THE DREAMING BODY: A CASE STUDY OF THE RELATIONSHIP BETWEEN CHRONIC BODY SYMPTOMS AND CHILDHOOD DREAMS ACCORDING TO PROCESS-ORIENTED PSYCHOLOGY

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Alan James Strachan

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Abstract of the Thesis

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The purpose of this study was to investigate the relationship between childhood dreams and the manifestation in adulthood of chronic body symptoms as theorized by Process-Oriented Psychology.

According to the theory, childhood dreams reveal fundamental life patterns or life myths. These fundamental patterns may manifest in adulthood in a variety of ways, including as chronic body symptoms. Process-Oriented Psychology also maintains that there is a process structure to all experience, and that a childhood dream and a chronic body symptom are related through this structure.

The hypothesis was that if, in a psychotherapy session conducted in accord with the principles and methods of Process-Oriented Psychology, the client works on both a chronic body symptom and a childhood dream, then the relationship between the symptom and the dream will have structural correspondence in terms of the process structure of the session.

The primary data was a videotaped 53-minute psychotherapy session. The client was a 27-year-old Caucasian female. Arnold Mindell, the originator of Process-Oriented Psychology, was the therapist. A transcript was made of the videotape identifying all verbal and nonverbal interactions between therapist and client. The secondary source of data was a follow-up interview with the client conducted 4 1/2 years after the psychotherapy session.

A content analysis of the videotape transcript showed that the structure of the dream was congruent with the structure of the client's body symptom in terms of her primary and secondary process, occupied and unoccupied channels, edges, and dream figures. Results from the follow-up interview supported these findings.

The findings suggest that the childhood dream and chronic body symptom conveyed the same information; that they were each reflections of a more fundamental process; and that the dream may have anticipated the subsequent development of the body symptom.

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CHAPTER I

INTRODUCTION

Introduction to the Problem

C. G. Jung made some remarkable statements about children's dreams in a series of lectures he delivered in 1938-1939 (Jung, 1938-39). Jung identified three kinds of children's dreams: ordinary dreams, dreams that reflect the psychology and behavior of the parents, and "far-seeing" dreams. It is a particular kind of far-seeing dream that is the focus of this dissertation.

In his first lecture Jung said, "These early dreams are most important, and it is not unusual for them to give a prophetic picture of a person's whole life" (p. 1). Further on, Jung commented, ". . . in the process of development, future forms of the personality are occasionally anticipated, which are utterly foreign and unrecognizable beforehand. When such dreams are very impressive, they may remain, indelibly stamped on the memory, through a whole life-time" (p. 16).

The far-seeing dreams reveal at a very early age the essential qualities of what Jung referred to as the life myth, the unique pattern or story that characterizes an individual's life and imbues it with a fundamental meaning and purpose. Jung believed that it was possible for children to have such dreams because they are, more so than adults, immersed in and influenced by the archetypal images of the collective unconscious.

Typically the far-seeing dream is forgotten as the individual learns to adapt to the external world. As the personality develops, it is usually one-sided and has not integrated the material contained in far-seeing dreams. As long as this is true, the unintegrated material will continue to affect the person, usually without his or her awareness. According to Jung, in order to individuate, to become whole, it is necessary to remember and integrate these dreams that are dreamt out of the depths of the personality.

Arnold Mindell further developed Jung's work on far-seeing childhood dreams. Mindell holds an M.S. in Physics, a Ph.D. in Psychology, and an Analyst's Diploma from the Jung Institute in Zurich, Switzerland. He was, for many years, a training analyst and teacher at the Jung Institute. For the past 20 years, Mindell has been developing a psychotherapeutic modality which he calls Process-Oriented Psychology.

Mindell agrees with Jung that childhood dreams reveal a fundamental life pattern or life myth. According to Mindell, the mythic pattern can manifest in adulthood in a variety of ways, including relationship problems, chronic illness, recurrent dreams, addictions, and the form of a person's death.

A major difference between Jung and Mindell is that, whereas Jung spoke briefly of the possible physical consequences of unintegrated childhood dream material, Mindell has placed more emphasis upon and worked more directly with body phenomena, including chronic physical symptoms. Mindell has emphasized, in particular, the relationship between

childhood dreams and subsequent development of chronic body symptoms. It is this relationship that is the focus of this dissertation.

Purpose and Hypothesis

Purpose

The purpose of this study was to explore the relationship between childhood dreams and the manifestation in adulthood of chronic body symptoms as theorized by Process-Oriented Psychology. Process theory maintains that a childhood dream and a chronic body symptom are related through the process structure of an individual's experience. One way of testing this theory is to study a psychotherapy session in which the client works on both a chronic body symptom and a childhood dream. It would be necessary and appropriate that such a session be conducted in accord with the principles and methods of Process-Oriented Psychology.

Hypothesis

The hypothesis is as follows. If, in a psychotherapy session conducted in accord with the principles and methods of Process-Oriented Psychology, the client works on both a chronic body symptom and a childhood dream, then the relationship between the symptom and the dream will have structural correspondence in terms of the client's primary and secondary process, occupied and unoccupied channels, edges, and dream figures.

The hypothesis was tested using a case study methodology. The case study is a transcribed psychotherapy session in which the client had a chronic body symptom and the therapist (Mindell) followed the precepts

and techniques of Process-Oriented Psychology. In the course of the session, the client spontaneously remembered and worked with a childhood dream that appeared to relate to the chronic body symptom. A follow-up interview with the client provided additional data.

As mentioned previously, Process-Oriented Psychology maintains that the information conveyed by a childhood dream can appear in later life as a chronic body symptom. This means that the childhood dream and the chronic symptom convey the same information or meaning. It was not my purpose in this dissertation to try to confirm that the chronic symptom developed from the childhood dream. However, it was possible to determine whether the analysis indicated that the dream and the symptom were conveying the same or similar information.

Process Structure

The elements of the process structure that were studied were the client's primary and secondary process, her edges, her occupied and unoccupied channels, and dream figures that appeared.

Primary processes refer to all of the body gestures, ideas, and behaviors with which a person readily identifies, or with which, it could safely be assumed, the person would identify, if asked. Secondary process refers to all of the experiences and behaviors with which a person does not identify. **Secondary processes** tend to be experienced as intrusive, as not belonging to oneself, as invasions or interruptions of the primary process. (It is important to distinguish Mindell's use of the terms primary and secondary process from the meanings assigned by Freud. For discussion of this point please refer to Appendix A.)

An **edge** represents the boundary separating the primary and secondary processes. It is the limit of someone's identity; that is, the limit of who the person imagines himself or herself to be and what the person imagines he or she can do.

A **channel** is the way in which a signal is represented. Signals may appear in a number of different channels, and each channel represents a different way of perceiving. Process-Oriented Psychology recognizes four basic channels and two composite channels. The basic channels are vision, audition, proprioception, and kinesthesia; while the two composite channels are relationship and world. (The channels are described in greater detail in Appendix A.)

The terms **occupied and unoccupied channels** refer to the tendency of people to focus on certain channel experiences and remain relatively unaware of others. If someone identifies with the experiences that are occurring in a channel, then that channel is considered to be occupied. If someone is not identifying with a channel experience, then that channel is unoccupied. The main channel is the one that a person usually occupies.

The concept of **dream figures** is a way of organizing and making sense of collections of signals over time. It is based on the observation that in many instances, signals—particularly secondary ones—appear to be generated by independently operating subsets of the personality. In Process-Oriented Psychology, these independent parts are referred to as dream figures. Dream figures act as though they have personalities of

their own, with accompanying voice tones, expressions, postures, and so forth.

There are several ways of analyzing data from the psychotherapy session and the follow-up interview. These are described in the section on Methodology.

This research did not try to confirm a general connection between chronic body symptoms and childhood dreams. While it may be possible to infer a general connection from the information collected in the dissertation, the case study methodology was directed toward determining the nature of the relationship between chronic body symptoms and childhood dreams in the specific case discussed in the dissertation, and in accord with the specific paradigm of Process-Oriented Psychology.

Research on Childhood Dreams and Chronic Body Symptoms

The relationship between either children's dreams, in general, or the "far-seeing" childhood dream, in particular, and chronic body symptoms in adults has been almost totally neglected as a focus of psychological inquiry. As is shown in the two literature reviews presented in succeeding chapters, there have been many studies of children's dreams, and many studies of dreams and illness, but very few studies that mention the relationship between dreams dreamt in childhood and illness developed in adulthood. Besides Mindell and Jung, there are only four references in the literature that mention this connection (Lippman, 1954; Lockhart, 1977; Saul & Bernstein, 1941; Schneider, 1973).

Lippman (1954) and Schneider (1973) were apparently providing medical treatment to their respective clients, but not psychotherapy. Each

noticed the connection between a childhood dream and a physical symptom and then provided medical treatment for the physical symptom.

Lockhart (1977) and Saul and Bernstein (1941) were psychotherapists working with clients. Lockhart reported that after the client completely worked through the issues symbolized by the childhood dream, the physical symptom (cancer) went into remission and the dream never returned. Lockhart approached psychotherapy from a Jungian perspective. He described the mythological theme represented by the dream, but did not provide details about the psychotherapeutic procedure whereby the client completed the dream. Saul and Bernstein reported the content of the therapy sessions with their client in slightly more detail. They described two sessions in which the recurrent childhood dream was reported and the physical symptom was in evidence. Saul and Bernstein appeared to have followed standard psychoanalytic procedure by eliciting associations and making interpretations of the client's statements.

The four articles postulated that there was a meaningful connection between a dream and a body symptom in each of the cases described. However, none of the authors explicitly mentioned the prospective or teleological function of the childhood dream. The articles contained no details of the actual moment-to-moment interactions between therapists and clients during the therapy sessions. Moreover, none of the authors approached psychotherapy from the perspective of Process-Oriented Psychology, and, therefore, did not describe the relationship between the childhood dream and the chronic body symptom in terms of the client's

process structure. These deficits in the reported literature were addressed by this case study.

Rationale of the Hypothesis

This section outlines the theoretical rationale for describing the relationship between a childhood dream and a chronic body symptom in terms of the process structure of a case study. The hypothesis is derived from the basic premise of Process-Oriented Psychology; namely, that there is an underlying structure to all human experience.

Mindell has based this assumption upon certain aspects of modern physics, Taoist philosophy, information theory, and his empirical observations of clients. In this section, I focus upon the principles of information theory because it addresses the question of structure very directly.

Although information theory was originally formulated as a mathematical model, it has been successfully applied to fields such as biology, sociology, and economics. Mindell has integrated information theory into the theory and application of Process-Oriented Psychology. (This integration is described in some detail in Appendix C, Section 3.) In the context of this discussion it will suffice to note that Mindell has described the process structure in cases involving body symptoms (1982, 1985a); relationships (1987b); extreme psychological conditions such as schizophrenia, bipolar disorders, and sociopathy (1988a); group and global processes (1989b); and comas (1989a).

Briefly summarized, information theory is the study of systems, and the manner in which information flows within and between systems. A

system is considered to be an integrated whole, and its properties are derived from the relationships between and among its parts rather than from the parts themselves. Information theory maintains that systems are characterized by both a process and a structure.

According to Process-Oriented Psychology, process is experienced or perceived by individuals as the flow of signals in different channels. The emphasis is upon movement, change, and the dynamic flow of relationships. Process is to be contrasted with a state. A state-oriented perspective is one in which a process is divided into discrete parts and described in a fixed way. As an analogy, process is like the ever-changing flow of a river in contrast to a static picture taken of the river.

Structure involves the principles of organization, that is, the pattern or order that connects the different parts of a system. For example, in his autobiography, C. G. Jung described the case of a patient he encountered in the Burgholzli Mental Hospital in Zurich. The woman had been a patient of the hospital for 50 years. She had been bedridden for 40 of those years, could not speak, and consumed only liquids which she fed herself with her fingers. In addition, Jung observed that "When not eating, she made curious rhythmic motions with her hands and arms" (1961, p. 124). These perseverating gestures held no meaning for any of the staff; but Jung eventually discovered that they were cobbler's motions, representing an unconscious identification with a shoemaker who had refused to marry the patient early in her life. The gestures had little or no meaning when they were considered by themselves, but when they were

related to the patient's life, a pattern became apparent that made the gestures meaningful, and connected different parts of her system.

In accord with information theory, a basic premise of Process-Oriented Psychology is that the process or flow of all human experience has an underlying structure. This suggests that the relationship between a chronic body symptom and a childhood dream can be understood in terms of the underlying process structure. As mentioned previously, the elements of the process structure that can be expected to demonstrate this relationship include aspects of the client's process such as primary and secondary process, occupied and unoccupied channels, and dream figures. The overall structure of the session—patterns and recurrent themes—is also important.

Process-Oriented Psychology, similar to information theory, is concerned more fundamentally with the information value of events than with the events themselves. Experientially, events occur in various channels such as vision, audition, proprioception, and kinesthesia, and on the most basic level, the information being "carried" in these channels is important rather than the channel itself. The current case study may indicate that the same information is carried from the symptom to the dream because of the way in which the client's experience is tracked, and because of the client's subjective report.

To summarize, Process-Oriented Psychology maintains that childhood dreams reveal fundamental life patterns or life myths; that these fundamental patterns may manifest in adulthood in a variety of ways, including as chronic body symptoms; that there is a process

structure to all experience, including childhood dreams and chronic body symptoms; and that, therefore (as stated in the hypothesis), there should be a structural relationship between a childhood dream and a chronic body symptom if both are worked on in a psychotherapy session conducted according to the principles and methods of Process-Oriented Psychology.

Significance and Implications

The study of the relationship between chronic body symptoms and childhood dreams is significant for several reasons.

First, investigating this relationship contributes to our understanding of the importance of childhood dreams. Current theories about childhood dreams emphasize aspects such as manifest content, wish fulfillment, unresolved infantile conflict, and emotional/cognitive development. This dissertation contributes to these theories by posing the possibility that certain childhood dreams may anticipate the subsequent development of chronic physical symptoms.

Second, relating childhood dreams to chronic body symptoms contributes to knowledge about the interrelatedness of psychological and physical phenomena. This connection has been established in many realms (placebos, psychosomatic illness, stress, meditation, hypnosis, and so forth). To relate such seemingly disparate phenomena as chronic body problems and childhood dreams is particularly compelling.

Third, this study contributes to psychological theory and psychotherapy by demonstrating an effective treatment of dreams and body phenomena. Current systems of psychotherapy are relatively limited in the manner in which they treat dreams and body symptoms. For example, they

do not move fluidly from the visual and auditory recounting of a dream to body phenomena such as proprioception, movement, and posture, and then back to visual or auditory information. Process-Oriented Psychology is a psychological model that effectively connects dreams and body phenomena in terms of both theory and practical psychotherapeutic technique.

Fourth, this study contributes to our knowledge of life myths. Both childhood dreams and chronic body problems speak to the deepest levels of meaning in an individual's life—the 'life task' or 'life myth.' As such, understanding the significance of a childhood dream or chronic body symptom may be valuable for an adult seeking to understand his or her life, and for psychotherapists working with their clients.

Fifth, this topic is important to me because I am fascinated by theories about and practical methods of accessing the deepest levels of meaning in people's lives. Childhood dreams and chronic body problems each appear to provide access to this level of meaning. I have chosen to study these particular phenomena because I have benefited greatly from processing one of my childhood dreams, and have learned a great deal (albeit reluctantly!) from my chronic body problems. It would be very satisfying to establish the significance of childhood dreams and chronic body problems beyond the scope of my personal experience.

Methodology

As I mentioned in the section on Purpose and Hypothesis, the sources of data for the case study are a transcribed psychotherapy session and a follow-up interview with the client.

A transcript of the videotape was made which includes all verbal and nonverbal interactions between therapist and client.

The follow-up interview was conducted approximately 4 1/2 years after the psychotherapy session. Questions were formulated after a study of the videotape and the transcript to elicit information about six specific topics: general background information, the chronic body symptoms, the childhood dream, a drawing made by the client during the session, integration of the work, and an interruption of the videotape.

Both the client and the therapist signed consent forms so that this data could be utilized. Samples of these forms are shown in Appendix D.

Criteria

The videotape was selected because it met four criteria: (a) Mindell was the psychotherapist, (b) the client worked on both a chronic body symptom and a childhood dream during the session, (c) the childhood dream originally occurred by the age of 8, and (d) the chronic body symptom was present for at least 6 months. The first two criteria satisfy conditions set forth in the hypothesis, while the latter two criteria satisfy the definitions contained in a subsequent section on Definition of Terms.

Treatment of the Data

I examined the case study by conducting a content analysis of the videotape transcript, with reference to the videotape where necessary, in accord with the principles and theories of Process-Oriented Psychology. Data from the follow-up interview served to confirm or amend the

conclusions drawn from the transcript. The data analysis had three objectives:

1. To determine whether the case study confirmed or refuted the hypothesis;

2. To evaluate the accuracy of the predictions made by Process-Oriented Psychology about the case study; and

3. To discuss the theoretical implications of the confirmation or refutation of the hypothesis.

Evaluation of the Hypothesis

The hypothesis was evaluated by analyzing the structural relationship between the chronic body symptoms and the childhood dream within the psychotherapy session. This analysis was conducted in accord with the theoretical principles of Process-Oriented Psychology, and considered the client's primary and secondary processes, her occupied and unoccupied channels, her edges, and any dream figures that appeared.

Evaluation of the Predictions Made by Process-Oriented Psychology

The mode of analysis employed to evaluate predictions in the study, referred to as pattern-matching (Yin, 1984), is one in which patterns in the videotape are compared with predictions made by Process-Oriented Psychology. According to process theory, the following statements were predicted to be true of the psychotherapy session:

1. That there is a process structure consisting of the client's primary and secondary process, occupied and unoccupied channels, edges, and dream figures;

2. That this structure is evident within the first several minutes of the session;

3. That the early analysis of the process structure makes it possible to predict (a) the channel(s) in which the client accesses the information she needs to learn to cope with her presenting complaint, and (b) the channel(s) that are most important as the client attempts to integrate new material;

4. That unoccupied channel experiences likely involve some sort of dream figure;

5. That there are three possible outcomes when a process is amplified (i.e., when the strength of a signal in a given channel is increased): the client may change channels, reach an edge, or de-escalate;

6. That body experiences vary according to the perspective of the observer, so that as the client's perspective changes, her experience of her chronic body symptoms also change.

These predictions were compared with what actually occurred in the session.

The identification of the client's process structure was determined by evaluating her verbal and nonverbal behavior. This included factors such as what she said and how she said it, her eye movements, breathing patterns, and physical gestures.

The four basic channels recognized by Process-Oriented Psychology are visual, auditory, proprioceptive, and kinesthetic. Some of the sensory-based cues that may be used to identify which processes are occurring in these respective channels include:

1. **Visual cues.** Cues that the client is processing information visually include actions such as the eyes looking up or the head tilting upward, statements such as "I saw that," "People look at me," or a visual descriptions of events.

