JOURNAL OF HUMANISTIC PSYCHOLOGY

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COMMENTARY

By the Editor

I am pleased to announce that David Cain has accepted the position of JHP's Psychotherapy Editor. This is a new position at JHP, and we are fortunate to have someone so experienced to help us coordinate the reviewing and editing of papers on psychotherapy and counseling with an existential-humanistic (and sometimes transpersonal) slant. David is the editor of a major book in press titled *Humanistic Psychotherapies: Handbook of Research and Practice* (Jules Seeman is the associate editor). He received his doctorate in clinical and community psychology from the University of Wyoming. After completing an internship at Larue Carter Psychiatric Hospital, he worked for 8 years as a child clinical psychologist at Clifford W. Beers Guidance Clinic in New Haven, Connecticut, where he was director of research, group therapy, in-service training, and graduate training in psychology. David then moved to the central coast of California where he worked as a staff psychologist in the Counseling Center at California Polytechnic State University, San Luis Obispo. While there, he developed an eating disorders program and a crisis intervention service, served as coordinator of graduate training in psychology, and worked with several varsity teams as a sports psychology consultant.

David moved to the San Diego area in 1987 and spent a number of years in private practice and teaching as an adjunct professor at several universities. Currently, he is the director of the Counseling Center at United States International University and adjunct faculty in the psychology department at Chapman University. He is the founder of the Association for the Development of the Person-Centered Approach and is the founder and editor of the *Person-Centered Review*. He is a fellow in Clinical Psychology of the American Board of Professional Psychology, a member of the National Register of Certified Group Therapists, and in addition to his service to JHP, is on the editorial board of *The Humanistic Psychologist*. He is presently working on a special issue of the *Journal of*

Humanistic Psychology titled "Advancing Humanistic Psychology in the 21st Century: A Call to Action."

His interests include the critical analysis and development of all major humanistic psychotherapies, refinements in empathy, understanding how people succeed or fail in processing their experiences effectively, and understanding the client's experience of psychotherapy. David's personal passions include managing and playing on the "Brooklyn Dodgers" baseball team, tennis, and the mind of the dog, especially that of his 4-month-old golden retriever who brings daily delight to his life.

Next, I want to call your attention to two important books by members of JHP's Board of Editors and authors. John Rowan has published *Ordinary Ecstasy: The Dialectics of Humanistic Psychology* (Brunner-Routledge, 2001). Here is what two members of JHP's Board of Editors have to say about it:

> John Rowan identifies the many threads of humanistic psychology, and then gets below the content to essential structures of humanistic thinking and clinical process: paradox and dialectics. The clarity of his theoretical contribution can help humanistic psychology develop needed advances in rigorous thinking about humanistic theory and practice. (Ilene Serlin, Saybrook Graduate School)

> I love this book. Comprehensive, informative and scintillating, *Ordinary Ecstasy* is a brilliant contribution to the renaissance of humanistic psychology. A valuable resource for professionals and the lay public, it explores humanistic psychology from the historical and global perspective. (Eleanor Criswell, Sonoma State University)

Back in 1967, Jim Bugental edited *Challenges of Humanistic Psychology* (McGraw-Hill), still one of the classics in the field. Now, thanks to editors Kirk Schneider, Jim Bugental, and Jean Pierson, we have "Son of Challenges," officially titled *The Handbook of Humanistic Psychology: Leading Edges in Theory, Research, and Practice* (Sage, 2001), weighing in at 730 pages and costing a mere $125. As I look through the list of authors, I see many JHP contributors and chapter titles based on articles in JHP. Here is what Sage says about the book:

> promises to be a landmark in the resurgent field of humanistic psychology and psychotherapy. Set against trends toward psychological standardization and medicalization, the *Handbook* provides a rich tapestry of reflection by the leading person-centered scholars of our time. Their range of topics is far-reaching—from the historical, theo-

retical, and methodological, to the spiritual, psychotherapeutic, and multicultural. Psychology is poised for a renaissance, and this *Handbook* will play a critical role in that transformation. As increasing numbers of students and professionals rebel against mechanizing or, on the other hand, relativizing trends, they are looking for the fuller, deeper, and more personal psychological orientation that this *Handbook* promotes.

John Vasconcellos, California State Senator, writes in the Foreword, "There is almost nothing as powerful as an idea whose time has come, and this volume demonstrates that our time has come for humanistic psychology." Says Irvin Yalom, "A cornucopia of valuable historical, theoretical, and practical information." Brewster Smith, former APA President, member of JHP's Board of Editors and frequent contributor, says,

> The editors represent both the founding generation and contemporary leadership, and the contributors they have enlisted include most of the active voices in the humanistic movement. I know of no better source for either insiders or outsiders to grasp what humanistic psychology is about.

Mihaly Csikszentmihalyi, who published about his flow theory in JHP back in 1975 long before he got involved with "positive psychology," writes in the preface,

> The chapters assembled in this volume show the exuberant variety of applications of the humanistic perspective and the way in which these follow from previous insights into the nature of human beings, from those of Nietzsche, James, and Kierkegaard to those of Camus, Vigotsky, and Fellini. There is no question that, now more than ever, we will need the insights into psychology that the humanistic perspective can provide.

And from Leslie Greenberg:

> As a humanist it offered me a breadth I had not known existed, as a researcher it offered me an excellent statement of in depth research procedures to get close to human experience, as a practitioner it offered me inspiration. For all those who work with and explore human experience, you cannot afford to miss the voice of the third force so excellently conveyed in this comprehensive coverage of its unique view of human possibility and how to harness it.

Is that enough to convince you? Order *The Handbook of Humanistic Psychology* from Sage at (800) 818-SAGE (7243) or (805) 499-9774 or order@sagepub.com.

I hope by now you all know what c/s/x means. This issue leads off with Ronald Bassman's article, "Whose Reality Is It Anyway? Consumers/Survivors/Ex-Patients Can Speak for Themselves." They are becoming increasingly vocal, although each group has somewhat different and sometimes conflicting things to say about what constitutes help and civil rights for troubled people. JHP has published a number of articles by survivors, including two by Karl Ericson (a pseudonym) in the Winter 1986 and Winter 1990 issues, and one more recently by Al Siebert in the Winter 2000 issue. We hope to publish more in the future.

When Ron Bassman was 25, he entered a psychiatric hospital for the second time in 3 years where he was blessed with electroshock, insulin comas, massive doses of drugs, and a psychiatrist's pronouncement that he must stay on drugs for the rest of his life and return to the hospital for weekly "treatment." With this unusual preparation, he moved on to graduate school, earned his doctorate in psychology, and now is a licensed psychologist working for the New York Office of Mental Health as the coordinator of self-help and empowerment projects. His article here tells his story and ends with the question of why mental health professionals are mainly allied with medically oriented, drug-dominated oppressive mental health systems "treating" what they call "illnesses" rather than allying with groups such as the National Association of Rights Protection and Advocacy (NARPA) (see NARPA's Web site: www.connix.com/~narpa).

Next is a related article that warns you, don't ingest the *Diagnostic and Statistical Manual of Mental Disorders*—it could be harmful to your health and that of others. That warning is issued by authors Lara Honos-Webb and Larry Leitner and illustrated by the case of "Steve." They show how his internalization of his stigmatizing diagnoses reinforced his negative "defective" identity, blocked progress in psychotherapy, and robbed him of hope. They cite research showing that when severe problems in living are reified as "diseases," clients receive harsher treatment. Steve arrived at a clinic where the authors worked after having been molested by a staff member during one psychiatric hospitalization and having

been given many diagnoses by previous therapists, in one instance three by one psychiatrist. We who champion the concept of "the person as process" and the growth potential latent in troubled people too often are confronted by colleagues and clients who use static, pathology-dominated concepts. At one point Steve says, "I'm crazy. What I think really don't matter." The authors believe it does matter, and that his self-efficacy can develop out of his thinking, and feeling, for himself. Furthermore, they argue that all diagnoses should include assessment of strengths and strategies for building on them. See what you think about this article and whether, in contrast to Steve, you dare trust your thinking.

I have a special fondness for studies of psychology and literature (my chapter in the above-mentioned *Handbook of Humanistic Psychology* is about Camus). One of my favorite related JHP articles was in the Fall 1995 issue in which Samuel Sackett wrote "The Application of Rogerian Theory to Literary Study." In the present issue, Will Adams entices us to read *Frankenstein* in the light of existentialism and psychoanalysis so as to develop a deeper appreciation of the daimonic, the return of the repressed, and the cost of evading existential challenges. You may be surprised to discover who Frankenstein actually was. Will Adams claims that in the process of writing the story, Mary Shelley was able to transform her own suffering into a work of art. But can psychology help Western civilization similarly redeem itself? The author quotes T. S. Eliot, "We had the experience but we missed the meaning," and Rollo May, "Not to recognize the daimonic itself turns out to be daimonic; it makes us accomplices." Will Adams was educated at West Georgia College and Duquesne University, institutions that have produced many humanistic scholars, and his article here is a significant continuation of that tradition.

Occasionally JHP publishes a poem, and this issue contains one by Barbara Patricola-McNiff that struck me as related to the previous articles, perhaps because it alludes to mourning and reparation.

Andrew Garrison, a Quaker, argues in the next article that humanistic psychology is closer to positivistic psychology than it would like to admit because it tends reductionistically to locate all values in the immanent human organism rather than viewing them as actual connections to transcendent values. For such secular humanistic psychologists, all values are inner, comparable to instincts, not transcendent except as they proceed upward out of

humans. Brewster Smith expressed this viewpoint well in his Winter 1986 JHP article "Toward a Secular Humanistic Psychology." But Viktor Frankl, Maurice Friedman, and others have expressed concern that this orientation may end up focusing on the self rather than transcendence of the self and that something more is needed. Maslow himself, as Andrew Garrison aptly quotes him, became concerned about this limitation. This article emphasizes the significance of dialogical, participatory, contextual human being and becoming in a vast "wonder-full" universe. Is this spiritual, transpersonal, or still humanistic? You decide.

Eugene Gendlin's book *Focusing* was published 20 years ago, and his method has had wide applications. Experiential Focusing-Oriented Dream Interpretation is an outgrowth of his work. This issue contains a convincing research report by Kuei-an Kan, Janice Miner Holden, and Andre Marquis demonstrating that the effects of this method can be reliably assessed with the authors' Dream Interpretation Effects Questionnaire, using a pretest-posttest control group design. This approach lends solid support to the claim that dream reexperiencing and interpretation can facilitate constructive psychological changes, not just insight. I especially like this study's combination of rigorous quantitative research with rich qualitative observations.

The concluding article in this issue is by David Ryback and three Japanese colleagues, Akira Ikemi, Toru Kuno, and Yoshihiko Miki, the latter being a proficient magician. Their article, however, is not about magic but rather about Tomoda, Renku Therapy, and Naikan Therapy, among other things.

And who was Tomoda? The translator of Rogers' *Counseling and Psychology* (1942), which did exercise a kind of magic at that time. A lot has happened since then in Japan's humanistic psychology, and this article helps bring us up to date with regard to a culture and a "Za" in severe crisis. Akira Ikemi was coauthor of a previous JHP article, "Humanistic Psychology in Japanese Corporations: Listening and the Small Steps of Change" (Winter 1996), and Toru Kuno was coauthor of "The Client-Centered Therapy and Person-Centered Approach in Japan: Historical Development, Current Status, and Perspectives" in the Spring 1992 JHP. David Ryback has been an associate editor of JHP for many years and most recently contributed the article "Mutual Affect Therapy and the Emergence of Transformational Empathy" to the Summer 2001 JHP.

This is the fourth issue of JHP's first 21st-century volume, and I hope you'll agree that we are off to a good start. If you want to review the previous century's issues, see the Fall 2000 JHP containing the 40-year index.

Tom Greening

WHOSE REALITY IS IT ANYWAY? CONSUMERS/SURVIVORS/EX-PATIENTS CAN SPEAK FOR THEMSELVES

RONALD BASSMAN is a licensed psychologist and a psychiatric survivor who works for the New York Office of Mental Health Bureau of Recipient Affairs as the coordinator of self-help and empowerment projects. He is a member of the APA task force on Serious Mental Illness, faculty member of the Center for the Study of Issues in Public Mental Health, and president of the National Association for Rights Protection and Advocacy.

Summary

The author uses personal narrative to vividly describe his entry into the mental health system with a diagnosis of schizophrenia. Based on his experience, he describes and criticizes a mental health system that forces people to endure oppressive treatments in the name of help. Interweaving first-hand experience as a patient with his later training as a psychologist, he challenges the biomedical brain disease model and advocates for self-help, empowerment, and peer-run alternatives. The history of the almost 30-year-old movement of activist consumers/survivors/ex-patients is described and introduced as offering promising possibilities for creating innovative options for services. Questions are raised as to why mental health professionals have absented themselves from speaking out against the obvious abuses, rights violations, discrimination, and social injustices faced by people who are diagnosed and treated for madness. An invitation is extended for professionals to modify and reconsider the usefulness of the expert role and instead to form new partnerships of collaboration and advocacy.

They rode in silence to Fair Oaks Hospital, parents aching for the recovery of a broken child. One powerful certainty bridged their differences—their son would never be abandoned. Without

knowing who was enemy or ally, a deadly threat propelled them on their mission.

Determined, unyielding tenacity was their strength. She was anxious, frightened, but above all, angry and intolerant of her own ignorance. He was unexpressive, appreciative of the control driving afforded. The car was his domain; the children hers. The unity mobilized by crisis muted years of quarreling. She would soon be asked to let down the walls of privacy that insulated and protected her family. The traditions and history of many generations made it impossible to trust the dreaded authorities. But the new danger required the summoning of strength from the deepest of human wells . . . a mother's resolve. Father would remain impassive; a lifetime of inaction would not be transcended. With an odd mixture of resignation and hope, they looked to the doctor for answers.

"What's wrong with him?" my parents pleaded. "He's always been a good boy. When will he get better? What should we do? How did this happen? Whose fault is it?"

The questions were for the doctor, but later would be asked of God. A broken foot was for the doctor, but a broken boy, who is to treat such a sickness? Their generation had witnessed the medical miracles of modern science. They regarded the doctor with reverence. Indeed, the doctor was royalty.

The doctor asked endless probing questions. She wished she could explain in Yiddish, but the doctor was a gentile; he would not understand her family regardless of the language. She forced herself to try—his guidance was desperately needed. The immigrant's dilemma, the inability to communicate in English, was for her always a source of pain and humiliation. She never forgave herself for her lack of education. Her husband's understanding of English could not compensate for his lack of knowledge about his children's lives. All he could do was help his wife understand the doctor's questions. As always, she would make the decisions. His typical response to crisis was activated; defenses went up as he distanced himself from the outside world.

"He is a very sick boy," the doctor declared. "You must authorize us to treat him in the way we know best; otherwise he could be in a mental hospital for the rest of his life. You have to follow our instructions and leave him to us or we won't be able to help him."

Alone and isolated, I in the locked seclusion room, mom and dad trying to deal with the mystifying loss of a once promising son, we could have been worlds apart, but we were just in adjoining build-

ings facing our shared helplessness from different angles. Locked in that room, my family and I lost my 23rd birthday.

I cried out, "Help me, let me out of here. You . . . over here, come here. I'm in here . . . can't you see me. You . . . stop, don't go. Just talk to me, tell me where I am. Come back. Open the door. Someone do something. I don't belong here, I didn't do anything. Somebody made a mistake. Is anybody out there? Please."

I have to figure out why I'm locked in this room. What am I being punished for? I don't feel good. I don't feel right, I can't think straight. Why won't anyone talk to me? God . . . I'm naked . . . my clothes, where are my clothes? I've got to do something. Are they watching me? Maybe it's a test. I can't stand it in here. I need space to walk, to breathe. I'm suffocating in here . . . I'm going to die if I don't get out of this room. I can't yell anymore, my throat's too dry and sore. I can't just wait. They want me to yell. It's a test. They're watching me to see what I'll do. They're trying to make me change. They won't change me. I won't give in.

"Open this door. I demand my rights. You can't do this to me. I'll tear this room apart. . . . I'll get you. You can't do this to me. Is there anyone out there? You better listen. . . . I'll be good." *Please hear me.*

My belief in fairness was severely damaged during my first few months of confinement. Foolishly, I continued to demand rights that I believed I had, only to discover that I would pay dearly for my ignorance at playing the hospital game. My angry demand, "You can't do this to me," was met with increases of my medication and extended stays in the seclusion room. My anger, my resistance, my noncompliance were serious concerns to the staff. I was not responding quickly enough to my psychiatric cocktail mixes made up of large doses of Thorazine, Stelazine, and intimidation.

My introduction to my new treatment was announced by my mother. "The hospital gave you a complete physical examination . . . you're in perfect health." A too brief elated thought, *They're going to let me go home.* The hope flew away quickly when next my mother said, "The doctors are going to give you insulin treatments and that will make you better so you can come home." A series of 40 insulin coma treatments was supposed to kill the dreaded disease even if it also destroyed my memory and whatever else (spirit) dared to get in its path and fueled my belief that I was not sick.

At some point during that series of coma treatments I began answering the psychiatrist's questions in a more acceptable manner. My senses were dulled and my memory began to fail. I was

becoming an automaton. They were impressed with my "progress." I became a good hospital patient and acquired privileges. Docile and trustworthy, I had an unlocked room and was permitted visitors.

My friends Elliott, Jack, and Julian were allowed to visit me for the first time. The three of them stood across from me in my room, and we tried to talk. They were as nervous and ill at ease as I. I couldn't think of anything to say. What could I say? We had no common experience to share. My reflexes and thinking were slowed down. I was embarrassed to be seen in my forlorn, defeated condition. My thoughts and feelings centered on pain, loss, and humiliation. They didn't take their coats off. I was probably relieved that their visit was short, but I did notice a small voice welling up inside of me. . . . *Please help me get out of here . . . take me with you . . . do something . . . don't you see they're killing me.*

I could not say it out loud. The game had become a part of me. Appearance was everything. I did not want them to know. I will not look desperate or crazy. I won't take the risk of being put back into seclusion or having the drugs increased or having my series of shock treatments extended. I will continue to be bland, apathetic, a threat to no one.

My friends left. Quickly, the sadness and hurt swept over me filling the emptiness inside and momentarily overpowering the deadening effects of the drugs. I could not block out the hurt; the tears came, but I made sure the staff did not see. Crying in public is inappropriate.

Months later I shuffled into the office, physically demonstrating the hospital's successful transformation of anger, fear, and defiance into apathetic compliance. Defeated and dejected, I was too weak to resist the psychiatrist's argument to my parents at my discharge meeting. His job was to convince us that I was an incurable "schizophrenic." I was 23 years old when that prosecuting doctor, serving also as judge and jury, sentenced me to a life of, at best, controlled madness. With the smug certainty of a bookie, the doctor told my family that my chances of making it without being hospitalized again were very slim. His medical orders were stated with an absolute authority that discouraged any challenge. Barely acknowledging my presence, he nodded toward me and declared, "Your son has to take medication for the rest of his life and must return to the hospital regularly for outpatient treatment. He

should not see any of his old friends. If his behavior changes or he gets upset, let me know."

Innocence vanquished, the life I once knew was gone forever.

A PLEA FOR HUMILITY: LOOKING AT
THE IMMATERIAL DYNAMIC OF HEALTH

In ancient Persia the first healers were priests. Their practice was based on the principle that the devil had created 99,999 diseases that should be treated by a combination of magic and hygiene. They favored the use of spells on the grounds that although they might not cure the illness, they would not kill the patient—which was more than could be said for drugs and physical treatments (Durant, 1954). In the treatment of "mental illness," the credo *do no harm* has too easily been ignored.

Attempts to unlock the mysteries of the disordered mind and the belief in its centrality to the understanding of human experience have attracted, stimulated, and frustrated "great thinkers" throughout our recorded history. Today, modern medicine through its biochemical model of illness has ascended to the position of pre-eminent authority in the understanding, care, and treatment of "mental illness." With an absolute certainty that parallels papal infallibility, organized medicine has promoted unproven dogma as scientific fact. Diagnosed into being objects, imprisoned with or without walls, cut off from meaningful dialogue, the psychiatric consumer/survivor/ex-patient (c/s/x) must adapt to an other-constructed, authority-blessed reality.

To attempt to understand what another feels, to be there with another is difficult even when one can rely on reference points drawn from similar experiences. But what of the attempts to be empathic with those who confuse or frighten us, where disorder and spontaneity give the appearance of random unpredictability? It is easier to attend to and be open to the experience of an *other* when the listener is told about the pain, rather then being right there with him while the psychic turbulence is being experienced.

What is crazy? Does it have an edge, an invisible boundary one steps over, or is it like falling off a mountain cliff? Falling onto the craggy ledges of the cliff may provide temporary porches of respite. Some may tumble into that black hole propelled by the pushes of seen and unseen forces from within and without. Those unlucky

enough to fall to the bottom suffer a hell that eludes description to all but the gifted artist. Once trapped, the slippery shiny sides of that imaginary yet real hole rebuff and taunt one's attempts at escape. Family, friends, and doctors drop ropes and ladders to offer their help, but absolute obedience is too steep a price for that assistance. Passion, drive, self-respect, and long-held dreams should not be regarded as excess baggage to be discarded before the ascent. And for some, the bottom of the hole is on paradoxically higher ground than the plane from which their stumble or leap originated. It is in the construction and articulation of the frame that the experience is positively or negatively defined.

Alone and surrounded by others, painful silence punctuated by unbearable noise, nothing is predictable. The confused darkness of dread, terror, and loneliness make night and day indistinguishable. Reality's laws have exploded. The self has disintegrated. All is possible. Nothing is doable. Yet, for those who are able to look into and see beyond their distorted reflections in the glistening, magical rock-solid walls of their mad confinement, hope can illuminate a vision of possibility for a better tomorrow (Bassman, 1999).

Drawing on my personal experience of madness and confirmed in conversations with many psychiatrically labeled people encountered in my work of the past 5 years, I have learned that some such people are in distress whereas others are not. Before people are officially labeled and treated for "schizophrenia" or "bipolar disorder," they are not necessarily suffering. People can and do enjoy an altered state in which mysteries, freedom, and transformative possibilities beckon. Gammill (1986) saw beyond some of the inaccurate theorizing and depictions of people "suffering" from "schizophrenia" as weak-willed and unable to take responsibility, and observed instead that there was a great deal of self-direction operating. However, postulating that the "preschizophrenic" made choices is only partially true. Such fixed-state theories that postulate a "preschizophrenic" condition that later manifests itself in "schizophrenia" string together too many unproven assumptions, not the least of which is calling a way of being and behaving sick and naming it "schizophrenia." Beyond the *choice* of sickness or wellness, the individual makes many choices every day; some are automatic and habitual, whereas others contain a fully conscious awareness not often accessible to the chronically normal.

Carl Jung (1958), R. D. Laing (1968), and John Weir Perry (1974) described feats of courage and heroism associated with one's

descent into psychosis, and the struggles and necessary battles to survive and overcome. Yale University's John Strauss (1992), internationally renowned psychiatrist and expert on "schizophrenia," told how his perspective has changed over the years. Once an investigator engaged in the identification of psychopathology, he now attempts to see the whole person. Strauss spoke of the great courage he has seen displayed by people living under extreme stress in near impossible circumstances. Expressing embarrassment at what he called psychiatry's rubber gloves approach to people, Strauss compared the methods of the biographer, who studies and researches a subject for years, with the absolute diagnostic and predictive statements required of psychiatrists based only on a 20-minute mental status examination. The disrespect for one's life story demonstrated in diagnostic interviews too easily breeds expedient shortcuts that masquerade as help.

I am not suggesting that the travails associated with madness can be simply explained as the adventures of heroes engaged in mythical quests to find their identity. But I do believe that each person's journey into and out of their altered states is unique and charged with heroic possibilities. Our understanding of these quintessential human conditions is severely limited by a Western societal penchant for accepting too facile generalizations and labels that do more to obscure than describe.

Magical thinking, the attributing of causation to unrelated phenomenon with disregard for the evidence, does not distinguish psychopathology from eccentricity or gifted insight. Weeks and James (1996) wrote, "Objective cannot always be distinguished from subjective intuitions . . . . Thus under certain circumstances a person's grasp of reality may be made to feel false . . . . It has been said, uncharitably, that while neurotics construct castles in the air, psychotics live in them. This formula is not only unkind: it is wrong. It overlooks the essential role played by fantasy in human affairs" (p. 36).

Feeling or being different, whether one sees oneself as touched with a gift or suffering a curse, sets one moving on an uncharted course. Too easily, stress, life circumstances, temperament, and motivations can lead one to misconstrue meaning and misapply knowledge. With the combination of naivete and desperation, and lacking supportive and empathic anchors, one might easily aggrandize this gift/curse and twist it into an overgeneralizing, all-powerful escape that is needed to replace an undesired self and an

accumulation of unsatisfactory life choices. In her article on the role of will in "schizophrenia," Hoover (1971) only glimpsed the extraordinary strength of will available when one's life is disengaged from habitual constraints. To those outside the process, what is primarily witnessed is a powerful oppositional resistance.

IN QUEST OF BECOMING: CAN IT BE OTHER THAN A RISKY PERSONAL JOURNEY?

How do you react to being trapped? Do you permit the frustration and hopelessness to expand and permeate all parts of your being, to take over your whole life? Only 22, I would not or could not accept the inevitable conclusions that life events were pushing on me. I knew I had to change something. Earlier, searching for the keys to transformation, I had studied psychology to discover the secrets of change. At some juncture during that summer preceding my first bout with generic "madness," I glimpsed my doorway—*not caring* would set me free. In Thomas Merton's book, *The Seven Story Mountain* (1948), he wrote of his admiration for the peaceful freedom of the Trappist monks. Rather than excelling from standing out, the most successful monk is the one who best blends in and is never noticed. Merton wrote that the Trappist monk is free from the constraints of living in the projected imagination of others and thus having to submit always to their perceived judgments. That summer in 1966, I was dabbling in that principle of freedom, but I lacked the faith, knowledge, discipline, and commitment of the Trappists. I also lacked a community of support.

Once diagnosed and treated for a "major mental illness," your life's course is deeply affected by how you integrate that experience into your identity. The number of obstacles you need to overcome after you have been hospitalized and permanently labeled discourages the "recovered" from being open about their experiences and becoming role models who could inspire hope in others. Engaged in an all-consuming struggle to stay out of the hospital and survive, I distanced myself from my psychiatric history by becoming a member of the "hidden recovered." What I experienced before and during my hospitalization demanded a new way of understanding in order for me to reconstruct my self in a form other than mental patient.

