of the restrictions of our roles to allow a uniting of mind, body and spirit. In that moment a relation of I–Thou occurred.

The painting became a selfobject for me, calling me forth, evoking a response. I in turn was able to be a selfobject for her, calling her forth into a reciprocal meeting of our wholeness. Such an experience strengthened our relationship by our turning towards one another.

For there to be such an 'integration that unites all values and organises all experiences' individuals are called to be responsible for those aspects of themselves that they did not bring about and cannot be held responsible for, but which are theirs now. Bragan uses the term 'agency' to include accepting such responsibility, for taking initiatives and exercising some control over personal interactions. Such a view certainly broadens our boundaries into a larger framework of being for potential responsibility.

One aspect of what Bragan calls 'expanded spiritual awareness of transcendency' which includes the whole of reality, links with Buber's three spheres that unite us with a larger framework of being. Bragan offers the most useful model in integrating spirituality with psychotherapy that is based on clinical experience and also on an experience of being alive – 'being in the spirit'.

By continuing to focus very much on the emotional space between people and also the other two spheres of relating, I want to explore further the selfobject function in spiritual experience. What is being described is very much a natural spirituality compared with a supernatural one.

Called into Being

> "The primary word I–Thou can be spoken only with the whole being. Concentration and fusion into the whole being can never take place through my agency, nor can it ever take place without me."[27]

Selfobjects provide a function of self-evoking and self-maintaining of the self-structure. There is a continuous ongoing need throughout life for such selfobject function. Individual selfobject mirroring, idealising, alter-ego and adversarial needs do not disappear with maturation and development. They become more diffuse and less personalised, however. As adults these selfobjects become

27 M Buber. *I and Thou.* p 11.

symbolised as the inner world is cultivated and becomes even more important as a means of evoking and maintaining the self as greater internal strength is developed. These symbolised selfobjects are representations of the original self-evoking and maintain experience. Individuals can experience the use of selfobject functions without the use of another person, they can be self-initiated and can be sustained outside the therapeutic relationship.

The self-evoking function of selfobjects is not only possible within a personal relationship, but also in the other two spheres of relation that Buber names, nature and spirit. For example, after five days on a retreat at Four Springs in California I was walking the main trail which was about an hour in length. All of a sudden I came upon an oak tree that stood in all its grandeur. Somehow it invited me to itself. I hugged it. I felt at one with it as it radiated energy from itself to me. For a moment in time all stood still, there was a unity of spirit.

Such an experience begins from beyond the self. This meeting with the tree began with the tree meeting me. As Buber says "the Thou meets me. But I step into direct relation with it. Hence relation means being chosen and choosing..."[28] Such an experience begins with an outer stimulus that evoked something in me. This function is more than a thing, an it, rather it is a Thou. There is a certain quality to the encounter. Buber says relation means being chosen which is an interesting way to think about selfobject function, that we are chosen, called, by some symbolic selfobject, into relation with it.

A second step to this encounter is that we have to respond. We need to choose to step into direct relation with it so that it becomes a two-way encounter, an I–Thou relation. It is, of course, possible to turn away from, and not towards the tree, in which case there is no reciprocity, no self-evoking, and no self-maintaining.

In this encounter there is genuine meeting of one with the other which is greater than the sum of the two parts. In the brief moment of time, when there is unity of spirit an extra dimension is present. The other, the Thou, the Holy Other, the Holy One, the mystery is present. Bragan described such a moment of being as "I meets Thou and lives in the spirit" and Buber the "fullness of being".

The third sphere of relation is that of spiritual realities. In this Buber saw that there is a spiritual character to various art forms such as music, painting, sculpture, poetry and drama. The art form manifests some kind of living presence drawing the viewer into reciprocity which is characteristic of the I–Thou mode of existence. These art forms are selfobjects that evoke the self into being in the same manner as that of human beings or nature. So when the I–Thou mode of existence is present there is a reciprocity and also the coming together of the two poles of the encounter. In such an encounter 'being in the spirit' is the result.

28 Ibid.

As we saw in the question "where are you?" there is a real external orientation and alienation of the individual with themself, between each other and the world in which they live. Is this because the selfobjects that helped evoke and maintain the self-structure in the past no longer call people forth, or is it because people turn away from that which confronts them? It is probably both.

Campbell says that the myths of the past helped unite mind, body and soul. These no longer perform such a function. He suggests we need to find new myths and stories that will unite mind, body and soul.[29] Certainly many of the selfobjects provided by the Christian church seem to have lost their evocative selfobject function, with the result people seem less cohesive today.

The other factor is the response of turning away from the self-evoking function of, for example, the homeless, or the tree, and hence not choosing to respond to being chosen by the Thou. The words 'hardness of heart' somehow seem to apply. There is an unwillingness to acknowledge or take seriously the inner stirrings, the 'still small voice'. Our culture encourages external focus and lack of introspection and therefore there is a danger of losing our essential being, our soul.

To have the feeling of being chosen, called forth, is essential to the emergence of the real self. For this to happen there is the need of selfobject experiences throughout life.

The degree to which one is able to reach a fullness of life will depend upon engaging the spheres of relation. It is possible to have fullness of being in relation to human beings, but for there to be real wholeness of being it requires that the other two spheres of life are also entered into. It is only when an individual is in touch with nature and other spiritual realities that true wholeness of being is possible. Life is more than an existence that focuses on myself and another person.

Conclusion

In seeking an integration of spirituality and psychotherapy it is necessary to begin with the human condition and a self-structure that needs the presence of selfobject function throughout life.

There is in the human spirit a yearning to be connected to a larger framework of being that is both part of the human condition, but also something that is beyond the normal level of functioning.

Spirituality arises out of being in relation to three spheres of life: human beings, nature, and spiritual realities. It is when there is a real reciprocity of meeting, a unity of mind, body and spirit with an other that an extra dimension (the other) is then present. This process comes about through the presence of the selfobject.

29 Campbell.

Selfobjects function in a way that can evoke from the person a response that is like a calling forth from their inner being.

Such an experience of 'being in the spirit' for that brief moment of time moves beyond dualism and opposites to a oneness, a wholeness which results very much in being alive. Such work belongs to the psychotherapist who is the servant of the soul.

The integration of spirituality and psychotherapy is holy ground, the realm of relation that calls us forth into a larger framework of being.

References

Benner, D. *Psychotherapy and the Spiritual Quest.* Hodder and Stoughton, London, 1988.

Bragan, K. *Self and Spirit in the Therapeutic Relationship.* Routledge, London, 1996.

Buber, M. *Hasidism and Modern Man.* Harper and Row, New York, 1958.

Buber, M. *I and Thou.* C Scribner's Sons, New York, 1958.

Buber, M. *To Hallow This Life.* Harper Brothers, New York, 1958.

Campbell, J. *The Power of Myth.* Doubleday, New York, 1991.

Geering, L. *The World of Relation.* Victoria University Press, Wellington, 1983.

Good News Bible.

Jones, J W. *Contemporary Psychoanalysis and Religion.* Yale University Press, New Haven, 1991.

Moore, T. *Care of the Soul.* Harper, New York, 1992.

Reed, B. *The Dynamics of Religion.* Darton, Longman and Todd, London, 1978.

Rizzuto, A M. *The Birth of the Living God.* University Press, Chicago, 1979.

Symington, N. *Emotion and Spirit.* Cassell, London, 1994.

Ward, I. (Editor) *Is Psychoanalysis Another Religion?* Freud Museum Publications, 1993.

Wolf, E. *Treating the Self.* Astam Books, London, 1988.

NARCISSISTIC VULNERABILITY IN MANIC PSYCHOSIS AND HOW IT PARALLELS WITH THE 'RITUAL PROCESS'

Laetitia Puthenpadath

Abstract

Anthropologist Arnold Van Gennep has studied the transformative potential of rites of passage. He identified a basic symbolic structure common in all forms of rituals. Self-psychology attempts to explain manic psychosis in terms of narcissistic vulnerability and shame. This paper reflects on the underlying similarities and contrasts between the ritual process and hypomanic episodes and draws out its implications for psychotherapy.

Introduction

Arnold Van Gennep (1909) has done extensive studies across cultures with reference to their rites of passage. He explained the significant role these rites played in the life of traditional societies that used rites of passage to structure life transitions. There are specific rituals associated with each developmental phase; pregnancy, birth, childhood, puberty, marriage and death.

Gennep came to the conclusion that there is a similar conceptual pattern in all rituals. This includes three related movements or phases, a separation phase followed by a phase of transition or liminality and a reintegration phase.

In the first movement of a rite of passage the person is separated from the ordinary social setting and is put through a symbolic death experience. As a result the individual comes face to face with themself without the cushioning effect of the symbols and structures of family and community. The individual thus enters, what Van Gennep called the "neutral zone", the second phase of the ritual process. This phase is marked by profound liminality with pronounced changes in the state of consciousness of the person.

The person is faced with incredible fears, anxieties and uncertainties. The old way of being vanishes, the new level of existence has not yet emerged. Faced with such existential dilemma, the person makes serious attitudinal changes. When the intended transformation has taken place, the individual is guided back into the social matrix of the tribe at a new level. This third phase is marked by the rites of reintegration.

Victor Turner (1969) in studying the ritual process of African tribal cultures elucidated the characteristics of liminality. In transition rites and healing ceremonies of tribal people, liminality is marked by changes in the consciousness of the group. This occurs within the framework of the tribal community, under the guidance of their spiritual leader. It is a structured experience contained within the norms of the community. It creates a safe context and provides appropriate techniques for changing consciousness. In our usual waking consciousness we experience ourselves within the boundaries of our physical body. Our perception of the external world is bound by the range of our five senses. We operate within the restrictions of space and time. In non-ordinary states of consciousness evoked by healing rituals or by hypomania a person experiences an expansion of boundaries of body–ego and the limits of space and time.

Stanislav Grof (1988) has done extensive studies on the effects of non-ordinary states of consciousness on healing. He argues that deep existential crises in a person's life could be resolved only through accessing powerful non-ordinary states of consciousness. Traditional cultures have inbuilt structures for providing such safe contexts for healing. What is appropriate in a healing ritual will not be permissible in ordinary life. For example, among the tribal people in India, when a family or community is afflicted by either physical or psychological maladies, healing ceremonies are performed to deal with the crises. Such rituals are designed to gain access into other dimensions of reality by changing the level of consciousness of the community. The behaviour of the people under these circumstances is appropriate only in the particular context of the ritual. Among Maori people there are specific healing rituals to deal with illnesses which come under the category of 'mate Maori'. Similarly Maori people mark their births and death with profound rites of passage.

Gerber (1994), in her work with Southeast Asian refugees, explored the traditional healing interventions that existed within these ethnic communities. When one of her Cambodian refugee clients began to suffer from visual hallucinations, Gerber faced the challenge of treating the entire family in a manner similar to what a traditional Cambodian healer would have done.

Straker (1994) experimented with establishing a dialogue between African healing practices and Western psychoanalytic psychotherapy. Drawing from the myths and metaphors of the tribal community, a team of Western psychotherapists worked with a group of young African women who were manifesting characteristic symptoms of Post-Traumatic Stress Disorder. The therapy was effective because the therapists were able to communicate with the clients in a manner congruent with African belief system and healing practices.

Hypomania and the Ritual Process

In modern societies there is a scarcity of rituals. Developmental phases or life transitions are approached from a logical-positivistic world-view. Often it has occurred to me that in manifested psychotic symptoms there is an underlying crisis of rites of passage. But the spontaneous and unstructured nature of these liminal experiences render them devoid of their transformative potential.

Van Gennep's phases of the ritual process can be distinguished in a hypomanic episode. The separation phase often begins with a symbolic death experience. The person perceives loss of love followed by rejection and abandonment. This frequently engenders feelings of inferiority and a lack of conviction in one's worth. The individual experiences unacceptability and unlovableness in themself. The person loses positive affect towards themself which is experienced as self-annihilation.