2. **Auditory cues.** Auditory processes are indicated by such cues as the eyes moving left or right, the body posture freezing without the head tilting down, or the person saying such things as "I can't hear you," "Listen to me," or "That sounds wonderful."

3. **Proprioceptive cues.** Some of the cues indicating proprioception include the head dropping forward, the eyes looking down and to the right, touching a painful part of the body, the accentuation of abdominal breathing, or verbal references to feeling states such as pain, joy, and depression.

4. **Kinesthetic cues.** Kinesthetic or movement processes are indicated by movement or lack of movement in any part of the body. These movements may be overt or very subtle. In addition, kinesthetic processes are indicated by statements such as "I ran around all day" or "That made me jump."

The use of language is an excellent cue as to whether a channel is occupied or unoccupied. The key element is whether the client is the active or passive agent in the activity being described. For example, if the client says, "I see," she is describing herself as the active agent in the activity of seeing, and is therefore occupying her visual channel. If she had said, "I'm seen," then she would be representing herself as a passive

agent in the activity of seeing, and would not be occupying her visual channel.

Theoretical Implications

The theoretical implications of the evaluation of the hypothesis are discussed by drawing upon process theory and the relevant literature. Yin (1984) referred to this method of analysis as explanation building.

Limitations of the Study

The main limitations on data gathering were imposed by the quality of the videotape that was transcribed and analyzed for the case study. Although the tape was of generally good quality in terms of both audio and video (and was chosen for that reason), there are certain inherent limitations in a videotape of this sort, as well as several limitations particular to this videotape. These limitations have to do with both the audio and video portions of the tape.

The session was filmed in color with a single video camera. The therapist and client were, therefore, filmed from a single angle, giving a restricted perspective from which data were gathered. A preferable technique would have been to use two or more cameras located in different locations in the room. This method would have recorded a wider range of data.

Data gathering was also affected by the proximity of the camera to the participants, that is, whether the focus was close enough to pick up relevant information. In addition, in several instances the camera was slightly out of focus. As a result, some of the more subtle aspects of body language may not have been discernible, for example, factors such as

changes in the size of the pupils, eye movements, subtle changes in the depth or rate of breathing, and changes in skin color.

In one instance, there was a brief interruption during which nothing was filmed. With the help of a colleague, I role-played the actions of the therapist and the client before and after the interruption. We estimated that a minute or less of the session was not recorded. This estimate was substantiated by the client's remarks in a post-session interview.

In that interview, the client said, "In some ways it doesn't seem like a broken tape to me. It doesn't look like you missed too much." This comment, along with an analysis of the process structure of the session, suggested that nothing of great consequence was missed.

The audio portion also imposed several limitations, insofar as there were seven instances in which it was impossible to understand what was being said because the audio portion was not completely clear. These instances were brief and did not significantly affect an understanding of the interaction between the therapist and client.

Pittenger, Hockett, and Danehy (1960) made the following observation:

> There are many terms that purport to describe the state of a single person—"anxiety," "depression," and so on. There are also some terms that purport to describe the state of a single person vis-a-vis another: "hostility," "fear," "love," and the like. But there are few ready-made terms that seem appropriate for describing the state of a two-person system as a whole (perhaps "in rapport" and a few others). Efforts to deal with such a system therefore tend to degenerate into an oscillating series of assertions about the participants: A behaves in such-and-such a manner toward B; then B does so-and-so to A; then A thus to B; and so on. (pp. 223-224)

I include this passage because in describing and analyzing the case study, I, too, had to work with the limitations and underlying epistemology of the English language. It is impossible, for example, to avoid sequential descriptions of the interactions between therapist and client. Fortunately, Process-Oriented Psychology is grounded in a systems perspective, and I have attempted to convey this perspective in my description of the therapeutic interaction.

Delimitations of the Study

I imposed delimitations in terms of both the focus of the study and the method of gathering data.

Jung and Mindell considered childhood dreams and certain childhood memories to be significant. I deliberately limited the investigation to childhood dreams, for several reasons. First, both Jung and Mindell focused primarily on dreams. Second, many psychological theories and countless authors have written about the significance of early childhood memories. Concentrating on childhood dreams narrowed the focus of study to manageable proportions and illuminated an area that was relatively neglected.

In addition, the study focused on childhood dreams remembered by adults, rather than childhood dreams told by children. Selecting adults as subjects had two advantages: adults have had time to develop chronic body symptoms, and they are more capable of discussing both the symptoms and the dreams.

In terms of the method of gathering data, I chose to do an in-depth analysis of a single case study. This limited the degree to which the

findings could be generalized, especially when considering individuals who are dissimilar to the subject of the case study.

Definition of Terms

Childhood dreams—In this dissertation, I make a distinction between the term "children's dreams" and the term "childhood dreams." "Children's dreams" is a generic reference to any and all dreams that are dreamt in childhood, while "childhood dreams" refers to the previously mentioned "far-seeing" dreams. Childhood dreams are the basis of this study. If a dream from childhood appears to be related to an adult body symptom, then the dream is presumed to be a "childhood dream." This distinction is maintained insofar as proper sentence structure permits. "Childhood dream" needs further definition, and I have turned to Jung and Mindell for clarification. Jung made several references to the age at which the far-seeing dreams typically occur. In one passage he stated that the children are 3 or 4 years old (Jung, 1988, p. xxii), and in another he mentioned they are 3 to 5 (Jung, 1959b, p. 50). In addition, Jung mentioned a specific case of a girl who at the age of 8 was still having dreams with mythological symbolism (Jung, 1976, pp. 95-96). Because Mindell has not mentioned specific ages for dreams, in the context of this dissertation I consider a childhood dream to be any dream remembered in adulthood that was first dreamt by the age of 8 since this is inclusive of all of the cases cited by Jung.

Chronic body symptoms—Mindell has often referred to "chronic body symptoms." In a personal communication (January 9, 1990), Mindell wrote that "a chronic body symptom is defined by the individual concerned.

The time involved is individual. It is subjective." In a conversation, he mentioned that in order to be chronic, the symptom should have been present for at least 6 months. In this context, then, a "chronic body symptom" is regarded as a symptom of which the person has been subjectively aware for at least 6 months.

Life myth—For the purposes of this dissertation, "life myth" is defined as the unique pattern or story that characterizes an individual's life and imbues it with a fundamental meaning and purpose. It is a central organizing principle in an individual's life.

Process work—In this dissertation the phrase "process work" is synonymous with Process-Oriented Psychology.

Process-Oriented Psychology has developed a fairly extensive set of terms to explain its concepts and principles. Some of these terms have been defined in this chapter. (For more detailed definitions, or for the definitions of other terms, please refer to Appendix A.)

Overview of the Remaining Chapters

In Chapter 1, I introduced the idea of far-seeing childhood dreams and chronic body symptoms. The purpose and hypothesis of the study were described; its rationale, significance, and implications were outlined; the methodology, limitations, and delimitations were described; and key terms were defined.

In Chapter 2, I review the literature on dreams and body symptoms.

In Chapter 3, I review the literature on childhood dreams.

In Chapter 4, I describe the subject, outline the procedures followed in selecting and transcribing the videotape, detail the procedures for

designing and conducting the follow-up interview, and describe the methods utilized in the treatment of data

In Chapter 5, I present a transcription of the verbal and nonverbal interactions between the Therapist and the Client.

In Chapter 6, I analyze the videotape in accord with the theoretical principles of Process-Oriented Psychology.

In Chapter 7, I review the purpose and hypothesis, summarize and analyze the findings, discuss the practical implications, and offer suggestions for further research.

CHAPTER II

LITERATURE REVIEW: DREAMS AND ILLNESS

Introduction

The material on dreams and illness is divided into six categories: brief summaries of the (a) historical perspective and (b) modern empirical studies; followed by discussions of (c) childhood dreams and illness; (d) contemporary theories, which focuses on Freud, Jung, and Mindell; (e) theoretical speculations on the relationship between dreams and illness in which the literature is compared and analyzed; and (f) concluding remarks.

Part 1: Historical Perspective

Dreams have been linked with the diagnosis, prognosis, and healing of illness throughout history. In classical times, there were two general theories about the relationship of dreams to illness. Artemidorus (1975) and the temples of Aesclepius (Meier, 1966, 1967; Sabini, 1981; Webb, 1979) made reference to the gods appearing in dreams in order to promote healing, while Aristotle (cited in Hammond 1902), Hippocrates (cited in Chadwick & Mann, 1987), and Galen (Hall, 1977) focused on how dreams may arise in response to natural causes in the body.

In the Middle Ages, the primary focus was on the divine or demonic origin of dreams. This debate contributed little to the understanding of the relationship between dreams and illness. The only known individuals to speculate about this relationship were Gregory of Nyassa, Michael Scot,

Bartholomew, Thomas Aquinas, and Albertus Magnus, who all believed that organic events could influence dreams (Hall, 1977). Gregory and Scott apparently focused on the diagnostic value of such dreams, while Aquinas and Magnus emphasized their prognostic value.

From the Renaissance to the 18th century, there was little focus on dreams, in general, or on the relationship between dreams and illness, in particular. Thomas Hobbes, Marin Cureau de la Chabre, and Thomas Willis were the exceptions, each speculating on the organic causes of dreams (Hall, 1977).

In the latter half of the 1800s, a significant interest developed in the scientific investigation of the relationship between dreams and illness. Freud's publication of *The Interpretation of Dreams* (1955) drew upon these studies and ushered in the modern age of dream research.

Part 2: Modern Empirical Studies of Dreams and Illness

Modern empirical studies cover a variety of topics, including dreams as aids in physical diagnosis, dreams as aids in determining a treatment plan, dreams that anticipate illness, rapid eye-movement studies, dreams and specific illnesses (i.e., cancer, heart conditions, and seizures), personality characteristics of psychosomatic patients, and miscellaneous studies. In this section I briefly summarize these studies.

There are several cases in the literature in which dreams were used to diagnose physical illness and to determine whether a given condition was primarily organic or psychological in nature. Savitz (1969) reported two cases involving the diagnosis of heart conditions, while Cheek and Lippman (1969) reported ongoing success in using dreams to diagnose

pregnancy complications and migraines, respectively. All three of the authors reported success in using dreams as an aid in physical diagnosis, although Cheek and Lippman appear to have systematized their approach to a greater extent than Savitz.

Several articles refer to cases in which patients received advice about the treatment of their condition in dreams. Sometimes this advice added to or conflicted with that provided by doctors. When this occurred the patient had to decide whether to follow the therapeutic suggestions contained in the dreams or continue to follow the treatment plan of the medical practitioner. In four of the five cases, the patients were afflicted with life-threatening cancer (Lockhart, 1977; Sabini & Maffley, 1981; Simonton, Matthews-Simonton, & Creighton, 1978), while the other case concerned tuberculosis (Amann, 1968). In each of these cases, the unconscious played a critical role in the healing process. Dreams served as one of the primary ways of accessing information from the unconscious, providing the patients with options to consider in responding to the illness.

Hall (1977), Sharpe (1937), and De Becker (1968) each cited a case in which a dream provided an indication of the presence of an organic problem prior to the patient being consciously aware of the illness.

Several rapid eye-movement studies affirmed that a strong correlation existed between physiological measures of REM sleep and gastric secretion rates (Armstrong et al., 1965), nocturnal angina pectoris (Nowlin et al., 1965), and asthma attacks (Ravenscroft & Hartmann, 1967).

Three authors described cases in which there appeared to be a meaningful connection between dreams and heart conditions. Ziegler (1962), Schneider (1973), and Saul (1940) believed that the patients' dreams portrayed long-standing issues that were fundamental to the structure of their personalities, and, in so doing, affected the physiological responses of the heart. Ziegler (1980) found that the dreams of patients in the latter stages of heart disease were significantly different from the dreams of a non-cardiac control group.

The studies cited above on the role of dreams in determining a treatment plan mentioned several cases in which dreams played a role in cancer. In addition, researchers reporting in the literature have shown that dreams can play a variety of roles in the disease process of cancer, including anticipating the illness (Hyman, 1977; Sabini & Maffly, 1981), helping to cure or improve the patient's condition (Lockhart, 1977), pinpointing the underlying psychological issues (Hyman, 1977; Lockhart, 1977; Sabini & Maffly, 1981), and providing information about treatment (Hyman, 1977; Sabini & Maffly, 1981). Epstein (1964, 1967) and Kupper (1947) described parallels between dreams and seizures in terms of content, timing of their appearance and disappearance, body image and position, and expression of affect.

A number of attempts have been made to determine the structure and function of the personalities of psychosomatic patients by studying their dreams. The studies of Dunbar (1943), Warnes (1982), Warnes and Finkelstein (1971), Levitan (1978, 1980, 1981) and Silverman (1985) each described a correlation between specific personality traits and a variety

of illnesses. In each case, dreams were helpful in pinpointing repressed feelings, fantasies, and attitudes that had a direct bearing on the development of physical symptoms.

Sabini (1981) analyzed 60 dreams, drawn from a variety of sources, which addressed themselves in an undisguised way to diagnosed illnesses. She concluded that the dreams were valuable sources of information in determining diagnosis, prognosis, and the patient's attitude toward treatment.

Finally, a number of additional studies further substantiated the connection between dreams and illness by describing cases involving edema and seizures (Kupper, 1947); rheumatism (French & Shapiro, 1949); headaches, nausea, vomiting, and abdominal pain (Waterman, 1910); asthma, cardiac arrhythmia, and fever (Ziegler, 1983); and hives (Saul & Bernstein, 1941).

Part 3: Childhood Dreams and Illness

There are a number of references in the literature to cases in which a childhood dream is linked to an illness that the dreamer developed as an adult. Saul and Bernstein (1941) described the case of a woman patient, approximately 25 years old, who suffered from chronic migraines and outbreaks of hives. They discovered that "Her deepest wish, judging by her frequently recurring dream, which began in earliest childhood, was for a good mother, actually for her concept of her own mother whom she had lost at the age of 2" (pp. 353-354).

Saul and Bernstein then made a connection between the childhood dream and the patient's chronic body symptoms.

> Grown to womanhood, she retained these intense longings of her childhood but was unable to satisfy them through a normal sexual life, because of her fears. . . . When her perpetually frustrated longings were increased. . . then she would become upset, frequently eat uncontrollably, be irritable, develop migrainous headaches, and also weep, or else . . . break out with hives. (p. 354)

Saul and Bernstein described two therapy sessions in which the patient reported that she had a recurrence of the childhood dream. In the first session she awoke weeping and developed a case of hives during the therapy session. In the second session she awoke from the dream with a case of hives.

Lockhart (1977) recounted a case in which a cancer patient reported the following dream which had recurred since childhood:

> I open the door of a darkened bedroom, and with the light shining from my back across the room to a window, I see a glowing face outside the window looking at me. I immediately become paralyzed, lift up off the ground so that I am floating, and begin floating slowly toward the face. The dream never resolves beyond this point. (p. 14)

Lockhart wrote that "It was only when the dreamer completed the dream by exposing himself to the awesome emotional power of the face that he experienced a release. . . . The dream has not returned, nor has his cancer" (p. 15).

Schneider (1973) treated a man in his mid-40s who had experienced a heart attack. The man reported a nightmare which he had dreamed recurrently since childhood:

> I am running all night. I am running along the rooftops of the city because I am being pursued. My pursuer changes shape. At first I am pursued by a woman, then she turns into a witch, then she turns into a cat—and I keep running as though my life depended on it. . . (p. 367)

> Schneider (1973) believed that the dream was directly related to the heart attack, interpreting the "I am running" image as "the heart pounding and running all night long, so that it can be said that in his sleep the heart attack man does not consistently really totally rest." (p. 368)

Although Schneider did not specifically mention another childhood dream, he did make the general observation that "heart attack personalities" often have experienced the shock of massive anxiety as early as 3 years of age, and that "Dreams reflect each stage of alarm very precisely" (p. 366). He cited, for example, a separate case in which a man had a symbolically significant dream hours before suffering a severe coronary. Schneider wrote that

> The events and the dream bring into sharp focus a repetitive obsessive-compulsive pattern fused with a running stream of anger which had been characteristic of him since early childhood and had now reached its inevitable self-destroying zenith. From the night-terrors of his childhood to this horror-dream of his sick adulthood—he had moved to this shocking climax. (p. 364)

As mentioned previously, Lippman (1954) discovered three kinds of dreams associated with migraines. He labeled one of these dream patterns "The Nightmare," and described it as follows:

> Dream Pattern #1: The Nightmare. These dreams begin in early childhood, recurring frequently until the 10th or 12th year. Some patients remark that their dream "began as far back as they can remember." In rare cases the dream may recur infrequently in adult life, usually during or following periods of illness. In such instances, it is remarkable that the dream is identical in detail with that of the early childhood years. (p. 273)

Lippman went on to say that the nightmare is characterized by intense terror and panic which his patients typically described as being completely out of proportion to the dream situation. This feeling

continues into the waking state, sometimes lasting for hours. Lippman provided case material of five patients, each of whom suffered from migraines, and each of whom experienced the nightmare dreams.

Although Jung (1938-39) did not cite a specific childhood dream and its relationship to a body problem experienced by an adult, he did make the general observation that such dreams can, in later life, affect an individual's posture, movements, and ability to feel his or her body. (This passage is quoted in Chapter 3, the literature review of childhood dreams.)

Mindell cited one case (1985b) in which a physical symptom was related to a childhood dream. The patient was a 40-year-old man with a recurring backache. As a child, the man had a dream in which he had tripped over his mother's feet, whereupon his mother had turned into a cow. The cow head grew ever larger until it filled his vision, with its mouth open in a silent scream. As they worked on the dream, the man said that the cow had a lot of pain that he could feel in his stomach. Mindell amplified the pain by applying pressure until, still with the man's encouragement, he was using a great deal of force. The man gave no indication of being in pain, and eventually they realized that he was exhibiting a cow-like nature. Both the dream and the backache were telling the man that he needed to express his pain.

To summarize, the five articles cited in this section described a connection between childhood dreams and a variety of physical symptoms that manifested in adulthood. The symptoms were migraines (Lippman, 1954; Saul & Bernstein, 1941), cancer (Lockhart, 1977), heart attack (Schneider, 1973), hives (Saul & Bernstein, 1941), and backache (Mindell,

1985b). Migraines were the only symptom that appeared in more than one case.

