THE HISTORY OF SANITY IN CONTEMPLATIVE PSYCHOTHERAPY

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There are two kinds of psychological history that we come to know when working with people. One of them is the history of pain, discouragement, missed opportunities, the continual accumulation of unfulfilled hopes and the consequences of unrealized actions in relationships. Such a history of neurosis has a compelling quality that can capture and freeze a psychotherapeutic relationship into an endless dissection, searching for the origin of an inhibited development. On the other hand, embedded within the history of neurosis is another kind of history whose subtlety and evanescence make it more difficult to explore. It is the history of sanity. In order for a healthy development to begin within the psychotherapeutic relationship it is necessary that both the therapist and patient shift their allegiance towards the history of sanity. That *shift of allegiance* might be more possible if we can identify and clarify the landmarks in the historical development of health or sanity.

Seeing psychotherapy from the point of view of eradicating or undoing an illness, one looks for signs of the disease process, perhaps to highlight it, expose it, or work it through. The implicit historical question becomes, "Where did things go wrong?" That kind of psychological history involves a limited conception of psychotherapy and imposes a particular kind of relationship. The form of such a relationship might range anywhere from a collaborative search for an object of blame to subtle forms of paranoia.

Ultimately, the point of view of psychotherapy is rooted in, and further raises the question of, what is meant by sane or healthy development. There is a particular impoverishment, however, in most psychological theory about the nature of

health, in general going little beyond the notion of domestication and survival in a complex world.

At the same time the development of psychological health and even brilliance does exist. Paradoxically, the history of sanity can be glimpsed even within the biographical history of neurosis. The development of health is especially prominent in recollections of the past and its manifestations in the present, of *how* people work with their states of mind. Other historical questions then become meaningful: what kind of training is needed to work with one's mind? Where does it come from? And, where in one's life is it missing?

FLIGHT OF IDEAS

A brief and ordinary clinical example might be useful here. When one talks with a man who is in a state of impending manic excitement there is a hectic quality to his ideas, stories, anecdotes, memories and plans. The pressure of his words fills up every instant of doubt and reflection, going further out on limb after limb, all of which is difficult to follow and oppressive to listen to. At some point we acknowledge this difficulty. Following this, a spontaneous gap frequently occurs in the patient's streaming thought processes. A moment of confusion is punctuated by the question: "Where was I?" Then there occurs a somewhat tortured return to the point, and the process of escalation begins again.

This natural occurrence comes from the sensation that one has gone too far in the elaboration of a daydream: a sudden awakening followed by a struggle about which way to go. The whole thing often happens very quickly and usually we notice it only after the fact.

The above example was taken from psychotherapy with a skilled musician. His musical discipline had been strengthened in the course of psychotherapy to the point where he could play his sight-reading exercises while entertaining a complex train of disturbing and self-condemning yet fascinating thoughts.

His musical discipline, which allowed him to cut short the wanderings of his mind, gradually was expanded into other areas of his life. The spontaneous returns from "flights of ideas" began to increase and gather during the psychotherapeutic sessions. He recognized that he had always had a latent ability to let go of thought patterns, even as a child. From that point he began to communicate the source of his pain while at the same time developing some confidence that he was not at the mercy of his thought processes. The patient was able to use the pressure of a chain reaction of thoughts as a sudden reminder. From that he was better able to *discriminate daydream from reality*. He then began to exert the effort to come back to the point and from there developed the courage to work directly with his twenty-year-old habitual tendency towards a manic state of mind. This is an example of the sharp, intelligent quality of sanity that can manifest moment to moment even in the midst of psychopathology.

The above example indicates that one could be relieved from the impulsive pressure of the chain reaction of thoughts, the root pathology of manic denial or obliviousness. Thereby one could cultivate the ability to discriminate daydream from reality with increased precision and could begin to rouse the effort, even courage, to come back to the point. Experience has shown that this leads to the development of patience.