The separation phase is marked by increased narcissistic vulnerability and shame. Onset of a manic attack marks the beginning of liminality. This is often exhibited by defensive grandiosity and delusional thinking. The consciousness of the person is definitely altered. The individual no longer perceives themself to be bound by the laws of society. The skin-encapsulated ego consciousness expands resulting in omnipotent and omniscient behaviours. The reintegration phase is often brought about by medical intervention.

	Hypomania	**Ritual Process**
Phase 1 Separation	•Experience of object loss, rejection and abandonment; sense of self is threatened by fragmentation and enfeeblement.	•Person experiences a symbolic death, led to let go of symbols and structures and protection provided by the family and community. •Pushed to the very edge of their limits the person makes the desired attitudinal changes
Phase 2 Neutral Zone	•Consciousness is altered; person experiences delusions of grandeur, extreme excitability, dramatic behaviours etc. •No containment or safety; liminality is unstructured and random.	•Alteration of consciousness within the safe and structured framework of the tribal community, guided by the spiritual healer. •Liminality is contained and protected by the community

Phase 3 Re-Integration	•Ritual to reinstate the person as a functioning member of the society •Rituals involve hospitalisation and psychopharmacological treatment. •Deformed social position; stigma of psychiatric label	•Rituals of reincorporation into the tribal community at a higher level and at a transformed social position.

Morrison (1989) argues that genetic and biological factors alone are not sufficient to generate a major affective disorder. Bipolar Affective Disorder is understood as originating from the interaction between genetic, biochemical as well as psychological factors. Self-psychological perspective on narcissism can shed light on the psychological causative factors of hypomania. Morrison views hypomania as a compensatory defence against shame-based depression in persons who are constitutionally vulnerable. In other words a self in a state of depletion having fallen short of its aspirations and goals may evoke manic states in a compensatory effort.

Grotstein (1995) emphasises that for effective treatment of persons suffering from psychotic illnesses, an integrative approach is essential. In his view, psychopharmacology and psychotherapy need to take into account the findings of neurobiology, infant development research and trauma research. He has coined a new term to represent the inner world of persons suffering from psychoses. For Grotstein, they are "orphans of the Real" (Lacan 1978), who suffer from ontological insecurity. These persons, as children, were exposed prematurely to the world of reality before they had the opportunity to develop the protective barrier of imagination, illusion and symbolisation. As children they did not receive the early attuning relationship to shield them from the intrusive realities of life. Grotstein expands the multiple factors underlying primitive mental disorders. These persons suffer from constitutional hypersensitivity or other constitutional impairments of the central nervous system. These constitutional factors together with critically unattuned early childhood relationship, render the person an ontological orphan.

The components of the unconscious of an ontological orphan are chaotic and complex. Their unmet infantile needs assume infinite proportions. They have not been able to structure their world through a process of symbolisation which normally occurs within the maternal holding environment. The frenzy of hypomania may be seen as an attempt by the defeated self to evoke some vitality. The chaotic components of their unconscious seek integration. Primitive cultures have discovered rituals and ceremonies to achieve this at various developmental

phases. Symbolic and structured madness visible in such rituals of healing and rites of passage performs a significant integrative function in these communities.

Viewing manic psychosis from the vantage point of the ritual process would expand the conceptual framework of psychotherapy. Psychotherapy would lend itself not only to the biographical level but also to the perinatal and the transpersonal levels of the psyche.

Therapy would widen its scope to embrace not only the intra-psychic world but also would establish a dialogue between personal, inter-personal and the community and societal systems. Therapeutic technique would take into account the basic human need to enter into liminal states of consciousness. The therapist would provide a safe and structured context for experiencing altered states within the therapeutic framework.

Case illustration

Liz was a thirty year old woman separated from her husband after ten years of marriage. I began seeing her after she had recovered from a hypomanic episode. She had been under intense psychopharmacological treatment for the past four years.

Liz had suffered three episodes of hypomania beginning from the age of nineteen. The first episode occurred after she attended a weekend workshop on personal growth. The weekend had all the characteristics of a rite of passage. The participants were physically separated from their ordinary world. They entered into a field of 'communitas' (Turner 1969) where tremendous bonding of individuals occurred. The result was a deeply accepting and nurturing community where Liz was able to address some of her painful childhood issues. Liz felt warmly held by the community and her shy, self-effacing personality was temporarily replaced by a confident, positive and vibrant self. Liz began to get a glimpse of what she could be. For Liz this felt like a genuine break through. This liminal state continued for few weeks after the weekend. There were no rituals to reintegrate her into the ordinary life with her deepened self knowledge. She began to lose weight and suffered sleep deprivation. Liz became self critical and gradually became depressed. Liz did not receive any treatment but recovered spontaneously after a few weeks.

The second episode happened when Liz was twenty-seven, two weeks after she separated from her husband. There were many triggers for this episode, within the marriage and in her job over a period of eighteen months. Liz felt her husband did not value her as a person and did not pay attention to how she felt. She had a sense of being taken advantage of by her employer. Liz challenged him, but was forced to retract her complaints. The hypomanic episode began with sleep deprivation for eleven days. Liz became very labile in mood, at times excitable, at other times tearful. She experienced ideas of reference, and began to hear

'voices', which were self-destructive in content. Liz began to dress flamboyantly, over spend money and become very extroverted and theatrical.

Liz was hospitalised for five weeks and was treated with medications. She recovered gradually and under pressure from her parents the couple decided to give the marriage another try.

The third manic episode occurred when Liz was thirty. During that period Liz was employed in a very stressful job. She had to attend conferences overseas as part of her work. When she returned after one of these conferences, her husband told her that he had made up his mind to separate from her. He had made this decision unilaterally and had informed his family about it prior to Liz returning from abroad. Liz felt deeply humiliated and discounted. She left the country abruptly. While overseas she began to experience an elevated mood. She began to behave in an aggressive manner and was hospitalised.

Developmental History

Liz was the oldest of four children. She had three younger brothers. Liz was not emotionally close to her parents. She described her father as unfeeling and distant, with high expectations of her. Her parents were in conflict most of the time and Liz could not communicate with either of them. Liz felt her mother was highly critically of her, often made comments about her looks and Liz felt that she was plain and unattractive. Her father paid a great deal of attention to her brothers, but ignored her. Liz desperately needed parental approval and struggled to be a high achiever. But whatever she achieved was not good enough to get praise or recognition from her parents.

Liz had a family history of psychological problems. Her maternal uncle and cousin committed suicide. Liz was sexually abused by a neighbour at the age of eight. She was not able to disclose this to her parents. A girlfriend told her mother about the abuse, but Liz's family did not take any action. From a very young age her parents expected Liz to be self-reliant. She was expected to be strong, good and responsible. Liz grew up with a world view that she had only herself to fall back on. Liz was a good student and was academically successful. She completed high school and continued technical studies. Liz met her future husband at the age of sixteen and married him at the age of twenty-three. Her parents approved this choice, because of the stability and security the partnership provided. Liz was ambivalent about her husband; he hailed from a closed family system and Liz was not included in it. Her husband always gave first priority to his family and Liz experienced a re-enactment of her childhood loneliness. Liz and her husband did not have emotional intimacy and consequently Liz found sexual relationship with him difficult. Both of them played stereotyped roles.

Liz's personality development centred around parental expectations to conform to a high standard of achievements and social grace. Consequently Liz developed

a 'doing self' and her 'being self' (Winnicot 1965) remained hidden. As a family, they were ambitious, calculating and concerned with status and appearances. There was always the threat of rejection if Liz displeased her parents. There was competition with her male siblings for parental approval. Liz has very little opportunity to enter into interpersonal relatedness with other members of the family. She grew up feeling very alone and isolated. As an adult Liz was socially adept but role-conscious and her relationships were superficial. She had an ongoing sense of inferiority and was deeply in need of external validation. She disliked herself and was painfully self-critical.

Implications for psychotherapy

Liz presented me with a typical schizoid experience. This reminded me of a cartoon I had seen a few years ago. This cartoon depicted a person inside a shell at the bottom of the sea. The shell remained within a brick wall. The entire construction was enfolded within a tunnel. The caption of the cartoon read "if you really loved me you would find me". In therapy with Liz, this meant that I establish a relationship with her hidden self. She told me that she did not want to dwell on her past. She had been learning to be positive in her thinking and move on. Yet it seemed to me that her hidden self was seeking to be met by me. She needed me to intuit her self-needs without ever communicating them to me. It was like a typical perinatal service, an umbilical-cord mode of relatedness.

Initially I maintained this type of relationship by accommodating to her external needs. I showed interest in her career, her overseas trips and conferences. I gave her flexible appointment times while maintaining the basic weekly pattern. I set the stage for the emergence of transference by suggesting that her therapeutic relationship with me would play a key role in her therapy. I pointed out that in her sessions if she allowed herself to reveal her thoughts, feelings of fantasies and her dreams (their content as well as what prevented the revealing of content), she would begin to understand herself more. I was aware that Liz was deeply ashamed of her hypomanic attacks and the resultant psychiatric label. She hated herself for being "funny in the head", as her husband never hesitated to call her. In my therapeutic interactions with Liz I made use of my knowledge and understanding of liminality and non-ordinary states of consciousness. I reframed Liz's hypomanic psychosis as part of a healing process. I emphasised its adaptive qualities, how she was able to protect herself from feelings of enfeeblement by changing her consciousness. This enabled Liz to overcome the stigma attached to mental illness.

Due to her disposition, Liz was rendered more sensitive to painful experiences. She often felt overwhelmed by feelings of unworthiness and emptiness. Whenever she perceived abandonment or rejection Liz' internal world of relationships assumed sinister nuances. Sadistic and persecutory figures emerged in her psyche to torment her. Under such an utterly bleak psychological ethos Liz was

not capable of regulating her self-esteem from within. Deep self-doubt and shame flooded her psyche and her sense of self was shattered.

Liz had learned to cope with such psychic fragmentation by evoking hypomanic affective states. In therapy, Liz learned to maintain consciousness of what was occurring in her inner world, even when it was distressing and turbulent. She learned to step back from experience; learned to be with what was happening rather than getting lost in the experience. In other words Liz began to develop an observing ego. This helped her to maintain an attentional process which monitored whatever emerged in her psyche with impartiality as an interested observer and an unreactive witness. In therapy, as she overcame each developmental hurdle, Liz ritualised her transformation. She created her own rites of passage.

Conclusion

Where constitutional hypersensitivity, together with misattuned childhood attachments prepare the way for primitive mental disorders, the person becomes acutely vulnerable to narcissistic injuries and shame. They may adjust to this inner milieu by evoking manic psychosis to ward off fragmentation of self.

There are similarities as well as contrasts between hypomania and the phases of the ritual process identified by Van Gennep. If psychotherapy incorporated this anthropological dimension it would have to address issues such as the roles and behaviours of the therapist, the nature of the therapeutic relationship, the role of family and community in the healing process and the involvement of religion and spirituality in the therapeutic process. This would also mean challenging the world-view and the value systems of an individualistic society and giving birth to a communitarian mode of existence. Psychotherapy would be challenged to openly address the relationship of intrapsychic phenomena to the historical, social and cultural milieu of clients. This would in turn shape the therapist's mode of being with clients as well as therapeutic techniques.

References

Bridges, William. (1980) *Transition.* Addison Wesley Publishing Company, NY.

van Gennep, Arnold. (1960) *The Rites of Passage.* Translation from French by Monika B Vizadom and Gabrielle L Caffce. Routledge & Kegan Paul, London.

Gerber, L. (1994) Psychotherapy with Southeast Asian refugees: implications for treatment of Western patients. *American Journal of Psychotherapy* v 48, no 2, Spring.

Grof, Stanislav. (1988) *The Adventure of Self-Discovery.* State University of New York, NY.

Grotstein, S James. (1995) Orphans of the 'Real': some modern and postmodern perspectives on the neurobiological and psycho-social dimensions of psychosis and other primitive mental disorders. *Bulletin of the Menninger Clinic* v 59 no 3, Summer, p 287 – 311.

