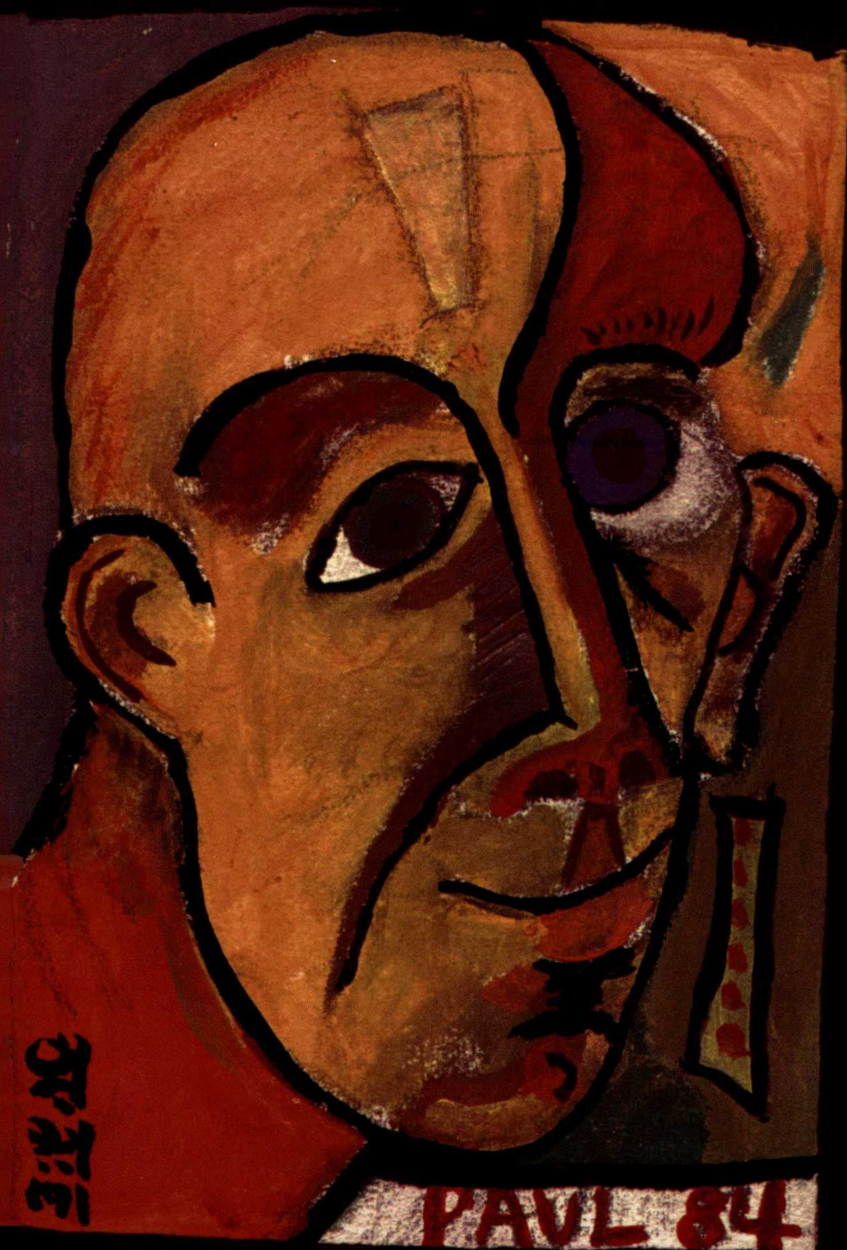
The Journal of Process Oriented Psychology

At the Edge of Process Work



Extreme States of Consciousness

An Interview with Arny Mindell on Extreme States

Homage to R.D. Laing: a New Politics of Experience

Madness as Feminism

Making Mental Illness Meaningful to the Mentally Ill

Being Prozac

Looking for Unicorns: Process Work at the Princess Royal Hospital

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Al de Half's Separate Reality

Return to Sender: the Spirit in Abortion

An Attack of the Heart

Facilitation and Multi-leveled Interventions in Community Building

Art Work by Linda Greischel and Paul Levy

The Journal of Process Oriented Psychology

A research journal
in Process Work

Articles by:
Arlene Audergon
Jean-Claude Audergon
Julie Diamond
Jan Dworkin
Joe Goodbread
Moses Ikiugu
Janiese Loeken
Guruseva Mason
George Mecouch
Dawn Menken
Arny Mindell
Maurice Shaw
Gemma Summers
Art Work by:
Linda Greischel
Paul Levy

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Summer 1995 Politics and Psychology deadline Sept. 1, 1994

Winter 1995 Foundations of Process Work, deadline March 1, 1995

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What is Process Work

Process Oriented Psychology, or Process Work, developed by Dr. Arnold Mindell, is an innovative and comprehensive psychotherapeutic modality designed for working with the entire spectrum of human consciousness. This dynamic approach to the unity of mind, body, spirit and the world has its roots in Jungian psychology, Taoism and modern physics. It integrates dream work, bodywork, relationship work, meditation and large group work into a single theoretical framework. This issue of the Journal focuses on extreme states of consciousness. Process Work approaches extreme states by understanding that these states are unusual only from the perspective of our own collective bias, and therefore attempts to unfold and discover these states on their own terms. (Dawn Menken)

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"Sunflowers" by Linda Greischel

Comment

The field of psychiatry as we know it is relatively young, and many working in the field could, by default, be considered pioneers. Enchanted by the incredible rewards of interacting with the extremes of the human psyche, we encounter a range of experience that can be daunting in its challenge. In the adventurous spirit of our ancestors in psychiatry who first dared to examine and relate to unknown and baffling states of consciousness, we are raising the issue of cultural-centrism in psychiatry. We feel that this topic is so important that we have chosen to take a potentially provocative stance.

Cultural-centrism

By and large the criteria for what is commonly considered "normal behavior" are based on western European cultural standards. The rules which we consciously or unconsciously live by in part define culture. In many cases cultural norms, and thus cultural-centrism, unconsciously work in the background as we evaluate others for normalcy. Cultural-centrism tends to assume that all people who live in a predominately European-derived culture are also from a European background and should thus behave accordingly. Cultural-centrism means that common behaviors which make sense in one culture are considered abnormal or inebriate when practiced in another. For instance, in India, standing in a river or pond and praying is normal spiritual practice. If a group of people trundled down to our local river to pray in the water, they would be seen as either an extremist religious sect, completely mad, or both.

This rather blatant example illustrates that behaviors which are transplanted from one cultural context to another may be considered abnormal. Similar evaluations of "abnormal" behavior happen in many small ways in everyday life. For example, the mainstream communication style in the United States values speaking in relatively quiet tones, not interrupting, keeping one's body still and holding back emotion in public situations. A person from a background which values simultaneous speaking and open expression of emotion with large gestures (such as southern European) will be evaluated by the mainstream as too emotional, odd or even sick.

For our purposes, we define the mainstream in the United States as consisting of people and values of more or less western European descent. A high value has been placed on assimilating into or trying to "pass" as belonging to the mainstream. This value leaves us with a doubly restrictive situation. The rich differences brought by people from diverse cultures are at best not valued and at worst seen as suspicious or pathological. Also, behavior that is not supported in the mainstream is easily projected onto different cultures. Projection can prevent the mainstream from noticing that both positive and negative qualities ascribed to non-mainstream groups may be unconscious aspects of themselves.

The mainstream in any culture defines and reinforces societal norms. Up to a point this is positive, since a certain amount of stability is necessary to maintain culture. Thus, the mainstream has a natural tendency to resist change in order to keep society intact. However, if the mainstream becomes overly stable, favoring one aspect of the culture over others (for example valuing only a linear, calm communication style), cultural impoverishment may result. Non-mainstream elements are left with the task of fitting in, being judged or stretching mainstream norms. In the history of the United States numerous minority groups have benefited from the leadership of African Americans who, through the civil rights and other movements, led the way in challenging and eventually changing mainstream values. Concur-

rently, other tendencies attempt to stretch the boundaries of mainstream culture. A possible explanation for various trends, ranging from fascination with violence and the paranormal to the recent surge of fundamentalist Christianity, is that the culture is attempting to rediscover aspects of itself which have been excluded. One way to discover what is trying to come to consciousness in a culture is to look at groups, trends, tendencies and extreme states which disturb and contrast with mainstream values.

Social issues and cultural projection

Projections, either positive or negative, can be harmful to groups and individuals receiving the projections. They objectify and dehumanize people, depriving us of the chance to see them as unique. Why are we talking about social issues and cultural projection in an editorial about psychiatry? For the following reasons:

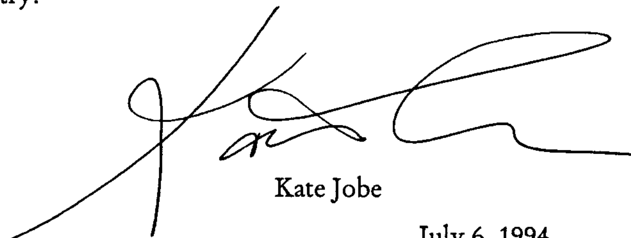
1) Traditional diagnostic practices derived from mainstream norms have a tendency to judge as abnormal any experience that doesn't fit the mainstream. For example, we once had the opportunity to be present at intake interviews in a psychiatric hospital in Cape Town, South Africa. A Black African woman was presented. She had been relocated from her home and sent to live with a brother, who was abusing her. She complained of being possessed by a spirit in her stomach which told her to do bad things to her brother. As we listened to the psychiatrists talking about her, one mentioned that in the woman's own culture this experience was well known and had a name. Even though in the context of her own culture there was a name, an explanation and a treatment for her experience, she received the diagnosis of schizophrenia. In this case, cultural-centrism restricted the psychiatrist to a narrow range of descriptions and treatments for illness. Wouldn't it have been wonderful if the mainstream psychiatrist and the healers from the woman's culture could have worked together to help her translate the messages from the spirit into the means to protect herself from her brother?

2) Elements that are projected onto other cultures, groups and races also appear in extreme states. The reoccurrence of these elements may indicate that they could be useful in the development of the mainstream. For example, many acute schizophrenic episodes in the United States include both highly sexualized and/or spiritual content. Sexuality is frequently split off by the mainstream and projected onto minority groups. Similarly, mainstream culture in the United States has become more and more secularized. Graphic sexual hallucinations and spiritual encounters may appear in extreme states in part because they are trying to work their way back into collective consciousness. (See Mindell, *City Shadows: Psychological Interventions in Psychiatry* (1988) for a complete discussion of this idea.)

Questions in conclusion

This brief discussion barely touches on the complexities of cultural-centrism as it relates to psychiatry. The topic deserves extensive research and ongoing consideration. Many questions need to be asked. For example: Who has the responsibility for waking up the mainstream to cultural assumptions and centrism? Should the mainstream take responsibility for awakening itself? Or, as has largely been the case historically, should the responsibility remain with minority groups and individuals? (See Dawn Menken and Arlene and Jean-Claude Audergon in this issue for exploration of the effect of cultural-centrism on women involved in the psychiatric system.) Currently, we are fascinated with how we diagnose our own extreme states, and about the tendency to self-medicate wild states with common substances, e.g., pulling ourselves out of deep catatonia-like states with endless cups of coffee. As we begin to explore how cultural-centrism affects our own lives, we are encouraged about the possibility of growth in many aspects of mainstream culture, including psychiatry.

Leslie Heizer



Kate Jobe

July 6, 1994

An Interview with Arny Mindell on Extreme States

THE JOURNAL: Could you talk about the history of Process Work and the basic approach that you take with extreme states?

ARNY: I was always fascinated with extreme states because I grew up in a time which was in the midst of one, namely the second world war. Most of the kids in my kindergarten in 1945 were angry, furious, wild, racist, sexist, anti-Semitic and belligerent. World War II had just ended, but battles continued in my home town in the United States. I often felt that people around me were fighting for life—yet there was no outer oppressor! Were they insane? As a child, I often asked myself, is the whole world crazy about war, or am I weird? My answer is no, the world is not crazy. We were carrying on battles which the international peace treaties never addressed.

Later, when I studied psychology in Zürich, the questions about who was crazy came back during my classes on psychopathology. I felt amazed that so many of the "patients," who just seemed wild and awesome to me, were understood as outside the context of the world we live in. I wondered, why could only people in white coats work with them? Who was crazy?

In any case, after I finished my studies, I went through a phase in my learning where I saw a lot of people with physical illnesses and those in near death situations. After I found my path in body work with symptoms, I continued through another phase of learning and accepted all clients with "strange" mental states. In the middle of this study and practice, I met Dr. Dieter Wartenweiler, the head of Social Services in Uster, Switzerland. He and I made a wager. I bet that the most difficult cases his agency cared for could be helped without medication. This led me to investigate the theory and practice of working with people in deep altered states. I also felt encouraged to go deeper with near death situations and comatose states. This work led to the publication of *City Shadows: Psychological Interventions in Psychiatry* (1988).

A basic process work approach to extreme states is non-dualistic. Process Work approaches extreme states like any other situation or state of consciousness, that is, with an open mind. Follow yourself, follow the other, watch the signals of the world, try to track what happens and make the best out of it. This basic Taoist attitude is easier to say than to do, because extreme states in yourself or others confront you with the limits of what you have been taught is "healthy, good and right."

THE JOURNAL: Psychotherapy historically has held some prejudice against altered states, i.e., valuing certain states as normal and others as pathological. What do you think about the relationship of psychotherapy to altered states?

ARNY: Psychotherapy, without quite realizing it, mirrors collective social, Eurocentric ideals. The "integrated person" works for a living, cares for herself, is more or less independent and not too loud. While this behavior makes life easier in a western country, it should not be assumed that this is normal. Any psychotherapy which mirrors collective ideals, but ignores and pathologizes altered states, runs the risk of being racist and sexist. If "health" means "acting like the majority," then being "unhealthy" means that all minorities are in danger of being pathologized by the mainstream in any country.

Pathologizing grows out of the mainstream judging instead of observing and wondering about certain states. We find it easier to talk about observing and wondering than to do it, because we have at the same time to quiet our inner social

police who want to keep anyone who cannot or will not adapt to the mainstream in jail or in a hospital. Even worse, our inner social judges make us think we are strange for even wanting to do research into such states.

The deepest and most meaningful changes in individuals, relationships and groups happen through the emergence of altered states. Anyone interested in change and process, transformation and development, cannot avoid strongly altered states. These include hallucinations, paranoia, megalomania and wildness, ecstasy and spiritual experience as well as sloppiness, depression, addictions or just wanting to "drop out."

Today, transpersonal and human psychologists like the Grofs and others are ameliorating the tendency to pathologize extreme states by including spiritual experiences as part of their work with extreme states. However, even this approach holds the basic attitude that there is "spiritual emergence" which must be differentiated from psychosis. So the dichotomy between well and ill still remains.

THE JOURNAL: We understand that the idea of primary and secondary processes[1] developed out of your work with extreme states. How did this happen? Are there other ways in which your work with extreme states has contributed to the development of Process Work?

ARNY: Consciousness and unconsciousness, ego and subconscious are non-relativistic terms based upon the assumption that a standard reality exists. These ideas are based upon a value judgement relative to an unmoving system called everyday reality. Altered states are to "normal mental health" as relativity is to Newtonian physics. These states show that the governing paradigm is non-relativistic. Parapsychological events, visions, UFOs and near death phenomena must fit into our world view if we are to accept our natures.

Inward oriented people who will not talk, who hallucinate, want to kill themselves etc., do not follow collective paradigms. We need a theory and practice which is not based upon health and illness, normal and abnormal, ego and unconscious, but which is based upon the way an individual identifies herself.

Primary and secondary process thinking relativizes the way people feel about and understand themselves. These process structures are not pathological, but are based upon individual experience. Moreover, these structures fit people from all cultures. There is no *a priori* differentiation between women and men, ethnic groups or ages, since the nature of the processes is structured by individuals. The idea of a primary and secondary process also fits couples, families and large groups, who have identities and secondary processes, all of which are steadily in the midst of change.

THE JOURNAL: What do you think about traditional psychodiagnostics? Given that Process Work does not pathologize extreme states, if you look into the future development of psychiatry, what do you imagine?

ARNY: There will always be something like psychiatry, because the majority will always take an interest in diagnosing out people it wishes to marginalize. At the same time, there will always be another stream in psychiatry and psychology, which is person, or rather experience and process centered. This stream is interested in both the individual person and the group.

I can also imagine a change in our culture in the distant future which will melt medicine, psychiatry, psychology and social work into one. Many helpers are already doing this in their practices.

THE JOURNAL: What about people who are a danger to themselves or others? How does Process Work deal with these people?

ARNY: The question "How to do this or that" must always be answered with, "every case is individual. Follow the individual. Follow the Tao." The Tao of the United States, for example, includes malpractice problems, so we also need to come up with temporary answers to the question, "What about people who might kill themselves and others?"

People who are dangerous to themselves and others bring up deep ethical problems and processes in the therapist. For example, I stand against people hurting themselves. I tell them I will fight them and that I do not want to see them hurt. Some get angry and tell me I am not open. I listen to them. I try to listen to nature's voice in all this. There are rare times when she too says, "Sorry, this client is mine and not yours, take your hands off and let fate do what it must." We humans are co-creators, not creators. Life and death are not our business alone, even though we can fight for those we love. Before giving in to nature, I must try everything, and know that others who are better qualified have been consulted and that they too have reached the end of their abilities.

THE JOURNAL: What is the role of psychotropic drugs in Process Work?

ARNY: There is no one "role," for this too is individual. On the one hand, everything is psychotropic: coffee, sugar, bread, alcohol, smoking. I am less interested in psychotropic drugs than in why I myself tend to experiment with foods, drinks and chemistry.[2] My own desires show me who I am; they inform me about the altered states I need. If I get addicted to something, this tells me I do not allow the altered state connected with the addiction to influence my life. So, in a way, psychotropic drugs open us up to parts which have been closed. All drugs open us up to aspects of our nature we struggle with. But the open door is not the passage through into the other room. It is up to us to take the opportunity to pass through the open door, or not.

THE JOURNAL: You developed the city shadow concept, i.e., that people in extreme states are relevant for the society in which they live. What do you think those of us who identify as so-called "normal" people should do about extreme states? What is our responsibility?

ARNY: Worldwork. Our responsibility in reducing the agony tied up with altered states is to involve ourselves in social change. Every process work session, even opening up to something new or wild or ecstatic in yourself, is worldwork.

You must help the client to know the personal, familial and social issues behind her edges. If she now feels freer because of her work, she too must involve herself in freeing others in her society whom she, because of her nature, may have been holding down.

THE JOURNAL: Your book, *City Shadows*, written in 1988, addressed Process Work with extreme states in detail. What are your current ideas about Process Work with extreme states?

ARNY: My current idea is that I should learn more about what I wrote then. I was at least twenty years ahead of myself.

THE JOURNAL: In September of 1993, you, George Mecouch and Joe Goodbread conducted a week-long clinic on extreme states. What was your greatest learning from this experience?

ARNY: It always amazes me to see how meaningful extreme state experiences are. I also learned that extreme states work can be done in front of others, taught, discussed and learned!

THE JOURNAL: Why do you use the term extreme state rather than psychosis?

ARNY: Psychosis is a term based upon the paradigm of pathology. Extreme state on the other hand is relativistic; it is neither good nor bad but simply says that someone's experience is unusual relative to her world.

THE JOURNAL: Do you experience extreme states? How do you deal with them?

ARNY: I go through wild states when I write. I go into a state of intense concentration and focus two to four weeks at a time. I always think this will injure my health, but it never seems to bother me. I don't deal with my extreme states, I get into them and try to find their purpose.

Every time I see someone using their rank consciously or unconsciously to ignore, marginalize or hinder someone else from flowering, I become extreme! I am furious about sexism and racism, they depress me deeply. I am utterly and hopelessly identified with the world. If anyone lords over someone else, I am hurt. It kills me. Only after having been extreme in some form or another can I open up and listen to and even love others.

THE JOURNAL: Extreme states are a part of most people's lives, but we tend to try to control or repress them. In your imagination, what would the world be like if we lived them more?

ARNY: Society too has its primary process. So there will never be a world as far as I can see which just lets extreme states rule the show. But the world would be a better place if we had more carnival time, where madness had its way. I love carnival, Fastnacht,[3] Mardi Gras! On the other hand, I find nothing more beautiful than normal, everyday reality after being far out for a long time.

THE JOURNAL: There is a theory that people with schizophrenia don't get as much cancer as the rest of the population. What do you think about this?

ARNY: Madness and cancer are both forms of the shaman's ally. Both are wicked powers which require warriors to fathom and bring these powers to earth. People who suffer from either cancer or attacks of wild fantasy are not only sick in the conventional sense. In my mind, they are channels for energies the rest of us fear.

THE JOURNAL: At various times you have commented on the connection between relationship difficulties and extreme states. Could you say something about that?

ARNY: We fall madly in love, hate, despair, get paranoid. The other person is everything or nothing, god or the devil. Relationships cause many of

us to live in permanent extreme states! Relationships are for warriors who know that their states are there for a good reason. They vow to process relationship states instead of repressing them, sinking into them or disappearing.

THE JOURNAL: If we all lived our extreme states, could culture in any coherent form exist? Or do we need to repress ourselves to have a society with structure?

ARNY: What a great question. I would hate to live anything all the time—even my most ecstatic states. I prefer to wander, as my process wanders, through "mad" periods, and then through "normal" social states as well. The year has seasons, and I love them all.

Notes

1. Primary process refers to aspects of a person with which she or he identifies. In contrast, secondary process refers to aspects with which a person does not identify.
2. See "Being Prozac" by Janiese Loeken on page 35.
3. Fastnacht is the name for Carnival in Switzerland.

Arny Mindell, Ph.D., the founder of Process Work, is the author of numerous books and a teacher at the Process Work Center of Portland and throughout the world. Along with his wife Amy, he teaches and learns about Process Work as it applies not only to psychotherapy but to world and social issues including racism, conflict resolution, extreme states, coma and dying.

Homage to R.D. Laing: a New Politics of Experience

Joe Goodbread

Mad individuals in a mad society

In 1967, R.D. Laing published his groundbreaking book, *The Politics of Experience.* In it, Laing expressed the radical view that insanity, however one chooses to define it, is only "mad" when viewed from the perspective of a mad society which forms its social context.

Psychiatric diagnosis, he points out, is based on a consensus view of reality which circumvents the notion that we are each constrained to filter reality through our own understanding, through our own experience. This applies to psychiatrists as well as to patients. Laing likens psychiatric diagnosis to judging prospective patients according to what is very likely yet another form of insanity. The failure of a person to concur with this possibly mad consensus state is called insanity.

Laing quite agrees that the states which we call mad may not be pleasant ones. He compares them with death, since they represent the death of the person's ego identification. But ego death is not, in and of itself, an illness, no matter how unpleasant, challenging or even permanent it may be. It is only an illness to a society which sees it as such. Healing, to such a society, means restoring the person to a "normal" state of personal isolation, greed, loneliness or any of the other concomitants of "properly functioning" ego boundaries.

To risk a vast oversimplification of Laing's intent, he sees madness as a necessary and potentially effective vehicle for social and spiritual transformation, in which the alienated individual becomes re-connected with the whole of humanity and the world. He acknowledges that this path is fraught with peril; the general disavowal of such processes in society at large virtually guarantees the individual's failure to make something useful of the experience of ego death. Madness is therefore a problem, but it is not necessarily the individual's problem. It is, rather, the problem of society as a whole. Were society to pay more attention to the experiences and values which seem important to people in their states of madness, we could provide a safe vessel for individuals called to embark upon the journey to redeem the self through the death of the ego.

Arnold Mindell's book, *City Shadows: Psychological Interventions in Psychiatry* (1988), represents a similar position. Working with clients in extreme states of consciousness, Mindell finds that their experiences express the shadow (in Jung's sense) of the society of which they are a part. The experiences of which these clients partake typify just those experiences which are disavowed and often despised by society as a whole—by extension, the people themselves form a disavowed and despised minority. In *The Politics of Experience,* Laing never explicitly defines schizophrenia. He does, however, give some of its characteristics, the most prominent of which is "ego death." The person has evidently lost the capacity of identification.

This corresponds to Mindell's notion of the missing metacommunicator. The metacommunicative function permits a person to speak about the states of consciousness which she or he experiences. A person who, for instance, is given to wild fits of passion, in which he produces a deluge of verbal material without much regard to the other person's feedback, is not necessarily in an extreme state of consciousness. If he can tell you, in the midst of his verbosity, that he sometimes gets this way when he is excited, and to please excuse him,

he doesn't have much control over it, nor does he want to control it because it's an ecstatic state—that person is capable of metacommunicating about his state of mind.

On the other hand, if the same person is either incapable of describing that state, or of relating to another person who does not join him in that state, then that person is, by definition, in an extreme state of consciousness. He is missing the ability or the inclination to metacommunicate about the state itself. He has no high ground from which to be aware of what he is doing, what is happening to him or how he is affecting those around him.

The Question of Therapy

Laing did not believe that people in extreme states of consciousness were ill, nor did he believe that they needed therapy. He believed that what was required was a helper who herself had an experiential familiarity with the states she presumed to help others into and out of. More important than therapeutic skill was a belief in the reality and importance of these states, and the confidence that return was possible, given faith in its possibility and proper guidance.

Laing, during a particular phase of his life, devoted himself to providing an environment in which people with schizophrenia could complete their journeys. He trained a staff of helpers who were sympathetic to the difficulties faced by the schizophrenic "patient" and who could devote great quantities of time and energy to accompanying their schizophrenic clients on their journeys. He used no psychotropic drugs for sedating these people; he believed that the process should not be interfered with, lest the patient be unable to complete his or her journey.

The effort was immense in terms of time, energy and money. The experiment ended without the method being accepted by mainstream psychiatry. Today's psychiatry is largely interested in restoring patients to a more "normal" state through the use of psychotropic drugs, rather than helping patients complete the experiences which are typical of their extreme states.

Laing's Legacy

What remains from Laing's initial project is a legacy of belief in the meaningfulness of mental illness. Although this belief was present in the work of his predecessors, Laing's courage enabled him to put his views into radical action. It is one thing to believe that a schizophrenic's ravings and trances are meaningful; it is quite another to take the same person out of the psychiatric clinic and into an environment where everyone is equal, where everyone has the same rights and privileges, and where no person's experiential reality is considered any truer or more valuable than anyone else's.

This legacy has been carried forth by Stanislav Grof, John Weir Perry and other pioneers. It has borne such fruits as Perry's therapeutic community, Diabasis, in which schizophrenics were treated with psychotherapy but no drugs, and Grof's Spiritual Emergence Network (SEN) which is devoted to providing people throughout the United States with access to helpers who know and respect extreme states.

There have been other experiments in the United States as well as abroad. They have, in general, led to more understanding and the potential for more humane treatment than has been provided by traditional psychiatry, with its emphasis on pathology, institutionalization and chemotherapy.

Despite these efforts, psychiatry is resolutely marching forward in its attempt to develop illness-specific chemical treatments for all manner of extreme states of consciousness. The current belief is that these states are produced by a biochemical disorder and can only be treated effectively by intervening in that chemical system.

Co-Existence of Contrasting Paradigms

The benefits of the chemical approach to extreme states of consciousness cannot be denied; over the past thirty or so years, periods of institutionalization have become shorter; people who were virtually imprisoned for long periods of time are now able to function in jobs, schools and home situations. Does the efficacy of chemicals at improving social functioning mean that the states which they are trying to treat are themselves meaningless?

To believe so would be to subscribe to the theory that extreme states of consciousness have but a single cause, and that the content of these states is an epiphenomenon of a more fundamental disorder. To subscribe to this theory is to say that our experience of these states is less true or less valid than their biochemical nature.

The biochemical theory supports some elements of empirical observations of extreme states of consciousness, but fails to explain others.

It supports the observation that certain measurable parameters of social functioning, interpersonal relationship and the like, show statistically significant improvement under chemical therapy.

There are certain other aspects of extreme states of consciousness which are not so clearly supported by the biochemical theory. These include the aspects to which Laing was referring, and to which Mindell's work has addressed itself.

1) Extreme states are relative to a "base" or consensus state of consciousness. This base state is not universal; it is the "normal" state for the social framework out of which the extreme state emerges. For example, a person living in a totalitarian state rife with government informers might have to develop a degree of suspicion of her fellow human beings which would brand her as clinically paranoid in a more democratic social system. With the collapse of the Soviet Union and the rapid transition to democratic process in the former Soviet satellite nations, people have not found it easy to relinquish old habits of caution acquired during a lifetime of repression. Has suspicion suddenly become an illness because of a change of governmental form?

2) Extreme states are defined in part with respect to a mainstream and often unconscious definition of truth. Schizophrenia, for example, is considered to be a disorder of thought. Schizophrenic thought is considered disorganized or even chaotic; it is deficient in "reality testing." Visual and auditory hallucinations are examples of disordered thinking; they refer to inner representations of things which "aren't really there." But "what is really there" is very much a matter of culture. "Talking to God" in the form of prayer is considered normal behavior as long as it is done in the right place at the right time. But if I begin to carry on a conversation with God in the midst of an oral examination on constitutional law at a university, I had better be willing to admit that God wasn't "really" talking to me nor I to she, lest I be suspected to be hallucinating and therefore psychotic. It is for this reason that psychiatry is so susceptible to being misused as an instrument of social repression. Mainstream culture establishes what is real, and, historically, has often depended on psychiatry to incarcerate or chemically alter those who do not subscribe to this standard.