Although the symptoms varied considerably, the cases have a number of elements in common. Lockhart, Schneider, Lippman, and Saul and Bernstein all noted that the dreams were recurrent. In all five articles, the dreams were characterized by extremely strong affect. In two instances the authors emphasized the antiquity of the dreams, noting that they began "in earliest childhood" (Saul & Bernstein, 1941, p. 353) and "as far back as they can remember" (Lippman, 1954, p. 273). Finally, in each case, the dream was in some way incomplete. For example, Saul and Bernstein's patient was left with intense, unresolved longings; Lockhart's patient floated toward but never reached the large face; Schneider's patient was endlessly pursued; Lippman's patients recounted a variety of unresolved terrors; and Mindell's patient dreamt of a cow whose mouth was open as if to scream. Both Lockhart and Mindell worked with their patients to help them complete the dreams. In Lockhart's case, the patient went into remission, while Mindell did not describe the effect of the work on his patient's physical symptom.

Part 4: Contemporary Theories: Freud, Jung, and Mindell

Freud

In *The Interpretation of Dreams* (1955), originally published in 1900, Freud wrote that there were four "stimuli and sources" of dreams: external sensory stimuli, internal (subjective) sensory excitations, internal organic somatic stimuli, and psychical sources. Freud established

the strongest connection between dreams and illness in his evaluation of the role played by internal organic somatic stimuli.

According to Freud, dreams display a heightened sensitivity to internal organic somatic stimuli because "during sleep the mind, being diverted from the external world, is able to pay more attention to the interior of the body" (1955, p. 35). It is this ability that makes dreams sensitive to the disease process.

In surveying the 19th century literature on dreams, Freud discovered that a number of articles had been published in Europe in the 1800s on the relationship between dreams and illness. Many of these articles focused on the function of internal organic somatic stimuli as a source of dreams. Freud relied heavily on this literature in drawing his conclusions about the relationship between dreams and illness. For example, Freud was convinced that disorders of the internal organs often instigate dreams, and he simply referred the reader to a number of sources that supported this connection (1955). He also agreed with his sources in writing about the significance of dreams in diagnosing and forewarning of illness.

A number of the sources cited by Freud maintained that disorders of specific organs give rise to specific dream themes. This would mean, for example, that lung disease triggers dreams of suffocation, crowding, and fleeing; or that individuals afflicted with heart disease have dreams that are typically short, come to a horrifying end, and include a situation involving a terrible death. Freud disagreed with the belief that there is such a deterministic correspondence between the afflicted organ and the resulting dream. He wrote that

> Every somatic dream-stimulus which requires the sleeping mental apparatus to interpret it by the construction of an illusion may give rise to an unlimited number of such attempts at interpretation—that is to say, it may be represented in the content of the dream by an immense variety of ideas. (1955, p. 223)

In summation, while Freud believed that dreams are influenced by internal organic somatic stimuli, and that they can diagnose and forewarn of illness, he also held that the relationship between organic problems and dream images is a complex one that is mediated by the psychology of the individual.

Jung

Jung described several cases in which dream analysis proved useful in determining the nature of a physical illness. In *Man and His Symbols* (1964) Jung described a series of 12 dreams from an 8-year-old girl which were submitted to him by her father. Jung thought that they were the strangest series of dreams he had ever seen. His analysis of the dream motifs led him to conclude that

> Little or nothing in the symbolism of her dreams points to the beginning of a normal adult life, but there are many allusions to destruction and restoration. When I first read her dreams, indeed, I had the uncanny feeling that they suggested impending disaster. The reason I felt like that was the peculiar nature of the compensation that I deduced from the symbolism. It was the opposite of what one would expect to find in the consciousness of a girl that age. . . . One would expect to find such images in an aging person who looks back on life, rather than to be given them by a child who would normally be looking forward. . . . They were a preparation for death, expressed through short stories. (p. 63)

Approximately a year after the girl dreamt these dreams she died of scarlet fever. References to this case may also be found in Jacobi (1959) and Jung (1938-39).

In another instance, Jung was asked to provide consultation in a case involving a 17-year-old girl. One doctor believed that she could be in the first stages of progressive muscular dystrophy, while another thought that it was a case of hysteria. Jung asked for and received two dreams from the girl. According to his interpretation, Jung concluded that "Both dreams point to a grave organic disease with a fatal outcome. This prognosis was soon confirmed" (Jung, 1966a, p. 160).

Another case involved a 27-year-old man who was experiencing severe attacks of pain near his heart, choking sensations in his throat, and piercing pains in his left heel. By eliciting dreams, Jung was able to understand and explain to the patient the reason for his symptoms (Jung, 1969).

In 1933, Jung was asked by Dr. T. M. Davie to help diagnose a case of epilepsy in which the etiology of the disease was obscure. Dr. Davie elicited a dream from the patient. Jung was given the dream without having met the patient and was asked for his interpretation.

> I thought it would be of interest to submit this dream to Jung to ask what his interpretation would be. He had no hesitation in saying that it indicated some organic disturbance, and that the illness was not primarily a psychological one, although there were numerous psychological derivatives. The drainage of the pond [an image in the dream] he interpreted as the damming-up of the cerebrospinal fluid circulation. (Davie, 1935, p. 296)

Dr. Davie was impressed with Jung's interpretation, concluding that

> Dream interpretation here corroborates the neurological hypothesis in a striking manner. . . . Dreams also, it would seem, do not merely provide information of the psychological situation, but may disclose the presence of organic disturbance and even denote its precise location. (1935, p. 297; see also Jung, 1976, p. 65, note 15)

When asked to explain how he was able to differentiate organic from psychological conditions by interpreting dream symbolism, Jung replied that it had been necessary to study not only Western psychology but also sources such as Chinese, Hindu, and Sanskrit literature, and medieval Latin manuscripts. In each of the cases cited above, Jung believed that the symbolism contained in the dreams was archetypal, and that interpretation of such material required extensive knowledge. Only then "can you begin to make diagnoses and say that this dream is organic and that one is not" (Jung, 1976, p. 67).

As can be seen from these examples, Jung believed that dreams were useful in the differential diagnosis between organic and psychogenic conditions, as well as in determining the prognosis of an illness. He wrote that "We must expect to find dreams which are more on the physiological side than on the psychological, as we have other dreams that are more on the psychological than on the physical side" (1976, pp. 65-66). Jung devised a method of making this distinction which was, for him, apparently quite effective.

Mindell

The relationship between dreams and body symptoms is an implicit part of Mindell's theory, so much so that 'dreambodywork' is a synonym for Process-Oriented Psychology. Mindell's clinical work led him to conclude that ". . . body symptoms are mirrored in dreams and that the reverse is also true. All dreams talk about, one way or the other, body conditions" (1985b, p. 3).

Mindell's theoretical position is that body symptoms and dreams are expressions of what he terms the "dreambody." Mindell has described and defined the dreambody in various ways in his different books. In *Dreambody* (1982), Mindell noted that concepts analagous to the dreambody are to be found in the chakra system, Taoism, shamanism, and in the yogic notion of the subtle body. The dreambody also has field-like qualities similar to those described in modern physics, in which a solid particle (or, by extension, the human body) is considered to be an example of a relatively high field density. Employing the language of physics, Mindell described the dreambody as a "highly energic field intensity, that is, a patterned experience without definite spatial or temporal dimensions" (1982, p. 51). He then applied this terminology to the psyche, stating that "The dreambody is a collection of energy vortices held together by the total personality" (1982, p. 32).

In a later work, Mindell offered a definition that emphasized the communication theory concepts of channel structure and information exchange:

> The dreambody is a term for the total, multi-channeled personality. . . .The dreambody is the empirical name for a mystery which appears in practice as dreams and body life. With the discovery of the dreambody, dreamwork, and bodywork have become interchangeable. I find that if I start working on the dream, it invariably switches to the body problem and vice versa. The dreambody is the part of you that is trying to grow and develop in this life. The dreambody is your wise signaler, giving you messages in many different dimensions. When it signals to you in the body, we call it a symptom. When it signals to you through a dream, we call it a symbol. (1985b, p. 39)

Thus, for Mindell, dreams and body phenomena are examples of the dreambody expressing itself in different channels. In the case of dreams, primarily the visual and auditory channels are used. In the case of body phenomena, primarily proprioception and movement are used.

This illustrates a basic tenet of Mindell's theory: that to know about the dreambody it is necessary to observe its effects. For example,

> When the dreambody manifests itself as an energetic charge shooting through the spine, we could call it by its ancient name, the Kundalini. When it is experienced as the essence of life, it is Mercury. When one visualizes its energy as streaming through the body, it is the 12 meridian system. If one sees it and acts on this vision, we have gestalt identification. If one feels it as a cramp in breathing, it is called character armor. If one senses it and changes, we might speak of biofeedback. If it appears as a force pushing one in the stomach to do a new task, it is personal power. (Mindell, 1982, p. 8)

Taking a teleological approach, Mindell considers dreams and body symptoms to be transmissions of information from the dreambody and therefore as opportunities for a person to learn and individuate.

In *Coma* (1989a), Mindell further differentiated the types of body experience, describing and defining the real body, the dreambody, the mythbody, and the immortal body. For the purposes of the current discussion, it is sufficient to note that dreams and body symptoms are for the most part a product of either the dreambody or the mythbody. The dreambody appears in the form of symptoms (such as those listed in the quotation above) that disturb the real or victim body. 'Big' dreams that reveal personal myths are produced by the mythbody (also known as the transpersonal dreambody), and the body symptoms associated with the mythbody are generally further from awareness than symptoms associated

with the dreambody. The mythbody is, therefore, responsible for a subsection of dreams and body symptoms. (The four experiential bodies are described in greater detail in Appendix A.)

Part 5: Theoretical Speculations on the Relationship Between Dreams and Illness

One way of trying to understand the connection between dreams and illness is to try to determine if either the dream or the illness appears to be the original symptom. The literature on psychosomatic medicine is replete with attempts to assign primacy to either the physiological or psychological process.

Writing at the turn of the century, Freud noted that "The somatic view of the origin of dreams is completely in line with the prevailing trend of thought in psychiatry today" (1955, p. 41). Although Freud himself believed that research would ultimately reveal the organic basis for mental events, his greatest influence upon psychosomatic theory was his emphasis upon the "unsuspected psychical sources of stimulation" in the formation of dreams (1955, p. 41). Freud's influence meant that for many years, physical symptoms were assumed to have been produced by the psyche. In the past several decades, with advances in fields such as biochemistry, psychopharmacology, and neurophysiology, psychiatry is once again acting on the assumption that biology is the fundamental basis for psychological conditions.

There are two underlying premises in the psychosomatic investigations. The first premise, based on the Cartesian paradigm, is that the mind and body are separate entities. A corollary is that an illness may

be either purely physical or completely psychological. The second premise, based on the Newtonian paradigm, is that the relationship between physical and psychological events is a linear, causal, mechanistic one.

Dreams as the Original Symptom

The first possibility to consider is that the dream itself precipitates the illness, that is, that no physiological change occurs prior to the dream.

In the majority of the sources cited in this chapter, the dream is, in fact, reported prior to the onset of the body symptom. Many of the authors asserted that there was no physiological change before the dream, including Epstein (1964), Kupper (1947), Schneider (1973), and Waterman (1910). In most of the cases, the body symptom appeared within a few hours or within a day of the dream. There were, however, several cases in which the time span was far greater.

Sabini and Maffly (1981) described a case in which a man dreamed that he had cancer and would live 6 to 8 more years. He developed liver cancer 5 years later and died in the 6th year following the dream.

Caire (1981) analyzed Freud's famous dream about his patient Irma. This was the dream Freud chose to illustrate his theory that dreams were primarily an expression of wish-fulfillment. Caire believed that Freud's dream contained a representation of the throat cancer that he manifested in later life. She wrote that "It is interesting to note that the very images which puzzled Freud and did not lead to satisfactory associations were those that represented the disease potentials" (1981, p. 137). Caire offered a holographic theory to explain how psychological and somatic

factors can become symbolically linked and thereby affect a disease process. If Caire's interpretation is correct, Freud's dream anticipated his throat cancer by 28 years.

As noted in the section of childhood dreams and illness, Saul and Bernstein (1941), Lockhart (1977), Lippman (1954), Schneider (1973) and Mindell (1985b) all referred to cases in which a dream from childhood was in some way connected to a physical illness that manifested many years later. The relatively long time span between the dream and the illness in these cases (ranging from 5 to approximately 35 years) supports the contention that the dream was the original symptom.

It is clear from rapid eye-movement studies, that dreams can have an immediate impact on physiological functioning. This was true in cases involving gastric secretion rates (Armstrong et al., 1965), nocturnal angina pectoris (Nowlin et al., 1965), and asthma attacks (Ravenscroft & Hartmann, 1967). Even in those instances in which the illness preceded the dream, the physical symptoms appeared to be exacerbated by the dream.

The possibility that a dream could precipitate an illness is also increased if it is a recurrent dream. Recurrent dreams are linked by Sabini (1981) and Lockhart (1977) to cancer, by Epstein (1964, 1967) to epilepsy, by Lippman (1954) to migraines, by Saul and Bernstein (1941) to migraines and hives, and by Levitan (1981) to susceptibility to psychosomatic illness. It is reasonable to assume that recurrent dreams are of greater significance psychologically, and that, through repetition, they could have a correspondingly greater impact physiologically.

Illness as the Original Symptom

We cannot simply conclude from this that dreams precede (and therefore "cause") illness, and not vice versa. This is because we are forced to rely on subjective reports, and although people may say that they had no symptoms prior to dreaming, there is no way to prove that their conscious, subjective evaluation is accurate. The possibility exists that the illness had already begun, and that the dream simply called attention to that fact before the conscious personality was able to reach the same conclusion.

Many of the authors cited in this chapter, from Aristotle onward, agree that somatic conditions are a source of stimulation for dreams. There is also general agreement that dreams are more sensitive to somatic signals than waking consciousness, and that this is why they are valuable in the diagnosis and prognosis of illness (Freud, 1955; Jung, 1969). Thus there is certainly reason to believe that dreams could bring to awareness a physiological process that had thus far escaped conscious attention.

This is particularly true if we consider Levitan's findings (1978, 1980) that some people who become ill have difficulty recognizing and identifying with their feelings. Such a lack of proprioceptive/affective sensitivity would allow an illness to develop without conscious awareness. It is only when a dream calls attention to the physiological events that the individual would know that something was occurring. Mindell, too, theorized about the possibility that a lack of awareness of feelings can lead to illness (1985b). (This possibility is discussed in greater detail in Chapter 7.)

Thus the sensitivity of dreams to somatic stimuli, combined with the tendency of some individuals to be relatively unaware of what they are feeling, supports the contention that dreams do not cause illness, but rather indicate that a physiological response is already underway.

The Limitations of Causal Explanation

It should be apparent that attempting to determine whether dreams precede, and therefore presumably cause illness, or whether illness is the cause of dreams, does not yield a black and white answer. There is evidence to support both perspectives. At one extreme we could assume that all dreams that have to do with illness are the by-product of an underlying organic condition. At the other extreme we could assume that all dreams actually trigger physiological responses that culminate in illness. In fact, there are probably dreams of both types: dreams influenced by physiology, and physiological problems triggered by dreams.

These findings challenge the Cartesian premise that mind and body are separate entities. In the case of dreams and illness, the available data indicate that physiological and psychological phenomena are so intimately connected that there is not a clear division between them. The corollary assumption that an illness may be either strictly physical or psychological must also be inaccurate. It seems safer to assume that in a given instance either physiological or psychological phenomena may be predominant but not exclusive .

Although causation is clearly a valuable explanatory principle, the Newtonian assumption that there is a mechanistic, linear (i.e., uni-

directional) interaction between dreams and illness also fails to adequately explain the data.

The Systems Perspective

The results in the literature are more accurately described by a systems or information theory model. (See Appendix C, Section 3 for a consideration of information theory.) From a systems perspective, dreams and body symptoms (or, more broadly, mind and body) are not separate. Instead they are different parts of an integrated system. Their properties are derived from their relationship to each other and to the other parts of the system, so they cannot be studied as separate entities. The data in the literature fits the systems perspective because the interactions between dreams and physiology appear to be circular, with feedback proceeding both ways rather than uni-directionally.

Rather than studying events and objects (in this case dreams and physiological reactions), information theory studies the information 'carried' by events and objects. The evidence in the literature indicates that both the dreams and the associated body problems are conveying the same information. That is, although the form taken by the dream and the body symptom are different, each is raising similar issues for the individual to consider. (See, for example, Saul and Bernstein (1941), in which the patient's dreams and her hives are both expressions of frustrated longing; Mindell (1985b), in which both a dream and a backache informed the patient that he needed to express his pain; Dunbar (1943), who described the relevance of the information contained in dreams for two cardiac patients and an arthritis patient, and the remission of

symptoms once the information was psychologically integrated; Sabini and Maffly (1981), who reported on the relevance of dreams for two cancer patients; and Kupper (1947), who described a patient's aggression that first became evident in a dream and also manifested in waking seizures.) The view that dreams and body symptoms convey the same information is consistent with the fact that most, if not all, of the studies cited in this chapter were motivated by the implicitly or explicitly stated belief that the connection between dream and body symptoms is a meaningful one.

According to information theory, processes are considered to be more fundamental than structure. Focusing on the information content of dreams and body problems means that the process that creates these symptoms is more fundamental than the form the symptoms take. From the systems perspective, understanding the origin of a dream or body symptom would require investigating not only somatic and intrapsychic phenomena but also external relationships such as those involving family, society, and the ecosystem. In other words, it is the web of inter-relationships comprising the larger interactive sphere that generates the symptoms appearing as dreams and body problems.

A number of the authors cited in this chapter have discussed the possibility that the dream and body problem are reflections of a more fundamental process. Their theorizing basically falls into three schools of thought: psychoanalytic, Jungian, and Mindell's Process-Oriented Psychology.

Bartemeier (1950), representing the psychoanalytic perspective, wrote that

> Inasmuch as dreams are the expressions of conflicts which are already activated and the acute reactions which follow them have the same psychological structure, we may need to look beyond the dream-acute-reaction sequence for the aetiology of both. (p. 9)

In looking beyond the etiology of both, Bartemeier concluded that dreams followed by physiological reactions during analysis represent a crisis in the transference relationship, and "represent attempts to cope with the very core of the patients' neuroses" (p. 10). In a similar vein, Saul (1940) believed a case involving dreams and hypertension was traceable to the patient's "original conflict with parents" (p. 468). As these examples indicate, the psychoanalytic perspective concludes that an underlying intrapsychic factor is the cause of the dream and body symptom, and therefore, that psychological conditions are the most fundamental.

From the Jungian perspective, each of the dreams Jung interpreted as indicating an organic problem (cited previously) contained what he termed archetypal symbolism. Jung conceived of archetypes as a link or bridge between body and mind. Archetypes represent a predisposition, a form without content which can manifest in any of a number of ways, including dreams, behaviors, and body symptoms. Archetypes represent a systems perspective in that they transcend mind/body dualism and emphasize process rather than structure.

Several Jungian authors, including Stein (1976), Ziegler (1962) and Meier (1986), preferred to speak in terms of the synchronous occurrence of dream and body symptom. A synchronistic event is one which is meaningful, but which does not always obey the laws of space, time, and causality. Meier (1986) proposed that there is a tertium, a third factor,

higher than both psyche and soma, which synchronistically produces symptoms in them both.