Returning to the story of neurosis, we find that a symptom or dysfunction is an attempt to tie together and find a coherent cause-and-effect relationship in the disparate phenomena of one's life. Such a story is frequently filled with fear, guilt, blame and aggression; it resembles the history of nations at war, where one war inexorably triggers another in the ageless recycling of insult and territorial revenge. The storyline threads together a variety of memories with an explanation of why one event follows another and how one got to be the way one is. Sometimes the therapist does the same thing by using the template of his particular developmental theory to string together a story line just as in a dream, where the display of

dream fragments forms a seemingly logical and expectable dream story.

The history of neurosis can seem like a complete cloth covering all of experience. The history of sanity on the other hand, is episodic and appears to be fleeting and delicate. Because it is the history of wakefulness, dignity and patience, its continuity is often lost by people in despair. To perceive the history of sanity, we need the curiosity and effort to look further. When the psychotherapist relates directly to another's wakefulness and becomes curious about the history of his sanity, a different kind of relationship develops: one of mutual appreciation and trust not based on dependence, hope or even memory.

The question arises of *how* to relate to the history of sanity: "what to look for." But the issue is not really what the therapist searches for or hunts; rather it is what the therapist recognizes. There are certain signs and landmark events that characterize wakefulness and sanity in another's life, but they can hardly be noticed until one first experiences and identifies them in oneself. Then one can recognize the inherent health in another person's experience. This is why the personal discipline of mindfulness-awareness meditation practice is so crucial for the development of the psychotherapist. Only by studying the nature of our own minds and examining the experience of wakefulness in our own lives, can we recognize and appreciate it in another. The practice of meditation is the most direct, straightforward way to do that. It is a tuning process, making one more sensitive to psychological and interpersonal experience. This way of training oneself in the history of sanity might appear to be an extra burden put onto the psychotherapeutic relationship, but it is hardly that. It is really the first necessary step taken toward fully appreciating the intrinsic health of another.

With that kind of training, a natural curiosity begins to develop about the other person's sanity and we begin to feel drawn to it. What we see occurring first in our own, then in another person's experience, is an *intrinsic instinct toward wakefulness*. It is first sensed as a flickering, and from that

flickering there can occur an enormous curiosity. We find that instinct to be as strong and as omnipresent as any described by Freud and his students, by ethologists, or by cognitive scientists.

While most other instincts appear to involve striving towards personal security, self-justification or pleasure, the instinct toward wakefulness is the urge to penetrate beyond the continuous cycle of ego's self-justification and aggrandizing daydreaming. The most subtle aspect of the history of sanity is how one works with that instinct. The signs of that instinct are manifest in the most confused and degraded psychopathology, as well as in mild neurosis. It becomes the choice of the patient whether or not to develop that instinct, and it becomes the option of the therapist to encourage and enrich that development.

We are always startled to see how people in intense despair, locked into a hallucinatory world, can suddenly step out of the grip of delusion in a moment of communal crisis, as for example during a fire in a hospital. Sometimes it takes that vivid an awakening to strike through the sleep of delusion. Less dramatically, we see any number of people who, in spite of their own turmoil, act wakefully in a crisis, maybe even showing the "best" of themselves. Something allows them to immediately drop their preoccupations and act appropriately, possibly even wisely.

MARKS OF SANITY

The signs or trademarks of the history of sanity can be recognized in both the development and the current experience of all neurosis and psychosis. They could be divided into several categories. It should be noted that these categories are not derived from a conceptualization about relationships or a theory of development traced onto the psychotherapy, neither do they come from any technique or proposed strategy. This view stems from direct clinical experience and the categories are

abstracted from a variety of clinical phenomena of patients during the phases of recovery. Interestingly enough, the therapist's act of recognizing signs of recovery, whether within the person's life cycle or on a moment-to-moment level, has the subtle effect of turning the psychotherapeutic relationship into an allegiance toward sanity.

REPULSION

First, there is a sign of *repulsion*: fundamental estrangement and a feeling of nausea about one's way of living. It might last for a brief moment or it might endure for years. One is simply sick and tired of unceasing daydreams, instantly manufactured hopes and fears, and the endless cycle of habitual patterns of thinking and acting.

The endless cycle of alcoholism and a variety of other addictions takes the following form: bingeing/repentance/self-aggression/despair/bingeing. That is the experiential form—almost an energy cycle of the psychopathology of addictions. Conventionally speaking, the "chief complaint" of the patient is usually self-aggression and contempt over the destructive quality of bingeing, gorging or any other collapse into animal-like indulgence. But that is only the outer shell of the "chief complaint." If it persists, it almost immediately chain-links into repentance, attempts at purification, and an insistent solicitation of forgiveness.