My desperate search for answers in psychology books was a fruitless endeavor. In 1971, Barnes and Noble did not provide coffee-drinking comfortable reading rooms, nor did they have shelves overflowing with self-help and New Age books to explain the heretofore unfathomable with a plethora of alternative reality explanations for those who chose to be believers. Then, the few romantic alternatives I could find to the despairing medical predictions of a disease that would run a lifelong deteriorating course were the works of R. D. Laing, Harry Stack Sullivan, and William Reich, but they were at that time too difficult for me to comprehend and did not connect with my experience. Books like *I Never Promised You a Rose Garden* (Greenberg, 1964) made me long for a therapist with the caring warmth and incisive brilliance attributed to Frieda Fromm-Reichmann, but I knew that my answers would have to be found elsewhere. Then, I was too damaged to be verbal enough, or open enough, or interesting enough (having the requisite ego strength) to be a suitable candidate for such insight-driven therapy. At that same time, my search for answers from professional experts sidetracked me from participating in the beginning of a movement in New York and California that was intent on transforming the roles of mental patients by liberating them from "mentalism" (Chamberlin, 1990). The birthing and development of the consumer/survivor movement did not come to my attention until 20 more years had passed. However, I persevered in my quest to find meaning through education; I eventually returned to school and succeeded in fulfilling my long-held dream of becoming a licensed psychologist.

THE C/S/X MOVEMENT

Today, having earned the "credentials" and respect of my professional colleagues and my c/s/x peers, I have the opportunity to speak out and advocate for those who have lost their voices. Too many of us have been made to accept the too strongly promoted, most current beliefs about "mental illness" with its pronouncements of lifetime disability and its associated demand to downsize one's dreams and aspirations. Others define realistic expectations for us as low stress jobs in the 4F fields: Filth, Filing, Food, and Fetching. Too many have learned to survive by becoming helplessly and hopelessly compliant. I join with my c/s/x peers in an expand-

ing social movement, a rights movement that has never before existed. Always in the past, mental health reform has been driven by the passion and leadership of a few special individuals, and when their time has passed, the reform and progress has ended. The hope now is that through the discovery of each other, the bonding and alliances, the once isolated closeted recovering, the recovered and transformed will find validation with others who have shared their experience of confusion, pain, and oppression. Having rediscovered the personal truths of their experience, they will no longer allow themselves to be defined by labels that deny their dignity and value as whole people with diverse strengths and weaknesses.

I had no exposure to the concept of a c/s/x movement in 1974 when I received my Ph.D. When I think about the development of that movement, it seems almost as if it or I traveled in parallel universes. Here I was feeling alone, different and continuously studying, searching and wondering if there was anyone out there who could understand or connect with my experience. At that very same time, some people who were lumped together as "mental patients" began rejecting the inevitability of passively accepting their powerless place in the world. After first co-opting their own pejorative labels (Insane Liberation Front, National Alliance of Psychiatric Survivors, Mental Patients Liberation Alliance) to draw attention to their new activism, these c/s/x activists used those same names to self-identify their relationship to the mental health system. The early names, "mental patient" and "client," were closely tied to the mental health system. The people who identified with names like "consumer" and "ex-patient" tended to be dissatisfied with existing mental health services but believed in the gradual reform of the system. They wanted more and better services that valued their participation. "Ex-inmate" and "psychiatric survivor" became the names favored by those who rejected the medical model of mental illness and its legal mandate to provide forced treatments. Regardless of where these new activists stood on the name continuum, they shared beliefs in the need to have their rights restored and protected (Bassman, 1997a). To be empowered and to advocate for user-controlled alternatives were common goals. For the psychiatric survivor as well as the consumer, the need for quality alternatives to forced treatment was a priority. No issue was more powerfully charged than *forced treatment*. The value of self-help begins with the free and noncoercive

choice exercised by participants. The denial of freedom in all its involuntary treatment forms cannot be overestimated in its implicit and explicit consequences (see Thomas Szasz's many critiques of psychiatry's reliance on force beginning in 1961 with *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*).

When you are no longer permitted to assume responsibility for your own health and actions, you are profoundly affected. Even those consumers who are grateful for what they construe as a life-saving intervention face the prodigious task of disengaging from their journey down the narrow regimented circular path of passive dependency. Others, after having been forced into a hospital, avoid mental health treatment, preferring a homeless life on the streets.

FORCED TREATMENT: AN OXYMORON

In a seminal research study supported by the California Department of Mental Health and conducted by c/s/x researchers, 55% of the people who had been involuntarily hospitalized reported that they would avoid treatment out of fear of involuntary commitment (Campbell & Schraiber, 1989). The authors reported that 93% of 234 clients felt that their human rights were violated. Among the freedoms taken away were the right to refuse treatment, the right to make choices, the right to have basic needs met outside of institutions, the freedom of self-determination, the freedom from incarceration with no crime committed, the right to refuse forced drugging and restraints, communication rights, the right to due process, and the right to be fully informed about the treatment and its side effects.

Attorney Susan Stefan (1994) questioned the validity of current conceptions of the term *involuntary*. Are you really voluntary when that status is dependent on your abdication of the right to refuse? And when you attempt to exercise your right to request discharge only to find that your status is changed from voluntary to involuntary, can you any longer ignore the truth about your confinement? Stefan cut through the "lie of voluntariness" and provided a more accurate look at the absence of choice in a mental hospital:

Imagine yourself in an institution. The people in power have complete authority to discharge you or keep you, to take away your so-

called privileges—outdoor exercise, visitation, whatever; to put you in seclusion or even restraints if they interpret that your conduct requires it. Think of the courage it takes to say no, to object, to resist, in that situation. Now realize that under the law, everything that any institutionalized person does without objection is considered done voluntarily by the law. (p. 12)

When consumers/survivors talk about what helped them, they generally credit some person who believed in them, who respected them; someone who made a genuine person-to-person connection with them. Often cited as a barrier to recovery is the inability to trust that accompanies the loss of one's freedom of choice. Psychiatrist Loren Mosher (1994) lamented the gross irony attendant to the branch of medicine that is supposed to be the most expert in the use of the patient-doctor relationship:

Psychiatry's current biologic Zeitgeist supports the position that it is not possible to have a therapeutic relationship with a person with a "diseased brain"; hence, coercion is justified. This rationalization flies in the face of decades of clinical experience and research indicating that while often more difficult, it is usually possible to establish a collaborative relationship with even the most disturbed and disturbing persons. When this is not possible, it is usually the result of multiple experiences of betrayed trust, which are then reinforced by involuntary hospitalization. It is very difficult to trust doctors who cannot only behave like cops, but also deny to themselves that is what they are doing. (p. 261)

There is a cruel joke well-known to consumers/survivors: You are put in a mental hospital for acting like you are crazy, but once you are in the hospital, you are punished if you do not act normal in an environment that is abnormal. For many, their first excursion into the world of psychiatric illness was made with an expectation to find help and relief. The need to find explanations, understanding, and above all a safe haven is rarely honored. More often they are confronted with a hospital reality that is far more frightening than they could have imagined.

SELF-HELP AND EMPOWERMENT

The c/s/x's gross dissatisfaction with the existing mental health system *is not a denial of the need for help, but rather a criticism of what is passing for help*. People who felt the abuses and inadequa-

cies of the mental health system, who felt betrayed by unfulfilled promises of help joined together to produce their own mutual support alternatives. They designed alternatives to counteract professionals' control over treatment, the view of patient input as irrelevant, the system's demand for mandatory patient participation in routinized activities and the pathologizing of patients' refusal to do so, and the dehumanizing focus on symptoms combined with neglect of a patient's history, strengths, and capacities for competence (McLean, 1994).

Rose and Black (1985) countered the medical community's claim that a biochemically based diagnosis of mental illness alleviates stigma. Instead, Rose and Black postulated that the medical model actually blames the victim and artificially separates the "subject" from the "objective" social world. Activists in the physical disability movement testify, by virtue of their experience, that stigma and discrimination are not alleviated because they are perceived to have no control over the cause of their disabilities. When the "mental patient" is viewed as a victim of a brain disease, at best, he or she becomes the object of pity. Even if pity is considered to be of positive value, the psychiatric survivor believes that the loss of personal responsibility for one's life and the diminution of hope is too steep a cost for sympathy. Empowerment serves to transform the passive objects called mental patients to active persons fully capable of changing the conditions that created such devaluing oppression. The medical model has ignored the multiple conditions that contribute to an individual's specific situation. In the self-help model, the personal and the political are irreversibly enmeshed.

Within the c/s/x movement, the once frightened and beaten down, the voice-hearers, the traumatized, the victims of tardive dyskinesia have banded together with their peers to advocate and lobby for rights, create self-help alternatives, share successful coping strategies, and inspire and instill hope through the personal examples of their lived lives. C/s/x activists speak of empowerment and liberation.

We are refusing to allow others to speak for us and are reclaiming ownership of our experience. When we look for therapy or help, we are looking for active collaborative relationships where power inequities are minimized. We have learned that we thrive on choice, hope, and possibility. And we wither and atrophy from force and coercion. Having learned from personal experience that all of our rights can be taken away from us, we know that we must fight

to keep our rights, and thus we may be suspicious of those who offer themselves as helpers. We resonate with the insight of an unknown aboriginal woman who said, "If you're coming to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, let us work together."

Today, self-help is well-known and accepted as a supplemental support in most areas of health care. Self-help support groups assemble around issues of cancer survival, diabetes, obesity, grief, personal growth, gender, race, and community concerns. Self-help referral services and clearinghouses keep extensive lists of existing services that are easily accessible by 800 numbers throughout the United States. Yet, apart from the peer-support model of Alcoholics Anonymous and the c/s/x self-help initiatives, there is little challenge to the primacy of experts by most of the self-help groups centering around issues of health and well-being. Many forms of self-help are supportive of and secondary to "expert" professional opinions. Rappaport (1981) credited Illich for drawing attention to conflicts in the physical health domain: "The pervasive belief that experts should solve all of our problems in living has created a social and cultural iatrogenesis which extends the sense of alienation and loss of ability to control life even to one's own body" (p. 17).

The self-help phenomenon is one of possibilities, where people of vastly different skills and abilities try to use and make the best out of whatever individual members have to contribute. In self-help groups and other peer-run alternatives, there is an awakening of the ability to trust oneself and others. For many, it is the long absent, genuine invitation to be real in a place of safety and hope, where the exercise of control is an individual responsibility, and you are able to rethink your professionally adjudicated label of incompetence. With everyone being equal, compliance and passive dependency are less valued than in therapy systems with designated experts and associated power imbalances. Inspired by the success stories of their peers, members of self-help groups see the new possibility of working toward goals that they had been told were beyond their reach. In a self-help alternative, each participant is valued for what they have to offer. Being for once in the position to help others feels good and increases self-esteem. With peers you do not have to bury your anger, but instead you have the opportunity to give it voice in advocacy efforts. Goals are there to be real-

ized as peers struggle to become a caring community of mutual helpers.

Most important, the self-help process allows people to redefine their experience by becoming the active narrators to their own unique stories. Brody (1987) asserted that the meaning we attach to our particular stories is the primary way that suffering is produced or alleviated. He argued that the placebo effect, or healing by symbolic means, occurs best when the meaning of the illness experience is changed in a positive direction.

Activist consumers/survivors see few boundaries to the self-help phenomenon and view the possibilities as only limited by the imagination and creativity of participants. Peer-operated alternatives take many forms. Peer-run telephone *warm lines* provide a service that professionally staffed or professionally backed-up hotlines cannot perform. C/s/xs often experience hotlines as entry points into forced interventions—as a last resort place to call when one is teetering on the edge and about to lose control. If someone is anxious, lonely, frightened, or desperate and calls a hotline staffed by a person who is legally responsible, who is instructed to reduce all risks, who is sensitized to expressions of anger or sadness and its "automatic" potential for triggering violence or suicide, safety is paramount and heroic interventions are standard policy. By contrast, warm lines offer the support of a peer who listens with the mindset of someone who may have been there, a peer who has not been trained to maintain emotional distance, a peer who can identify alternative resources and who is not mandated to "always be safe rather than sorry."

Peer-operated clubhouses and drop-in centers are showing their value in cities and towns across the United States (Carpinello & Knight, 1992; Mowbray & Tan, 1992). Their emphasis on personal responsibility, camaraderie, and freedom to choose your own level of participation is appealing to people who have lost trust in a coercive system. Clubhouses and drop-in centers are becoming places where the seeds of advocacy and empowerment are nurtured among members.

C/s/xs have formed organizations to develop a variety of housing options. C/s/xs are developing unique crisis response alternatives, such as "crisis hostels" and in-home support. Peers have developed formal and informal outreach networks to people they know who are experiencing distress and have isolated themselves. C/s/xs are

helping their peers navigate the maze of social security disability requirements. Peers are sharing information about medication and coping techniques and educating each other as to their rights.

In New York, creative programs like *Incube* and *Share Your Bounty* were started by c/s/xs who saw needs that were not being met. Peer initiated and operated, Incube provides technical assistance and support for aspiring c/s/x entrepreneurs. Incube is a business incubator helping peers start and run their own businesses. Share Your Bounty (Stastny, 1993) was conceived and developed by inpatients at Bronx State Psychiatric Hospital. Noticing that large amounts of food were being wasted at the hospital, Lenox, an inpatient at that time, suggested that the food could be delivered to homeless and hungry people on the streets of New York City. With the acceptance of key staff and the participation of other residents, a weekly food-run to the Bowery was begun. The functions of this small core group grew more complex and evolved into an organization that distributed food to multiple sites: Grand Central Station, Port Authority Bus Terminal, Central Park, and a number of soup kitchens in Manhattan and the Bronx. After existing informally for more than 3 years, Share Your Bounty applied for and received a 3-year, $350,000 National Institute of Mental Health grant. The success of Share Your Bounty challenges the commonly held myth that inpatients at a psychiatric hospital are incompetent and incapable.

In dialogues between consumers/survivors and mental health professionals, the New York State Office of Mental Health reported key problem areas identified by c/s/xs:

Hopelessness. People are told they will be sick for life. They are taught not to trust their own perceptions. People lose focus on development and growth; there is an overfocus on symptoms.

Depersonalization. The system treats clients as objects and with mistrust and defines a person as an "illness." Individuals' behaviors are explained by diagnosis; they become their diagnosis. Diagnosis invalidates the person and interferes with trying to truly understand the person.

Negative effect on self-image. A person is never again seen as being the same. There is self-doubt, unworthiness, and a feeling of being less than others. C/s/xs see themselves as being perceived by others as incompetent, violent-out-of-control, retarded, unreliable, able to do only simple work, dangerous to kids, weak, and lazy.

The theme of loss. Loss of control over one's life, loss of one's freedom, and loss of trust were expressed. There is a loss of personal identity that is

replaced by the identity of illness and a loss of normal coping strate-
gies for those individuals who have experienced being in an institu-
tion. Economic loss and loss of family were also cited.

Isolation, exclusion, and being uninformed. This includes being unable
to explain one's experience to others, not being understood, being
isolated, not being enlisted as a collaborator in one's own care, and a
perception of distance between "labeler" and "labelee" (Bassman,
1995, p. 6).

Despite the progress, for psychiatric survivors like myself, the
heart of the mental health system remains fatally flawed. People
with a "mental illness" label reside at the very bottom rung of our
culture's pecking order. Beneath them are only "mental illness"
combined with other discriminated-against subsets further
defined by age, gender, minority race or ethnicity, outsider sexual-
ity, addiction, and frightening communicable diseases (such as
AIDS). Our culture's current fascination with bootstrap individu-
alism, the disappearance of community, and the devaluing of
empathy and compassion underpin a reluctance to provide public
support (such as housing, jobs, education, and a range and choice in
health and mental health services) to people in need.

COLLABORATION WITH MENTAL HEALTH PROFESSIONALS

Fostering understanding and modifying the power inequities
between mental health professionals and consumers/survivors is a
daunting task. At a recent meeting, there were three of us who
were survivors as well as professionals: Peter, a licensed psychia-
trist; Celia, the state director of peer specialist services; and I, a
licensed psychologist. As soon as we introduced ourselves, and
even before we could describe our objectives for the self-help and
empowerment training seminar, the challenges by other profes-
sionals began:

"What can self-help do that we don't already provide?"
"We're sick and tired of being bashed. We've worked hard to get the edu-
cation and training to become professionals. We care about the peo-
ple we treat."
"I resent your telling us that the mental health system does not work. It
is working. People are getting the help they need."

We were supposed to lead this seminar to help mental health professionals understand self-help and empowerment services in order to facilitate its implementation at their facilities. In the group of 80, there were administrators, psychologists, social workers, nurses, and a few psychiatrists from the seven downstate psychiatric centers. Understandably, they were threatened by the increasing popularity of low-cost self-help and empowerment services. With rising costs and the shrinking resources allocated to mental health services, the loss of their jobs was an obvious fear. Trained to diagnose pathology and treat people who are too "sick" to be responsible for themselves, these experienced mental health professionals saw their work and skills being devalued by us. Their belief in the efficacy of their roles as benevolent helpers always was supported and sustained by the feedback of other professionals. Now for the first time, they were being held accountable by the people receiving services. The three of us representing a c/s/x point of view were challenging the twin standards of maintenance and stabilization as the ultimate measure of success for their "chronic low functioning mental patients." Our audience of trained clinicians was very uncomfortable with the rejection of key assumptions that underpinned their mandate to provide traditional clinical services. Discouraged by our attempts to raise awareness, we concluded that we would be more effective in creating systemic change in the public mental health system by building grassroots c/s/x self-help networks. Staff training would have to wait.

During the 5 years that I have worked in New York as a self-identified psychiatric survivor, I have watched the remarkable growth in the number of c/s/xs who have embraced the value of self-help and empowerment. The increases in recipient involvement and participation in their treatment in New York is a direct result of a pilot managed-care Medicaid initiative called the Prepaid Mental Health Plan (PMHP). It is remarkable that self-help and empowerment were included with treatment, support, crisis, and rehabilitation as the five contracted service requirements for the PMHP's Federal Medicaid waiver. Now, promoted and nurtured through the leadership of the Recipient[1] Affairs Office, the 19 New York psychiatric centers have more than 80 sites with active self-help groups and programs run by recipients. The PMHP, initially motivated by cost savings, became an opportunity for recipients to actively participate in building community by creating alternatives.

The opportunities for consumers/survivors to have genuine input into the planning, implementation, and monitoring of services in a variety of settings are encouraging signs of progress. Exposing clinicians and policy makers to the ideas and experiences of c/s/xs is an eye-opening educational experience. Rappaport (1981) recommended that experts turn to nonexperts to discover the multitude of different, paradoxical, and sometimes contradictory ways that people gain control, find meaning, and empower their lives. One example would be the Hearing Voices Network, where people who hear voices share different coping strategies that they have learned through personal experience (i.e., listening to music with headphones, blocking the sound in one ear, identifying triggers).

When I attend taskforce or workgroup meetings and I am there to represent the c/s/x point of view, I continue to be surprised by the inability of many professionals to see what is fundamental and extremely obvious to anyone who has been diagnosed and treated for serious mental illness. Working on problems together, even being on opposite sides of an issue, permits professionals and c/s/xs to get to know what they like or dislike about a specific person's ideas rather than what they represent as a class or category. When professionals are required to move out of their caretaker roles and look at the whole person, it becomes much more difficult to remain unaware of the oppression faced daily by particular persons in specific real-life situations. When c/s/xs no longer have the dubious luxury of having their own and others' obnoxious behavior excused or rationalized, when accountability is expected, a major "all people who . . . " myth is debunked. When people are locked on wards where they have no control of their environment (when they get up in the morning, access to their beds, toothbrushes, cigarettes, or other personal possessions) and are given advanced training in dependency and then discharged into economic ghettos bereft of hope, where bizarre behavior is expected, is it any wonder why those well-publicized yearly stigma-busting campaigns by the Mental Health Association and the National Alliance for the Mentally Ill have no impact? Stigma, discrimination, and patronizing attitudes are undermined when people are working shoulder to shoulder or even shoulder against shoulder as respected adversaries.

RECIPIENTS SHARE WHAT
HELPED IN THEIR RECOVERIES

When I was asked to be part of a work group that was charged with designing a core curriculum for the mandatory training of the staff of 19 state-operated adult inpatient psychiatric centers, it was my chance to facilitate the reclaiming of our stories (Bassman, 1997b). When you become a mental patient, you are no longer a credible narrator of your life story. How you experience the world is unacceptable and is replaced with interpretations that are considered more valid than your perceptions. The project was an ambitious task for our work group. The team was made up of Central Office administrators, facility directors, clinicians, members of the personnel department, myself, and another peer from our Bureau of Recipient Affairs. The projected 3-day, 24-hour training would be presented to all hospital staff who had any patient contact on all three work shifts. The core curriculum training was expected to take 2 years to complete. It was organized into six modules: Team Training, Working in a Changing Environment, Selected Clinical Issues, Cultural Competence, Creating a Safe and Therapeutic Environment, and Recovery. My responsibility was the 3-hour recovery module.

The content of the recovery module was created from input and discussion with recipient leaders throughout the state. Adopting a train-the-trainer model, three of us developed the general threads of the protocol and refined them by doing the initial series of presentations. We then taught recipients from all over the state different ways to present their personal experience as inpatients in a psychiatric hospital and suggested that they give examples of what was and was not helpful. Personal stories were used to illustrate the values and recovery concepts that had been identified consistently by recipients. The key themes were as follows: choice; hope; we are more than our diagnoses; we speak for ourselves; and the importance of peer support, self-help, and empowerment.

Recipients were encouraged to present in teams of three and have supports built in for what could be difficult emotional presentations to hospital staff. All presenters were paid for their preparation, rehearsal, presentation time, and other associated expenses. We strongly supported the requirement that recipient presenters needed to be paid fees that reflected the significant value of their unique expertise. Presenters also were given the opportunity to

participate in 2 days of platform skills training to prepare them for speaking in front of groups of people.

The recovery module gave many of the hospital staff the opportunity to see recovering and recovered people for the first time. Seeing people at their worst had shaped the almost unshakeable attitudes of hospital staff. Now, hearing and seeing first-hand the articulate and thoughtful stories of people who once had been considered hopeless challenged their beliefs about mental illness. Trained to focus on deficits and weakness, they were learning that recovery is a reality for many people. More important, staff were learning about the impact of their relationships with people. When recipients poignantly described such human contact as instrumental in their recovery, several of the aides expressed their pleasure at discovering for the first time that people actually remembered and deeply valued their simple acts of kindness and warmth. "I'll never again assume that people are so out of it that it doesn't matter what I do" and "This made me remember the reasons I got into human services" were typical comments on written evaluations of the recovery module. Of the six core curriculum modules, the recovery module was rated highest by the trainees. Participants spoke of being profoundly touched by hearing powerful human stories that bridged the chasm between patient and caretaker and forced them to think less about differences and more about similarities.

Although the recovery module afforded consumers/survivors the opportunity to teach from their experiences, it was no more than a small opening into a larger culture that oppresses people who do not fit into a narrow range of roles or acceptable modes of personal expression. Recovery is a complex, time-consuming process in which the iatrogenic effects of treatment, crushed dreams, and stigma may be more difficult to overcome than the original condition (Anthony, 1994).

CREATING NEW POSSIBILITIES: BUILDING COALITIONS

Now is an important time for mental health professionals to join consumers/survivors in reforming a medically based, drug-dominated oppressive mental health system that is harmful to people who have been diagnosed with major mental illness. Genuine allies are welcome. You are invited to learn about the rich diver-

sity of projects and c/s/x literature and research that has been emerging during the past 20 years but is virtually absent from academia, major publications, and mainstream practices.

I deeply appreciate the professionals who are willing to shed the hierarchical role of expert helper in favor of open person-to-person collaboration in a mutually beneficial developmental journey. I am cautiously optimistic and encouraged by the support and openness I am beginning to discover among some psychologists. But overall, as a psychiatric survivor and a psychologist, I am disappointed and embarrassed by the almost complete absence of psychologists from the political arenas where c/s/xs have had to speak out without allies.

I encourage professionals to educate themselves by asking about and seeking out the rapidly expanding body of c/s/x writings. Find out how a self-identified consumer differs from a self-identified psychiatric survivor. Learn the differences between the consumer/survivor groups and family advocacy groups such as the National Alliance for the Mentally Ill (NAMI). NAMI, a junior partner to the drug companies, purports to speak for and advocate for members' sons and daughters who they believe suffer from a brain disease, a neurobiological disorder from which there is no hope of recovery. Although NAMI has done an excellent job of promoting itself as the voice of families with "mentally ill" members, there are many families who do not believe that their sons' and daughters' destinies are predetermined by their biochemistry. NAMI is currently engaged in an organized, well-financed national campaign to lobby state legislatures to enact involuntary outpatient commitment laws. This campaign shamefully exploits people's fears of violent acts committed by mental patients. Everyone loses something precious when we sacrifice an artificially defined group of people's freedom in an ill-conceived quest to maintain the illusion of control, predictability, and safety.

Will the "mentally ill" continue to serve as the "not us" scapegoat that conveniently diverts people from confronting the always possible terror of life and death? As I watch the growing numbers of people who are diagnosed with some form of "mental illness," and even more sadly, the number of children being prescribed Ritalin and whose diagnoses are preparing them to become the new group of "chronically mentally ill," I shudder at the price being paid to feed our community's need for safety. I ask you to do some introspection to see if your beliefs are supported by the willingness to

take the risks inherent in the actions required to remove the barriers to empowerment for the most disenfranchised among us: the person diagnosed and treated for major "mental illness."

As a person working to assist others in their struggles—who is often seen as individuals' and families' last desperate hope—I urge you to learn how to use your education, talents, and skills in new ways by engaging in an exciting journey of creativity and personal growth in which people support each other as equals and speak of what is in their hearts. To be more effective in the service you provide for a c/s/x, it is imperative that you see the *individual* and value that special individual by engaging in a collaborative search to find understanding, meaning, and connection in this person's unfolding life narrative.

REFLECTIONS ON MY OWN TRANSFORMATIVE JOURNEY

My first presentation of a paper at APA went well, but a lot of compliments and requests for reprints are not necessarily reflective of understanding. The audience of psychologists seemed to be stirred by my personal story of recovery/transformation and my description of the evolving c/s/x movement. However, I knew that interest, moral indignation, and a stirring of feeling would quickly fade and blend with other information stored in the intellectual realm. The brief glimpse of drama does not stir the playgoer to action.

My wife, Lindsey, our 7-year-old son, Jesse, and I walk up Broadway to find a restaurant for dinner. My mind is drawn to a time 25 years ago. Discharged from my second psychiatric hospitalization, I walked the streets of New York City. Despair and loneliness were my constant companions. I needed people. I wanted to be around people. But how do you relate when your dominating feelings are fear and embarrassment? Emptiness, nothing to say, nothing to contribute. Only with anonymity as a shield could I be with people and not have to face my humiliating inadequacies. How well I remember believing a bleak future with no friends was my destiny. Marriage and children would not be available to one such as I. Dull and slow, devoid of spontaneity, my muffled spirit hurt quietly.

Walking on those same streets embraced by my family's love, how could I not glow? Whenever I consider those painful times, no

matter how down I might now get, my perspective is always jerked back, and the picture gets clear and bright.

My own good fortune and hard fight for recovery and success have never dimmed the memory of an insider's knowledge of what has been done, *is* being done in the name of treatment—to and for but rarely with—those lacking the power or voice to fight the abuses and keep their basic human rights.