3) Extreme states of consciousness are judged in part through differences of communication style. Each culture and subculture carries with it a largely unconscious set of communication protocols. The more conscious of these are formulated as rules of courtesy and politeness. Those of which we are less conscious establish a kind of mood or atmosphere which emerges in reaction to those whose communication style conflicts with the mainstream norm. People who are by nature shy or introverted may be thought to be seriously depressed by adherents to a mainstream communication style which favors loud and spontaneous verbal interaction. Conversely, in a cultural framework which is marked by little body movement and soft speech, a person who speaks loudly and gesticulates may be thought manic.

Laing's program for the understanding and treatment of mental "disorders" was an attempt to take into account factors such as these, in addition to those which could be accounted for by the biochemical theory of mental illness. Having laid out these positions, I wish to consider why Laing's model was not picked up more enthusiastically by mainstream psychiatry, and to show how Mindell's approach promises to preserve Laing's basic intent while building a more durable bridge between the two paradigms.

Process and state: madness in sanity, sanity in madness

Despite the evident truth of many of its observations and assertions, Laing's program has not had the sort of impact on mainstream psychiatry for which we might have wished. Laing seems to have viewed extreme states of consciousness as a "separate realm" to which people "journeyed" in the course of a psychotic episode. In *The Politics of Experience* he repeatedly uses the metaphor that psychosis is a journey to a distant realm. This realm, he claims, is inaccessible to people in consensus states of consciousness. He likens the journey into this realm as comparable to breaking through a fifty-foot thick concrete wall. The experience of an extreme state of consciousness has something of violence to it. This is in keeping with the common experience that there is something sudden, violent, disturbing, destructive and final about many episodes of extreme states of consciousness. This experience seems to lead people to characterize such states as pathological.

Despite Laing's claim that extreme states of consciousness are not pathological, we often experience them as such. When we are confronted with someone in a state of consciousness which

differs strongly from our own, it is difficult to escape the feeling that something is wrong with that person. A shift in our own state of consciousness is necessary before we can see the other person as simply partaking of another version of reality different from our own. The fact that the other person frequently appears to suffer in her or his state reinforces our belief that the other person is sick.

Laing's approach depathologizes extreme states in principle but does not deal with the fear and hopelessness that these states engender in both those who experience and those who observe them. He asks, instead, for a radical and probably unattainable shift in mainstream consciousness. He wishes a majority to shift its experience and perception to conform to that of a minority which it fears and often despises. As essential as this shift may be, the chances that it will ever occur on a large scale are negligible. Like many well-intentioned programs for social transformation, Laing's approach does not address how it can be implemented without first destroying all the social structure and process which preceded it. The theory does not consider the backlash that inevitably comes by denying the verity of the consensus or mainstream mode of perception.

To put the matter more strongly, Laing's model sets the stage for a serious split between itself and psychiatry. It sets up polar opposites which are so disparate that the chances of finding a metaposition which encompasses both positions and allows their adherents to communicate with one another are as good as nil. It also stops short of attempting to mediate a rapprochement between those two positions.

Laing's theory, on one hand, and mainstream psychiatry, on the other, form two poles of a continuum which neither recognizes as such. While they obviously disagree on most of the important issues in psychiatry, such as the existence, genesis and treatment of psychiatric disorders, they share one important point in common: both see extreme states of consciousness as binary or polar phenomena. They are two-state theories, in which a person occupies either one state or another. Both would agree that this separation of states is radical and tenacious. Neither would put much emphasis on these states as the extremes of a continuum of experiential process.

The Radical Polarization is Only Apparent

Mindell and others have found, however, that the split between extreme and "normal" states of consciousness is not as radical as we tend to imagine. Careful observation shows that each state carries with it a vestige or trace of the other.

Laing's metaphor of the "concrete wall" which separates normal consciousness from the state of consciousness found in schizophrenia highlights the experience that the change of state from one to the other is radical and complete. Everything that existed in the normal state is cast asunder when the person embarks upon a schizophrenic episode.

If we believe this is so, and the dramatic quality of many extreme states supports this belief, we are unlikely to look any further for bridges between the two realms of experience. But if, following Mindell, we approach the person in an extreme state with a "beginner's mind," we often find that these realms are not as completely separated as we initially believed them to be.

It is unusual nowadays for a psychotherapist to encounter someone in a floridly psychotic state; the ethics and practice of psychiatry require people deep in extreme states of consciousness to be medicated and brought back to more normal states as rapidly as a diagnosis can be reached and a treatment plan can be formulated and implemented. Psychotherapists who work with people subject to extreme states of consciousness will most likely work with them when they are in a more "normal" or consensus state of consciousness, either as a result of remission of their symptoms, or through the use of psychotropic drugs. Because of this binary model of states of consciousness, both the psychotherapist and the psychiatrist may believe that the client's extreme states of consciousness are inaccessible to psychotherapy, and that psychotherapy can only serve as a supportive measure between the client's more extreme episodes.

Mindell's experience suggests, however, that a person in the most extreme hallucinatory or paranoid state of consciousness retains a vestige of ability to metacommunicate about her or his state. In order to find this trace of metacommunicative ability the therapist needs first to believe in its existence, and then to have the perceptual tools to locate and amplify it until it crosses the client's threshold of awareness.

Conversely, the person who is in remission between episodes of an extreme state will show evidence of that state as a secondary process (in the process work sense), namely, as disturbing perceptions, projections and other manifestations with which he or she does not identify. Again, it is up to the therapist's awareness and willingness to perceive these manifestations as perturbations of the client's more normal state. I will illustrate this situation through the example of a brief interaction I had with a so-called paranoid patient at a large state psychiatric hospital.

Clarence's Story

Clarence, a forty-nine year old man, was brought to the admissions conference suffering from apparent delusions that he was being poisoned. He delivered a monologue to the staff psychiatrist, social workers, mental health workers, psychologists and nurses present at the meeting.

CLARENCE: "They're putting that old Nazi stuff in the water at the camp. They're trying to poison me, they've been putting that stuff in the water for years, down at the camp...did you find the poison?"

The staff psychiatrist tells Clarence that they haven't found any evidence of poison in his blood.

CLARENCE: "Yeah, but it shows up in the eyes, you see my eyes (holds his eyelids up so that the staff can see the whites of his eyes)...you see it? Are you sure you have the right reagents to test for that old Nazi poison? Not all labs have the right stuff to do the test. My brother-in-law is head of the laboratory at the National Institute of Health, if the hospital doesn't have the right chemicals, I'll talk to my brother-in-law and make sure you get them..."

His monologue went on and on in this vein, repeating the same basic thoughts in several variations, as the psychiatrist questioned him and made notes. Clarence was duly sent back to the ward, and the staff continued to discuss his case. No anomalies had been detected in his lab reports; his suspicion of poisoning was therefore thought to be a paranoid delusion. He was deemed schizophrenic and needed to be medicated. The trouble was, because he felt he was being poisoned, he refused to take his medication, and the staff was pessimistic about being able to reduce the level of his paranoia and bring him back to a more normal state of consciousness.

Binary Logic

Clarence is clearly in an extreme state of consciousness: he cannot talk about his impression that he is being poisoned. When presented with evidence that no poison could be detected in his system, he seamlessly integrates this by saying that it is the hospital which is faulty. He appears to be totally identified with his experience of being poisoned. This absolute and airtight conviction, not subject to modification by argument, is one of the characteristics that makes him seem mad. There is only one state to his thinking, and although it runs counter to our own convictions, there is no way to loosen his hold on it.

But the psychiatric framework in which Clarence is being evaluated suffers from a similar difficulty. Its job is to decide whether or not Clarence is psychotic, and if so, in what way. Its further task is to pry Clarence loose from his psychotic state and restore him to a normal state of consciousness. In doing so, it largely ignores the content of Clarence's story, listening and looking mainly for diagnostic indices which confirm one diagnosis or another.

The psychiatric approach to Clarence's story is binary in nature, attempting to assign Clarence's perceptions and experiences to one state of consciousness or another. In doing so it runs the risk of missing nuances of content which would add depth and even meaning to an otherwise mad-sounding story.

Experiential Logic

The logic of experience is less concerned with a statement's objective truth than with its place in the person's total world of experience. In the realm of experiential logic, a statement cannot be false; it is always an expression of an aspect of the speaker's experience. Although we may not share that experience, the experiential view makes this at most a matter of relationship, rather than of objective fact. If another person's experience doesn't make sense to us, we can only say that it is false in light of our own experience, rather than saying that it is objectively false.

Whereas the binary logic of objective truth is a state-oriented logic, experiential logic is process-oriented logic. When people speak about their experience, they are speaking about an ongoing process of perception and awareness. It is only

later, in conceptualizing this experience, that we turn it into a state.

Whether we hear people's stories and view their nonverbal communication as a description of a process or of a state depends on our own attitude toward experience. If we ourselves are attuned to the binary logic of state-oriented diagnosis, we are apt to hear people's stories as signs of permanent states of being; we are left with the choice to either let them be or to attempt to heal them by changing their states. If, on the other hand, we are interested in the logic of their experience as an ongoing process, then we have at our disposal a range of techniques and attitudes which are useful for unfolding the person's experiential process and helping it to find its own completion.

I believe that this process orientation toward experience in all of its forms, including extreme states of consciousness, can carry Laing's vision a necessary step further in two ways.

1) It can reduce the radical division that Laing's vision produced in the psychiatric community by building a bridge of experiential process between the two poles of medical intervention and social transformation.

2) It provides, in addition to a unified and evolving theoretical background, a whole spectrum of interventions and attitudes for helping extreme experiential processes to complete themselves. Under the theory and methods of Process Work, the immediate state of the client (medicated or unmedicated, in remission or in an episode) is less important than the therapist's openness, awareness and skill in finding and processing traces of all of the client's experiential states in his or her immediate situation. Put more simply, it may not be necessary for a person to go mad in order to process the states which that madness would otherwise produce.

Working with Clarence

We left Clarence as he posed a dilemma for the treatment team at the hospital. How can you medicate someone who is afraid that everything he ingests may be poisonous?

This is a dilemma born of binary logic. It is only daunting if one's goal is to change Clarence's state. Clarence is clearly in the middle of an extreme state of consciousness. His fear that he is being poisoned is very real and immediately present. As we have seen, it is so pervasive that it permits no relativization through objective "fact." The hospital's failure to find any poison is evidence to him that the hospital itself is "sick" and needs to be healed.

Experiential logic leads us to try to determine the totality of Clarence's experience, not just the part with which he is strongly identified. Using awareness skills of the sort which Mindell has described in *City Shadows*, my approach was to listen carefully to find the vestiges of experience in Clarence's story with which he did not identify, with the idea that these would form the elements out of which he could eventually assemble the ability to metacommunicate about his experience.

Viewed from an experiential standpoint, Clarence's description of both the Nazi poison (and, presumably the Nazis who produced or placed it) as well as his offer to have his brother-in-law check out and properly stock the hospital laboratory, are instances of secondary processes. An immediate goal of Process Work with people in extreme states, who are totally identified with one element of their experience, is to get them to identify, if only for a moment, with other aspects of their experience. Mindell has found that if this happens, the person does not simply "flip" into the other state, but often is able to metacommunicate about both states for a longer or shorter period of time.

One method which seems effective for getting someone to identify with a secondary process while they are in an extreme state is to join them in that state, to congruently partake of the same experience with which they are identified and to share that experience with them. With the permission of the chief psychiatrist, I went on the ward and met Clarence. I went up to him and said, "They're trying to poison me too!" To my utter astonishment, he looked at me, smiled, put his arm around my shoulder and said, "Don't worry, it won't kill you."

This is an exceptional response from someone who is supposedly in the midst of a paranoid schizophrenic episode. In that moment, he was very related to me—I experienced a great deal of warmth of feeling when he put his arm around me. He became, for an instant, "normal" in the sense of speaking about the experience of being poisoned, instead of simply acting like the victim of that poisoning.

Clarence then began speaking in detail about the poisoning process. He said that I should call the Army, because people in the Army had the antidote to the poison. He refused, in fact, to

speak to me any more until I contacted the Army to secure the antidote. We then each went our separate ways.

The following day, I ran into Clarence in a hallway in the hospital. He looked well-groomed and showered (in contrast to his disheveled appearance the day before) and recognized me immediately. He smiled and asked me how I was doing.

Accessing the Inner Healer

I was able to follow Clarence's case in the coming months. He was soon discharged from the hospital, only to re-enter several weeks later. But on his re-admission, he was very cooperative with the staff, and told them what drugs had worked for him in the past. They provided him with this medication, which he took without resistance. His symptoms abated, and he was able to leave the hospital in a few days.

Clarence had a good deal of inner knowledge of how to deal with his own extreme state. It was, however, knowledge that was largely inaccessible to him in his "normal" state. This knowledge was represented in his extreme state in the story of the brother-in-law who worked for the government and could heal the hospital's difficulties. It was also represented in his story of the Army personnel who had an antidote for his poison. Why is this state of affairs "extreme"?

It is an extreme state relative to mainstream North American culture. In other cultures, it would not be considered extreme at all. In the worldwide traditions of trance shamanism, practitioners are always going into deep trance states and coming back with information about healing. Despite some modern attempts to romanticize and popularize shamanism, the true shaman seldom has an easy time of it. Many shamans are called to their vocation through near-death experiences, spiritual crises and other terrifying and harrowing rites of passage. The success of the shaman's calling often depends on having a trusted elder who knows the perils of the journey through first-hand experience and can use this experience to offer support and guidance to the suffering and endangered apprentice. How would someone with a genuine shamanic calling fare in a social setting without elders who had trod the same path before her?

Here we get a hint of the picture which Laing is trying to reveal to us. Is Clarence considered mad because there is something wrong with his biochemistry, or because he has a shamanic calling but lacks an elder to guide him along the arduous path which lies before him?

I suspect that these paradigms do not, at their root, conflict with each other. I cannot escape the lurking suspicion that the very same biochemical disposition which will earn one a label of "mad" in one society may be the prerequisite for a life of sacred healing in another.

Processing the Inner Healer

What are some possible goals for psychotherapeutic work with Clarence in his extreme state? The acute ward of a psychiatric institution, with its complex and restrictive legal and administrative constraints, is an unlikely setting for psychotherapeutic treatment of people in extreme states of consciousness. Triage, diagnosis and short-term treatment are the functions of this system. Even if it were thought that psychotherapy could be of positive value in working with people in extreme states of consciousness, the gap between the patient load and the available therapeutic resources make the whole question seem absurd.

Experiences like the one I have described with Clarence occupy a kind of middle ground; they are not psychotherapeutic in the sense of providing healing through a "psychological" channel, nor are they psychiatric in the sense of (necessarily) producing a lasting and measurable change in the client's state of consciousness or level of functioning. Rather, they are aimed at addressing the client's total world of experience in the moment with the intent of temporarily restoring the client's capacity for metacommunicating about the totality of that experience.

This seems to serve at least two functions. In the event that the client is capable of and interested in gaining insight into his or her psychological processes, it may be possible, once the person can metacommunicate, to work on the person's relationship to the extreme state of consciousness. In Mindell's and others' experience, people are frequently able to widen the boundaries of their lives to include the disavowed experience implicit in the extreme state. Through embracing the disavowed and nearly inaccessible experiences locked up in those states, people discover callings as teachers, healers, spiritual leaders and even politicians.

Other clients are less interested in personal growth, or are less privileged in their access to resources for pursuing self-knowledge. For them, Process Work may not be explicitly therapeutic,

but can, in such cases, serve to elicit the experience which drives their states, and bring it to the attention of the collective consciousness as an instrument of social change.

Conclusion

Stories like the one I have told here show a direction for Process Work with people in extreme states of consciousness. This direction pays homage to Laing's original vision, but with an added ingredient. It emphasizes the experiential aspect of Laing's approach to extreme states while remaining open on the question of just whose experience we are talking about, and what ought to be done to make the whole extreme state experience less painful and less destructive. Process Work adds the element of a Taoistic approach which encourages all participants in an experiential process to unfold their experience, regardless if they are momentarily identified as healer, patient or bystander.

This work demands an extreme degree of flexibility and creativity from the therapist. At times the therapist must act like a physician. At other times, as golden-tongued Aaron spoke for a barely coherent Moses, the therapist must be the ambassador bringing the message of divinely inspired chaos from the back wards of psychiatric hospitals to a depressingly normal and often suicidal mainstream culture.

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Madness as Feminism

Dawn Menken

All of the kids knew who Angela was and most of them kept their distance. I was afraid of her too. She was twice my size and the toughest girl in school, the only girl I knew who could beat up boys. She really commanded respect. Although we were the same age, Angela had been kept back a year, so I never saw her in any of my classes. I would notice her across the school yard, lingering alone in the bushes, beating someone up or holding court with a group gathered around her. I had my own group of girlfriends. Angela was someone to watch out for, to make sure I didn't cross her path.

In fourth grade we had our first personal encounter. We were in the schoolyard during lunch and the bell was just about to ring to call us back inside. Angela approached me to play "colors." Only a few of us girls collected baseball cards. The cards themselves weren't the point for me, but I loved the games we played with them. "Colors" was a game in which a pile was created by each player putting down a card on top of the previous card. The team name on each card had a color. When one of your cards matched the color of the previous card, you would win the entire pile of cards that had been put down.

I was afraid to begin playing right before the bell, knowing that once you started you couldn't stop until one person had no cards. Being late to school was not part of my identity. But Angela insisted and I felt scared. We hunkered down next to the cool brick building and got serious. The more I won the more terrified I became. Not only was I going to be late to school, but I was beating the toughest girl in the whole world. I was convinced she was going to kill me. Since this game depended on luck, I couldn't even throw the game. There were other games which had to do with flipping and knocking down cards that were propped up against a wall; at least with these games I could lose on purpose and save my life. The next thing I remember was running wildly back to class with a stack of cards in my pocket.

Weeks later I somehow found myself standing in the bushes with Angela and her gang. I obviously didn't belong. I wasn't Italian and I wasn't Catholic and I was about to get the shit beat out of me. To my surprise, Angela stood in front of me. Alone, she prevented a whole group from tearing me apart. From an early age Angela was pressed to stand up against collective powers. This myth would later culminate in her tragic encounter with the psychiatric system.

My next meeting with Angela didn't occur until years later in Junior High School. We sat next to each other in chorus, enjoying the same songs. Carole King's album "Tapestry" had just come out and we would walk outside screeching, "I feel the earth move under my feet..." These moments of friendship were few. We came from different worlds, with some unspoken rule that our paths should never really cross.

Silver Lake had a reputation as a tough small town where first, second and third generation Italian Americans defended their turf and way of life. There were three Jewish kids in my grade besides me and a few kids who were Protestant. St. Anthony's was right down the street and all social life was organized through the church and local Catholic organizations. I was not merely an outsider. By the time I was twelve I was fighting daily for my survival against blatant anti-Semitism.

Angela must have had her own troubles. Although a key figure in the higher echelons of the Silver Lake gangs, she seemed awfully alone. Everyone knew and respected her, but no one seemed really close to her. Angela was tough,

loud, physically imposing and heavyset, not the kind of conventionally attractive girl who drew others to her. She was abrasive, always ready for a fight and often getting in trouble with authorities. Later her family and the doctors at St. Vincent's hospital crushed that spirit, leaving her unable to defend herself.

Music really brought us together, crossing cultural and ethnic boundaries, but that didn't happen until years later in high school. We would strum out simple chords and sing beautiful harmonies to the introspective and political tunes of the early 1970s. High school was larger and a little more diverse. We benefited from some of the liberal curriculum changes of the time. Humanities classes included social issues, women's studies, political movements and history. These put us in closer contact with the spirit of the songs we sang, expanding our views of ourselves and the confining town in which we lived.

Angela began to attend my humanities and women's studies classes. She was a grade behind me and tracked in different classes. Most of her educational history had been spent going to as few classes as possible, so it was quite a shock to see her going to classes she was not registered for. We'd pass each other in the halls. She'd yell, "see you in class," and I knew which class she meant. This class was team taught. We had never met teachers who invited us to call them by their first names, cursed, and spoke openly about sexuality. They challenged the way we saw the world by their own behavior and brought in ideas from outside the borders of Silver Lake. The radical zeitgeist of the early 1970s was seeping into the schools of small town U.S.A.

Something was happening to Angela. I had never seen her excited about learning. The old Silver Lake gang began to keep their distance and told her she should stop hanging out with her "Jew friends," hippies and freaks. She brushed off hurtful comments and held strongly to her new interests and friendships. I think I only saw the inside of her home a couple of times. She only came to my house a few more times. Bridging our worlds in high school was no less difficult than in junior high. My parents looked down on her and hers did the same to me. Our friendship blossomed in school, in the streets, in cars and in the woods.

The early 70s was an exciting time for an adolescent young woman. The women's movement was in full force and Title IV was passed, demanding equality in schools for girls' activities and sports programs. Female sexuality was shedding its shackles, pushing out of its culturally defined limitations. Many women from my generation lost our virginity without thinking of ourselves as "whores," "sluts" or "loose." Many of us dared to conflict with the beauty myth, wore our jeans and flannel shirts proudly, threw our bras to the winds and let our body hair be.

We all pushed limits with our parents, but Angela's struggle seemed more burdened than my own. I knew I would get out of this town. I knew my new ideas and impulses had a future. I knew there was a world where I could live all that I was learning and fighting for. I knew I would leave home and go to college. I think for a time Angela actually felt maybe she could get out. She refused to serve her father and brothers and began to stand for her dreams of living a life outside Silver Lake. She even thought she might attend college. In her traditional Italian family the roles of daughters and sons were laid in stone. No one left the family; no one even left the town. Even though Silver Lake was a 35 minute train ride to New York City, no one ventured out.

Angela's troubles became more severe. The higher her spirits, the more oppression this constellated at home. I wanted to save her, and I knew that according to her mother I was part of the problem. I thought in my teenage naïvete I could help her. I thought if I loved her enough, encouraged her enough, helped her find scholarships and financial aid, she just might have a chance. My own privileges blinded me to the complexities of the social issues she was dealing with. I sensed my privileges in my own embarrassment and discomfort about the future. I felt shy to admit that I would go to college, that my parents could afford to help me with tuition, and that I had the freedom to dream of other life-styles. It is a privilege to know that you can leave home and that your parents want you to. My parents saw the times changing and knew that I would go my own way regardless of how much they protested. Angela's parents kept to their old world views and enforced them with physical abuse. I could see the jealousy of generations of women holding her back, not allowing her to do things that they could never dream of. As a matter of fact, I saw that happen to many of the girls in my town, girls who had hope, vision and intelligence. I watched

them gradually trade in their independence and self-determination for the security of collective approval. And I watched Angela, a shining warrior blazing new paths and fighting impossible powers, but even all her years of toughness couldn't help her in the end.

In early Spring during our junior year, Angela hadn't attended school for a couple of days, so I called her up. "My father died," she said quite lightly. "Will you be at the funeral?" St. Anthony's was crowded and the Latin chants and heavy incense transported me to another world. Angela seemed strangely detached, waiting for it all to end. Some family and friends commended her for her strength and others attacked her for her lack of feeling. At last alone, she confided to me. She wouldn't miss him. At times she had wished him dead, wanting to free herself from the senseless brutality of a disturbed man.

Angela was not mourning and her mother didn't like it. Her newfound excitement flourished and we talked for hours about our latest ideas and discoveries. Angela's mother thought this sacrilegious and blamed Angela for her new interests. I became more frightened to call her home and never went inside when I would go pick her up. Angela became zealous about losing weight. Amphetamines helped her to curtail her appetite and gave her lots of energy to exercise. Her enthusiasm for learning and new relationships continued. One of those relationships was with Ms. B., a teacher Angela was fond of and who encouraged her learning.

One day after school we went to Angela's house. No one else was home. I felt uncomfortable, knowing I wasn't really welcome. My uneasiness grew when the lights went out suddenly. We were in the basement and Angela had turned the lights out. She searched for me in the dark. My heart beat rapidly and I yelled for her to put the lights back on. Something really strange was happening and I began to search for the door. I told her to cut it out, that she was scaring me and I wanted to leave. She said she wanted to kiss me and she'd turn on the lights if I let her. I followed the walls in the dark, dank room, hoping to feel a doorknob. Suddenly Angela was upon me, kissing me. I struggled to get out from under her. "Okay, now let me go!" I screamed, scrambling to my feet. She turned on the lights and I fled outside.

I needed to go home where I was expected for dinner. I had just gotten my driver's license and had my parent's car. I walked to the car and realized my jacket and keys remained inside Angela's house. As I walked back Angela sauntered out, dangling the keys before me. She closed them in her fist, saying she wouldn't give them to me unless I kissed her. I became furious with her, screaming at her to give me the keys and let me go home. I was already late. It was getting dark, and my parents were going to be angry. She came after me, pinned me against the fence, pressed herself against me and tried to kiss my neck. I thrashed out wildly, trying to get away. She slapped me across the face. In the struggle the keys fell to the ground and I grabbed them. I ran desperately to the car. She followed. Each time I attempted to open the door she pushed herself in the car with me. It seemed to take forever to get myself in the car with the doors locked. Finally, I could go home.

But Angela became more desperate and more reckless. She jumped on top of my parents' car and pounded on the roof. Then she took a huge stone, smashed it down on top of the roof, glued herself to the windshield and dared me to drive. By this time I was hysterical. Tears of hurt, anger and desperation rolled down my face. Something had flipped in Angela. I felt like a trapped animal willing to do anything for my survival. I slowly began to back the car out of her driveway, hoping she would jump off, but she clung to the windshield wipers. I opened the window and told her to get off the car. She refused and again I felt cornered.

I drove up her street to the stop sign, all the while honking my horn and yelling for her to get off. She didn't move and pleaded with me to let her in the car. I felt terrified, praying for her to get off the hood before I turned onto the main road. She wouldn't move, and in my own panic and desperation, I turned left on Lake street with Angela hanging on the hood. I honked my horn hoping someone would come out and help. After driving about a third of a mile I realized she would not move and could really get hurt. I pulled into a local Italian restaurant and leaned down on my horn. The waiters came out and laughed at the sight of Angela hanging on my car. I pleaded with them to get her off, but Angela knew everyone. She addressed them all by name, telling them to go inside, that everything was all right. I was shocked and incredulous that they did nothing despite the fact that I was crying and screaming. Finally, a police car drove up and Angela jumped

off the car. They sent me home while Angela pleaded with me to take her home too. The police asked about the damage to the car and I told them to forget it, that Angela should go home too.

I was crying and shaking when I arrived home, terrified by having to explain the damage to the car and consequently reveal the whole story. The next day at school I felt dazed and tried to keep a safe distance from Angela who searched for me throughout the day. At the end of Ms. B's class, she found me and lunged towards me. She chased me through the maze of chairs and desks until Ms. B. came between us. Ms. B. talked to us each separately. I broke down and confided in her. She told Angela to give me some time and space. I felt afraid of Angela, but I also wanted to maintain our friendship and didn't want to reject her.

Angela's extreme state unfolded in the following days. She was found naked and disoriented in a deserted lot close to her house. At home she shocked her family by sprawling naked on the living room couch, publicly removing her tampon and throwing it in the air. She then threw used tampons and sanitary napkins all over the house and refused to put her clothes on. Another day she was found jogging naked on a busy highway. The next thing I knew she had been institutionalized and I was fighting the authorities to allow me to bring her guitar to her.

I visited her regularly despite the negative vibes from my parents and her mother. For some strange reason I remained oddly detached from our incident. I saw it as part of a larger process that she was involved in. It felt strangely impersonal to me. I missed her friendship and spent many hours wondering what had happened to her. Although I knew nothing about extreme states, I developed my own theory. My teenage brain concluded that the world of her conventional family had no room for all of her dreams and passion. She couldn't deal with the tension between the two worlds and she cracked.

Even back then I knew culture and extreme states were somehow connected, although I couldn't have said how until I studied Process Work. I was convinced that if Angela had had support for her deepest nature she wouldn't have gone "crazy." What I didn't see at that time was the meaningfulness of her extreme behavior, not only for herself but for the collective around her.

Angela was one of many women trying to become herself in the midst of cultural oppression. Even with a trend towards women's liberation and progressive education, Silver Lake remained as conventional as old Italy. One reason I am telling this story is because it reflects the stories of many women who have had to become extreme in order to break out of terribly oppressive conventions. Often when women have dared to do this, they have been institutionalized.