The inner aspect of the "chief complaint" is actually repulsion toward the cyclic nature of the whole situation, the endless circularity, the nauseating rotation. That repulsion degenerates into self-aggression and begins the chain reaction.

When seen together, the outer and inner "chief complaints" reveal intelligence in the original repulsion. The patient says, in one form or another, "I'm tired of this because I see through things." From the viewpoint of the history of sanity, the question becomes, "What does one see?"

This disgust is connected with how one is working with one's state of mind. One could acknowledge that a real discrim-

ination takes place. That discrimination requires a moment of clarity, a sign of active intelligence. A feeling of despair might occur, but that is only an elaboration or turning away from the insight that things could be different.

The ability to discriminate that something could be different in one's life means that something different has been glimpsed. Where and when has that happened? And how can one carry through with that? Perhaps it has been in relationship with one's grandfather, a teacher, or oneself during a particular year of school. It might include subtle or subconscious distinctions between what is healthy and what is not, and it frequently occurs at the height of neurosis itself.

An unnameable feeling of guilt can develop because one cannot live according to the more wholesome vision. It was at such points that the insane John Perceval would look into the mirror and lacerate himself with the word *hypocrite,* later echoed in his hallucinations.[1] Such repulsion can happen in a moment of clarity but may soon degenerate into despair and self-loathing; ending in a nihilistic view about the worth of life at all. In the same way, each landmark event or moment of wakefulness in the history of sanity can be distorted into an aggressive drama. That is the basic perversion: the turning away from intelligence. But with the help of a therapist the situation need not go that far.

It is the sense of repulsion that usually leads one to a psychotherapist. Quite early in the psychotherapeutic relationship—during the initial allegiance toward sanity—the heightened discrimination between what is healthy and unhealthy may take the form of token actions such as the long-awaited giving up smoking, a sudden end to chronic nail biting, or an attempt to attenuate obsessional masturbation. These are more likely to happen when the patient has recognized some glimpse that such activities are mindless, that they have the qualities of absorption or trance.

BEYOND SELF

From the moment of repulsion there occurs a *longing to transcend the sense of self.* This longing can become manifest in an instant, or from one sentence or association to another, or occur over a period of months. But it is the moment-to-moment phenomena that provide the seed and the pattern for the more gross forms of behavior and pathological symptoms. This is one of the important contributions that contemplative psychotherapy has to offer: by understanding the patterns and tendencies of the mind, our understanding of both pathology and the variety of spontaneous attempts at recovery of health is vastly enriched. One of those spontaneous attempts at recovery is an urge to go beyond a stifling sense of self.

It is a fascinating and mercurial moment. For example, a patient in crisis often arrives at the statement, "I don't know who I am any more. I used to know, but now I don't." This might happen from the shock of awakening from a manic spree, from psychotic delusion, or from a dream. During moments of depression the statement might be made, "I don't know myself any more. I have lost myself."

When we try to find out who this self really is or was, there usually occurs an immediate confusion, followed by a series of confabulations. Then tenuous attempts are made to construct a cohesive story that describes the nature of self. Nietzsche called this the major obsession of Western man. A feeling of uncertainty, of cloudiness and doubt undercuts each attempt to materialize a consistent sense of identity. But we forget that it is a futile task. No wonder that the syndrome of "identity crisis" has become such a popular conception. Even though the seemingly reflex attempt to manufacture a self can be seen to be made up of a series of discrete habitual patterns which yield a momentary sense of security, there remains a gnawing doubt about the creation. Sometimes, if this doubt is intensified, there may occur frantic efforts to override it, to strengthen an image

of identity or jump to a new one. Such a situation is involved in the "actual neurosis" of adolescents.

No matter how vigorous the effort becomes to reinforce or idealize a feeling of centeredness or self through identifications, projections or denials, there is dissatisfaction. Discontent or loneliness arises, not simply because one cannot safely live up to that ideal image but also because there is a clarity and awareness that one is actually more than that. One senses that the limitations of that image are not only false and arbitrary but are also constricting and inhibiting one's health. That feeling might escalate into a sense of self as monstrosity, but even that can be abruptly undercut, as in the experience of falling in love, where the feeling of who one is can change in a moment.