Morrison, P Andrew. (1989) *Shame the Underside of Narcissism.* The Analytic Press, Hove and London.

Pritchard-Evans, E E. (1981) *A History of Anthropological Thought.* Edited by Andre Singer. Faber and Faber, Boston and London.

Straker, G. (1994) Integrating African and Western healing practices in South Africa. *American Journal of Psychotherapy* v 48 no 3, Summer.

Turner, W Victor. (1969) *The Ritual Process.* Aldine Press, Chicago.

STANISLAV GROF'S SYSTEM OF HOLOTROPIC THERAPY: A THEORETICAL PRESENTATION

Peter A Jackson

Abstract

This paper explores the *Holotropic Therapy System* of Stanislav Grof. Although Grof's psychotherapeutic system is not well known, it is an important system and, in fact, acts as a theoretical framework within which many better known and more traditional systems of psychotherapy can be located. Grof has always fully recognised the *psyche* (soul) in psychotherapy, where the trans-egoic experiences tapped during therapeutic sessions facilitate the movement to full psychological health and, from there, to the full utilisation of human potential. An overview will be given, covering origins, underlying theory, the practice and the relationship between Grof's system and more traditional therapies. This will cover the cartography developed by Grof to embrace the range of therapeutic experiences undergone by 4000 clients. These experiences were located by Grof into one of three categories: *psychodynamic, perinatal* and *transpersonal.* Grof argues that healing comes about in the reliving of these experiences where they are integrated into adult waking consciousness.

Introduction

In a book that is widely regarded as a comprehensive handbook of the activities included under the heading of psychotherapy, Corsini and Wedding's *Current Psychotherapies* (1995), you will not find any reference to any of the following: *Stanislav Grof, Holotropic, COEX, Basic Perinatal Matrices, good and bad womb experiences, body armour* (except, perhaps, indirectly in a section on Bioenergetics Analysis), or *Transpersonal matrices*. The name, Grof, and the other terms relate to a therapy that not only deserves mention, but is worthy of a section to itself.

I hope to show that not only is the therapeutic system I shall discuss worthy of a full statement in any putative handbook on psychotherapy, it has an overarching nature such that it embraces many other more traditional therapies. I also hope to show that this therapeutic system deals with aspects of human nature that either are not dealt with in any other therapeutic system, or are dealt with inadequately.

But more than wanting to provide evidence of the strengths of Grof's claims, I want to show psychotherapists that in his system not only do they have a theory

and set of techniques they can use with clients, they also have a tool for use in their own self-growth. It is my firm conviction that, for psychotherapists to work successfully with clients they have to have done work on themselves. It is not enough to have a grounding in the theories and to have been trained in the practices. For psychotherapists, clinical psychologists and other mental health professionals, I know of no more effective way than Grof's techniques for rapidly accessing deeply repressed material and for working toward wholeness. In addition to these benefits, the theoretical underpinnings of the system are in a conceptual language that is readily amenable to the mental health professional.

Stanislav Grof

Stanislav (Stan) Grof started his career as a medical doctor working in a psychiatric clinical setting, in his homeland of Czechoslovakia. There, in 1956, he joined the Psychiatric Research Institute of Prague, researching into psychedelic (meaning *psyche revealing*) drug use. In this work he did in Prague, he generated a large data base. Analysis of these data, arising from his work with his patients, indicated the highly specific relationship between LSD and subjects. In 1967, Grof left Czechoslovakia to work in the United States of America, continuing his work at Spring Grove, in Baltimore, Maryland, at the Maryland Psychiatric Research Centre, where controlled LSD studies were being conducted.

Grof's earlier clinical experience in Prague with LSD entailed some 2500 LSD sessions. He also had access to records of over 1300 sessions run by others in the Baltimore team. The clinical subjects had a wide variety of disorders. As in Grof's Czechoslovakian researches, there was also a wide range of normals (nurses, doctors, students, artists and so on). The records of these psycholytic sessions became the basis of Grof's assumptions and theorising. Grof came to see LSD acting as a catalyst, activating unconscious material (Grof; 1972, 1973 & 1975).

Grof found that the real effect of LSD was that of a powerful unspecific amplifier-catalyst, creating undifferentiated activation facilitating the emergence of unconscious material from different levels of the personality. The maps or cartographies that Grof has identified (Grof, 1975, 1985, 1988) seem to be fully compatible-parallel with other therapeutic systems. Grof has developed four levels or types of experience. The levels he evolved and still uses are: *abstract-aesthetic; psychodynamic; perinatal* and *transpersonal.*

Grof now calls his technique *holotropic* (moving towards wholeness) *therapy* (or *holonomic integration*), and no longer relies on psychoactive drugs to induce the deep experiential states his therapy requires (Grof, 1985; 1988). He now uses a mixture of controlled breathing, music, focused body work, and mandala drawing. It was never LSD itself that drew Grof. He viewed LSD as a catalyst. It was what it catalysed that was of far greater interest and importance (Grof,

1985). Thus, as long as he could find a technique acceptable to society in general, the therapeutic value and importance of his system remained undiminished

Grof asserts (1975; 1985; 1988) that all other therapies prior to his do not deal with actual physiological responses. Most deal with biographical material (for example, the psychodynamic therapeutic models and their derivatives). Some deal with the affects, but most operate at the cognitive–verbal level. Only his therapy uses the body's own activities as a part of the therapy. This assertion, though generally true, ignores the therapeutic system, devised by Alexander Lowen, called Bioenergetics.

The Theory

Of the four experiential characteristics: *abstract–aesthetic*; *psychodynamic*; *perinatal* and *transpersonal*, Grof found, with the exception of the first category (the intense perceptual alterations and distortions that occur with LSD), that the next three arose using his holotropic techniques. The exposition given here of the theory underlying holotropic therapy is taken from Grof's three key books (Grof, 1975; 1985; 1988).

Psychodynamic

This deals with the traditional psychodynamic processes and structures, where the experiences seem to originate in the individual unconscious, particularly those relating to unresolved conflicts and repressed material. Experiences range from reliving memories (perhaps unpleasant) from the past, to unconscious material appearing in a highly symbolic form. The intensity depends on the state of the person. Clinical patients have far more repressed material, hence reliving at the psychodynamic level figures strongly, whereas emotionally stable people produce little at this level. The phenomenology of the psychodynamic experiences in these sessions largely agrees with classical psychoanalysis. Psychosexual dynamics manifest with unusual clarity. However, not all that happens at this level falls within the psychodynamic framework.

For this psychodynamic or biographic category of experience, Grof uses the acronym COEX, which stands for *condensed experience*, where these are specific memory constellations. The memories belonging to a given COEX system have a similar basic theme, or contain similar elements, and are associated with a strong emotional charge. The deepest layers come from very early childhood. The more superficial layers are from later in life and current situations. Each COEX system has some very specific theme, such as all those experiences in the life of an individual that relate to being humiliated, where self-esteem is damaged. Other themes may be anxiety, claustrophobia or frightening events. Common, is the theme that presents sex as dangerous or disgusting, along with aggression and violence. Also of importance are those dealing with extreme danger and life-threats.

COEX systems have fixed relations to certain defence mechanisms and clinical symptoms. They organise components into distinct functional units. COEX systems are either negative (unpleasant) or positive (pleasant). Although there is some overlapping, each COEX functions fairly autonomously. They selectively influence a person's self and world-view. The outermost layers, representing most recent experiences, are linked back in a regression that ultimately leads to perinatal experiences, the core of the COEX system. With clinical patients, Grof found that a typical holotropic session starts with the reliving of memories related to the presenting symptoms. As the session continues, the memories come from further and further back in the life, until early childhood is reached. Although, at this point, there may be a deepening of insight as to the causes of the presenting problem, there may be no relief of symptoms at this point. However, the deepest layer is ultimately reached, and this always involves the birth experience. It is the reliving of this that discharges the negative energies and heals.

The reliving is vivid and hard to distinguish from the reality (for example, the body image corresponds with the age to which those memories belong). Some achieve deep age regression in the first session (characteristic of hysterics). More typically, several sessions are required. Relived at the earlier stages of infancy are a range of mainly unpleasant memories (e.g., coldness, hardness, bombardment by noise, weaning and so on). Later infancy-early childhood contain COEX systems relating to urination-defecation and sexual feelings. In later childhood are COEXs containing shocking-frightening events, cruel treatment, sibling rivalry, harsh criticism and so on. Prepuberty events rarely appear as COEX cores unless associated with a shocking event (e.g., sexual molestation). Pleasant COEX are much simpler than unpleasant.

Authenticating relived experiences is difficult in most cases, but Grof was able to do so in certain cases (Grof; 1972, 1973, 1975) where striking accuracy was noted, such as, near-photographic accuracy description of a room occupied in infancy, but never again seen as child or adult. Each relived episode seems to contribute a certain missing link in the psychodynamic understanding of the patient's psychopathological symptoms. The totality of the emerged unconscious material then forms a rather complete gestalt, a mosaic with a logical structure. But, even where the relived experience has no basis in reality, it has psychic reality for the patient. The reliving of traumatic experiences is usually accompanied by powerful emotional abreaction. The intensity can seem out of proportion to the relived events, until it is realised that this event summarises similar events throughout the life. Also, there follow far-reaching changes in the clinical symptoms, behaviours, values and attitudes.

Grof uncovered the fact that more recent experiences must be lived through first, in order to get back to earlier ones, because the later ones are the outer components of the COEX cluster, and cover the deeper ones. Most important in

the COEX systems is their core experience, because this laid the foundations for the rest. It is not clear why certain events from infancy-childhood should have so profound and long-lasting an influence. Grof speculates that determinants may go beyond the individual into ancestral, racial or even phylogenetic memories, including past-life memories (Grof, 1975). Important is the emotional atmosphere of a family and its interpersonal relationships. A single traumatic event is amplified in significance when set against a discordant familial background. Patients themselves recognise the generalising nature of a single important relived event.

The historical development of a COEX is important. In very early childhood, the child is a passive victim of the family environment and has no active role in the core experience. In later childhood, the child is more instrumental. Once laid, the foundations of the COEX influence perception of the environment, world experiencing, attitudes and so on. The core influences expectations towards certain others (for example, that people in general cannot be trusted, or that emotional attachment is threatening). Such *a priori* attitudes and expectations result in specific maladjusted behaviours toward all new persons entering one's life. A person whose new human encounters are contaminated by the influence of strong negative COEX systems enters new relationships heavily biased. The gradual successive growth of COEX systems by positive feedback could account for the latency (incubation) period between the original trauma and future neurotic-psychotic episodes. Such symptoms appear at times when the COEX system reaches a certain critical extension, and traumatic repetitions contaminate important areas of the patient's life, interfering with satisfaction and basic needs. There is a strong parallel between the contents of the core experience of their COEX systems and patterns of their personal interactions at the time of the onset of clinical symptoms. Multiple repetitions of themes from one or more COEX precede immediately the first manifestation of disorder.

When a strong negative COEX emerges in a session, the normal flow of images and sensations is disrupted, and the subject feels as if in a whirlpool consisting of fragments from the past. Later, when the core experience is relived, the fragments make sense. There is also a disassociation between object and affect (for example, a water jug eliciting strong sexual feelings). The seeming absurdity is removed on reliving the core experience. The arising in a session of intense anxiety, panic and so on also signals the onset of a COEX, as too with dramatic motoric activities (for example, nausea, vomiting or intense pain). There is a repetitious quality in movements and speech which seem to precede the emergence. The emerging COEX assumes a governing function and determines the nature – content of the session. For example, the therapist can take on the form of someone hated or that of a tormentor. There is also the reliving of the roles of victim and aggressor.