For those unheard voices who have entered the labyrinth of the mental health system, for their families and loved ones who seek understanding and guidance, for the mental health professionals who genuinely struggle with their own and others' frightening existential plight, and for all those activists who demand the absolute entitlement of dignity and respect for everyone, I offer my voice to join them in their continuing fight . . . and to inspire HOPE.

NOTE

1. *Recipient*, as in recipient of service, is the term used in place of consumer, survivor, or ex-patient in New York. The Recipient Affairs Office is made up of the director who reports directly to the commissioner and supervises a staff of 12 recipients who work full-time throughout the state.

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HOW USING THE *DSM* CAUSES DAMAGE: A CLIENT'S REPORT

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Summary

This case study illustrates the potential for the application of *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) diagnoses to exacerbate clients' symptoms and inhibit the healing process in psychotherapy. Passages are excerpted from therapy sessions to demonstrate that the multiple diagnoses imposed on "Steve" coalesced into his core construct of himself as "crazy." When his

diagnoses became internalized as a construct, his world became viewed through a lens that believed itself to be defective. The use of diagnoses may also have negative consequences for the process of psychotherapy. Alternatives to traditional *DSM* diagnoses are reviewed. It is proposed that diagnoses should be tentative and rejected if they reify negative self-concepts and do not promote change in clients.

A group of scholars has written about the potential negative impacts of psychiatric labels on clients' self-esteem, self-efficacy, and on the therapeutic relationship (e.g., Farina, Holland, & Ring, 1966; Kelly, 1969; Page, 1977; Rogers, 1951; Szasz, 1960, 1974, 1987; among many others). Ignoring these criticisms, mainstream psychiatry continues to elaborate newer versions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). *DSM-IV* (American Psychiatric Association, 1994), the current edition, is arguably the most ambitious and influential of these elaborations. Its power is enhanced by the recent emphasis on managed care and empirically validated treatments (Bohart, O'Hara, & Leitner, 1998). However, a newer group of scholars has continued questioning the utility of the *DSM* on theoretical, philosophical, political, and clinical grounds (Breggin, 1994; Caplan, 1995; Faidley & Leitner, 1993; Hillman & Ventura, 1992; Kutchins & Kirk, 1997; Levy, 1992; Raskin & Epting, 1993; Sanua, 1994). All of these criticisms imply that the use of the *DSM* may be irrelevant or destructive for clients.

This article investigates some of the destructive implications of the *DSM* through systematically exploring the ways that traditional understandings of psychopathology damaged "Steve," a person seen in therapy by one of us (LH-W) under the supervision of the other (LML). First, we will present some aspects of Steve's history. Next, we will discuss ways in which *DSM* diagnoses have played a role in undermining and changing Steve's basic views of himself (i.e., stigma, countertherapeutic metacommunications, not taking into consideration the client's meaning, detrimental effects on the therapeutic relationship, and focusing only on the negative). We conclude with a brief discussion of alternatives to the *DSM*.

In emphasizing the negative impact of the process of diagnosis, we do not intend to diminish the reality of Steve's complaints about the actual disturbance that led to his engagement in the mental health system. We attempt to illustrate through intensive qualita-

tive analyses that labels added "insult to injury." Empirical research suggests that when problems in living are represented as a disease rather than in psychosocial terms, clients receive harsher treatment by others (Mehta & Farina, 1997). Thus, the use of *DSM* labels, by implicitly adopting a disease model, increases societal stigma faced by clients. The increased social rejection exacerbates interpersonal struggles.

Rather than merely providing a summary of a theoretical possibility, we will allow Steve's own words from his therapy to illustrate the damage. Although the conclusions drawn from a single case study are necessarily tentative, this method allowed for an in-depth documentation of the intrapersonal and interpersonal damage inflicted by use of diagnoses that might not have been captured by more controlled methodologies.

THE CASE OF STEVE

Steve entered therapy voluntarily after having seen a flyer in a campus building advertising a psychology clinic. His chief complaint was anxiety ("I feel like I'm on pins and needles") and depression that interfered with his desire to succeed in the classroom. He also sought treatment for frequent and uncontrollable anger outbursts. He had been given the following *DSM* diagnoses by previous psychiatrists and psychologists: Obsessive-compulsive disorder (OCD), generalized anxiety disorder, major depressive disorder, bipolar disorder, attention-deficit hyperactivity disorder (ADHD), intermittent explosive disorder, and paranoid personality disorder. According to Steve, these different diagnoses were assigned sequentially by different psychiatrists, and in some cases he was given as many as three diagnoses by one psychiatrist.

Steve was a Caucasian male, age 27, at the beginning of treatment. He worked as a part-time janitor in a hospital. From the age of 7, Steve was raised by his grandparents. Steve described his grandmother as "always playing with my mind" and his grandfather as an alcoholic. Steve described many incidents of physical abuse by his grandfather, although he would not call him "abusive." His father abandoned the family when Steve was 6 years old. Because his mother neglected Steve and his sister, his grand-

mother gained partial custody. Steve's mother was an alcoholic for most of his life, drinking "a gallon of vodka a day" before she sought treatment; she quit a year prior to his entering therapy. Steve spent 2 years (ages 7-9) in a state psychiatric hospital and was given a diagnosis of ADHD because of behavioral problems such as impulsivity. At this hospital, he was sexually molested by a staff member. He was in special education classes through most of grade school. For 1 year of high school, he went to a military school. For 2 weeks during high school, he was again hospitalized in a psychiatric ward, reportedly for impulsive and aggressive behavior. In spite of these disruptions in his education, Steve went on to earn a college degree.

Steve spent a large amount of time in therapy expressing his hatred of "shrinks" and his anger at mental health professionals. We wondered if this was a diversion, a way of warding off his true anger at his father and mother who both abandoned him. It was many months before we realized the appropriateness of his complaints concerning the mental health system as a central theme for psychotherapy. He had been saying that the essence of his identity, his core construct (Kelly, 1991), was his label as "crazy." In his own words,

> Steve: . . . I had to have something wrong with me . . .
> Therapist: So you have this deep sense that something's wrong . . .
> S: Yeah, I mean, come on, I mean, yeah, something's wrong with me.
> T: And your question is what was it?
> S: Well I'll never know, doctors couldn't figure it out, some of them said I was hyperactive, and then some of them say I'm depressed and some say I'm manic-depressed and some say I'm . . . let's see, hell, there's so f—ing many of them, major depression, yeah, there's one of them, and then some say explosive impulsive disorder (laugh), yeah, I think I have that (laugh) yeah that's when you get mad and get in fights isn't it? (T: um hmm) yeah I have that definitely, and then, I don't know what to think.

We will argue that this core construct is, in many ways, one source of his distress at this time. In addition to the abuse and neglect that Steve experienced throughout his life, his central view of himself as defective contributed to his psychological symptoms of anxiety, depression, and uncontrollable anger.

STIGMA

The stigmatizing effects of *DSM* labels have been well-documented (Corrigan & Penn, 1999; Farina et al., 1966; Piner & Kahle, 1984; Rabkin, 1972). In essence, these writers have argued that a *DSM* label is linked to stereotyped, negative views of the client. Research suggests that in addition to the general public, well-trained mental health professionals also subscribe to stereotypes of the "mentally ill" (Corrigan & Penn, 1999). Societal constructions suggest that mentally ill persons are weak, irresponsible, and potentially violent (Brockington, Hall, Levings, & Murphy, 1993). Researchers who have been examining this issue have not found support for the idea that "mental illness" causes violence (Arboleda-Florez, Holley, & Crisanti, 1998a, 1998b).

According to a recent analysis on stigma, mental illness "strikes with a two-edged sword": In addition to the injury of the original psychological symptoms (e.g., uncontrollable anger, mood disturbance), diagnoses lead to stigma by society and by the self (cf. "self-stigmatization"; Corrigan & Penn, 1999).

> The stigma of severe mental illness leads to prejudice and discrimination. Stigmas are negative and erroneous attitudes about these persons. Unfortunately, stigma's impact on a person's life may be as harmful as the direct effects of the disease. (p. 765)

For example, psychological symptoms often impair a client's social functioning. The stigmatization of psychiatric labels may in some cases exacerbate interpersonal problems and increase social isolation for individuals who likely have increased needs for social supports.

Steve's story demonstrates that stigmatization can scar a person for the entirety of his or her life. For example, Steve recounted incidents of talking about military strategy he had learned in military school and of having others assume that he was pathologically preoccupied with violence. He described the impact of having a psychiatric history:

> Steve: I'll never be able to erase the ink that's been put on me.
> Therapist: And the ink being?
> Steve: When I'm labeled as crazy, I never will erase that, and, you know, even, I could take a psychology test now and probably pass it to being maybe normal, or a little abnormal, but people who've seen me, would say I'm totally crazy . . .

Steve reported that the shame and stigma that accompanied his psychiatric diagnoses prevented him from developing socially. Steve's perceptions of the permanence of his labels has received empirical support. Many studies have replicated the finding that individuals who are identified as former mental patients experience social degradation (see Mehta & Farina, 1997, for a review). The effect of the psychiatric label on his social development can be gleaned from Steve's experiences:

> Steve: I am crazy, everybody knows I'm crazy, people don't like me just because I'm crazy, and you know people don't like crazy people, you always hear jokes about nut house or you're nuts, you always hear jokes.
> Therapist: And that hurts a lot.
> Steve: Yeah it hurts, I mean yeah, it does.

The stigma that is associated with mental illness is illustrated in the dismissal of Steve's reports that he had been sexually molested while he was in a psychiatric hospital. When he asked other psychiatrists years later about how he could seek recourse, he was again dismissed. Because he was viewed as "crazy," his experience was discounted as unreliable. In the context of trying to seek recourse about being molested in a psychiatric hospital, Steve had this to say:

> Steve: Just like that doctor when I went to see him about that, I told him all I wanted him to do is find out if it's true, he had to make one phone call, let me know, and then, I wanted to talk to the police about if he does it again, I will testify, that's all I wanted you know, and he's like it's not my job to do that . . . it doesn't concern him that the guy's still maybe doing it, . . . and he sticks with them, that's why the people in the mental health field are very powerful people you don't really want to, you don't really want to fight against them because you can't win, they all stick together.
> Therapist: So you're feeling betrayed, not only were you raped or molested, but you were betrayed by the other mental health professionals who wouldn't help you out when you wanted to do something about it or even protect someone else.
> S: They wanted to shut me up basically.
> T: Just wanted to shut you up, so you feel betrayed and voiceless.
> S: Yeah, basically, powerless too, like I was when I was in there (T: so powerless) I feel like they raped me again you know.
> T: So they raped you again.
> S: I don't think he raped me though, but you know he abused me. I'll never be able to get him back, you know.

Steve believed (perhaps accurately) that if he ever tried to take his case to court his testimony would be dismissed, he would be an unreliable witness, because of his psychiatric history. He had internalized this social consequence of diagnosis and was incapable of trusting his own judgments and perceptions. Recent research has proposed that "the detrimental impact of stigma is not limited to discrimination by others. Some persons with severe mental illness also endorse stigmatizing attitudes about psychiatric disability and hence about themselves" (Corrigan & Penn, 1999, p. 767). Over the course of therapy, Steve continued to question whether the incident of sexual molestation was abusive or, even more inimically, if he deserved it. The reported effects of the stigma were twofold: The stigma not only alienated Steve from others but led him to denigrate himself.

COUNTERTHERAPEUTIC META-COMMUNICATIONS OF DIAGNOSIS

One reason for the destructiveness of diagnoses is the meta-communications that they convey to the clients about who they are. Clients look to therapists to help them understand the nature of their complaint and even what it means to be human. When a diagnosis becomes a central aspect of a person's identity, the person's world becomes viewed through a lens that believes itself to be defective.

Diagnoses can convey the following meta-communications: (a) The client has a "disease," (b) the self and the disorder are identifiable entities, (c) the client is a victim of the disease, and (d) the self is fundamentally untrustworthy because it is disordered or "ill." These metacommunications not only inhibit therapeutic progress but worse, they may undermine identity and diminish ability to relate to others, thereby leading to the very disorders that bring people into therapy to be treated.

DSM *diagnoses as static entities.* Faidley and Leitner (1993) pointed to the potential of *DSM* diagnoses to convey to the client that their difficulties are unchanging static entities. The reification of disorders suggests to clients that they are permanently stuck with this disorder. This does not convey hope that change is possible.

Many have argued that hope is central to therapeutic change (Frank & Frank, 1991). Kelly (1991), for example, argued that being able to apply a construction of change to one's identity made change more likely to occur. Leitner (1984) provided some empirical support for this notion. Thus, the static labeling associated with the *DSM* may actually work against the client's best interests.

The following comment illustrated how the use of *DSM* diagnoses reified Steve's experiences of anger outbursts into an unchanging disorder. This comment occurred in the context of talking about his feelings toward his previous mental health treatment providers:

> Steve: I don't really think it's anger towards them though, I just think I'm naturally this way, to be honest with you. (Therapist: naturally angry?) yeah I just get agitated sometimes, I mean, I'm just that way you know.

Although Steve's anger was a serious problem that impaired his level of functioning, the reification of this symptom as "intermittent explosive disorder" diminished his confidence that he could change his maladaptive emotions and behavior. This passage illustrated how he came to think of himself only in terms of the diagnoses that had been put on him. This can be seen in Steve's comment that his anger is the way he "naturally" is. He viewed his anger as an essential, integral, unchanging part of his identity.

To the extent that diagnoses convey to the client that he or she is a static entity, they may work against some humanistic principles of therapy. For example, Rogers (1957) argued that, in successful psychotherapy, the person must move from being in stasis to being a process. Similarly, Kelly (1991) has emphasized that the person is a constantly evolving process. Thus, use of *DSM* diagnoses communicates counterproductive assumptions about the nature of the person to the client, and potentially to the therapist.

The client as a victim. Raskin and Epting (1993) have suggested that the use of *DSM* diagnoses promotes the belief that clients are victims of a disorder or illness and that they are therefore less capable of making choices. When clients construe themselves as suffering passively from a disorder, the implications are that they are not in control of and therefore are not responsible for their behavior (Raskin & Epting, 1993; Szasz, 1987). Kelly (1969) illustrated the prevailing norm that diagnoses convey to the client that

they are not responsible for their symptoms in his remark that our culture has decided that "a problem is not something you solve, but is something you lie down and are treated for. The idea is catching on fast" (p. 185). More recently, a disorder has become something to be cured or controlled by medication.

Rogers (1951) also commented on how *DSM* diagnoses have the effect of making clients more passive: "There is a degree of loss of personhood as the individual acquires the belief that only the expert can accurately evaluate him, and that therefore the measure of his personal worth lies in the hands of another" (p. 224). Thus, the use of *DSM* diagnoses makes the client a passive victim in two different ways. The client is a victim of both the purported disorder and the process of diagnosis itself. The client believes that the diagnosis means that he or she has very little control over the course of the disorder and is therefore a victim of it. In addition, the client has no control over the labels that are applied to him or her that will in many ways determine the client's fate. Both of these forms of "victimization" contradict the therapeutic aim of enabling clients to see themselves as active agents in constructing their worlds as persons who have the ability to choose (Bohart & Tallman, 1996; Kelly, 1991).

Steve often described his thought processes as something that happened to him, as being beyond his control. The diagnosis of OCD contributed to Steve's belief that he was a passive victim of a disorder. The following passage occurred in the context of Steve's description of an encounter with a psychiatrist who diagnosed him with OCD.

> Steve: But she was right saying I was crazy, when she said "when you have OCD it will drive you crazy when you get to thinking about something" and she was right, I did and it was true, you get to thinking about something over and over again and it drives you nuts.
> Therapist: Right, but that's a lot different from saying "I am crazy."
> Steve: Well, I might as well admit it, you know, they say, it's good to admit it, like when you're an alcoholic, they make you admit you're an alcoholic, well I'm crazy.

The label of OCD appears to have had two negative impacts on Steve: (a) diminishing Steve's self-efficacy in relation to his symptoms ("I might as well admit it") and (b) intensifying his negative view of himself ("I'm crazy"). The application of this diagnosis conveyed to Steve that he had no control over his own thought pro-

cesses and that he was subject to his ruminations because of yet another disorder of which he was the victim. Although the issue at stake here is the potential for labels to further impair a client who already experiences some level of disturbance, it may also be noted that it is questionable that Steve ever met *DSM* criteria for OCD. Steve never reported any compulsions or ritual-like behavior. In addressing this discrepancy, we consulted with his previous psychiatrist who stated that the diagnosis was made in large part due to his "obsession" with his hatred of the mental health system.

Steve's comment, in reference to his psychiatrist, that "she was right, I did and it was true" may indicate the potential of diagnoses to become self-fulfilling prophesies. As one physician concluded (Tournier, 1957/1973):

> The power of suggestion exercised by the labels we are given is considerable . . . . Unfortunately, even we doctors are often guilty of saying thoughtless things which can have a dangerous suggestive effect on our patients; and the suggestion is all the more powerful because of the halo of scientific prestige with which we are invested. To tell a patient he has a 'delicate liver' because he has vomited bile during a fit of bad-tempered annoyance, is to implant in his mind an idea of which he may never be able to rid himself and which will be really harmful to his health." (p. 47)

The possibility of labels, in part, creating the disorders their use is intended to describe does not diminish the reality that Steve was disturbed by obsessive thoughts (not meeting full criteria for a diagnosis of OCD). However, Steve's case illustrated that the label itself, whether or not he met full criteria, could inhibit the client's recovery.

The client's perceptions as untrustworthy. The application of *DSM* diagnoses and the attendant stigma have the potential to convey the message to clients that their perceptions are untrustworthy. These messages may undermine therapeutic growth. When clients' experiences are labeled as pathological, they may learn that their interpretations of reality cannot be used as an acceptable guide. In Steve's case, the diagnosis of paranoid personality disorder diminished his capacity to determine when he was in situations of real threat. Steve tended to assume that most of his fears were irrational and therefore lost his ability to trust his own evaluations of situations. The following exchange illustrated Steve's inability to accept his own experiences:

Steve: That first hospital I went to, the orderlies, the people that worked there I couldn't stand . . .

Therapist: So you have a lot of anger about, against the whole mental health system pretty much, most of the people?

S: Yeah, well, got a lot of paranoia towards them too . . .

T: Paranoia?

S: Yeah, I mean, how many people do you know that learn lock picking? [Steve was referring to himself.]

T: Or fear maybe, is another word.

S: Yeah, fear, paranoia, well if you were a shrink you'd call it paranoia.

T: What would you call it?

S: I don't know.

T: Do you think your fear is justified?

S: I don't know that either, I guess the psychiatrist would say no, most psychiatrists would probably say no, of course, they wouldn't, if most psychiatrists had their way, if they knew what I knew, and knew I had that much hate towards them, would have me locked up indefinitely if they could, I mean that's a fact you know, they're paranoid people themselves, most shrinks are paranoid.

T: So you feel like you've been really abused by the mental health system.

S: I don't know.

T: You don't know? How can you say you don't know? Obviously you feel like you have been.

S: I don't really know, I just don't like the people.

T: How can you say "I don't know"?

S: How do I know I wasn't abused, maybe it was proper treatment.

T: Under what sort of belief system would that be proper?

S: Any shrink could tell you it was proper.

T: I'm asking you . . .

S: Sigmund Freud would say it was proper.

T: I'm asking you what do you think, what do you think?

S: I'm crazy, what I think really don't matter . . .

If he were able to fully trust his own powerful anger toward "shrinks," perhaps he could limit the power the diagnoses had over him. The diagnoses led to a central distrust of his own beliefs, emotions, reactions, and perceptions, preventing him from challenging the diagnoses. His own anger at the mental health system was considered by his previous psychiatrists as more proof of his craziness. His legitimate fear and terror of "being locked up" by the mental health system were interpreted by mental health professionals and himself as further indications of his "paranoia." The central issue was that he was not sure; he did not know if he was paranoid or not.

As a result of his being given the diagnosis of "paranoid" (among many other diagnoses), Steve had lost his ability to know what his own perceptions meant; he lost his ability to navigate through life. If a person cannot trust his or her evaluations of situations, there is no reliable guide to what is real and what is not real. This is what is conventionally meant by "crazy." Therefore, in Steve's case, *DSM* diagnoses may be implicated in causing the very disorders they purportedly describe.

NOT UNDERSTANDING THE CLIENT'S MEANINGS

In applying *DSM* diagnoses, mental health professionals typically consider only a checklist of symptoms, without taking into consideration that the symptoms and complaints have different meanings for each client. A symptom may be useful, and similar symptoms may mean quite different things to different people (Laing, 1967). Radical behaviorists (Carson, 1996; Follette, 1996) agree with humanistic psychologists (Kelly, 1991; Rogers, 1951) that symptoms cannot be understood in isolation of their context. For the behaviorist (Follette, 1996), "behaviors are not understood to exist in isolation from a set of contextual influences . . . . To treat the target behavior in the absence of a specific understanding of its function will almost certainly produce a diluted treatment effect" (p. 1118).

Not taking into consideration the context and significance of Steve's paranoia is to disregard the potential meaningfulness or usefulness of the symptoms. In the case of Steve, it could be argued that his paranoia was an appropriate protective device. Steve had been emotionally and physically abused by his grandfather and his mother. In this context, Steve's "excessive" fears reflect the degree to which his environment was threatening while he was growing up, not his degree of "craziness." Steve's paranoia may be seen as his way of making meaning out of an otherwise incomprehensibly threatening environment.

Similarly, his paranoia about mental health professionals may have been realistic, if he in fact suffered sexual abuse in the mental health system. For example, comments such as are made in the following passage led to Steve being diagnosed as paranoid by his psychiatrist (as determined through consultation with his psychiatrist):

Steve: I'll always have fear of psychology, anyone in the mental health field . . . well not really, you know, psychologists, you know, they, some of them are pretty evil people . . .
Therapist: um um, but . . .
Steve: I'm afraid you'll have me locked up sometimes too you know I get that fear . . .

When context and meaning are taken into account, his comments may be seen as a reflection of his traumatic experiences rather than as delusional. The treatment implications for trauma-based anxiety and delusional paranoia are quite different. Because treatment providers may fail to account for the context and meaning of the symptoms, treatment regimens can be irrelevant or countertherapeutic.

FOCUS ON THE NEGATIVES

DSM diagnoses have also been criticized (Leitner, in press) for focusing exclusively on the clients' areas of dysfunction. Viewing the client only in terms of symptoms overlooks the whole person and potential strengths that would be central to therapeutic improvement. In using *DSM* diagnoses, clinicians may fail to note the self-actualizing elements in the clients' lives. Many humanistic psychologists would argue that the therapist needs to understand the whole person and not just the complaint, or symptoms (Kelly, 1991; Maslow, 1971; Rogers, 1951).

For example, it seemed a startling oversight that the label "courageous" was never applied to Steve throughout all of his contact with mental health professionals. Despite his terror of his therapist and the mental health system, he continued in therapy for more than 2½ years. The fact that he sought therapy out again, despite the degree to which he had been failed by mental health professionals, is a testament to his determination to regain his navigational tools and reorient himself so he can make his way through the world that had so profoundly failed him.

The following passage illustrated not only the courage it took for Steve to engage in therapy but also how even his positive traits became subsumed under his core construct of being crazy.

Therapist: . . . so, what, do you think about the courage that it takes for you to be here, I mean I respect that a lot, do you ever . . .

Steve: No, not really, I think I'm stupid I guess . . .
T: So you, so you see your being here as stupid?
S: Yeah, crazy, crazy is better, that better to put it: crazy.
T: So you being here means that you're crazy?
S: Yeah, I'm definitely crazy, now you know I'm crazy.
T: So that proves it . . .
S: That's proof right there. I mean if you were me would you really go
   back, what would you do if you were in my shoes? . . .

Thus, Steve came to understand all aspects of his experience through the lens of his diagnoses. The above passage suggests that he lacked the ability to generate alternative explanations for his behavior other than that he was crazy. Steve may have had many motivations for entering therapy. In addition to courage, he may have felt dependent on guidance from an "expert." Whether Steve sought therapy because of his courage or for other reasons, the previous passage illustrated that his global construction of himself as crazy was applied indiscriminately to most of his behaviors.

THERAPEUTIC RELATIONSHIP

DSM diagnoses work counter to many humanistic approaches toward the therapeutic alliance. Raskin and Epting (1993) have noted that use of *DSM* diagnoses hinders the therapeutic relationship: "Clients who are treated as 'abnormal' by their therapists are more likely to act in an 'abnormal' manner; they adopt the appropriate role in a therapist-patient social process" (p. 362). Leitner and Faidley (1995) argued that the therapist should strive to "construe the construing process of the client" (p. 292) (i.e., struggle to see from where the client is looking rather than trying to see "eye to eye"). Constructivists (e.g., Neimeyer & Raskin, 2000) have also emphasized the importance of allowing clients to be the experts on their own experience. Leitner has advocated the adoption of the credulous approach: taking what the client says at face value (Leitner, Dunnett, Anderson, & Meshot, 1993). Use of traditional diagnoses sets the therapist up as the expert and fails to see how clients construe their own experiences. Since use of traditional diagnoses requires the therapist to impose labels on the client, the process may invalidate the client's own understandings. Steve's comment in the following passage, "you people were always telling

me though that I was wrong," exemplifies the potential for diagnoses to undermine a therapeutic alliance:

> Therapist: So again I hear you doubting yourself, saying "Oh maybe I'm just paranoid" (Steve: yeah, well I am a little bit) you're having a very hard time, well I'm saying it sounds like you're having a hard time just trusting your own instincts.
> Steve: I don't trust my instincts, well I'm crazy how can I trust my own instincts?
> T: But, I've thought that at times you've had pretty good instincts . . .
> S: Well, all the, you people were always telling me though that I was wrong so what do you expect? What do you, you know, if you tell somebody over and over and over . . . and over and over and you raise them up like that when they're a kid, what do you expect? So that's why. And maybe they're right though, you know, I was crazy, still am . . .

LACK OF TREATMENT IMPLICATIONS

Diagnoses have been criticized by both humanists and behaviorists for the fact that they often do not have implications for how to treat the client or how to help the person change. Humanistic psychologists have long argued that diagnoses do not facilitate therapeutic progress (Kelly, 1991; Rogers, 1951). Behaviorists have also joined in the complaint against the lack of usefulness of traditional diagnoses for directing treatment (Follette & Houts, 1996; Wulfert, Greenway, & Dougher, 1996). Behaviorists have noted that similar behaviors may have very different causes and that very different behaviors may have similar causes (Wulfert et al., 1996):

> For example, it is an established fact that a host of different variables can produce the same psychological syndrome (e.g., depression may be caused by biological factors, irrational cognitions, a social skills deficit, or a lack of reinforcement). Conversely, functionally similar behavior patterns may have very different structural characteristics (e.g., alcoholism, binge eating, or compulsive gambling may all be used to relieve marital distress and might respond to marital therapy). (p. 1141)

Therapists of diverse orientations agree that in some cases *DSM* diagnoses do not help the client and, as many have argued, that they can be destructive at times.