Jung's references to archetypes and Meier's theory of the tertium are attempts to move beyond mind/body dualism, and to suggest that dreams and body symptoms are influenced by factors belonging to a domain inclusive of them both. In contrast, the psychoanalytic perspective is more Cartesian and mechanistic, maintaining a stronger distinction between mind and body, and representing the psyche as a self-contained entity consisting of definite structures moved by specific psychological forces in accord with a strict determinism.

Both Jung and Mindell introduced a teleological perspective to the consideration of dreams and illness. While causal interactions are clearly in operation, at the same time there is an underlying purpose trying to become more manifest. Thus teleology appears to be as useful as causality in explaining the relationship between dreams and illness.

Mindell is closely aligned with the Jungian perspective, with an important difference: Mindell has explicitly incorporated information theory into the framework of Process-Oriented Psychology. This orientation has allowed Process-Oriented Psychology to sidestep the issue of the Cartesian dualism of mind and body and the Newtonian idea that psychological and physical events must be mechanistic and causal in their interactions. Instead both dreams and body symptoms are regarded simply as sources of information, albeit through different channels. In addition, neither the dream nor the body is considered to be primary; rather, both are expressions of the dreambody. In many ways this approach makes

Process-Oriented Psychology the most flexible model for evaluating the relationship between dreams and somatic phenomena.

These speculations about the relationship between dreams and illness may be summarized as follows: dreams and body symptoms are different ways of conveying the same information; dreams and illness each appear to be symptomatic of a more fundamental process; a systems model is more accurate in explaining the data than a model based on Cartesian and Newtonian assumptions; and both causal and teleological explanations are useful in describing the relationship between dreams and illness.

Part 6: Conclusion

According to the references cited in this chapter, it is apparent that a connection may exist between dreams and a wide range of body symptoms. This connection has been established through investigations that span several thousand years.

The historical evidence shows that investigators from classical times to the 19th century noted and theorized about the apparent role of dreams in the diagnosis, prognosis, and healing of illness.

Modern empirical studies, which include both psychophysical investigations and clinical case material, have corroborated the historical speculations, though in far greater detail. These studies demonstrate a connection between dreams and a wide range of illnesses, including heart attacks, cancer, seizures, hives, premature labor, migraines, tuberculosis, hypertension, ulcers, angina pectoris, asthma, arthritis, diabetes, German measles, nonspecific urethritis, edema, fever, and back pain. The studies show that dreams can play a role in diagnosing an illness, determining a

prognosis, and formulating a treatment plan, as well as by contributing to the healing process.

In addition, five of the studies described a meaningful connection between dreams that were dreamt during childhood and a variety of illness (migraines, cancer, heart attack, hives, and backache) that appeared in adulthood. The childhood dreams tended to be recurrent, may have been the earliest dream remembered, were characterized by strong affect, and depicted an unresolved situation.

Thus the literature supports the hypothesis set forth in Chapter 1 that there is a meaningful connection between dreams and illness, and, in the case of the five studies of children's dreams, establishes a specific connection between childhood dreams and the subsequent development of illness in adulthood.

CHAPTER III

LITERATURE REVIEW: CHILDHOOD DREAMS

Introduction

The material on children's dreams falls into four general categories of thought: laboratory investigations (Breger, 1969; Foulkes, 1971, 1979, 1982; Foulkes, Larson, Swanson, & Rardin, 1969; Foulkes & Vogel, 1974; Kales, Kales, Jacobson, Po, & Green, 1968; Kohler, Coddington, & Agnew, 1968; Roffwarg, Dement, & Fisher, 1964; Trupin, 1976), psychoanalytic studies (Ablon & Mack, 1980; A. Freud, 1935, 1965; S. Freud, 1955; Niederland, 1957), analytical psychology (Fordham, 1973; Jung, 1938-39, 1959, 1969, 1976, 1984; Marcus, 1972; Neumann, 1966; Wickes, 1988a, 1988b); and Process-Oriented Psychology (Mindell, 1985a, 1985b, 1989).

As mentioned in Chapter 1, the dreams considered in this dissertation are childhood dreams remembered by adults, rather than children's dreams told by children. Since the literature deals almost exclusively with children's dreams told by children, I will summarize only those findings from the above schools that are relevant to childhood dreams.

Laboratory Investigations

In the 1950s, it was discovered that dreams transpired most often when certain electroencephalograph (EEG) patterns occurred in conjunction with rapid eye-movements, or REMs (Aserinsky & Kleitman, 1955; Dement

& Kleitman, 1957). This landmark discovery heralded a new era in the investigation of dreaming. In the years that followed, many studies were conducted on the stages of sleep in subjects of all ages, including children.

Laboratory studies of children's dreams have for the most part focused on the physiology of dreaming and the manifest content of the dreams. These studies have produced significant results, including demonstrating that children's dreams are associated with REM sleep (Kohler, Coddington, & Agnew, 1968), that dreaming is apparently a universal phenomenon among children, and that the percentage of time spent in REM sleep declines with age (Roffward, Dement, & Fisher, 1964). In addition, laboratory studies have established that far more dreams spontaneously occur than are spontaneously recalled (Foulkes, 1979). Only laboratory investigations can access all spontaneously occurring dreams, and therefore provide an accurate picture of how often children dream.

Although these studies establish how pervasive dreaming is during childhood, none of the laboratory studies have focused on children's dreams that individuals remember as adults.

One of the implications of these findings, in the context of this dissertation, is that if all children dream, then there is the potential for any adult to remember a dream from childhood.

Psychoanalytic Studies

Whereas laboratory studies have primarily focused on physiology and the manifest content of children's dreams, psychoanalytic studies have been mostly focused on latent dream content and personality psychodynamics. Psychoanalytic theories and observations of children's

dreams have addressed a wide range of topics, including the problem of investigator bias; children's dreams as an expression of wish fulfillment, as defense mechanisms, and as representations of developmental issues; mythological themes; and the importance of some children's dreams in later life. The latter two topics are the most relevant to the study of childhood dreams, in general, and the case study, in particular.

Ablon and Mack (1980), in their excellent overview of research on children's dreams, underscored the powerful affective content of dreams, especially children's dreams. Children's dreams are frequently symbolic portrayals of intense dramas in which the child experiences himself or herself as the central figure. The dreams reflect the influence of external events such as elements of the culture, family life, and daily experiences. Children's dreams also reflect the influence of inner drives and the stages of ego development, highlighting issues such as language development, competence in handling affect, and cognitive capacities.

In view of the affective power of dreams and the key role they play in development, it is not surprising Ablon and Mack (1980) observed that "Often early dreams are remembered into adulthood with clarity, deep feeling, and a sense of lasting personal significance" (p. 179). Such a dream ". . . may provide a kind of signpost or landmark for the early memories which it both reveals and conceals" (p. 191).

The other aspect of children's dreams concerns those dreams in which the content resembles that of myths. Freud (1933) observed the general connection between dreams and myth when he wrote that ". . . In the manifest content of dreams we very often find pictures and situations

recalling familiar themes in fairy tales, legends, and myths" (p. 25). Ablon and Mack made the specific connection between children's dreams and myths when they wrote that "Attempts to understand the language of children's dreams relate directly to the characteristics of prelogical thinking, which they as well as myths and other creative and artistic endeavors possess" (1980, p. 191). From the psychoanalytic perspective, mythological dreams are examples of primary process thinking.

Analytical Psychology

As noted in the introduction to this chapter, a number of Jungians have written about children's dreams. C. G. Jung's work in this area is seminal, and this section is, therefore, a recapitulation of his theories about children's dreams.

Jung (1988) distinguished three types of children's dreams: ordinary dreams, dreams that reflect problems of the parents, and the great or 'far-seeing' dreams that indicate future forms of the personality.

The ordinary dreams are those that are "very simple 'childish' dreams and are immediately understandable" (Jung, 1969, p. 52). These might correspond to wish fulfillment dreams mentioned in the psychoanalytic literature.

The second type of children's dreams are those that reflect the psychology and behavior of the parents. Jung wrote that the more unconscious the child, the more likely it is that his or her dreams will portray the unconscious problems of the parents.

> We cannot fully understand the psychology of the child or that of the adult if we regard it as the subjective concern of the individual alone, for almost more important than this is his relation to

> others. Here, at all events, we can begin with the most easily accessible and, practically speaking, the most important part of the psychic life of the child. Children are so deeply involved in the psychological attitude of their parents that it is no wonder that most of the nervous disturbances in childhood can be traced back to a disturbed psychic atmosphere in the home. (Jung, 1988, p. xvii)

The third type of dreams are the great or "far-seeing" dreams. These are the dreams in which "future forms of the personality are occasionally anticipated, which are utterly foreign and unrecognizable beforehand. When such dreams are very impressive, they may remain, indelibly stamped on the memory, through a whole life time" (Jung, 1938-39, p. 16). As I noted in Chapter 1, I am referring to this category of children's dreams as "childhood dreams."

Jung believed that children could have far-seeing dreams because the child is influenced from birth by the archetypes of the collective unconscious. As the child develops ego consciousness and the capacity for speech, individual memories and experiences begin to block the collective contents (Jung, 1977). Before this blockage occurs, children may have dreams "among which there are some so strikingly mythological and so fraught with meaning that one would take them at once for the dreams of grown-ups, did not one know who the dreamer was" (Jung, 1988, pp. xxii-xxiii)

Jung made several references to the mythological motifs that may occur in childhood dreams. His most extensive discussion is in *Man and His Symbols*, in which he recounted a dream series of an 8-year-old girl. Jung highlighted several mythological motifs that appeared in this series, such as death/rebirth and the cosmogenic myth (the creation of the world and of people), as well as discussing the collective aspect of some of the

individual dream images. In his essay on "The Psychology of the Child Archetype," Jung observed that symbols of wholeness, such as the circle, sphere or quaternity, "frequently occur at the beginning of the individuation process, indeed they can often be observed in the first dreams of early infancy" (Jung, 1959b, p. 165). The appearance of symbols of wholeness in the dreams of young children was independently observed by Fordham (1973a).

According to Jung, the far-seeing dreams are typically forgotten or become less important by the age of 6. There are two reasons why this happens. The first is that if the dreams do not diminish in importance, then the pull of the collective unconscious will remain strong and the child will have difficulty adapting to the external world. Jung cited several consequences of this lack of adaptation: either these individuals simply remain uninterested in daily life, or they

> do not really get into their bodies, or at least they are not, psychically, in possession of many parts of their bodies. They know the body only from looking at it. They themselves are not really in it enough to feel through it. . . . Many people are unable to be fully in the body, you can see it in their stiff and awkward bearing, they go around like marionettes. That is the effect of the past which still hangs over them, it is still too strong. (Jung, 1938-39, pp. 97-98)

The second reason that the far-seeing dreams tend to be forgotten or ignored is that such dreams are beyond the scope of the child's developing consciousness, and can only be understood in retrospect by the adult. Jung believed that there are certain times in life, such as between puberty and the age of 20, and then again after the age of 35, when the farseeing dreams are most likely to become significant. If the material from the

childhood dream is not integrated into the adult personality then the individual will not become integrated and whole.

Process-Oriented Psychology

Mindell's interest in children's dreams is derived in several important ways from the work of Jung. In his writings and teaching seminars on children's dreams, Mindell focuses almost exclusively on the type of dream that Jung termed "far-seeing." Mindell became aware of the significance of this kind of dream through his readings of Jung: "I loved Jung's work on childhood dreams, he gave me the insight that these dreams describe and predict whole life times" (A. Mindell, personal communication, January 9, 1990). Thus it was from Jung that Mindell understood the teleological function served by the far-seeing childhood dream.

For Mindell, as for Jung, the childhood dream reveals a fundamental life pattern or life myth. It is often, but not always, the first remembered dream that is the significant one. According to Mindell, "The first dreams we remember are significant in a process-oriented sense because 'first' means to us 'most ancient,' most prominantly significant in describing our longest and most typical patterns" (A. Mindell, personal communication, January 9, 1990). This is also a holographic notion, insofar as the part (the childhood dream) contains information about the whole (the lifelong issues and challenges).

Mindell differentiated a wide range of symptoms that can result when the dream material has not been integrated by the adult. In *Working With the Dreaming Body* Mindell wrote that "Very often, chronic illnesses

appear in the childhood dreams. These major dreams pattern our lives, our problems with the world, and our body problems" (Mindell, 1985b, p. 67). In a workshop on "Chronic Body Symptoms and Childhood Dreams," conducted in 1986, Mindell added that childhood dreams govern the life task, crises, near-death experiences, falling in love, and the form of a person's death.

As these examples indicate, the material contained in the childhood dream may eventually appear in any of the channels recognized by Process-Oriented Psychology. For example, in the visual channel, the person could have a recurrent dream; in the auditory channel, someone might hear voices that pronounce opinions about important personal concerns; in the proprioceptive channel, there might be a chronic body symptom; in the kinesthetic channel, the person might have repeated accidents; in the relationship channel, there could be a particular recurring interpersonal pattern; and in the world channel, the individual might repeatedly encounter difficulties with various institutions representing the collective interests of society.

In order to respond effectively to a chronic symptom, it is necessary to become aware of its underlying meaning. For Mindell this often means understanding the childhood dream and the mythic message it conveys. Then the challenge is to integrate the life myth, to live it fully and consciously: "Living the childhood myth in reality must be the new plan" (Mindell, 1989a, p. 35). Thus, for Mindell, the childhood dream can and often does play a key role in the unfolding process of self-discovery.

Conclusion

This section summarizes and contrasts the findings of each of the schools of thought that have contributed to an understanding of children's dreams, in general, and childhood dreams, in particular.

There is general agreement among the different schools that it is difficult to obtain accurate accounts of dreams from children. This is because of the natural tendency (among both children and adults) to forget or distort dreams, the fact that children may lack the vocabulary to accurately describe their dreams, and the influence of the investigator (Ablon & Mack, 1980; Foulkes, 1979; Wickes, 1988a). Although it is clear that when there is an observer—whether schooled in laboratory techniques, psychoanalysis, analytical psychology, or Process-Oriented Psychology—the results will be affected, Foulkes seemed least aware of this.

Physiological studies have revealed that children have many more dreams that those they spontaneously recall. With the exception of Breger (1969), the studies cited are primarily focused on the manifest content of children's dreams.

Psychoanalytic studies emphasize both manifest and latent content. By fully exploring these two aspects, children's dreams show evidence of wish fulfillment, defense mechanisms, cognitive and affective development, and adaptation to current life experiences.

Analytical psychology places far less emphasis than psychoanalytic studies on childhood development and on the role that children's dreams play in such development. Both psychoanalytic studies and analytical psychology agree that the meaning of a child's dream can often be

understood by analyzing familial circumstances, especially relationships with parents.

In addition, both psychoanalytic studies and analytical psychology acknowledge that children's dreams sometimes duplicate the imagery and motifs of myth. Analytical psychology has placed a greater emphasis on the appearance of mythological material in children's dreams, and the two schools offer differing explanations for this phenomenon. From the psychoanalytic perspective, myths and children's dreams are examples of prelogical, primary process thinking. Analytical psychology, on the other hand, maintains that the child is inclined to have mythological dreams because his nascent personality is heavily influenced by the archetypes of the collective unconscious.

Ablon and Mack (1980), from their psychoanalytic perspective, have observed that a childhood dream may remain significant well into adulthood. Jung agreed with this, but formulated it a bit differently. For Jung, the far-seeing childhood dreams anticipate future forms of the personality. His teleological approach to these childhood dreams contrasts with the more reductive approach of psychoanalysis.

As I mentioned in the introduction to this chapter, the literature deals primarily with children's dreams recounted by children. This is particularly true of laboratory investigations and psychoanalytic studies. Jung and Mindell have focused more on dreams from childhood that are remembered by adults.

Mindell agreed with Jung that certain childhood dreams are teleological and that they can reveal a fundamental life pattern or life

myth. Jung mentioned several of the life patterns that may occur as a result of the influence of the childhood dream: a lack of adaptation to the world, and the inability to truly feel and psychologically inhabit one's body. Mindell has further differentiated the chronic patterns, whether behavioral, cognitive, or physical, that can emerge as a result of an unintegrated childhood dream. In particular, Mindell's theoretical and practical emphasis on chronic body problems, linking them to childhood dreams, adds a clarity and focus that is otherwise missing from the literature.

The literature raises several questions about the reliability of data obtained from children's dreams.

In this dissertation a childhood dream is, by necessity, one which is remembered by the adult subject, and I therefore have had to rely upon the subject's memory. It is consequently pertinent to explore issues related to the accurate remembrance of childhood dreams. Another concern is whether a remembered dream—particularly one that is remembered into adulthood—differs in some significant way from a dream that is not remembered.

As mentioned previously, the literature indicates that it is difficult to obtain accurate dream records from children. It is reasonable to assume that a childhood dream remembered by an adult might be particularly vulnerable to such distortion due to the long passage of time. There is no way of determining whether childhood dreams, in general, are remembered accurately by adults, or whether the subject of the case study, in particular, accurately remembers her childhood dream.

In evaluating this issue, there are several factors to take into account. One consideration is that dreams from childhood remembered by adults are often recurrent, thus increasing the likelihood that the individual would remember the dream—or at least the same version of the dream—with a significant degree of accuracy. In terms of this dissertation, the childhood dream recalled by the subject of the case study was recurrent. In any case, the issue of accurate recall may be moot, for the reason that although there is no way to prove that the subject's dream is accurately remembered, it is apparent that the dream as it is remembered is of lasting importance. Mindell has made this point in teaching seminars, stating that it is the way in which the dream is remembered that is significant. Jung's statement that "Dreams seem to remain spontaneously in the memory for just so long as they correctly sum up the psychological situation of the individual" carries a similar implication (Jung, 1970c, p. 51).

The other question concerns the significance of remembered dreams versus unremembered dreams.

Laboratory studies have demonstrated that not all children's dreams are remembered, and Foulkes (1979) argued that spontaneously remembered dreams may not be representative of children's dreams in general. Thus Foulkes maintained that the spontaneously remembered dreams of children may not be a reliable source of data.

This line of reasoning would be relevant for this dissertation if I were trying to determine what constitutes a typical children's dream. Instead I am singling out a particular subcategory of children's dreams,

that is, those remembered in adulthood. Clearly the childhood dreams remembered in adulthood are not representative of children's dreams, in general, and it is precisely because of their unique, "far-seeing" attributes that such dreams are the focus of this study.

Information value is another factor to consider when evaluating the quality of data derived from children's dreams. According to information theory, the less likely something is to occur, the more information it contains. One way of applying this principle to children's dreams is to note that since children spontaneously remember far fewer dreams than they actually have, the remembered dreams are less probable and are therefore more likely to contain important information. Since it is even more unusual for a childhood dream to be remembered by an adult, such dreams should have an even higher information value.