Women and "mental illness"

Statistically, more women than men have been institutionalized for mental illness (see Chesler 1972).[1] In her book *Women's Madness: Misogyny or Mental Illness?* (1992) Ussher asserts that such statistics are not due to the female gender being more prone to mental illness, but result from a world cultural history that oppresses women. She says:

> ...misogynistic practices are construed as analogous to the discourse of madness, in that they act to contain us, and as a part of the constrictions which lead to madness itself because they create a culture of incarceration and oppression within which madness is the inevitable outcome for women. (20)

Angela dared to venture out of her role as a daughter, whose sole purpose was to be subservient, find a husband and have a family. The history of marriage is not based on the dream of romantic love and partnership, but on ownership; women as property, owned by men (Chesler 1972; Ussher 1992). Chesler postulates that many women have gone "insane" to avoid marriage and the conventional life-style expected of them. Therefore, the following statistics come as no surprise:

- Women who rejected the domestic role have a higher chance of rehospitalization (Chesler).
- Female schizophrenics conformed the least to social roles, even as children (Chesler).
- A 1958 study confirms that when people act outside of their gender roles they are more subject to hospitalization (Chesler). Ussher's more recent research confirms these findings as well.
- Lesbians are committed at earlier ages than heterosexual women and are kept three times as long in institutions (Chesler).
- "Less educated and more 'attractive' women are probably released sooner and more easily from state hospitals and from private treatment." (Chesler: 69. From Orr, Anderson, Martin Des. F. Philpot 1954).

- In 1964 the number of American women involved in the psychiatric system began to dramatically increase (Chesler).[2]
- Sixty-nine percent of suicide attempts are by women (Chesler).

Angela became one of these statistics. As she remained in the hospital, I sadly watched her spirit die. Her enthusiasm for life and learning vanished; even music held little interest. Her eyes glazed over and she seemed to move through a haze. Heavily medicated, she became disoriented and emotionless. She didn't relate to anyone, even those of us who had been close friends. She looked defeated and empty. I mourned the loss of a friend and a great spirit. Visitors were forbidden for a period of time; finally I got to see her again. Upon arriving I discovered that she had been given a series of electro-shock treatments.[3] I felt horrified and saddened. Angela had become a zombie, a human being with no personality, no color, walking aimlessly through the corridors. I couldn't reach her. She was gone. They had crushed her spirit, her music, her zest for life and our friendship. I too was defeated. At sixteen, I felt powerless to interact with the system that had done this.

The doctors and her mother all said this treatment was for her own good. They saw it as therapeutic; with time she would eventually be released and lead a "normal" life. They expected her to be able to hold down a job with minimal stress and intellectual requirements and to develop a social life through which she would eventually meet the man of her dreams and settle down. Ussher (1992) questions for whom this treatment is therapeutic. She asserts that such treatment does not serve the needs of the women themselves, but is meant to maintain the dominant societal order. In my opinion, this treatment certainly did not serve Angela.

City shadows: honoring Angela

Mindell's central contribution to the field of psychiatry postulates the concept of a "city shadow" which furthers our understanding of so-called psychotic or extreme states and their relationship to the collective. Mindell adopted the neutral term "extreme state" in order to show that certain states are deemed "psychotic," "crazy" or "insane" relative to the cultural norm. The word "extreme" implies that these states occur relatively infrequently for a given culture. Thus the dominant culture has difficulty understanding them and considers them unacceptable (1988). In her historical review of women's madness, Ussher sees this similarly. She asserts that "...madness is not an illness but a social construction" (1992: 166).[4] Chesler proposes that:

> Men are generally allowed a greater range of 'acceptable' behaviors than are women. It can be argued that psychiatric hospitalization or labeling relates to what society considers 'unacceptable' behavior. Thus, since women are allowed fewer total behaviors and are more strictly confined to their rolesphere than men are, women, more than men, will commit more behaviors that are seen as 'ill' or 'unacceptable.' (39ff)

Mindell demonstrates that the individual in an extreme state is a city shadow, displaying behavior that goes against the collectively accepted consensus of the norm. This individual acts like a dream figure for the collective, embodying behavior split off from mainstream consciousness. Mindell explains:

> This shadow is like the city's dream portraying its neglected gods, the hopelessness it will not admit, its withdrawal from superficial communication, its suicidal tendencies, mania, addictions, murderous rage and hypersensitivity. The shadow reminds us of the smoldering revolution we normally perceive only in the dark of night or in the impinging quality of physical symptoms. (1988: 162)

I had always seen Angela's "odd" behavior as a manifestation of the terrible social and inner pressures she was under. However, I want to honor her here by acknowledging her as a city shadow for the town we grew up in, the school we went to, the families we came from and the larger world around us. Her extreme state is a collective dream, a message for us all. We are the dreamers challenged to grow.

When I began to research women's extreme states relative to culture, I found numerous cross-cultural taboos regarding women's behavior. Most of these are associated with the body, sexuality, reproduction and menstruation (Ussher). There are volumes of study about this; I offer a few tidbits.

Ussher (1992) offers a brief history of the menstrual taboo. Women have been seen as contaminated and unclean when menstruating, barred from worship and work.[5] A man who risks sexual intercourse with a menstruating woman

could become impotent or brain damaged. Women are thought to not be able to think clearly when they have their periods. A menstruating woman could cause crops to fail or fruit to rot. These things might seem outdated to the modern reader: however, menstruation is still used as an excuse that women cannot perform as well as men in the workplace. Women's emotions, moods and ideas are often dismissed and not valued during menstruation. Pre-menstrual syndrome (PMS) can be used as a medical way to further categorize and dismiss women. Additionally, the sense of being dirty is still with us, whether as an attitude held by men or internalized by women themselves.

Women have been seen as sexually out of control if left on their own. Women have been kept under lock and key with chastity belts. Cultural morality has held the keys to women's virginity. Openly sexual women were accused of being witches. Chinese women endured foot binding so they would be more sexually attractive to men (Chesler, Ussher). Millions of females worldwide succumb to genital mutilation; one of the background myths is that female genitals left intact will grow down to the women's knees and make them sexually ravenous (Walker and Parmar 1993). Lesbian sexuality has been taboo throughout the ages; these women have been viewed as witches or pathologized and incarcerated (Ussher). Homosexuality remains illegal in many parts of the world.

Ancient and modern practices which denigrate the female body and control female sexuality are central to misogyny. Cross-culturally, generations of women have existed solely to please others. These misogynist attitudes have seeped into the female psyche, tarnished self-esteem and encouraged self-hatred. Women feel torn, longing for love and acceptance for their innate selves, while they simultaneously strive to achieve the cultural female ideal by inhibiting and molding themselves into the culturally acceptable female form.

Angela was caught in this vicious struggle. She broke familial and cultural rules and simultaneously fanatically exercised and starved herself to attain the norm. Like most women, she was split between embracing mainstream ideals and fighting against them. In her extreme state the cultural chains were broken and everything forbidden was released. In a culture that shamed her for her heavy body, wanting her to hide her flesh and disguise her appearance, she stripped naked. In a culture that is repulsed by women's menses and that teaches us ultimate discretion during these periods, Angela acted flamboyant, rambunctiously forcing us to notice a natural female beauty. In the extreme state, the naked woman in her natural state is unearthed!

Angela's behavior also broke relationship taboos. In a world that condemns same gender love, in a country where the highest teenage suicide rate occurs amongst gay teenagers,[6] and in North American high schools where the nastiest insult is to call someone "queer," "fag," or "dyke," Angela dared to express her desires.

In a world that has been so unconscious in the area of relationship and sexuality, relationships have been monitored for all kinds of potential abuse. Therefore, when Angela gave Ms. B. a Mother's Day card with her deeply expressed sentiments, Ms. B. blamed herself. She felt she should have remained more distant and abruptly pulled away from Angela. Such relationship regulation spoils spontaneous and life-transforming relationship contacts. Angela broke this taboo as well, seeing correctly that Ms. B. mothered her more than her own mother did.

Angela also broke the convention around mourning her deceased father. I know she suffered this conflict greatly. She felt incredible pressure to grieve and many people in her environment criticized her distant demeanor. Beneath her coolness lived years of pain and fury from being hurt and mistreated. If she had been able to totally throw off the chains of social convention, perhaps she would have celebrated, free at last from a man who had never been fatherly.

Mainstream thinking is zealously moral about relationships, regulating the kinds of relationships and behavior it deems acceptable. Angela's state gives us a glimpse of a world in which nature or spirit creates relationship life, not humans or morals. Nature draws us to someone regardless of their gender, position in society or racial and ethnic background. These are matters of the heart, not of laws or morality.

Extreme states and the mainstream

Extreme states remain difficult for the mainstream because they not only threaten basic cultural beliefs and norms, but they generally manifest themselves with little regard for mainstream feedback. There is usually little interaction

around the extreme state. Fear and shock result in mainstream withdrawal and rejection. We often feel threatened by the unusual and try to stop it, unable to appreciate and unfold its inherent intelligence and meaning. Such fear also indicates our lack of familiarity with our own internal and altered states of consciousness.

In the acute phase of Angela's extreme state, she no longer adapted herself to the behavioral expectations of the mainstream. Her inability to pick up feedback from the environment and adjust her behavior accordingly allowed her to live her dreaming process completely. Mindell states that the lack of picking up feedback is not a pathological feature but can be observed in each of us at one time or another. We become unconscious of outer phenomena

> ...in order to preserve and complete the inner story or myth (we) are working on. In other words, having no feedback loop functions to keep (us) in (our) own dream world, and this is a function of unconsciousness which can be observed in all of us. (1988: 39)

Since we all have difficulties relating to our own extreme and unconscious states, we lack the ability to relate to others in those states.

Mindell has demonstrated that when we experience an extreme state we lack a feedback loop and cannot metacommunicate about our experiences. The lack of a metacommunicator, a part of the person that is able to meta-comment on experiences as they occur, over an extended period of time is a central aspect of extreme states. Mindell describes a feedback loop as what occurs when an individual adjusts her behavior to the opinions, expectations and signals coming from the environment. A missing feedback loop can be another characteristic of extreme states; this lack of outer adaptation enables the individual to remain in her inner process. The identity which normally adapts to outer feedback is not accessible. There is little regard for what were once personal or collective edges. This disregard allows new parts of ourselves to emerge. Not in contact with the edges of her identity, meaning collective norms and her own personal inhibitions, Angela temporarily lived parts of herself otherwise forbidden. Not only did she step into the dreaming world of her own personal psychology, but her behavior was a dream for her environment as well. Extreme states such as Angela's portray the dreaming drama of a given culture, showing us our collective conflicts by revealing that which we disavow (1988).[7]

Angela was not able to pick up my negative feedback to her advances and I was not able to relate to the shadow she revealed. I can only praise her now for carrying the ghost of an irrespressible woman and having the soul to tread unknown land in a town that stood against her, in an environment that eventually destroyed her spirit. But the essence of that spirit can never be destroyed. It is the eternal spirit of Kali, the mythical goddess of Indian culture, dancing in her innate female pleasures and furiously stomping the collective which has downed her (Guirand 1959; Hoch-Smith and Spring 1978). Her spirit is evoked today throughout the world as women struggle, not only in the field of psychiatry, but as all of us try to live our most genuine inner natures. This is liberation for women and for men—a human liberation, free from culturally induced roles. Angela takes her place in centuries of women who have foreshadowed this revolution, blazing the trail for many of us to come. I pay homage to them all.

Notes

1. Also, see Ussher 1992, for information on recent studies in Britain, Europe and the United States which confirm these statistics. Ussher refers to studies that indicate that women are referred more frequently for mental health services than are men. Psychotropic drugs are prescribed for women twice as frequently as they are for men, and more women receive ECT (electrò-convulsive therapy, or electroshock).
2. I think this is due to the zeitgeist, the beginnings of the women's liberation and civil rights movement; a time when many women began to conflict with their limited roles and began to seek psychiatric help for their unhappiness.
3. Ussher, 1992, presents various studies showing that ECT is more widely prescribed for women than men (108). From her footnotes: "Malla (1988) in a study which examined 5,729 psychiatric admissions over three years reported that the 1,236 patients who received ECT were more likely to be female and older than the patients who received other treatments. Breggin (1979) reported that 80% of patients who receive ECT in one USA hospital are women, because its disabling effects are deemed less problematic in women" (124).
4. Mindell's ideas about the city shadow also find support from those in the so-called "antipsychiatry" movement. Ussher presents such theorists as Scheff

and Goffman who argue that "...all madness is dependent on social and cultural values, not scientific objectivity. Psychiatry is thus seen as an agent of social control" (1992: 135). She also presents various authors who assert that pathological behavior has a definite cultural bias and gives examples of how definitions of madness are inconsistent between various cultures and societies. (135; 138).

5. See also Lara Owen, *Her Blood is Gold: Celebrating the Power of Female Menstruation.* San Francisco: Harper, 1993.

6. A study compiled by the Hetrick Martin Institute in New York in 1992 revealed that gay teenagers are two to three times more likely to commit suicide than heterosexual teens. The Secretaries Task Force on Youth Suicide at the Department of Human Services in 1989 also reported similar findings.

7. See Mindell, *City Shadows*, Chapter 3, for a deeper theoretical discussion about metacommunication, feedback loops and the connection between extreme states and field theory.

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Making Extreme States Meaningful

Moses Ikiugu

Introduction

This article is based on the author's experiences as a therapist in a psychiatric hospital. Most people who have worked in psychiatric hospitals know the frequent sense of futility and meaninglessness in working with people in extreme states. The author especially experienced this in Kenya, where rehabilitation programs are not comprehensive enough. Therefore, patients are frequently readmitted a week or two after discharge. This produces a feeling in therapists that they do nothing useful. Although no survey has been done to establish the following assertion, it is highly probable that this feeling is a big factor in the "burnout" of mental health workers in Kenya. Such workers often lose all interest in their work, and sometimes even treat patients cruelly.

This state of affairs led this author to search for better ways to work with people in extreme states. Through his search he fell into counselling and later studied Process Work. Over the course of his studies, he discovered the ideas that inspired this article.

If we want to be of maximum help to people in extreme states, we need to change our attitudes towards "mental illness." We need to start viewing it as meaningful rather than just a pathological problem. This brings up two questions: why a change of attitude is necessary; how this change in attitude affects therapy.

Mental health is defined in various ways. One definition is as follows:

1. the ability to make harmonious relationships;
2. the ability to be socially active and to be able to interact constructively with one's physical environment;
3. the ability to balance and harmonize conflicting internal instincts.

Here, the author wishes to note that "harmonious relationships," "interact constructively" and "balance and harmonize internal conflictual instincts" are concepts applied from the viewpoint of "normal" people. A "normal" person follows his/her society's norms. Normalcy in this line of thinking is a statistical phenomenon; the majority of people believe and do "A," therefore "A" must be the norm. "Mental illness" is a deviation from such norms. "Meaning" refers to the feeling of orderliness and purpose to an otherwise chaotic event. These definitions form the basis of the discussion in this article.

Why a change of attitude is necessary

The biomedical approach to mental illness sees a person in an extreme state as dysfunctional and needing to be fixed (Wilson 1982). The approach is to repair whatever is organically wrong and the person will be cured. "Cure" in this sense means that the person starts functioning in ways the majority considers "normal." As Wilson (1983) points out, this view sees a human being as a "machine" with different parts (biological systems) that should work together for efficiency. This frame of reference is the typical Newtonian approach to life (Mindell 1985a), involving cause/effect relationships governed by clear natural laws. In this view, the natural laws have only to be discovered in order for humans to control things. This frame of reference allows us to correct whatever may be physically wrong. Through medical procedures, we are able to correct a host of anomalies in the human body. The biomedical

approach is as useful to the human body as Newtonian physics is to the creation and repair of machines. However, we need caution here. As Newtonian physics holds the view that we can understand and control anything, so biomedical science tends to believe we can understand any human phenomenon and bring it to "normalcy." This may not prove to be true.

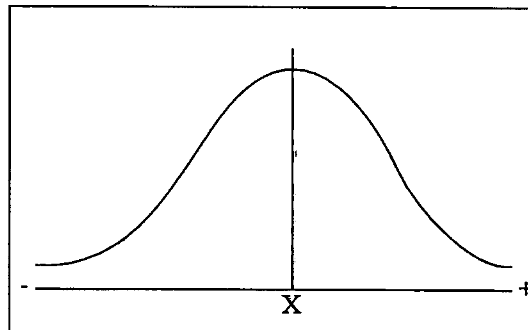
Newtonian physics was challenged when Einstein introduced his theory of relativity and when quantum mechanics was introduced (Mindell 1985a; Hawking 1988). Physicists discovered that physical laws do not explain everything, and that a cause and effect relationship is not always clear. They found that non-local causation is sometimes in operation, as when a photon is automatically released and moves parallel to another photon that was intentionally released although there is no known connection between the two (Robinson 1983). Similarly, biomedical science cannot explain and deal with all human difficulties. Trying to do so would be overstepping its boundaries. The biomedical view that whatever is disagreeable to the norms of society is wrong and needs correction or cure probably needs some revision.

There is also evidence to show that the boundary between "normal" and "abnormal" in mental health is quite a problem. The definition of what is normal or abnormal varies from culture to culture. Augsburger (1986) for instance tells us that:

> Effective mental health is measured by self-reliance, self-sufficiency, inner-directed responsibility for oneself, and an internal sense of personal identity...in the West. In Eastern cultures these traits are considered undesirable, abrasive, and disruptive of harmonious social relationships. (139)

Such obvious disagreements make one wonder what exactly comprises mental health and mental illness. Can a person be "mentally ill" in one society and become "mentally healthy" when he/she shifts to another society? If that were the case, it would be utter nonsense to even talk about mental health and mental illness. Such is the position of this article.

Furthermore, we can prove mathematically that concepts like "normal," "abnormal," and "chance" are meaningless. Let us take one of the basic truths of statistics, that all phenomena are distributed naturally in a certain predictable pattern. This has resulted in what in statistics is referred to as "the normal curve" (Jaeger 1990). The normal curve looks as follows:



The above diagram shows that for any phenomenon, the natural distribution is such that most of the phenomena clump together in the middle and only a few go to the extremes on the positive or negative side of the mean (X). This is true regardless of the phenomenon: height, weight, intelligence or even what we call "mental health."

This means that for any recurring phenomenon that happens by chance, there is a high probability that it will occur in a similar fashion each time it happens. One may argue that there are chances that an event will happen differently and such happenings will be "abnormal" since they do not fall in the average. However, even such happenings are predictable as shown by the tails of our normal curve, and are therefore normal happenings; it is quite normal for certain events to go to the extremes.

It is common for us to see events as abnormal when we do not understand them. We may also consider events that we do not understand to be chance or meaningless occurrences. From our normal curve, however, we see that it is meaningless to call an event a chance happening. If we take this view, we may start to see all events, including extreme states, as essentially meaningful.

Mindell (1988), Szymkiewicz (1992) and Stewart (1992), among other writers, have embraced this view. Mindell (1988) views psychiatric conditions, although we may not understand them, as altered states of consciousness which are highly structured and meaningful. If we look closely at psychiatric conditions, we start noticing highly structured and meaningful patterns that recur with almost mathematical precision. Moreover, as Mindell points out, we all have these states,

although we do not all access them. Most of us are aware of how we go a little crazy, or into an altered state of consciousness, for instance when we are annoyed or have so many things on our minds that we talk to ourselves.

People in extreme states represent what Jung (1974) calls our "shadow," the side which we have disowned and cut off. There always seems to be a certain percentage of "crazy" people in any community. This number neither increases nor decreases but seems to be the same percentage of the population. For instance, studies of the epidemiology of schizophrenia show a high similarity in prevalence of this condition across many countries. It ranges between 0.1 and 2 cases per 100 people (Gelder, Garth and Mayon 1983). Even where an increase in prevalence is noted, it does "not necessarily reflect increased incidence, it may reflect differences in the duration of illness" (229). It is possible that the distribution of other psychoses behaves similarly. The shift that we make in our thinking when we consider this phenomenal constancy of mental illness can be enormous.

This phenomenon is similar to Lovelock's discovery in the 1950s that oxygen always makes up 21 percent of the total atmospheric gasses (Mindell 1989; Walsh 1990). Lovelock noticed that this constant percentage of oxygen is not all that logical. Oxygen should combine with other gasses and therefore its proportion in the atmosphere should decrease. He concluded that nature seems to regulate these gaseous proportions for the maintenance of life. He theorized that our universe behaves like a living being with different systems working together. This discovery brought a shift in many people's thinking. They started viewing and treating the universe as a living thing. The Gaia hypothesis resulted from Lovelock's discovery. Similarly, if we accept that people in extreme states occupy a certain percentage of the total population at all times, then we start to see that "mental illness" probably plays a very significant role in our human system.

Thus, we may start viewing extreme states as meaningful rather than as pathological. This shift in viewpoint becomes even more potent when we realize that we all have "crazy-like" states. For instance, these states may emerge when we conflict with others or fall in love. When we take mood altering or hallucinogenic drugs, we may become manic or experience hallucinations. When we enter a psychological crisis, we may start talking to ourselves. When we get drunk, some of us become extreme. These states are potentially useful to us. However, we rarely accept them as parts of ourselves, but instead attempt to disown them.

According to Mindell (1988), people in extreme states remind us of the parts of ourselves we have disowned. They express unconscious aspects of so-called "normal" culture and can remind the mainstream of the occasional desire to escape reality and to live extremes. This view of mental illness challenges us to respect and trust the process of extreme states. People in extreme states become not only occupants of an important role in life, but also become teachers about how to "individuate" (Jung 1974), or to become whole by incorporating more parts of ourselves. This is a very different view from the mechanistic one that sees people in extreme states as broken machines to be fixed. For a person who is labeled as mentally ill, this view has serious implications.

Implications of a shift in attitude for people in extreme states

This shift in attitude towards "mental illness" carries enormous meaning for people in extreme states. A natural drive for many individuals, healthy or not, is the search for meaning. This search for meaning is often not so explicit in our culture, but it is there nevertheless.

The biomedical approach does not address the question of meaning because, as Deikman (1990) says: "...either the question lies outside the scope of science or that the question is false because the human race has developed by chance in a random universe." (201)

However, we need to know what we aim for in working with people in extreme states. It seems that rather than labeling people, calling them schizophrenic, manic, depressive, etc., it is better to aim at helping to find meaning in their illnesses. Labelling people is in itself harmful to a person. As Augsburger (1986) tells us:

> From this view, the label "mentally ill" is a stigmatizing and brutalizing assessment in any society, particularly those of the West. It robs the person of identity through profound mortification and depersonalization and forces an ascribed role with an extremely difficult exit. (317)

This author is aware of this brutalization from his work with people in extreme states at Mathari

Mental Hospital in Nairobi, Kenya, where he and some colleagues started a therapy group for the patients. Those who participated in the group had already been treated with drugs and many were ready for discharge. Some of them were concerned about going home to a society that would not accept them. They said that they were referred to at home as "x" (meaning those who had been in psychiatric hospitals). Thus, they could not make intimate friends, and could not find marriage partners if they were not already married. This stigmatization makes their lives meaningless.

Very often their treatment in the hospital is similar to what happens outside the hospital. Mental patients are categorized when they are given a diagnosis, and the treatment focuses on having the patient take drugs. The questions of what their lives and their illnesses might mean are not addressed. The treatment of these patients seems to confirm Deikman's suspicion that:

> It may be that the greatest problem confronting psychiatry is that it lacks a theoretical framework adequate to provide meaning for its patients, many of whom are badly handicapped in their struggle to overcome neurotic problems because the conceptual context within which they view themselves provides neither meaning, direction, nor hope. That context derives from the modern, scientific world view of an orderly, mechanical, indifferent universe in which human beings exist as an interesting biochemical phenomenon—barren of purpose. (1991: 202)

This article proposes a framework that requires the therapist to view extreme states as meaningful processes from which a person can learn and thus experience life as more whole and full. Working from this framework, the therapist encourages the client to believe that his/her experience has a meaning and to trust it and try to learn from it. Glasser (1965) says that there is nothing wrong with people diagnosed with mental illness but that they are individuals who are unable to fulfill their essential needs. He maintains that symptoms disappear when people successfully get these needs met.

This author agrees with Glasser that need fulfillment is a basic element of human life and considers one of the greatest needs to be the need for a sense of meaning in life. The point I wish to make here is that showing trust in a client and his/her extreme state can help the person trust that the state is not pathological, but a meaningful, personal process that can lead to growth and wholeness if it is fully discovered. As we will see in subsequent pages, this simple change of attitude can have a very dramatic effect on the client. In short, if we change our attitude towards "mental illness," we may stop putting labels on clients and recognize them as individuals who are playing an important role in life. We may even see them as teachers modeling wholeness for the culture. This shift in attitude has many implications for the practice of therapy.

How this attitude affects therapy

Trusting that everything that happens to a client is meaningful comes directly from Jung's teleological approach to psychology (Jung 1965; 1974). Jung believed that anything that happens in life is meaningful. This approach was developed further by Mindell in his formulation of the dreambody theory (Mindell 1982). Dreambody theory suggests a background field of energy that organizes our experiences. What we experience through various channels of perception is the dreambody trying to communicate to our conscious selves. A group of people, such as those prone to extreme states, can channel expressions of the dreambody as it tries to communicate to society. Individuals are drawn to a role by the dreambody, much as a magnet draws iron filings to various poles.

With this view, the therapist approaches the client with an appreciation for and trust of the process behind the illness. The therapist believes that illness is a natural process and trusts its wisdom. If followed, this wisdom brings wholeness to individuals and systems. This attitude is what Amy Mindell (1991) calls a metaskill, a feeling approach to life. This particular metaskill has to do with the sensitivity to the human need for a meaningful life.

This attitude helps the therapist view the client as his/her teacher and to learn from him/her. Stewart (1992) writes about how she went to work with the homeless in a bid to help them and instead became their student. The mainstream often considers many of the homeless to be lazy bums or vagabonds. Among them, however, Stewart discovered great poets, philosophers, and those committed to a life passion. She eventually learned how to bring so-called "laziness" into her

life so that her work was more enjoyable and fun. The following is a story about a woman who helped Stewart explore her own relationship to laziness through interacting with someone "lazier" than she was.

> I was in Yachats, Oregon, when a neighbor woman, an Oregonian, told me that every evening the whole village gathers at the ocean to watch the sunset. Even when it is rainy and foggy and there will be no sunset, they meet at the ocean. She warmly invited me to join them. I liked the invitation and I thanked her. I ran into her the next morning. "Where were you last night at sunset? I was looking for you. I missed you," she said. I had forgotten completely. I was disappointed. The woman looked at me with a peculiar expression on her face, as if to say, "How can you forget a sunset, what else is there in life to do that matters more than watching a sunset?" (71)

This example teaches us that what we see as "laziness" may well be a reflective mood that appreciates the simple mysteries of nature. In our success-oriented culture, we tend to forget to appreciate the fact that we are alive. The "bums" in our world can remind us to balance our lives by being a little bit slower, more appreciative or "lazy" at times.

Trusting that what happens to a client is meaningful also helps us communicate with people in their own styles. Szymkiewicz (1992) writes about how she was able to communicate with developmentally delayed teenagers in cases that were considered hopeless. One fascinating case was her work with a boy whom she calls "Nick."

> Nick is a tall, handsome, 16 year old boy. He has blond hair and blue eyes. I had been working for a month already when I first met him. He came back from holidays he spent with his father (his parents are divorced, and his father takes care of him during holidays and most of the weekends). Nick did not want to stay. He seemed to be very tense, his movements sharp and determined. There was a lot of noise around staff members trying to stop him and his father talking about how hard it was to leave him. Somebody said father should go, while Nick kept repeating "being a good boy" and "sorry." I couldn't understand what was going on. Nick is labelled as "mentally retarded with autistic tendencies." He is very tense most of the time. He presents a lot of fixed behavioral patterns (called "obsessive"); if such activity is triggered, he will fight to finish it no matter what the obstacles. (42-43)

Szymkiewicz worked with Nick by trusting that his autistic and "obsessive" process was meaningful. Nick was considered difficult to communicate with, but due to her attitude of trust in the manner of his behavior, she communicated with him. In the end, Szymkiewicz helped Nick contact a restraining side of himself that commanded him to be a good boy, "a policeman" while at the same time staying in touch with the rebellious side that wanted to run away from the restraining policeman. She also appreciated the fighter in him who would fight to complete whatever he wants to do. This is the "obsessive" part of him. By appreciating and communicating with all these different parts of Nick, Szymkiewicz established communication which worked better for both Nick and the staff who worked with him.

Thus, the teleological approach enables the therapist to help discover, unfold and transform what appears as problematic behavior into useful and meaningful parts of a person's life. Mindell (1992, in *The Journal of Process Oriented Psychology* Vol. 4 No. 1) tells a moving story of how he discovered love in a seemingly menacing young man in a prison ward of a state hospital. "The young man had been accused of killing his girlfriend in an automobile accident. He appeared to be pretty menacing now. He was tough and apparently brutal" (53).

Mindell began arm-wrestling with the young man. This was to affirm his "toughness" which is probably often condemned. The two of them do many other things together and finally Mindell verbally tells him how strong he is."'Nay, ain't true,' he said. 'I also got a big heart.' Shocked, we were all touched, amazed by his change" (54).

By appreciating and communicating with his often condemned "tough" process, Mindell was able to get beyond the toughness to the side of the young man who "also got a big heart."