There is a tendency to act out the reliving of the COEX and shape the

circumstances of the session to the COEX theme. This is because it is painful to experience a mismatch between certain intense feelings and outer events. Thus, the emergence of deep feelings of guilt may cause the patient to act the role of therapist, or provoke hostility in the therapist. It is, of course, absolutely essential that therapists avoid being unconsciously manipulated into replicating the roles the patient is demanding of them. Similar dynamics can be exhibited in the case of positive COEX systems. Serial psychodynamic sessions can be viewed as a process of gradual unfolding, abreaction and integration of various levels of negative COEX systems, opening pathways for the influence of positive ones. Elements of a particular COEX constellation keep appearing in the sessions until the oldest memory (core) is relived and integrated. Sessions cause profound change in the dynamics and mutual interrelations of COEX systems and initiate dramatic shifts in their selective influence on the subject's ego.

Where unconscious material is not worked through, a patient can remain under the influence of a COEX long after the session. Or, the resolution may be incomplete and result in a precarious emotional imbalance. There may also be belated flashbacks outside of the therapeutic session. Conversely, resolution during a session produces a highly positive, tension-free experience. If this occurs earlier in the session, a positive COEX emerges. There is usually a striking clinical improvement. There may also occur a COEX transmodulation, wherein the hegemony of one negative COEX is replaced by that of another. This will be paralleled by a dramatic change in clinical manifestations, to such an extent that clinical rediagnosis is needed. The duration of sessions in which a given negative COEX dominates varies enormously from one to twenty.

Perinatal

The characteristic of the perinatal experience is existential, relating to pain and the frailty of the human condition (Bache, 1981). There is the *life in death, and death in life* paradox. People who experience these deeply also come to see the utmost relevance of things religious-spiritual. For one reliving the birth experience the physical manifestations can seem like those of dying. Grof says that a causal link between the actual birth and the unconscious matrices for these experiences is yet to be established (Grof, 1975). These levels are reached only after a great number of more typically psychodynamic sessions (at least with psychiatric patients). With normals, the perinatal level can be reached in far fewer sessions. According to Grof, alcoholics and drug addicts have the quickest access. Grof points out that there are other routes to this level, than that of holotropic therapy (such as, gestalt, encounter, bioenergetics and rebirthing, Orr & Ray, 1977). Grof sees these perinatal experiences as representing an important intersection between individual psychology and transpersonal psychology (Grof, 1975).

Grof noted a transition between the purely Freudian level and Rankian level

(Rank, 1945) where the experiences are physical rather than psychological (for example, reliving threats to bodily survival). These elements appear in four typical clusters, matrices or experiential patterns. There is a deep parallel between these patterns and the clinical stages of delivery. For this reason, Grof calls these clusters *Basic Perinatal Matrices* (BPM), of which there are four. This is a useful model, and does not imply a causal nexus. The BPMs are hypothetical dynamics governing systems that have a function on the Rankian level of the unconscious, similar to that of the COEX systems on the Freudian level. They have a specific content of their own – perinatal phenomena – and have two components, biological and spiritual. The biological consist of concrete-realistic experiences related to delivery stages. Also, each physical stage has a spiritual counterpart. The BPMs function as organising principles for the material from other levels of the unconscious, namely the COEX systems, as well as some transpersonal material.

Basic Perinatal Matrix 1

This level relates to the original intra-uterine condition of symbiotic unity. Usually, this is near-paradisiacal, but can be disturbed either temporarily or permanently (for example, mother's temporary illness or drug-addiction). This enables us to differentiate between a *good* and *bad* womb in much the way Sullivan talked of good/bad nipples (Sullivan, 1953).

When a good womb is involved, the common relived feeling is of oceanic bliss, timelessness, and ineffability. Some may feel themselves to be tiny, and have a head much larger than their body. There are often religio-mystical connotations. The world seems a friendly place, permitting a childlike, passive-dependent attitude of trust. There may be experiences of a sequence of visions allowing for interpretation in historical time. For example, embryonic sensations, ancestral memories, elements from the collective unconscious and even phylogenetic flashbacks. The COEX associated with good womb experiences include carefree childhood games, satisfying love relationships, natural beauty and human works of great art. In the case of bad womb experiences, the COEX are the reverse, including childhood dysfunctions, familial difficulties, dirty industrialised cities and polluted countryside. At the Freudian COEX level, there are no tensions in the erotogenic zones, where all partial drives are satisfied.

Where a bad womb is involved, the intra-uterine condition was far from perfect, and the holotropic experiences reveal this, as in feelings of discomfort, oceanic visions suddenly blurred by an ugly film. There may be feelings of weakness, influenza-like attacks and small muscle tremors. There may also be unpleasant tastes-smells. Visions of wrathful deities can also be present. Even schizoid-like states can arise. These contrast sharply with the sense of spiritual enlightenment accompanying the undisturbed womb states. Grof points out the closeness of the two contrasting situations and the ease with which some schizophrenic patients

oscillate between them (Grof, 1975). At the Freudian COEX level, erotogenic zonal tension is experienced. Satisfaction of these needs can result in a superficial-partial approximation to the tension-free state of the good womb. BPM 1 experiences rarely emerge in the first few sessions.

Basic Perinatal Matrix 2

BPM 2 is related to the first clinical stage of delivery, where the idyllic intra uterine existence comes to an end. There is both chemical and mechanical interference, and there arises a situation of extreme emergency. Uterine contractions occur, yet the cervix is closed and there's no way out. Mother and foetus are a source of pain to one another. There is, of course, a tremendous variation in this phase, ranging from a short labour and easy birth, to pathological delivery (for example, Caesarean) and complications.

The therapeutic experiences may be purely biological in form but, more characteristically, there is the feeling of *no exit* or *hell*. There are often visions of the metaphysical-religious hells, and of the most negative aspects of this world (e.g., world wars). There is also an empathy with all who are downtrodden, or who have to die in pain and alone. Coupled is the feeling of a robotic cardboard world which is ultimately meaningless. It is here that the link is made between birth and death, where the existential crisis is at the root. Feelings of separation, alienation, metaphysical loneliness, helplessness, inferiority and guilt are standard components. These may be symbolised as in the case of Greek figures such as Sisyphus, Ixion, Tantalus and Prometheus, or expulsions from paradise, Gethsemanes and Dark Nights. There is often a feeling of intense but vague anxiety, even of paranoia and the danger of cosmic engulfment.

Typical physical symptoms include extreme pressure on the head-body, ringing in the ears and difficulty with breathing. BPM 2 is the matrix of all that is unpleasant in the extra-uterine life (for example, disease, operations and injury). There are associated feelings of abandonment and rejection. At the Freudian COEX level, all of the erotogenic zones are experiencing extreme tension such as thirst, retention of faeces-urine, sexual frustration and labour pains. Sophisticated clients can readily relate BPM 2 experiences to such as bondage to the Wheel of Becoming, and realise that the more one struggles to be free the more one is impaled in the senseless reality.

Basic Perinatal Matrix 3

BPM 3 relates to the second stage of delivery where the uterine contractions continue but the cervix is now wide open. There is an ensuing struggle for survival with crushing pressure and suffocation. But, at least, there is release, and a synergy between mother and child to end this painful experience. There may also be the contact with the mother's faeces and urine. This is a complex matrix, involving a variety of phenomena at different levels. There are four distinct experiential aspects: *titanic struggle, sadomasochistic, sexual* and *scatological,*

with the underlying theme being encounter with death. There are, too, associated physical symptoms such as crushing pressures, cardiac distress and breathing difficulties.

The key is the titanic struggle component, which, in holotropic therapy, can seem to be more than a human can bear. It is symbolised by vast natural disasters (for example, Krakatoa), or atomic explosions. Some witness scenes from the destruction of Pompeii, where fire is often the destroying element. The suffering reaches beyond what is bearable and transforms into rapture-ecstasy, but of the volcanic type, rather than the oceanic type of BPM 1.

Sadomasochism is a prominent feature where energy discharges are both outwardly destructive and self-destructive. Visions of cruelty and bestial orgies arise, including self-mutilation and such figures as Salome, or others, who have employed sadistic torture.

The third component is that of sexual arousal, which seems to have a physiological basis (males hanging on gallows frequently exhibit erections and even ejaculation: Grof, 1975). Some subjects spend hours in an all pervasive sexual ecstasy, with accompanying orgiastic images. There may be visions of red-light districts, or identification with famous figures such as Casanova. There is a generalised releasing of repressed sexual energy and aggressive impulses.

The scatological element involves contact with all that is repulsive (for example, immersing in excreta or products of putrefaction). However, the initial disgust can change to passive acceptance or even pleasure. There may be scatological visions (e.g., heaps of rotting matter or corpses).

The *consuming fire* feature of BPM 3 is what seems to purify the subject after having seen all that is worse in self and others. The fire destroys all that is rotten-corrupt, and prepares for the renewing-rejuvenating experience of rebirth. The Phoenix is a common symbol here. There are also religious symbols, as in the punishing gods (for example, Yahweh in relation to Sodom and Gomorrah). BPM 3 experiences have helped subjects understand such as Black Masses or Satanic Rites where sex, aggression and sadomasochism are all involved. There are often visions of great painters' works, entailing scenes of destruction, orgy, death and fire. The Gothic era is especially relevant, as is purgatory, Faustus and Parsifal. All this causes patients to re-evaluate their lives and values. Contrasts such as complex versus simple living, professional ambition versus family life, and real love versus lustful promiscuity. At the Freudian COEX level there is the sudden release of tension (for example, swallowing, defecation, urination and orgasm).

Basic Perinatal Matrix 4

BPM 4 is related to the third and final stage of delivery where the neonate emerges down the birth canal. The first breath is taken and the cord is cut, and anatomically independent life begins. Although this stage is infinitely better than

the preceding two, it is worse than the first of symbiotic union. There may be a concrete reliving of the birth experience, or it may remain purely symbolic-psychological, which relates to the death-rebirth experience. Suffering-agony culminate in total annihilation on physical, emotional, intellectual, ethical and transcendental levels. The world seems to collapse and all referents are lost. There is ego-death. The cosmic bottom is hit, then follows feelings of liberation. So, there is some overlap between BPM 1 and BPM 4.

In BPM 4, positive self-values can be discovered, such as love and a sense of beauty, and these are not amenable to psychoanalytic analysis. However, the positive side can be interrupted by unpleasant experiences, such as pains in the umbilical region or genitals. There is a rich symbolism in BPM 4, and usually centres on sacrifice, death then resurrection. There can also be images of heroic deeds, as in the Greek myths. The liberating aspect is often experienced as radiant, blinding or supernal light, or perceiving God as pure energy. The more secular symbolism involves overthrowing of dictators, the ending of a long war or termination of great danger. In terms of nature symbolism, typically, in BPM 2, there are barren wintry landscapes, in BPM 3 fiery volcanic eruptions and hurricanes, whereas in BPM 4 there are scenes of spring, melting snows and green meadows and calms after a storm. In physical terms, there is withholding of breath, muscular tension then sudden relaxation and wellbeing. Memories in BPM 4 relate to endings of wars, surviving danger, and a problem resolved by one's own skill-effort. In Freudian terms, there is the satisfaction that comes from discharging or reducing tension, such as quenching thirst, or the feelings after orgasm.

It needs to be stressed that the chronological sequence presented above is rarely maintained in actual therapeutic sessions. There are great individual differences. In highly disturbed clients, after the psychodynamic material has been worked through, the no-exit experience of BPM 2 is met, then the birth-death struggle of BPM 3, some of BPM 4 rebirth experience and cosmic unity of BPM 1. Beyond this are the more transpersonal experiences. In less disturbed people, the sequence is often positive BPM 4 – 1, then some BPM 2 and 3, then the fuller versions of BPMS 4 and BPM 1.

Important is the BPM governing the terminating phase of the sessions. For example, if BPM 1 is governing then, long after the session, there can be a depression (with many of its clinical symptoms) that persists for days. Conversely, if BPM 3 was dominant, the feelings are of anxiety, apprehension and irritability. The governing by BPM 4 is best of all, where all presenting symptoms disappear and life seems good and simple. Similarly for BPM 1.