In conclusion, it is clear from the literature that all children dream, and that children's dreams serve a number of functions, including wish fulfillment, defense of the ego, representation of developmental issues, processing of daily experiences, and the portrayal of mythological symbolism. Reports from the psychoanalytic, Jungian, and Process-Oriented literature indicate that certain childhood dreams are remembered into adulthood with a sense of deep personal significance, while information theory predicts that such dreams are laden with meaning. Thus reports from the literature as well as information theory analysis support the thesis put forward in this dissertation that childhood dreams remembered by adults are not only a reliable source of data, but are in fact a unique and especially valuable source of information.

CHAPTER IV

METHODOLOGY

Introduction

This chapter presents the methods and procedures of the study. The chapter is divided into five sections: statement of the hypothesis, description of the subject, size of the sample, description of the procedures, and treatment of the data.

Statement of the Hypothesis

The research hypothesis of this dissertation was as follows: If, in a psychotherapy session conducted in accord with the principles and methods of Process-Oriented Psychology, the client works on both a chronic body symptom and a childhood dream, then the relationship between the symptom and the dream will have structural correspondence in terms of the client's primary and secondary process, occupied and unoccupied channels, edges, and dream figures.

Description of the Subject

The subject of the study was a 27-year-old Caucasian female. At the time of the study she was a graduate student in psychology, and had been studying Process-Oriented Psychology with Mindell for approximately 6 years.

Size of the Sample

The original data gathered for this dissertation was from a single case study. The literature indicates that such studies are relatively common in the field of psychotherapy.

For example, Dukes (1965) discovered 246 single-subject studies between 1940 and 1965. Chassan (1959, 1960, 1961, 1967) strongly advocated the use of such designs in clinical psychology and psychiatry, and Thoreson (Thoreson & Anton, 1974) conducted significant single-subject research in counseling.

Yin wrote that

> one rational for a single case is when it represents the critical case in testing a well-formulated theory. The theory has specified a clear set of propositions as well as the circumstances within which the propositions are believed to be true. To confirm, challenge, or extend the theory, there may be a single case, meeting all of the conditions for testing the theory. The single case can then be used to determine whether a theory's propositions are correct, or whether some alternative set of explanations might be more relevant. (Yin, 1984, pp. 42-43)

Process-Oriented Psychology represents a well-formulated theory which has specified a clear proposition about childhood dreams and chronic body symptoms. This proposition, upon which my research hypothesis is based, is that a childhood dream and a chronic body problem are related through the process structure of the client's experience.

As Yin has noted, a single case may serve to "confirm, challenge, or extend the theory" provided that it meets all the necessary conditions. In the next section, I outline the criteria I used in selecting the videotape that formed the basis for the case study. These criteria should make it possible to test the proposition set forth by Process-Oriented Psychology.

Description of Procedures

In this case study I collected data from two sources. The first source is a single 53-minute videotaped psychotherapy session. The second source is a follow-up interview with the subject of the psychotherapy session.

Criteria Used in the Selection of the Videotape

I wanted to study a videotape of a psychotherapy session which met four criteria.

1. The first criterion was that Mindell be the psychotherapist. This was because Mindell has developed Process-Oriented Psychology, and is the most experienced and expert practitioner. This increased the likelihood that the psychotherapy session would be a good illustration of the Process-Oriented approach.

2. The second criterion was that the client worked on both a chronic body symptom and a childhood dream during the course of the psychotherapy session. This made it possible to analyze the relationship between the chronic body symptom and the childhood dream in terms of the process structure of the session. (It did not seem critical whether the childhood dream or the chronic body symptom was mentioned and/or worked on first in the session, so I did not make this one of the criteria.)

3. The third criterion was that the childhood dream had to have originally occurred at the age of 8 or younger, thereby fitting the definition of "childhood dream" offered in Chapter 1.

The fourth and final criterion was that the "chronic body symptom" had to have been present for at least 6 months, so that it too would fit the definition in Chapter 1.

Selection of the Videotape

After establishing these criteria, I utilized a systematic sampling technique to select the videotape. I advertised for a videotape that met the above criteria by word of mouth and by placing an announcement in a Process-Oriented Psychology newsletter. I was told of two videotapes by word of mouth, while the newsletter did not bring any response. Both of the psychotherapy sessions occurred in the context of training seminars, so that to some extent, Mindell was demonstrating and teaching in addition to providing psychotherapy. The clients in each of the videotapes gave me permission to use the tapes for my doctoral research. After viewing the two videotapes, it was clear that each of them met my criteria. I selected one of the videotapes because it was of superior visual and audio quality, thereby increasing the data that I could collect. The videotape I selected was of a psychotherapy session conducted at a workshop entitled "Deep Bodywork and Religious Experience." The workshop was led by Mindell and was held in Tschierv, Switzerland in April, 1986. At the time of the psychotherapy session, neither Mindell nor the client knew that the tape would be selected for this study.

My Qualifications for Transcribing the Videotape

Pittenger, Hockett, and Danehy (1960) wrote that creating a transcript from a videotape is ". . . hardly feasible unless one of the participating specialists is a kinesicist (an analyst of body motion)" (p. 6). I do not agree with these authors, and, since I have transcribed both the audio and visual portions of the videotape, it is relevant to note my qualifications for doing so.

From 1978 to 1986 I received training in a number of bodywork modalities, including neo-Reichian, deep-tissue therapy, and acupressure. These modalities each focus to varying degrees on perceptions of gross and subtle physical cues as an integral aspect of diagnosis and treatment.

I have received training in Process-Oriented Psychology since 1986. This training has included close attention to both verbal and nonverbal signals by observing demonstrations, studying videotapes, participating in training exercises, as well as applying this information in my private practice.

Finally, I have studied the five instances in the literature in which psychotherapy sessions were transcribed and analyzed. These studies are listed in a subsequent section in this chapter, entitled Other Transcriptions of Psychotherapy Sessions.

Procedures Followed in Transcribing the Videotape

Since the psychotherapy session took place in Switzerland, the filming was done in accord with the technical specifications that are characteristic in Western Europe, that is, the PAL standards. VCRs that are sold in the United States can only play videotapes that have been

recorded by NTSC standards. In order to view the tape, I had it converted from PAL to NTSC by Video Transform, a Palo Alto, California, company. Because the conversion from PAL to NTSC involves a change of the encoding signal, there is a greater loss of audio and video quality than if a straightforward copy had been made. Video Transform estimated that there would be a 10% to 20% loss of video, and a 10% loss of audio. The final NTSC version was on a standard 1/2 inch VHS videotape.

I then took the following steps to transcribe the videotape.

1. Before transcribing the videotape, I watched it in its entirety two times.

2. I listened to the tape in 10-second segments and then wrote down in longhand the dialogue that occurred during the 10 seconds. I proceeded in this fashion through the length of the tape. Whenever a 10-second segment was difficult to understand, I replayed it as many times as necessary, and as loud as necessary, to make an accurate transcription. When I had a complete audio transcript, I entered it into my computer and printed it out. I then checked the accuracy of the transcript by listening to the entire tape in 15-second segments while reading the printed transcript, and corrected whatever errors I noticed. There were seven instances in which the audio content was unintelligible, and these were so noted in the transcript.

3. At this point I played the videotape again, and, using the time counter on my VCR, inserted the elapsed time in front of every audio entry. This served several purposes: it allowed me to quickly find specific sections of the tape when creating the transcript, to refer to specific

segments when doing the videotape analysis, and to use the factor of elapsed time in the analysis.

4. With the time-specific audio transcript in hand, I then began to watch the videotape in order to record the nonverbal components of the session. I began by describing the sitting positions of therapist and client at the beginning of the session. I then recorded any changes in posture, facial expression, and so on, as they occurred, inserting the movement descriptions at the appropriate places in the audio transcript. I placed the descriptions of the body movements in brackets to distinguish them from the audio portions. In some passages I had to replay the videotape from three to five times in order to assure accurate juxtaposition of the verbal and nonverbal components.

5. After completing a description of all of the nonverbal elements, I reviewed any areas that had seemed problematic. After making necessary changes in the transcript, I viewed the videotape once more and made any necessary changes in either video description or audio content, or in the juxtaposition of the video and audio portions.

Checking the Accuracy of the Transcription

I then arranged an independent check of the accuracy of the transcript. I did this by providing committee member Dr. Nisha Zenoff with copies of the videotape and the transcript. Dr. Zenoff is a licensed psychotherapist and a certified practitioner of both Process-Oriented Psychology and Dance-Movement Therapy. Dr. Zenoff was of the opinion that the verbal and nonverbal transcriptions were accurate.

Other Transcriptions of Psychotherapy Sessions

I have found five instances in the literature in which therapy sessions were transcribed and the transcript then analyzed. Each of these cases is an example of a single-subject research design. In two of the cases (Erikson, Haley, & Weakland, 1959; Pittenger, Hockett, & Danehy, 1960) the transcripts were prepared from audio recordings, while in the other three (Dennehy, 1987; Goodbread, 1987; Mindell, 1985b) the transcript was prepared from a videotape.

In *The First Five Minutes*, psychiatrists Pittenger and Danehy, and linguistic anthropologist Hockett made a detailed linguistic transcription of an audio recording of the first 5 minutes of a psychiatric interview (Pittenger, Hockett, & Danehy, 1960). The transcription includes all audible sounds, ranging from voice pitch and inflection to sighs and throat clearings. After completing the transcript, the three authors (and occasionally other colleagues) listened to the tape and analyzed the conversation according to factors such as word selection, inflections, and the rate of speaking. The result is an extremely detailed analysis of all of the verbal and paralinguistic messages conveyed during the 5-minute interaction.

In "A Transcript of a Trance Induction with Commentary" (Erickson, Haley, & Weakland, 1959), an audio recording was made of a hypnosis session that Milton Erickson conducted with a client. The next day Erickson listened to the recording and discussed it with Jay Haley and John Weakland. The conversation was audio recorded, and then the hypnosis

session and the discussion were transcribed. The article consists of an introduction followed by the two transcripts juxtaposed in two columns.

The intent of the follow-up discussion was to explain "the significances, purposes, and interrelationships of the various suggestions and maneuvers employed in developing the subject's hypnotic responses" (Erickson, Haley, & Weakland, 1957, p. 84). With this objective in mind, Erickson, Haley, and Weakland focued on the way in which Erickson phrased his commands, noting variables such as word selection, voice volume, and repetition. They also commented extensively on his close attention to and incorporation of the minimal physical responses of the subject, factors such as the movement of the chest during breathing, flutters of the eyelids, lifting motions in the hands, and subtle muscle contractions.

The remaining three cases (Dennehy, 1987; Goodbread, 1987; Mindell, 1985b) were each transcribed and analyzed from the perspective of Process-Oriented Psychology.

Although he was apparently working from a videotape, Mindell (1985b) provided what is largely a verbal transcription of one of his psychotherapy sessions with a client, with occasional parenthetical descriptions of movement. Mindell chose his example because it lent itself to omitting movement descriptions:

> The following transcription is suited to my present purposes because the seminar participant in question has an especially strong verbal-auditory function. Thus, she reported most of her feelings, vision, voices, and movements, in contrast to a proprioceptive, kinesthetic, or visual person who would feel a great deal, move gracefully, dance or fantasize, without the slightest interest in verbalizing these experiences (1985b, p. 93).

The transcription of the tape appears in a left-hand column, while the right-hand column contains explanatory comments about the channel structure, psychological interpretations of the client's remarks, additional descriptions of movements made by either therapist or client, and therapeutic strategies. Mindell concluded with a brief summary of the session.

Dennehy (1987) transcribed a videotape of Mindell working with a client in a training seminar. The transcription includes all verbal comments as well as detailed parenthetical descriptions of movements. As with Mindell, the verbal transcript and movement descriptions are in the left-hand column, a running commentary is in the right-hand column, and a detailed analysis of the session follows.

Goodbread (1987) also transcribed a videotape of a psychotherapy session conducted during a training seminar. The therapist was not identified, but was described as someone who had been trained in Process-Oriented Psychology. The session was conducted in German, and, for the purposes of the transcription, was translated into English. Goodbread provided detailed movement descriptions along with the transcribed audio portion. He followed the same two-column format as Mindell and Dennehy.

The transcripts prepared by Dennehy and Goodbread differed from the other three transcripts in that they included extensive descriptions of the nonverbal positions and movements of the participants. Pittenger, Danehy, and Hockett (1960) remarked that there are a number of methods of observing therapeutic interactions. They regarded post-session interviews of the participants as the least profitable method, an audio

recording as much more useful, and a videotape as the most complete source of information. The limitations of audio recordings is evident in the two examples described here. Pittenger, Danehy, and Hockett (1960) were forced to rely exclusively upon a linguistic analysis of their transcript. Erickson, Haley, and Weakland (1957) referred to physical cues, but did not have a video record to confirm and augment their recollections of the session.

In preparing the transcript for the dissertation, I followed the format and methodology exemplified by Dennehy and Goodbread, including both audio and movement descriptions, and dividing it into transcript and commentary, followed by a separate analysis.

The Follow-up Interview

The interview was designed to be what Yin referred to as a focused interview, in which

1. A respondent is interviewed for a short period of time—an hour, for example. In such cases, the interviews may still remain open-ended and assume a conversational manner, but the interviewer is more likely to be following a certain set of questions derived from the case study protocol (Yin, 1984).

2. I designed the interview in the following manner. I began by transcribing the videotape and then studying it at length. I decided that there were six topics about which it would be helpful to have more information:

- general background information;
- the chronic body symptoms;
- the childhood dream;
- the drawing that the client makes during the session;
- subsequent integration of the work;
- and the interruption in the videotape.

3. I then created a questionnaire which was designed to elicit information about these six specific topics.

4. The actual interview took place in Waldport, Oregon, in October, 1990. This was approximately 4 1/2 years after the original psychotherapy session. I gave the subject the list of questions several days prior to conducting the interview so that she had time to think about her answers. Due to scheduling constraints, we conducted the interview in two parts, 2 days apart. Each interview took between 20 and 30 minutes to complete. The interviews were audio taped, and the transcript of the interviews is reproduced in Appendix B.

Treatment of the Data

The primary source of data for the case study was the transcribed psychotherapy session. The follow-up interview was the secondary source of data.

Data from the psychotherapy session was examined by conducting a content analysis of the videotape transcript, referring when necessary to the videotape itself, in accord with the principles and theories of Process-Oriented Psychology. Data from the follow-up interview was used to confirm or amend the conclusions drawn from the transcript.

The data analysis had three objectives:

1. To determine whether the case study confirmed or refuted the hypothesis;

2. To evaluate the accuracy of the predictions made by Process-Oriented Psychology about the case study; and

3. To discuss the theoretical implications of the confirmation or refutation of the hypothesis.

Evaluation of the Hypothesis

The hypothesis was evaluated by analyzing the structural relationship between the chronic body symptoms and the childhood dream within the psychotherapy session.

Evaluation of the Predictions made by Process-Oriented Psychology

This mode of analysis is referred to as pattern-matching (Yin, 1984), in which the patterns in the videotape are compared with the predictions of Process-Oriented Psychology. Yin (1984, p. 100) referred to this mode of analysis as "relying on theoretical propositions," in this case, the propositions of Process-Oriented Psychology. Process theory predicted that the following statements would be true of the psychotherapy session:

1. That there would be a process structure consisting of the client's primary and secondary process, occupied and unoccupied channels, edges, and dream figures.

2. That this structure would be evident within the first several minutes of the session.

3. That this early analysis of the process structure would make it possible to predict (a) the channel(s) in which the client accessed the information she needed to learn to cope with her presenting complaint, and (b) the channel(s) that were most important as the client attempted to integrate the new material.

4. That unoccupied channel experiences would be likely to involve some sort of dream figure.

5. That there were three possible outcomes when a process was amplified (i.e., when the strength of a signal in a given channel was increased): the client may change channels, reach an edge, or de-escalate.

6. That body experiences would vary according to the perspective of the observer, so that as the client's perspective changed, her experience of her chronic body symptoms would also change.

These predictions were compared with what actually occurred in the session.

The nature of the client's process structure can be determined by evaluating verbal and nonverbal behavior. There are different cues that indicate that processes are occurring in each of the four basic channels. These cues are listed in Chapter 1.

Theoretical Implications

The theoretical implications of the evaluation of the hypothesis were discussed by drawing upon process theory and the relevant literature. Yin referred to this method of analysis as explanation building (Yin, 1984).

Explanation-building began in Chapter 1 when I formulated a hypothesis about the relationship between childhood dreams and chronic

body problems. Chapters 2 and 3 provided important information from the relevant literature. Chapter 5 provides the data from the videotape. In Chapter 6, I analyze the videotape and the follow-up interview according to the theories of Process-Oriented Psychology. In Chapter 7, I summarize the findings from the videotape and the interview, and, on the basis of this analysis, assess the hypothesis. Discussion of the theoretical implications are built upon these findings.

CHAPTER V

VIDEOTAPE TRANSCRIPT

Introduction

This transcript is from a videotape of one psychotherapy session from a seminar entitled "Deep Bodywork and Religious Experience." The seminar was led by Arnold Mindell, and was held in Tschierv, Switzerland, in April, 1986. Mindell was the Therapist (T), and a seminar participant was the Client (C). The seminar was conducted in English.

As the session began, the Client and Therapist were sitting on the floor facing one another. They were surrounded by seminar participants who were either sitting on the floor or on chairs (see Figure 1, located at the end of the transcript). The room was roughly square, approximately 50 feet on a side. The session was conducted during the daytime, either in the late morning or the early afternoon.

The numbers in brackets represent the elapsed time, in minutes and seconds, since the session began. The verbal interactions were transcribed verbatim. The comments in brackets are descriptions of the nonverbal interactions between T and C. All of the figures cited in the transcript are located at the end of the chapter.

Transcript

[0:02] **T:** Well, let's see. Do you want to work in general or did you have some part of your body you needed to work on? Did you want to find out more about yourself or—[*As T is speaking C sits with legs bent at the knees, the soles of her feet touching, massaging her feet. T has a pad of paper resting on his legs, and is holding a pen in his right hand, prepared to take notes.*]

[0:11] **C:** I want to find out more about myself, and I also have a specific part of my body [*pulls her feet toward her and crosses her ankles, so that she is sitting cross-legged*] to work on. [*C's shoulders are rounded slightly forward.*] I have a chronic symptom in my chest [*touches chest area with her right hand* (see Figure 1)] and a constriction normally [*exaggerates the forward-rounding of her shoulders*]. When you asked us to press those points, I have a lot that hurts right here [*still touching her chest*]. And also across my back. [*C touches her back with both hands, brings her hands back in front, then swings her arms front to back, parallel to the floor, like a breast stroke.*] I'm always trying to get more room. And that's a chronic thing.