Finally, trusting the patient's disease process, the therapist helps the patient discover what his/her life is all about and to follow his/her fate through conscious choice. This author once worked with a client who had been discharged from Mathari Hospital. The client had the nega-

tive symptoms of schizophrenia. He slept most of the time and did nothing. His mother washed his clothes for him. The young man himself was able to bathe and was quite clean. At home, he was described as being withdrawn and not communicative.

At first, I worked with this young man, whom I will call "Patrick," in the usual biomedical way. I assumed that these symptoms were wrong and to be alleviated. So, I made beautiful programs for the client to follow which included doing some cleaning during the day, helping his younger sister with her schoolwork in the evening, and playing games such as checkers with his brother and sister. The client failed to follow any of these programs. So, I decided to change my approach. I suggested that Patrick follow his tendency to withdraw and do nothing. I told him to imagine a life where he didn't have to do anything or talk to anybody. After a while, Patrick said that he was trying to be a writer but nobody would understand him or take him seriously. I thold him that he could actually be a writer. Together, we explored the possibilities of his writing something.

Together, we discussed how Patrick also needed to earn a living in order to write. Patrick concluded on his own that he had to go to college first. The next day he was looking for a college. Unfortunately, I left the hospital before seeing if Patrick was successful. However, we see that Patrick's seemingly negative symptoms were actually meaningful. He needed encouragement to detach, study and write about his life from an objective point of view. But he was misunderstood, and the label of schizophrenia became more important than trying to find the meaning of his behavior. By changing my attitude and subsequently my approach, I could communicate with this client meaningfully. As a result, the client almost miraculously came out of his private world to follow his life myth in the world. The above examples illustrate that by simply changing our attitude towards extreme states we can have very dramatic and positive results in therapy.

Conclusion

This article proposes that in order to be of maximum help to people in extreme states, we need to change our attitudes towards so-called mental illness. This requires a shift of paradigm, so that instead of seeing mental illness as merely pathological, we see it as a meaningful and essential process. This process is important not only for the growth of the patient but also for the growth of the human system. Extreme states can then be viewed as an expression of the individual and collective dreaming process. Seeing extreme states as meaningful psychological processes can have the long-range effect of helping the mainstream to appreciate and consider as teachers people in extreme states. Additionally, this attitude helps any of us dealing personally withextreme states to trust ourselves and our disease process. As we have seen in the discussion above, this attitude towards extreme states holds far reaching implications for psychotherapy. The author believes that it is beneficial for every therapist to eventually attain this viewpoint.

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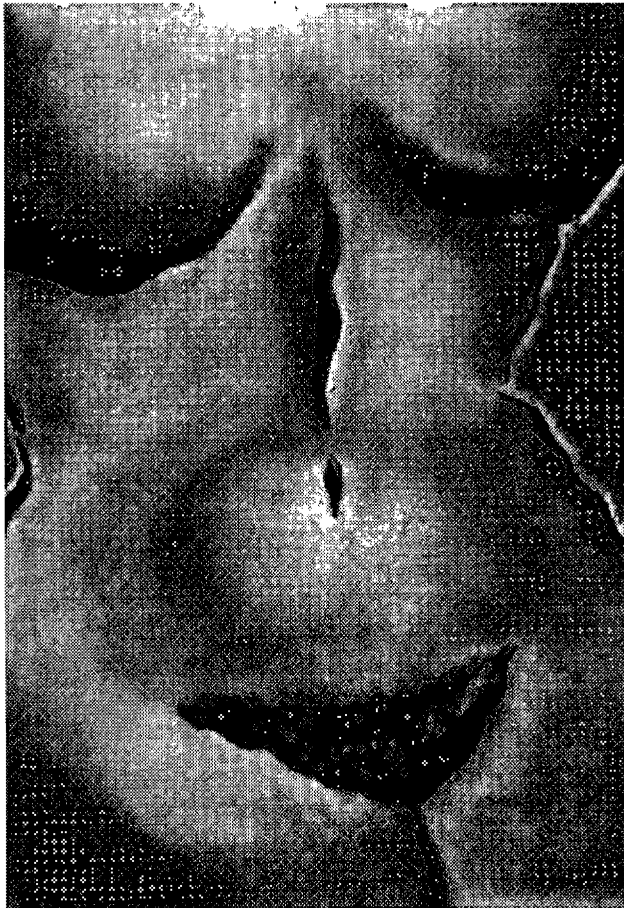


"Efflorescence" by Linda Greischel

Being Prozac

Janiese Loeken

I am a psychiatrist working in a health maintenance organization (HMO). I live in a world where Internet has replaced aboriginal mental telepathy, Tonya Harding news supersedes news of suffering in Sarajevo, jokes about the Bobbitts surpass the wisdom of true humor, the Dow Jones Average matters more than dreams, and Prozac threatens to surpass aspirin in popularity.

I feel troubled by the indiscriminate use of medications in psychiatry, but also recognize that clients benefit when they take them. This challenges me to find new ways to integrate medications and to make their use more meaningful, rather than just swallowing a pill each day. For some clients "swallowing the pill" is enough, but for others it is not. Establishing a relationship with the medication or actually "becoming" it, as the following examples will demonstrate, provides one way to integrate medication and the individuals' desire for increased awareness about themselves.

Fortunately, after my psychiatric training, I had the opportunity to study Process Work. Both my professional and personal life were impacted and deeply changed by this study. As a result, I now look at medication prescription with a different perspective. Putting together Process Work and traditional psychiatric training has challenged me. The process work approach offers a way to enrich psychiatric practice with a respect for exploring individual processes in a psychiatric setting.

Outside of private practice, much of mental health treatment is now governed by cost and not necessarily by quality. Insurance companies pay for the shortest possible route to improvement. Medications can bring improvement in several weeks; consequently, some insurance companies pay for only two to five sessions to treat such problems as major depression. Life situations, intrapsychic conflicts, spiritual crises, etc., that may lie at the root of a client's difficulties are subsequently not explored. This turns much of our current mental health practice into an "anti-awareness" system. Many clients worry about "just taking a medicine," feeling like "passive recipients" while the medicine contains all the healing power. Hearing from my clients about this conflict led me to think about and explore possible ways of "relating" to medicines. Since time with clients is so limited, I needed to find a method that interested clients could also do on their own each time they had contact with their medication.

In this article I will share with you some of the ways that seem helpful for individuals who wish to increase their awareness. These methods are applicable in a psychiatric setting that challenges awareness to the limits and which frequently provides only a few opportunities to be with a client.

The tools of psychiatry no longer seem built on human relationships, but are related to psychopharmacology: Buspar, Zoloft, Effexor, Wellbutrin, Haldol, Clozaril, Risperidone, Prozac, Lorazepam, Lithium, Tegretol, Nortriptyline, and many more. Most of the clients I see come specifically with a referral or request for medication evaluation. Some come asking especially for Prozac since it has achieved such popularity in the media. Others arrive from the hospital where they have been treated with Haldol for their psychoses. Still others are referred by their therapists because they wonder if medications would help. Many come because they suffer from drug or alcohol dependency.

Depression has become an epidemic in our society. Therefore Prozac, a newer antidepressant with fewer side effects, has gained immense popu-

larity. The following examples will focus on how, in a brief period of time, the use of Prozac can provide a key to explore the deeper aspects of a person's life. It is interesting to note that the clients in the following examples all had different experiences of Prozac in their bodies. Some details have been altered to protect confidentiality.

Client A is a professional woman, married and the mother of a four year-old child. She is an attractive, athletic woman who is troubled by the amount of time her profession takes when she really wants to spend more time with her son. She adamantly asks for Prozac, which a friend had recommended because it helped the friend with a similar conflict.

This woman and I went together on a "Prozac journey." Initially we explored her feelings and fantasies about what an antidepressant might act like in her body and what it might do for her. She was curious and courageously responded positively to the suggestion that she actually pretend to be Prozac inside her body. As Prozac, she pushed against a big heavy weight. I pushed against her, standing in for the big heavy weight. She responded by pushing against me with a strength surprising to her. She spontaneously made a shift in awareness and saw that her profession was like the weight she pushed against. She realized that she really disliked her profession and that she experienced it as very oppressive. Previously, she had been aware that she wanted to spend more time with her son. Through this experience, she contacted the thing that oppressed her. She also contacted her strength, a previously unknown resource.

She returned three weeks later having made a job change, one in which she had much more time to spend with her family. She continues to use Prozac, which she now identifies as a powerful ally.

Client B is a 39 year-old woman referred by her therapist for assessment of depression. She has had a long history of deprivation and neglect. In her family of origin, she was the youngest sibling, with five brothers and a sister at least ten years older. Her father died when she was five years old. In order to remove her from the abuse of her alcoholic mother, an older brother invited her to live with him, but he also abused her emotionally and physically. A later placement with foster care did not prove significantly more supportive. Thus, the client remembers being depressed for most of her life. This depression had worsened for three to four months prior to the evaluation. She came to the interview saying, "I feel like I want to die."

I suggested to the client that perhaps something wanted to happen in her, something motivated by her thoughts of wanting to die. Also, I suggested that going into a deeply internal state might have great benefit to her. I invited her to "die" right now by acting out her death. She immediately leaned back and closed her eyes. I supported her by suggesting that she trust what was happening. She suddenly opened her eyes with a surprised look, saying that she heard a "voice" telling her she was okay and that she could live. This was a new and exciting experience for her. During our discussion of what it meant for her, a "critic" began to reveal itself. Getting to know the critic helped because she saw how much the critic resembled the early abusive relationships in her life. A next step in working with this client would be to help her identify with the power of the critic, something that she was unable to do at that time.

This experience was mirrored later, when she asked for Prozac and I invited her to become the drug. When she imagined into what it would be like to be Prozac, she described herself as a collection of atoms like that found in any aspect of creation. Within this experience she found a transcendent element, similar to her earlier experience of "dying." This made her feel content and happy. As Prozac she found herself doing battle with obstacles that stood in the way of her feeling happy. At this point I had a strong urge to arm wrestle with her and thus represent the obstacles in her way. She seemed not to have had much opportunity to realize her strength. She won with dancing eyes. I prescribed Prozac.

At follow-up she had continued to develop a relationship with the drug which minimized the feeling of powerlessness that so often accompanies the use of medications. She had also increased her own ability to do "combat" with obstacles.

Client C is a single woman who had already been placed on Prozac by her family physician and now wanted to work on problems and "stop fooling around." She gave a history of having a very abusive father. He told her numerous times that he hated her and would try to break her spirit. Her early adolescence was spent defying him, which provoked physical beatings. To escape, she eventually started drinking. She considers herself alcoholic, but stopped the use of alcohol several years ago. However, she now felt

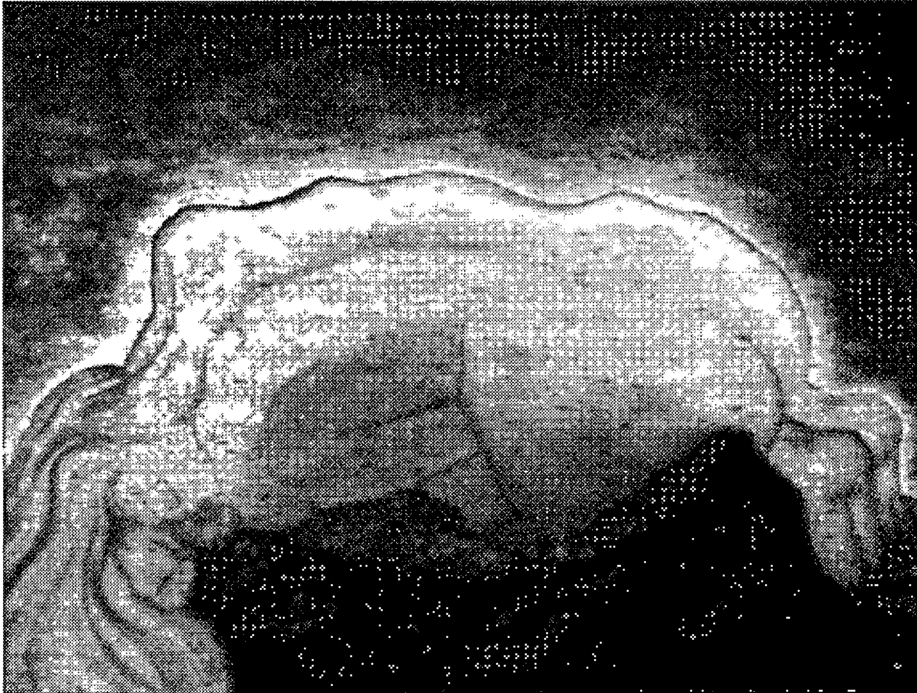
addicted to caffeine and wondered if she might be addicted to Prozac, since she felt her mood had improved since being on it.

I also invited this client to become her experience of Prozac, the "mood elevator," as she put it. She made a spontaneous arm movement. When we amplified the movement, she flew bird-like through a forest filled with tall trees, wild animals and beautiful streams. A huge contentment filled her being.

This woman's worries about addiction diminished as she grew aware of her own ability to embody the "mood elevator." Prozac seemed to help her contact the mood elevator inside of her. This state is already a part of her that, partially due to her abusive past, isn't easily accessible.

These case studies exemplify a way in which I feel more satisfied about prescribing medications, especially with clients who are seeking to understand more completely the relationship of medication to the difficulties which have prompted a referral for pharmacologic evaluation. This method offers clients two new opportunities. First, it provides an active relationship with not only the medical system and caregivers but also with the pharmacological interventions themselves. Second, it offers a way to use the crisis that brings people into psychiatric care. They gain an opportunity for growth and development instead of just receiving a pill to help them cope. This approach is a beginning in exploring medication intervention in a mental health culture driven more and more to brief solutions and the use of psychopharmacologic interventions.

Jan Loeken, MD, who learned to love nature in her growing up years in Montana, currently lives on a houseboat and works as a psychiatrist at an HMO in Seattle. She will soon return to work at a women's prison. Through her work, she hopes to help others touch the wondrous spirit shared by us all.



"Aqua Vitae: the gestation and regeneration of Psyche" by Linda Greischel

Looking for Unicorns: Process Work at the Princess Royal Hospital

Arlene and Jean-Claude Audergon

A seminar participant and frequent patient at the hospital asked me (Arlene) to meet someone. We were introduced and sat down for a smoke. I asked him about himself. Before being in the hospital, he had traveled the world searching for two lost unicorns. I told him he was a spiritual man on a long journey; unicorns weren't easy to find these days. He nodded. How was life in the hospital? Great, he said, not only because he could focus on his search, but because fate brought him to meet his wife-to-be. I'd met a brother in spirit. We too were seeking unicorns at Princess Royal, tracking the mercurial mystery of life in the unexpected and irrational which slip through the fabric of social adaptation.

Society sends people with overwhelming emotional and perceptual experiences to psychiatric hospitals, not only from compassion, but due to fear and prejudice toward highly emotional states. Psychiatric patients often feel misunderstood, lost in inner turmoil. Their freedom goes. Along with the patients, professionals often take the brunt of wider social issues involved. They feel ignored for their efforts, and challenged to the limits of knowledge and energy when faced with acute and chronic extreme states categorized as "mental disorders."

This article describes our experiences at the Princess Royal Hospital in Haywards Heath, outside of London, where we gave five seminars over a four year period. We hope to add to the growing literature on extreme states and inspire those working in similar situations who may be stimulated to discuss the ideas or try something similar (or different) in their own environments. The article focuses on:

a) the history of the seminars and how and why their format and content evolved over the years. Originally the seminars were designed to introduce Process Work to psychiatric professionals. They evolved into training and experiential seminars, where professionals, patients and process work students joined to explore the multi-leveled dynamics in mental health issues.

b) the connections among an individual focus with people in extreme states, issues concerning therapist and client roles, and underlying social and human issues. We addressed these areas in group processes made up of patients, psychiatric professionals and process work students.

What is a psychiatric hospital?

The definition of a psychiatric hospital depends on one's perspective. For the man mentioned above, it was a place to search for unicorns and meet his wife-to-be. For society, the psychiatric hospital houses and rehabilitates people in wild states in order to protect the person and the community. Psychiatric hospitals are places where people are diagnosed, receive medications and get therapy. Some receive shock treatment. Some come for a day or two, others for thirty years. Sometimes patients receive loving and skilled help through times of inner turmoil. Sometimes help doesn't come.

Some patients experience the hospital as a place to take a break from the pressures of daily life

while receiving assistance with a crisis. Others experience it as a prison. At Princess Royal, some patients are "leveled" out of concern that they might hurt themselves or others. This means that they require certain levels of observation until they are considered of sound judgment, free to go out into the community for an evening, permanently, or until the next hospital visit. Personal freedom and basic human rights become important issues.

Psychiatric professionals such as psychiatrists, internists, nurses, art therapists, occupational therapists, psychotherapists and social workers are usually deeply involved with their work. While some consider this work as just a job, the majority have a strong interest in helping others. The mental health professional holds a complex job. She is held responsible for the safety of patients and the community. She is asked to heal the patient, although both diagnoses and methods of treatment remain uncertain. While exciting team work across disciplines and opportunities to learn from others occur, she is often on her own. There is never enough time. She fights hopelessness and burnout daily.

Many hospitals focus on research to gain knowledge to work better with physical or mental illness. The National Health Services partially sponsored our seminars over the past five years. Thanks go to Sheila McClelland, Dr. Alison Abrahams and the interdisciplinary process work group that formed at Princess Royal.

For us, working in a psychiatric hospital has been challenging and fun. We have been interested for many years in how to bring a process work approach into contact with community services, including mental health, prisoner rehabilitation and social action projects. We were therefore happy to support Sheila McClelland's project at Princess Royal.

The hospital setting allowed us to use the process orientation to extreme states. We assumed that they contain an impulse for the system's evolution, within the evolving system! Psychiatric hospitals are microcosms of society's tendency towards homeostasis. They reflect the desire to keep out trouble, and the tendency for trouble and extreme states to erupt. These hospitals sit at the "edge" of culture. They are intended to protect the status quo, retaining patients until they can safely return as functioning members of society. Sitting on the edge of society, a psychiatric hospital provides prime ground to research and bring awareness to collective and individual issues surrounding extreme states (see Arlene Audergon 1990).

History of the project

After the first process work seminar she attended, Sheila McClelland began to experiment with Process Work. With enthusiasm and persistence, she tried out process work methods, created her own methods to access and amplify processes using art materials, and talked about Process Work around Princess Royal Hospital. She emerged from the inner sanctum of her far-out art therapy office and began tackling the "system." Dr. Alison Abrahams, a senior psychiatrist, became interested in Sheila's work.[1] Soon, they invited us to give our first seminar.

The first seminars

We planned the first seminar with respect for the existing system. We hoped to contribute a taste of Process Work as an orientation and methodology which might prove useful to people in addition to their existing framework and skills. This was a one day introductory seminar for about sixty psychiatric professionals. We gave a brief presentation of the process-oriented approach, highlighting special methods of working with acute states. We included case material and some simple exercises for communicating with people in extreme states. The day was very well received. The following day in the morning, we worked privately with clients and their therapists and videotaped these sessions. In the afternoon, we held a case control and video study session. The two days were exciting and created enthusiasm for further learning.

The following year, we used a similar format, adding an extra day. Process work students were invited to join the seminar and to participate in an extended video study and case control session. Late at night, we studied the day on video with process work students and some staff members to prepare for the next day's presentation. The video study spurred interest in further training in observational skills leading to accurate interventions in unfolding processes.

The third seminar

Sheila and her colleagues worked closely with us in developing the seminar design. We extended

the seminar to four days and changed the format. The staff expressed interest in training to deal with everyday situations. These ranged from working with acute psychotic states through crisis and suicide to addressing issues of hopelessness and abuse with outpatients.

The seminar was designed for professional training. Clients interested in the opportunity to work on personal issues in this setting also attended portions of the seminar. In the morning we presented theory and skills, then people met in subgroups where patients had the opportunity to work on personal issues. The five subgroups were facilitated by psychiatric professionals or process work students. Each day, a different group of five patients attended. The two of us supervised the groups. We worked with patients, supported students and professionals in their learning, and frequently helped with relationship issues between patients and their regular therapists. It was a large bite to chew but worked very well. Afterwards, we met in the large group for theory, to complete unfinished issues from the small groups, and to practice skill building exercises. In the evening, we did video case studies.

We wanted to invite patients into the whole seminar if they wished to attend, but they expressed concern about confidentiality amongst themselves. Therapists also worried that if clients came to the seminar, therapists would feel obliged to stay in a caretaking role and thus not feel free to engage as seminar participants. The direct involvement of patients in the seminar excited professionals and students. Most patients were eager for this opportunity to work on personal issues. It was also touching to see their interest and support of professionals wanting to learn. While the seminar was designed for professional training, patients were invited to stay for the afternoon sessions on days they came to work with personal issues. Most did.

Seeing issues emerge for therapists, we changed our training focus. We realized that many of the problems therapists face have to do with a learned need to keep distance from their patients. Also, they feel afraid to be themselves and use their experience and perceptions. Focusing on "special methods of working with acute states" inadvertently supported the learned tendency to work "on the client." Hence, our focus turned to bringing awareness to the feelings and behaviors of the therapists. We wanted to find out how the therapists' processes fit together in a systemic way with the patients' signals and processes. For example, a therapist could help the client pick up the "healer," "nourishing parent," "doer" or "critic," instead of the therapist staying unconsciously identified with these qualities. As therapists began to process the unconscious identification with certain roles and behaviors, they experienced a connection with another person's totality. This was relevant to the therapists' concerns of having to caretake patients during the seminars. There was a lot of learning going on and it was fun and dynamic for most everyone involved. We were excited that the basic skills and methods of Process Work helped therapists establish communication with their clients. Process Work also helped support therapists' freedom and curiosity to unfold the most difficult experiences.

Another change involved doing a group process session on the final day, when many of the patients attended. Around this time, the National Health Services (NHS) in England underwent a major shift in structure which deeply affected everyone. This created uncertainty as to the professionals' jobs and the availability of services for clients. The NHS was moving toward local rather than central management. These changes stirred the hospital's homeostasis.

Doing a group process with patients and psychiatric staff together was experienced as revolutionary in this environment. There was usually more separation between patients and staff. The group process began with a discussion of the mental health workers' problems with the administration. Two important events during this process became the basis for structural changes in later seminars. One was that the patients became very active. They were shocked to see that their therapists felt powerless against the system. Until now, the patients had identified as powerless and seen the therapists as the "system." The patients were suddenly freed of their role and strongly challenged the mental health workers not to act like administrators themselves and to be human. The mental health workers acknowledged their strong feelings and need for one another. They broke the tendency to remain isolated in their professional personae and separate jobs. Then some began to pick up their own authority rather than splitting it off on the administration. They began to organize ongoing groups to support one another and work on relationship issues.

The seminar received very positive feedback, which in true British understatement means people were highly emotional and happy. The main wish for a change in the following year's seminar was that patients were eager to participate. Therapists learned they could handle this and did not have to feel stuck in the caretaker role.

The fourth seminar

This year the seminar was geared for professionals, process work students and patients. Rather than coming only on the days that they worked on personal issues, patients participated in the whole seminar. We could feel the tension and excitement. We were all doing something a bit revolutionary.

The medium is the message

Having the seminar with professionals, psychiatric patients and process work students together as participants seems utterly sensible and natural, no big deal, yet it is deeply radical. A format which combines these groups breaks a major societal agreement or collective edge. It steps over a boundary which allows us to keep our society intact by splitting off and projecting what we fear as the irrational. This format steps over the boundary which allows us to know who is crazy and who is not. Breaking these implicit agreements gave us the opportunity to process these issues together as a group. The format clearly reflected our goal to create a forum where all are equal and supported to be their whole selves.

The common myth —what links patients, professionals and students

We started the seminar addressing the group's common concerns. These included the emotional world, the search for meaning, and the importance of finding a way to be oneself in relationship to others and in the community. We talked about the pain, which most of us know, of being diagnosed and labeled. We talked about the difficulty of being a patient or a therapist. Mention you are a psychiatric patient at a cocktail party and you get blank stares and flat conversation. You get the same stare if you mention you are in the psychiatric professions.

Though we have different roles, we are linked. Several years ago, when we worked in a psychiatric hospital in Milwaukee, Wisconsin, we went to a local bar one night. The "normal" people there looked more "altered" than anything we had encountered in the most acute unit of the hospital. We realized that many of us exist in altered states most of the time. At least on the ward there was awareness about this. Whether patients or professionals, we all somehow share a myth. We are face to face with ourselves, looking for meaning in our most impossible emotions and altered states.

One of the most humiliating things for anyone is to have his or her perception denied repeatedly. This is one of the problems of western psychiatry. Someone behaves strangely and says he sees the devil or that a spirit talks to him. After compiling the symptoms systematically, a diagnosis is made. The illness is perhaps caused by a biochemical disturbance. The perception of the devil or spirit is denied and understood only as a hallucination. While the fact that the person hallucinates is carefully recorded, the content of the hallucination is often disregarded as meaningless.

In cultures with shamanistic practices, we might see an individual act wild and announce that he sees or hears a spirit. While the experience might be welcomed for its spiritual value, it is likely that he too will be considered ill and even become an outcast. But there tends to be an agreement as to what caused the illness! The healers and the sufferer both believe a spirit is at work. They share a basic agreement of perception. The shaman and the ill person deal with the same stuff, operate in the same territory.

In a sense, this seminar began to create a place where patients and professionals operated in the same territory. They shared awareness of a field in which we are all involved with altered states, emotions and the challenge to become ourselves in this world. In western medicine and psychiatry, this territory is rarely shared. The therapist or doctor tends to observe from a distance, evaluating the patient's experience from a safe spot in a separate world.

Contempt and fascination for the irrational

When in extreme states territory, we deal with the world of the irrational, the unknown. Most people try to repress, split off and project this realm onto others. We coined the word "psychephobia" to describe this fear of the soul, fear of the irrational, which is left to patients and their mental health workers to deal with in hospitals. This attitude is at the seat of prejudice. We seek out a group of people different than ourselves and project everything we don't know in ourselves onto them. We imagine these qualities belong to

the other group, and this imagination is in turn supported by collective fantasies. We form attitudes and judgments towards the group based on our projections.

The projection of the unknown in our society is compounded by the value placed on the rational and logical. Those who hold social, political and economic power identify with the rational. Strong emotions and all that is irrational are projected and assigned to other groups. The privilege of identifying with this power while projecting unknown aspects of ourselves onto others, accompanied by fascination and contempt, add up to oppression. This "psychephobia" is one link between sexism, homophobia and racism. Strong emotions and violence are projected on people of color. Gays are considered child molesters. Moodiness and weakness are projected on women and homosexuals.

We are quick to split off and project the irrational onto people who give free expression to their emotions and altered perceptions. This tendency to believe that the irrational belongs to these "others" and not to "us" makes all people feel isolated. The ones suffering these states feel truly cut off in a time when they could most use support for their difficult experiences. Isolation and loneliness are immense social problems even for the mainstream. Such loneliness stems in part from the mechanism of splitting off parts of ourselves and enduring this separation.

Through circular thinking, this process leads to a kind of collective muteness or trance, a lack of societal reaction to these issues. Take the example of sexism. Speaking out tends to go like this: a woman speaks out about what she feels is a sexist attitude towards her. She is told she is too sensitive. If she reacts to this accusation of being too sensitive, she is labeled hysterical. She grows furious, and the others use this to reinforce their prejudice and sexism.

Take the example of racism. You react to the prejudice and racism in society. Mainstream society may retreat and think, "Good that you speak out, it's not my problem." Mainstream culture may also feel threatened and lash back in the form of hate groups or trying to equalize the suffering inherent in mainstream problems, i.e., "my neighbor suffered from reverse racism." Again left alone with the issue, you can either stand boldly or retreat in hopelessness. This reinforces the mainstream prejudices: "those people of color are all overboard about this racism stuff" or "look how those people of color lack ambition." Perhaps you react with a rage. The mainstream thinks, "I always knew these people were violent." This mechanism creates and reinforces isolation between ethnic groups. The privileged perpetuate this hurt on a daily basis by disowning their own behaviors and projecting them on other groups over whom they have social and economic advantages.

As we talked about these issues in the seminar, a strong response of recognition welled up in the group. Many women felt their own situations around mental health problems were strongly linked with issues of sexism. Some felt the pattern of being called hysterical and too emotional had escalated until they landed in the hospital. Both men and women felt this circular reinforcement of their diagnoses as particularly oppressive. As soon as they received a mental illness label, it was used to reinforce prejudice against their behavior. Once labeled, they were treated with disdain and the label was used to shut them up. Any display of emotion or reaction of anger would elicit comments about the need to cool off or go back to the hospital.

We spoke with therapists about recognizing the political dimension of their communication and intervention with patients. Every intervention is a social and political action, not only a therapeutic one. You may choose to encourage someone to settle down or to support their emotional reactions or bring out your own emotional reactions to the social issues involved.