Transpersonal

Transpersonal experiences occur rarely in the early sessions. They are more common once the psychodynamic and perinatal material has been worked

through. The common denominator in these experiences is the feeling of expansions beyond the usual ego boundaries and spatio-temporal boundaries. Gone is the strong body image and sensory dominion. Grof has developed the following classificatory scheme:–

Extension within objective reality:

Temporal: embryonal; ancestral; collective-racial; phylogenetic; past-lives; extrasensory.

Spatial: ego transcendence; identification with others; group consciousness; animal and plant identification; oneness with life; consciousness of inorganic matter; planetary and extraplanetary consciousness; out-of-body experience, travelling clairvoyance, telepathy. Spatial constriction of consciousness to organs, tissues or cells.

Extension beyond the objective framework:

Spiritistic–mediumistic experiences; encounters with superhumans; experience of other universes; archetypal experiences; mythological sequences; encounters with deities; intuitive grasp of universal symbols; chakra activation; arousal of kundalini; consciousness of universal mind; experience of the VOID.

The embryonal-foetal experiences are not to be confused with those of the BPMs. These transpersonal experiences are specific memories of intra-uterine life, and include that of sharing the mother's affective states and a telepathic rapport. It is hard to know whether these are truly relived memories or simply experiences. But Grof (1975) has had many corroborations of these particular experiences, including the fact that often experiencers are displaying a knowledge of intra-uterine conditions well beyond their prior knowledge.

In ancestral experiences there is a regression in time to before conception. Usually these are many generations in the past rather than recent past. They may be specific, as in tuning in to one individual, or they may be more generalised. Often, information unknown to the subject in ordinary awareness is contacted.

The collective–racial experiences relate to the Collective Unconscious posited by Jung (1970). They can relate to any country, period and culture, although often the culture is ancient and having a highly developed religio–philosophical culture, such as ancient Egypt, India or China. This is quite independent of the subject's background. The information contacted is usually very accurate, even when occurring in unsophisticated subjects having no prior knowledge of such cultures. Some subjects (without prior knowledge) exhibit mudras or obscure yogic postures.

Phylogenetic or evolutionary experiences involve realistic identification with animals. They often seem to transcend human limits of fantasy–imagination.

Past-incarnation experiences consist of fragments–scenes, or entire sequences of events. The subjects maintain ego identity, and even though experiencing themselves as some one else, feel themselves to be basically the same individual. There is a strong *deja vu* feeling. Belief in reincarnation is not a prerequisite. Relived karmic links can be positive, as in good relations with past others, or negative as in reliving past pain, suffering and hatred. The mere reliving is not enough. The events must be transcended emotionally, ethically and spiritually to be classed as truly transpersonal. Sometimes, the laws governing reincarnation are transmitted by non-verbal or intuitive means to subjects as they relive them.

In experiencing extra sensory perception (ESP) phenomena there is the transcendence of space-time limitations. Objective verification is usually difficult and, after the session, the subject does not display any increase in ESP ability. Ego-transcendence is characterised by going beyond the usual spatial limits of consciousness. There is a loosening of the ego boundaries, while retaining an awareness of identity. Related is the feeling of identification with another person, where the sense of self-identity is lost. Often this identification is with some famous personage, where the Christ and Buddha figure prominently. There is also group consciousness or identification, as with the persecuted Christians of Roman times. The animal identifications must be distinguished from the more superficial autosymbolic animal transformations which are psychodynamic in origin, and carry some cryptic message for the experiencer. Genuine animal identification cannot be derived from other unconscious material. Plant identifications are more rare, and usually occur in advanced stages of the treatment. They can be accompanied by philosophical or spiritual insights, as into the purity and selflessness of the plant kingdom. In rare cases, subjects experience an expansion to encompass all life on earth, human or otherwise.

The consciousness of inorganic matter is fairly common, such as in feeling oneself to be the ocean, or of the forces unleashed during a natural catastrophe. Subjects conclude that consciousness is a basic cosmic phenomenon, and related to the organisation of energy. Also, there is a new understanding of animism and pantheism. Planetary consciousness is rare, and occurs only in advanced sessions. In these experiences the earth seems a living entity with which the subject identifies. Extraplanetary consciousness is just as rare. Out-of-body and related experiences are more common. There may or may not be a feeling of being able to control the experience. ESP is common too and, although difficult, Grof has occasionally been able to verify these experiences (Grof, 1975; 1985; 1988).

In the spatial constriction mode, consciousness is confined to areas smaller than the body, such as to organs or cells. Again, there are accompanying insights and evidence of knowledge that lies outside the subject's prior knowledge.

Spiritualistic experiences are rare, wherein the subject enters a quasi trance state, including voice and facial changes. Similarly with spirit guides or teachers, perceived by the subject as superhuman. Mostly, the contact is non-verbal and the beings are of light or energy rather than of human form. They may give advice or information about the session and its value to the subject, or they may take the subject on a guided tour. There are, too, experiences of alien worlds and other universes having strange physical laws and totally different life-forms.

A more important class of experiences are those that involve complex archetypal and mythological sequences. Grof is using the term *archetype* here for all static patterns or dynamic events within the psyche that are transindividual and universal in quality. Some such are the martyr, fugitive, outcast, ruler and wise old man. More universal still are Great Mother or Cosmic Man. There are also commonly experiences of the animus, anima and shadow. There may also be myths such as of Tantalus and other heroic or tragic figures. Related are encounters with deities. These latter fall into two categories: those associated with the forces of light and good such as Isis and Apollo; and those of darkness and evil such as Kali and Satan. These experiences usually first appear in the perinatal phase, where the dark deities accompany BPM 2 and 3, and the bright deities BPM 1 and 4. There can also be an experiencing and understanding of universal symbols, such as geometrical or mandalic. The most frequent symbols include the cross, six-pointed star, swastika, crux ansata and circle. Subjects with no prior knowledge of occult systems have had profound insights into such as cabbalistic symbols (Grof, 1975).

Many experiences bear striking resemblance to the phenomena described in Kundalini Yoga, such as the activation of the chakras or the rousing of kundalini, where kundalini is a psych-spiritual evolutionary force. Neither prior experiential nor intellectual knowledge of kundalini is a prerequisite for having these experiences. However, the actual arousal and upward movement of kundalini is extremely rare in a therapeutic session. The most profound experience in this category is the consciousness of universal mind, in which ultimate understanding is felt to be reached. Similarly, consciousness of the Buddhist condition of the Void.

The influence of transpersonal experiences lasts well beyond the session in which they occurred. Much depends on the nature of the experience and the level at which it occurred. Especially influential are experiences that remain unresolved in the session. Where there is resolution, actual changes can come about in the person's life circumstances as though some past karmic blockage has been removed. This can be startling in the case of relived past incarnations, where changes occurred in relation to people who are part of the experience. There is in this strong support for Jung's notion of synchronicity. The intense level of identification with another experienced during a holotropic session can, in real

life, spill over into a new understanding of and love for that other. Similarly with more collective identifications.

Grof believes that many helping professionals either ignore the evidence offered by transpersonal experiences, or regard them as too bizarre and are ready to label them as psychotic (Grof, 1975). This view is more recently supported by the researches of David Lukoff (1988). Some professionals accept the validity of the experiences, but produce their own bizarre theoretical framework rather than utilise that of the perennial philosophy. Often, their theories are highly reductionist (for example, treating mystical experiences as primary infantile narcissism: Deikman, 1963, 1969). It is a rare few eminent psychological theorists who have shown a genuine interest in transpersonal phenomena. In particular, Grof mentions Jung, Assagioli and Maslow. Grof is convinced that transpersonal phenomena are not reducible to psychodynamic concepts. Grof's own background as a psychoanalyst and physician had set him against the acceptance of transpersonal experiences, and also against the notion of memories from before birth (he regarded the foetal brain as being too immature). However, his work has convinced him otherwise (Grof, 1985; 1988).

The Practice

The holotropic therapist is a facilitator who facilitates and assists in the healing process, and must support the experiential unfolding even when this is not understood. While psychoactives are the most powerful route to deep material, Grof was obliged to develop a non-pharmacological technique which is characteristic of ancient procedures such as those in shamanic practices. One especially powerful technique is that of intense breathing or hyperventilation (a form of yogic *pranayama*). Grof (1988) confirmed the findings of Reich that psychological resistance and defences use breath restriction. Conversely, self-initiated deep breathing removes autonomic control and resistances. This releases many conscious experiences, as being flooded with light and love.

Grof (1988) argues that the physical symptoms of hyperventilation are usually seen in pathological terms (for example, carpopedal spasms – tetanic hand-feet contractions). He has found that only a few clients exhibit such symptoms, even when the sessions go on for long periods. Rather, there is a progressive relaxation, intense sexual feelings and mystical experiences. There is also a progressive decrease in muscular tensions and difficult emotions. This occurs through intense abreaction, which can entail tremors, twitches, dramatic body movements, coughing, vomiting, screaming and increased autonomic activity. In addition to abreactive processes, there is the prolonged contraction and spasms of muscle groups, which use up a great deal of pent-up energy. The typical outcome of a good holotropic session is profound emotional release and physical relaxation. Grof calls this *pneumocatharsis*.

The emotional qualities expressed in a session cover a wide range, including anger, aggression, anxiety, depression, guilt and disgust. Some clients show little motor activity, while others are very active. Pains occur in certain parts of the body at times, and these are psychosomatic in origin, as intensified forms of pains the subject is familiar with. Grof has, over many sessions with many clients, been able to catalogue the relationship between the locations of the pains and the underlying psychological causes. For example, pains-tensions in hands and arms reflect deep conflicts between strong impulses and their opposing tendencies. The typical release finds outlet in creative activities, such as painting. Tensions in legs and feet have similar structures, but these are less complex, because these limbs have a simpler role. The other common locations all seem to relate to the locations of the chakras. Release in these centres liberates the energy that is traditionally related to that centre.

Music is also combined with hyperventilation, where skilful use of musical selections facilitates the emergence of specific contents such as aggression, emotional and physical pain. The music is usually played very loud and over high quality equipment. It is important to surrender to the flow of the music, letting it resonate in one's entire body and respond in a spontaneous, elemental fashion. Intellection should be suspended. The music is chosen by the facilitator-therapist to suit the phase the subject is going through. Sexual experience is, for example, facilitated by such as the Venusberg music from Wagner's Tannheuser, aggression by Holst's Mars. It is always of high artistic quality. The major objection to the use of music is that it has a strong structuring influence on the experience. But, because the music is usually chosen so as not to be well known, learned responses are prevented. Also, songs are rarely used because the lyrics produce a cognitive focus. Sometimes, even white noise is used, to avoid the structuring effect, and the recipient transforms this into their own internal music.

Focused body work is a supplement to the general therapeutic regime, and is not always used. It is used where distress occurs. The principle is to use it in the terminating period of a session. Localised pains are exaggerated either by the subject or by the sitter and possible helpers. Physical supportive contact is also used, such as touching and holding hands. This contravenes the taboos in many other therapies, especially the talk-only variety. However, these meet the anaclitic needs of the client which relate to basic mothering. The choice and timing of such interventions involves the intuition, but a general rule is that it is used when the subject is deeply regressed, helpless and vulnerable. Most of Grof's work is done in group settings, so the risks of impropriety are much reduced. The members are always divided up into an experiencer and sitter, who are allowed to choose each other. Some sorting out goes on over the first few sessions, until people tend to stay in a certain dyadic relation through the remaining sessions.

Grof uses a basic preparation procedure with each group of clients before actual therapy begins. This makes the clients aware of the sorts of things that may happen and the procedures used to ensure personal safety, and about the setting and appropriate clothing and so forth. The room needs to be big enough, the floor padded, located where loud noises will not cause problems, and where music can be played loudly. The lighting is reduced, and such things as tissues, buckets are provided. Pre-session screening is used to eliminate those clients with severe disturbances (they would go to individual sessions), and those with certain medical conditions, such as heart problems or pregnancy. Also, clients should be off all medication and not be currently using drugs.