[0:53] **T:** Yeah, uh huh. [*Pause.*] Do you like being in Tschierv?

[0:56] **C:** [*C is sitting still, cross-legged. She turns her head and looks right, hunches her shoulders, looks right again, smiles, rocks back.*] Uh yeah. [*Laughs.*] Yeah.

[1:00] **T:** What do you like about it?

[1:03] **C**: Uh, in Tschierv? [*She continues her movements.*] In the seminar?

[1:04] **T**: Yeah in Tschierv.

[1:05] **C**: [*Client looks left.*] I like being away [*leans back*] from Zurich a lot; being away from my normal life. [*Leans forward, upright again, then leans right, still smiling.*]

[1:11] **T**: And, uh, do you like the mountains?

[1:13] **C**: Yeah. [*Nods, smiling.*]

[1:15] **T**: How come?

[1:16] **C**: [*C turns her head and looks to her left, looks down, smiles, leans back, looks left, hunches her shoulders, looks down, puts her left hand over her face, leans back, stretches out her legs, looks right, rests her arms on her legs, leans back, looks up, smiles, and begins to rock forward and backward. She laughs and says—*] Why are you asking me these questions? [*Tugging at her sweat pants.*]

[1:25] **T**: Well, uh, I like to know.

[1:28] **C** About if I like mountains? Yeah, I like mountains. [*Turns left, looks out window.*] Can't see them today.

[1:37] **T**: Thank you.

[1:39] **C**: [*Turns her head so that she is once again looking at T.*]

[1:44] **T**: I'm trying to find out your main channel so I know if you go into a far out place where I can, where to go with you. [*Puts down note pad.*]

[2:04] Question from a seminar participant: I didn't quite get that.

[2:06] **T**: Yeah, I need to know that if you use---whether the body channels are occupied for [*client's name*] or whether she has other channels that are occupied. Her main channel is visual. She just used visualization first in terms of enjoyment so to me that's an important piece of information. If she goes into a far-out state [*C nods*] I can, it's a way of helping her to integrate information afterwards by using visualization. Somebody else will use movement. Somebody else will be singing songs. The best way to find out a main channel is by disrupting the person's attention, [*gestures at C, C smiles and moves her leg*] otherwise you are doing something (unintelligible: "difficult to do"?). [*C smiles, hunches her shoulders, looks shy.*] I like it here, too [*smiles, moves closer to C, gestures out window*]. You know why I like it? I like the altitude, I like being above the city. It feels differently. I have a very different main channel. I feel things. Well, maybe we should get right to work and work on your chest. Anything else you want to say first?

[3:13] **C**: Um [*Head tilted forward, looking down, rocks back and forth, rubs her hands on her knees.*] I could also say . . .[*Rubs knees with hands*] I could also say that like I'm [*lifts right hand and makes a gesture in front at chest level, looks up and makes eye contact*] I feel lately like I've been looking for something deeper in my life, for the past few months now. [*Tilts head forward and looks down, pauses, looks up, shrugs.*] Yeah, so I'm interested in that.

[3:49] **T:** What are you looking for?

[3:52] **C:** [*Puts head down, pauses, rubs knees with her hands.*] I feel like I'm needing a new direction. [*Gestures with right hand in front of her chest.*] A new like attitude toward my life. [*Gestures with her left hand in front of her chest.*] I don't really know, I'm trying to move out of something, I feel.

[4:18] **T:** [*T picks up his pad of paper and makes some notes as he speaks.*] The reason I asked you those questions [*C looks up*] is also to use the information that I get afterwards [*C looks down, rubs knees, rounds shoulders, looks up, nods*] in the integration phase to help you find out what you are moving out of and to see if you find a new direction.

[4:36] **C:** [*Nods.*] Uh huh.

[4:38] **T:** I want to relate to these interests of yours.

[4:40] **C:** Yeah. OK.

[4:46] **T:** If you have stuff in the front of your body I recommend we work on that.

[4:47] **C:** OK.

[4:48] **T:** I recommend you lie on your back and uh . . .

[4:50] **C:** [*C lies on her back, moves her legs and arms, stretches and shakes her arms*].

[5:04] **C:** I'm nervous.

[5:06] **T:** What's all that? [*smiling*].

[5:08]**C.** I'm nervous. I always get nervous when I work. [*Client shaking hands.*] I don't know what's going to happen. [*Moves legs up and down.*]

[5:16] **T:** [*Takes C's hand, shakes it gently.*] What sort of nervous is it?

[5:18] **C:** [*Shakes hands and forearms.*] Uh, shaking. [*Shakes hands.*]

[5:23] **T:** You get the jitters?

[5:28] C: [*Shakes arms and sits part way up, shakes upper torso, exhales audibly.*]

[5:30] **T:** Like that?

[5:32] **C:** Yeah.

[5:34] **T:** Yeah, I see what you mean. [*C laughs*] I could work with that first but I'm going on the other side of it.

[5:40] **C:** Whenever I work I work on the jitters first. So I'm interested in something different.

[5:45] **T:** I like your jitterbug. Where did you say in your chest that you have . . . ? [*Client touches her chest in the center of her sternum.*] What do you have underneath this shirt?

[5:57] **C:** A t-shirt.

[5:59] **T:** Would you be cold if you took it off?

[6:02] **C:** [*C sits up, takes off her sweater, lies down, and points to the center of her sternum.*]

[6:35] **T:** I'm just going to touch different parts in your chest to begin with and then I'll work there, okay?

[6:38] **C:** [*C nods.*] Uh huh.

[6:42] **T:** [*T touches C below her ribs, on her lower ribs, lower ribs, in the intercostal spaces, and on the upper sternum. Then he says to the group:*] I'm just investigating, letting my fingers get to know her a little better and also trying to find out like I asked her questions, trying to find out more about—through my hands—the nature of who she is. There's a lot of stuff I feel when I put my hand on the left part of her chest there. [*Pause.*] [*Touching C's sternum.*] Some things I feel right here in the moment. Uh huh. [*To client, both hands on center of sternum.*] You also feel free to direct me, (name of client). There are like lots of spots here. Direct my fingers where there's . . . Ouch. Does that hurt?

[8:51] **C:** A little.

[8:52] **T:** Yeah. Uh huh. Does that hurt? [*Therapist presses point in center with thumb.*]

[9:08] **C:** Uh huh. Yeah

[9:12] **T:** Uh huh. [*Pause.*]

[9:25] **C:** Feels like a bruise there.

[9:27] **T:** Feels like a bruise there?

[9:29] **C:** Like a black and blue mark.

[9:39] **T:** Uh huh. Right here? Like a bruise, uh.

[9:43] **C:** Yeah, right there.

[9:50] **T:** Does it hurt a lot?

[9:54] **C:** No. If you pressed harder it would hurt a lot. [T appears to press a little harder.] [*Pause.*] . . . (unintelligible) sharp pain.

[10:14] **T:** Sharp pain.

[10:16] **C**: Just localized in that point there. [*Pause.*]

[10:19] **T**: Hm hm. Yeah.

[10:55] **C**: [*Taking deeper breaths. T reaches his right hand under C and presses upward into her back while his left hand continues to press in her chest. He then removes both hands and presses on C's chest with his right hand.*]

[11:17] **T**: Hm hm. Yes, you're breathing . . .in . . .

[11:25] **C**: [*Pressing her right thumb into the carpet.*] My thumb is working with you.

[11:26] **T**: Your thumb is working with me?

[11:28] **C**: Yeah.

[11:30] **T**: What a companion to have! [*C smiles, laughs.*] That's wonderful. [*Moves to client's right side.*] Would you like to, would your thumb like to help me directly?

[11:48] **C**: Um. [*C puts her right hand on her chest and presses her thumb on the sternum point.*]

[11:50] **T**: There, that's it.

[11:52] **C**: [*Places left hand on her chest also. She feels her sternum with both hands. T then helps her press on sternum. C exhales.*] Uh uh. I feel like my chest is like it's such a small chest, but it has such strong walls. Like a, kind of like a barricade or something.

[12:45] **T**: Like a barricade?

[12:46] **C**: Yeah.

[12:47] **T**: A barricade against what?

[12:52] **C**: Um . . . [*Grimaces.*]

[12:55] **T:** What do you feel here? In this point?

[12:58] **C:** Well, it hurts a lot. [*Frowns and swallows.*]

[13:02] **T:** Go ahead and feel it for a minute and tell me what it's like. [*T has thumb on C's sternum. C puts her hands at her sides.*]

[13:08] **C:** [*Grimaces and lifts shoulders towards her head.*]

[13:10] **T:** Ouch.

13:11] **C:** It's just pain. [*Shaking her head.*]

[13:12] **T:** Yes, pain.

[13:15] **C:** Pain.

[13:18] **T:** Yeah. Like anything—?

[13:21] **C:** [*Raises right arm, hand made into a fist.*] Like a knife.

[13:22] **T:** Like a knife?

[13:24] **C:** Like a knife. [*Makes a stabbing motion with her right arm and hits her right hip.*]

[13:27] **T:** Uh huh. Like a knife in you?

[13:31] **C:** Like being stabbed with a knife.

[13:33] **T:** It's like you're being stabbed with a knife?

[13:35] **C:** Uh huh. Uh huh.

[13:37] **T:** Actually I'm applying very little pressure on the top. It's amazing. And there is not much energy there. You feel it like a knife?

[13:44] **C:** Yeah.

[13:48] **T:** Can you—how do you know it's a knife?

[13:53] **C**: [*Right hand in fist, arm up a little* (see Figure 2).] Uh, I know it because my hand went into a fist and it felt like it was holding a knife.

[14:00] **T:** Uh huh. I'm going to let go of this point and I want to go on with the knife for a moment—okay?

[14:08] **C**: Uh huh.

[14:17] **T**: [*T uses a pencil to mark the place on her shirt where he was pressing. He pauses for a few moments, then puts his hand against C's fist, pushing it toward her shoulder. She presses back, her fist against his hand. Her eyes are still closed.*] Who is this knifer?

[14:32] **C:** [*She exerts more force, raising her arm, fully extended. She makes a forceful stabbing movement, exhaling audibly, her arm moving in the air across her chest from right to left until her hand is nearly on the ground by her left shoulder. This movement has shaken free T's hand. She then returns her arm to her right side, still making a fist. She replies to T's question:*] A killer.

[14:40] **T**: A killer?

[14:42] **C:** [*C smiles, laughs, puts her arm at her side.*]

[14:43] **T:** Uh huh, it's funny.

[14:52] **C**: Yeah. [*Client tries to strike again—therapist restrains her arm.*]

[14:58] **T**: A killer.

[15:00] **C**: Yeah. [*Makes a big stabbing stroke straight up into the air, and exhales in time to the stroke.*]

[15:02] **T**: [*Pressing his hand against C's fist.]* What is he after?

[15:06] **C:** He loves violence. [*C is pressing her fist against T's hand. She raises her head, then sits up.*] He's a killer.

[15:12] **T:** Killer likes violence?

[15:19] **C:** [*Client has turned to face T. They are both sitting. C pushes her left arm against T, pulls back her right arm and moves it forward in a 'knife stroke,' exhaling as she does so.*] Like it's only happy killing [*Looks down, spreads arms palms up, shakes her head. Smiles, scratches her head, rubs her hands on her legs.*]

[15:31] **T:** [*T lifts C's right arm so she is in position to make another knife stroke and says—*] No, go ahead.

[15:33] **C:** [Stabs again.]

[15:34] **T:** No don't do it.

[15:36] **C:** [*C keeps her hand pressed against T's arm, then slides her fist to his chest, rises higher on her knees as he leans backward.*]

[15:38] **T:** [*Gasps, like someone being stabbed*]

[15:40] **C:** [*Client stabs again in slow motion. T blocks the blow with his arm. They press arms against each other. T falls backwards so that he is lower on the floor.* [16:10] *They stop and slowly sit up facing each other. Then C says:*] So many knife killings are in the chest.

[16:13] **T:** Uh huh, yeah.

[16:16] **C:** So many. [*C looks down, shakes her head, looks up, raises her right arm, brings her arm forward a few inches, stops, drops her arm to her knee, sighs.*]

[16:24] **T**: Go ahead. [*Raises his arm in the same gesture C has been making.*]

[16:30] **C**: [*C puts left hand on T's right shoulder, raises her right arm, grimaces, leans forward, threatens a blow, starts to strike, stops, sighs, sits back, drops her arms.*]

[16:38] **T**: Don't stop. Go back to that. [*Reaches for C's right hand, raises it up.*]

[16:41] **C**: [*Resumes previous position.* (See Figure 3.) *She slowly brings her right arm forward until it presses against T's chest, exhaling as she does so.*]

[16:58] **T**: Why are you doing this to me? Huh? Why do you do this? [*Puts sweater over his head. Pushes his hand against her hands.*]

[17:11] **C**: [*C pushes back and resumes her stance with her right hand raised. The she hesitates, sighs, frowns, and lowers her arm.*] It's the only thing that makes me feel free is to kill—but then there's a sad feeling about it somewhere. Let's see. [*Raises arm, stabs slowly to T's chest. T groans, pushes sweater off his head, leans back. C rises high on her knees and stabs again, exhaling, to T's chest. T is now flat on his back.* (See Figure 4.) *C stabs again. T provides resistance with his arm as the blow approaches his chest. Once on his chest, C's hand and arm shake/vibrate. T grabs C's hand and pushes it back. T pushes C back with his foot. T sits up. C raises arm. C and T face each other on their knees. C hesitates to strike.*]

[18:32] **T**: You don't stop . . . (unintelligible) This is murder!

[18:34] **C:** I'm not going to stop. [*C keeps stabbing therapist. T blocks the blows. C stands up. So does T. C opens her eyes and looks at T. C has had her eyes closed or nearly closed until now.*]

[19:02] ***INTERRUPTION OF TAPING SEQUENCE***

[19:05] **C:** [*C's comment is difficult to hear, but sounds like:*] I have to kill you first.

[19:07] **T:** I think I'll have to kill you first. [*Standing straight, body posture quite rigid.*] You're interrupting my life. Say good-bye to your friends. [*Whistles.*] I'm going to kill you.

[19:17] **C:** Try it. [*Pause. T touches C's arm. C shakes his hand off several times.*] What <u>are</u> you? [*C pushes T on the chest with both her hands. T raises his right arm as if to stab. C raises her left arm to defend herself, and her right arm to stab. T moves toward her, makes a knife stroke toward C's chest. C blocks it. C swings her right arm forcefully from behind her body around to the front in a sweeping motion parallel to the ground. She does this twice with her right arm and once with her left arm, exhaling in time to the strokes. T backs up. C stops her arm movements. T raises his right arm again. C pushes T's arm back with her left arm. T stabs to C's chest, then they push hands.*]

[20:16] **T:** Let me be. [*Stabs.*]

[20:20] **C:** [*Resists. Attacks. Defends herself. C and T stand a few feet apart. C looks at T very intently, exhaling audibly.*]

[20:32] **T:** Uh huh. What happened there?

[20:34] **C:** It's like a fight for my life or something.

[20:36] **T:** Yeah. A fight for your life or something. [*They are pushing their hands against each other.*]

[20:44] **C:** You're going to kill me.

[20:46] **T:** You're going to die. In slow motion. [*Steps back, raises his arm, steps forward, C waves her arm in defense.*] This is your last minute, here I come.

[21:04] **C:** [*Lashes out against him, waving her arms, snorting. T backs up. C stops. T advances. C escalates her defense, grabs T's arm, steps forward, pushes T. C is making sharp, audible exhalations. C waves her arms again. They stand facing each other 3-4 feet apart.*]

[21:19] **T:** This doesn't work. I feel like a figure that could go on like this. [*C puts hands on her hips.*] I'll certainly murder you. I've been trying to do it for years. [*Points at C, and C raises her hand to defend herself.*]

[21:46] **C:** What are we going to do? [*Rubs her head with her right hand, looks down.*] Let's think about something. [*Rubs her head with both hands.*] Let's think.

[21:53] **T:** Okay. Do you feel its your nature—this figure?

[21:58] **C:** I feel like I'm on a physical edge.

[22:00] **T:** Sounds very right.

[22:02] **C:** I have all of your energy except at a certain point. Then I get weakened. My stamina goes.

[22:07] **T:** This is the pattern of a chronic symptom: that you're up against a force that you are like stalemated with. That's a chronic symptom. So, uh, if I were really to do justice to your entire process, I would leave it here and would wait until something came up. But I want to recommend an idea to you, okay? I want to go back to your chest.

[22:34] **C:** Huh. [Nods.]

[22:34] **T:** Because I think that in your body is the answer to this.

[22:38] **C:** I would like to. I know this pattern too well My body keeps (unintelligible).

[22:42] **T:** I recommend going back to your chest and having your body give us the answer. All right? [*C begins to lie down.*]

[22:48] **C:** Uh huh. [*Client lies down on her back, eyes closed, arms at her sides.*]

[23:00] **T:** [*Sits by C's right side. C's right hand twitches several times. C looks at T and smiles.*] Uh huh. That point and all the psychology around the point, the physiology, whatever. Now we see what else is there. [*Puts hands back on client's chest.*] You OK? [*Puts hand on C's stomach and lets it rest there.*]

[23:33] **C:** Um humh.

[23:38] **T:** [*Hand back on C's sternum in the same spot as before, presses point with his thumb.*] Is that it? I'm having trouble finding it.

[24:00] **C:** [*Client lifts left hand as T removes his hand. C feels for the spot, then T also tries. C feels around some more by herself.*] I don't. I'm having trouble, too.

[24:20] **T:** So the point that was there before is not quite there. Before it had a rise in it like this [*Gestures*] around that bone. It was like a button, now the button isn't there. But I'm going to press in that area anyhow.

[24:43] **C:** Uh huh.

[24:53] **T:** That's really something. I'd like you to feel it for yourselves. [*addressing seminar participants. Still pressing point. C feels for the point also.*] Processing the point.

[25:05] Question from a seminar participant: Can I ask you a question? If this happens and you process all the stuff and you come to the very end, the point changes. And you're looking for the answer in the body, can you just find another point?

[25:16] **T:** You can do whatever you like. The point is that if you start this processing in movement, or something like that, that the body changes, and if the body hasn't changed then you haven't really processed the material that was there.

[25:38] Question from a seminar participant: You said you thought the answer was in the body; would that be a general thing, or particular with (name of client)?