Psychosis has one of its primary origins in the desire to transcend the sense of self. One generates an enormous hope of arising fresh and purified from an abandoned and disfigured self. This leads to unwitting mental manipulations through which a former identity can be discarded and a new self hallucinated.

However, in psychotic mental turmoil a genuine and wakeful vision of self, freed from the boundaries of identity, may fleetingly occur before it is degraded by the lust and greed for a purified self of pleasure or power. Such people may demonstrate a belief in the fantasy of rebirth through letting go completely, touching bottom, getting it over with, as if to exhaust the self that craves alcohol, violence or withdrawal. This completes another form of the perpetual cycle we saw occurring in the alcoholic who is forever bingeing, insightfully repenting and bingeing again. Suicide, of course, would be the ultimate perversion of a desire to transcend self.

Many of the so-called "mystical experiences" during psychosis or other states of mind undergo a similar kind of abortion. Often they are felt to be "awakenings," and the accompanying psychological fireworks are seen as evidence of personal extraordinariness. Hallucinogenic experiences take this familiar course: having briefly experienced the potential beyond self

and having seen through the beguiling machinery of continual self-reorientation, the experience frequently deteriorates into arrogance and paranoia.[2]

Unlike the conventional psychological models of "ego" that view an identity as formed bit by bit from childhood through adolescence to form a vehicle that carries one to adult life, the history of sanity exposes the quest for identity as a perpetual crisis. In adults it can be recognized as a primordial anxiety. In children it may translate itself into a sense of fragility or a threat to bodily survival. The perpetual crisis is not in failing to achieve a substantial enough identity but in recognizing that it is an unstable state, a delusion, and always falling apart. Thus the history of neurosis points to the anxiety, self-consciousness and embarrassment of self-fabrication, while the history of sanity emphasizes the clarity of perception behind the anxiety.

The first hint of a longing to transcend self and an urge toward a fresh start can be provoked by experiences of body-mind synchronization. People in morbid states of mind, even in the grip of self-hatred, have said that their nihilistic depression dissolved in a moment while somehow "engrossed in activity." Ordinary everyday experiences, in particular the disciplines of art forms, provide a glimpse beyond walled-off territory, beyond the hesitations imposed by identification. When these glimpses occur, one's curiosity begins to heighten further.

THE URGE FOR DISCIPLINE

From the point of repulsion or nausea and then a longing to transcend one's conditioned personality, there usually develops a desire for action towards making things more straightforward: a sense of pruning or paring down. A natural movement develops that has the quality of renewed energy. With it one feels a sense of urging towards *simplicity and discipline.* It could be as simple as beginning to make schedules for daily activities or meeting a therapist with regularity. It could

happen in a moment of cleaning one's desk before working. The urge for discipline may develop over a long period of time or it may appear in a moment.

From the point of view of the history of sanity the therapist would be particularly curious about the details of the experiences of discipline that have taken place in another person's life. The reasons why the history of discipline should be so precise are twofold: to find out exactly what another person understands by the nature of discipline and what his or her relationship has been to it; and secondly, because there is a possibility that within that discipline, there has occurred some insight into how mind and body work.

Everyone seems to have a basic curiosity about how mind works and this can be provoked even in periods of extreme disinterest or distraction. On looking into the nature of discipline, one often finds that one has learned more than one realizes. The practice of a discipline might have sharpened one's accuracy to perceive smaller moments of psychological time. It might be exactly that quality of precision that will allow for the recovery of health.

An episode of discipline often stands out. One woman, who for several years drifted around the country and wandered from one source of entertainment to another until her aimlessness ended in despair and suicidal preoccupation, recalled a year of her otherwise futile college experience during which she went swimming every day. Not a very dramatic memory, but the daily discipline had become a focus of her life; she had a sense of "taking care" of herself properly. Consequently, she studied in a more orderly way and felt some sense of development taking place. Rejection by a boyfriend ended all this. Her statement, "If only I had that kind of energy again," turned out to be a comment on the accuracy and effort that resulted from her simple discipline. Within such episodes of personal discipline, people often talk of a feeling of dignity, not necessarily because they were happy, but because there was a sense of doing something correctly and relating straightforwardly and pointedly to the rest of their lives.