Style: learning about prejudice and polarization

One of the seminar participants, a frequent inpatient, currently an outpatient, was very pleased to attend the seminar for the second year. One day, as we broke for lunch, a hospital administrator came in and spoke to him in front of the group. She said he must leave the premises promptly at the end of the day and not linger on the hospital grounds. We had understood that in the morning he had been stopped in the building and had not been believed when he said he was attending a seminar. We responded that this might have hurt him, but did not mention how the current interaction was hurtful. The participant politely agreed to do as requested.

Much later we found out that we had gotten the facts wrong. The administrator had asked the man to leave for a different reason, because he had

arrived that morning in the casualty department, requesting treatment, apparently on drugs. He was also found to be carrying knives. The casualty unit was busy with acutely medically ill patients. Porters were called to remove him and one got slightly cut. The patient had been carrying knives recently due to neighbors threatening him in connection with drugs. In the process described below, we think that while we misunderstood these initial facts, the process that came up concerning split off aggression as a major collective issue was to the point.

We had initially thought the unpredictability and violence was projected on this man only because of his appearance. It turned out this was not only a projection. Had we known the facts, we would have supported the administrator to ask him to take responsibility for his behavior, while supporting the patient in his perceptions. We want to emphasize, however, that he is an identified patient or "disturber" in a society which is filled with violence belonging to all of us! The following interventions involved not wanting to leave him alone in this role.

We left for lunch and realized over a sandwich that we felt hurt and furious. We realized people treated this man as threatening because of his wild appearance. He dressed in far-out, creative clothes, wore beads and had long hair. He carried himself with an air of defiance. We saw projection and prejudice at work and decided to bring this issue back into the group. Stumbling into our hotel room half laughing and half in a huff, we gathered up our wildest clothes—an orange sweatshirt and orange socks, our hats and sunglasses.

Sitting on the floor instead of chairs, we peered through our tinted shades and opened the afternoon session. Jean-Claude said he felt rage about prejudice against different styles of behavior and how people projected their own violence on anyone looking a bit wild. Ready to enter a different style of communication and express his rage rather than talk about it, he asked people who were afraid of strong emotional expression to hang on to someone near them. Then he yelled. A few others joined in and began to yell. A therapist expressed her rage at being constantly under suspicion, her every move watched if she did anything out of the norm around the hospital.

A group process unfolded between those who were furious and those in shock and afraid of such emotions. First we supported those in tears, both patients and therapists who had been abused or who felt frightened by expressions of anger. Encouraged to express their fears, those who had been most afraid said they felt a deep relief to see it was possible to express rage with consciousness and safety.

The group experimented with standing up for different communication styles and a leadership process emerged in which a small group of patients began to lead the seminar. Working as a team, they were fabulous at facilitating the discussion which revolved around problems of pathologizing and labeling.

What emerged was a group in which people differentiated themselves from their roles. We were people, not "clients" or "therapists." As we seemed to be closing with a feeling of our common humanity, the therapists began to stand up for their work, clarifying that a therapist is certainly a person first, but with a job to use her humanity along with special skills in a way which is useful to the client. They expressed their need to be valued. This brought out the issue of therapists feeling subtly despised for asking for money for such a personal business. The clients loved this! They spoke about their need for support in times of crisis. They also needed challenges and skills from the therapists.

The group began to form subgroups for follow-up after the seminar. They discussed setting up a group in which everyone could work further on such issues together. They talked squarely about distinguishing when therapists would be working for the clients' needs and should be paid. A professional group formed to work on its own issues. We have never seen a group of people able to divide themselves into subgroups so clearly, without painful feelings about insider/outsider issues. Once the common humanity was shared, differentiation was both needed and easy.

The man who had dressed in wild clothes appeared promptly the next morning. He wore a three piece suit, his hair neatly tied back. He was especially friendly. We had the feeling he had gone to this trouble to help us make our point. He had learned something and been touched. We were impressed by his fluidity. He reminded us not to unconsciously identify with any one part of a process, but to maintain the fluidity to support all the interactions. We learned to intervene without fear of feedback, and without unconsciously expecting to "change" or "heal" the

system. We learned to intervene, to react, and then to simply pick up and support the feedback. After the seminar, this man was said to be "acting out" around the hospital. One main problem had to do with drug use and pushing drugs on other clients. He was, however, communicative and very loving with his therapist who had been with him at the seminar. Later, he viewed tapes from the seminar with her, took a good look at himself, and went out and got his life together. He hasn't been back to the hospital, though he keeps in touch. We hear many such stories of people who have come to the seminar and gained something for themselves.

The fifth seminar

At this seminar we had the feeling of coming full circle. We went from introducing a process approach to working with extreme states, through working with the systemic relationships between therapists and clients, to addressing social issues concerning prejudice, fear of the irrational and the political dimension of mental health issues, and finally to a forum which included all these elements. The interplay of these levels, particularly individual and group work, brought tremendous learning. We chose a format similar to the previous year, with patients, professionals and process work students learning together about many aspects of mental health issues. This year, we had a session in which top managers came to discuss an issue with the process work group at Princess Royal. We worked with patients in acute states in the center of the large group in addition to working in the small groups.

From pathology to focus on individual needs

During the fourth seminar, there had been open seat times when anyone could work with us in the middle of the group. We explicitly presented this as an opportunity for students or mental health professionals to work. Identified patients had either worked in the small group sessions or were shy to show themselves to one another. Professionals felt leery of asking patients to work in the middle, due to the history of psychiatry where patients were "shown" in front of groups of doctors.

We liked the idea of professionals and students working in the middle to support the awareness that we all have issues and are growing. We thought it might reduce the tendency for everyone to pathologize the patients. It worked very well. We decided in the fifth seminar to try something new, integrating what we had learned from the group process in which group members had first shed identification with "therapist" and "patient" roles and then were able to differentiate the actual needs behind these roles. We learned that if the field is addressed with respect to unconscious identification with roles, the fear of the irrational, along with such issues as sexism, racism, and homophobia, we can again focus intently on individuals in acute states. Once the field is addressed, one can focus on an individual with compassion, without prejudice and pathologizing. Pathologizing means burdening someone with individual and collective projections.

In the fifth seminar, we worked each day with one or two individuals in acute states in the center of the large group. These sessions were often experienced as life changing for the individual and radically affected the atmosphere of the whole group. We also focused deeply on group process. Interweaving different levels clearly created a useful forum for working with extreme states, in which the individual is not used as a scapegoat for split off processes of the group or society, nor is the individual forgotten. The highlight of this seminar was how the individual sessions combined with group process. This gave most people an emotional grasp of the connection between individual mental health issues and social issues.

Listening: power, sexism and mental health issues

a. Management and clinicians

At this seminar, hearing emotions and hearing one another was a main issue. In one session top managers and the interdisciplinary group of psychiatric professionals worked as a subgroup in the center of the large group. There was a common complaint that each felt unheard by the other, although both sides wanted to listen. It became apparent that what was not heard was pain. The psychiatric professionals felt despair because their clinical input was ignored in administrative decisions. The managers in turn felt unheard and misunderstood. They felt they alone had to take the pressure to make necessary cuts so the hospital could survive financially. The process came to a close when the managers felt touched as they listened to a patient speak emotionally about his very personal story in relation to financial cuts.

Managers then expressed their need to hear the patients and the clinicians. The managers recognized

that they had been afraid to listen for fear of having to make painful decisions regardless of what they heard. They realized they needed this input to fight for resources and to make informed decisions, even when they hurt. The professionals realized their need to stand up and offer to get involved in the tough decision making process rather than remain identified as victims of the hospital administrators. Both realized they were in a position to work together when they listened to the patients they were there to serve.

b. Linking the individual and the group: men, women and the recurring auditory hallucination

On the last day, we had a group process session about issues between men and women. The day before, a man inadvertently started a group process by telling a sexist joke. Men had been asked if they would be willing to listen to the women's side for 30 seconds. As is often the case around this issue, the men focused on their feelings and need to first be heard and understood for their side of the issue.

The connection between the individual and the collective and particularly the connection between sexism, power, communication style and mental health issues became strikingly apparent. In the midst of this process a young woman began to shake and complain that her auditory hallucination of her pleading father had returned. The previous day, this woman worked in the middle of the group on the constant guilt she experienced since her father's suicide. For two years she had heard his voice pleading nonstop in her head, "Help me, help me." The voice made her frantic. She felt guilty for his suicide because she had reached her limits in helping him with his chronic depression and had asked him to get help from a doctor. He had committed suicide the same night.

The enormous quantities of psychotropic drugs her doctors gave her didn't help. She was left shaking and frozen with a flat affect from the drugs and her own altered state. A whole system of doctors, psychiatrists, social workers and therapists had been unable to help. She came to us as a last resort. She had participated in the fourth seminar. Although she had enjoyed it, the work in the small group had not changed her hallucinations. She worked in the middle of the group at her own request. The whole system involved with her care, including her therapist and the seminar participants, all felt under pressure to do something and guilty they couldn't do more.

In her individual work, we told her we felt helpless, yet didn't want to feel guilty. Together with us, we wanted her to find a solution to an impossible situation. She suggested perhaps she should commit suicide. We strongly asked her not to act like her father. We proposed that she seek other solutions rather than leaving it to us. Her long-term therapist asked to come in. Lovingly, and very loudly, she yelled at and pleaded with her client to stop listening to the father's voice and to recognize her father as the abuser, not the victim. He had left her with this shit when he committed suicide. It was time for her to tell the voice to "fuck off"! The therapist too was tired of feeling guilty for being unable to help! The client seemed to wake out of a daze, looked around and started to cry. She apologized to the therapist and to the group for acting like her father and making everyone feel guilty. We acknowledged her deep feeling and power to be able to apologize in such a difficult situation.

She said she had never had the courage to face the voice coming from over her shoulder. Did we think that saying "fuck off" would help? She gathered up her courage, and following a body signal, held herself high. She looked over her shoulder. In a stronger voice than we had heard her use she said the two words. The voice went away for the first time in two years. She kept telling us during the day she felt she was in a dream. She wondered whether it was real and if it would last.

About 24 hours later the voice came back. She heard it at the moment in the group process when the men pleaded to be heard first and complained that the environment felt unsafe because the women were so angry. The whole discussion was tense but subdued. We pointed out that the solution the day before had occurred when her therapist burst out emotionally. She had challenged the woman's relationship to her father's lament and her lack of awareness that he had been the abuser, not the victim. We suggested a need for an emotional style in the group process. This might help the woman get rid of the voice again and help the group go further with the issue of sexism. The connection was recognized, picked up and led to a dramatic change both in the individual and in the group.

A female therapist spoke out emotionally. She felt fed up with men for never listening to anyone unless their feelings were cared for first. Then a man, a professional, began to talk very rationally

about his point of view. He went on at least a minute when the young woman who was hearing the voice of her father stopped shaking and shouted "fuck off." This time her eyes were open and she looked directly at the man who was speaking. He stopped in mid-sentence. Her internal voice stopped, too. The next moment, another woman who had suffered a breakdown and had worked in a small group on issues of abuse stretched out her arms and hands. She closed her eyes, and with great intensity chanted, "No, no, no, you may not do this," as if an internal drama was finally closed. A third woman, who had worked in the middle of the group on horrendous abuse issues and had emerged from an acute state of severe suicidal depression, spoke lucidly and lovingly that we needed to remember that all men were not bad and that she had three sons whom she loved and needed to help grow up in this world. We agreed that men were not bad—the issue had to do with listening to women's hurt, instead of focusing only on themselves.

A man, a patient with extreme states, picked up her comments and stated that his mother had treated him badly and that he was angry at her. We said we were aware mothers could do awful things, but wanted to check—where was his father in his story? Without hesitation, he replied that his father abused his mother consistently. Silence came over the room. At this point, men began to listen and speak out. One after the other, men and women spoke movingly about how easily they had always blamed their mothers instead of fathers. A man expressed his sadness as he realized how he had constantly tried to inhibit and control the wildness of his daughter. The feeling was not of expressing guilt, but of true recognition.

A young man, a client who had suffered chronic depression, panic and anxiety since his mother's death, spoke about how he suffered from seeing his mother constantly put down by his father, grandmother and family. He had tried but couldn't help her. Tears flowing freely, he implored the world to answer to why women are treated as second class citizens. The man who had been so rational at the beginning spoke. He realized he had also blamed his mother and had kept himself distant from his own children while blaming his wife and remaining identified with his professional status. Another patient on the ward who was trembling, her face buried in someone's arms, emerged with a beaming smile and said, "That's like my dad." The session ended with most everyone deeply touched, in tears, holding hands. It was a striking demonstration and group discovery of the connection between sexism and many mental health problems.

c. Discussion

This process brings up questions about the relevance of doing group process on social issues as part of a seminar on extreme states. It also brought up the relevance of doing such seminars in a psychiatric hospital. Could this be done on a regular basis, with a resident facilitator? How could clients, staff and professionals best evolve in their learning and skills? What kinds of processes would we expect to deal with in addition to sexism and abuse, which are major issues in connection to mental health? Would the processes of individuals diagnosed as bi-polar, schizophrenic, catatonic or paranoid connect with specific kinds of group processes?

In the moment, staff are learning to deal with reactions of patients who have either participated in the seminar or heard about it. Some of the staff who did not participate in the seminar, and some who did, feel criticized by patients who want more of this work. Some staff feel unappreciated for their regular work. These issues need careful attention and an opportunity to be processed. Those with such feelings who are already involved with the seminars will be interested in processing their feelings and conflicts. For those who do not want to come to the seminars, there is no consensus to meet and deal with these issues. We are studying ways of supporting all points of view. If more psychiatrists and ward staff could feel welcomed and needed in such an experiment, it would be very exciting.

Communication and awareness at our edges—the process paradigm

To bring Process Work to a psychiatric hospital means much more than introducing an orientation and methods of working with individuals in acute states. The methods of Process Work allow us to work with the individual, with the dynamics between therapist and client and with the wider systemic issues of the field, be it the environment of the hospital or the society in which we live.

We were first invited to Princess Royal to teach the usefulness of Process Work methods in reaching people in acute states. Sheila's work caught the attention of the psychiatric professionals in large

part because of her "results." Doctors and therapists sent her patients they could not reach, and she found ways to work deeply and help them. Their rate of return to the community without coming back to the hospital was unusually high. This matches the goal of the hospital. Sheila had written an article about her powerful experiences doing brief therapy with people in acute states using Process Work and Art Therapy. Brief therapy is an important concept in public mental health systems. It suggests clarity in respect to effectiveness and accountability and it costs less.

Process Work was seen as an effective method of treatment, helping people lead more functional lives. A process orientation views extreme states not as illnesses in need of treatment, but as impulses of potential growth for the individual and the field in which she lives. The "metaskills" or attitudes which allow a process worker access to his or her skills involve welcoming and unfolding trouble, rather than trying to eliminate problems to make the person function better.

One possibility is to debate the conflict of orientations. Process Work welcomes and unfolds the unexpected in what appears as the worst problem or acute state. One goal of Process Work is to bring awareness to the field and to different levels of interaction, from the intrapsychic to relationships and societal debates. It does not pathologize the patient, but sees extreme states as containing valuable information needed by the individual and the community. The medical model at the hospital is oriented towards pathology and healing. It is interested in making accurate diagnoses and finding methods of treatment, with the goal of helping people return to normal lives. We found that debating a pathological vs. a creative approach to extreme states, and trying to talk people into a new orientation, was not the most useful approach. It leads to a tendency to "heal" the system by challenging its orientation of pathology and healing.

Process Work offers a new orientation that need not be at odds with the dominant paradigm in psychiatry. The new "world view" of Process Work does not conflict with the questions and methods which were based on the assumptions of the previous paradigm. In fact the process paradigm addresses these questions while also producing a new set of questions and methods (see Kuhn 1970). Although Process Work is not based on a premise of pathology and healing, it addresses the very real goals and needs of therapists and clients to find methods of working with acute states. It offers no panacea, but often "works" to reach people quickly, defrost long-term frozen states, and communicate with and unfold highly emotional experiences and altered states.

At the same time, a process orientation makes one humble before the long-term, circuitous and surprising nature of process. It is nature, not the method, which is truly awesome. A process orientation also observes the importance of the social environment of the client and the wider societal issues and collective dynamics that are linked to mental health issues and which concern us all.

A process orientation also means staying with hot spots, bringing awareness to the moment of change where the energy emerges from the process itself. Having a process approach in the hospital means supporting the reactions of excitement as well as the resistance and conflicts we encounter. It means working with the interests and needs of the therapists and clients as well as the momentary and long-term feedback of the system. It involves learning from the process by staying with the hot spots or "edges" as they arise at different levels of the system.

It is a matter of habit and comfort to become identified with certain behaviors, attitudes, theories and methods of work. Many therapists become interested in learning when they start to feel bored, drained of energy and dissatisfied with their work. This describes the situation of many of the hospital staff and community professionals who attended the seminars. They are talented and overwhelmed with very difficult situations. It also describes the situation of the National Health Services which are in dire need of another form of energy, money.

In the hospital, the process feels energetic when we address edges of awareness at various levels of interaction: individual processes, the roles of therapist and client, management and professionals. The group is excited when we process social issues which arise in the group format. Professionals and patients feel energized at their growing edges. People often fear the energy it takes to study, learn and grow. Staying away from one's edges may work well for a while, but over time leads to loss of energy. Cycling around the same issues or homeostasis leads to "negentropy" or "burnout." At one's growing edges nature offers change and life energy.

Process Work is a powerful tool and its relevance in the long term depends on the attitudes of the person using it. A basic question in any intervention concerns your goal. If you identify with a goal of getting "results," you may soon feel exhausted if your client doesn't change. If you do not identify with a goal, you can follow the process that includes your goals and which expresses itself in the most impossible disturbances. In the first case, you begin to resent your job, yourself or the client. In the second, you'll have fun, whatever the pain and sorrow involved, because you'll be connected to a deeper source, life's creative energy.

This attitude helped as we attempted to work with the feedback of the system over time. At one point we noticed we were pushing against fear and resistance to the seminars. We decided, together with Sheila, to pick up the resistance and stop pushing the project, even to drop it all together. Then the process work group at Princess Royal picked up the energy and made the project happen. This group evolved over time and became deeply involved with studying. They began to have philosophical conflicts and relationship issues, which they took as opportunities to learn. Therapists and clients study videos and research their work together. Process work students around England are stimulated in their studies. Thus the edges of the system are addressed throughout the year.

New management appeared with a philosophy of empowerment and communication, a difficult ideal to implement, and one which many feel is not happening. When the interdisciplinary process work group at Princess Royal addressed the management with their concerns, the top management was motivated to work with them in the seminar. Some felt that the session only pointed out the tip of the iceberg. Others found it fruitful. One of the managers appeared strongly moved. It will be interesting to study the dialogue around this topic after the seminar.

Most people felt deeply touched and awed by the last group process on sexism and mental health issues. It also brought up controversy. Some "backlash" and relationship issues may emerge. These present opportunities for continued communication and awareness around the hot spots and growing edges of the field, which will lead the development of this project at Princess Royal.

Summary and follow up

We found that Process Work gave us an extraordinary toolkit to work with the many different issues and levels of interaction at the hospital. The process has been our teacher in the situations we encountered and in the evolution of seminar format and content. The seminars reflected Sheila's vision of bringing Process Work to the hospital and Arlene's idea that an institutional setting has the potential to be our community's learning ground (see Arlene Audergon 1990). Given tools of awareness as a guide, and given the structure of the psychiatric hospital, there is a place, time, energy and interest to unravel issues of community life.

We hold the idea of a sustainable culture where large groups of people, including those suffering mental health issues, work together to process issues for the benefit of all. Mental hospitals may offer fertile ground for this to happen. Rather than only housing and rehabilitating people in extreme states, they could provide the container to explore the link between deeply personal and collective issues in our communities.

We were interested in how strikingly apparent the connections became between mental health and sexism. We addressed racism and homophobia, but these issues were not focused on deeply in the group sessions. The group was for the most part European, predominantly white. How do racism and cultural prejudices link specifically to issues of mental health? How would it look to process issues of homophobia in their link with mental health issues? Homosexuality has until recently been classified as a mental disorder; in some circles it is still considered a mental illness. We are also interested in exploring the link between specific mental health issues and social issues. For example, some people we met at the hospital were plagued by a compulsion about cleanliness. Would working on environmental issues alter these processes?

We did not set out to do a long-term research project, but it would be interesting to study how the seminars and the follow up between seminars has affected patients and therapists. Some patients and therapists have attended several seminars. We hear many anecdotal comments about their development over time. We have heard strong feedback that not having to stay stuck in a role as therapist or client has proven extremely useful to both therapists and clients. For therapists, this feeling

has increased their professional growth and freedom to learn from their experiences. It would be interesting to further investigate and report on long-term developmental issues.

An area of ongoing learning for us has to do with bringing a process orientation into the hospital in a way which does not impose a new system, but brings awareness to the ongoing edges of growth in this project and the environment. When old models are challenged, some people feel frightened because new possibilities and power issues arise. We are interested in how to support people to process tensions concerning the introduction of Process Work in a hospital. These include relationship issues, competition and conflict about working methods which arise among staff. We are also very interested in supporting patients to address the systems in which they live. For the next seminar, we may consider adding a day or two to link the events of the seminar with daily life. We would invite people to bring their families, community members, or perhaps ward staff who are not attending the whole seminar to come to sessions. They could work together in small groups, in subgroups in the middle of the large group, or in the large group on personal and community issues.

We have not addressed the wide use of psychotropic drugs in the hospital and would like to focus on this issue more in future seminars. Psychotropic drugs help many people and provide a necessary ally for some patients and doctors in the mental health system. Many patients have been helped to return to their lives, their families, jobs and communities. Our opinion is that psychotropic drugs are overused as the major way of attempting to hold down acute states for lack of other ways to deal with the situation. This is frequently an emotional topic for both patients and doctors. It raises clinical and social issues. The use and abuse of drugs, whether legal or illegal, to alter our emotions, moods and perception, is a major collective problem that deserves attention.

We sent special word to invite the unicorn man to the most recent seminar, since we met him only moments before the end of the fourth seminar. He couldn't come because he was involved with pushing drugs to other patients and therefore not wanted around the hospital. We were quite disappointed. If you see him, tell him we sighted unicorns at Princess Royal and are still shivering!

Note

1. Sheila began training groups for professionals in the hospital and the community. These groups evolved into a weekly process work group. She wrote a chapter on "Brief Art Therapy in Acute States: a Process Oriented Approach." (McClelland, in *Art Therapy, a Handbook*. D. Waller and A. Gilroy, (Eds). Open University Press: Buckingham/Philadelphia, 1992.) She also co-authored an article on Process Work and Art Therapy with two clients ("The Art of Science with Clients." Sheila McClelland, Pat and Ann. In *One River, Many Currents*. Helen Payne, (Ed). London: Jessica Kingsley, 1993). Sheila's unit is called the Process Work and Art Therapy Unit—perhaps the only one of its kind to date in a psychiatric hospital.

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Arlene Audergon, Ph.D., is a Process Worker and teaches this work around the world in its application to psychotherapy, extreme states in psychiatry, organizational development and conflict resolution. She has a background in the field of disabilities as a director of services for deaf-blind people. She is currently based in Los Angeles where she teaches Process Work, consults with business organizations and is on the faculty of Antioch University. A main focus of her work concerns diversity and working with social issues and conflicts. She is also writing a children's book on conflict resolution and experiments with the application of Process Work skills for training actors.

Hidden Process Work with Adolescents

Guruseva Mason

A teenager experiencing an extreme state of consciousness which a psychiatrist judges "sufficient to render the patient unsafe and/or dysfunctional in the community" is likely to be brought to the adolescent psychiatric unit of the hospital where I work. Voluntarily or involuntarily, the young person will be confined until a psychiatrist decides that he or she is over the crisis or in need of long term institutional care. The average stay is two to three weeks.

In my position as an inpatient counselor, I am not authorized to do therapy with clients. My job is to keep clients safe from harming themselves or others and to assist them in the "milieu"—the self-contained culture which the hospital as agent of the larger society creates to change or manage people whose behavior society considers extremely disturbing but not criminal.

During a typical eight-hour shift, I have lots of time in bits and pieces around the formal therapeutic activities to build relationships with those clients who are open to it. I am able to intervene in many small ways and to study feedback from these relationship attempts and interventions. Minimal staffing gives opportunities to intervene without the presence of co-workers who are trained to use interventions which follow theories of pathology rather than feedback from clients. These co-workers might not be supportive of my methods, even though they notice positive outcomes and say things like, "You seem to have a calming effect on Jimmy. Why don't you stick with him and I'll take the others."

Although I am not authorized to do therapy, I still wish to make my time with patients and their time with me as satisfying and heartful as possible. To do this, I feel it is necessary for me to get as good a sense as I can of the client's gifts and challenges, of his or her long-term process. In short, what divine purpose does this individual have to fulfill on the planet? I need to find out what kinds of encouragement, support or experiences I may be able to offer this person at this point in their personal and collective development. I don't think anyone can become him or herself in a vacuum. A few can make it with only the help of guardian spirits; the rest of us need the help of other human beings. Without this support, life may be unbearably painful, lonely and violent.

The interventions which I am about to describe were developed to facilitate the foregoing needs, and to contribute what I can to the atmosphere on the psychiatric unit, so that clients, visitors, family, friends and staff have as positive an experience as possible. They are based on the principals of Arnold Mindell's Process Work and on his general approach to work with people in extreme states of consciousness.

Here are some interventions which I've found to be useful with many clients. Whenever I perform such interventions, I always observe verbal and nonverbal feedback to guide how much I say and what direction to take as I have these conversations.

1. Value diversity; keep rules to a minimum.

Many adults seem to have an endless list of expectations for "proper" or "appropriate" behavior for adolescents. My approach is to state, and monitor for compliance, only those expectations which are necessary for safety and for following the daily schedule and program requirements of

the hospital. This gives me opportunities to study (rather than try to eliminate) behaviors that are disturbing or unusual before intervening. For example, if a client has a habit of eating noisily, burping, farting and laughing loudly, I will tend to take these behaviors as curious bits of information whose meaning I don't yet know. Trying to stop them may not be the best way to begin a relationship with this client.

2. Offer choices whenever possible, and honor them.

If I see a client looking upset, I may say, "Would you like company, or would you prefer to be alone?" If the client says she wants to be alone, I'll say, "If you decide you'd like company, just let me know," and give her as much privacy as safety allows. If she says she wants company, I'll say, "If you want to talk, I'll listen, otherwise I'm glad just to be with you." Not everyone wants to talk; some people are helped by not being alone (and possibly overwhelmed) with memories or feelings, while others prefer to process their upsets internally. I believe that people who have already been deprived of choice by being confined deserve every choice possible within the limits of the system.

3. Support the client's "strangeness" by discovering and affirming its value.

Many adults believe their job is to help emotionally disturbed teenagers to be more normal or to "fit in." In my experience, many teens are disturbed by the awareness that they can't fit in although they are constantly pressured to do so. They believe that "there is no place in this world for someone like me." I try to let them know that the world is bigger than they have been led to believe.

For example, I worked with a depressed young woman who appeared to be struggling with the conviction that she was "too sensitive." She described painful relationship experiences or situations she observed in the world around her. These situations bothered her but did not appear to bother others. Then she criticized herself for her strong emotional reactions in ways which sounded to me like the responses she got from people, especially adults, around her. In my experience, young people, like other disempowered persons, often have a highly refined ethical sense of fairness and justice. Typically, people with more power, for example, adults, do not like to be confronted with ethical objections or strong emotional reactions to their abuses of power. They tend to prefer to blame the victim for having faulty perceptions and for overreacting. This young woman seemed to have internalized such an adult figure.

I told her that her sensitivity to very small emotional shifts was very important in a culture where most people don't notice or respond to such things. I said, "People have a lot to learn from you. By keeping your sensitivity and developing your ability to work with it, you will be able to help and support others in ways most people can't. I wish I had met someone like you when I was confused about my emotions and no one I knew would even talk with me about it. This world needs people who spend as much time with their feelings as you do."

I used my power as an adult to affirm her perceptions of relationships and events in the world and encouraged her to use her own sense of justice to evaluate them. I tried to give her the message, "You have every right to stand up for your own values unless and until you yourself decide to change them." I believe that if I can support a young person to keep her ethical values intact as opposed to "growing up" to develop a "functional" or mainstream value system, I've helped make the world a better place for all of us.

Her response to my support was to seek me out when she was upset by current or remembered experiences and tell me her analysis of the situation and her reactions. By talking with me and receiving support, she was able to cope with her strong emotions without getting depressed and harming herself.

Some people might say, "What good is that? You won't always be around to talk to." It's true, I won't, but for someone who has never received the developmentally necessary validation of her emotional experience from another person, to get it even once is to begin to move from the despair of "no one can ever understand me, so I might as well die" to the more useful pain of "no one understands me right now but I know that it's possible because someone once did, and maybe someone will again if I keep trying."

Another patient, a young man with a strong interest in spiritual experience, felt that no one shared or understood his concerns. One of his complaints was "anxiety attacks." He did not want to use medications if he could avoid it,

although the hospital staff was encouraging him to do so. While it would have been considered inappropriate for me to bring to awareness and work with his anxieties, it was within my duties to teach relaxation techniques which help clients to maintain behavioral control.