Steve has commented that shrinks knew what was wrong with him, but they did not know how to help him. Steve spoke poignantly about his previous therapists' ability to apply a label to him that did not provide a guide for how to treat him:

> Steve: Yeah, I am crazy, I mean I've been told it over and . . . by everybody and I am.
> Therapist: So . . .
> S: I mean the doctors told me I was basically and they got paid big bucks, I mean they're the doctors, they know it all.
> T: So, on one hand you . . .
> S: They are very intelligent people, they know it all . . .
> T: And yet you're saying that sarcastically.
> S: Well they are very intelligent people.
> T: Do you mean that?
> S: Yes, I mean they're geniuses (laugh) . . .
> T: You don't even mean what you're saying, that's why . . . you're being sarcastic, so I don't why . . .
> S: But they are right though when they say I'm crazy, but half the stuff about how to cure me—no, they don't know the answer.

ALTERNATIVES TO THE *DSM*: DIAGNOSIS AS AN INTERPRETIVE ACCOUNT

A review of Steve's case suggested that the use of *DSM* diagnoses has the potential to damage self-images (e.g., decrease self-esteem and self-efficacy) and to inhibit the therapeutic process. This possibility calls for a review of the strengths and weaknesses of alternative methods for assessing clients' symptoms and complaints. In a recent "case study of the DSM," Follette and Houts (1996) concluded that "it is time for alternative classification schemes to emerge to compete with one another . . . the DSM-IV needs to be relegated to the status of 'a,' not 'the' way of organizing scientific research" (p. 1129). Many critics from diverse orientations have proposed alternatives to the *DSM*. Behaviorists advocate the use of "logical functional analyses" (Wulfert et al., 1996) or a "functional dimensional approach" (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Psychodynamic theorists have proposed that the Structural Analysis of Social Behavior (SASB) (Benjamin, 1974) is a preferable alternative to the *DSM* because it includes a model of etiology and a criteria by which successful change can be measured (Henry, 1996).

Kelly (1991) has proposed "transitive diagnosis" as an alternative to traditional diagnosis. Transitive diagnoses are efforts to understand the client in ways that see him or her as a process. Such diagnoses are therefore always evolving. Similarly, dispositional assessment (Cole, 1966; Cole & Magnussen, 1966; Faidley & Leitner, 1993; Leitner, 1995) is a method of assessment that has as its goal a treatment disposition. This means that unless the therapist's way of understanding the client contains within it a means of helping the client, then the assessment is not useful.

Illustrative example. An example of transitive diagnosis is Leitner and Pfenninger's (1994) nine dimensions of optimal functioning that provide categories for assessing clients. The nine dimensions (Discrimination, Flexibility, Creativity, Responsibility, Openness, Commitment, Courage, Forgiveness, and Reverence) provide guidelines for describing a client's struggles in interpersonal relationships. These dimensions help the therapist look for strengths of the client in addition to identifying areas in which the client can grow. The identification of Steve's courage in seeking treatment resulted from application of the nine dimensions to Steve. A dimension that was considered as an area for growth was that of creativity. Noting Steve's struggle with creativity differs from traditional diagnoses in that it pointed to treatment implications. In formulating a treatment plan, one goal of therapy was to encourage creativity in Steve. Specifically, Steve needed to generate many plausible constructs with which to understand himself that would serve as an alternative to seeing himself as mentally ill.

Empirical evidence points to the benefits of using interpersonal formulations when describing dysfunction. Studies suggest that when patients describe their conditions as interpersonal problems rather than as diseases they receive more favorable evaluations from others (Mehta & Farina, 1997; Rothaus, Hanson, Cleveland, & Johnson, 1963).

Diagnoses as tentative interpretations. In the face of the proliferation of alternative yet not widely accepted diagnostic systems, we suggest a broader criterion for the therapeutic use of diagnosis. Perhaps more important than the specific content of the diagnosis (*DSM* label, analysis of social behavior, etc.) is the way the diagnosis is presented to the client. We recommend that a diagnosis be

presented as a tentative interpretation. Qualitative researchers have delineated the criteria for evaluating an interpretive account (Packer & Addison, 1989; Stiles, 1993). The "validity" of an interpretive account is determined by its "catalytic validity"—the extent to which it promotes change in those to whom the interpretive account is applied (Stiles, 1993). The goals of therapy and the goals of qualitative research dovetail in that both promote change (catalytic validity in qualitative research). Thus, the validity of a diagnosis could rest on its catalytic validity or ability to help the client change.

Considering diagnoses as interpretive accounts would convey therapeutic metacommunications to the client. It would be communicated to clients that diagnoses should be evaluated based on the clients' experiences. Interpretive accounts are, by definition, tentative. Similarly, diagnoses could be presented not as static labels but as open to revision. If the label did not promote change, it would be the label that would be invalidated—not the client's experience. This conveys the message that the client's experience is fundamentally trustworthy and should be used as a guide to understanding the client's evolving state.

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MAKING DAEMONS OF DEATH AND LOVE: *FRANKENSTEIN,* EXISTENTIALISM, PSYCHOANALYSIS

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Summary

Psychology and literature are kindred approaches to the depth dimensions of life. By reading Mary Shelley's *Frankenstein* in light of existentialism and psychoanalysis, we may develop a deeper appreciation of the novel and of key psychological phenomena such as death-repression, the return of the repressed, and the daemonic. In evading life's challenges, Victor Frankenstein makes daemons of four great existential mysteries: death, love, nature, and spirit. His disowned conflicts return to haunt him in the guise of the creature, in his implicit captivation by death, in his alienation from people and nature, and in perversions of authentic spirituality. In contrast, Shelley was able, via *Frankenstein*, to transform her suffering and hope into a deep, enduring work of art.

Mary Shelley's *Frankenstein* is a profoundly strange story, a mythic tale whose allure has persisted for nearly 200 years.

Mysterious, horrifying, exciting, haunting, uncanny: These qualities compose the essence of Gothic novels. Yet, they are also the stuff of daily life, usually not so apparent, but pervasive nonetheless. *Frankenstein* is strange indeed, but even further, *life—just as it is—is strange*. Forever colored by our greatest hope and our greatest dread, ordinary existence is awesome, astonishing, bewildering, and inspiring. Everyday life is always deeper than we can conceive and often deeper than we even wish to conceive. If we look carefully we will discover depth in every surface, the extraordinary in the ordinary. Human subjectivity pervades all supposed objectivity. Whenever things are being concealed, explicitly, they are also being revealed, implicitly. Throughout conscious awareness there is unconscious sensitivity. We intuit the mystery that exists within and beyond our conventional lives, but alas, letting ourselves be carried away by busyness or defensiveness, we often overlook it.

Frankenstein addresses this mystery and allows the mystery to address us. It does so by exploring four archetypal realms of human existence, four essential realities we all must face in one way or another: death, love, nature, and spirit. These existential givens tap into the depth dimensions of our lives and call us to bring forth the very best of ourselves. How we respond to this call largely creates our destiny. This was certainly the case with Victor Frankenstein and with Mary Shelley as well.

To provide some common ground for this interpretation of *Frankenstein*, I will mention a few episodes of the novel that are especially relevant. We are given the story in a series of letters from Walton, an explorer and ship's captain, to his sister. We read Walton's version of a tale he hears from Victor Frankenstein, who himself tells the story through the lens of a delirious consciousness while he is just on the verge of death. Long before, when Victor is 4 years old, his family adopts a little girl, Elizabeth. From the beginning his parents prepare the way for these children to marry

each other. When Victor is 17, his mother dies after contracting scarlet fever from Elizabeth. Three months later he leaves home to start his studies at the university.

Soon Victor begins the grand project of creating a living, sentient human being from the bodies of the dead. After working for 2 years with frenzied intensity and single-minded focus, he succeeds in bringing a being to life. However, with the first stirring of the creature Victor is horrified and disgusted by its ugly appearance, and he immediately flees. The abandoned creature is never given a name but is deemed a "daemon," "devil," and "monster" by Victor. Struggling to survive on his own, the creature finds shelter in a small hovel connected to a cottage, home of the De Lacey family: an old blind man, his daughter, and his son. Keeping himself hidden, he works diligently to understand these people, to make sense of their language and customs. Eventually he presents himself to the father alone, hoping that the old man, unable to see, will perceive more deeply and discover the sensitivity and kindness that are obscured by his horrible appearance. This strategy works for a few minutes. Unfortunately, the others return, become terrified, and attack the creature. This and a series of other unwarranted rejections lead the desperate creature to seek compensation or revenge from his creator.

The creature encounters Victor's 7-year-old brother William and ends up killing him, perhaps accidentally. Soon thereafter he confronts Victor, eloquently tells him of his struggles, and beseeches Victor to create a female partner for him. His deepest desire is to share understanding and love with another being. Victor first refuses but then agrees. Later, however, Victor destroys the creature's mate when he has nearly completed her. Enraged and despairing, the creature becomes even more murderous. He kills Victor's best friend Clerval and goes on to kill Victor's bride Elizabeth on her wedding night.

Obsessed with wreaking revenge, Victor pursues the creature for 3 years far into the frozen Arctic. Near death from psychosis and physical exhaustion, Victor happens upon a ship trapped in the ice. Moving in and out of a hallucinatory state, Victor tells his strange story to the ship's captain, Walton. Then he dies. The creature finds Victor dead, confronts Walton, vows to make a funeral pyre to kill himself, and (as the novel ends) disappears "in darkness and distance" (Shelley, 1818/1990, p. 165).

THE RETURN OF THE REPRESSED
AND THE MAKING OF DAEMONS

Victor frequently curses the creature by calling him a "daemon." This epithet of abomination carries abundant significance, especially when interpreted in light of a key psychological phenomenon, namely, the return of the repressed. Traditionally, daemons were experienced as powerful numinous spirits, spiritual beings, or disembodied souls that could be benevolent, malevolent, and often both. For the ancient Greeks, a *daimon* was "a semidivine being (normally regarded as beneficial to humans) whose nature is intermediate between human and god" (Long, 1987, p. 282). In her dialogue with Plato in the *Symposium*, the wise-woman Diotima teaches that Eros "is a great spirit [*daimon*], and like all spirits he is intermediate between the divine and the mortal" (Plato, circa 360 B.C.E./1953, p. 534). Socrates often spoke similarly of a *daimonion* that guided his life. Around the third century B.C.E., in the earliest Greek version of the Old Testament, *daimon* and *daimonion* began to indicate malevolence exclusively. This connotation continued in the New Testament and other Christian writings where the traditional vast assortment of devils and demons became consolidated primarily into a single, evil archdaemon, the Devil or Satan. The English words daemon and demon were derived via the Latin *daemon* from the original Greek *daimon*. For the past few hundred years, some writers have deliberately chosen the form daemon, in part to emphasize the psychological and spiritual character of these beings who are midway between humans and gods. Whereas demon conventionally connotes an evil monster with an external existence independent of the perceiver—for example, a red devil with horns, tail, and pitchfork—daemon, in contrast, tends to carry a psycho-spiritual connotation and is associated with various manifestations of the perceiver's psyche.

Early in his work, Freud discovered two psychological phenomena, "repression" and "the return of the repressed," which guided him through the rest of his life. Although the foundational insights of a theory tend to be taken for granted, it is often enlightening to reconsider them and to contemplate their enduring significance. Thus, this article explores the nature of daemons in light of the return of the repressed. Freud knew that repression and other defenses help us survive in situations that feel unbearably painful. Further, he demonstrated that whatever we make unconscious

tends to return in some disguised, symbolic form. Dreams, slips of the tongue, and pathological symptoms are common ways in which repressed feelings, thoughts, urges, and aspects of our self reappear in our lives. (I will use the phrase "the return of the repressed" to refer broadly to the reemergence of anything that has been defensively disowned, dissociated, or otherwise split off from consciousness, regardless of the specific defense that is being employed.)

Since Freud and Jung's groundbreaking explorations of paranoia, psychologists have been aware of the defense of projection. This is a phenomenon wherein, mostly without reflective awareness, we repress feelings, ideas, urges, and qualities of our self that feel painful and intolerable. Once these have been split off, they do not simply disappear but rather return and are reexperienced (by the projector) in an externalized (projected) form. For example, a paranoid man does not recognize his own anger, but finds—actually, unwittingly creates—evidence that his coworkers are trying to get him fired. Unwanted or misunderstood aspects of our self can be projectively personified (sometimes in daemonic form) and experienced as if they were external to us. In the hallucinations of a schizophrenic woman, the supposedly separate voices that she hears are usually her own (dissociated) thoughts. From this perspective, depth psychology has demonstrated that some daemons are our disowned characteristics returning in projected, symbolic form. When we become divided against ourselves, aspects of our wholeness can be dissociated and transmuted into (supposedly) external daemons. Such daemons can torment us in dreams, fantasies, delusions, illusions, and hallucinations. Freud (1920/1961a) attested to the "daemonic" force of the return of the repressed (while emphasizing the existential responsibility we each have for our own daemons):

> The impression they [patients] give is of being pursued by a malignant fate or possessed by some "daemonic" power; but psycho-analysis has always taken the view that their fate is for the most part arranged by themselves. (p. 21)

In this sense—and without disavowing the reality of evil—daemons certainly exist as psychological realities.

When a person is engaged in a personal conflict that simultaneously involves an existential or archetypal challenge—a challenge inherent in being human, for example, an interpersonal cri-

sis of love or an artistic crisis of creativity—the powerful energy, emotions, ideas, and actions of this process often manifest in daemonic form. Daemonic, in this context, carries no value judgments, as Rollo May (1969) observed: The daemonic "is potentially creative and destructive at the same time" (p. 162). Daemonic energy is available for us to take up, respond to, and channel as best we can. Thus, the way in which we relate to our psychological daemons is crucial in determining our destiny. If we respond with openness and understanding, then our daemons tend to be integrated as benevolent, creative, energetic guides to transformation and health. But if we react with defensive avoidance, they tend to appear as malevolent, destructive sources of suffering. Fear of pain—and, ultimately, fear of death—is the greatest factor that inhibits our ability to be fully alive in the present and to evolve psychologically. Confronting our painful daemons, therefore, is essential in transforming *excessive* defensiveness into authentic existence and development.

This process is illustrated by the universal mythical theme of the archetypal hero, one who must courageously overcome dangerous daemons or monsters to fulfill his or her calling. Jesus and the Buddha both confronted powerful daemons in the process of their spiritual liberation. During his 40 days in the wilderness, Jesus was repeatedly tempted by the Devil (Matthew 4: 1-11, Luke 4: 1-14, King James Version). And the Buddha, when on the threshold of awakening as he meditated under the Bodhi tree, was attacked time and again by evil lord Mara and his army of daemons (Coomaraswamy, 1916/1964, pp. 32-35). Like these great spiritual sages, we each must acknowledge, understand, transform, and integrate our own psychological daemons lest they return to torment or destroy us. Thus, as D. M. Dooling (1981) described, "a *demon* is: a force that must be conquered in order that it can become one's *ally*, but which, if it is not conquered, becomes a scary monster" (p. 86). May (1969) offered a similar perspective:

> *Identify with that which haunts you, not in order to fight it off, but to take it into your self; for it must represent some rejected element in you*. (p. 131)
>
> The denied part of you is the source of hostility and aggression, but when you can, through consciousness, integrate it into your self-system, it becomes the source of energy and spirit which enlivens you. (p. 132)

As Victor's sad and horrifying tale illustrates, when we don't deal with our daemons, they will deal with us.

Of course, it is much more difficult to actually face our traumas, crises, and fears than merely to affirm we should. Indeed, to engage our daemons consciously is the way of a hero. A hero here is not some superhuman being but an ordinary person aspiring to be fully human, one who calls forth the courage and devotion to be responsively aware in the face of whatever challenges life presents. And whether we choose to confront or repress our daemons, the ordeal will almost certainly be painful. In the wise words of May (1969):

> If we repress the daimonic, we shall find these powers returning to "sicken" us; whereas, if we let them stay, we shall have to struggle to a new level of consciousness in order to integrate them and not be overwhelmed by impersonal power. . . . *Either way will hurt*. (pp. 175-176)

The interrelated phenomena of psychological defensiveness and the return of the repressed exemplify the astounding resourcefulness of human consciousness. When overwhelmed by pain or fear, defense mechanisms spontaneously serve to divert excessively traumatic feelings, thus allowing us to adapt in a threatening situation. Later, when the repressed returns and reveals itself in symbolic form (such as symptoms of psychopathology), we give ourselves the opportunity to face, understand, and integrate our daemons, to master both our present distress as well as the original trauma (or cumulative traumas). In this process, we may deepen our psychological development. By repetitively relying on unconscious, habitual patterns of defense, we simultaneously re-present (and symbolically represent) to ourselves the very daemon that we need to address consciously. Defenses thus work in a paradoxical manner, concealing and revealing, closing and disclosing.

It is often said that the creature and Victor (like Dr. Jekyll and Mr. Hyde [Stevenson, 1886/1998]) are, uncannily, two sides of the same being, that the creature represents a repressed aspect of Victor, his double or doppelganger. Even Victor refers to the creature as "my own spirit let loose from the grave" (Shelley, 1818/1990, p. 57). And Victor certainly does behave in daemonic ways. (From this perspective, we find an important psychological truth in the popular misconception that Frankenstein is the name of the mon-

ster in the story.) In a literal reading of the novel, Victor makes a daemon when he creates and abandons the creature. Here the daemon is a distinctly other being. Further, metaphorically and psychologically, the creature is a daemonic manifestation of the disowned forces in Victor's life (such as anger, sadness, guilt, creativity, death, and the yearning for connection and meaning). This helps us make sense of the fact that even though the creature appears strangely alien—a singular, isolated, non-human being with no kin nor friend—he is also strangely familiar, universally understandable, and intimately connected to (even identical with) Victor. Along the same lines, Freud (1919/1955c) associated "the daemonic" with "the uncanny" and discovered that "the uncanny is that class of the frightening which leads back to what is known and familiar" (p. 220). Indeed, he said, the "uncanny is in reality nothing new or alien, but something which is familiar and old-established in the mind and which has become alienated from it only through the process of repression" (p. 241). As we shall see, Victor's relationship with the creature is a vivid expression of the inability to integrate familiar but disturbing daemons, thus leading to a kind of daemonic possession (in the form of defensive projection, or more precisely, projective identification). Further still, as part of the same defensive reaction against his fear and pain, Victor daemonizes the great archetypal powers of death, love, nature, and spirit.

MAKING DAEMONS OF DEATH

According to Martin Heidegger (1927/1962) and the existential tradition, to live an authentic human existence we must acknowledge, accept, and be guided by an awareness of our own inevitable death. In staying conscious that we will certainly die—and appreciating that we don't know when or how, that death could come at any moment—we may realize the preciousness of the present moment, of each experience and relationship, and thus, with resoluteness, be more fully awake and alive. This is a heroic aspiration, one that can be actualized only by repeatedly overcoming our urge to turn away from the anxiety of being human, by surpassing our willingness to close off and settle for the tranquilizing consolations of inauthentic existence. Indeed, Ernest Becker (1973) asserted that "*Consciousness of death* is the primary repression, not sexual-

ity" (p. 96). With a remarkably existentialist perspective, Freud also found a crucial connection between death-denial and psychological suffering. Ultimately, in Freud's view, psychopathology is a defensive reaction to the fear of death. For example, Freud (1913/1955b) remarked that obsessive acts are "designed to ward off the expectations of disaster with which the neurosis usually starts. Whenever I have succeeded in penetrating the mystery, I have found that the expected disaster was death" (p. 87).

We are afraid of things that threaten our biological life, of course, but also of things that threaten to destroy our ensconced self-sense and worldview. Both kinds of death are real and dreadful. Even so, facing death—the death of our loved ones, the reality of our own finitude, as well as the death/transcendence of our supposedly separate and exclusive egoic self—can initiate a deep developmental transformation. If we are able to move beyond our habitual defenses and stay open to this process of transcendence, we may experience profound aliveness, growth, and liberation.

In the character of Victor Frankenstein, Shelley presented us with a man who cannot bear the reality of death and who suffers greatly because of this defensive denial. When Victor is 17, Elizabeth contracts scarlet fever but recuperates quickly. However, when his mother goes to care for Elizabeth—"her favourite" child according to Victor (Shelley, 1831/1994, p. 23)—she becomes fatally infected and dies within a few days. His mother's death is a fateful trauma from which Victor never recovers. He considers her death to be "evil," declaring that his "dearest ties are rent by that most irreparable evil" (Shelley, 1818/1990, p. 33). This expression is quite significant. First, it shows how profoundly traumatic it is for Victor to lose his mother. Even though she died of natural causes, he repeatedly associates her death with malevolence and evil. Thus, he daemonizes death, daemonizes a reality that is completely natural and unavoidable. Further, Victor is driven by the unconscious fantasy that her death is not "irreparable" and tries to make reparations by creating a living being.

Strangely, although Victor claims to feel "despair" and the "bitterness of grief," there is no evidence that he actually allows himself to grieve. With intellectualization and isolation of affect he remains aware of the factual idea of his mother's death but not of the feelings associated with the loss: "My mother was dead, but we still had duties which we ought to perform" (Shelley, 1818/1990, p. 33). Ironically, by defending against the sadness, anger, and guilt

evoked by his mother's death, Victor deadens himself. It is just as Becker (1973) said, "The person seeks to avoid death, but he does it by killing off so much of himself and so large a spectrum of his action-world that he is actually isolating and diminishing himself and becomes as though dead" (p. 181).

Three months after losing his mother, Victor leaves his Geneva home to attend the university in Ingolstadt, Germany. Abandoning his grieving father, brothers, and future wife, he flees into the more manageable intellectual tasks of academic study. Once Victor is away, his inability to grieve becomes even more extreme, his defenses even more destructive. He cannot find a way to face the meaning of his mother's death, bear his painful feelings, put her death in some perspective, and reengage authentically his own life. Instead, he resorts to more primitive or immature defenses such as splitting, projection, grandiosity, devaluation, idealization, and hypomanic activity (see Schneider, 1993).

It is often difficult to discern precisely if and when our use of defenses takes a pathological turn, when we diverge from effective coping and begin to react destructively. Nonetheless, we can sense such a pernicious shift in Victor. Consider his extraordinarily haughty reaction upon arriving at university and meeting one of his first professors (Shelley, 1818/1990):

> I did not feel much inclined to study the books which I procured at his recommendation . . . . I had a contempt for the uses of modern natural philosophy. . . . I could not consent to go and hear that little conceited fellow deliver sentences out of a pulpit. (p. 35)

With defensive splitting, Victor elevates himself and devalues Professor Krempe in a manner that rivals the mythological Narcissus. This hostile, demeaning view is coming from a 17-year-old freshman who has yet to begin classes!

Later, after only 2 years, Victor arrogantly believes he has learned all he can and that the university is of no use to him. He briefly thinks about returning home, but instead, with growing grandiosity, he concocts the idea that he can create a living, sentient human being, and hastily begins work. Victor's narcissism and compensatory need for admiration were evident before but now intensify: "A new species would bless me as its creator and source; many happy and excellent natures would owe their being to me" (Shelley, 1818/1990, p. 40).

The way Victor handles this grand project reveals his extravagant efforts to come to terms with losing his mother and his ultimate inability to do so. From the outset, he realizes that to create life he must explore death (Shelley, 1818/1990):

> To examine the causes of life, we must first have recourse to death . . . I was . . . forced to spend days and nights in vaults and charnel houses . . . I saw how the fine form of man was degraded and wasted . . . I saw how the worm inherited the wonders of the eye and brain. (p. 38)

In the 18th century, many people were not buried individually. The poor, especially, were placed in huge open graves—charnel houses or charnel grounds—which typically held between 600 and 1,500 corpses. Often the bodies were just piled on top of each other and left to decay (Aries, 1981, pp. 51-62).

Imagine Victor spending "days and nights" in charnel houses, seeing and smelling putrefying corpses, cutting off and collecting body parts to compose his creature. Victor's intuition that he must confront death is a profound one. Yet, because he takes his intuition literally, he doesn't realize the message he is giving himself. It is true of course that he must confront death, not just to bring a creature to life but, more deeply, because he never mourned the loss of his mother. Victor is drawn to graveyards and charnel houses because there, by facing death literally and materially in the decaying bodies, he is giving himself a chance to face death symbolically, psychologically: to realize that he has not only scientific work to do but the emotional, psychological work of grief as well. He might also remember that his family and friends are still alive and longing for his love.

This is a vivid example of the return of the repressed and the wisdom of the human psyche (with its inherent reparative and healing capability). It may seem strange, yet people often feel compelled to place themselves in distressing circumstances, especially situations that are similar to previously traumatic ones. Freud (1920/1961a) stressed the tremendous, haunting intensity of such confrontations: "The manifestations of a compulsion to repeat . . . give the appearance of some 'daemonic' force at work" (p. 35). Indeed, such situations have an uncanny allure. However, this compulsion to repeat the trauma is not necessarily pathological. It can serve as an opportunity to master, integrate, and grow beyond the trauma. Even if we turn away many times, we also want to deal

with our daemons because they are the source of so much unlived life.

As time passes, Victor's fantasies grow more extreme (Shelley, 1818/1990): "I thought, that if I could bestow animation upon lifeless matter, I might in process of time (although I now found it impossible) renew life where death had apparently devoted the body to corruption" (p. 40). Here, it seems, he literally wants to revitalize his dead mother. (In the end, he certainly resurrects her symbolically, albeit unconsciously, by identifying with her. That is, Victor himself becomes a mother who labours to give birth to a new being. He often uses the term *labour* with regard to his process of making the creature.) Further, if we see the creature as carrying disowned aspects of Victor—as his double—the insights of Freud and Rank become especially revealing (Freud, 1919/1955c): "For the 'double' was originally an insurance against the destruction of the ego, an 'energetic denial of the power of death,' as Rank says. . . . But . . . the double reverses its aspect. From having been an assurance of immortality, it becomes the uncanny harbinger of death" (p. 235).

Being intensely anxious, Victor feels compelled to create a living being out of dead bodies, in part because he has not been actualizing his great intellectual and creative abilities, but especially because he is driven by the unconscious, death-denying fantasy of bringing his mother back to life. Ironically, if he could let himself grieve, perhaps he could *bring himself back to life*, back to an integrated existence and to loving participation in the shared human community. Potentially, by dwelling with the dead, his consciousness may deepen and he may understand the symbolic message: These bodies are more than materials for a scientific experiment, they refer to your dead mother and to the deadening of your very own self. Yet, as Victor watches corpses decay and be eaten by worms, he keeps himself protected by the beliefs and goals of scientific materialism. Clinging to the single-minded, literal-minded pursuit of bringing dead matter to life, he unknowingly avoids the pain of losing his mother. Misled by defensive maneuvers, he overlooks the deeper point of his desire. In the poignant words of T. S. Eliot (1943), "We had the experience but we missed the meaning" (p. 39). Alas, Victor experiences death again and again, but the meaning of these experiences is never allowed to break through. Herein we see a recurrent source of his suffering.