Each seemingly mundane attempt at discipline carries within it the urge to work with one's state of mind, by directly connecting or synchronizing physical and mental activity. It might be athletics, survival disciplines, art forms, cooking, collecting stamps—any of which can become highly discriminating disciplines that sharpen the senses and create further vividness and appreciation for the sensory world.

The history of the experience of discipline and "settling down" can give us important clues about working with people. How does a person relate to that discipline? What is the experience of effort? Is there a love-hate relationship with the discipline? What did they learn from it about cutting daydreams and taming the mind? How do they expand that to other activities? Who were their teachers and what were they like? These experiences can become directly intertwined with the psychotherapeutic relationship. The discipline of the relationship itself can become a prototype of how one works with one's state of mind and life situations in general. When the musician in the state of mania, who was mentioned before, became irritated by even the most simple daily structure that might harness his energy, he said, "It's too much for me. I can't do it." When asked what he would reply to his young music student who voiced the same hesitation many times, he said, "I would tell him to start again and take it very, very slowly." His own advice soon became a useful guideline to the psychotherapy.

Yet, any discipline can become perverted into the service of neurosis, providing all the possibilities for escape, avoidance and trance states. That is, the discipline may be distorted into an activity which causes disconnection between body and mind, leaving mind unanchored, out of control and free to hallucinate. From this point of view, the relevant history of neurosis involves curiosity about how such disciplines were lost, where and why they broke down, how they were perverted, and how the feeling of dignity was lost.

COMPASSION

The history of *longing toward compassionate action* is continually present in the lives of our patients. It is this compassion that is the key to psychotherapeutic work of any kind. Generally, we see compassion as arising out of the development of basic warmth toward oneself, but most of our patients are particularly undeveloped in this area. In fact, it is usually obvious that much self-hatred has accumulated over the years. Nevertheless, patients manifest compassionate urgings, even in moments of extreme despair, and are unable to recognize them. An elderly woman whom I worked with for several months said, "I have become obsessed with myself; I don't seem to care for anyone else anymore." I replied that that couldn't be true because I felt her recently caring a lot about me.

In some types of psychopathology, compassionate longing takes a particularly disfigured form, as in the undercurrent of messianic megalomania. It appears that, when compassion is frozen, either situationally or developmentally, it undergoes a perverse form of development. From the point of view of the history of sanity, the therapist can begin to recognize, even within the crudest symptoms, aspects of healthiness. This means that psychopathology is not something to be eliminated but to be worked with in its momentary detail, because it is primarily seen as the result of obstruction to intelligent impulses.

Because of the history of discipline, both therapist and patient should be able to become acutely precise about the chain-linking states of mind particular to any psychopathology. The therapist might weave back and forth between the accuracy of the patient's real discipline—for example, skiing—and bring that same precision to bear on the patient's symptom of fear, paranoia, the wish to regress, to sleep.

When a therapist begins to recognize the enormous richness and fertility of another person's psychopathology, a relaxation appears that allows one to begin working with people exactly

as they are, without the slightest desire to change them. In fact, out of that, a vivid sense of appreciation for the other develops. I recall many delightful hours I spent with a young woman recovering from psychosis, turning the accuracy she developed during her competitive skiing career toward the phenomena of thoughts escalating out of control into hallucination. Recently, I was pleased to find myself talking with a diminutive but rugged ex-jockey who was determined to ride through a violent alcoholism. I wondered what he knew about how to hold his seat on a wild horse on the verge of being out of control. It is just this quality of appreciation and heightened curiosity that makes "burn-out" out of the question.