I talked with him about cultures which have developed thorough and detailed technologies of the sacred, and told him how modern material technology has made it possible for teachers of spiritual practices to travel throughout the world. I gave him practical tips for finding these people and encouraged him to pursue his interests.

Along with these discussions, I taught him several breathing exercises based on yoga techniques, which he could use to alter his physical, mental and emotional states when he felt stuck in an unpleasant experience. He found these exercises useful, saying, "Wow, this is amazing!" He invited me to guide him through the exercises, and he continued our discussions whenever I was on duty. He would come up to me and say "I'm not anxious right now, but would you show me that breathing exercise again?"

4. Support and help unfold clients' experiences of extreme states of consciousness.

One young woman used to cry and say she was scared whenever it was time to go to her room to sleep. It took her a long time to settle down at night. Many staff believed her tearfulness was a sign of her depression. They considered her fear and her calling "Mom, Mom" despite the absence of her mother as signs that she was hallucinating. Since she didn't talk much, I did some guessing based on my observations, and watched for her verbal and nonverbal feedback. Here is a conversation we had:

Me: It's scary to be here isn't it?
She: (Nods "yes")
Me: So many people!
She: (Nods)
Me: You miss your Mom.
She: (Cries)
Me: Of course you miss her!
She: (More tears, then...) Mom! Mom!
Me: Yes, go ahead and call her.
She: Mom! Are you OK? (pause) Yes, she says she's OK.
Me: That's great that you have a way to find out that she's OK. It's important to know the people we care about are OK before we rest.
She climbed into bed and fell asleep.

A fundamental attitude or metaskill in all of my work is this: everything I do while interacting with another human being is significant, even though I may not be around to witness the results. Here is a supposedly true story which a friend told me.

An unhappy young woman walked into the elevator on the first floor of a tall building. As the elevator went up, many people got on and off. No one looked at her or spoke to her. In her culture of origin, you always acknowledged the presence of another human being, whether or not you had met before. The young woman got off at the top floor, made her way to the roof, and jumped off. Question: Would it have made a difference if even one person on the elevator had smiled or greeted her?

Guruseva Mason lives parts of the year in Rochester, New York where he co-facilitates groups for men who batter their women partners and works with individuals, couples and groups challenged by the mysteries of life on earth. At other times he is a nomadic process work student reconnecting in this lifetime with far-flung members of his spiritual family and clan.

"Possession" by Linda Greischel

Al de Half's Separate Reality

George Mecouch

Last year I was studying for my psychiatric specialty board exams. I felt pretty nervous, so I began reading Freedman and Kaplan's *Comprehensive Textbook of Psychiatry* (1989), the "bible" of information in the field. After reading one day on the psychoses, I dreamed the following dream: I am back at the Milwaukee County Mental Health Center, where I used to work. I call the medical director about an escaped chronic psychotic patient who is planning to murder me. They finally catch him and bring him to talk with me. He is a huge man, slumped over with arms that droop and hang down ape-like. He tells me his name is Al de Half (my other half). He looks absolutely enraged with me, saying that I read the wrong books. He pulls out a book and says "this is my Bible." It is *A Separate Reality* (1971), Carlos Castaneda's book about don Juan. I tell him I have read it, but he comments sarcastically, "Apparently not very well." He is showing me a page from the book with eight principles on it when I awake.

There could be many layers of meaning to this dream. Typically, most dreams are interpreted according to the individual's psychology, but I would like to view this dream through a cultural or "big dream" perspective, as Jung used to call it. One might say the psyche or soul represented as Al de Half tells us that extreme states form a "separate reality." This seemingly strange reality has its own governing principles. To begin to understand and help people in these states of consciousness, we must learn to jump in and live these principles.

What are these eight principles? Are they methods and techniques for working with people in psychotic states? I do not believe Al de Half referred to techniques. Instead, I believe he meant the background attitudes or philosophies we bring to our work. Techniques and methods only become useful after the crucial background attitudes are brought to awareness. In this article, I will attempt to delineate eight of the principles I imagine Al de Half felt were crucial to help souls navigate the sometimes dark shores of his separate world.

1. Hercules' sword be damned

In one of the many stories of Hercules' adventures, he goes down into Hades. Dropping into the underworld, he finds it hazy and lit by moonlight, not the bright light of the sun. As he tries to accommodate his eyes to this new world two shades (ghosts of the dead) approach him. In a flash Hercules pulls his sword and beheads them.

Hercules responds exactly as he has been trained in the day world. "This is good, this is bad," thinking the ego possesses the right to conquer and divide. Freud mirrors this attitude in his famous therapeutic goal: where the id is, there the ego shall be. But our heroic egos fail to see that the underworld is bathed in a different light, moonlight! We must get used to haziness and lack of clarity, unsureness and uncertainty. Good and bad are not so clearly divided here.

This principle helps us open to relationship, with "deep democracy" (Mindell 1992: 148). This is the realization that you are not the only ruler in your psychic house and that all inner parts deserve a voice.

2. Panic can be the deadliest enemy

We can see in the last story that panic leads to Hercules' precipitous reaction against the shades. Panic is an extreme bodily reaction often brought on by an overwhelming fear of the unknown. But what if Hercules could have stood with someone who reacted with more understanding toward the contents arising from his unconscious? Jung points out this same thing beautifully in his intro-

duction to John Perry's book *The Self in Psychotic Process* (1987) when he says:

> One should not underrate the disastrous shock which patients undergo when they find themselves assailed by the intrusion of strange contents which they are unable to integrate. The mere fact that they have such ideas isolates them from their fellow women and men, and exposes them to irresistible panic, which often marks the outbreak of manifest psychosis. If, on the other hand, they meet with adequate understanding from their physician, they do not fall into panic because they are still understood by a human being and thus preserved from the disastrous shock of complete isolation. (Forward: v)

In R. D. Laing's famous book the *The Politics of Experience* (1968) he wrote a chapter called "The Ten Day Voyage." In it the client was asked what would have made a difference in his treatment, and he responded, "A sheet anchor, a feeling that someone understood" (163). These ideas of Jung's and Laing's were well tested in the late 1970s in facilities such as Diabasis and Soteria House, hospitalization alternative treatment facilities for people in psychotic states. When helpers met acute psychotic experiences (the shades of Hercules) with an attitude of openness and validation, they found that clients often came through these extreme states more rapidly than similar patients treated in less open facilities (Mosher 1975; Perry 1974).

3. Random firing neurons do not exist

I took this comment from James Watson, winner of the Nobel Prize, who went into dream research after his DNA fame. He implied that dreams were random neuron firings with a purely biological purpose. This theory makes it very hard to validate a person's experience as useful. Armed with this attitude one would tend to compare the psychoses to chronic physical illnesses caused by biochemical abnormalities and genetic predispositions. Biologic theory has many merits. But I state unequivocally that no matter what a person's genetic and medical history, they always have a psychology. Therefore they always have a communication system, albeit sometimes very difficult to understand. I believe in the irreducibility of a person's psychology.

This belief allows us to continue to look for new ways to work and communicate no matter what the current prevailing theories. The idea that a client's attitude can effect the outcome of their psychosis was shown very nicely by Sokis and Bowers' (1969) research. They found that clients who were interested in how to make sense of their psychotic experiences had a much lower rate of recidivism than did the clients who considered the experiences as "nothing but" part of a biochemical illness.

4. Purpose and meaning exist even in the most obscure communications

This principle follows Jung's famous ideas about finality, also known as the synthetic method or teleology. This is the idea that women and men are not created by past history alone, that is causa efficiens, or the reductive method. They are also pulled toward the future by personality parts that wish to express themselves and to expand the person's personality into its total creative potential.

> The psychology of an individual can never be exhaustively explained from himself alone... No psychological fact can ever be explained in terms of causality alone; as a living phenomenon, it is always indissolubly bound up with the continuity of the vital process, so that it is not only something evolved but also continually evolving and creative. (Jung 1921: 430)

Jung's finalistic ideas separated him from Freud, and Freud's more causal emphasis, near the beginning of Jung's career. Jung's finalistic principles came to be widely held about neurosis. Jung also held the same ideas on psychosis in the last paper he delivered on the subject. He says:

> it is now just about fifty years since I became convinced, through practical experience, that schizophrenic disturbances could be treated and cured by psychological means. I found that, with respect to the treatment, the schizophrenic patient behaves no differently from the neurotic... I have now, after long practical experience, come to hold the view that the psychogenic causation is more probable than the toxic causation. (Jung 1958: 258; 263)

This attitude of belief in the purpose of the psychic contents of their clients helped distinguish the pioneering work of John Perry and Arnold Mindell. I feel this attitude is absolutely crucial in working with clients, regardless of how bizarre their statements seem.

I became even more convinced of the importance of this idea after recent work I did with a woman at a local mental health center. "Sandy," a woman of about 25, had a long history of recurrent depression and psychosis. She came into my office in an extreme state, saying that she was one of the people who killed Christ. She also felt she had sinned against the ten commandments and felt quite paranoid about people at her workplace knowing her business. Sandy spoke in a crying voice, with huge gaps in content as if every time she had a thought an opposite one would come and attack her. This made verbal communication almost impossible. At one point she became quiet for a moment, then meekly said she felt like the holy spirit but was unworthy.

Her head then went down as if someone pushed her. I followed this signal by gently pushing her further down and telling her she was unworthy. I embodied the thing pushing her down as an intervention. She resisted slightly, then crumpled in a heap on the floor. We switched roles since she identified more with the pusher, or critic. She immediately demonstrated a lot of energy for this part, telling me I was unworthy. I countered by slowly resisting and turning to face her, telling her I was worthy. She escalated, pushing me and saying, "I hate you and I want you out of my life." She suddenly stopped, gasped and began to weep uncontrollably. I asked her, "Who do you want out of your life?" She gasped, "The devil." I encouraged her to tell me someone more personal and she gasped again, "My husband." Sandy began to tell me the rage and despair she felt over an affair her husband was having that she could not confront. For the next 30 minutes, we spoke about her feelings with no further evidence of the thought disorder and psychotic thinking that had been present just a short time before.

5. Don Juan's ally or Jacob's angel

If you begin with an attitude of purposefulness toward the psyche, then even frightening figures which appear, such as the "critic" in the example above, may become allies for you. I use ally in the dictionary sense as someone or something that may prove useful on your path. The ally usually arrives in even scarier disguises than above. An ally may come dressed in the paranoid fears of someone breaking into your house; you triple bolt the door in response. It may also appear as auditory hallucinations too bizarre to understand and too unbelievable to carry out, like the client who heard a voice which identified itself as his conscience and told him to have sex with his mother. The ally doesn't just hand over helpful information "free of charge." Jacob discovered with the angel God sent to wrestle him that the fight with the ally could be a fight to the death.

Don Juan says of the ally:

> when a man is facing the ally, the giver of secrets, he has to muster up all his courage and grab it before it grabs him, or chase it before it chases him. The chase must be relentless and then comes the struggle. The man must wrestle the spirit to the ground and keep it there until it gives him power. (Mindell 1993: 114)

In psychological terms we might say the first step involves filling out the unconscious material, the hallucination, or overwhelming paranoid fear, into a figure with which we can relate. Then the key is the "Auseinandersetzung", having it out and coming to terms with the figure. The ally must deliver its message to someone—the message must be heard. If you do not translate the message consciously, the ally controls you unconsciously, often acting out its message in literal forms in the day world.

6. An ear for the symbolic

It is one thing to believe in the purpose and meaning of the psyche when it shows you how you need to be more assertive in relationships. But what do you do when the message is not so understandable? Take for instance, these statements from clients I have seen: "You need to have sex with your mother." "You know that you must stick the cross in the urine; it is finally the time." "You must put the evil mind away in a coffin in the center of the ring of fire the temperature of the sun."

The language of "the separate reality" is symbolic and we must practice developing an ear for it. People who fall unwillingly into psychosis often lose the ability to hear the metaphor in many of their allies' messages. One of the first clients I saw as a resident was a young man living with his elderly parents. They brought him for hospitalization because he had become quite paranoid, barricading his door, staring out the window watching for intruders and hoarding knives under his bed. The court released him from the hospital after a two week stay because he failed to meet the criteria for long term commitment.

The client then refused all further treatment. A few months later he tragically came to my attention again when the police arrested him for murder. He had stabbed a five year-old boy to death because he thought the boy was an alien invader from outer space!

This topic has many unanswered questions in need of research. How do you take these symbolic statements and feed them back to clients so they can live them more usefully in the moment? How do you help connect the symbolism to the personal emotional core? The main principle to remember is that clients cannot hear the metaphor while in an extreme state of consciousness. The therapist must hold the awareness and be prepared to jump into the emotional caldron with them.

7. A nose and stomach for the putrefactio

Psychosis is the state of dissolution. The dissolving of the old personality is in the midst of occurring. When things dissolve and decay, they often smell: dirty clothing, caried teeth, malignant emotional disorganization, contorted postures and regressed behaviors, loose, tangential thoughts moving too quickly to catch. Speaking of this state, Bleuler said that we react to these experiences as something that threatens our very existence (1963). Harry Stack Sullivan noted that the normal have an aversion for the insane. How can we learn to stomach states like this long enough to work with them? An idea from Jung helps me. He said, "the establishment of order and the dissolution of what has been established are at bottom beyond human control. The secret is that only that which can destroy itself is truly alive" (Jung 1944: 73).

John Perry realized this when he said that it is the order (the pre-morbid personality) that becomes the problem. The psychosis itself is the attempt by the psyche to destroy itself (the putrefactio) so that it can be reestablished in a new and revitalized form. He demonstrated this beautifully in his book *The Far Side of Madness* (1974).

Cross-culturally, this same pattern appears in Mircea Eliade's writings on shamanism and anthropologist Victor Turner's research showing that various tribes actually sought this dissolved state for long periods of time as a key to initiation rights (Turner 1987). Scholars call this state the "limen," which means being in between doorways, or not yet one place or another. In some traditional cultures young boys and girls stayed in this state as long as a year, as a transition from childhood to adulthood. Turner delineated three stages of the process: separation or dissolution; liminality; aggregation.

He found that in times of sociocultural transition the limen phase was induced in the tribal initiates by tribal leaders as a rite of passage.

The limen consists of an area symbolic of no past and no future, yet both. The candidates are stripped of all clothing, have no place to live except the wilderness, and are nameless. Every trace of graspable identity is removed. Turner found that "logically antithetical processes" symbolize this period (1987). For instance, the snake is chosen because it sheds and regrows its skin. The tunnel represents the womb and the tomb, the moon waxes and wanes. All symbolize the death and rebirth theme that occurs over and over again in work with extreme states clients.

8. What's love got to do with it?

Everything! As therapists know, technical interventions do not equal cures. Interventions help in the moment, often getting crucial information to help with the integration of split off personality parts over time. But no technique will replace the traits of love, patience, and devotion. "The thing that really matters the most is personal commitment," Jung said, noting that he had seen miraculous cures "...by nurses and lay people through their courage and steady devotion, to re-establish psychic rapport with their patients" (1958: 265). This was hammered home in the 1973 study of cross-cultural psychosis by the World Health Organization. They found that in non-westernized, non-technical countries the cure rate and lack of recidivism far surpassed westernized, technologically developed countries even with so called modern treatment. The conclusion drawn was that the non-westernized countries keep individuals involved in the community, and therefore not isolated and ostracized (Sartorius, Jablensky and Shapiro 1978).

In Closing

I want to reiterate that these eight principles are just beginning musings to fill out the pages of Al de Half's bible. The ending is nowhere in sight. We need new ideas and insights from patients, their families, mental health professionals and ordinary citizens. Hopefully some day not too far in the future, we will be able to have an open discussion in collective mental health circles about

the importance of psychotherapy in the treatment of psychoses.

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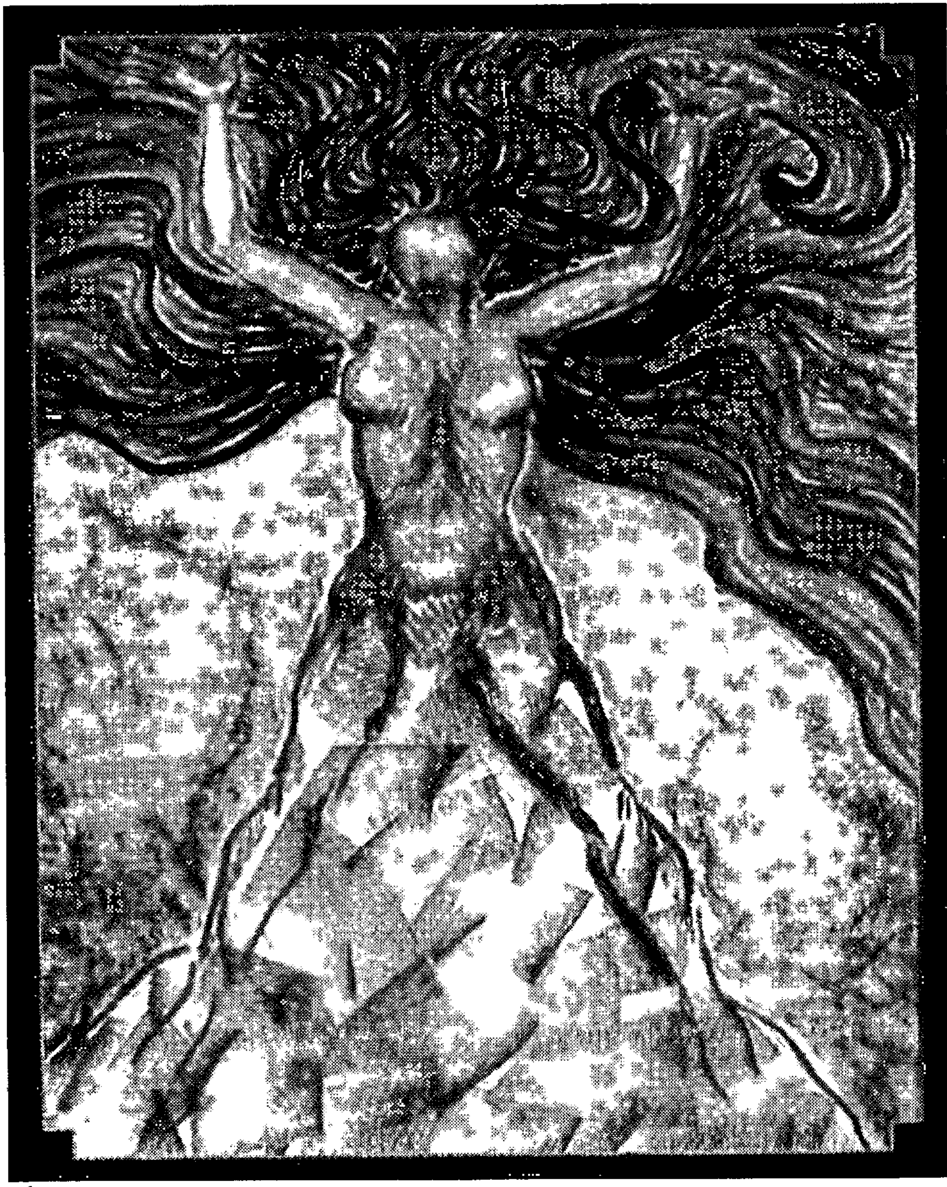

"Volcano Woman: the Warrioress" by Linda Greischel

Return to Sender: the Spirit in Abortion

Jan Dworkin

The following article is a personal account of a seven week pregnancy and an abortion. It is the story of the various extreme states which this experience brought on and the learning which came forth. I went through the entire experience with Robert King, my partner and lover, and all the learning came from the source between us. This is a deeply personal account. I am moved to share it because the dreaming world has indicated that my story is meant for the public. I am prone to altered and extreme states of consciousness, particularly through relationship experiences. I usually feel that these experiences are deeply private and embarrassing.

Those who suffer extreme states over long periods often feel isolated from the "normal" population and hide their experiences. However, Mindell (1988) shows that extreme states are extreme relative to a cultural mainstream.[1] Extreme states happen in part as compensation for a culture which disavows aspects of itself in order to preserve its identity. Hiding these extreme experiences supports cultural "splitting." Those who conform to the Eurocentric style of living, loving and communicating are considered "normal" and inherit the right to describe and delineate consensus reality. Others appear unusual, crazy or simply deviant, and either remain closeted or spill onto the streets and into our families, unwanted and marring the clean mainstream image. This splitting results in a myopic mainstream which doesn't know its own wholeness.

Although I appreciate so-called "sanity" as one spice in a very flavorful stew, I do not support the hegemony of the center or "centered," including its rational, linear, academic and non-emotional style. I cannot be a part of cooking, eating or serving a bland and one dimensional future. I cannot endorse a system which makes it dangerous to reveal unusual proclivities and extreme states.

I believe many of our most secret aberrations can be deeply meaningful and potentially spiritually enriching for ourselves and for our world. Sharing these deeply personal experiences and learnings is outside the cultural norm. I do so now with trepidation, knowing that I risk being judged for both my viewpoints and my person.

I recognize that abortion can be a very painful and traumatic process for women and men and in no way mean to undermine that fact in this article. Although abortions were common in ancient and pre-industrial societies, Christianity always considered abortion sinful. By 1880 the procedure was prohibited in the United States, except to save the life of the pregnant woman. When abortion became a crime, many women endured the pain, humiliation and risk of illegal abortions. Abortionists often forced women into sexual relations prior to performing an abortion. In the 1950s one million illegal abortions were performed in the United States and one thousand women died each year from the procedure. Approximately 75% of those who died were women of color. It was not until 1973 in the Roe vs. Wade Supreme Court decision that abortion became legal in the United States. We are all familiar with the worldwide movements which are attempting to criminalize abortion once again.[2]

I dedicate this article to all the women who have gone through abortions before me. I especially honor those who have suffered or died from illegal abortions or for whom abortion was not a

choice but a necessity dictated by social, economic or emotional constraints.

Although Robert and I experienced emotional turmoil and pain in choosing abortion, we had the time and resources to use the experience in order to learn and grow. This is a privilege which many women and men do not have. We want to use that privilege by sharing our learning with you. In addition, we will continue to work towards insuring that women retain the right to choose.

The viewpoints expressed in this article are mine exclusively and do not necessarily represent the beliefs of the editorial board of this journal.

A public calling

While I was pregnant, I dreamed about a pregnant woman with a shamanic calling. In the dream, she appeared as Shelly Tambo-Van Coeur, an oddball character from the television show "Northern Exposure." I identified with Shelly in my dream, and learned that my pregnancy itself was a calling, meant for an audience—the public.

In some indigenous cultures, shamans believed that when women became pregnant, their task was to discover if they carried an 80 year old baby or an 800 year old baby. The 80 year old spirit was the seed of an ordinary child, meant to be born to this world. If the couple discovered an 800 year old spirit, the woman was not to give birth to a human child—rather, a shamanic calling was indicated and the couple was given a task. They were meant to find their song and bring it back to the community as an offering.[3]

The dreaming world indicated that ours was an 800 year old baby. In this article, we offer our song: our personal learning and inner research. We also hope to bring a new voice to the controversial subject of abortion. Our perspective may not yet have been represented by pro-choice or anti-abortion viewpoints. It is one story of the discovery of spiritual meaning through an extreme state in relationship.

About five weeks into my pregnancy, I walked into a room full of people. A close friend asked the group gathered, "How many people think Jan should have the baby? Let's see a show of hands." Is that normal? To make a public spectacle of the most private and personal of decisions? Hardly a soul had known I was pregnant.

My life has seldom been private, my decisions have rarely been personal. I've always sensed something uncanny in the boundaries between my private self and the public. As an art major in college, I painted huge portraits of myself and my closest friends, stark naked. They are still showing on the walls of my home today. And then there is the behavior of my purse, safekeeper of my identity. I misplace my purse once a week. I've been doing so for years, leaving it in public places: restrooms, restaurants, trains. It is always returned to me, intact: commonly it is handed to me as I frantically return to the site of its disappearance. I once lost it in the Chicago O'Hare airport, stuffed with five thousand dollars in cash. Detectives informed me that the airport was crime-ridden and whomever had stolen it had probably already left the country. Two days later I was contacted by airport officials. My purse had shown up in the lost and found, complete with all the money, passport and credit cards. I received it, via UPS, the following day.

I don't believe these events can be completely reduced to carelessness, extraversion or narcissism. I am slowly discovering that I am public property. My life belongs to a greater spirit. Among most feminists today, being the property of others is not popular; liberated women ought to demonstrate independence, self-reliance and autonomy. Perhaps some of contemporary sado-masochistic sexual practices compensate rigid demands of Eurocentric feminism by teaching us to relinquish control and give ourselves over to something greater, stronger and more powerful (Paglia 1992: 147). The more I identify with my bondage to the Spirit, the more liberated I feel to become the woman I am meant to be.

Pregnant with love

Conventional wisdom told us that our pregnancy, this seed of life between us, had the potential to grow, to come to birth and to make us a family. It is said that having a baby and nurturing a child as she grows creates a bond equal to no other. Many say childbirth is a peak experience to which nothing can compare. "It is the ultimate." "There is nothing like it." "You aren't complete without it," I've heard. At this time, we said no to that. We killed it. And through that "no," we have begun finding our song, our 800 year old baby. The ancient and eternal soul. Our bond.

My personal decision not to carry the child occurred in the midst of lovemaking. It must have been about 9:30 am. And then it was 11 and 11:30. I was looking into Robert's eyes, and I thought, "I

couldn't have this. We couldn't make love all morning if we had to care for a child." And then I knew that this was my child. THIS. This moment. This feeling. This love. This bliss. This bond. This was the child which I want to have again and again to love and to nurture.

Of course, I want to make THIS into a permanent state—I want it to last forever. That's when I lose the baby. A few short hours later we were out of that extreme passion and into another one—a violent fight, a bad mood, the pits. THIS never lasts. It always turns into something else which we don't welcome. I'm learning to say yes to it all. Yes to love and yes to conflict!

Our baby was conceived on or around Thanksgiving, at a time when I had made a huge transformation in myself. One evening, walking along 23rd Avenue in Portland, in an unusually lucid and altered state of consciousness, I realized that I could accept certain people in my life who had hurt me. I felt a deep love for my own mother! Despite her mistakes and shortcomings and hurtfulness, I could love her. I saw that she needed my love. She would blossom from my love. I made a change. And I got pregnant.

We never thought we could get pregnant. Robert didn't think he was fertile. He was sure he was "shooting blanks" (metaphor of a true warrior). So he had a fertility test. He shot his wad into a cup, which he reported is no easy feat in a doctor's office with attendants waiting patiently for the sample. They tested it. His little soldiers were marching with their guns loaded! But we played with fate anyway.

I thought I must be the infertile one. I've never been careful about birth control. I was sure I was too cold to be fertile. My hips are too narrow, I'm too thin. I don't eat enough and until then, I didn't cook. I thought there wasn't much motherly about me. I had never baked a cake, planted a garden or taken my nephew to the zoo.

But things were changing. My heart seemed to be opening more and more, even to myself. During that same week, I spent an entire Tuesday, that is a weekday, a WORKDAY, in bed with Robert watching TV and making love. I don't watch TV. I hate TV. As far as I'm concerned it is a creativity killer and devours brain cells. But I lost my mind and my metacommunicator and had one of the most blissful days of my life. Relaxing, being, breathing, loving.

And we got pregnant. Sometime that ecstatic, blissful week, love got us pregnant. We found out the day before Christmas. In time for Christmas. Jesus said "Love thy enemy. Love thy neighbor as thyself. Love takes precedence over the law."[4] The trick is in learning to love all the states—the friend, the foe and the self.

My deviant body parts

In the 1990s in the United States, abortion should be a fairly straightforward procedure. I elected to go early in the day to have a seaweed laminaria inserted in my cervix to dilate it slowly over a few hours. This is a more natural method, which I chose over the steel rod approach, where they pry open the cervix, allowing the procedure to happen more quickly. But things rarely go as planned when it comes to my body.

My body is a garden. I grow tumors, cysts, polyps, lumps, bumps and babies. I cut them out, or have them removed, and they grow back again like weeds. Recently I had a polyp removed from my cervix during a routine pap smear. I fainted on the doctor's table, once again alarming professionals as I tripped to the other world. If only the doctor had encouraged me, like the Senoi elders do when a child falls in a dream, saying "You must relax and enjoy yourself when you fall (faint)... Falling (fainting) is the quickest way to get in contact with the spirit world... The falling spirits love you..." (Larson 1988: 98). When I returned from the trip, I looked at the polyp in the test tube and imagined it was a fetus. A few weeks later, we discovered my pregnancy.

The "pregnancy," with its little heartbeat, must be located on the ultrasound before it can be aborted. The mass of cells is referred to by clinicians as the "pregnancy" so as not to offend the parents and make us feel we are killing a human being. We preferred to call it the "spirit" the "baby" or (endearingly) the "little pooper." We couldn't be fooled. At seven weeks it had a heartbeat and we believe, a spirit. Eternity.

But my pregnancy proved hard to detect and the procedure could not be carried out as planned. In fact, when they went in with the ultrasound they couldn't even find my uterus! No uterus had ever been lost before, but mine was nowhere to be found. We thought for a moment it was an hysterical pregnancy, complete with morning sickness and mood swings—a case for Freud. Perhaps I just needed some attention and some time off.