Guided unwittingly by his psyche's inclination toward healing, Victor consistently places death right in front of his eyes, giving himself a key symbol to contemplate, a potential resource for revelation. To understand the meaning of any symbol, however, we must go through and beyond the literal significations that lie on the surface. Taking the obvious, superficial, and literal as our point of departure, we move on to see differently, more, and deeper. Yet, this is the very thing Victor cannot bring himself to do. Martin Buber (1921/1965) described this great existential dilemma:

> Each of us is encased in an armour whose task is to ward off signs. Signs happen to us without respite, living means being addressed, we would need only to present ourselves and to perceive. But the risk is too dangerous for us, the soundless thunderings seem to threaten us with annihilation, and generation to generation we perfect the defence apparatus. (p. 10)

Victor actually boasts about his defenses because he doesn't even realize he is being defensive, thinking instead that he is simply engaged in a rational, scientific approach to death (Shelley, 1818/1990): "Darkness had no effect upon my fancy; a church-yard was to me merely the receptacle of bodies deprived of life" (p. 38). Preoccupied with a totally technological solution to his distress, he avoids the psychological work necessary for a real resolution, thus setting the stage for disaster. "*Not to recognize the daimonic itself turns out to be daimonic; it makes us accomplices on the side of the destructive possession*" (p. 129), as May (1969) asserted.

Victor frequently remarks on his maniacally fixed focus (Shelley, 1818/1990):

> A resistless, and almost frantic impulse, urged me forward; I seemed to have lost all soul or sensation but for this one pursuit. (p. 40)
>
> I could not tear my thoughts from my employment, loathsome in itself, but which had taken an irresistible hold of my imagination. (p. 41)

This acknowledgment is quite revealing, especially when we listen for the truth that Victor intuits but keeps mostly unconscious. After obliterating his grief and isolating himself from others and from aspects of his own self, he has indeed lost much of his soul. His imagination degenerates into literalism and narcissism, and he is held captive by (what appears to be) a merely technical, scientific project.

Bolstered by the genuinely progressive and emancipatory achievements of Enlightenment philosophy, traditional physical science prided itself on adhering to (what it believed to be) a purely objective, rationalistic, and materialistic approach. However, when scientists like Victor are captivated by an unreflective allegiance to these reductive ideals, they often miss much of the meaning of the phenomena they are exploring. The Romantic movement criticized this trend toward an exclusively physical scientific approach to reality. For example, William Blake (1802/1988) warned vehemently of the dangers of accepting this view as the whole truth, the peril of not seeing more deeply:

> Now I a fourfold vision see
> And a fourfold vision is given to me
> Tis fourfold in my supreme delight
> And threefold in soft Beulah's night
> And twofold Always. May God us keep
> From Single vision & Newton's sleep (p. 722)

Shelley's father, William Godwin, was a philosopher who, influenced by great advances in the physical sciences, advocated a rationalist approach that was extreme and exclusionary. His reaction to his dying wife provides a chilling example of the sleep that can be induced by such "single vision." Mary Wollstonecraft Godwin—one of the first feminists and author of *A Vindication of the Rights of Woman*—suffered an extremely painful death from birthing complications just days after Mary was born. Contrary to her husband's atheistic views, she had sustained her faith in God. It is reported that upon feeling her suffering subside momentarily as she lay on her deathbed, she exclaimed, "Oh Godwin, I am in heaven" (Wolf, 1977, p. 48). Although Godwin loved his wife, at this crucial moment he countered her with the contention that, "You mean, my dear, that your symptoms are a little easier" (p. 48).

We can imagine the effects of such a rigidly rational and anti-emotional style on young Mary's development. *Frankenstein* furthers the Romantic attack on the Enlightenment's *exclusive* idolatry of rationality, materialism, science, and technology. (It is important to acknowledge that the novel is complex. In fact, Shelley criticizes certain aspects of Romanticism, such as the move-

ment's propensity—manifested by Godwin, Percy Shelley, and Victor Frankenstein—to excuse narcissistic self-interest and the avoidance of interpersonal responsibility in the name of higher principles. Despite its profound contributions, Romanticism has other shortcomings as well, but they are not the focus of the present article.) With regard to the critique of narrow-minded science, consider Victor's solution to a problem he encountered while making the creature (Shelley, 1818/1990): "As the minuteness of the parts formed a great hindrance to my speed, I resolved . . . to make the being of a gigantic stature" (p. 40). Lost in his fantasy of personal power and death-repression, Victor is consumed by his own egocentric view and needs. Ordinary body parts are merely an inconvenience to him, so he uncritically makes a giant. Spellbound by scientistic "single vision," a monological perspective that conceives no need for interpretative dialogue, Victor can only see the material / mechanical/technological dimension of his work (Wilber, 1995). May (1969) observed that when the daemonic is projected "*imagination and vision are blocked*" (p. 157). Victor's single vision certainly keeps him asleep, anesthetized to painful feelings concerning death and love. Nonetheless, the pain returns in increasingly horrible forms (including murder).

"Suffering is the first grace." This ancient Christian teaching, wisely interpreted, offers tremendous potential for transformation. Paradoxically, when confronted with suffering we are being given the opportunity to realize that something is awry. And with this insight we may begin working to change our lives, gradually growing through and beyond the pain. Victor suffers because he avoids his mother's death and cuts himself off from his loved ones, yet he never discovers the meaning inherent in this suffering. No wonder he is haunted by daemons of death. As Freud (1909/1955a) warned, "a thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell broken" (p. 122). For Victor, the daemonic spell is never broken. He works for almost 2 years and still never discovers the significance of his obsession with life and death. Eventually, of course, he does give birth to the creature. Thus, Victor becomes a mother, accomplishing an identification with his own mother while symbolically bringing her back to life. But this is a far cry from grieving.

DEATH AND LOVE IN SHELLEY'S LIFE AND ART

From the moment Shelley was born, her existence was inscribed with the trauma of tragic death. Her mother died due to complications from childbirth 10 days after she was born. Not only was Mary left without a mother, but she was also haunted by fantasies about her responsibility for her mother's death. When Mary was 17 (and not yet married), her first child was born prematurely and died 2 weeks later. (This was about a year and a half before she began *Frankenstein*.) While she was writing the novel, both her half-sister Fanny and Percy Shelley's wife, Harriet, killed themselves in separate incidents. Jealousy of Mary seems to have contributed to each suicide. At age 19, Shelley finished *Frankenstein* while pregnant with her third child, Clara, who died just a year after she was born. Her cherished son, William, died when he was only 3. When Shelley was 24, she nearly bled to death from a miscarriage, but her life was saved by her beloved husband, Percy. Terribly, he drowned in a boating accident 3 weeks later.

I take it for granted that some of the meaning we discover in *Frankenstein* is a manifestation of Shelley's conscious and unconscious intentions, while the story is also meaningful in ways that transcend the author's intentions. Along with other complex motives (partially in and partially out of her awareness), it is clear that the 18-year-old Shelley used her writing of *Frankenstein* to grapple with her daemonic conflicts concerning death and love, especially the traumatic deaths of her mother and her first child. In creating *Frankenstein*, the pain of these losses returned powerfully into Shelley's awareness. In contrast to Victor's pathological reliance on primitive defenses, however, Shelley is able to receive messages from her unconscious—such as dreams, visions, and memories—and transform them into a work of art. As May (1969) attested, "The daimonic needs to be directed and channeled. Here is where human consciousness becomes so important. We initially experience the daimonic as a blind push . . . . It pushes us toward the blind assertion of ourselves . . . . But consciousness can integrate the daimonic" (pp. 124-125).

Shelley's feelings and fantasies about killing her mother became one of the formative influences in her life. In part, *Frankenstein* is a meditation on the destructive consequences of growing up

without a mother (or consistent father, for that matter). Time and again the creature desperately criticizes Victor for abandoning him (Shelley, 1818/1990): "No father had watched my infant days, no mother had blessed me with smiles and caresses. . . . What was I?" (p. 90). The creature attributes his violence to being deprived of mutual relationships and love: "I was benevolent; my soul glowed with love and humanity: but am I not alone, miserably alone?" (p. 74).

Shelley's journal reveals the suffering she endured at age 17 when her first baby died just 2 weeks after being born. Three days after finding her baby dead, she wrote (Feldman & Scott-Kilvert, 1987), "still think about my little baby—'tis hard indeed for a mother to loose [*sic*] a child" (p. 68). It is even harder for a mother to lose an infant after losing her own mother as an infant. A week after her daughter's death, she said, "think of my little dead baby— this is foolish I suppose yet whenever I am left alone to my own thoughts & do not read to divert them they always come back to the same point—that I was a mother & am no longer" (Feldman & Scott-Kilvert, 1987, p. 69). We can sense Shelley's grief along with her efforts to assuage the great sorrow she feels. She is aware that she (like everyone else) tries to manage her pain by diverting herself, by using defense mechanisms to ease her suffering. She also knows that these methods can be successful only temporarily, that the pain will resurface.

Thirteen days after her baby died, Shelley has a powerful dream, poignant in itself, but especially intriguing in light of *Frankenstein* (which she began writing 16 months later) (Feldman & Scott-Kilvert, 1987):

> Dream that my little baby came to life again—that it had only been cold & that we rubbed it by the fire & it lived—I awake & find no baby—I think about the little thing all day. (p. 70)

Naturally, Shelley would wish to bring her baby back to life. Most astonishing, however, is how an 18-year-old girl transforms this dream-fantasy (along with other experiences, hopes, and fears) into a deep work of art.

To understand how significant the themes of this dream were to Shelley, it is important to know that *Frankenstein* was shaped at

its inception by an intense, nightmarish reverie. Shelley (1831/1994) recounts the story of how she, "then a young girl, came to think of and to dilate upon so very hideous an idea" (p. v). Shelley, Percy, their baby William, and Claire (her stepsister) travel to Switzerland to visit Lord Byron. One evening, after reading ghost stories together, Byron proposes that they each write a ghost story. A few days later, while lying awake late at night, Shelley has a terrifying yet thrilling vision (Shelley, 1831/1994):

> My imagination, unbidden, possessed and guided me, gifting the successive images that arose in my mind with a vividness far beyond the usual bounds of reverie. I saw—with shut eyes, but acute mental vision—I saw the pale student of unhallowed arts kneeling beside the thing he had put together. I saw the hideous phantasm of a man stretched out, and then, on the working of some powerful engine, show signs of life, and stir with an uneasy, half-vital motion. Frightful it must be; for supremely frightful would be the effect of any human endeavor to mock the stupendous mechanism of the Creator of the world. His success would terrify the artist; he would rush away from his odious handy work, horror-stricken. He would hope that, left to itself, the slight spark of life with he had communicated would fade; that this thing, which had received such imperfect animation would subside into dead matter; and he might sleep in the belief that the silence of the grave would quench forever the transient existence of the hideous corpse which he had looked upon as the cradle of life. He sleeps; but he is awakened; he opens his eyes; behold, the horrid thing stands at his bedside, opening his curtains and looking on him with yellow, watery, but speculative eyes. (pp. viii-ix)

Having spontaneously given herself this visionary vignette—with images so evocative of her personal conflicts concerning birth, death, life, and love—Shelley courageously shapes it into a revelatory novel. By transforming suffering into art, *Frankenstein* is a beautiful example of the immense human potential for resiliency, sublimation, creativity, and healing. "Art can, indeed," as May (1969) said, "be defined from one side as a specific method of coming to terms with the depths of the daimonic" (p. 127). This is not to suggest that Shelley was completely able to work through her deep conflicts. She struggled intermittently with depression and psychosomatic problems throughout her life. Nonetheless, *Frankenstein* is a tremendously insightful literary and psychological accomplishment, one that continues to speak to us across cultures and eras.

MAKING DAEMONS OF LOVE

After briefly considering how Shelley used her art to work with her tragedies of death and love, let us see how Victor struggles with these same issues. Victor's repression of death is linked inextricably with his inability to love. Although he often proclaims that he loves his family dearly, he never actually behaves in a loving way toward them. After rushing away from his grief-stricken family soon after his mother dies, Victor does not return home for 6 years! It is not until he hears about brother's murder that he forces himself back to the place of his mother's death. Beckoning him home in a letter, his father writes, "Come, Victor . . . . Enter the house of mourning . . . with kindness and affection for those who love you" (Shelley, 1818/1990, p. 54). These words are unwittingly oracular. They testify to the indestructibility of the unconscious and inevitability of the return of the repressed. As we have seen, Victor had never really allowed himself to enter the house of mourning. Instead, he fled the house and family of mourning, displacing his energy and attention into scientific work. Addressing Victor on many levels, his father gives voice to the family's recurrent grief and resentment of his absence.

Yet, even when he comes home he still does not engage authentically in mourning, nor appreciate the pain his family is suffering. Victor's brother, Ernest, greets him when he arrives following William's murder. Ernest cries as he describes his father and Elizabeth's terrible sorrow. With a disturbing lack of empathy, Victor ignores his brother's pain and instead insists that Ernest soothe him (Shelley, 1818/1990): "Ernest began to weep . . . . 'Do not,' said I, 'welcome me thus; try to be more calm, that I may not be absolutely miserable the moment I enter my father's house after so long an absence'" (p. 58). This is a chilling response, one that demonstrates how incapable Victor is of moving beyond his own egocentric perspective and self-interest. For Victor, as for so many of us, fear of death manifests as fear of life and love. His death-denying defense, employed initially to save his life, is now dominating his existence, deadening, and draining him of authentic life. As Norman O. Brown (1959) demonstrated, it is our avoidance of death that is morbid, not death itself:

> This incapacity to die, ironically but inevitably, throws mankind out
> of the actuality of living . . . the result is the denial of life . . . . The dis-

> traction of human life to the war against death, by the same inevita-
> ble irony, results in death's dominion over life. The war against
> death takes the form of a preoccupation with the past and the future,
> and the present tense, the tense of life, is lost. (p. 284)

Captivated by such a "life against death" (Brown, 1959), Victor can neither live nor love fully.

"We have to realize," said R. D. Laing (1967), "that we are as deeply afraid to live and to love as we are to die" (p. 49). Intuiting this conflict, but fighting its clear emergence into consciousness, Victor often struggles to reassure himself that he is a loving person. Right after letting the family servant, Justine, be unjustly executed for William's murder—having chosen not to intervene, not to reveal the truth that the creature killed William—Victor proclaims that "my heart overflowed with kindness, and the love of virtue" (Shelley, 1818/1990, p. 67). Victor's intensely conflicted feelings are evident when he speaks of his family in comparison to his work: "I wished, as it were, to procrastinate all that related to my feelings of affection until the great object, which swallowed up every habit of my nature, should be completed" (Shelley, 1818/1990, p. 41). With grandiose ideas, he excuses his lack of love and empathy. He copes with his mother's death by developing a pseudo-amorous relationship with his scientific work. Victor's love for his mother and for Elizabeth (his bride to be) are displaced onto the not-yet-animated creature (who also serves as a symbolic container for his displaced attunement to death).

I have used the term *narcissistic* to characterize Victor's thinking, feeling, behavior, defensiveness, and character style. Although Victor meets the *Diagnostic and Statistical Manual of Mental Disorders* 4th ed. (*DSM-IV*) diagnostic criteria for narcissistic personality disorder, I believe that his suffering reflects, more broadly, shared human struggles. We all grapple with narcissistic conflicts, with issues of self-esteem, self-coherence, care for self versus care for others, and so on. The etymology of the word *psychopathology* is especially pertinent in this regard: psychopathology, seen deeply, is the meaningful (*logos*) suffering (*pathos*) of our soul (*psyche*). Victor suffers because he has difficulty confronting the pain of his personal challenges and collective existential realities. In the complex venture of living an ordinary human life, conflicts over love naturally blend with conflicts over death.

Victor's incipient narcissism—his "hyperexpansive" style (Schneider, 1993)—grows to pathological proportions as he moves

closer to animating the creature. "I was surprised," he boasts, "that among so many men of genius . . . I alone should be reserved to discover so astonishing a secret" (Shelley, 1818/1990, pp. 38-39). Victor even places himself above "the wisest men since the creation of the world" (p. 39). After making the creature, he reflects, "I could not rank myself with the herd of common projectors" (p. 155). In this light, consider May's (1969) observation with regard to "the self-righteousness and aloof detachment which are the usual defenses of the human being who denies the daimonic" (p. 132).

When haunted by the death of his mother and the existential reality of human finitude and vulnerability, Victor's grandiose notions serve as a compensatory defense, placing him in a powerful (albeit self-deceptive) position. Victor argues that he wants to benefit all of humankind by the fruits of his labor. This appears to be a noble wish. And to his credit, he certainly demonstrates intellectual and scientific brilliance by creating a living being. Thus, Victor's work resembles sublimation, the mature process of transforming disturbing feelings and ideas into creative, socially beneficial actions and products. In skillful sublimation, we acknowledge, bear, and eventually transcend the pain of our lives. Sexual urges can be sublimated as Freud showed, but so can grief, sadness, dread, guilt, rage, alienation, and yearning for connection. Indeed, all of these are potential sources of creative energy for Victor. His suffering is partially sublimated in bringing life to the creature. However, this process is aborted when he abandons the creature. Human consciousness and actions are usually composed of complex, multiple, conflictual moves both toward health and away from it. Motives are rarely pure or univocal. Nonetheless, Victor's reactions suggest that egoic, self-serving, death-denying motivations outweigh his genuine wish to serve humankind. His possibilities for sublimation, creativity, and altruism degenerate into displacement, splitting, and projective identification.

Eventually, Victor's narcissistic defenses become more destructive than protective. His lack of empathy for the creature is especially painful to witness. (Because of this, most people who read *Frankenstein* identify more with the creature than with Victor.) Focused on self-aggrandizement and his own narrow scientistic perspective, he fills himself with images of fame and glory. Thus, he is never able to see and empathize with the creature as a real other person, a being with legitimate thoughts, feelings, and needs of its own. Because Victor consciously chooses to piece the creature

together from dead bodies and parts of other animals, his horrible appearance could serve as a further invitation to accept the reality of death and the correlative call to love. But again, Victor flees from the potential message that he is sending himself, inauthentically avoids accepting responsibility for his behavior—essentially for his own child—and actively seeks unconsciousness. Consider his reactions in the very first moments of the creature's life (Shelley, 1818/1990):

> I saw the dull yellow eye of the creature open; it breathed hard, and a convulsive motion agitated its limbs. How can I describe my emotions at this catastrophe . . . ? . . . now that I had finished, the beauty of the dream vanished, and breathless horror and disgust filled my heart. Unable to endure the aspect of the being I had created, I rushed out of the room, and continued a long time traversing my bed-chamber, unable to compose my mind to sleep . . . . I threw myself on the bed in my clothes, endeavouring to seek a few moments of forgetfulness. (pp. 42-43)

Tragically, unable to process his intense feelings—both of horror and narcissistic injury—Victor's immediate reaction to the creature (in its initial moments of consciousness) is that of defensive abandonment. After just creating a living being, Victor runs away to a nearby room where he hopes sleep will make him oblivious. But our disavowed daemons come back to haunt us. Here the repressed returns, thinly disguised, in a dream that blends seamlessly into a waking life (Shelley, 1818/1990):

> I slept indeed, but I was disturbed by the wildest dreams. I thought I saw Elizabeth, in the bloom of health, walking in the streets of Ingolstadt. Delighted and surprised, I embraced her; but as I imprinted the first kiss on her lips, they became livid with the hue of death; her features appeared to change, and I thought that I held the corpse of my dead mother in my arms; a shroud enveloped her form, and I saw the grave-worms crawling in the folds of the flannel. I started from my sleep with horror; a cold dew covered my forehead, my teeth chattered, and every limb became convulsed; when, by the dim and yellow light of the moon, as it forced its way through the window-shutters, I beheld the wretch—the miserable monster whom I had created. He held up the curtain of the bed; and his eyes, if eyes they may be called, were fixed on me. His jaws opened, and he muttered some inarticulate sounds, while a grin wrinkled his cheeks. He might have spoken, but I did not hear; one hand was stretched out, seemingly to detain me, but I escaped, and rushed down stairs. (p. 43)

It is crucial to recognize that these are the very first experiences of the creature's life. A new being comes into this world and, smiling, yearning, reaches out to its creator, its fused mother and father, but is immediately scorned and rejected. Without any reflection, compassion, or curiosity, Victor misinterprets his child's wish for connection as a threat, presumes its desire for love to be a danger. These consecutive acts of abandonment create a key turning point. If Victor could have had the courage, or we could say the ego strength, to consciously accept responsibility for his grand venture, everything may have turned out differently. But he could not, and daemonic disaster ensued.

In Victor's dream, Elizabeth undergoes a metamorphosis into his mother who in turn metamorphoses into the creature. This deeply disturbing dream provides perhaps the most vivid evidence that his labour of birthing the creature is driven by death-denial and defensive displacement. The dream powerfully illustrates that Victor's scientific work is simultaneously psychological work (however unrealized), work that is permeated with his unacknowledged, unresolved feelings about his mother's death and with his inability to let himself really love. The reemergence of death into his awareness is too much for Victor to bear, so he retreats even further into a psychotic, hallucinatory delirium (the first of several still to come).

Just as Victor is unable or unwilling to face the full reality of the creature, he actively hides this truth from others. Significantly, May (1969) observed that "the most important criterion which saves the daimonic from anarchy is *dialogue*" (p. 154). In fact, the day after animating the creature, Victor encounters Clerval who recognizes something is terribly wrong. Nonetheless, Victor actively chooses to conceal the truth even from his best friend. By neglecting the opportunity to share his story, Victor distances himself from those who care about him and dooms himself to bear the burden of his actions in isolation. However, he is unable to handle this responsibility and is overcome by a psychotic delirium lasting several months. Clerval sees Victor's wild distress and pleas for an explanation (Shelley, 1818/1990):

> "Do not ask me," cried I, putting my hands before my eyes, for I thought I saw the dreaded spectre glide into the room; "*he* can tell.— Oh, save me! save me!" I imagined that the monster seized me; I struggled furiously, and fell down in a fit. (p. 46)

Victor withdraws from others and from reality—he covers his eyes literally and psychologically—and moves into a defensive, reactive psychosis. Nevertheless, visual hallucinations of the daemon haunt him with the truth.

The execution of innocent Justine, noted above, is only one of a series of tragedies that ensue from Victor's self-imposed secrecy and alienation from others. He does make a chilling allusion to the creature in a letter to Elizabeth, but in a manner that can ease only his own anxiety while tormenting his fiancée (Shelley, 1818/1990):

> I have one secret, Elizabeth, a dreadful one; when revealed to you, it will chill your frame with horror . . . . I will confide this tale of misery and terror to you the day after our marriage shall take place. (p. 140)

However, he never fulfills his promise to confide in Elizabeth even though the creature specifically promised that he will wreak revenge on the night of their wedding.

Once Victor brings the creature to life and then flees, it is 2 long years before they have their first (and only) conversation. After murdering William, the creature finds Victor and presents an eloquent plea for love, understanding, and acceptance. Victor immediately reacts with contempt. But the creature is not deterred (Shelley, 1818/1990):

> Begone! Relieve me from the sight of your detested form [exclaims Victor]. "Thus I relieve thee, my creator," he [the creature] said, and placed his hated hands before my eyes, which I flung from me with violence; "thus I take from thee a sight which you abhor. Still thou canst listen to me, and grant me thy compassion . . . . Hear my tale; it is long and strange." (p. 75)

This is a profound moment. By covering Victor's eyes, the creature asks him to see more deeply, to transcend his prejudicial, narcissistic "single vision." He wants Victor to realize that beyond superficial ugliness he is a being with sensitivity and intelligence. Yearning for a real relationship, he hopes "to meet with beings, who, pardoning my outward form, would love me for the excellent qualities which I was capable of bringing forth" (Shelley, 1818/1990, p. 163). For a brief moment, Victor allows the creature's articulate and heartfelt appeal to get through to him: "For the first time . . . I felt what the duties of a creator towards his creature were" (p. 75). Victor has had 2 years to reflect on the meaning of his creation, but

not until this late moment does he even begin to realize the implications of what he has done and to sense the responsibility he has toward the being he brought into this world.

This encounter is an excellent example of what we sense throughout the novel, that in many ways the creature is more fully human than Victor. Psychopathology involves part of a person relating to a partial world. And indeed, Victor does lose much of himself in his efforts to avoid death and real relationship and to compensate for his narcissistic vulnerabilities. Whereas initially the De Laceys are as alien to the creature as he is to Victor, the creature strives to understand them, be kind to them by secretly helping with chores, and eventually communicate with them. This involves entering their world with attentiveness and empathy. Gradually, with tremendous perseverance, the creature learns their language and customs. Even though he is rejected when the De Laceys become terrified by his horrible appearance, he accomplishes (for a while) what Victor is never really able to do. That is, the creature transcends his own egocentric perspective, sees through the eyes of an other, feels love, and acts kindly.

In contrast, lost in his own needs and fears, Victor repeatedly abandons every significant person in his life, the creature as well as his family, friends, and wife. One of the most disturbing examples of this is the way that Victor egocentrically misperceives a threat made by the creature. After the creature watches Victor violently dismember his promised wife, he proclaims his vow of vengeance (Shelley, 1818/1990): "Remember, I shall be with you on your wedding-night" (p. 124). Victor reflects that "then was the period fixed for the fulfillment of my destiny. In that hour I should die . . . . I thought of my beloved Elizabeth,—of her tears and endless sorrow, when she should find her lover so barbarously snatched from her" (p. 125). Victor remains focused on himself, and even his semi-empathy with Elizabeth is evoked only by imagining his own death. Victor has about 9 months to ponder the creature's threat. On the day of his wedding, obsessed with the idea that the creature will try to kill him, he arms himself with pistols and a dagger. Remarkably, however, Victor does not even consider an obvious possibility which looms just beyond his literal and self-referential interpretation of the creature's threat, namely, that Elizabeth may be in danger as well. In fact, when the time arrives for the fulfillment of the creature's revenge, Victor leaves his new wife alone as he searches the house and prepares to do battle. Of course,

the creature takes advantage of Victor's preoccupation with his own safety (and his abandonment of Elizabeth) to murder the bride on her honeymoon bed. Love, disowned and daemonized, returns again as death.

MAKING DAEMONS OF NATURE

In much the same way he treats people, Victor treats nature with an unempathic, literal-minded, utilitarian attitude. Alienated from nature (like he is alienated from others and from himself), Victor aggressively seeks to increase his own egoistic power and dominate the natural world by denying the natural reality of death. For him, nature becomes merely material to be exploited for his own needs. In the first lecture that Victor attends at the university, Professor Waldman praises the "modern masters" of chemistry who "penetrate into the recesses of nature, and show how she works in her hiding places. They ascend into the heavens . . . . They have acquired new and almost unlimited powers . . . and even mock the invisible world with its own shadows" (Shelley, 1818/1990, p. 36). Waldman's aggressive glorification of scientific materialism (and control of supposedly feminine nature) is unforgettable for Victor. He identifies with Waldman, idealizes him (with the same intensity he devalues Professor Krempe), and becomes his disciple.