[25:48] **T:** Normally, it's a good idea. Whether it's going to be a good idea here or not remains to be seen. I thought the point would still be there and would give us more information. I can't find it. It's not there in the same bone any more. So I'm just going to follow the process. You go ahead [*addressing Client*] and do what is right for you. [*T places his hands palm down on C's upper chest and abdomen. C takes several deeper breaths. T uses his hands to follow and encourage the breathing movements. C tilts her head back slightly. T presses with his left hand under C's chin, pushing gently in the same direction her head has begun to go. T places his right hand on C's neck, helping to accentuate the added length, then on C's stomach as she breathes.*]

[27:31] **C:** [*Grimaces, clenches jaw, tightens arms, makes fists. Arches back slightly. T removes hands. C sighs loudly, then relaxes the arch in her back. Her legs move slightly further apart. T places his hand under C's lower back.*] I feel like I'm going to pass out. [*C's legs bend at the knees and lift slightly off the floor.*]

[27:54] **T:** Uh huh. I like how you use your legs.

[27:55] **C:** [*Continues to draw up her legs until both are in the air, bent at the knees. C's arms are slightly off the ground, hands made into fists.*]

[27:56] **T:** Yeah, hold that. That's a great position, hold that. [*C holds her position, exhales.*] Know what this position is about. Keep it until you know what it's about. Go ahead.

[28:15] **C:** [*Legs in the air. Arches back. Hands clenched, grimacing. T places a hand under C's neck/upper back and his foot under her low back.*] Oh. [*Grimaces, her face has a very pained expression. Hands clenched. Legs bent up and apart, up from floor. Groans. Arches her head further back. T provides some resistance to C's right hand* (see Figure 5), *then places his left hand under C's upper back and his right thumb on C's sternum point. C is still tensing, then relaxes for 35 seconds, breathing more deeply than normal, and then goes back into a full contraction.*]

[30:17] **T:** Uh huh. Can you see your position?

[30:19] **C:** [*Relaxes a little.*] Can I see it? Yeah.

[30:21] **T:** What does it look like it's doing?

[30:24] **C:** I get to a point where my whole body is tense. And then I see I can almost die. And then my whole body just goes . . . [*Client allows her upraised hands to drift down to her sides and makes an exhaling sound like air being released from a balloon.*] And I float. It's like—[*Raises her tensed arms, hands made into fists, then relaxes her arms and lets them drift down.*]

[31:20] **T:** Uh huh. Uh huh. That's a great solution.

[31:23] **C:** [*C lies still and relaxed for 15 seconds, then returns to the tensing position with an agonized expression.*]

[31:39] **T**: [*Gives resistance to right hand and arm.*] Uh huh. Yes. Very good. [*Stands and steps over C so that he has one foot on either side of her and says—*] I'm going to use this. [*Puts his hands against her upraised hands. C retracts her hands.*] I'm going to be this mythological figure and I'm going to kill you and see how you do that, do that with me. [*T steps to C's right side, kneels down, makes a slow knife stroke to C's chest.*]

[31:59] **C**: [*Grimacing, eyes closed, arms tensed and bent at the elbows, hands in fists, legs bent at knees, tensed, feet in the air.* (See Figure 6.) *Rolls slightly to her left, then to her right toward T. At this point he removes his hand from her sternum. C rolls from side to side, even more contracted, knees and arms closer to her chest, grimacing.*]

[32:35] **T**: [*Still kneeling by C's side.*] I can't strike you when you do that. It's an incredible protection. I can't play my role any more.

[32:41] **C**: Really? [*Relaxes a little.*]

[32:43] **T**: It's impossible. [*C relaxes more.*] It's such an incredibly agonized and painful and sensitive and tortured-looking expression. I can't possibly touch you. [*Pause.*] I'm going to try it once again and see if I can do it. Here I come. [*C begins to tense. T raises right hand, lowers it with exhale of breath to C's chest. C is grimacing and tensing her body as before. T pulls his arm back.*] I can't do it. I'm sorry I even did it. Oh, shit.

[33:32] **C:** [*Still tensing, begins to shake her arms, then just right arm. T provides some resistance to C's right hand. C pushes her hand against T's hand. C continues to tense her body and groan. T twice gives some resistance to C's left hand, but C withdraws her hand both times. T then takes both of his hands away.*]

[34:14] **T:** I'm sorry I did it. I'm sorry, I'm sorry.

[34:18] **C:** [*Continues to tense, groan.*]

[34:24] **T:** I didn't mean it. [*Touches C's right hand gently.*] I didn't mean it. I didn't mean it. I had to do it.

[34:59] **C:** [*Still tense, groaning.*] I've given you everything I got—

[35:03] **T:** I didn't mean it.

[35:05] **C:** —and you make me go to the other world. [*R hand pushing against T's right hand.*] I gave you the best of me, the best of me, everything—I gave you. I gave every bit of blood I have, every ounce of my life, my energy, until you forced me to bleed. I matched you blow for blow.

[35:49] **T:** I had to keep doing it.

[35:51] **C:** Why? [*Screams.*]

[35:52] **T:** You didn't react enough before.

[35:57] **C:** I didn't react. What do you mean?

[36:00] **T:** You've been too passive with me.

[36:04] **C:** [*Grimaces, shakes arms, still with eyes closed.*] Give me some air. [*Screams.*] Give me some air!

[36:18] **T:** I'll move away. I'm leaving. [*Walks a few feet away.*]

[36:24] **C:** No! No. [*Raises her right arm, fully extended, straight up, with a fist.*]

[36:29] **T:** I'll just sit by. [*Returns to C's right side and sits. Touches her right fist.*]

[36:35] **C:** You've taken everything. Now you have to give something to me.

[36:39] **T:** I don't know how.

[36:48] **C:** How? How? [*Grimacing more. Tensing arms. T touches C's right arm..*] I love you. I love you. [*Slides closer to T, still tense.*]

[37:10] **T:** [*Gives resistance to her right hand.*]

[37:18] **C:** I <u>like</u> that you've been doing that. Why?

[37:26] **T:** I guess I'm your Karma. [*Gently places both hands on her right arm.*] Be my friend.

[37:40] **C:** You didn't kill me [*Sounding surprised*].

[37:42] **T:** Uh huh.

[37:43] **C:** You couldn't do it.

[37:44] **T:** I didn't want to kill you.

[37:48] **C:** How come? You've killed everybody.

[37:58] **T:** Uh huh.

[37:52] **C:** You've killed everybody. Why didn't you kill me? I thought you'd killed me. How come you didn't kill me?

[38:02] **T:** I'm just looking for people. I didn't want to kill them. I've been looking for someone to take me, and to match me, and be with me.

[38:17] **C**: [*Still tensed, shaking her right arm.*] God. This is how we've been. Like this, you and I. [*Reaches out with her left hand, takes T's right arm, puts it against her right arm, so their forearms are pressed together.*]

[39:29] **T**: Yes, let's change it.

[38:31] **C**: We've been like this for years.

[38:32] **T**: We've just been in physical contact. How about looking at me. Why not look at me? And see me?

[38:40] **C**: Look at you?

[38:43] **T**: Uh huh. Let's change our contact methods.

[38:45] **C**: Okay. Okay. [*Lies more relaxed, quiet. Feet on floor, knees bent, hands on thighs.*]

[38:51] **T**: Look at me with your inner eye.

[39:10] **C**: Uh huh. [*Pause.*] God, you know what I don't understand about you?

[39:14] **T**: Uh uh.

[39:17] **C**: I can't see your face yet, but I can see your nature. That you are so violent but you're so loving. It surprises me. How can you be both?

[39:31] **T**: You listen and you will hear the answer.

[39:38] **C**: [*Big sighs. Grimaces. Breathes deeply.*] You're . . . you're desperate. [*Pause.*]

[39:55] **T**: Uh huh. I'm desperate.

[40:04] **C**: It's your desperation that makes you so violent.

[40:06] **T**: Uh huh.

[40:11] **C:** Huh. You're like . . . . [*Pause.*]

[40:20] **T:** See I'm a mythical figure. I'm desperate.

[40:28] **C:** You're like you're running around the earth on a rampage, like you're desperate. You're going to kill until you find some people—

[40:37] **T:** —Who react to me.

[40:39] **C:** Who will react to you and will let you inside them. You want to come in me. I'm so, I feel like, I'm . . .

[40:48] **T:** Too young?

[40:49] **C:** Yeah. Like I'm little, like I have fine bones [*touching the point on her sternum*] and you're like the big strong thing. [*Said in a child-like voice.*]

[41:02] **T:** [*Smiles.*] Well!

[41:04] **C:** But you know what?

[41:05] **T:** What?

[41:08] **C:** Huh. [*Laughs.*] It's not all me . . .

41:10] **T:** I don't blame you, though. I have to speak as Arny. You're in a rough spot there. These things don't have much respect for people. And I think it's really true. This thing is not well aware of your—of the size of your bones. The only thing that it reacts to is your total human reaction to it. That's your strength. And I think it's true what you're saying. That it would like to come inside of you and it doesn't know how to do it in a way that's going to be easy for you. And I agree with you. I think it's unfair in some ways. You'd like to be an ordinary person but you've got this big thing

that's after you. And the point of your contact with it till now has been this area [touches her sternum].

[41:56] **C**: Yeah.

[42:00] **T:** And, uh . . . It's, uh—

[42:03] **C**: Oh, you know what though?

[42:04] **T:** Yeah.

[42:05] **C:** I have to say only part of me is complaining.

[42:08] **T**: Yeah.

[42:09] **C**: Another part of me I feel like I'm in love.

[42:10] **T**: Yes.

[42:11] **C:** I really do.

[42:12] **T**: Yeah.

[42:14] **C:** I feel like—

[42:18] **T**: —You want to embrace it?

[42:20] **C:** Yeah, like I want it.

[42:22] **T:** Well . . .

[42:29] **C:** But I don't want . . . I don't want to be at war.

[42:34] **T:** You don't want to be at war with it.

[42:36] **C**: Uh uh [*shakes her head, and then puts palms of both hands over her eyes.*] I don't want to be at war.

[42:39] **T**: What's rubbing your eyes do for you?

[42:51] **C:** It helps me to come back.

[42:57] **T**: [*Puts hand under C's upper back, helps her to a sitting position.*]

[43:05] **C:** [*Sits with her hands over her eyes. Turns and faces T, her head down.*]

[43:43] **T:** This looks to me like the beginning of the second work. Now you've got—like interested in (unintelligible) now. And it's turned full cycle.

[43:58] **C:** Can I take just a couple more minutes? [*C is sitting on her bent legs, hands in her lap, looking down at the floor.*]

[44:00] **T:** OK, let's take a couple of minutes. I'm going to make a recommendation of how to do it. I might not follow the individual details but I'm thinking about your main questions. I'm going to get my block of paper. [*Retrieves his notepad.*] Also I want to get feedback. You wanted to move out of something. You wanted a new direction.

[44:23] **C:** Uh huh. [*Still looking down, hands in her lap.*] I'd like to finish something. I just need a few minutes.

[44:37] **T:** Go—take your time.

[44:44] **C:** Okay.

[44:45] **T:** Yes . . .

[44:47] **C:** Okay. [*Still looking down, then nodding her head yes.*] I accept it.

[44:56] **T:** You accept it.

[45:00] **C:** [*Nods yes.*] I think we'll have some troubles but I feel like you want me, you have me. [*Again nodding yes.*]

[45:06] **T:** [*Laughs, nods his head.*] Sounds realistic.

[45:08] **C:** I'm ready to—I feel like you want me. Like you're important. [*Nodding her head.*]

[45:15] **T:** Uh huh.

[45:19] **C:** So I'm going to try to take you on. In that way I accept you.

[45:25] **T:** How does the figure's wanting you look? [*Drawing on a piece of paper.*]

[45:32] **C:** How does it look? [*Head still down, eyes closed.*]

[45:40] **T:** Does it look like this? I'm drawing pictures. [*Hands pad and pen to the client. T has drawn a small face on it.*]

[45:48] **C:** [*Reaches out and takes pen in right hand. Starts drawing. Draws figure. Begins with outline. Then head, then arms. Large arms which form a circle as they hang from the shoulders. The figure fills the page.*]

[46:58] **T:** A great picture [*in soft voice*]. *Zackig.* It's *zackig* looking.

[47:15] Seminar Participant: *Zackig?*

[47:17] **T:** "*Zackig*" is, like . . . It's a fantastic picture. [*C is still drawing.*] It's also a pleasure for me as an onlooker to be able to visualize what it is you've been dealing with.

[48:10] **C:** Me too.

[48:12] **T:** You too.

[48:14] **C:** Uh huh. Couldn't see it before.

[48:16] **T:** Couldn't see it before.

[48:18] **C:** Only saw the qualities. [*Still drawing.*]

[48:24] **T:** Uh huh. God! [*Looking at the drawing.*]

[48:32] **C:** [*Finishes her drawing.*] (See Figure 7.)

[48:34] **T:** May I show some of that to the other people, too?

C: [*Nods yes.*]

[48:39] **T:** [*Shows picture drawing to others. Puts picture back in front of client.*]

[49:00] **C:** I understand—(unintelligible).

[49:02] **T:** Uh huh.

[49:06] **C:** [*Looking down at the picture.*] The problem is you can't tie up your lifetime against a figure like that. [*Laughs.*] You have to believe it is something that is very real and not fight against it, but jump in with it and then you can fight with it. The deeper meaning is you can't push—[*looks up at T*]—you can't push these things away forever.

[49:34] **T:** This is what life is about [*Gesturing at the picture*]. Amazing.

[49:40] **C:** [*Looking at picture.*] I guess that's what I always wanted. What a weird guy.

[49:54] **T:** (unintelligible) like that.

[49:57] **C:** Yeah?

[50:00] **T:** Yeah I got something like that too.

[50:20] **C:** It's like a missing figure in my childhood dream—one of my childhood dreams [*fully looking at T again*]. In one of my childhood dreams there is this kindergarten girl who is locked up in the bowels of the earth. And there are all these boulders. And I just recently found out who she was locked up by. I forgot that part of the dream when I was younger. She was always alone. And it was, like, this giant. And I could only hear him. [*Makes sounds like*

footsteps, hitting her hands on the floor.] Boom, boom, boom. I was terrified of him.

[51:02] **T:** Uh huh. The giant had locked her up.

[51:04] **C:** Uh huh.

[51:12] **T:** [*Pause.*] Interesting in the childhood dream she could only hear him and that in life she's been only feeling him, but nobody's seen him yet.

[51:25] **C:** Uh Uh [*shakes her head*]. I've never seen him.

[51:30] **T:** All of my arthritic [this word is not very intelligible] patients make things like these [points at drawing].

[51:31] **C:** Hm! Really?

51:32] **T:** All of them.

[51:33] **C:** What is it?

[51:34] **T:** The feelings of the bone—this *zackig* quality. The point in this is the experience that they have, actually it's also what the bone looks like.

[51:48] **C:** Really?

[51:50] **T:** Yes. Crystal structures are located there under the bone surfaces and that's what hurts. [*Pause.*] But what do you think about that—

[52:04] **C:** That's what I feel my experience is though—is very much like this. [*Makes slashing motion with her right arm, then her left arm.*] And I feel—

[52:08] **T:** Just like this. [*Makes a slashing movement with his arm.*]

[52:10] **C:** I feel like I shouldn't be like this sometimes. [*Makes slashing motion with her right arm, then her left arm.*]

[52:11] **T:** We're all very—[*strokes his arm gently.*]

[52:12] **C:** I feel like I should be more rounded. [*Makes soft curving movements with her arms.*] And I feel over the years my body has become very angular. And like this: [*Makes direct angular moves with arms.*] I only enjoy making movements like that. [*Repeats the angular movements.*]

[52:24] **T:** That's right. Your body is changing, it looks more angular.

[52:31] **C:** [*Nods, smiles.*] Thanks.

[52:43] **T:** I look at myself in the mirror every morning, pointed chin. [*Gestures at his features, then at the drawing.*] They take over after a while.

[52:55] [*T and C smile at each other and hug.*]

END OF SESSION.

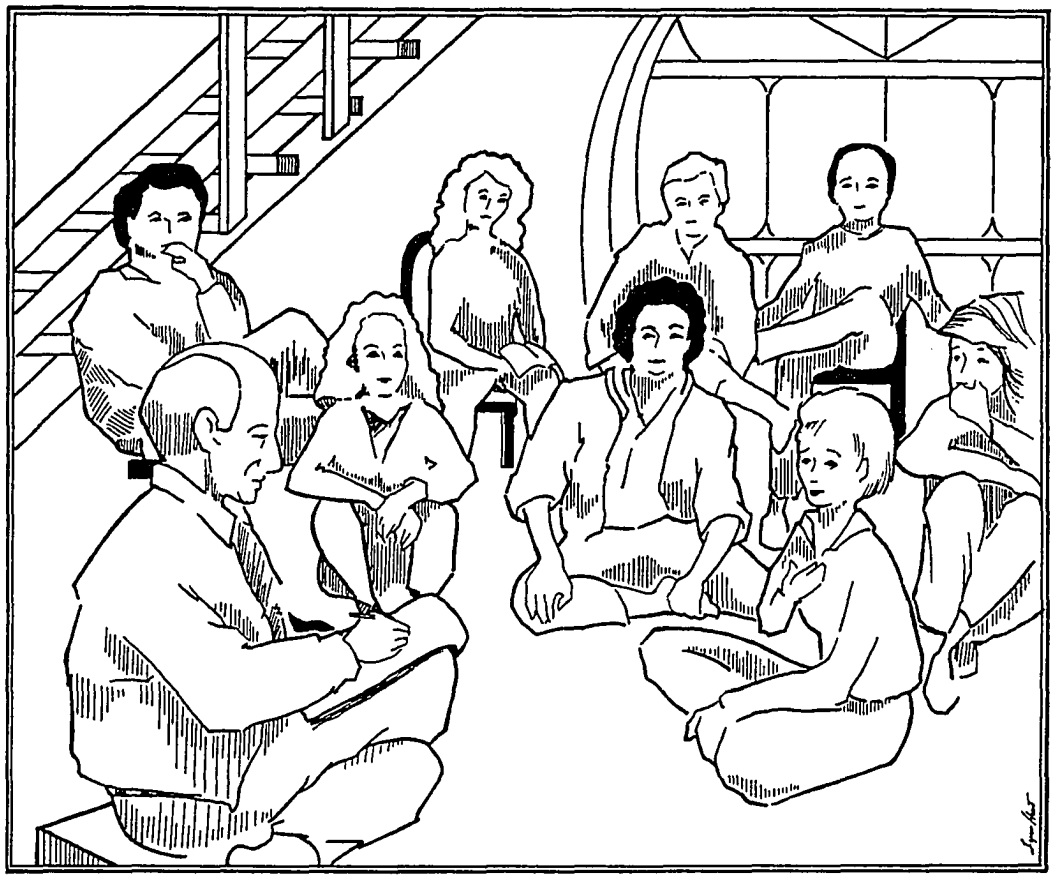

Figure 1. Therapist (left, writing on pad of paper) and Client (right, touching her chest) 40 seconds into the therapy session.