It is this very same progression—from compassion to appreciation and vividness—that our patients need to make to recover genuine health. Once I worked with a woman in her seventies who had been in a state of deteriorating depression and alcoholism for three years. She was obese and slouched but also manifested the robustness and courage of her earlier life as a farm woman building a home on the great plains. She said she "just wanted to die"; more than that, she was "already dead." She felt that she had completely lost her connection with the outside world. Nothing struck her any more. Nothing moved her or inspired her: colors failed to excite her, birds were of no interest, and even as she watched her young grandchildren playing she was appalled by her lack of feeling for them. Her mind was obsessed with the following recycling obsession: "What has happened to me . . . I am a monstrosity . . . I am losing my mind . . . I want to die. I must go to sleep." But she was also severely insomniac. She would sit in a chair at home churning her obsessive thoughts, immobilized in a state of daydreaming. She dreaded her lack of energy, though at one time she had had a relentless enthusiasm for work; she was unable to concentrate on any detail, although she had been a suberb craftswoman at patchwork quilting.

Passion arose in psychotherapy. In turn, it awakened her love for her husband, which over the years had become frozen by fear and ambivalence. Her dreams were filled with glowing

warmth about the way "things used to be"—energetic, warm and childishly joyful. They were patently nostalgic and provoked her irritation with the way she was living. Then there came a time when she delightedly schemed to win back her husband, to seduce him out of the torpor and constriction that he called his "old age." Along with this, there gradually developed an increasing interest in her perceptual world, an appreciation for her environment, and then insight into the patchwork quality of her depression.

The course of the relationship showed that kind of progression which later could be seen happening even within one psychotherapeutic session. It was not as though the course of therapy did not have some serious interruptions, but the repeated sequence of passion, opening toward concern for others beyond an impoverished self, leading to a more general appreciation and vividness, had a cumulative effect. The recovery of her health was inseparable from the recovery of her compassion.

The experience of compassion and its relationship to recovery is rarely talked about in psychotherapeutic writings. One striking exception is Harold Searles who refers to "a therapeutic devotion that all human beings share." He says, "I am hypothesizing that the patient is ill because, and to the degree that, his own psychotherapeutic strivings have been subjected to such vicissitudes that they have been rendered inordinately intense, frustrated of fulfillment or even acknowledgement, and admixed therefore with unduly intense elements of hate, envy and competitiveness." He goes so far as to say, "I know of no other determinant of psychological illness that compares in ideological importance, with this one." About the course of recovery, he has observed, "The more ill a patient is, the more does his successful treatment require that he become, and be implicitly acknowledged as having become, a therapist to his officially designated therapist. . . ."[3]

When such strivings are not acknowledged, their sudden upsurge in the form of selfless devotion could become intoxicating because they expand so vastly. It could become a com-

passion run wild. In fact, this is related to the fifty-year habitual tendency to manic-depressive cycles experienced by the elderly farm woman. When faced with an exploding generosity and warmth, the compassion turned aggressive and became only a burden to others. Then the object of passion became an object of disapproval and rejection. That sequence, which could be seen in a single hour, was the seed of psychotic depression, because any feeling of sanity or worthwhileness that she felt was directly dependent on her compassionate strivings.

The permutations of passion and compassion are of course endless, and the forms are completely individual. But experience shows that people recover when their compassion is more fully developed. This is why the unfolding or the journey of compassion within the psychotherapeutic relationship is such a crucial factor in the awakening of one's history of sanity.

ENVIRONMENT OF CLARITY

Psychotherapy can be a specialized environment where the history of sanity is articulated and acknowledged. One's active relationship to basic wakefulness or intrinsic health could begin at that point. Many moments of any psychotherapeutic encounter are marked by a *sense of clarity* and complete presence. Actually, such moments are continually happening throughout our lives. Even our dreams bear the imprint of this intelligence. At the moment of awakening from a dream, we frequently find that the whole dream experience is totally clear, translucent, and even brilliant. At that moment we are beyond reflection, before interpretation or analysis. The dream is vivid and clear, without subterfuge or disguise. It is a naked experience of clarity that becomes clouded over and forgotten.

These barely perceptible moments of clarity are highlighted within the context of disciplines that synchronize or balance body and mind. A young rock climber bitterly complained about the meaninglessness and oppressiveness of his life. His ordinary adolescent life was sullen and confused but while

climbing he felt accomplished and thoroughly awake. No matter what problems occupied him in his internal dialogue, while climbing they were cut through as every foothold and piton placement became a life-or-death possibility.