With this exclusively materialistic and utilitarian view of nature, Victor shows contempt for the psychological and spiritual dimensions of existence. Significantly, these aspects of our lives are usually somewhat hidden. Often they are not accessible, much less understandable, by simply observing the (supposedly) objective, exterior surfaces of things with the monological gaze of physical science. Instead, understanding psycho-spiritual existence requires a dialogical exploration of depths; a hermeneutical meeting of heart, mind, and soul; a mutual conversation that brings forth another being's unique subjectivity and reveals and interprets the *meaning* of experience and behavior (Wilber, 1995). Materialistic science severely limits itself by explaining all phenomena with physical principles exclusively. Through this reductionistic, single vision, the deeper and more complex dimensions of the world (such as consciousness) are minimized, explained away, or ignored. We have seen how Victor misses the psychological mean-

ing of his own and others' experiences and behaviors. This also happens in his relationship with the natural world.

Victor devotes all of his attention to science in part because he is unable or unwilling to engage in reciprocal relationships with nature or other people. Having abandoned Elizabeth in favor of his grandiose and death-denying project, displaced erotic energy pervades his scientific work (Shelley, 1818/1990): "The moon gazed on my midnight labours, while, with unrelaxed and breathless eagerness, I pursued nature to her hiding places" (p. 40). If we didn't know the story, this account would sound like sexual seduction or rape. Strangely, Victor's fear of death, his necrophobia (as it might be called), manifests as necrophilia.

Victor's daemonization of nature gives us an opportunity to acknowledge, briefly, the significance of the sociocultural milieu of Shelley's Europe on the psychology of *Frankenstein*. Waldman and Victor view nature as a woman who must be violently forced to submit to "man's" (supposedly) rational and technological control, to be exploited for material resources that gratify man's desires. In the early 1600s, this way of construing nature emerged as the guiding principle in Francis Bacon's work (Leiss, 1972; Merchant, 1980). It was soon incorporated into the Cartesian-Newtonian paradigm of reality and into the values and practices of the scientific and industrial revolutions.

Consider just a few passages from Bacon, disturbing passages that express a perspective that Victor uncritically adopts and enacts with a vengeance. Bacon's basic premise is that "natural science has therefore no other goal than to more firmly establish and extend the power and domination of men over nature" (Bacon, quoted in Leiss, 1972, p. 48). He exhorted "man" to pursue a relentless "inquisition of nature" (p. 51), "to bind her [nature] to your service and make her your slave" (p. 55), thus making nature "serve the business and conveniences of man" (p. 58). Do not think, Bacon warned, that technology has "no power to make radical changes, and shake her [nature] in the foundations" (p. 58). Bacon exhorts man to torture nature just as "witches" were tortured by the inquisition (Merchant, 1980): "You have but to follow and as it were hound nature in her wanderings . . . . Neither ought a man to make scruple of entering and penetrating into these holes and corners, when the inquisition of truth is his whole object" (p. 168). Justified (in his mind) by the ideal of disclosing (what he conceives as) scientific truth, Bacon believes that man should act violently against nature with no hesitation nor thought of scruples.

Like the great Romantic authors, Heidegger (1954/1977a) realized the terrible danger inherent in this grandiose glorification of human power and reductionistic objectification of nature: "Man . . . exalts himself to the posture of lord of the earth" (p. 27). From this position, Heidegger (1952/1977b) asserted critically, "The world changes into an object. In this revolutionary objectifying of everything that is, the earth . . . itself can show itself only as the object of assault . . . . Nature appears everywhere . . . as the object of technology" (p. 100). To a large degree, according to Heidegger, this worldview is motivated by our efforts to avoid death. And it is this worldview that guides Victor's life.

Recurrent deadly disasters ensue from the way Victor treats nature and the creature. Likewise today, with pervasive environmental devastation, we see the catastrophic consequences of this immature and arrogantly egocentric attitude toward nature. Driven by fear, greed, and misunderstanding, we assault the natural world, but not without daemonic consequences, whether the daemon be a murderous monster or a carcinogenic ecosystem with decimated biodiversity.

MAKING DAEMONS OF SPIRIT

Victor's need to deny death, his scientific materialism, and his narcissistic wish for power interact in peculiar ways, leading him to develop an unconscious identification with God. From a spiritual perspective, it is God or Spirit (by whatever name) that brings life into being. Often the creature castigates Victor for presuming that he could fulfill this role, and ultimately for his failure to succeed (Shelley, 1818/1990): "I remembered Adam's supplication to his Creator; but where was mine? he had abandoned me, and, in the bitterness of my heart, I cursed him" (p. 97). Because Victor focuses exclusively on the material challenges of making the creature and represses the psycho-spiritual significance of his work, his implicit identification with God is especially revealing.

The world's great spiritual traditions and contemporary transpersonal psychology concur in their appreciation of a profound human phenomenon. That is, we each have the potential to discover (via mature conscious awareness) that "Reality," "God," "Spirit," or "Emptiness" is our true nature, our ultimate identity. Of course, it is not that we as individual egos are God—à la the delu-

sional person who believes he is the historical Jesus—but that in and as our deepest self we (along with everyone and everything) are manifestations of essential, eternal, absolute Spirit. Here we could easily turn to the Buddha or Jesus (among countless others) for supporting words of wisdom but instead we will rely on a spiritual genius from the Romantic tradition. A friend of William Blake (1825/1946) once asked him about "the imputed Divinity of Jesus Christ. He answered: 'He is the only God'—but then he added—'And so am I and so are you.'" (p. 680). In the same conversation, Blake remarked that "we are all coexistent with God; members of the Divine body, and partakers of the Divine nature" (p. 680).

Such a conscious, transpersonal identification with Spirit involves the development and eventual transcendence of a coherent and stable ego: Who we are goes far beyond our supposedly separate self. Victor's grandiosity is evidence of an immature, weak ego rather than a mature, strong one, evidence of dread-driven compensation rather than authentic agency and power. Because of his narcissistic insecurity and vulnerability, Victor is spellbound by an unconscious, egocentric identification with God. Jung would say that he has become possessed by the God archetype. Far from realizing his deepest transpersonal identity with God, Victor inflates his ego, deigns to personally usurp God's position, and thus, becomes blinded by fantasies of egocentric glory. The ancient Greeks warned that such hubris will lead to nemesis, as it indeed does for Victor.

Sadly, Victor's life is consistently marked by aborted psychospiritual development. Often confronted with real and painful challenges, he has the opportunity to learn and grow. Yet, he repeatedly turns away. Along with the implicit, unconscious conflation of his ego and God, the explicit expression of Victor's spirituality is quite immature and misguided. After Elizabeth is murdered and Victor's father dies of a stroke (upon hearing the news), Victor devotes his life to killing the creature. He goes to the graves of his family and in a furious rage invokes "the spirits of the departed," praying that they will help him wreak revenge (Shelley, 1818/1990):

> I knelt on the grass, and kissed the earth, and with quivering lips exclaimed, "By the sacred earth on which I kneel, by the shades that wander near me, by the deep and eternal grief that I feel, I swear; and by thee, O Night, and by the spirits that preside over thee, I swear to pursue the daemon, who caused this misery, until he or I

> shall perish in mortal conflict. For this purpose I will preserve my life: to execute this dear revenge. . . . And I call on you, spirits of the dead; and on you, wandering ministers of vengeance, to aid and conduct me in my work." (p. 149)

Victor actually becomes psychotic (again) as he engages in this quest. Under the influence of delusions and visual hallucinations, he believes that his family has returned to support his murderous endeavor: "The spirits of the dead hovered round, and instigated me to toil and revenge" (Shelley, 1818/1990, p. 152).

Nietzsche (1892/1968) and Freud (1927/1961b) showed how religion can be a defensive, child-like reaction to the fear, pain, and difficulties inherent in human existence. In this type of religion, we evade the responsibility for our lives, abdicate our own resources for managing real challenges, and instead turn to God—the great father in heaven—to protect us and to fulfill our wishes. (In my view, Freud understood half the story of religion and spirituality, being remarkably blind to mature, authentic spirituality. Nietzsche's understanding was more subtle and complex.) With regard to our present inquiry, Nietzsche and Freud's interpretation accurately conveys Victor's psychological condition as he pursues the creature.

Victor's vengeful rage is not an impulsive reaction that quickly passes away, but a state that he sustains, relentlessly and uncritically, for over 3 years, until he dies because of it. Allowing hate to supersede grief, Victor never, in all these years, deepens his consciousness enough to develop a mature and authentic spiritual life, one guided by awareness, wisdom, and compassion. These are the central values of all the great spiritual traditions, but Victor is a stranger to these qualities. Entranced by the accomplishments of the Enlightenment and scientific revolution, Victor reduces psychospiritual depths to superficial materialism and egocentric glory. He confuses his ego with God and tries to create a human being by merely joining dead body parts and charging them with electricity.

In the end, partially recognizing his spiritual impoverishment, Victor confesses that he has devoted himself to "unhallowed arts" (Shelley, 1831/1994, p. 60). Never growing beyond fear and defensiveness, he misses the opportunity for a real evolution of consciousness (see Schneider, 1993). Just before dying, he resorts to a pseudo-spiritual approach, calling on the spirits of his dead family. His hallucinations of his family are another version of the repressed returning, yet another opportunity to become aware and

begin healing. For example, he might have accepted his share of responsibility for their deaths (and for the love he withheld), asked for forgiveness, and eventually resolved the traumas of love and death. Instead, Victor suffers through an unreflective life, tragically consumed with unremitting dread and hostility. Spirit perverted manifests as egoic ambition, again with disastrous results.

THE CALL OF *FRANKENSTEIN* IN EVERYDAY LIFE

With *Frankenstein*, Mary Shelley has given us a precious gift, a symbolic offering that calls for contemplation and even transformation. The wayward ways of Victor and the creature are always present as possibilities in every human life. You and I may ponder how we are like these two lost souls. And we may discover how to shape our destiny differently.

Pain is inherent in human existence, but suffering is not. Our destiny depends on how we respond to the individual and collective existential challenges that are sent our way, especially those involving the sacred concerns of love and death. To live an ordinary human life—and to imbue this life with goodness, beauty, and truth, with awareness, wisdom, and compassion—this truly is a heroic aspiration. I need not invoke ordeals of extraordinary trauma here. We are each called to face and overcome great pain simply by dint of being human. Initially, we may need to move away from pain, trusting our psyche's astonishing ability to render just the right defense at just the right moment. But eventually, the challenge that first generated the pain will return. We must answer this call consciously if we hope to create a life of integrity and fulfillment. Otherwise, we suffer.

Because Victor never heard the call clearly nor consciously, he could not find an authentic way to respond. He succeeded scientifically (at least in part) but failed interpersonally and morally. Having deadened himself in reaction to his mother's death—by closing himself off from others and being driven by the unconscious fantasy of bringing her back to life—he was never able to bring himself back to life, courage, care, and responsibility within the shared human community. Fear of death became a fear of being fully alive. He did bring life to the creature, but never brought love to him, nor to anyone else for that matter. Victor's inability to bear death and share love became a daemon, embodied externally as the creature,

but also powerfully present as an unconscious aspect of his own being. This death-dispensing daemon haunted Victor forever because it was never fully faced nor understood. Of all the experiences that can awaken and transform us, love and death are the most profound. These awesome archetypal forces returned again and again, beckoning Victor to break through his dread and narcissism, to deepen his consciousness, and, ultimately, to be loving. But alas, Victor evaded this call, made daemons of life's challenges, and deprived himself and so many others of love and of life.

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ROADKILL

There are cats dead at the side of the road
I look away, blink my eyes,
Turn on the radio, adjust the mirror
Acts of avoidance

You died in a hospital bed facing a window
I called the nurse, asked for a doctor,
Spoke soft words, touched your hair
Acts of denial

Then knowing you dead I mourned for you

Today I turn the plants each to the light, each to the sun
Pay a bill, call a friend,
Bring the amaryllis out of hiding
Acts of forgetting

There are cats dead at the side of the road
I look away, blink my eyes,
Then weeping mourn them as my own
Acts of reparation

Knowing now I never mourned for me.

Barbara Patricola-McNiff

RESTORING THE HUMAN IN HUMANISTIC PSYCHOLOGY

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Summary

Positivistic psychologies marginalize transcendent human values by reducing them to by-products of naturalistic mechanisms. One result is a depersonalized and depersonalizing psychology. Humanistic psychology reasserted transcendental values and made them the central motives of its theory of human behavior. However, humanistic psychology shared the core secularizing assumptions of positivism in locating transcending values as "inner" impulses and instincts rather than as experiences of real participation in the transcendent order toward which they aimed. Lacking an understanding of a real reference point outside the self, humanistic psychology tended to divinize the self and its higher values, minimizing as it did so the infrahuman and societal conditions of the self. To contribute to a truly human psychology, the radical critique of positivist reductionism that began with humanistic psychology can only move forward by taking seriously the realities indicated by the human experiences of participation in embodied, social, and transcendent being.

Given the climate of siege that currently threatens the theory and practice of humanistically oriented psychology, it has become an urgent matter to clarify the conception not only of humanistic psychology but of the human condition itself. Failure to clarify what is meant by *human* has made it difficult for humanistically minded theorists and practitioners to respond to charges of therapeutic unaccountability and lack of theoretical rigor. In initiating their protest movement against reductionist psychology, third-force theorists of the postwar era tended to describe what humans were not: mechanisms determined by drives or shaped by social forces. Positive statements about human nature tended to use key terms like *growth, transcendence, self-actualization*, and *being* without clear definition. Ironically, because of the lack of clarity about such terms, many of the core assumptions of the humanistic movement led to the perpetuation of the very forms of alienation they were designed to oppose. In this essay, I suggest that theorists and practitioners of humanistic psychology should work to clarify their definition of the human condition in terms that acknowledge the situation of human being within the larger realities that give human life meaning.

THE HUMANISTIC PROJECT: INWARD AND UPWARD

The modernist image of the human that formed around the scientizing agendas of the scientific revolution, the Enlightenment, and the new social sciences of the 19th century was paradoxical: It both elevated and diminished the role of human beings. The human scientist, from the time of Bacon on, was supposed to be a powerful transformer and creator of the world, both natural and human. However, the human as an object of social-scientific study was also supposed to be reduced to the same predictability and controllability as the rest of mechanistic nature. It is the latter aspect of the image that formed the core of both psychoanalytic and behavioristic social thought, a reductionistic image that traced human purposes and actions to determining causes located either outside the person or below the level of conscious thought. Behaviorists saw human actions as initiated and shaped by environmental stimuli and reinforcements; psychoanalysts saw even private thoughts as the outcome of unconscious impulses, early influences of others, and the defensive structures built up by the interaction of

these factors. In both theories, the agency of human life was no longer the person, but impersonal forces. There was little room in either theory for the experiences of primary motives that lead beyond the individual toward others: love, justice, and reverence.

In reaction to the depersonalizing tendencies of scientistic psychologies and their reductionistic attitude toward human thought and behavior, the humanistic or "third force" psychologies that emerged in the 1950s sought to reassert the primacy of specifically human faculties and capacities as the proper subject matter of psychology. Theorists emphasized especially those human values that transcended the immediate needs of the self: ethics, truth, beauty, wholeness, spontaneity, and creativity. Whereas both psychoanalysis and behaviorism had seen these impulses as derivative, humanistic theorists saw them as primary. Drawing on the romantic tradition, the humanistic image of the person, as developed by Sutich, Rogers, Maslow, and others, drew attention to the individual person's potential for self-transformation, growth, and freedom, ultimately independent from biological demands or societal conditioning. What was essentially human was an inner drive toward health, growth, and wholeness, which was often stifled or compromised by social "oughts" and "shoulds" but which could be therapeutically reawakened in the presence of empathy and understanding (Rogers, 1961). The humanistic view tended toward a romantic model of expressive individualism in which the individual person naturally moved toward an expression of full potential when unencumbered by external demands. The authentic motives for the humanistic model were accordingly all internal to the person and often inner-directed as well; *innerness* became a major value-term for the movement.

Humanistic psychology was also a response to the problems of modern suffering and alienation it saw as resulting from the depersonalizing institutions of scientific and industrial modernity. Theorists such as Sutich and Maslow saw the 20th century's deindividuating demands for conformity as a violation of the basic nature of humanity. The way to correct the damage to persons living in the modern regime was through individual and group therapy, which would rekindle personal growth and free the person from the stifling expectations and conformity imposed by others (Rogers, 1961). For many, this meant that the problem of alienation was to be solved by turning inward and relying on one's own potential for self-actualization. Relationships with others, it was urged,

should be "authentic," based on mutual freedom, and freedom meant release from any demands of others that would compromise one's own quest for actualization (Perls, Hefferline, & Goodman, 1951).

Although rejecting most of the depersonalizing agenda of reductionist social science, humanistic psychology shared that science's most important assumption: the secularizing notion that there are no absolute, objective values in the universe, apart from those constructed and imposed by human beings. The transcendental values of truth, beauty, justice, compassion, and so on are seen as human constructs that rest on human beings' will and ability to implement them. The evidently transcendent orientation of these constructs did not, for the humanists, suggest that they had any external referent; such values are "inner," comparable to instincts, and for Maslow (1970) and Rogers (1961) biological in origin. There is no God, for example, toward whom mystical impulses are drawn; there is only the mystical impulse. There is no divine order toward which the search for justice could strive; there is only a drive for justice. As part of its reaction against the theoretical emphasis on impersonal forces, these theorists sought a way to incorporate transcendental values in some other form than as religious dogmas that were seen as limiting human freedom. The search for a secular alternative led the humanists to the assumption that humans and their immanent drives were the sole moral reference point in the universe. Under this assumption, humans are created neither by random evolution nor by God but are self-creating beings. Humans do not discover justice, beauty, and truth; they create it by projecting their transcendent drives. In the absence of God, human beings assumed God's theoretical place. This displacement has been called "self-divinization" (Voegelin, 1978) and "anthropocentrism" (Walsh, 1990; Wilber, 1995).

Ironically, although humanistic psychology began as a revolt against modernism and its reductionisms, it ended up sharing with modernism its fundamental agenda of deifying human potential, making humans the ultimate agency in the universe. So conceived, humans are capable of transcending any limits, moral or physical, set by biology, society, or God. In the Promethean view shared implicitly by scientists and humanists, the person is ultimately solitary, ultimately responsible for construing and shaping his or her life; is ideally capable of modifying or overstepping any

given conditions of life; and creates his or her own values. As James Bugental (1978) enthusiastically put it,

> The dream of being God is the dream of being most truly what we are . . . . Human beings must certainly recognize at last that each is the center of a subjective universe. We are God . . . . We are not the creatures we imagined. We can become the creators of what we will be. (p. 142)

More recently, M. Brewster Smith (1986) proposed that a secularized humanism, given a liberalized and expanded definition of *human*, should be the foundation of theories that seek to empower humans to cope with the predicaments of the human condition. "Spiritual" humanistic theories, he believes, have failed to provide solutions to human problems.

CRITICAL RESPONSES TO HUMANISTIC INNERNESS

The reassertion of the human being as the primary agent of psychological life and the allocation to the human being of indefinite potential for self change were greeted with enthusiasm by both practitioners and lay people who found both behavioristic and psychoanalytic mechanisms confining. Uncritical lay enthusiasm, in the form of the "human potential" movement, carried self-divinizing tendencies beyond the bounds of careful theory and beyond the experiential base on which Maslow had hoped to rest the movement. Workshops, weekend retreats, encounter groups, psychedelic drugs, and self-help books promised transformation, self-actualization, and peak experiences on demand with evangelistic fervor. Critics, often from within the humanistic movement itself, began to point out that self-actualization was not a goal in itself but a by-product of a quest that went beyond the interests of the individual. Many (e.g., Friedman, 1976; Lasch, 1979) noted the implicit narcissism of a psychology that located salvation entirely within the individual self. Others (e.g., Lerner, 1986) pointed out that the excessive focus on individual subjectivity deflected attention and effort away from the need for real social reform. Frankl (1959) warned of the implicit solipsism that lurked in the innerness of the movement:

> I wish to stress that the true meaning of life is to be found in the world rather than within man or his own psyche, as though it were a closed system. By the same token, the real aim of human existence cannot be found in what is called self-actualization. Human existence is essentially self-transcendence rather than self-actualization. (p. 115)

In other words, Frankl was insisting that human existence is oriented to something beyond and outside the self and that the focus on enlarging the self does not enhance the person's response in existential relatedness to reality. Frankl elsewhere (1966) pointed out that humanistic theory often seems to ignore the objective referent of the major human values. Instead of loving something or someone, we exercise a drive or impulse to love, as though love could be understood purely in reference to the impulses of the loving person. Frankl insisted that transcendent values such as love, justice, truth, and beauty only make sense as intentions directed to real goals beyond the self. Maslow (1969) came to agree:

> My experience agrees with Frankl's that people who seek self-actualization directly, selfishly, personally, dichotomized away from mission in life, i.e. as a form of private and subjective salvation, don't, in fact, achieve it.

Maurice Friedman, writing from the theoretical vantage point of Martin Buber's dialogical theory of the human, pointed out that "growth" is meaningless as an end in itself and that self-realization and self-actualization can only be by-products of noninstrumental dialogue and meeting between persons (Friedman, 1967, 1984).

A major problem for the humanistic movement was the assertion of a moral reference point located entirely within the individual, to be accessed by the intuition or felt sense of the individual. As Bellah, Madsen, Sullivan, Swidler, and Tipton (1985) observed, such a privatization of moral sense raises the question of how persons are to negotiate or coordinate with one another their inevitably discrepant moral claims. In a society of any complexity, subjectified inner senses may respond to very different interests and motives. Without an appeal to an outer, public search for moral meaning, the moral life of the person becomes isolated and empty. May's (1958) "inner sense of being" (p. 45), although a real, constitutive, and fundamental experience, is insufficient in itself as a basis for a theory of the person that is open to the moral experience of human beings. What is missing is the fact that human being is

actually, not just projectively or transferentially, oriented toward its participation in other contexts of being.

For some humanistic critics, these considerations pointed to a need for theoretical elaboration of the transcendent values and the meaning of human. From very early in the movement, the term *transpersonal* was used to indicate that human life includes experiences that point to concerns beyond the person. As Rowan (1989) pointed out, the result was a paradoxical tension in the humanistic movement between the secular/humanistic and the transpersonal standpoints. Theories that have developed out of the transpersonal standpoint reasserted the critical role of the human orientation to transcendence and sought to clarify practices that implemented and developed the person's "transegoic" impulses (Washburn, 1988; Wilber, 1995). Whereas they emphasize the importance of a human urge toward the divine, transpersonalists share with other humanists an equivocation about the ontological reality of the divine ground toward which that urge tends. Frequently that equivocation leads, as it does for other humanists, to divinizing the human subject either in present reality or in potential development (Friedman, 1967; Wilber, 1997). In other words, transcendent realities are still located not beyond but within the person. This emphasis on the transcendent potential within tended to obscure both the human potential for evil and suffering (May, 1986) and the equally essential human involvement in other self-transcendent contexts such as nature and society. Transpersonal psychology has tended to locate human potentials at the higher, divine end at the expense of articulating other arenas to which human potential belongs and responds.

In their rejection of causal constraints on human being, divinizing theories tend to ignore the boundaries that define the human condition. Focus on inner transcendence ignores the fact that limitations and boundaries are equally intrinsic to the human order: finite life in a fallible physical body; mental and emotional experiences that are conditioned by physiological states; an identity and a belief system that develop in a cultural and economic context that the individual self does not control; behavior that is conditioned by rewards and punishments, and dependence on others, societally and individually, for our basic needs and our well-being. One-sided transcendentalism either obscures the fact that human life is messy, physical, finite, and tragic or relegates these contingencies to an unfortunate and unnecessary slipup in cre-

ation that must be overstepped by spiritual practices. Suppressing the unavoidable facts of existence by divinizing human potential in this way is a form of denial. To the extent that transpersonal theory has simply attributed more divinities to human nature, it has not solved the problem of the source and destination of human values.

Theories that assert the divinity of human motives and theories that reduce human motives to infrahuman impulses are alike in denying or minimizing the fundamental existential importance of human beings' contextuality. Human beings are essentially grounded in various areas of relationship: the natural order, the social order, and the divine order. These constitutive contexts, or "contexts of participation" (Garrison, 1995, 1997), are those dimensions of participation in which human being is formed, defined, and limited. Human beings are human by virtue of their distinctly human involvement with these contexts. Authentic human involvement is dialogical and participatory rather than deterministic, reducible neither to mastery of the contexts of participation nor to mechanical determination by them. Human action and motivation must be understood as initiatives and responses within an ongoing dialogue within multiple contexts of reality. To claim that human beings, as individuals, are themselves the self-contained, immanent sources of meaning ultimately disconnects and alienates the human self from participation in reality just as much as does reduction to mechanical causes. Both the reductive and the grandiose distortions of the human condition therefore close off aspects of human reality and thus contribute to human alienation. Both as psychological theory and therapeutic practice, such distortions discourage and obscure self-aware participation in the contexts that constitute human being.

SEARCHING FOR ALTERNATIVES: TOWARD A METAPSYCHOLOGY OF THE BETWEEN

As we have seen, humanistic theory sought to counteract the deterministic claims of reductionistic psychologies by designating inner areas of human experience and motivation as essentially human and minimizing or denying the causal relevance of other domains. This theoretical move was intended to restore to psychology the central role of human motives and potentials. As I have argued, this move led to an exclusion of significant aspects of

human participation that has tended to perpetuate the very alienation it attempted to heal.

The emphasis on innerness stemmed from a recognition of the ultimate freedom of human beings from determinism by extrahuman causes. Given a scientific worldview that seemed to claim total determinism by outside forces, the world within the self seemed the only place that had room for the experience of freedom. The cost of this withdrawal into the self was humanism's eclipse of the constitutive contextuality of the self. But is deterministic or coercive causality the only possible relationship between the human realm and the biological, interpersonal, and transcendent domains?

Nondeterministic relations with reality are, in fact, a common human experience but are notoriously hard to examine objectively. Martin Buber's (Buber, 1958, 1965) famous distinction between "I-it" and "I-Thou" relations affords a pattern for such relations. In I-it relations, we confront others (persons, nature, etc.) as inert objects to be acted on and used instrumentally. In I-Thou relations, we meet others as active subjects like ourselves, to be met and joined with rather than manipulated for our ends. In the I-Thou encounter, things and persons do not impinge on each other causally, though both may be changed in the encounter. Instead, they coexist in a dialogue of beings whose outcome is unpredictable and uncontrollable. Buber insisted that both kinds of relationships can exist among all beings, although often the I-it relation obscures or usurps the I-Thou. The frequent misunderstanding of human relations as contractual is an example.