Usually a session starts with relaxation exercises and guided imagery. The focus should be the here and now. Expectations should also be absent, because the work is open-ended. The sitter-therapist is far from the active agent, because the therapeutic outcome of most sessions is indirectly proportional to the amount of external intervention. Grof also uses mandala drawing in his sessions, in combination with the other procedures.

In part, Grof bases his understanding of the dramatic healings he has witnessed on some mechanism akin to that working in shamanic healing (Grof, 1988). Associated is the pseudo-religious conversion-like process that sometimes occurs in those who have come very close to death. Holotropic therapy seems to use similar mechanisms, but without the biological danger-crisis.

One explanation offered by Grof lies in that holotropic therapy intensifies the conventional therapeutic mechanism of abreaction. Grof (1988) points out that Freud knew this, but played its value down and focused instead on transference as being the important process. Abreaction applies to strictly biographical material, whereas the more generalised release of emotional – physical tension is called catharsis. The value of these two has been known at least since the ancient Greeks. A reason given by Grof as to why Freud and others have played down abreaction is that few psychiatrists have the training or inclination to take a patient through a full-blown abreaction as Grof describes it (Grof, 1988).

However, abreaction-catharsis is not the only factor. The experiencing of traumatic events from infancy–childhood while being able to evaluate them as an adult permits their integration. The adult can face traumas that the child could not face, in addition to which the therapeutic setting offers support that the childhood setting probably did not. Also, it is likely that the original event was not fully experienced, due to its interfering with consciousness (for example, fainting). In holotropic therapy, the potential for transference is greatly enhanced, but is seen as a hindrance rather than a curative factor. In fact, Grof (1988) argues that it should be seen as a resistance to or defensive ploy to the process, a way of opting out.

The general strategy in holotropic therapy sessions is to reduce negative charges by: abreactive discharge; conscious integration of painful material; facilitating experiential access to the positive dynamic constellations of COEX, BPM and transpersonal matrices; and terminating each session by successful integration of that day's psychological gestalt. Those tuned into some negative matrix view themselves pessimistically and experience varying degrees of emotional and psychosomatic distress. The reverse is true for those under the influence of positive aspects. In general, the nature of the influence relates to the nature of the COEX or BPM. The exact effect of the transpersonal matrices are more difficult to describe synoptically, because there is such richness and variety.

Many cases of dramatic improvement can be explained in terms of a shift from a negative system to a positive one. This is not to say that all of the negative material has been worked through. This is what Grof calls *transmodulation*, and can occur within COEX or within BPMs. There can also be transpersonal transmodulations. A typical positive shift initially involves the intensification of the negative system, followed suddenly by a dynamic shift to a positive one. This does not necessarily lead to a clinical improvement. If the shift is from positive to negative or from one negative system to another negative system, there can be a change of symptoms which, if severe, can need rediagnosing, such as, from depression to hysterical paralysis. The latter Grof calls *substitutive transmodulation.*

The therapeutic potential of the death – rebirth process is very powerful, because negative BPMs are an important repository of emotions and physical sensations of great intensity. Symptoms such as anxiety, depression, guilt and sadomasochistic tendencies have their roots in the BPMs. In particular, in successful sessions, suicidal tendencies will go or be greatly reduced, as is a reliance on alcohol or drugs. Similarly, sadomasochism, aggression, impulsive behaviour, self-mutilation and a variety of phobias and sexual disorders may go or be greatly reduced. Many of the states that traditional psychiatry brands as psychotic result from activation of the perinatal matrices.

There are also therapeutic mechanisms on the transpersonal level, where many of the presenting problems of a complex-subtle nature have their origin (for example, embryonal traumas). The resolution of, or insight into, past-life conflicts and traumas can eliminate certain problems. Likewise, certain negative archetypes bring an *evil* influence into a person's life, akin to spirit-possession. The experiencing of Universal Mind and identification with the Metacosmic Void have extraordinary therapeutic potential, bringing spiritual and philosophic understanding of such a high level that everything in the person's life is redefined. It can also initiate its own crisis.

Healing can be regarded as a movement toward wholeness, which implies a common dominator. Such a universal mechanism implies that consciousness is

all-pervading, and primarily an attribute of existence rather than an epiphenomenon of matter. Human nature is paradoxical in that everyday consciousness seems to conform to the Newtonian world-view yet can, at times, function in an infinite field and transcend space-time. The first type of consciousness Grof calls *hylotropic* and the second *holotropic* (Grof, 1988). In the former, we experience only the here and now of consensus reality, whereas the holotropic mode has unlimited access to other times and other spaces. Also, we can experience the superphysical realms, such as astral and beyond. A psychogenic symptom represents a hybrid between the hylotropic experiencing of the world and the breaking through of a holotropic theme. Grof (1988) argues that neither hylotropic nor holotropic in their pure forms present problems, only their admixture. Viewing psychopathology as the negative mixing of hylo- and holotropic modes throws a new light on therapy. This new view entails the use of methods of inducing non-ordinary states of consciousness.

Emotional and psychosomatic healing occurs in experiential forms of therapy, because these loosen defence mechanisms and dissolve psychological resistances in a much more efficient way than the purely verbal therapies, where these can take months or even years (Grof, 1988). Grof argues against performing holotropic therapy on oneself while alone, because even the most balanced person is liable to experience traumatic and seeming life-threatening modes of being. Also, the nourishing human contact with the sitter is a key part of the method. In holotropic therapy, there is a clear causal link between the procedure and results, whereas in the traditional verbal approach the sessions extend over such a long period that such a causal connection is hard to establish and too many other variables contend as causes (Grof, 1988).

The pursuit of a more rewarding life strategy is facilitated by holotropic psychotherapy, which goes far beyond the mere relief of psychopathological symptoms. Victor Frankl (Frankl, 1963) talked of *noogenic depression* – a condition experienced by those who were far from being either psychotic or neurotic, but due to their seeming balance and worldly successes, were the envy of friends and others. At root this condition manifests as an intense awareness of life's seeming meaningless coupled with an inability to enjoy success. The uncovering of perinatal, biographic and transpersonal factors by reliving them can remove this noogenic condition. There is the discovery that the entire life to that point is inauthentic and misdirected. This is usually due to the influence of some one or several negative matrices. For example, BPM 2 produces resignation, submissiveness and passivity toward life, whereas BPM 3 gives an unrelenting obsessive drive toward future goals such that the present moment is never perceived as satisfactory. At the planetary level we are seeing the negative results of this obsessive drive taken beyond sanity. A shift to the positive aspects of the BPMs brings an ability to enjoy the moment, and the emergence of an ecological consciousness in which one participates in life rather than viewing it as a

challenge or threat. When the self-exploration reaches the transpersonal levels, the philosophical and spiritual quest comes to dominate. People who live only in the hylotropic mode, even when healthy by clinical standards, are cut off from their real source and need healing.

Traditional – Holotropic Relationships

Grof (1985, 1988) argues that LSD research and other experiential self-exploration methods throw light on the labyrinthine nature of the traditional systems of therapies, and the conflicting views surrounding them. In Grof's original system of *psycholytic therapy* (using LSD) and his more recent holotropic therapy, initially the patient's reliving of biographical material fits the basic Freudian schema (includes Adlerian and Sullivan's views). The patient moves beyond this into a stage which can be conceptualised by Reichian therapy. There follows a stage best framed by the views of Otto Rank (1945), then onto one which fits the Jungian view (Jung, 1970). Once the sessions move on into the transpersonal realms, only Jung and, to some extent Assagioli's psychosynthesis (Assagioli, 1965), can address the processes involved, because the experiences take on a philosophical- spiritual - mystical - mythological emphasis (Grof; 1985, 1988). The therapy at this point equates with the spiritual quest. Taking each of the key theorists in turn, Grof argues as follows.

Freud

Grof (1985) argues that, above all, Freud sought to make of psychology a science in the same sense that physics is a science. Especially, he was influenced by classical mechanics and conservation of energy. In Freud's topographical descriptions, dynamic processes are intimately interwoven as specific individual structures of the psyche (Freud, 1985). There is also a classical causal determinism in Freud's scheme. Also, there is (as in the Newtonian– Cartesian world view), the objective, independent observer. Freud's contributions are three thematic categories: a theory of instincts; a model of psychic apparatus; and a pyschoanalytic therapy. Important to his theory are the pleasure and reality principles (Freud, 1985). However, Freud found that aggression does not always serve self-preservation, thus seeming to undermine the theory's Darwinian basis. Thus, Freud had to develop the notion of an instinct toward destruction (or Death). The Id represents a primordial reservoir of instinctual energy, governed by the primary process. The ego retains its close connection with consciousness and external reality, yet performs unconscious functions. The super-ego only comes in fully with the resolution of the Oedipus complex, and one of its aspects is the recovery of the narcissistic perfection of early childhood. Another aspect reflects the introjected prohibitions of parents backed by the castration complex. Superego operations are largely unconscious, and carry some Id- like aspects (for example, its cruel streak – Grof, 1985).

Freud (1985) distinguished between real anxiety (due to concrete danger) and neurotic anxiety (due to some unknown cause). Not only is there a strong mind-body split, but problems are isolated from their interpersonal, social and cosmic contexts. Where only biographical levels of the unconscious are involved, psychodynamics fits the data from Grof's LSD research (for example, observed regressions to childhood are very common). However, Grof feels that psychodynamics has no right to generalise the way it does from such material, to other areas of the COEX systems (Grof, 1985). The shift of emphasis from biographically determined sexual dynamics to the dynamics of the basic perinatal matrices is possible because of the deep experiential similarity between the pattern of biological birth, sexual orgasm and the physiological activities in the individual erogenous zones.

Grof (1985) further argues that psychodynamics has failed to explain many aspects of psychopathology that his LSD research throws light on (such as, the puzzle of the savage part of the superego, or failure to embrace anthropological findings as in shamanism). Importantly, Freud (1985) tended to classify anything relating to prenatal conditions as fantasy, in contrast to postnatal experiences. Grof feels that Freud failed to see that *birth-sex-death* form an inextricable triad, intimately related to ego death. For example, the link between castration fear with *dentate vagina* is readily understood in terms of the potential danger of the contracting vagina during the birth process (includes the cutting of the cord). Even the more recent *Ego-psychology* (as developed by Federn in 1952, a close associate of Freud, and as modified by J Watkins: Watkins, 1978) fails in the same respects, because bound to a narrow biographical orientation.

Adler, Reich, Rank and Jung

Adler remained linked to the biographical level, but had a different focus, being teleological–finalistic (Adler, 1959). The guiding principle was to be complete, with a built in inferiority complex (includes insecurity–anxiety). Adler argued that consciousness and unconsciousness are not in conflict: they are two aspects of the same system serving the same purpose. Social usefulness is important. Neurotics and psychotics have a private logic, protective in nature. Therapists take an active role, interpreting society to the patient. Grof (1985) argues that his LSD research shows that Freud and Adler, due to the inadequacy of their approaches, focused on two categories of psychological forces that, at a deeper level, are two facets of the same process. Both were deeply concerned about death – Freud feared it, and Adler narrowly escaped it at age five (Grof, 1985).

For Reich, it was the suppression of sexual feelings that caused neurosis which, in turn, were the result of a repressive society. He developed a system which released energy using hyperventilation and bodily manipulations, leading to the ability to experience full orgasm. Later, he became involved in the *Orgone* affair, which lead to his imprisonment and death (Grof, 1985). LSD work confirms

Reich's views about the psychoenergetic and muscular aspects of neurosis. However, rather than being due to pent up libido, in Grof's view the energy represents powerful forces from the perinatal level of the unconscious. The mistake made by Reich and his followers was due to BPM 3 having a substantial sexual component. Grof believes that Reich teetered on the edge of a transpersonal understanding, but he never reached a true understanding of the great spiritual philosophies, and confused true mysticism with mainstream dogmas.