Within that framework, he described how he would work with the tendency of his mind to wander. The accuracy of his discipline sharpened his ability to notice shifts or transition states of mind. At that point he would allow himself to come back to the sensation of his body hugging rock or the wind whipping around him. If this was particularly difficult, he would remind himself to wake up with the saying, "Come to your senses!" It was not just the exhilaration of accomplishment that he longed for but also the sense of sharpness and precision that can arise out of fear. When such experiences were clarified and he could appreciate them within the context of psychotherapy, he became able to recognize their natural and spontaneous occurrences in the less dramatic aspects of his life. In the same way, he began to recognize the effort that was required to notice the elastic drifts and returns of his state of mind.

But this longing for clarity might have some perverse variations. People might put themselves in extremely frightening situations in order to experience moments of clarity, as in the ritualistic preparations for some types of self-mutilation, or the fearful drama of recurrent suicide attempts.

There are also more subtle forms of perversion such as the manic "flight of ideas," which may be an attempt to cover over any moment of gap or doubt, or the "pressure of speech," which can become a systematic resistance to coming back to the senses or the situation. Eventually they become mindlessness practices to produce altered states of consciousness. Perhaps this is the ultimate meaning of the word *resistance:* an unwillingness or an incapacity to experience intrinsic health. It may even lead to pain, envy, or paranoia when wakefulness is experienced in the therapeutic environment.

The clarity of the therapeutic environment is crucially involved in the practice of psychotherapy. The qualities of

wakefulness, crispness, simplicity and dignity provide an extremely important environment for patients to observe the shifts in their state of mind. It is that kind of atmosphere that might be the provocation that awakens one to the natural history of sanity.

COURAGE

Finally, it is important to talk about *courage* and history. In his autobiographical journals, Charles Darwin asks, "Why don't the psychologists ever talk about courage?" Darwin traveled widely during his development as a field biologist and also became something of an anthropologist. He came to feel that courage was the most significant factor in allowing individuals and tribes to survive and propagate their culture, even in the most remote places and extreme conditions of isolation and loneliness. Darwin was no stranger to fear, loneliness and courage. It could be said that Darwin's courage was the primary factor in his struggle between confidence and debilitating neurosis. He held back for some thirty years the explosive announcement of the non-theistic origin of the species. During that time he suffered with his own cycle of confidence, fear and isolation while he amassed overwhelming evidence. But before that, his nightmares were concerned with the murder of God, the destruction of his father's well-being, and the ransacking of the deepest convictions of his culture. In the end, he would publicly be accused of exactly that.

Before he could make his outrageous statements however, symptoms developed. He developed a profound revulsion toward aggression, especially his own. Each occasion of confidence that arose in his investigations faced him with the action he might have to take and its fearful deterioration into aggressive pride. He would then collapse in punishing headaches and exhausting physical illnesses of unaccountable origin. His courage was continually fluctuating. It was only through the force of circumstances and his deep friendship with a group of naturalists turned street-fighters that he was able to persevere.

Because the experience of courage in the history of sanity is so connected with the experience of fear, it is useful to look into the psychological structure of fear at a moment-to-moment level. Fear is particularly observable during the stages of recovery from a psychosis, when one feels so vulnerable and tender.

One young woman vividly described a cycle of fear occurring throughout the day that turned her "blood into ice-water" and culminated in shaking chills that made her irresistibly drawn to return to bed to crawl under the covers to sleep. This was especially exaggerated at the moment of awakening in the morning.

At first, her descriptions were only of intense fear. When her attention was turned toward the nature of that fear, she began to notice a preliminary phase of "overwhelming brightness." Then there appeared the thoughts, "I can't go on, I can't get up." She felt herself pulled back to "dimness, warmth and coziness." From there she would begin to indulge in fantasies of safety that progressively enclosed her in a dream. Coming out of that state took excruciating effort, and any interruption was met with aggression.

Gradually, the oscillation between brightness and fear was seen in a variety of life situations and was understood to be an exaggerated habitual regressive tendency accumulated over many years of psychotic episodes. On the one hand, her psychotherapy consisted of arousing her courage to work directly with her fear, and on the other hand, her environment was arranged so that she could relate with many courageous people.