They probed my most private sanctum with a microphone-shaped ultrasound device, covered with a condom ("safe" exploration), for what seemed forever. Eventually, the nurse located my uterus. Apparently my cervix is very long and narrow (like me) and my uterus is tipped and hiding way back there somewhere (like Robert). My vagina apparently is short, which complicates matters further.

After the discovery of my uterus the baby seemed to be missing. It could not be detected on camera. More poking, more prodding. When it was finally confirmed that I was indeed seven weeks pregnant, it came time to insert the laminaria and dilate the cervix. Foiled again. My long and narrow cervix takes strange turns and twists. It refused to accommodate the laminaria.

With reluctant kindness, the nurse suggested that I come back the following day when the doctor on call had more experience. "He's seen everything," she said. "Even weirdos like you!" I heard. "I think your procedure might be more complicated. I recommend giving you a narcotic." "It's going to hurt like hell and you might die," I heard.

Although I no longer expect to be like others, I still feel disconcerted hearing about all the deviance of my body parts. I would prefer the medical establishment not compare my private organs to some standard of normalcy. I wish they wouldn't enter me with their machines and technology. But this is all happening in a social milieu which is dangerous for doctors and clinics. There is so much fear of malpractice in the United States that medical people have to move slowly and test thoroughly to protect themselves. I'm grateful to abortion doctors, nurses and technicians who sometimes risk their personal safety to make sure that women maintain reproductive freedom.

In retrospect I appreciate my body's wisdom. My uterus hid, protecting the spirit to give us an extra day to discover our calling and our song through this ordeal. However, with the disappearance of my uterus, my metacommunicator also left. We went home and I sobbed and trembled and felt sorry for myself. Why does it always have to be so complicated with me? Why couldn't we have gotten it over with? I felt so out of control. I thought I was losing my mind, going crazy, having a psychotic break.

With Robert's loving support, I managed to work on myself. I gave up my need to stay in control and let myself be moved by something greater. What finally moved me was hunger. Amazing. For me to feel hungry is unusual; to be moved by hunger is monumental. I eat according to schedule, often pre-determined quantities. This was revolutionary; a momentary satori. "When tired sleep, when hungry eat." A new form of mothering.

While I was lying down, letting myself be moved, the world channel began to express itself. Our household machinery became animated—the answering machine clicked on without the telephone ringing, the VCR turned on and off, lights flickered. It was eerie; we were spooked. As we unfolded the experience, we recognized the participation of our appliances as another signal telling us that our story was meant for the public.

Aborting and being

When the moment arrived to have the abortion, I felt terrified. I feared death. I dreaded knowing that strangers would enter my most private temple to tamper with the mystery of creation.

The receptionist at the clinic cracked all these jokes about my name, in the waiting room, in front of everyone. "How inappropriate," I thought. This is a serious matter. Then she began to tease me about a free trip to the Bahamas—as if I were about to go on vacation. I wondered why she was being so jovial. She seemed so serious with the other patients. Had she no feeling for me?

Her lighthearted reference to a vacation portended the wild trip I was about to embark on. Who would have believed that a couple of minutes later I would be roaring with laughter? I breathed into the nitrous oxide and absolutely exploded with laughter. The doctor, the technician, the nurse, the counselor, Robert, the whole room was in stitches. My pelvis was shaking so much they could hardly do the procedure.

All the medical people had urged me to take a narcotic to reduce pain, being that my organs were so oddly placed and shaped. But I resisted, and I'm glad I trusted myself. The procedure hurt a lot, but there was no need to have been knocked out. It hurt terribly when they stretched my cervix, and the suctioning felt awful, but it ended so quickly. Then I felt hot. Then I felt cold. They covered me with blankets and wheeled me to the recovery room.

Most women get up off the table and walk to the recovery room. Not me. I was out of it, shaking and cramping and holding Robert's face close to mine. He was asked to leave when another woman came into recovery. I just lay there for a while. Then came the bliss.

I never wanted to leave that recovery room. It was perfect. I felt perfect. Caressed by the Spirit. My temperature was just right. I felt so much love for Robert and so lucky to be with him. I experienced no pain. I was in heaven, looking out the big windows over the city. The light was perfect, the city was paradise. Other women came and went. They wanted to get out of that room, back to their normal lives. I wanted to stay there forever, in God's arms, the perfect womb. Everyday life seemed far away.

As I lay in reverie, one of the nurses asked me if I would be willing to do counseling for women who need support after an abortion. They wanted my card. The public wanted me. They had heard about the work that Dawn Menken and I had done years ago around the abortion debate.[5] I had been very supportive of the doctors and nurses during the abortion procedure, encouraging them in their work. They enjoyed me.

When I was ready to leave I found Robert in the waiting room. He brought me to the window and showed me an incredible double rainbow across the sky. He had been sad, mourning the loss of the baby and feeling guilty about having to send the embodied spirit back. "Return to sender. Address unknown," he was lamenting. Then the rainbow appeared. All was right. We recalled the last rainbow we had seen together, over Portland. It was during one of our liaisons as we were falling in love. I had joked that I wanted to have a baby with him as we ate pancakes in this funky cafe. Then we went out for a walk and saw a rainbow.

Dream song

Robert dreamed a song the night before the abortion. In the dream, an old geezer was walking along the street with his dog. He was singing and roaring with laughter. And then the bum grabbed a machete and sliced the dog's head off. Just like that. He was laughing and blood was spurting everywhere. He told some guy to eat the dog's brains—to eat the whole dog. Then he began to sing a song about breathing and living. "Oh the air is clean."

Dreams happen. I feel Robert's machete sometimes and he feels mine. The machete is an aspect of both of us which we need. Driving to the abortion we had a violent fight. Robert was in a rough mood and it came through in his driving. I was nauseous, freaked-out and wanting a smooth ride. We blew up at each other. I yelled at him not to come, that he was not welcome at MY abortion. He insisted despite my anger and vehemence. I didn't mean it anyway; it would have been terrible without him. He was incredible, so supportive, my love. We can find better uses for our swords.

Our song, the piece of the Spirit we bring to you, has to do with love and murder, with breathing and being. These are extreme states because they are disavowed aspects of our community and relationship life, often coming out without awareness. I believe we all need access to these states to grow together as a culture.

A spirit of murder

"Abortion is murder," the Right to Lifers say. Yes we say. Yes to murder. Sometimes it is right to kill. We got a lot of murder out of this experience. The troops were armed and ready, this time. Let's talk about some of the things which Robert and I needed to murder. The beliefs that the true bond between lovers only happens by having a child and that having a child is the ultimate expression of a couple's love are now dead. The dream that we can always be in a state of togetherness and bliss is over. The ideal about absence of conflict in love is finished. My determination to be creative by pushing myself and the idea that I can force a baby out is gone by. Robert is killing aspects of his thinking and analyzing and ingesting his more wild instinctive nature. Our self-hatred bites the dust.

There is so much to kill—so many wrong ideas about life, so many plans and programs which are always defied by nature, by the Great Mother, the Tao, the whirlwind, the snow storm which wipes us off the road when we think we have control. We could make a life's work out of murder, if only we had the right intentions. Many of the social and cultural norms and rules regarding love still need to be killed. In our culture, certain loves are valued, others outlawed. Some of the beliefs to murder include: a heterosexual man and woman make a family, so only heterosexuals can marry. Homosexuality is a disease, an addiction, a sin. Gays should not raise children. Interracial

marriages are wrong. There is only one way to God, through an organized religious form.

These beliefs are insufficient, I say. They deserve recognition as one viewpoint among many, but must be challenged as the ruling paradigm. For me, God is where love is, and passion and conflict and nothingness. God is in the mystery, the unknown, the numinous. I don't believe that culture should dictate rules and regulations for love. This must be killed so people can be free to discover their unique relationship to the divine.

Anti-abortion groups claim they want to protect the lives of children. I believe this worthy goal could be better accomplished by working in the inner cities, creating social programs and economic opportunities for disenfranchised youth who don't expect to live past their teenage years. We could work together to combat institutionalized racism which leaves people of color with little or no support and protection from the mainstream United States.

Anti-abortion groups seem to me sentimental primarily about the lives of unborn white middle class fetuses. They say these "children" have no protection, no voice. Certainly this is true, but we haven't yet developed the psychological, spiritual or scientific technology to communicate with these "unborn children" in order to hear their voices. Developing such technology could help determine whether or not they wish to be born at this time, in this place, to these parents and into this difficult and complex world.

We take the message from anti-abortion groups even further. We needn't stop with giving voice to unborn children. We could listen to living children as well. We'd listen to the voices of youth, people of color, women, the differently abled, the elderly and many other groups in this country who are systematically abused and silenced by the mainstream. We would give voice to our own creative impulses, our feelings, our jealousies, insecurities, dreams and ideals. We would listen to all the parts of ourselves which we tend to silence and repress because they don't go along with our desired identities. Let's use the message from anti-abortion groups to wake up and embrace an inclusive spiritual calling. We can attempt to make our home, this planet, a more humane and democratic place for all people.

The spirit of murder can be positive if used to serve the spirit of life. I recommend it. Instead of killing each other we might begin to abort the laws and systems which create the competition for resources, the abuse and the desire for vengeance which drive us to destroy each other.

We offer a new perspective on abortion. Some of us may need to abort some of our rigid sentimentality around traditions such as marriage and childbirth and even life and death. It seems to me that in many inner city communities where murder and random violence have become daily threats for many people, some youth have been robbed of their natural sentiment for humanity. Perhaps so much of the explicit violence in the United States happens in certain subgroups in part because others, who identify with law-abiding mainstream values, do not use their own violent impulses consciously. Many people express violence behind closed doors towards those less powerful. Or they repress violent impulses, allowing them to tear apart their bodies and souls. Violence is a capacity we all share and should put to use for the benefit of all. We have so much to kill, except time.

Birth of a mother

Through these many deep and rich and extreme experiences, I became a mother, a mother whose identity is not defined by traditional mainstream or Eurocentric feminist conceptions of womanhood. She is sometimes a nurturing caregiver, devoting herself to the creation of food and comfort for her loved ones. At another moment she becomes a holy harlot, a temple prostitute, offering her body and soul to god, unrelated to the cares and needs of others. She can appear as Sheila-na-jig, the mother goddess and womb of Celtic myth, all head and vulva, no softness, no breasts, athletic and acrobatic, an exhibitionist. Sometimes she manifests as the fanged Hindu goddess Kali, at once sane and insane, who adorns herself with human skulls and dances on graves (Paglia 1992). I say yes to supporting all these aspects of womanhood. I say yes to life and love and the sword and murder.

When we first found out about the pregnancy, we referred to the growing cells as "the little pooper." This is yet another aspect of womanhood, of humanness, which I have birthed. We offer the spirit of the pooper: a naive, happy child of the universe, enjoying life without worries, breathing freely, knowing that she is in the hands of the Spirit. I wish every child and every adult could have this feeling, at least for a moment.

I feel the presence of an affirming, loving and democratic mother, one like the sun which shines on flowers and feces alike. I'd like to be this mother to you. I want to say yes to you. The 800 year old soul in me can feel you. I feel for you if you've wanted a child and couldn't have one because of economic or legal issues, fertility problems, emotional constraints, homophobia, sexism, racism. If you've had an abortion, I feel your suffering, your ambivalence, your elation, your sense of empowerment. I say yes to you. I say yes to the conflict between pro and anti-abortion viewpoints. Yes to your love and your murderousness and your being. Yes. You can breathe, you belong here on this earth, each and every pooper, all your instincts, your creative and destructive urges, your messy poops. Yes to your blocks, your pain, your symptoms and your death. Yes. Yes. Yes. Live it here now. THIS is the moment. You never know when it will be time to "Return to Sender."

Notes

1. A complete description of Process Work with extreme states can be found in Arnold Mindell, *City Shadows: Psychological Interventions in Psychiatry.* London: Routledge and Kegan Paul, 1988.
2. For a concise overview of the history of abortion and abortion rights see *The New Our Bodies Ourselves.* Boston: Touchstone, 1992: 370-82.
3. This story was told to us by Arny Mindell, who first heard it from Franz Ricklin. Arny told us that the story was repeated to him by a Native American elder in New Mexico.
4. *The Holy Bible. New Testament.* (Matthew 23: 37-40).
5. In 1990 Dawn Menken and I facilitated a conflict between Advocates for Life and National Abortion Rights Action League (NARAL) during a class held at the Process Work Center of Portland.

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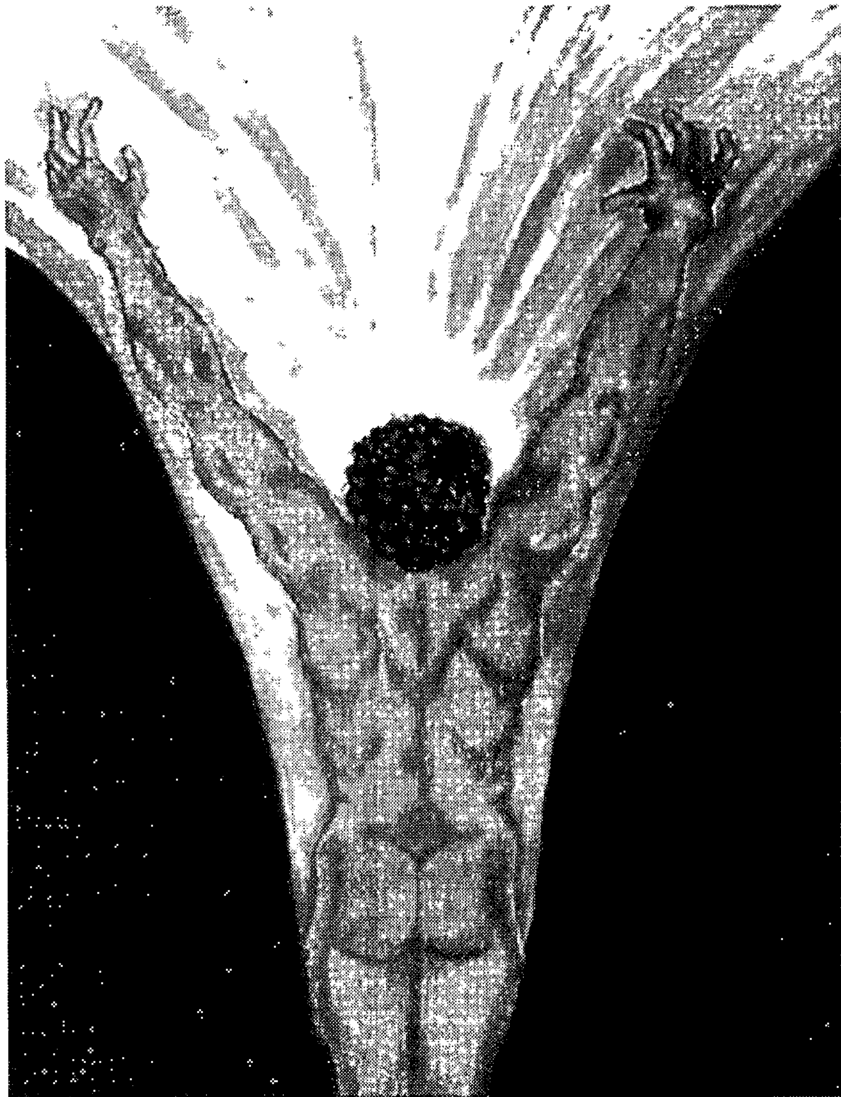

"The Seeker" by Linda Greischel

An Attack of the Heart

Maurice Shaw

Introduction

In August of 1992 I experienced an "acute dissecting aortic aneurysm"[1] involving the part of the aorta closest to my heart. Without surgery this sudden condition proves fatal. To my knowledge, I had no predisposing health problems. I had been working at full capacity, as is my style. I cared for people with HIV in many ways, including education, counseling, friendship, advocacy, nursing, volunteer training and preparation for dying. This article is an account of my own experiences when death came so close.

The attack

Chest pain. Difficulties breathing. I rang my friend Jennie to take me to the hospital. Then Paul, a good friend who is a nurse, arrived and drove me in immediately. The accident and emergency department admitted me and placed me on a trolley. A nurse stayed to look after me.

After two hours of waiting, I grew so tired that my head jerked to the side. The nurse hit the cardiac arrest alarm button. Five doctors arrived. They held my arms and legs while they inserted intravenous catheters, took oxygen levels, connected me to machines, and placed a big black mask over my face to help me breathe. My pulse was being taken in my leg; on two occasions they said that they had lost it. One doctor prepared to do cardiac massage. I tried to push them away and tell them that I was not having a cardiac arrest, but this was impossible, as I had a mask over my face and was being held down.

If the doctor had administered cardiac massage, the aorta would probably have split there and then. Because it was dissecting, very little blood reached my feet at certain periods. This explained the faint pulse.

The next afternoon, Saturday, I found myself in a ward at the Cairns Base Hospital, on the Northeast coast of Australia. I had been in the Intensive Coronary Care Unit (ICCU), where tests were done all the previous night and in the morning. The tests found nothing wrong. I had been waiting for the doctor to arrive to perform a final test, and then I could go home.

The doctor was halfway through the test, an echocardiogram, when the Sister from the Cardiac Unit came in with my clothes and shoes. The doctor asked her what she was doing. She replied that she was bringing my clothes, since I would be going home soon. The doctor said, "Mr. Shaw will be back in Coronary Care in about ten minutes. Tell Doctor... to ring the Flying Doctors, and organize a team to fly him to Brisbane as soon as possible. She will need to ring Prince Charles Hospital, let them know that he is arriving and that he will need to have open heart surgery immediately. That is, if he makes it."

There it was. Just like a UFO. Something foreign, dropped in from outer space. Difficult to believe that it had something to do with me. I was on my way home. Wasn't I????

Parts of me started leaving at that moment. It was as if I were 25 different people, with many feelings. Some of them included: happy, sad, angry, loving, vicious, timeless, in the present, pain-filled, abused, vengeful, loved. I felt young and old, male and female, like a teacher, friend, child, enemy, abuser, father, mother and brother. Over the next hour, I felt less and less present. I could call up fewer parts of myself; I slowly went numb. It was like being in a trance where I felt very young and vulnerable and very old at the same time.

They took me back to ICCU and started putting in drips, catheters, naso-gastric tubes, etc. "Just relax and swallow," the medical personnel said, while putting a tube down my nose. After six attempts they eventually got it down. "Just relax," while a tube was being put down my penis. After many attempts and three tubes of lubrication it was in place. I challenge any doctor or nurse to relax and swallow while having a naso-gastric tube put in. I also challenge any male to relax while having a tube shoved down his penis.

Prior to this, I had very little to no pain. Now that they were on their way to healing me, I felt a mass of pain. I know the medical personnel did what they had been trained to do. But the PAIN. I realize that I desperately needed allopathic care, and for that care I feel very grateful. But parts of that care were abusive and unnecessary. For that I am not grateful.

The stupidity of this situation still amazes me. The interventions themselves are against nature. Meanwhile, I was told to go against nature in a way that implied I was doing something wrong, and that the discomfort I felt was my fault.

Before long I was winging my way to Brisbane with the Flying Doctors. This air service in Australia provides emergency transport to hospitals and also delivers health services to remote areas. The trip lasted three hours. By the time I arrived in Brisbane, only two of the many parts of myself remained; the little boy who felt frightened and scared, and the strong defender who could come out and fight for rights.

Upon arrival at the hospital, they asked if I was married. No. Was I gay? Yes. Was I in a relationship? Yes. Was I HIV positive? No. Did I mind if they did a test? No, but if I was infected they would have to review transmission methods. Then another doctor arrived and yet another, all asking the same questions. Then I heard one doctor telling the main doctor that I had lied about my HIV status. Although heavily sedated at the time, and unable to talk and think properly, I called over the main doctor. I told him to please remove the other doctor from the room, that I didn't want him anywhere near me. I didn't trust him. The doctor tried to make excuses, and I told him that we had both heard him call me a liar, and to cut the bullshit. Either he left, or I was going home. The doctor was asked to leave. I never saw him again.

Rob, my boyfriend at the time, had flown to Brisbane to be with me. I was a little surprised by this, as we had not been getting along very well over the last few weeks. Shar and Pam, my two best friends in Brisbane, were there also. Having these friends there was so encouraging and supportive for me. I will never be able to thank them enough.

I remember a doctor saying that they didn't have long and they would have to start operating soon. By the time they opened me up, my aortic valve had expanded by three times. It wasn't working.

Although under anesthetic, I remember this time very clearly. I was walking down a tunnel, with a blue-white light at the end. I felt really excited. I felt like jumping up and kicking my heels to the side. At last I was going home.[2] Part of me remained in the operating room; I didn't identify with this part in the moment. That part brought up arguments about why I should stay here on this planet. It said my family and friends needed me and argued about why they needed me, etc. But none of these points changed that feeling of exhilaration about going home as I continued down the tunnel. As I got closer to the end of the tunnel, I thought of Rob. Immediately when I thought of him, I came back to the operating room. The tunnel had closed over. At that point I felt certain that I was going to live.[3] At the same time the tunnel closed, I separated from the part of myself on the table and floated up into the corner of the room to watch the operation. The part of me that watched felt detached, like a medical observer.

When I came out of surgery, I had a tube through my mouth into my lungs to allow adequate oxygenation and to help my breathing. There were also many other life support tubes and lines attached to me. I made good progress, and they took the tube out of my lungs sooner than expected. However, it was too soon for me to adequately take over my own breathing, and consequently they had to reintubate me (again put a tube down into my lungs). Within twelve hours, they performed a tracheotomy, an incision through the air tube (trachea) in the front of the throat. A tube for ventilation is passed through the incision. This feels more comfortable for the long term than a tube through the mouth, and damages the vocal chords less.

Because of the technicalities of the bypass[4] during the operation, my right leg sustained damage due to low blood supply. This can be so severe that the leg has to be amputated. I faced this and other major risks post-operatively, and they were watching my leg carefully with this in mind. I kept my leg in the end.

The next few days were spent in a different world. Rob, Shar and Pam have told me various things that happened, but my experiences during that time were very different. The staff were always trying to get me to rest. For some strange reason, I had it clearly in my head that when you rested, you shut your eyes, stopped thinking, and stopped breathing. So, every time I closed my eyes, I stopped breathing, causing all the alarms on the heart and lung function monitors to go off, which woke me up. I used to wonder how they expected me to get any rest with all that racket going on. All they had to do was explain to me that I had to keep breathing when I closed my eyes!

During that first week in Intensive Care, when there was the constant risk that I might die, people from the process work community stayed with me 24 hours a day. They touched me and stroked me in time with my breathing. This communication was way beyond words, but nevertheless deeply communicated. Their presence felt deeply important and healing for me. I would open my eyes, look around, see one of them there, and go back to my own world. Knowing that Rob, Shar and Pam were looking after me, keeping my body safe, gave me the freedom to explore other places.

Every time I closed my eyes during that time, whole worlds opened up. Compared to the actual experiences, my descriptions seem flat and two dimensional. However, I shall attempt to describe some of the worlds I experienced.

I always noticed some type of theme. One world was full of colors—as if all the colors and combinations that have ever been floated past in the most dazzling display of light and hue. Different textures, mixtures, patterns and shades combined to create an ongoing living experience of color. I saw a similar world full of bolts of fabric. The textures, colors, and patterns passed before my vision. It seemed that all the materials ever made or that will ever be made were represented there. After these experiences in the hospital, I had a dream where emotions were expressed in music and projected as colors and patterns on a screen.

At times I would open my eyes to see who was there protecting me from what seemed the excesses of allopathic medicine. Then I would travel back to these wonderful worlds.

At another point, I saw scenery, as if I were watching an ongoing documentary film. At another time, I observed animals, some which I recognized and some I didn't. This was like a trip through history and into the future. All the animals, plants and trees that have existed, do exist, and will exist appeared there. I felt warm and special as I lazed in the beauty. I'd open my eyes, check that someone was looking after me, and travel off again to this other place.

Yet another time I saw all these faces of people. All the people I ever met were present, one at a time, and also all the people that I will meet in the future were there. Some of these people I have since met. I also saw them at all ages at the same time, as children and at different stages to old age.

These experiences make me wonder, do I just limit myself, and the potential of life and the experiences it has to offer? If I opened more to life, maybe I could experience many things beyond my narrow life experience to this point. Through my illness process, I feel led into places of healing and love and peace, not only in that magical other place, but also in the here and now. So many people shared their wide range of healing skills. I have known the healing skills that some mothers have, and I know that my mother has them. Friends have shared their touch and knowledge, love and care. Many shared their culinary skills, medical skills, knowledge of Chinese medicine, their Reiki, prayer, crystals, massage and meditation.

Some would say drugs were responsible for this trip, but I don't believe it. Drugs can't take you on a trip you aren't already connected to. Somehow I have access to all the things that have been, that are, and that will be. Over many years, my upbringing and the society I live in have limited the ways I experience life, and the types of experiences that I allow myself. I learned to think in a linear manner, within a time frame of past, present and future. Maybe, just maybe, I can access all these things and more all the time.

The road to recovery has been long, and difficult in places. Finding meaning in what happened challenges me, particularly about my heart itself. Now it ticks,[5] just like a metronome, the device that musicians use to keep a constant beat. How to live with a built in metronome that keeps strict

time? What will life lived this way sound like? How will it look? What will it feel like? How will it move? How will I be in the world? How will I be in relationships? How do I make sense out of coming back for Rob and having him walk out on me five months later?

The conflict between staying in this world and going into the next seems to be a lifelong theme for me. This coming and going was the theme of my work with Arny and Max during the Lava Rock Clinic in March 1993.[6] As I sit here typing, I find myself drifting off into the other world. Sometimes being here is just painful, and the other side looks inviting. Sometimes I stay here; sometimes I drift off there. This pattern is also present in my earliest childhood memory: I am under a year old, standing in a crib, holding onto the bars. It is a hot afternoon, and my parents sit next to the crib having a cold drink. I look down the hallway and see dust particles playing in the rays of the sun. I feel pulled away into this sunny universe, and I also feel the pull of the warmth of my parents. The conflict between coming and going was there that early. How I am in that conflict now is different. The questions that I live with are different.

Now I wonder, how to live my life sometimes here and sometimes not? When to come and when to go? When to drift off? And how to bring things back from that far off place, which I sometimes think of as not so far off? I ask more questions than ever, but I'm exploring them. I suspect it may take a lifetime. What else is there to do, but to explore this life that is mine?

Notes

1. A dissecting aortic aneurysm is when there is bleeding into the walls of the aorta, causing it to bulge and "balloon out." If not treated, the walls continue to bulge, eventually bursting and causing immediate death.
2. I worked on this later, and continued down the tunnel to find out about home. I stepped out into the universe. As I looked around, the stars appeared so clear, like diamonds. The black was like a deep ebony, and the silence was deafening.
3. A midwife recently told me that she thought that the light at the end of the tunnel is the light of day that a baby sees as it is about to be born.
4. Tubes are passed into the femoral vessels to allow the blood to "bypass" the heart.
5. The ticking sound is caused by the metal in the artificial aortic valve clicking open and shut.
6. The Lava Rock Clinics, led by Arnold Mindell and Max Schupbach, provide an opportunity for people to come together to work on, learn about and unfold symptoms and illness processes.

Maurice Shaw was born in 1950 in New South Wales, Australia. He taught Music and Science for a number of years and has worked with young unemployed people in Gympie, Queensland. Most recently, Maurie has worked with people infected and affected with HIV and AIDS. He started studying Process Work with Max Schupbach on Max's first trip to Australia.

About the Artists

Paul Levy

Paul Levy is an artist and a devoted disciple of dreams. Thirteen years ago he had a spiritual awakening where people were literally healed through him. During the early stages of his experience he was hospitalized and diagnosed as insane. His "insanity" was part of a spiritual initiation process, an experience which would be both honored and supported in many societies. Paul has recently begun to teach about his experiences. He is currently in private practice, assisting people through their own processes of awakening.

About his art:

Paul Levy paints out of his unconscious, never knowing what is going to emerge. In one way everything he does is a self portrait. Art allows him to separate from and relate to internal states instead of being unconsciously possessed by them.

Linda Greischel

Linda Greischel, MSW, is a psychotherapist in private practice in Seattle. She studies Process Work, teaches meditation and has been meditating for twenty years. She loves exploring the similarities and differences among Buddhism, Hindusim and Taoism. Linda is particularly interested in kundalini and paranormal experiences.

About her art:

Art has been an essential aspect of my healing journey, amplifying very deep sensations and feelings with each brush stroke on the canvas or molding of the clay. Art has aided me in the descent into darkness, enabling me to move through the nadirs of the nigredo with a deeper embodiment and embracing of these arduous cycles. My art has led me to immersion in the extremes of light and dark and helped me reclaim the full spectrum of the feminine and masculine dimensions. The magical resonance of symbols and hues which swells up in dreams, meditations and therapy is my greatest joy in life and an awesome divine gift.