Otto Rank (1945) departed considerably from the Freudian mainstream. His system was humanistic–voluntaristic as opposed to Freud's reductionist, mechanistic, deterministic scheme. He also emphasised the birth trauma, and insisted that a patient has to relive it in therapy, because post partum separation is the most painful-frightening experience. This led to primal anxiety and primal repression. He saw sleep as reliving the intra uterine life, and the Oedipal process in relation to desire to return to the womb. Rank argued that women can relive their immortality by their procreative ability, whereas for men sex is mortality and only in non-sexual creative acts can they find their strength. Rank saw the ultimate goal of religious activity as an attempt to return to the womb. Grof's LSD therapy strongly supports Rank's thesis about the birth trauma. However, for Rank, the trauma lay in separation and the unpleasantness of extrauterine life. In LSD work, these facts are true, but also the passage down the birth canal is extremely traumatic. Additionally, Grof argues (1985) that most psychopathological conditions are rooted in BPM 1 and BPM 2 (prior to postnatal experience).

Grof regards Jung (1970) as the most famous renegade of the original Freudian camp. His analytical psychology is far more than modified Freud. Jung accepted the new relativistic physics and saw the Cartesian–Newtonian paradigm as deficient. He also respected the mystical traditions of both east and west. Jung's ideas are closer to Grof's than any other western psychological tradition, because Grof regards Jung as the first transpersonal psychologist (Grof, 1985).

Existential – Humanistic Psychotherapies

These arose as a reaction to the mechanistic and reductionist nature of behaviourism and psychodynamics, and began with the work of Rollo May (May, 1967), but had roots in the work of Kirkegaard and Husserl. Individuals are unique, inexplicable in scientific terms, and have freedom of choice, where death is inescapable. This comes out strongly in the experiences of the BPM 2 condition (eg, feelings of meaninglessness, rat-race, treadmill). Frankl's *Logotherapy* also relates to these experiences (Frankl, 1963). Maslow was the great champion against reductionism in psychology, and introduced for psychological study topics such as love, a sense of beauty, justice and optimism (Maslow; 1968, 1976, 1993). He also saw value in combining observation with introspectionism. From this arose true humanistic psychology. There also arose a neo-Reichian school

(eg, Lowen, Rolf, Feldenkrais, Kelly and Trager), which attempted to liberate locked-in human potentials, with the emphasis on the bioenergetic systems, for example, the Rolfing massage system (Rolf, 1977).

There also arose the Gestalt therapy of Perls (1951), with its focus on re-experiencing conflicts-traumas, and the here-and-now. Perls' therapy involves working as an individual in a group, using breathing, attention to posture and so on. Related is primal therapy (Janov, 1970), wherein pent up energy is released in a scream. Janov's therapy is said to dispel the unreal system that drives one to neurotic–defensive behaviour. Grof argues, however, that the results lag far behind Janov's original claims (Grof, 1985). LSD research strongly supports the humanistic theses and the human potentials movement in general. Perls' system is probably the closest to what Grof is describing here.

Transpersonal therapies

The humanistic goal of self-actualisation was seen as too narrow, and the recognition of spiritual dimensions came to the fore (Sutich, 1968). The important representatives of this fourth force in psychology were Jung, Assagioli and Maslow. Jung stressed the importance of the unconscious, mystical, creative and religious, and developed the notions of complexes (constellations of psychic elements) and their primordial base, *archetypes*, where these create a disposition and synchronistically influence the very fabric of the phenomenal world. Dreams were seen as individual myths, and myths as collective dreams. Libido was not seen as a purely biological-sexual force aiming at mechanical discharge, but as a creative force in nature. Unlike Freud, who saw a historical-deterministic cause in his patient's problems, Jung saw a relativistic, acausal world.

Grof argues that his LSD research has repeatedly confirmed Jung's insights (Grof, 1985). The system of complexes is very similar to that of COEX systems, at the biographical level. Also supported is the collective unconscious, and archetypal dynamics. However, Jungian analysis doesn't deal effectively with the psychosomatic dimensions of the birth-death process, nor with the actual biographical aspects of perinatal phenomena. Jung explored some transpersonal aspects in great depth – collective unconscious, mythopoeic properties of the psyche, certain psychic phenomena and synchronistic links between psychological and phenomenal reality (Jung, 1970). But there was no exploration of transpersonal experiences that mediate connection with various aspects of the material world.

There is some similarity between Assagioli's and Jung's cartography of the human personality, since it includes the spiritual realms and collective elements of the psyche. Assagioli (1965) posited seven levels, where the lowest relate to primordial instincts and emotional dynamics, the middle to Freud's preconscious, and the highest to superconscious which is the seat of the intuitions-aspirations. His system is called psychosynthesis, where the therapeutic goal is self-

realisation and the integration of the sub-selves around a unifying psychological centre. However, as broad as this scheme is, there is, again, a lack of recognition of the biological components that certain psychosynthesis practitioners are integrating.

Maslow (1976) studied peak (mystical) experiences, and defined the stages leading to self-actualisation in his concept of a hierarchy of needs. In this he analysed human needs and revised the theory of instincts, where higher needs are not reducible to base instincts. Grof (1985) has found that Maslow's ideas receive powerful support from LSD work, as for example in peak experiences and Maslow's structure of the personality, with its lowest Freudian end and its highest transpersonal end. Grof concedes (1985) that Dianetics (more recently called Scientology) has far reaching parallels with his own work and findings, as pointed out earlier by Gormonsen & Lumbye (1979).

Conclusion

Grof (1988) argues that holotropic therapy has implications far beyond mere therapy, because its results point to a new understanding of human nature and human society. In particular, it gives insight into the underlying causes of malignant aggression in all its manifestations, because war in many aspects is relived in BPMs 2 and 3. The difference between these two is that in BPM 2 experiencers are passive victims, whereas in BPM 3 they can also be the aggressor.

Modern science and technology has provided the wherewithal to send people to the moon and do many other truly amazing things, and yet has done nothing for humankind's primitive instincts. According to Grof (1988), what we seem to have done is exteriorised our BPM 3 nature, as would be expected from the view of an evolving humanity. This can be seen in many aspects of modern life, from sexual promiscuity, through interest in the demonic and cults expecting salvation. The scatological element is there, too, with global pollution. All this seems as inevitable in the human race as it is in the individual undergoing holotropic therapy. It is the only way to reach what Grof calls higher sanity – that based on holotropic consciousness.

References

Adler, A. (1959) *Understanding human nature* Premier Books, NY.

Assagioli, R. (1965) *Psychosynthesis, a Manual of Principles and Techniques* Hobbs, Dorman, NY.

Bache, C M. (1981) On the emergence of perinatal symptoms in Buddhist meditation. *Journal for the Scientific Study of Religion* v 20 no 4, p 339 – 350.

Corsini, R J and D Wedding. (1995) *Current Psychotherapies.* 5th edition. F E Peacock Publishers Inc, Itasca, IL.

Deikman, A J. (1963) Experimental meditation. *Journal of Nervous and Mental Disease* v 136, p 329 – 373.

Deikman, A J. (1969) Deautomatisation and the mystic experience. *Psychiatry* v 29, p 324 – 338.

Frankl, V E. (1963) *Man's Search for Meaning.* Washington Square Press, NY.

Freud, S. (1985) *Early Psychoanalytic Writings.* Collier, NY.

Gormonsen, K and J Lumbye. (1979) A comparative study of Stanilav Grof's and L Ron Hubbard's models of consciousness: Presented at the *Fifth International Transpersonal Conference,* Boston MASS, November 1979.

Grof, S. (1970a) Psychotherapy and human culture: Part I. *Journal of the Study of Consciousness* v 3, p 100.

Grof, S. (1970b) Psychotherapy and human culture: Part II. *Journal of the Study of Consciousness* v 4, p 167.

Grof, S. (1970c) The use of LSD in psychotherapy. *Journal of Psychedelic Drugs* v 3, p 52 – 74.

Grof, S. (1972) Varieties of transpersonal experience: observations from LSD psychotherapy. *The Journal of Transpersonal Psychology* v 4 no 1, p 45 – 80.

Grof, S. (1973) Theoretical and empirical basis of transpersonal psychology and psychotherapy: observations from LSD research. *The Journal of Transpersonal Psychology* v 5 no 1, p 15 – 53.

Grof, S. (1975) *Realms of Human Unconscious: Observations from LSD Research.* Viking Press, NY.

Grof, S. (1980) *LSD Psychotherapy.* Hunter House, Pomona, CA.

Grof, S. (1985) *Beyond the Brain: Birth, Death, and Transcendence in Psychotherapy.* State University of New York, NY.

Grof, S. (1988) *The Adventure of Self-Discovery: Dimensions of Consciousness and New Perspectives in Psychotherapy:* State University of New York, NY.

Janov, A. (1970) *The Primal Scream: Primal Therapy – The Cure for Neurosis.* GP Putnam's Sons, NY.

Jung, C G. (1970) *Analytical Psychology: Its Theory and Practice.* Random Press, NY.

Maslow, A H. (1968) *Toward a Psychology of Being.* 2nd edition. Van Nostrand Reinhold, NY

Maslow, A H. (1976) *Religious Values and Peak Experiences.* Viking Penguin, Harmondsworth,

Maslow, A H. (1993) *The Farther Reaches of Human Nature.* Viking Penguin, Harmondsworth.

May, R. (1967) *Existential Psychology.* Random House, NY.

Orr, L and S Ray. (1977) *Rebirthing in the New Age.* Celestial Arts, Millbrae, CA.

Perls, F, R Hefferline and P Goodman. (1951) *Gestalt Therapy.* Julian Press, NY.

Rank, O. (1945) *Will Therapy, Truth and Reality.* Knopf, NY.

Richards, W A, S Grof, L Goodman and A Kurland. (1972) LSD – Assisted psychotherapy and the encounter with death. *The Journal of Transpersonal Psychology* v 4 no 2, p 121 – 150.

Rolf, I. (1977) *Rolfing: The Integration of Human Structures.* Harper & Row, NY.

Sullivan, H S. (1953) *The Interpersonal Theory of Psychiatry.* W W Norton, NY.

Sutich, A J. (1968) Transpersonal psychology: an emerging force. *Journal of Humanistic Psychology* v 1, p 77 – 78.

Watkins, J. (ed.) (1978) *The Therapeutic Self.* Human Sciences Press, NY.

BIBLIOGRAPHY

Bateson, G. (1972) *Steps to an Ecology of Mind.* Chandler Publishing Co, San Francisco.

Gelso, C J and R E Fassinger. (1990) Counselling psychology: theory and research on interventions. *Annual Review of Psychology* v 41, p 355 – 386.

Goldfried, M R, L S Greenberg and C Marmar. (1990) Individual psychotherapy: process and outcome. *Annual Review of Psychology* v 41, p 659 – 688.

Goodman, F D. (1986) Body posture and the religious altered state of consciousness: an experimental investigation. *Journal of Humanistic Psychology* v 26 no 3, p 81 – 118.

Grof, S and C Grof. (1980) *Beyond Death: The Gates of Consciousness.* Thames & Hudson, London.

Laing, R D. (1972) *Politics of Experience.* Ballantine Books, NY.

Lukoff, D. (1988) Transpersonal perspectives on manic psychosis: creative, visionary and mystical states. *The Journal of Transpersonal Psychology* v 20 no 2, p 111 – 139.

Lukoff, D, R Zanger and F G Lu. (1990) Transpersonal psychology research review: psychoactive substances and transpersonal states. *The Journal of Transpersonal Psychology* v 22 no 2, p 107 – 148.

Lukoff, D, R Turner and F Lu. (1992) Transpersonal psychology research review: psychoreligious dimensions of healing. *The Journal of Transpersonal Psychology* v 24 no 2, p 41 – 60.