Buber's model of noninstrumental relationship suggests a pattern for understanding human relatedness to other areas of participation besides the interpersonal. Most people have experienced contemplative and relational attitudes toward infrahuman nature. Enjoyment of the outdoors, the companionship of other animals, and sensory pleasure are familiar examples of the appreciation of one's physical being. As an example of social participation, many people commonly experience and initiate challenges to social injustice based on an open, collaborative search for just alternatives (Bellah et al., 1985; Bellah, Madsen, Sullivan, Swidler, & Tipton, 1991). Although rarer, mystical awareness of the divine order, personified or not, is a form of nondeterministic relation. Likewise, as Aristotle observed, philosophical wonder is an experience of relation to being. The significance of these experiences is

that they point to substantial realities beyond the self, realities that the person meets but does not own, and that contribute dialogically to the person's own substance.

These forms of human relatedness are common but are seldom given the theoretical weight they deserve. For example, few people (except for sociopaths and dogmatically modernist social theorists!) would claim that their relations with their children were basically contractual or instrumental, that they had never felt contemplatively moved by experiences of nature or art, or that they had never been troubled about questions of ultimate concern. But these common experiences are marginalized by modern social theories that confine human understanding to a search for causal and reductive explanation. The neglect of these core experiences has been exhaustively documented in the case of the overextensions of positivist science. Whereas humanistic theories refocused attention on these experiences, they tended to obscure the significance of these essential aspects of human being when they minimized the person's outer contextuality and restricted human potential to inner sense, inner feelings, and inner impulses. Transpersonalizing can become as depersonalizing as dogmatic scientizing if it denies the full spectrum of the essentially participatory human condition. To be fully humanistic, we have to recognize that human being is spiritual, but it is fatal to claim that human being is only spiritual. We need a theoretically inclusive vantage point from which we can locate human being among the domains that limit it and give it meaning.

REDISCOVERING THE CLASSICAL MODEL

A theoretical model that attempts to root social theory in the participatory nature of human being is found in the work of Plato and Aristotle and developed in the work of the contemporary social philosopher Eric Voegelin (1978; see also Webb, 1981). According to this theory, the human condition is existentially defined by the tension between human finiteness and the human longing for transcendence. Both the individual person and the society in which the person lives are bounded by material and cultural conditions but also look toward a comprehensive and transcendent reality beyond those finite horizons. The tension between finitude and transcendence is inescapable and cannot be overcome by denying one pole of

the tension and resting in the other. It is ultimately untenable, for example, to deny the reality of transcendence and build a life (or a society) entirely around mundane or material satisfactions. It is also untenable to deny the real boundaries of human life and assume a utopian existence of divine knowledge or perfection, as some transpersonal theorists seem to attempt. The mundane and the divine are both dimensions of human life, but neither is a resting place.

In the classical view, this two-fold tension is a defining feature of the human condition. Existentialist philosophy has clarified one pole of this tension, at least, by pointing out the sense of absurdity and anxiety that characterizes life in a world with no objective referent for transcendent meaning. The difficulty of living with the tension of the human condition in the "Between" (Plato's term is *metaxy*) is such that humanity, individually and collectively, constantly tends to flee toward either a totalizing materialism or a totalizing spiritualism and to reduce its representation of reality accordingly. Social institutions and theories come to embody and reproduce such distortions. Alienation, in classical diagnostic terms, consists in estrangement from the sources of meaning afforded by conscious relation to the infrahuman and superhuman dimensions of human participation. Living in the Between means living in a participatory relationship to both poles of the human dilemma, a relationship that relativizes the individual ego to larger wholes. To refuse that participation by fleeing from anxiety to certainty means to be alienated from the sources of human being.

An authentic response to the human situation, on the other hand, stems from acknowledgment of the intermediate place of human existence. Such an authentic attitude may be rooted in experiences of noncoercive participation like those described above. This authenticity affords a criterion for mental health that is unavailable under either of the reductionist models: True mental health is a state of good order in which the person participates in both the mundane and divine without identifying with either, without possessiveness or domination toward either. This life in the middle is inevitably a political life because the middle ground is populated by other human beings and because the encounter with others is itself an occasion of the self-transcendence toward which humans are drawn. Mental disorders are states in which unilateral identification with the infrahuman world or the super-

human world lead to suffering: anxiety, depression, manic denial, and sociopathy. The classical model helps to clarify why a flight to either pole of the human tension fails to address basic problems of human alienation: The person is no more at rest in the extremes than in the middle.

Both psychological theory and the practices to which it gives rise would, in this model, avoid reducing human experience either downward toward the infrahuman or upward toward the divine. To be faithful to the conditions of human existence, psychology would instead articulate the experiences of tension toward the realms of nature, society, and the divine ground toward which moral and spiritual impulses point. Maslow began such an approach with his study of peak and plateau experiences and came to recognize that these experiences pointed toward realities that were not reducible to the intrapsychic. Psychology can continue to seek relevance to the human condition by studying the ways in which human beings respond to encounters with nature, with other persons and societal challenges, and with questions of ultimate concern.

CONCLUSION: CONSEQUENCES FOR PSYCHOLOGICAL THEORY AND PRACTICE

Psychology is not reducible to biology, sociology, or theology. It has its own theoretical and empirical realm, demarcated by its subject: the person as perceiver, interpreter, actor, and sufferer. But no disciplinary demarcation can relieve it of the demand that its theory must be consistent with the human condition. Anthropocentric theorizing that denies that human life consists of response to actual biological, societal, and transcendent participations cannot comprehend anything but narrow solipsistic experiences. Such misconceived efforts are like attempting to understand the nature of the eye without recognizing the objective existence of light.

Therapeutic practice that treats human responses to the realms of participation merely as impulses originating within the person (e.g., as projections or transferences) cannot take seriously the real existential concerns that underlie human disorder, suffering, and health. We must recognize that the symptoms that bring people to therapy as patients are inevitably rooted in the tensions of the human condition, in the problematic nature of their ineluctable connectedness to the somatic world, the social world, and the tran-

scendent world. In practical terms, this means that we should not automatically translate symptoms into purely intrapsychic terms. In the world of the Between, sometimes an ulcer is just an ulcer, not displaced rage. A client's sense of guilt is not necessarily the voice of a punitive superego; guilt, although it may be misplaced, must be respected as a self-transcending awareness of real responsibilities to other, real, human beings. Depression, as James Hillman (e.g., 1975) frequently pointed out, is an opening into ego-transcending depth, not just poor self-esteem and vegetative signs. Because the self is biological and socially conditioned and spiritual, the disorders of the person may be situated and addressed therapeutically through any or all of these realms of participation. It is just as dogmatic to disdain chemical and behavioral therapies because they are "nonhumanistic" as it is to disdain existential and spiritual therapies because they are "unscientific."

In both theory and practice, a psychology that seeks to be true to the human condition must recognize the actual participations within which human being is constituted. Human life is not reducible to either the by-product of inhuman forces nor the expression of pure spirit unfolding itself in the void. Humanistic psychology's reparative mission can be better attended to by acknowledging and articulating the full range of dialogic realities that constitute the person and by refusing to collapse the basic existential tension of human existence. As Aristotle said, we are neither beasts nor gods.

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EFFECTS OF EXPERIENTIAL FOCUSING–ORIENTED DREAM INTERPRETATION

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Summary

This two-part study investigated the effects of a particular approach to dream interpretation. In the first part, the Dream Interpretation Effects Questionnaire (DIEQ) was developed to assess both quantitatively and qualitatively seven specific effects of Experiential Focusing–oriented dream interpretation. In the second part, the DIEQ was used along with a structured interview in a pretest-posttest control group design to examine the effects of Experiential Focusing–oriented dream interpretation. The results were, first, that the DIEQ proved to be highly reliable and, second, that Experiential Focusing–oriented dream interpretation demonstrated significant results. This study offers support for Gendlin's assertion that an Experiential Focusing approach to dream interpretation facilitates constructive psychological change for the dreamer.

The idea that a dreamer can benefit from understanding the hidden information in a dream appears in ancient texts and in numerous cultures around the world (Meier, 1987). This idea also was central to the very foundation of Western psychotherapy, psychoanalysis (Freud, 1900/1952, 1935/1963), and has been acknowledged if not emphasized in several of the other psychotherapeutic approaches developed over the past century. The study described in this article used Gendlin's (1986) Experiential Focusing–oriented dream interpretation. Because Gendlin's approach to dream interpretation includes other approaches, the latter are briefly reviewed.

In psychoanalysis, Freud (1900/1952) considered a patient's conscious memory of a dream the manifest, or obvious, content. He believed that as the patient reflected on the dream and reported any associations that came to mind, the unconscious latent content of the dream, consisting of repressed wishes or conflicts, would emerge. Thus, he achieved a primary goal of psychoanalysis: to make the unconscious conscious. Freud proposed specific interpretations, mostly sexual and aggressive, for a number of dream images.

Adler (Mosak, 1995) believed that dreams reveal a person's future movement. According to individual psychology, the purpose of various types of dreams is to rehearse, postpone, or dissuade oneself from action. Affirming the uniqueness of both the dreamer and the dream, Adler disagreed with the idea of fixed symbolism of dream images.

Jung (Hall, 1983; Jung, 1963, 1964, 1968/1979) viewed dreams as natural, healthy, creative, progressive, and purposive psychic processes that reveal rather than disguise less developed sides of the personality crucial to individuation, the process of psychological completion and wholeness. His psychotherapeutic approach also employed free association and interpretation of symbols. Jung believed that symbols could have meanings not only uniquely individual but also universally derived from the collective unconscious, the repository of all human experience.

Perls (1969), in his Gestalt therapy, asserted that every dream element is the projection of a disowned part of the dreamer's personality. Rather than analyzing dreams, the Gestalt therapist facilitates an experiential process for the dreamer (Fantz, 1983). The therapist directs and guides the client to recount the dream in the first person and present tense, to take on the roles of each of the various elements of the dream, and then to carry out dialogues between some of those parts. Perls believed this process enables the dreamer to reown the disowned aspects of self and thus become more whole.

Hill and Ullman are two contemporary practitioners who have developed approaches to dream interpretation. Hill (1996) believed that humans engage in an ongoing process of encoding experiences into cognitive schemata, that is, "clusters of related thoughts, feelings, sensations, memories, and actions" (p. 49). Remembered dreams reflect waking experiences that cannot be assimilated into existing schemata but need to be accommodated by the restructuring of existing schemata. The goal of her three-stage model of dream interpretation—exploration, insight, and action—is to facilitate that accommodation and any resulting impetus for action.

Ullman (1996) developed a four-stage group approach to dream interpretation. In Stage 1, the dreamer shares the dream, and group members ask clarifying questions. In Stage 2, group members work with the dream as if it were their own—projecting feelings and meanings onto the dream. In Stage 3, further dialogue develops between the dreamer and group members to facilitate the dreamer's exploration, felt connections, and understanding of the dream. The dreamer is free to respond or not respond to any of the projected connections offered by the group members. In the final

stage, the dreamer is invited to take a second look at the dream and to share further insights.

Moustakas (1994) presented an existential-phenomenological approach to dream interpretation in which the dreamer is encouraged to trust his or her own intuition of the dream's meaning and to take responsibility for the direction of his or her life. Dreams are seen as projecting the dreamer into the future. This critical viewpoint implies that personal meanings and goals exist and can be actualized: The dreamer can live differently, more in touch with his or her Being. Moustakas's approach involves five steps: incubating (upon falling asleep, requesting help in understanding a pressing concern) and recording the dream immediately upon awakening; determining the horizons (what stands out to the dreamer as most significant); clustering the horizons and deriving core themes; determining the Existential A Priori (the central theme that requires elucidation and exploration and strongly influences the direction the dreamer will take in life); and the course of action (moving toward or away from the Existential A Priori).

Gendlin (1986) asserted that all approaches to dream interpretation can be used when anchored in the experiential felt sense of the individual. He developed Experiential Focusing–oriented dream interpretation in which the dreamer uses his or her bodily felt sense to discover and affirm the meaning of the dream and possibly to discover new insight or new direction for development.

Experiential Focusing

Gendlin (1981) originally termed his approach *Focusing*. Others later referred to it as *Experiential Focusing*. In this article, *Focusing* and *Experiential Focusing* will be used interchangeably.

Focusing (Gendlin, 1974) evolved from Rogers's client-centered therapy. In his efforts to experimentally study human change, Rogers's conceptualization shifted from a static view of personality to a process view of human nature (Rogers, 1958). At the same time, psychologist Gendlin was developing his theory of experiencing. He reformulated Rogers's approach in experiential terms by emphasizing the essence of client-centered therapy—accurate listening—that facilitates clients' contacting and staying in touch with their experiences (Gendlin, 1974). Research (Walker, Rablen,

& Rogers, 1960) suggested that clients who were high in experiencing level, that is, in awareness of inner experience—particularly of bodily feelings—tended to have more successful outcomes in therapy. Consequently, Gendlin developed a procedure to facilitate and use that awareness. He called the procedure Focusing.

The basic principle of Experiential Focusing is that the experiencer directly senses what is concretely felt in the body. Change occurs when the process of experiencing becomes fuller and moves beyond blockages. An inner checking with the directly felt experience allows the experiential approach to be used in conjunction with all theories, concepts, and techniques.

According to Gendlin (1981), Focusing is a process through which an individual attends quietly to the bodily felt sense of a concern and waits for the meaning to emerge from that felt sense. Focusing is not merely feeling without thinking. Rather, it is the kind of thinking that is in touch with what the unsplit body-mind already knows and lives. This is what makes Focusing more powerful than thinking or feeling alone. Gendlin argued that Focusing is analogous to a scientific approach. When one's felt sense is used as the touchstone, one can test out different concepts, assumptions, or theories against one's concretely felt experience to understand, to create, and to live further the meaning of one's existence.

Felt sense and Focusing attitude. Focusing involves two essential elements: felt sense and Focusing attitude. Gendlin (1974) considered a felt sense to be "both psychic and bodily" (p. 241). According to Gendlin (1974, 1981), a felt sense is an implicitly complex and not yet conceptually clear bodily felt whole of a person, situation, or event that encompasses everything one feels and knows about the given subject at a given time. Implicit in that bodily knowing is the next growth step for the organism. If one allows a felt sense to open up and move forward on its own, one will experience a shift in the bodily sense of the concern. This shift signifies a movement in the direction of growth. The problem may not be solved, but the way it is carried or experienced in the body is different (Campbell & McMahon, 1985; Gendlin, 1986).

According to Gendlin (1974), the Focusing attitude necessitates a quiet, gentle, curious, nonjudgmental, accepting, letting, allowing, and friendly attitude toward what is emerging from inside one-

self. This attitude involves a different way of being with one's "problem." In fact, the adoption of a Focusing attitude is, in and of itself, a step toward overcoming that which contributed to the problem (Campbell & McMahon, 1985; Gendlin, 1981, 1986).

In summary, a review of the literature on Experiential Focusing seems to indicate that Focusing promotes change through facilitating a high experiencing level in individuals. It has also been demonstrated that anyone can learn Focusing (Gendlin, 1981).

The literature on Experiential Focusing indicates that Focusing can be applied to many areas of interest, including dream interpretation (Gendlin, 1986). However, a thorough review of the existing literature revealed that no research had been conducted on Focusing-oriented dream interpretation.

A few researchers using non-Focusing approaches found some support for the efficacy of dream work (Falk & Hill, 1995; Hill, Diemer, Hess, Hillyer, & Seeman, 1993). These and other researchers and clinicians have indicated the need for measures sensitive to the effects of dream work and for empirical studies using those measures to assess the effects. Kan designed the following study to fulfill both needs.

FIRST PART OF THE STUDY: DEVELOPMENT OF THE DREAM INTERPRETATION EFFECTS QUESTIONNAIRE

Kan designed the Dream Interpretation Effects Questionnaire (DIEQ) as a preliminary instrument to assess both quantitatively and qualitatively the effects of Focusing-oriented dream interpretation. Based on the existing Experiential Focusing and dream interpretation literature, she identified seven categories of possible effects: (a) a sense of easing or release of tension associated with the dream; (b) a sense of fresh air or increase of positive energy associated with the dream; (c) increased self-understanding; (d) a sense of movement, reconciliation, or healing; (e) development of a new step or new direction with regard to a concern; (f) enhanced valuation of dreams; and (g) enhanced understanding of the meaning of the dream. DIEQ Part 1 assessed these effects quantitatively, whereas the cover page, Part 2, and Part 3 assessed them primarily qualitatively. Kan established content validity for the DIEQ through the support of the existing professional literature.

Development of DIEQ Part 1

The DIEQ Part 1 constituted a quantitative assessment of the effects of Focusing-oriented dream interpretation. For each of the seven categories of possible effects, Kan developed six to eight one-sentence items of which no fewer than one third were stated in "negative" syntax. After reading each statement, the participant would circle one response on a 7-point Likert-type scale from *not at all like me* to *very much like me*. Sample items include the following: I experience a sense of positive energy flowing when I think of the meaning of the dream, I experience a sense of uneasiness associated with the meaning of the dream, I did not see new ways to make things in my life different, I have a new understanding of myself as a result of the process, I feel I got no new ideas for ways of dealing with people or problems, dreams are insignificant, dreams are meaningful, the process helped facilitate some movement toward resolution of a concern, the process resulted in no personal change or transformation, I have a better understanding of the meaning of the dream because of the process, the process was not beneficial to my understanding of the dream, dreams are valuable, and my understanding of the meaning of the dream stayed the same.

To establish the reliability of the DIEQ Part 1, Kan recruited 52 volunteer participants from graduate counselor education courses at a moderately sized Midwestern university. Volunteers paired up as speaker and listener. The speaker told a dream in the first person, present tense, and in as much detail as possible then freely associated the perceived meaning of the dream. Meanwhile, the listener used nonverbal skills and verbal reflective responses to listen to the speaker without making any interpretation. After the speaker completed the DIEQ Part 1, the pair reversed roles and went through the same process.

Development of the DIEQ Cover
Page, Part 2, and Part 3

The DIEQ cover page addressed information on preexisting factors that may have influenced research participants' experience with this study: demographic data, information concerning participants' dream life and dream recall frequency, participants' attitudes toward dreams, previous experience with dream interpreta-

tion, and expectations for participation in the study. Another item assessed the length of the dream that each participant chose to use in the study, included to examine any possible relationship between the length of a dream and the effects of dream interpretation.

The DIEQ Part 2 consisted of 24 items, including Likert-type scales, multiple choice items, and open-ended questions, to gather in-depth information concerning the same phenomena as assessed in Part 1. Kan included these items to examine more closely (a) theoretical assumptions of various dream interpretation theories, (b) existing research findings of dream interpretation, and (c) results specific to Experiential Focusing.

The DIEQ Part 3 consisted of 7 items, including Likert-type scales, yes/no items, and open-ended questions. Kan designed this part to assess in greater depth participants' views of the meaning of their dreams before and after dream interpretation as well as their reactions to the process. She developed three versions of Part 3 to match for the participants' status at the time of administration: the first for pretest, the second for the control group's first posttest, and the third for the experimental group's posttest and the control group's second posttest.

SECOND PART OF THE STUDY: EFFECTS OF FOCUSING-ORIENTED DREAM INTERPRETATION

Hypotheses and Research Question

In the second part of the study, Kan employed a pretest-posttest control group design to examine four hypotheses and one research question with regard to the effects of Focusing-oriented dream interpretation:

Hypothesis 1: The experimental group's mean posttest score on the DIEQ Part 1 will be significantly higher than their mean pretest score, reflecting a reported benefit from Experiential Focusing–oriented dream interpretation.
Hypothesis 2: The control group's mean first posttest score on the DIEQ Part 1 will not be significantly different from their mean pretest score, reflecting no change after a waiting period.

Hypothesis 3: The mean difference between the experimental group's posttest and pretest scores on the DIEQ Part 1 will be significantly greater than the mean difference between the control group's first posttest and pretest scores, reflecting a reported benefit from Experiential Focusing–oriented dream interpretation.

Hypothesis 4: The control group's second posttest mean score on the DIEQ Part 1 (after the intervention) will be significantly higher than its first posttest mean score (after the 45-minute waiting period), reflecting a reported benefit from Experiential Focusing–oriented dream interpretation.

Research Question: What patterns can be discerned from data from the DIEQ cover page, Part 2, and Part 3 and from the structured interview?

Selection of Participants

Kan contacted the local Focusing center for a list of potential participants: people who had participated in the Experiential Focusing training offered by the Focusing center and had expressed interest in Focusing-oriented dream interpretation. The potential participants' involvement in the Focusing center did not constitute a counseling relationship and consequently was not subject to the limits of confidentiality.

Kan selected participants on the basis of their ability to recall one or more dreams per week. The first 20 potential participants who met the criterion and who consented to participate became the participants of the study. No exclusion was made on the basis of age, gender, ethnicity, or disability.

Intervention

The intervention consisted of a 45-minute Focusing-oriented dream interpretation session guided by Kan. A guided Focusing session refers to a Focusing session with a partner who can listen with accurate empathy and can make Focusing process suggestions. Examples of Focusing process suggestions are as follows: "You might want to ask yourself, how does this whole thing feel in your body?"; "You might want to ask yourself, what in my life feels like this?"; and "You might want to ask yourself, what does this whole thing need?" A Focusing session is considered successful when a "felt shift" occurs, which involves a distinct physical shift—perhaps a sense of easing, release, or fresh air—in the bodily sense

related to a concern. Although a shift can happen with or without a Focusing guide, the authors and other expert Focusers (Hinterkopf, 1998) had observed that it occurred more frequently with a guide.

Kan acted as Focusing guide for all research participants. At the time, she had a master's degree in counselor education and was working toward completion of a doctoral degree in counselor education. She had formal training in Focusing and Focusing-oriented dream interpretation and 11 years of experience as a Focuser. She also had cofacilitated Focusing training and workshops with a certified Focusing trainer.

Instrumentation and Procedures

Kan used two instruments in this study: the DIEQ and a structured interview. She designed the structured interview to obtain further information (Heppner, Kivlighan, & Wampold, 1992). It consisted of four open-ended questions that gave participants the opportunity to clarify, elaborate on, and make comments on their previous responses. For a complete copy of these instruments along with a thorough review of relevant literature, see Kan (1998).

After matching the 20 participants for whether they had experience with dream work, Kan randomly assigned each member of the pair to either the experimental or control group. She carried out the Focusing-oriented dream interpretation intervention in individual sessions with each participant and gathered data using the DIEQ and a structured interview.

In the first phase of this part of the study, each experimental and control group participant began by completing the informed consent for the study and the DIEQ cover page. The participant then described a dream in the first person, present tense, and in as much detail as possible and completed the DIEQ Parts 1, 2, and 3 (pretest). Kan then guided each experimental group participant in a 45-minute Focusing-oriented dream interpretation session with the dream the participant had described. By contrast, each control group participant engaged in personal activities irrelevant to dream work during a 45-minute no-intervention waiting period. Each participant then again completed the DIEQ Parts 1, 2, and 3.

This posttest was referred to as posttest for experimental group participants and first posttest for control group participants.

In the second phase of this part of the study, immediately following each control group participant's completion of the first posttest, Kan guided the participant in a 45-minute Focusing-oriented dream interpretation session. Each control group participant again completed the DIEQ Parts 1, 2, and 3 (second posttest).

Participants in the experimental group participated in the structured interview after the posttest. Participants in the control group participated in the structured interview after the second posttest.

LIMITATIONS

The quantitative portion of the first part of the study was limited in at least two ways. Participants were graduate students and were volunteers (Heppner et al., 1992).

The second part of the study was limited in the following ways. Participants in both the experimental group and control group were a small number of volunteers and were not matched for age, gender, race, or socioeconomic or educational status. The DIEQ is not a well-established but rather a preliminary instrument that relies on self-report (Heppner et al., 1992). Because Kan conducted all the research reported herein, the results could be biased; however, the adoption of an experimental-control group design, the use of standardized research procedures, and the use of objective measures are strategies she used to minimize bias (Heppner et al., 1992).

The final limitation involves the use of experienced Focusers as participants. Although research (Gendlin, 1981) has suggested that anyone can learn Focusing, the authors and others (Hinterkopf, 1998) have observed that most people require a few Focusing sessions to become familiar enough with the process to benefit maximally from it. For this reason, Kan involved only experienced Focusers in this study. Because participants were experienced in Focusing, the results may not be generalizable to the population at large. Such participants may have been predisposed to benefit from and report positively on the Focusing method used.

ANALYSIS OF DATA AND RESULTS

First Part of the Study

Kan established reliability for the DIEQ Part 1 through the examination of its internal consistency by Cronbach's alpha (Cronbach, 1951) for each of the seven categories and for Part One as a whole. For the purpose of this study, a Cronbach's alpha of .80 or higher was considered reliable, .65 to .79 marginally reliable, and .64 or lower unreliable.

Results revealed that the Cronbach's alpha coefficients for the seven categories were, respectively, .91, .80, .92, .90, .86, .91, and .93. The coefficient for Part 1 as a whole was .96. Each of these results met or exceeded the criterion of .80, and follow-up analysis revealed that elimination of any item or items did not increase the coefficient. Consequently, Kan retained all 52 items in the final instrument.

Kan did not assess reliability of the DIEQ cover page, Part 2, and Part 3. The purpose of these parts was to gather qualitative, in-depth information.

Second Part of the Study

Quantitative

To minimize the Type I error rate in analysis of quantitative data from the DIEQ Part 1, Kan established a significance level of .01 as the criterion for either retaining or rejecting the hypotheses. She performed a *t* test for dependent samples on Hypotheses 1, 2, and 4 and a *t* test for independent samples on Hypothesis 3. The Type I error rate for this study was .04.

Hypothesis 1. The experimental group's mean posttest score on the DIEQ Part 1 will be significantly higher than their mean pretest score. The experimental group's pretest and posttest mean scores were 96.90 and 306.60, $SD = 66.86$ and 14.01, respectively; $t = 9.93$, $df = 9$, $p < .001$. Kan retained this hypothesis.

Hypothesis 2. The control group's mean first posttest score on the DIEQ Part 1 will not be significantly different from their mean pretest score. The control group's pretest and first posttest mean

scores were 99.70 and 99.80, SD = 42.79 and 42.64, respectively; t = .095, df = 9. Kan retained this hypothesis.

Hypothesis 3. The mean difference between the experimental group's posttest and pretest scores on the DIEQ Part 1 will be significantly greater than the mean difference between the control group's first posttest and pretest scores. The mean difference between the experimental group's posttest and pretest scores and the mean difference between the control group's first posttest and pretest scores were 209.70 and .10, SD = 66.80 and 3.31, respectively; t = 9.91, df = 18, p < .001. Kan retained this hypothesis.

Hypothesis 4. The control group's second posttest mean score on the DIEQ Part 1 (after the intervention) will be significantly higher than its first posttest mean score (after the 45-minute waiting period). The first and second posttest mean scores for the control group were 99.80 and 282.20, SD = 42.64 and 39.62, respectively; t = 9.18, df = 9, p < .001. Kan retained this hypothesis.