Even in the case of what seems to be irreversible damage, we find that a quality of courage is not only necessary for recovery but is the nature of health itself. There is much to learn from the case of the warrior Zasetsky.[4] His life as an enthusiastic engineering student was interrupted by war, during which he manned a flame-thrower on the Russian front. There he endured a penetrating brain wound to his left parieto-occipital cortex. The resulting disability was vast and every aspect of his life seemed damaged beyond repair. His memory, cognition,

and perceptions were all in disarray and he lived in a "terrible body" which he could no longer recognize.

His aphasia was almost complete and he could not communicate even his fragmented world. He suffered from severe attacks of "catastrophic reaction" with the usual progression of confusion/fear/stupor/grief/denial and outrage. Intense headaches and incomparable fatique exhausted his endurance. He found himself "waiting for the nightmare to be over," but eventually began to realize the hopelessness of either waiting or suicide.

He said, "I can't just wait until I wake up," and he resolved "to start all over again . . . without a past . . . to make bits and pieces into a coherent whole . . . to break out of the fog . . . never give up." He began to work directly with the ground of his damage. Over the years he gradually developed practices that allowed him to partially circumvent the defects in his neurological circuitry. His journal of twenty-five years was one such painstaking practice, through which he felt he discovered further depths of patience and tenacity and the possibility of a fresh start within illness itself. Throughout it all, his major inspiration was to "be useful . . . to contribute to others about how to live beyond helplessness" and what it means "to be human."

The experience of psychotherapy teaches us about aspects of courage, that of the patient and that of the therapist. The patient's courage takes many forms—for example, the effort to follow a path out of addiction or the weaning from chronic psychoactive medications. The therapist's courage also takes diverse forms, but the most comprehensive of all is the ability to be in a relationship beyond memory, repetition, or transference. But if such a relationship is not guided by a variety of personal practices it could become dangerous. The extreme might be therapeutic megalomania or lesser forms of what used to be called "furor therapeuticus."

Something quite interesting occurs when the therapist practices the various disciplines of courage: courage becomes a quality of the therapeutic relationship, and as that expands

into the total therapeutic environment; it begins to attract and motivate the intelligence and healthiness of everyone involved.

The practice of psychotherapy involves a therapist in the whole sequence of events, from revulsion to courage, just as it does the patient. The conventional psychotherapies have attempted to describe in great detail the history of neurosis or pathology, but even the most useful, such as the concept of "developmental lines" described by Anna Freud,[5] neglect the developmental line of mind: wakefulness, inquisitiveness, and curiosity.

A genuine contemplative psychotherapy adds that crucially missing dimension, the training and study of mind. This was understood by William James from his observations of nitrous oxide intoxication, psychosis, and religious conversions, but he was unable to follow through with his studies because he lacked a framework or discipline to continue.[6]

The various disciplines of contemplative psychotherapy can vastly extend our understanding of mind and relationships. When one trains in this way, one naturally becomes interested in history from the point of view of sanity, and that gives rise to the development of compassion. From the perspective of the history of sanity, it is apparent that the pathway of psychotherapeutic training has the same form as the pathway to recovery from illness.

NOTES

1. J. Perceval, *Perceval's Narrative, A Patient's Account of His Psychosis,* ed. G. Bateson (Stanford, CA: Stanford University Press, 1961).
2. H. Michaux, *The Major Ordeals of the Mind and Countless Minor Ones* (New York: Harcourt Brace Jovanovich, Inc., 1974).
3. Harold Searles, *Countertransference and Related Subjects* (New York: International University Press, Inc., 1979), Chapter entitled "The Patient as Therapist to His Analyst."
4. A. R. Luria, *The Man With A Shattered World* (Chicago: Henry Regency Co., 1972).
5. A. Freud, *Normalcy and Pathology in Childhood* (New York: International University Press, 1966).

6. W. James, *Psychology: Brief Course* (New York: Dover, 1961). "The faculty of voluntarily bringing back a wandering attention, over and over again, is the very root of judgement, character, and will. No one is *compos sui* if he have it not. An education which should improve this faculty would be the education *par excellence*. But it is easier to define this ideal than to give practical direction for bringing it about." (p. 424).