"Dante's Inferno" by Linda Greischel

Facilitation and Multi-leveled Interventions in Community Building

Julie Diamond and Gemma Summers

Introduction

Community building is an umbrella term for working with a group of people who hold something in common, whether history, geography, a social network, spiritual vision or task. Traditionally, communities have been understood as "communities of the ground," groups of people sharing land and housing, connected through local family relationships, etc. (see Gumperz 1989; Bott 1957). Today, there is a growing phenomenon of "communities of the mind," groups held together not necessarily geographically but through ideas, spirituality, ideology or professional activities. For instance, due to migration patterns and advanced telecommunications within the last half century, some ethnic, racial and religious groups consider themselves communities even when they do not share a physical location. Thus, a community of the mind is any group of people bound together by an idea, heritage, goal or belief.

One type of community of the mind is a learning community, a group of people who learn, explore, grow and develop together. In such a group, not only do the individuals within the community identify as learners, but the community itself learns and evolves. Some believe that people involved in Process Work worldwide constitute a learning community.

Although individuals involved in Process Work around the world live in different regions, they are bound together by certain ideas and attitudes, such as a love of learning, a spirit of optimism and the belief that trouble and conflict can lead to growth and creativity. In our experiences working with and living in different communities involved with Process Work, we have found that while the communities share similar ideas and visions, each expresses a unique flavor, style and nature. Even within one country or state, different process work groups are unique. The politics of the area, the indigenous spirits of the land, the weather, history, geography and resources all contribute to this diversity.

Even the issues we encounter in the process work communities differ. Some groups focus on training issues, others on political issues, and still others on relationships and intimacy. Specific issues vary from place to place. Some groups deal with conflict around money, others with scarcity and competition. Some groups concentrate on issues of confidentiality and gossip, while others grapple with social and political issues. Though the issues or content may differ, from a process-oriented perspective, we find certain structural dynamics that are similar. We discuss these further below.

What is community building?

A community differs from a group in that a community is a group over time. It is difficult to say at which magical moment a group becomes a community. Sometimes we feel the development of a community begin to happen over the course of a weekend. At other times, we could sit in a particular group for a month and never feel a sense of bonding, common vision or relationship. In defining community, we come across an interesting set of problems. A group rarely expresses a consensus about identity. Each individual or part

of the group has something different to say about the group, about its identity, and about its status as a community. Thus, using a subjective definition, that is, asking the members of a group to identify whether or not that group forms a community, leads to a big discussion of whether or not the members feel their group is a community.

This in itself makes up an aspect of democratic community life: discussion about identity and various competing viewpoints about the nature of the group. Thus, we take a phenomenological approach and assume that a group is a community when discussion about community arises, regardless of the outcome or decision from that discussion.

Community building, a new widely interdisciplinary field, will become increasingly important as communities take a more active role in social and political life. Community building refers to many different aspects of working with groups of people who share a past and/or future. Today, community builders comprise a diverse array of occupations. Some community workers help rural or urban communities acquire resources and funding for planning and developing projects such as parks, new schools and buildings, traffic regulations or bicycle paths.

Community workers also act as social activists to help advocate for non-mainstream communities, such as racial minorities, poor rural areas threatened by illegal toxic waste dumps, high unemployment, alcoholism, illiteracy, etc. Community workers may also involve themselves in helping fight for land rights for indigenous peoples, or in working with the homeless, juveniles or mentally ill people within a city. Community building also refers to people doing organizational development in business, as businesses are forms of community.

Community building can also create strategic interventions into problem areas of diversity and multi-culturalism. For instance, the National Coalition Building Institute (NCBI) works to reduce prejudice and stereotyping and enhance community by bringing diverse populations together to learn about one another.[1] Speaker and author Scott Peck also promotes community building as the key to creating peace and addressing many societal problems (Peck 1980; 1988).

In Process Work, building community happens through working with a group on whatever issue emerges in the moment. The process work paradigm sees groups as multi-leveled fields which, like individuals, have a personality, identity, edges, unconscious aspects and directions of growth. Process Work adds to other paradigms the concept of channels, that is, levels of experience through which groups and communities function. These levels of experience include individuals, relationships, subgroups and large groups (Mindell 1985; 1989; 1992). Working with a group, therefore, means identifying which level a group is currently addressing and approaching it through this level. Thus, group work may look at moments like individual therapy, group process, relationship work or subgroup work. This idea of working with a group at different levels comes from Mindell's application of channels to group work.

The central concept of community building in the process paradigm is to help the group contact the background dreaming process in whatever channel it appears in the moment. The dreaming process is the new element of growth trying to emerge in a group, typically in the form of disturbance, relationship problems, money difficulties, and social or political conflict. Mindell refers to the new growth as a "dreaming process." Similar to the messages of dreams and body symptoms, a group's new growth often first manifests as an invisible, irrational or somewhat mysterious force.

History of group paradigms

The pre-World War II individual psychology paradigm considered groups as collections of individuals. For instance, Freud's concept of groups, still found in many of today's therapies, is based on the idea that individuals in a group project their internal psychology and family of origin dynamics onto others and onto the leader (Freud 1921). During the second world war, government funding for research into communications, information exchange and small group dynamics led to the cross-pollination of sociology, communication theory and psychology.

Social psychologists from George Herbert Mead to Erving Goffman (see Mead 1934; Goffman 1959) have shown that our experiences in groups are not just determined by our personal psychology, but also by the roles, interactions and norms of the group. The logical extension of this idea means that groups have a life of their own. They develop, have identities, complexes, rules and issues, just as individuals do. This new paradigm views a group as a whole living organism, not reducible to the sum of its parts.

Process Work follows in the tradition of sociologists and social theorists who have shifted the focus to the largest level of analysis: the group as a whole. However, unlike social theorists, Process Work sees the group as a multi-leveled phenomenon. Process Work includes moments of individual focus, work on abuse, illness and symptoms, and relationship work. It also encompasses the outer world of politics, issues such as racism, classism and sexism. And, borrowing from indigenous religions and beliefs, it includes the spirit world of intangible experience, such as dreams, synchronicities and environmental phenomena.

In this article, we would like to show how this multi-leveled concept of groups and communities can aid community building. We will illustrate this using our work with numerous process work communities around the world. Our goal is to show the uses and flexibility of a multi-leveled approach to community building. The communities we have worked with and lived in consist of loosely connected groups of participants, organizers, students, diplomates and trainers of Process Work, as well as interested people from the general public.

The importance of the multi-leveled approach became clear to us in our travels. We noticed that the large group process forum often took precedence as the primary method of community building, emphasized over other levels of community life. We would like to show that working with the large group alone does not necessarily create community or address all community problems fully. Other levels, such as the individual, relationships, and subgroups, need to be addressed.

Community developers as participant facilitators

Working with a community at many different levels requires various skills and abilities. The facilitator needs to know something about working with individuals, relationships, families and subgroups, as well as with the large group. As we demonstrate below, the approach the facilitator takes to the problems of the community should reflect the level that the group is working on. Thus, we need to look at the concept of facilitator first.

The traditional community developer enters as an outside consultant hired by those within to help the organization with its development. However, our experience indicates that the best help comes from inside the group. Someone from within can understand the heart and soul of their own community. Ideally, everybody in a community should identify as a facilitator, responsible for long term development, for creating healthy and healing atmospheres, and for furthering individual as well as group growth. Facilitation means not only leading or intervening into group process, but actively working on relationships, on oneself, on one's subgroup, and on political issues of the larger society.

This ideal situation challenges the inside facilitator, because those within a group have biases, prefer their own subgroups, and have interpersonal conflicts with one another. In some situations, the community may lack experience or tools and may therefore ask someone from the outside for help.

We have had the good fortune to act as visiting facilitators in numerous places in the United States, Europe, Australia and New Zealand, in learning communities ranging in size from three to one hundred people. We remain outsiders in the sense that we do not live in those areas, yet we are insiders since we maintain ongoing relationships with the people and we belong to the global process work community.

Traditional concepts of the facilitator, from psychotherapist to organizational developer, are based on the separation of therapist and client roles. To avoid painful and difficult conflicts of interest, the facilitator and client traditionally remain separate. However, we find that facilitation from within is an important form of working with groups. When a facilitator works with a community, she becomes a part of it. She feels its tensions, lives on that particular land, eats its food, picks up its communication styles and labors under its political system. As a facilitator, she also needs to be a participant. How can the group trust her unless she also becomes an insider, someone who suffers, feels, commiserates and understands?

Just having the answer to a community's problem is not a solution; it is an irritation. Communities don't want answers, they want growth. They want to continue as a group and if the facilitator provides all the answers without suffering the problems, she will be regarded as an outsider. Growth needs to emerge from within, not come from without.

Mindell has written extensively about the diverse roles, responsibilities and skills a facilitator needs in order to work with groups (see Mindell 1992; Mindell forthcoming; Summers 1994). The diverse functions of the facilitator revolve around the process-oriented concept of "neutrality." This means that the facilitator remains open to many things at once. She can work with different roles and experiences of the group and its members while remaining detached from the success of any one role or position. This sense of neutrality differs from having to stay neutral by not taking sides or not having an emotional position. Process-oriented neutrality requires fluidity or flexibility, the ability to follow many different experiences without remaining identified with any particular one.

Mindell states that the "leader" of the group is not only the designated or elected official, but the people who bring forward the secondary process, who represent the dreaming process trying to emerge (Mindell 1992; forthcoming). Thus, leadership and direction come from every member of the group, and potentially everyone should take part in this facilitative task of noticing what is happening in the whole group. Ideally, the facilitation role is momentary, shared and floating. It depends on people's interest and ability to notice and represent the whole and not just a part of the group's process.

After analyzing the work we have done in various communities, we came up with five overlapping roles for the community facilitator. We created these artificial categories to study different levels of community work and the skills needed to work with each level. We recognize that in practice facilitators perform all of these tasks simultaneously, with varying degrees of effectiveness.

The therapist

The therapist facilitates by paying attention to and working on the momentary atmosphere, tensions, conflicts, emotions, moods, relationship or individual troubles of the community. The therapist goes into tense, troubled areas and helps the community with its emotional states. Specifically, the therapist is trained to work with communication, interpersonal dynamics, edges, abuse, symptoms, and altered and extreme states of consciousness. The therapist part of the facilitator identifies the time spirits in the community's polarization or tension and helps bring these spirits into relationship with the community.

The structural and organizational consultant

The consultant knows organizations, their history, structures, procedures and policies. She can offer practical, immediate ideas to a group. Ideally she has experience with money and running a business. She can suggest structural changes and procedures which make an organization more efficient. A consultant in a process-oriented paradigm does more than just give ideas. She feeds back to the organization those ideas and structures which are already organically happening. Her chief task is to help the organization pick up the organic, natural rhythms, methods and procedures of the community, making them more useful.

In addition to the tasks of the organizational consultant in an organizational development (OD) paradigm, a process-oriented consultant keeps an eye on the mythic, historic and political dimensions of the group. She asks, where is the community going? Where has it been? What are the stories of the group? What parallels in history can help illuminate the community's path? What larger historical process is the group working on: racism, classism, human rights, colonialism? By finding history happening in the moment, the consultant helps the group find its direction for the future.[2]

The activist

The activist helps the unrepresented voices speak out. The activist knows which voices, both historically and currently, have been squashed. She consciously advocates for these unheard and neglected voices. She also knows about history and privilege and can identify when privilege appears in momentary interactions. The activist helps support and bring out ideas from those with less power in the community.

The activist holds a vision of human rights and global change. She recognizes that change comes from minority groups and the disempowered. Her larger goals are education and social evolution. She actively encourages the community to wake up to social issues and democracy at all levels (Mindell forthcoming).

The networker

The networker acts as hostess and ambassador, mingling with people and making them feel at home. She draws out people's needs, ideas, experiences and thoughts. She knows that change comes from the grassroots level. The networker knows

that no idea, no matter how brilliant or compelling, can achieve success without backing from the larger community. This backing may have as much to do with friendship, connection and spirit as with the merit of the idea itself.

If the therapist works with tensions and conflicts, the organizational consultant addresses long term structures and myths, and the activist educates, the networker drinks tea with people and brings them together. Her best work comes during the breaks, the "off-duty" moments. The networker gets to know people, not only because she is hired to do so, but because she genuinely likes people. She knows community is built on genuine friendship and intimacy, and that vision alone does not glue people together.

The elder

The elder is the keeper of the spirits. She cares for the whole, whatever level is being addressed. She asks not whether the group or individuals are happy, but whether the spirits agree with what the group is doing. The elder supports conflict and honors difference. She does not put the group or individuals down for conflict, but creates a vessel to address conflict.

The elder seeks to give back leadership to the group. She likes to stay in the background and support the natural wisdom of the group. She offers perennial wisdom and experience, and is like the grandmother who tells stories around the fire, helping people understand their part of a larger dream (Mindell forthcoming).

These facilitator roles overlap and interconnect. For instance, in the case of the organizational consultant who helps a group implement structural changes, she knows that changes have an emotional impact that will need processing. In fact, even before implementing structural change, she needs to network with the various subgroups who will be affected by it.

The different levels of the group demand different aspects of the facilitator. Each moment in a group may require a different set of skills from the facilitator or facilitation team. A relationship conflict in a group may require a therapist, while a large group process may require an elder. A social activist could help with subgroup conflicts concerning social inequality within the large group. Administrative and financial issues may resolve more quickly if the structural consultant role presides. The next section applies these ideas of facilitation skills to the multi-leveled approach to community building.

Multi-leveled interventions of community building

Community consists of individuals, the relationships between them, the subgroups that individuals belong to, and the whole group, the collection of all individuals. No one of these elements alone creates community. Community is the experience of the group through all of these different levels. If we neglect any one of these levels, the general health of the community may suffer.

The individual

Although we see community life and collective experience as increasingly important to global change, individual focus also plays a very important part in community life. A one-sided focus on collective life at the expense of the individual can lead to individuals protesting, withdrawing or even leaving the community. Recent developments in worldwork[3] show that individuals in groups need support, and that groups can only go as far as individuals have gone (see Heizer, *Journal of Process Oriented Psychology* Vol. 5 No. 2; Amy Mindell, *Journal of Process Oriented Psychology* Vol. 5 No. 2). Democratic community life relies upon individuals' abilities to speak out, to participate in debate and discussion, and to represent different roles and positions within a group. Without support, focus and therapeutic assistance, individuals' participation may reach limits. The idea that abuse plays a role in curtailing democracy and participation in groups has been discussed extensively by Mindell (see Mindell forthcoming; Summers 1994).

Individual focus is important for other reasons. People won't stay in a community for shared vision or relationship alone. Individuals need support and freedom for their unique paths and processes. When people feel that community life demands that they conform to group norms, stop pursuing their own projects, or spend less time on their inner life, they will want to leave the community.

Relationships

Though many sociologists and organizational developers stress that shared vision creates community, visions require people to carry them out, people who can work together, conflict together and love together. Therefore sustainable relationships which endure ups and downs,

conflicts and changes, can turn a group into a community. Where there is room for intimacy, conflict and love, there is a solid community. Visions and great ideas are forfeited when people cannot get along. Relationships weave the net of the community by bringing together separate threads.

Subgroups

Subgroups make up the energetic and creative hubs of a community. They need time, space and support to grow. People have different interests, hobbies, social roles and goals. They naturally gravitate towards others who share some of these features, so mini-communities or subgroups naturally form. For instance, in a community with teachers and students, both groups look to others in the same role for support, shared experiences, learning and comfort. Likewise, artists may seek other artists, people from certain regions may seek the company of one another, etc.

Socio-political subgroups, such as women, men, teachers, students, people of color, gays and lesbians, younger and older people, may not explicitly identify themselves in the community, but it remains important to acknowledge their existence and concerns. The existence of social minorities and the problem of human rights always creates a central issue, whether consciously acknowledged or not. Even when group members say, "Oh, that's not really an issue in our community," sooner or later the issue will come forward.

The administrative group is another type of community subgroup which needs emotional and financial support. With the exception of organizational developers, community builders sometimes neglect the administration, especially in non-business communities. Yet neglecting financial and structural needs can undermine the stability of a community. Furthermore, emotional and social issues within a community will often show up in the form of fiscal problems, personnel issues and management troubles. The administration reflects the emotional and social well being of the community at large.

Large group forum

What role does the large group forum play in community building? Large group forums act like town hall meetings or village gatherings where everyone can be seen and heard and the collective can experience itself. In addition, large group forums provide an excellent diagnostic tool. By noticing what happens in the large group one can sense which issues and polarities the group is grappling with, and at which level these issues manifest. How does the community look when they all meet? Can everyone speak? Does competition for the floor arise? Do individuals look depressed, tired or in need of personal focus? Do people act friendly, warm and related to one another or do they seem fearful and hesitant to speak and make physical contact? Do subgroups look neglected or disempowered? Do some vocal subgroups dominate? Are there minority members in the group? Do they look empowered? Comfortable? Included?

Thus, when working with a community, it's important to be aware of the different levels. Where does the problem show up? What level needs attention and focus? Do people's relationships need work? Are individuals overly burdened by collectivity, not getting enough time and attention for their personal growth? Are subgroups allowed to form? Are they stuck in conflict with other subgroups? Do political divisions surface between minority groups and those with more power? What is the overall vision for the entire community? Is there a forum for airing and expressing what happens in the community as a whole?

Examples from the field

In our work with different communities, we found that each community differed in the problems they encountered and the support they required. Though issues and needs differed, we found a similar tendency. Many groups attempt to solve their community problems through working on them in the large group forum.

In one group, the belief that the group needed to work in the large group forum became a block. This belief undermined community development because the group members felt demoralized about their ability to work through issues at the large group level. Specifically, this community suffered from organizational difficulties. For years they had troubles keeping the group active between visits from process work trainers. They also had trouble networking among themselves and with other groups in the area. They suffered over what they felt was a personal failure to create a functioning group. After four years of involvement, they still felt isolated from each other and experienced difficulty working together.

Unfortunately, these individuals took on an identity as a dysfunctional group, hopeless at organizing, destined to never quite succeed. Yet, when

we sat with individuals, we discovered enthusiasm, dedication, great ideas, leadership and spirit. They impressed us with their level of skills. But what was happening at the group level?

Some members blamed the city itself, saying that it was conventional and formal and did not embrace new ideas readily. Others accused themselves, feeling inadequate about their group facilitation skills. Others put down their organizational skills. Some blamed the global process work community for neglecting them, and some blamed others within the community for holding up progress.

We asked the members what happened at the very beginning. How did they get involved? Did they know each other? Were they friends? Did they belong to the same network? We discovered that except for some couples within the group, the only thing these people held in common was a love of Process Work and a desire to bring it to their city. They had no relationship with one another at the beginning. In effect, they were strangers trying to build an organization.

Trying to work at the group level only made them feel more estranged and separate. The remedy for their problem came out of their dreams, individual processes and what happened organically when we sat together with people. One member who had been trying to perform organizational work for the group had dreamed of baking cakes for the others. This dream reflected a disavowed background tendency to hang out, gossip, tell jokes and get to know one another. The individuals in the group needed help to form close relationships and to be more personal and intimate with one another.

Instead of baking and eating cakes, the group had been engaged in serious large group processes to sort out their issues. That sorting was nearly impossible without a spirit of friendship and closeness. The continual failure to solve problems at the group level led them to doubt their abilities, question their own leadership, and to lose faith in being able to sustain their learning.

In this example, the community's focus on the large group forum level created a sense of failure and hopelessness. The issues involved concerned relationship. Thus, we attempted to match our methods of intervention with the nature of the problem. We spent more time as networkers, helping people hang out and build friendships. Here facilitation roles and group levels come together. Both the methods and the facilitator's role need to reflect the level of the problem. Once the impasse is resolved, other levels of community life come into play.

In another community, we attended a meeting where the air felt thick with tension. No one wanted to speak. We tried working directly on the atmosphere, because it seemed so palpable. We imagined a critic in the background, ready to judge or criticize people for speaking. We even played the role of critic for the group and encouraged others to help fill this role or to react against it. But it didn't work. The sense of criticism was so strong that people were too afraid to stand up and speak!

When we asked the group why they felt it was so hard to speak, some people finally spoke of past relationship conflicts but dared not name them directly. We realized that the silence involved hurt, mistrust and fear. An important prerequisite for speaking in a group is not just one's skills or personal development, but having an ally in the room. Having even one enemy present can silence someone, especially if the enemy maintains a higher social rank within the community.

Seeing that perhaps many relationship conflicts remained unresolved, we acted as therapists and encouraged the group to work on relationship conflicts. The group broke up into many dyads. Some people travelled around the room, from one to another, working on different conflicts. Others made themselves available as helpers. We gave the group thirty minutes to do this, but they stayed in dyads for close to an hour. When they finally did come together, they managed to implement a decision about regularly scheduled community meetings and thus ended a six month stalemate about whether or not to continue as a group.

In this case, the difficulty of the large group was a symptom of numerous relationship conflicts that had grown rigid over time. Our role as therapist for the community meant working with the immediate communication problems and strong emotions between people. In both instances above, the community needed help with the relationship level, but the role demanded of the facilitators was different. In the first example, the process demanded that we be networkers, encouraging people to hang out. In the second instance, the community needed the facilitators to be more directive, helping people to confront difficult issues in relationship.

Every community struggles with the social and political issues of the world at large. The facilitator as social activist needs to address social issues such as human rights, money, class, ranking and privilege. A community's growth is ultimately tied to its ability to broach the socio-political issues in their group. Resentment breeds when social problems are left to individuals to solve. A social activist facilitator raises these issues on behalf of those who cannot bring them up because of their lack of power. In doing so, the social activist may momentarily incur the ire of the group because she questions the status quo. The activist facilitator does this because she is interested in social action, education and global change.

In one community, the organizers and facilitators of a conference were approached by a small subgroup of participants, comprised of single parents who wanted child care provided at the seminar. The parents offered to pay for it themselves, but the facilitators and organizers wanted to consider other options. Who should take responsibility for this subgroup's problem? Who should pay for child care at a seminar? Should it be included in the tuition costs of the seminar? Should it be an organizational expense, deducted from the income of the seminar leaders and organizers? Are parents responsible for daycare costs? Perhaps it should be a little of each?

Like most minority issues, this was not identified as a problem by the majority of group members. By raising the issue publicly, the organizers and facilitators took the role of social activist. They prompted the group to gain awareness as a collective of child care, families and single parenting. They spoke up for a minority, background issue that otherwise would not have come forward.

In this particular example, as in many issues of social activism, the momentary outcome is secondary to the raising of public awareness. However, concrete action needs to follow this raising of consciousness, or else the same issue or set of issues will continue to push forward for resolution. Awareness needs to result in visible, social change.

Emotions, administration and policies

The large group process ideally provides a forum for expressing tensions, emotions and issues which would not otherwise come to the attention of the whole community. Different parts get to connect, know each other and interact. But in large groups, policies and business matters are rarely accomplished. That's to be expected. Twenty-five people can hardly come up with a date for the next meeting, let alone decide on a format for a conference. One of the few times large groups are able to take specific action is during crises or emergencies when they agree to follow the direction of an individual or subgroup for a short period of time. Large group work helps facilitate administration by creating greater trust among members, greater understanding and empathy, clarity of vision, and acceptance of diversity and conflict. Once the group has processed emotional issues, it often lets a subgroup develop ideas to bring back for further discussion or ratification. Not everybody wants to get involved in every decision. It only seems that way when mistrust, jealousy, competition and conflict need attention. For example, in a working task group, sometimes all the members volunteer to do every project. Behind this may be a sense of competition and jealousy, a desire to be recognized.

Lack of approval for ideas and policies doesn't necessarily reflect on their validity or effectiveness. It often indicates conflict and a lack of trust in the community. Good ideas will not be followed if they do not match the organic movement of the group. In fact, they may not even be noticed. Groups, like individuals, give positive feedback to those ideas and interventions which they are already following in some manner. For example, a group in which individuals are trying to develop their own projects will probably not give good feedback to an intervention which requires them to meet together to work on one joint project. This group would probably respond better to a format in which individuals present the projects they are developing.

Sometimes ideas and policies appear brilliant, but emotional issues prevent the community from utilizing them. This is when the organizational consultant needs to become a therapist and dive into the tensions and conflicts in the group. For example, groups may say "no" to a new idea, even if the timing is right, just because they haven't been included in developing the idea. The bottom line is that people don't like to be told what to do! Individuals may resist new ideas presented by someone else. We all need to feel that we're creating change, not being changed by others. No matter how much a group trusts an individual or

subgroup, it will feel excluded, even threatened, when left out of the creative process. It may become paranoid, feeling that power lies behind the scenes.

This paranoia is wise because we all know deep down that the best ideas are those which are generated out of the entire group. An idea will just remain an idea if no one follows it. Thus, the facilitator needs to be a networker, to solicit input, feedback and individuals' creative leadership.

On the other hand, emotional processing can hinder structural change, or be insufficient to implement the next step in the group's development. Sometimes an over concern with individuals' emotions and needs may cause us to miss the moment to take action and make structural changes. If no outer change follows emotional processing, it can generate a sense of hopelessness, leading to frustration, sabotage or resignation. Emotional processing needs to be backed by a path of concrete action.

This is a tricky point. If emotional issues are not sufficiently addressed, the new structures will generate the same emotional problems and conflicts that the old structures generated. Balancing emotional processing and structural change is the process-oriented component of community building. This means exercising flexibility and awareness to shift levels as the community's process demands.

Conclusion

In conclusion, we find that a multi-leveled approach to communities necessitates multi-faceted roles in a facilitating team. The multi-leveled approach is not new in Process Work; we find it in channel theory, relationship work and group work. We have attempted here to convey how this multi-leveled view works in community development, what it means for working on a community's tensions, and the types of interventions a facilitator needs to make.

The unstructured, large group forum remains an important contribution to the field of psychotherapy and community building. It has been traditionally neglected, primarily because it is so difficult to facilitate, and because issues of diversity and justice press forward in the lack of structured activity. However, we would like to show that in work with communities over time, the large group forum is only one way to work with the group. Other components of the community, including individuals, relationship units, subgroups, administrative core and socio-political subgroups need addressing. Otherwise, the overall development of the community may be held up, and individuals may feel a sense of failure and despair.

We also have attempted to show the inter-relatedness between the method and level of intervention. The method of intervention includes the facilitator's role: is she an activist, therapist, elder, organizational consultant or networker? If the community needs focus on socio-political issues, but the facilitator works therapeutically, only addressing the issues at a psychological level, the problems will perseverate. Conversely, trying to solve organizational issues in a group that needs relationship and intimacy will result in a feeling of failure and avoidance of group life.

A process-oriented community developer is equally at home working with couples, working with individuals on their personal troubles, hanging out with subgroups, developing policies and strategies, advocating for social change, and working with the large group forum. Through it all, the community developer is an elder. She nourishes and cares for the whole, and fosters a sense of awe and meaning towards the troubles, tensions and difficulties a community experiences in its quest for wholeness.

In our introduction we defined a community as a group over time. Thus, community building resembles, in some ways, long term therapy. It is a long term growth project. Problem solving and working with the momentary issues and tensions is only one piece of community building. Community building, like long term therapy, requires more than just working with an identified problem. Its larger task involves supporting the overall health and evolution of a group and nourishing all its different parts. The community builder, like a long term therapist, becomes less enchanted by the momentary issues and struggles of a group and more concerned with the eternal aspects of community. Does the way the group deals with problems change over time? Is the group growing increasingly open to tension and diversity? Are the group's boundaries flexible, allowing members to come and go without reprisals? Is love present? Are altered states of consciousness and emotions permitted and welcomed in the group? Above all, is learning and growth taking place?

Notes

1. The National Coalition Building Institute, headquarters in Washington D.C., offers prejudice reduction workshops and facilitation training around the world.
2. See Mindell, *The Leader as Martial Artist*, for a discussion of groups and historical processes.
3. Worldwork seminars, held internationally by Amy and Arny Mindell and staff, are large group forums on issues of diversity, racism, sexism, homophobia and other global concerns.

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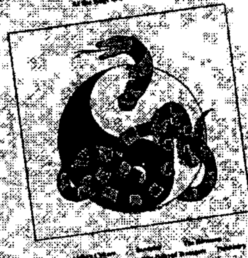

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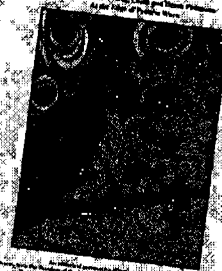

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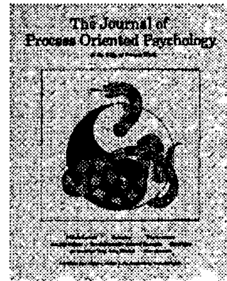

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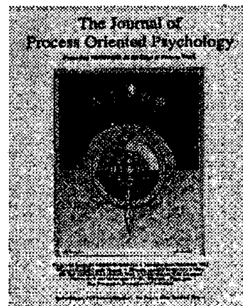

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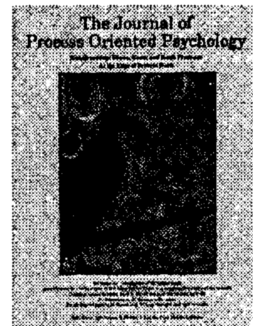

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