Pressman, T E. (1992) The therapeutic potential of nonordinary states of consciousness, as explored in the work of Stanislav Grof. *Journal of Humanistic Psychology* v 32 no 3, p 8 – 27.

Tart, C T. (1991) Influences of previous psychedelic drug experiences on students of Tibetan Buddhism. *The Journal of Transpersonal Psychology* v 23 no 2, p 139 – 173.

Wilber, K. (1995) *Sex, Ecology, Spirituality: The Spirit of Evolution.* Shambhala, London.

Zaehner, R C. (1972) *Zen, Drugs and Mysticism.* Vintage Books, NY.

Book Review: *Psychotherapy in the Age of Accountability:* Lynn D Johnson, Norton

Marilyn Morgan

I picked up this book with reluctance. It felt like a 'should read', rather than a book that would be enjoyable or instructive, or both. For some time I have been aware of the direction ACC, and other funding agencies, are moving with regard to funding counselling and psychotherapy. Less of it, more control by them, and accountability from us. This move takes place in a general social climate that is putting an increasing value on efficiency, outcomes, economic units, accountability and cost effectiveness. To put it simply, funders want to cut costs and be reassured that they are funding a service that can be seen to work in a measurable way.

My first reaction, to both the current climate, and the book, was one of resistance. I resonate more easily with 'feminine' values of flow, unfolding, depth, mystery, psychotherapy as sacred, as relationship, as an area of knowing and unknowing finely balanced. Art and creativity flowing equally from intuition and knowledge. My instincts pull me away from the modern economic focus, seeing me retreat to a quiet schizoid cave, where I can savour my attachments to my own ways. Like my clients, I am wary of change, and I cling to what has served me well.

It would be easy to anticipate this book would be cold and inhumane. It is neither. I was surprised to find myself invited out of my cave, engaged and interested. The book is rigorous, (constantly referring to relevant research), and at the same time has a feel of warmth and concern for the cherished values of psychotherapy. Lynn Johnson's openness and creativity are endearing.

The author begins, "Psychotherapists face challenging times". I was challenged by this book, challenged to think, dust off some assumptions, and question my practice. But I was not provoked to reject. The content of this book, in general, is not easy to reject. I am left with the sense that I would be very foolish to ignore what Lynn Johnson presents. This book is not only an excellent manual for coping with increasing levels of managed care, but also educative in terms of ways to give our clients a high quality service. Johnson does not ignore the tough therapeutic situations, giving many usable suggestions for using his model with traumatised clients, substance abusers and adolescents.

Like it or not, we as psychotherapists, operate within the current social milieu. Our future livelihood may well depend on our ability to adapt. Clients are likely to start demanding a more focused approach as they become more knowledgeable about therapy, and funding providers and reviewers are already beginning to insist on time-limited, focused therapy. After all, they have the power of the cash-flow. Johnson humorously compares those who adapt and those who don't, to

mammals and dinosaurs. The dinosaurs decide that continuing to do what has always been done is the best way to meet the crisis.

Lynn Johnson is the director of the Brief Therapy Centre in Salt Lake City. He presents an integrated model of therapy, including elements that have been shown by research to be effective. He discusses the therapeutic relationship, and ways of focusing therapy to be effective within prescribed time-frames. Some of his material is very practical, and concisely outlined and readable. I sense an opportunity to prune dead wood, to cut away that which is not of value, or that which may be detrimental to our clients, and also ourselves. To do my work with more effectiveness and precision.

Lynn Johnson quotes research that shows a significant proportion of clients terminate after a few sessions. I'm not sure if that is the experience here. I am also not entirely comfortable with the 'problem' focus of Johnson's therapy. For providers who fund psychotherapy or counselling this focus is important, as it is for many clients. We have to meet them there, I acknowledge that. Funders do not see themselves in the business of providing therapy for 'unfolding', 'personal growth', or similar. Our society is nowhere near a place where spiritual growth or recovery is seen as a priority for the public purse.

Some clients will continue to choose a more unfocused psychotherapy. I believe there is an important and vital place for that in the unfolding, and healing of humanity. However, those who choose this will have to pay for it themselves. For me, the jury is still out on whether one can blend the focused, problem-centred approach, with a more unstructured way of working, that allows more space for the unconscious to emerge. I feel it is possible. Lynn Johnson's book has given me rich material and stimulation to address this question. Maybe 'focus' will be brought into the foreground for certain clients, and a different 'unfocused-focus' for those who Arnold Mindell calls the 'Growers Club', those who want to embark on the more unpredictable journey of 'finding/losing the self'.

BOOK REVIEWS: *Life and How To Survive It* Robyn Skynner and John Cleese, Methuen, and *The Nemesis File* Paul Bruce, Blake.

Peter Greener

Families and How to Survive Them, Skynner and Cleese, Methuen, London, was released to worldwide acclaim in 1983 and instantly became a best seller. *Life and How To Survive It* is the second part of the project the authors began in 1980. They "wanted to make available to the general public, in a way that was easy to absorb, those aspects of psychological knowledge we had found most helpful ourselves, towards making life more understandable, meaningful and enjoyable".

Families went on to become a classic text for mental health professionals and an excellent introduction to the psychodynamics of everyday life for the lay reader. By the time I'd finished reading *Life and How To survive It* I wondered whether a copy should be compulsory reading for every politician or aspiring politician in the land.

Following on from their previous book, Skynner and Cleese begin by re-visiting those factors which make for healthy individuals and families, but then move beyond, to explore recent research on characteristics of exceptionally health individuals and families.

They subsequently take the ideas from this research and, successfully I feel, extend and develop them in other contexts outside the family, examining the behaviour and characteristics of schools, businesses and organisations, social groups and societies.

When they move beyond the family and the organisation to examine societies, they explore the correspondence between the sickest and most healthy levels of families and their counterparts in societies. They develop a framework of analysis which helps to make sense of how political systems develop. They identify the characteristics of chaotic societies (Somalia comes to mind), totalitarian societies (Nazi Germany is the illustration they use), and democratic societies. They look at the part splitting and projection play in helping political leaders develop and maintain their power, and they emphasise how the form of government of a people relates to the stage of development of the society concerned.

To help encourage and develop debate about what might constitute elements of optimally healthy societies, they compare and contrast two peoples – the Ik of Uganda ("the loveless people") and the Ladahkis of northern India ("so healthy and so emotionally secure"), and two nations, the United States of America and Japan.

As with so many authors, they go on to highlight the danger of the deepening divide between nations of the first and third worlds, but they bring a new perspective to the argument. They look at the psychological elements that are at play in these situations. The richer nations, often former colonisers, continue, they suggest, to act out a parent/child split – projecting all their childish 'bits' onto less developed nations, just as within nations the rich view the poor as lazy, irresponsible and unwilling to work.

Moving beyond the social, economic and psychological discourse, they acknowledge that they take a risk of losing readers in Chapter 4, where they explore the place of spiritual and religious ideals in our lives. Those who stay with the chapter will be rewarded with some frank revelations about the place of spiritual and mystical experience in the lives of the authors, timely, following the theme of this year's Conference in Nelson.

The final chapter addresses what we can do to change not only ourselves, but our organisations and the society in which we live. Throughout, the emphasis is on the importance of personal growth and development and on influencing society so that change is organic, not brought about through the enforcement of power. Skynner says that people who are attracted to politics are often trying to change everyone else as an alternative to the real need to change themselves. Taking back projections and avoiding splitting, they suggest, is central to the development of real power; that is the challenge they leave us with.

"When democratic nations use the CIA and MI5 to behave like Big Brother we should not hesitate to see that it corresponds to behaviour in the sickest societies" (Skynner and Cleese, 1993, p 152)

In 1169, at the invitation of Dermot MacMurrough, the banished King of Leinster, Strongbow arrived with his troops in Ireland. Exactly 800 years later, British soldiers were to arrive again following the current round of 'The Troubles". Three years prior to this, in 1966, a young man called Paul Bruce, following in his father's footsteps, joined the British Army. *The Nemesis File* is the account of his six year career in the Army, though more precisely is a chilling and sickening account of the 12 months he spent in Northern Ireland on active service with the SAS.

Skynner and Cleese highlight the impact that positive experiences outside our family of origin can have on us, and explore how an experience in a 'healthy school' or organisations) can help overcome the experience of growing up in an 'unhealthy family'. The experience of Paul Bruce demonstrates how the development of apparently healthy attributes – trust, loyalty and obedience – can be used by the state to turn a young man, fiercely proud of his achievement at successfully becoming a member of the SAS, into a cold-blooded killer.

After leaving the army, Paul Bruce became an alcoholic. Over twenty years later this book strikes me as part of his therapy. The grammar and style are not those of a professional author, and at times the themes are repetitive, but that's hardly surprising. For those who think the world should be fair, this book is a rude awakening.

CONTRIBUTORS

Brian Broom MBChB *Otago* FRACP, MSc(Imm) MASCIA MNZAP. Committed to integrative and holistic approaches to healing. Is consultant physician in Allergy and Clinical Immunology, and an active psychotherapist with a specialisation in the psychotherapy of somatic illnesses. Interested in the potential of the spiritual focus for healing. Works from the Arahura Christian Counselling and Medical Centre, Christchurch.

Bruce Hart BSW, MSc, MAFT(UK), MUKCP, NZAP Applicant. Trained in Family Therapy at the Tavistock Clinic in London. Moved to New Zealand in 1995 and is working at Starship Children's Hospital in Auckland, building a private practice, and teaching a family therapy module at AIT. Interested in exploring ways of integrating object relations ideas with systemic approaches.

Helen Palmer BA, LLB, DipPsychotherapy *London* MUKCP, MNZAP. Co-founder and Director of the Institute of Psychosynthesis (NZ) in Auckland. Worked as a psychotherapist and trainer in Britain and Ireland before returning to New Zealand in 1986. Has a private practice and does process consultation to organisations.

Laetitia Puthenpadath MSc *India* MRed *Manila* DipPsychotherapy *Auckland* MNZAP. Lives in a small community of Christian women. Has been training further in psychoanalytic psychotherapy with AFCP and IPP in Auckland since 1993. Worked in private practice for five years and has been working in Community Mental Health since 1993

Margaret Bowater MA, Clinical Member of ITAA, MNZAP. Co-Director of the Human Development and Training Institute of New Zealand. Tutor, supervisor and psychotherapist in private practice. Is the facilitator of a three stage dreamwork programme in Auckland. Loves beaches, books and jigsaw puzzles.

Marilyn Morgan SRN, BA (Soc Sci) MNZAP. Psychotherapist in private practice in Napier, teacher and artist. Trained in Process Oriented Psychology, and Hakomi Body-Inclusive Psychotherapy. Particularly interested in trauma recovery, and integrating social and spiritual perspectives in psychotherapy.

Neal Brown BA DipTheol, DipAdultPsychotherapy, MNZAP. Working as a member of the staff at the Cameron Centre at Presbyterian Support Services in Dunedin. Has an ongoing interest in the integration of psychotherapy and spirituality.

Peter Greener DipBusStudies *Kingston* CQSW *Croydon* MPP *Victoria* MAFT, MIPP, MNZAP. Director of Auckland Family Counselling and Psychotherapy Centre, Chairman of the New Zealand Institute of International Affairs, and is a PhD candidate in the Political Studies Department of Auckland University. Has a major interest in conflict prevention, conflict analysis, and conflict resolution.

Peter Hubbard MA, DipPsychotherapy *London* MUKCP, MNZAP. Co-founder and Director of the Institute of Psychosynthesis (NZ) in Auckland. Trained and worked in London before returning to New Zealand in 1986. Is a psychotherapist and supervisor in private practice and is interested in the psychology of men's issues and the contexts of psychotherapeutic practice.

Peter Jackson MA(Psych) MNZPsS, MNZRS. Teaches psychology courses within the degree programme of the Open Polytechnic of New Zealand. Special area of interest is the relationship between the transpersonal psychotherapies and the evolution of human consciousness.