Further analyses. From the most statistically conservative point of view, the ordinal data obtained through the use of Likert-type scales in this study could be considered most appropriately analyzed with nonparametric tests. Therefore, Kan reanalyzed the data using the Wilcoxon matched-pairs signed-rank test on Hypotheses 1, 2, and 4 and the Mann-Whitney U test on Hypothesis 3. For Hypotheses 1, 3, and 4, results showed differences in the expected directions at the .01 level of significance. For Hypothesis 2, results showed no significant difference. Consequently, Kan retained all hypotheses. Thus, parametric and nonparametric analysis yielded equivalent results.

To examine further the effects of Focusing-oriented dream interpretation, Kan performed a category-by-category analysis of the seven major effects of Focusing-oriented dream interpretation. The posttest mean of the experimental group and the second posttest mean of the control group were combined to compare with the combined pretest means of both the experimental and control groups (see Table 1).

The results revealed that the DIEQ Part 1 combined mean score on after-intervention posttest was significantly higher than the DIEQ Part 1 combined mean score on pretest for all seven categories, indicating significant beneficial effects from Experiential

TABLE 1: Seven Major Effects of Focusing-Oriented Dream Interpretation

Effect	*Pretest*	*Posttest*	Pretest SD	Posttest SD	t	df	p
Easing or release of tension	7.35	33.10	8.34	6.34	10.80	19	< .001
Fresh air or increase in energy	10.15	44.70	10.79	6.98	11.35	19	< .001
Increased self-understanding	8.90	39.75	9.35	4.64	13.30	19	< .001
Movement, reconciliation, or healing	7.90	45.00	10.85	4.79	13.78	19	< .001
Development of a new step/direction	6.90	38.10	8.55	6.35	13.24	19	< .001
Enhanced valuation of dreams	50.15	53.45	4.07	1.19	3.66	19	< .01
Enhanced understanding of dream's meaning	8.25	40.30	9.49	3.37	14.25	19	< .001

Focusing–oriented dream interpretation on all seven dimensions. For six of the categories, the pretest and posttest means were different enough to yield ps < .001. Only the sixth category, enhanced valuation of dreams, yielded a p < .01.

Qualitative

Kan tallied control group and experimental group participants' gender, age, marital status, educational level, ethnicity, previous experience with dream interpretation, and length of the dream. Because of small numbers in each category, statistical analysis was not viable. However, Kan made several observations. First, with regard to demographics, participants represented a broad spectrum of socioeconomic categories (lower class to upper class), as well as a range in age, educational level, and marital status. Moreover, both genders and three ethnic groups (Asian American, European American, and biracial [Asian American and European American]) were represented. Results did not appear to differ based on these characteristics. In addition, neither the amount of previous experience with dream interpretation nor length of the dream appeared to contribute to differences. Finally, participants' experience in Focusing ranged from 9 participants who had

experienced only one weekend of training in Focusing to 3 participants who had practiced Focusing for 2 or more years. The effects of Focusing-oriented dream interpretation appeared to be equivalent for these participants. In summary, Kan could discern no pattern of relationship between the cover sheet data and the quantitative results.

Using participants' responses to the DIEQ Parts 2 and 3 and to the structured interview, as well as from observations and comments from field notes, Kan found that the data corroborated the quantitative results. In addition, she discerned the following patterns that had not emerged from the quantitative data:

1. Each dream in this study appeared to reflect either a current concern of the participant or an unresolved issue from the participant's past.
2. Focusing-oriented dream interpretation helped each of the participants in this study reconfirm the meaning of their dream and deepen their insight.
3. All participants in this study reported having experienced insight and/or movement with regard to an individual need as a result of the Focusing-oriented dream interpretation. Some participants reported experiences of healing or movement beyond where they felt stuck in addressing a psychological issue, whereas others reported gaining awareness of a need to work on a certain psychological issue. All reported receiving something from the process that they needed, whether it was healing, movement, or a new insight into an unresolved issue.
4. In every case in which the participant used a dream involving distressing emotions, after Focusing-oriented dream interpretation the participant reported an abatement of distress and an experience of positive insight from the dream.
5. The largest difference in pretest-posttest data appeared to occur with dreams or nightmares that the participants initially described as frightening or strange. Of the 20 participants, the 5 who described on the pretest that their dreams were scary or strange reported having the most profound experiences of transformation after the intervention. This dramatic shift occurred despite participants at pretest reporting little or no association to, or mainly distressing associations to, the meaning of the dream. All 5 participants reported on posttest that their experiences of the meaning of the dream turned into something very positive and even, in their views, spiritual.

DISCUSSION

According to the findings of the first part of this study, the DIEQ Part 1 can be preliminarily regarded as a reliable instrument that

assesses seven effects of Focusing-oriented dream interpretation. Because of the relatively high Cronbach's alpha coefficients and also on the basis of the consulting statistician's suggestion that more items tend to generate higher statistical power, Kan retained all 52 items of the DIEQ Part 1. However, several research participants commented on the redundancy of several items and reported fatigue associated with responding to a long questionnaire. This suggests a need for revision of the instrument, eliminating items that can be deleted without greatly reducing the Cronbach's alpha coefficient for each category and for the instrument as a whole. This study also suggests that the DIEQ cover page, Part 2, and Part 3 can be used to gather more in-depth information with regard to the effects of Focusing-oriented dream interpretation.

According to the findings of the second part of this study, participants greatly benefited from Focusing-oriented dream interpretation. All four quantitative hypotheses were retained. The after-intervention posttest for all research participants revealed a significant increase in each of the seven effects of Focusing–oriented dream interpretation. These quantitative results were corroborated by qualitative results.

Fourteen of the 20 participants were available for a follow-up telephone interview approximately 1 week after the research. Each of these participants reported one or more of the following applications of the insight gained from participation in the study: (a) The participant was able to make further connections, based on the insight gained from the dream work, to understand the underlying factors influencing his or her emotions, thoughts, or behaviors; (b) the participant gained an immediate awareness during acting out of an undesired pattern of behavior and was able to respond differently based on the insight gained from the dream work; (c) the participant continued to experience at a bodily felt level a different way to be or to handle a concern; (d) the participant began working, or continued to work, on the issue reflected by the dream work; (e) the participant took actual behavioral steps to carry out the insight gained from the dream work; (f) the participant realized the value of adopting and applying the Focusing attitude to life in general; (g) the participant gained deeper appreciation of dreams and no longer believed in a merely intellectual approach to dream interpretation; and (h) the participants who worked with distressing dreams in this study no longer viewed such dreams as something to be avoided.

Kan observed a wide range of characteristics of participants in the second part of the study. These observations suggest possibly greater generalizability than some of the previously stated limitations would indicate. Although based on preliminary observation rather than statistical analysis, these indications suggest that Focusing-oriented dream interpretation is equally effective and useful for individuals representing a wide range of characteristics.

Gendlin (1981) asserted that anyone can learn and benefit from Focusing. Although this may be true, the current study involved only those participants who had some experience with Focusing. The results of this study strongly suggest that people with some Focusing experience, who can remember a dream, and who are guided by someone well trained in the Experiential Focusing method are highly likely to benefit from Focusing-oriented dream interpretation.

RECOMMENDATIONS

This study presents several opportunities for further investigation. These include the following:

1. Confirm the reliability findings of the DIEQ Part 1.
2. Examine the applicability of the DIEQ to other approaches to dream interpretation.
3. Use the DIEQ to compare the relative effectiveness of Focusing–oriented dream interpretation with other approaches to dream interpretation.
4. Use the DIEQ to explore the effects of long-term interventions, consisting of 8 to 10 sessions of Focusing-oriented dream interpretation, with both general populations and populations with specific presenting problems, such as depression, eating disorders, or survival of any form of trauma.
5. Use the DIEQ to explore the effects of short-term or long-term Focusing–oriented dream interpretation on specific types of dreams, such as pleasant dreams, nightmares, recurrent dreams, or mystical dreams.
6. Use the DIEQ to examine the effects of Focusing–oriented dream interpretation with people who are not experienced in Focusing, perhaps compared to effects with those who are experienced.
7. Use the DIEQ to examine the effects of Focusing–oriented dream interpretation with people who, on learning about Focusing, are not attracted to it, perhaps compared to effects with those who are.

CONCLUSION

This study demonstrated that the effects of Experiential Focusing–oriented dream interpretation can be examined through the use of the DIEQ. In this study, individuals trained in the use of Focusing and guided by a well-trained and experienced Focusing guide were very open to examining psychological material reflected by their own dreams. This study strongly suggests that dreams reflect a person's current psychospiritual issues and that Focusing helps the person experience new insight or movement concerning these issues. This finding offers support to Gendlin's (1996) proposition that Focusing helps individuals make use of the "clues to and energy for the steps to a solution" that are implied in dreams (p. 200).

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JAPANESE PSYCHOLOGY IN CRISIS: THINKING INSIDE THE (EMPTY) BOX

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Summary

In part because of the information revolution, Japan is experiencing a crisis in culture. Because it is more sensitive to culture than other approaches, humanistic psychology may have much to offer in this time of crisis, particularly because of the Japanese value of inner privacy. Tomoda has explored ways of translating Rogers's approach into a Japanese context of Zen, including the use of *renku*, a form of poetry collectively written by members of a group exploring their process in "a vague atmosphere of togetherness." Another approach to bridging the East/West gap is explored in *Naikan* therapy in which an empathic therapist visits the client who sits and meditates

on the dynamics of his or her personal relationships during a week-long retreat. In the end, it is thinking inside the box, contrary to Western contemporary values, that seems to make humanistic psychology work for the Japanese, whose aesthetic values have persevered through the ages.

In the early 1950s, humanistic psychology was first introduced to Japan by Logan Fox, a student in Carl Rogers's classes at the University of Chicago (Kuno, 2000). When Fox came to work at Ibaraki Christian Junior College in 1948, he shared his copy of Rogers's *Counseling and Psychotherapy* (1942) with a young psychologist by the name of Fujio Tomoda.

Tomoda translated this book into Japanese, and in 1955, he and Fox held the first ever event of humanistic psychology in Japan for a group of 50 from all over that country. This was the seed that ultimately gave birth to humanistic psychology in Japan as it grew in healthy fashion throughout the 1960s.

BEGINNINGS

In 1955, Tomoda was among the first to found a humanistically oriented program in Japan—the Tokyo Counseling Center—which led to more than 30 similarly oriented programs during the 1960s, although showing a slight decline into the 1970s as it began to include other approaches, becoming more eclectic with the passing years (Hayashi, Kuno, Osawa, Shimizu, & Suetake, 1992). Among other humanistic activities, T-groups flourished at such sites as Sangyo Noritsu Daigaku (later Sanno) during the 1960s, and AHP meetings were held in Japan during the 1970s, attended by Carl Rogers and other American AHP members.

The client-centered approach was given somewhat of a boost by a visit to Japan by Rogers and his daughter, Natalie, in 1983. The place of the client-centered approach in Japanese psychology has been explored by many. For example, Toru Kuno, in a series of publications (1983, 1985, 1986, 1990), analyzed the limitations of this approach in light of the perspective of Japanese culture and attitude. A recent paper (Ikemi et al., in press) summarizes the status of this approach, particularly as seen in the corporate context and the recent interest in emotional intelligence as a vehicle for client-centered values (Ryback, 1998).

CRISIS IN CULTURE

At present, Japan is enduring what can be characterized as a culture in crisis. It has been fortunate in gaining undreamed of freedom and prosperity in the past half-century since the end of World War II.

Following that war, Japan became the second most economically powerful nation in the world. The trade-off has been the stress in the industrial environment involved in transforming its complex, traditional heritage.

There are three components to this stress:

1. The breakdown of social structures that have characterized Japanese society for centuries. Even the economic alliances between banks and their client corporations (*zaibatsu* or *kieretsu*) are coming undone, not to mention the firing by corporations of many loyal employees who believed their futures were assured when they committed themselves to their first jobs on graduation from college.

Another breakdown in social structure has become evident in a gap between the generations. Traditionally, workers would unwind from strict protocol in interpersonal communication in the workplace by gathering for drinks after work and sorting out conflicts and other difficult issues under the influence of alcohol. Nowadays, the younger generation elects to communicate primarily through the Internet and looks askance at the tradition of after-work drinking parties. This generation gap is parallel to the one in the West separating the computer-attuned younger generation from the relatively computer-illiterate older generation.

2. Forced confrontation by alien cultures. The Japanese, in an island culture, have enjoyed a degree of isolation from the outside world because of their geography. They've enjoyed an inordinate sense of cultural intimacy with their fellow citizens. Outsiders could never truly fit in, no matter how long they lived in Japan or how rich they became. Now, with global economics urged on by electronic communication across national boundaries, Japan is shocked into becoming more of an international player, whether or not it's ready, not only economically but culturally as well.

3. Questioning of inner identities. Tradition is very strong in Japanese culture. Most Japanese identify themselves with their national culture even before their religious affiliations. Religion is the backdrop; national culture is the foreground. As Japanese customs give way to modern challenges and as the waters surrounding the island nation no longer serve as a culturally protective moat, many Japanese are beginning to notice a form of identity crisis. With all those changes, where do individual Japanese find themselves? Are they ready to enter the new millennium as global citizens or can they still trust a maternally protective national culture despite the grave disappointments in the past few years and the somewhat scary economic challenges ahead?

PSYCHOTHERAPY IN JAPAN

Considering all the components of a national inner crisis, how can psychology help, especially given a culture in which seeking therapy is seen as a clear sign of weakness, at least in the industrial setting?

This is where humanistic psychology once again comes into play, primarily because it is more sensitive to culture than other approaches.

The structure of psychology in Japan is quite different from that in the West. Whereas in the West, psychotherapy often has been characterized by patients' paying for their own sessions (more recently paid for by insurance and HMOs), in Japan most psychotherapy is paid for by employers or by state-run programs. Although more Japanese are becoming aware of, and accepting, the importance of psychological services, as time goes by, as a response to family- and school-related issues, the idea of seeking professional help for one's personal problems has not been widely accepted. Yet, Japanese are just beginning to seek out therapy in clinics and hospitals. There are "life-line" crisis-counseling services available by telephone, and the Ministry of Education offers free counseling as well. Private practitioners are finally beginning to enter the marketplace. At work, where personal problems can result in absenteeism or lowered productivity, psychotherapy is made readily available at some of the larger corporations. But even

here, the potential client is likely to reflect: Who wants to talk about personal issues knowing that counseling will be closely monitored by the boss? This concern reflects a real possibility (but fortunately not a certainty).

INDUSTRIAL COUNSELING

The Japanese government first got involved after a plane crash in the early 1980s was caused by a pilot suffering from what was characterized as "mental illness." Subsequent to that, the Japanese Ministry of Labor called for inclusion of mental stress issues in the existing Silver Health Plan, the purpose of which was to promote healthier conditions for middle-aged workers. In 1988, it was revamped to include all ages and was retitled the Total Health Promotion Plan. That same year, the official Law for Industrial Safety and Hygiene was amended to make employers more responsive to the mental as well as physical health needs of employees. Since then, various nonprofit organizations have made available training in counseling techniques to psychologists, other occupational health professionals, and human resource managers. Due to rapid technological growth, Japanese workers were becoming subject to more and more stress in an increasingly industrialized society, resulting in more diagnosed cases of high blood pressure, ulcers, and various mental symptoms (Kunisada, 1999).

Employers began to assume more and more responsibility to help their workers with such ailments. Daihatsu Motor Company, for example, began active listening programs in 1988 and, 2 years later, experimented with humanistically oriented encounter groups. This was in response to a study within Daihatsu, using the Ministry of Labor's diagnostic categories, resulting in a finding that 44% of employee health problems were related to stress and that 25% of sick leave was due to stress factors (Kunisada, 1999). Such training soon included managers and supervisors as well as frontline workers. This training in active listening is ongoing and even included executive board members in 1993.

Another contemporary example is offered by the Mitsubishi Chemical Corporation, which now separates counseling services for mental health problems from systematic management training. For the past 5 years, in addition to such counseling, the

Mizushima plant of Mitsubishi has provided active listening skills to its managers as a form of leadership training.

But, all is not as smooth as may appear at first glance. For example, Mitsubishi managers were confused by the prospect of active-learning principles. Japanese society has a very strong hierarchical structure deeply embedded in its history, from the feudal Shoguns who lived in heavily fortified castles hard won in military conflict, to the more contemporary time of the unwritten contract between employer and employee of lifetime protection, both in terms of job protection and supplementary benefits. The idea of flattening the hierarchy by adapting to one another's perspective is quite alien, given this history.

On the other hand, there is a paradox here that is very difficult for the Western mind to understand. Within this strong cultural value of strict adherence to hierarchy emerges a very different value system of shared togetherness that is best illustrated by scenes of Japanese tourists traveling in tight-knit groups or the Japanese classroom in which no one dare stand out, creating, to the unsophisticated Western eye, a bland sea of expressionless faces.

When the Japanese Ministry of Labor completed a long-term survey of its efforts at improving mental health issues (Noda, 1999), it was discovered that the number of work sites adopting mental health promotion was declining over the years—to 34.5% in 1982, 30.3% in 1987, and only 26.5% in 1997. Although this decrease may in part be due to a troubled economy, a deeper reason might be the absence of well-defined objectives and a low priority for these programs on the part of company executives. In addition, there may be too few occupational health professionals with adequate training to provide effective programs.

All in all, a picture emerges in which cultural issues become increasingly prominent. Despite the modernization of Japan, psychotherapy, as Westerners know it, exists only in small part for the Japanese. Although clinical psychologists in hospitals and social agencies still outnumber industrial counselors by far (S. Hayashi, personal communication, 2000), it still remains a work issue as well as a personal one. The Japanese sense of inner privacy is inscrutable. Although emotional problems are as great for the Japanese as for any other culture, the Japanese person is not likely to take initiative in seeking help. So what solutions can humanistic psychology offer?

ZEN ALONENESS

Let's return to one of the founders of humanistic psychology in Japan, Fujio Tomoda. This man was supremely sensitive, in his writings, to the integration of client-centered therapy (CCT) or active listening to Japanese culture. Intuition, an emerging component of CCT, could best be acquired through *mui-shizen*, the attainment of natural feelings in themselves (Hayashi et al., 1998). Tomoda (1970) saw this as the best way to manifest Rogers's necessary and sufficient conditions of acceptance, genuineness, and empathy. He characterized the optimal result as creating a "vacuum" for the client, freed of external social influences to allow for the inner dialogue necessary for inner growth.

As Tomoda struggled to better understand the workings of the inner Japanese soul, he studied and wrote about the self-concept as seen through the ancient Oriental philosophies. In a 1992 article titled "Go, Ga, and Yo," he characterized *Go* as the true, inner self, what we might see as the authentic self; *Ga* as the conceptual self or ego, what we might see as the public image; and *Yo* as the interpersonal or relationship-oriented self, what we might see as the managed or socially interactive self. This was a stalwart attempt at bridging the Western concept of humanistic psychology to Eastern sensibilities. Tomoda urged a closer examination of the inner Go rather than the social Ga with which most Japanese seemed concerned. Look inward, not outward, he seemed to be saying.

Tomoda (1968) also emphasized the Zen nature of inner awareness by focusing on the "alone" nature necessary for the inner reflection or inner dialogue that he adds as the fourth essential to Rogers's three characteristics of acceptance, congruence, and empathy. In fact, according to Tomoda (1970), Rogers's three characteristics set the stage for the needed sense of "aloneness."

The paradox is that this alone sense can best be manifested in relationship with the counselor who becomes a Taoist-like entity, listening without interfering. The counselor conveys a caring, noninterfering listening that gives the client the safe, nurtured space to explore inner dialogue.

Tomoda was fascinated by this paradox of aloneness in the relationship of CCT. He was struck by the writings of Matsuo Basho, a famous haiku poet in the Edo period of Japanese history. In his attempt to create a "counseling for the Japanese by the Japanese,"

Tomoda (1979, p. 5) found in *renku* poetry the right Japanese balance between relationship and aloneness.

RENKU THERAPY

Renku has its origins in *waka*, a Japanese style of poetry that is more than 1,000 years old. Literally interpreted as "linked verses," renku typically involves two or more people who alternate in writing verses, traditionally 36 in number, each of which is either a long verse of three lines in 5-7-5 syllable structure or a short verse of two lines in 7-7 syllable structure. This structure stems from the old Japanese style of poetry called *tanka* (Hayashi et al., in press).

Each verse or stanza, after the first verse is presented, is a highly personal response to the preceding one, by another person. The entire renku, when complete, ideally consists of three parts: a quiet, steady introduction; an interesting middle section tinged with brilliant development; and the speedy resolution, reflecting irony or even humor. The key, as each subsequent verse is written in response to the former, is to see the inner truth of life form one's deeper perspective. By looking at the preceding verse from such a quiet, inner perspective, one can hopefully achieve the inner quiet Tomoda describes as aloneness. This can best be accomplished by a group feeling that meets Rogers's three characteristics. Morotomi characterizes this group acceptance as resulting in "a vague atmosphere of togetherness," becoming lost in one's own feelings, going on to say, "That is why group approaches in Japan have the power of cure."

Hayashi makes a clear connection between renku groups and CCT groups:

1. Grasping the meaning of the former stanza or verse requires respectful sincerity, relating to the quality of genuineness.
2. Faithfully appreciating the reverberations woven into the image expressed relates to the quality of unconditional positive regard.
3. Understanding the inner world of the author of the preceding stanza relates to empathic understanding.

According to Basho, understanding the previous stanza can be realized by leaving oneself, or becoming ego-less, by becoming *kyo*, or emptiness in the Taoist sense.

Confucius was believed to have said, "Listen by your *ki* (spirit), not by mind . . . *ki* stays in the state of emptiness and accepts all things."

Renku practice involves the coordination by a *sabakite* (sa-ba-keeteh) or facilitator who more or less manages to help a new group adhere to the rules of the creative process. A more seasoned group shares such responsibility among all group members. As in any therapeutic group process, the time and place should be free from outside distraction.

The challenge of each individual is to render the previous stanza as deeply understood as if one were in the person of the author of that stanza, with both conscious as well as unconscious spheres of knowing. The Japanese term for empathy is *aite no mi ni naru*, literally placing oneself in another's position but understood as "becoming another's body." In this sense, empathy might be translated as entering the phenomenological body of the other.

Another helpful term is the Japanese word, *za*, meaning psychological field. Za can be understood as the group phenomenological field, the organic togetherness of which all involved members partake.

Whereas *mi* is the empathic agency, za is the group consciousness as experienced by the various mis making up the group. If my empathy goes out to you, my mi experiences your *mi*. My *mi* vibrates with and echoes your mi at both conscious and unconscious levels. The modern concept of entrainment (Leonard, 1978, pp. 13-15), in which our heartbeats and breathing become synchronous with those of another after we "connect," helps put concrete meaning to these esoteric terms.

NAIKAN THERAPY

Another psychological approach to resolving this cultural dilemma between East and West is offered in the form of a meditative type of therapy called Naikan (Miki, 1976). In Japanese, this term can be broken down into inner (*Nai*) looking (*kan*). This introspective meditative form of therapy was founded in 1953 by Ishin Yoshimoto, who set up the first Naikan center in Japan, which has currently grown to 20 in number as well as in other centers in the United States and Europe.

Unlike the weekly 50-minute sessions typical of most schools of psychotherapy, this approach involves a week-long stay at a center. The *Naikan-sha* (client) is invited to meditate from 6 in the morning until 9 in the evening (meal and bathroom breaks excepted) in a comfortably seated position focusing on problematic interactions with significant others, taken in life-long chronological order—parents, siblings, spouse, and so on.

Specifically, the Naikan-sha is instructed to focus on the dynamics of receiving and giving and the troubles or difficulties that emerged from these transactions. This is best done by putting oneself in the other's shoes (as in Rogerian empathy) and trying to recall specific, concrete memories.

Every 1 or 2 hours, the Naikan therapist visits the Naikan-sha and has a face-to-face interview for about 3 to 5 minutes. Each Naikan-sha has a separate room and meditates behind a Japanese screen or panel called a *byobu*. A theme might be the following: How much did you receive from your father in your life? What did you return to him? How much difficulty did you cause him? A subsequent figure of focus might be a coworker, a child, and so on. During the therapist's brief visit, the question might be the following: What have you examined this time? The response is listened to quietly and dispassionately. The only task of the therapist here is to keep the Naikan-sha on track should the focus veer from the task at hand.

The Naikan therapist does not reflect but rather allows the Naikan-sha the task of self-reflection and continues to encourage this inner meditation. This is more in tune with Japanese self-reliance. The Rogerian aspect, as mentioned previously, is the encouragement to put oneself in the significant other's shoes.

It is interesting that the client may start off resisting, even asking the therapist for helpful advice, but as treatment develops in the stages experienced, from guilt and remorse through self-discovery to inner peace, there's a rough parallel to Maslow's hierarchy, going from basic needs to merging with others through self-actualization.

Humanistic psychology in the West works to bridge the gap between people to align their perspectives so mutual understanding is enhanced. In Japan, it is more difficult to "bring" people together. Japanese come together at their own slow, inexorable pace. And, when they do, it is more likely to be longer lasting than those in the West might expect. Westerners are more likely to seek

a "quick fix" in psychotherapy. Japanese are not so psychically malleable. Consequently, the psychotherapy process for Japanese is a slow, osmotic process as opposed to a rushing river. Personal boundaries do not break down easily for the Japanese, but when they do, there is greater permanence to the bond created. The poetic sensitivity of renku or the week-long meditative contemplation of Naikan therapy may be more effective for them than an intense weekend of group encounter.

INSIDE THE BOX

When Fujio Tomoda tried to make the pieces of the East/West puzzle fit, he saw the sharing process of renku poetry as a viable option to bringing humanistic psychology to the Japanese people. As modern-day Japan evolves from its chauvinistic past, entering a globally driven economy, the need for psychotherapy will only increase greatly. Japan is facing a national crisis of unprecedented dimension. Stress factors for workers facing such job uncertainty are bound to increase the Japanese Ministry's concern and create greater need for occupational counseling and training. What form will this increased training take?

Clearly, humanistic psychology will continue to play a large role. Active listening will likely be the primary approach. Will there be a place for such Eastern forms as renku and Naikan therapy or other similar approaches? Western leadership experts have touted the concept of "thinking outside the box." In Japan, it may be wise to respect the inscrutable inner soul, where Taoist and Buddhist values encourage an inner emptiness in which to reflect on the need for outer change. The Japanese are facing a crisis both economically as well as personally. The electronic environment has beaten down Japan's isolationist walls. But Japan's inner soul—aided by a strong work ethic and technological virtuosity—will prevail.

Where the proverbial picture may be worth a thousand words, an actual example of renku may have added value as well.

SPRING WIND AT SUNSET

While attending a workshop in renku led by Tomoda, Yasuhiro Suetake wrote the following:

Reaching
A terminal station
A spring wind blew.

Suetake had just arrived at the workshop site held in a small village nestled between majestic hills. His stop was the terminal station of the train route. Anxious and excited at the same time, Suetake was refreshed by a brisk spring breeze.

It was Tomoda's challenge to respond to Suetake's verse. His empathic reply,

Let's pick angelica buds
before the sun sets.

What sage advice as we confront the current crisis in Japanese psychology!

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