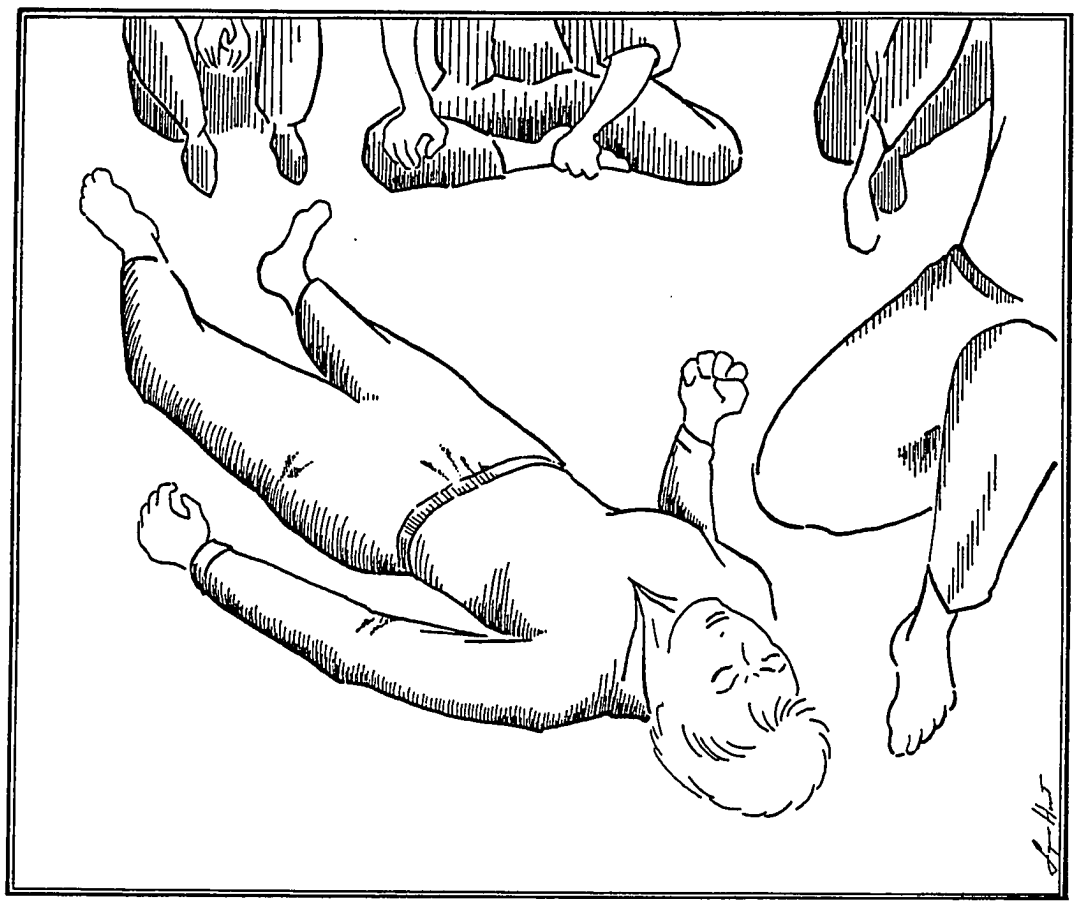

Figure 2. Client (lying down, fist clenched) and Therapist (seated immediately to Client's right) 13:53 into the therapy session.

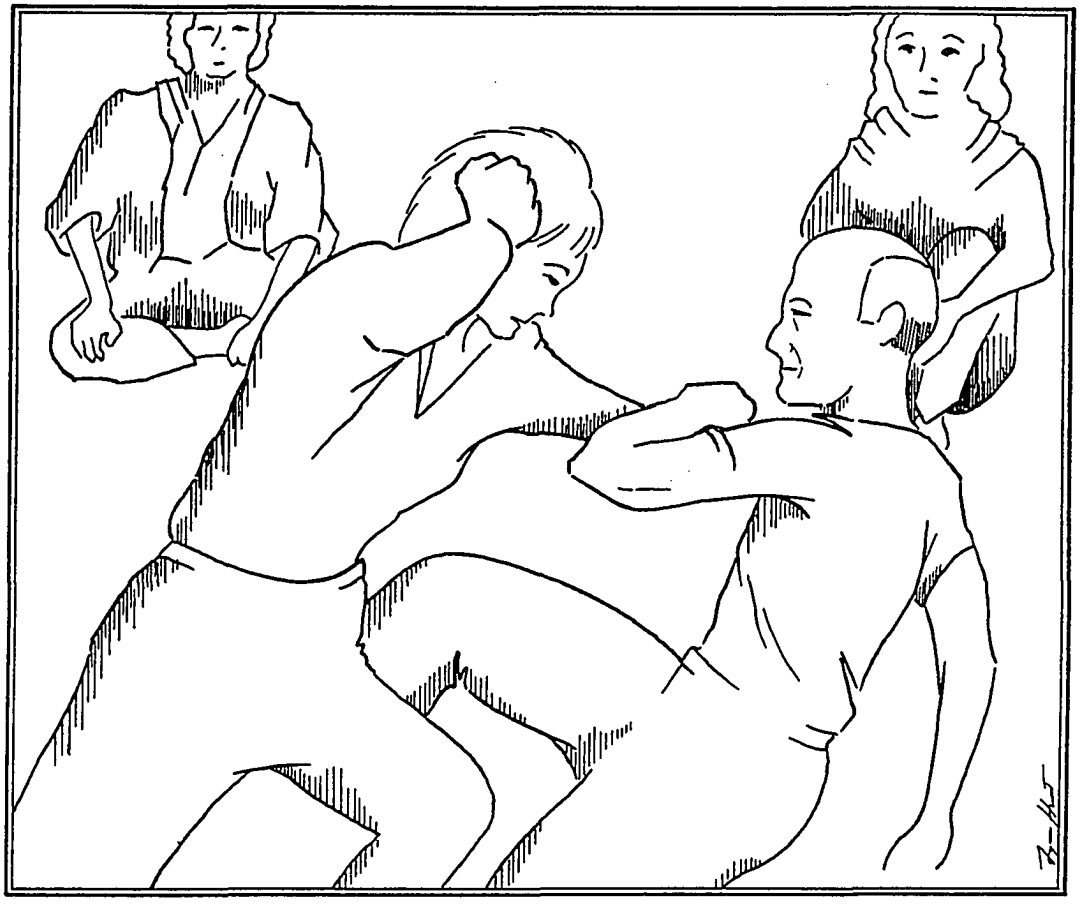

Figure 3. Client, playing the role of the killer, attacking the Therapist at 16:50 into the therapy session.

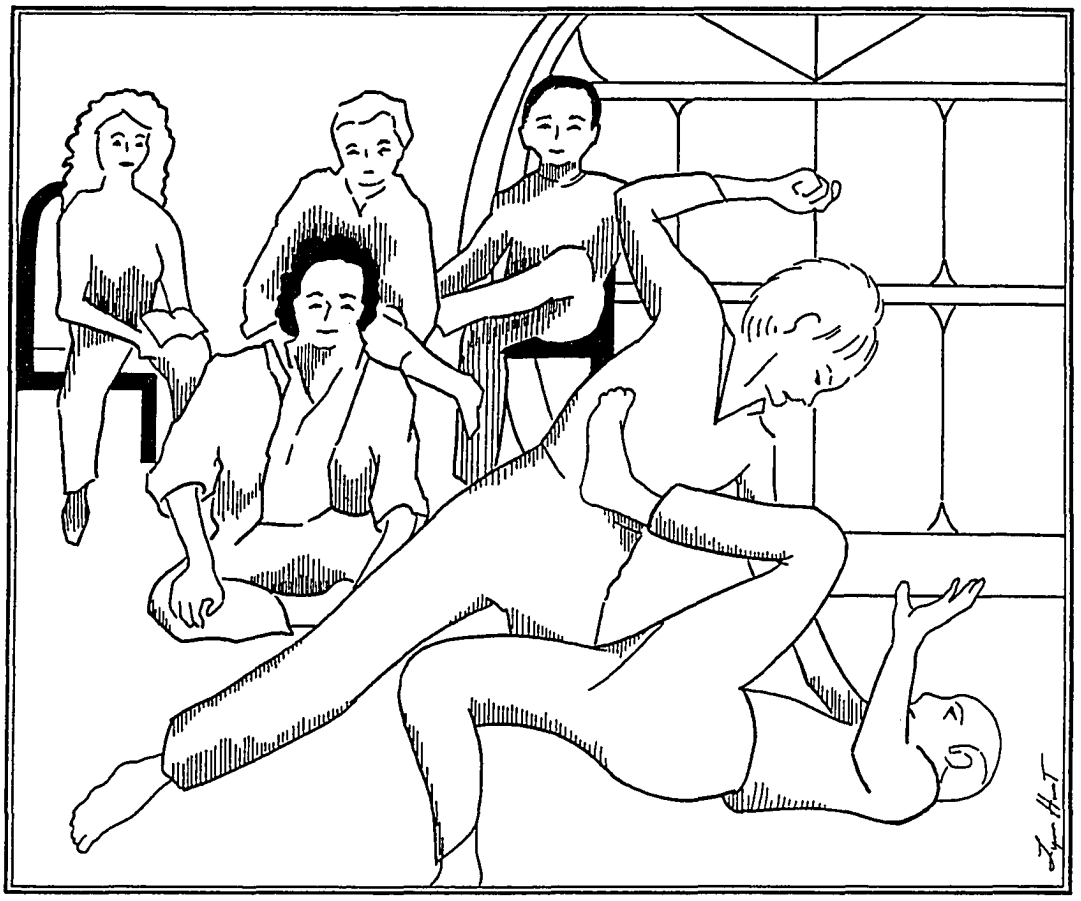

Figure 4. Client attacking Therapist at 18:26.

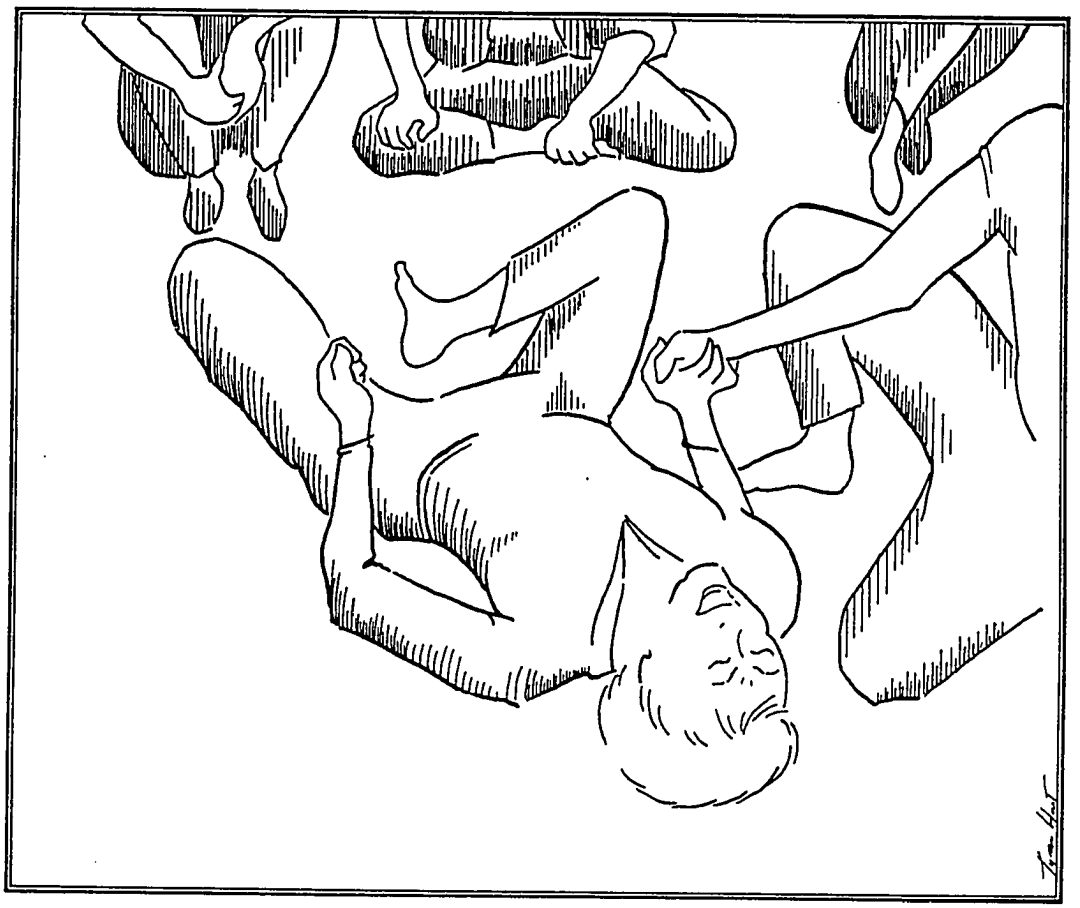

Figure 5. Client grimaces and contracts while the Therapist provides resistance for her right hand at 29:22.

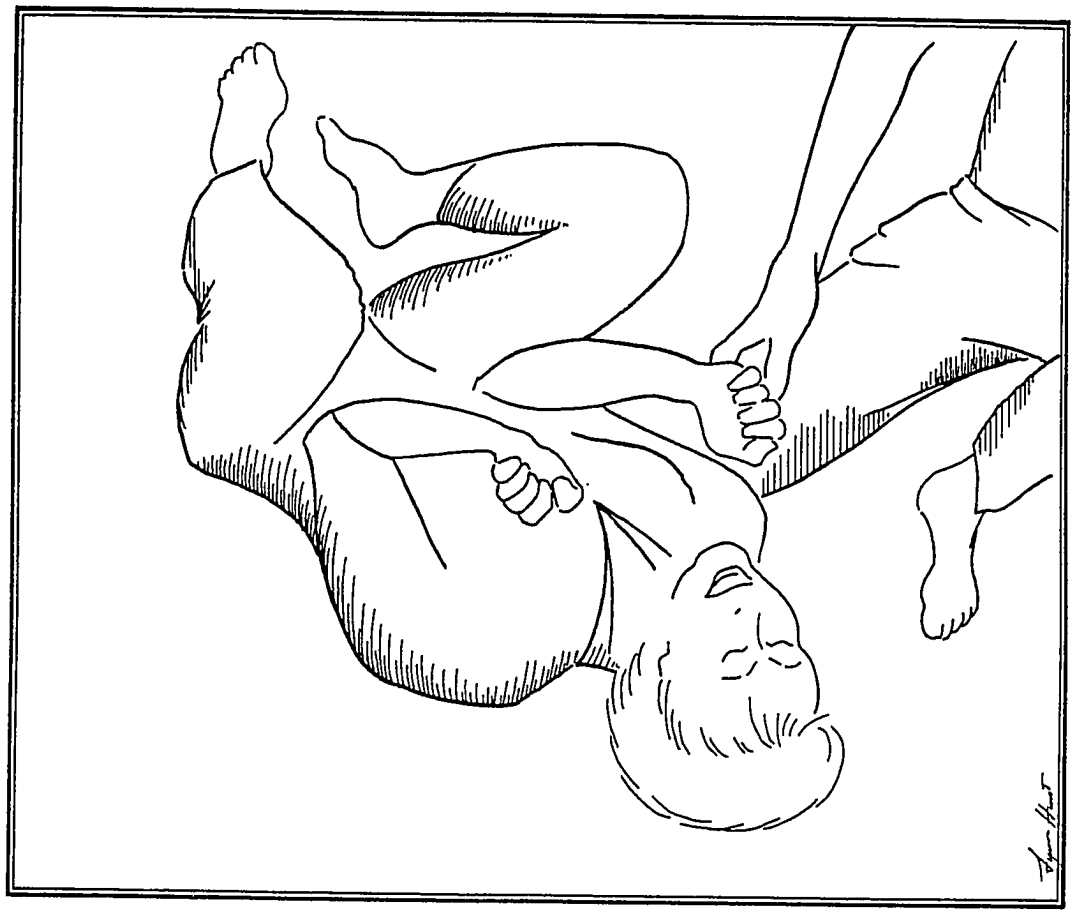

Figure 6. Client in a more amplified version of contraction at 31:59.

Figure 7. The Client's drawing of the killer, completed at 48:32. This reproduction has been reduced to 65% of original. The round face on the killer's right shoulder was drawn by the Therapist as a means of prompting the Client.

CHAPTER VI

VIDEOTAPE AND INTERVIEW ANALYSIS

Introduction

The purpose of this chapter is to analyze the videotaped interactions between the Therapist (T) and the Client (C) in accordance with the principles of Process-Oriented Psychology.

The analysis focuses upon structural elements, which includes key aspects of the Client's process (such as primary and secondary process, occupied and unoccupied channels, and edges), as well as the overall structure of the session (i.e., patterns and recurrent themes).

The analysis also examines the underlying beliefs and philosophies of the Therapist, such as the assumption he makes that experience is structured, his teleological interpretation of symptoms, his systems perspective, and his phenomenological attitude toward signals.

Therapeutic strategies and procedures are explained, including channel-specific interventions, amplifying symptoms, the approach to role-playing, and methods of integration.

The significance of the childhood dream is analyzed in terms of the over-all process structure of the session.

The terminology of Process-Oriented Psychology is explained where appropriate.

And, finally, the results of the follow-up interview are compared with the information contained in the session.

Discovering the Process Structure

Process-Oriented Psychology makes the assumption that there is an underlying structure to all human behavior and experience, even in situations that appear chaotic.

This assumption is derived, in part, from the discoveries and theories of modern physics, information theory, and Taoism. The common thread in these theories is that they all emphasize relationships between events rather than the events themselves. The focus is upon principles of organization, that is, upon the underlying pattern or order that connects 'separate' phenomena.

This approach assumes that there is an underlying pattern even when events appear unique or without direct causation, such as in the case of the behavior of subatomic particles, the arrangement of yarrow stalks thrown to the ground for divination, or the word salad of a schizophrenic.

Applied to psychotherapy, the Process-Oriented therapist assumes that there is a structure to every client's process. An important early goal in the psychotherapy session is to discover this structure.

The most important elements of the process structure are the client's primary and secondary process, and occupied and unoccupied channels.

The primary process consists of all the body gestures, ideas, and behaviors with which the client readily identifies. The secondary process consists of those experiences with which the client does not identify. Secondary processes are experienced as intrusive, as not belonging to oneself, and as invasions of the primary process.

The primary process cannot be equated with being conscious and the secondary process cannot be equated with being unconscious. Mindell wrote that

> Consciousness is a term which I use only for those moments in which the individual is aware of primary and secondary processes. Consciousness refers to a reflective awareness, to the existence of a metacommunicator, someone who is able to talk about his experiences and perceptions. (1988a, p. 25)

Unconsciousness refers to all other types of processes.

Suppose clients identify themselves as being caring (their primary process). If they are totally aware of how they experience their caring, then they are conscious of this process. But if there is any aspect of their process of being caring that occurs without their awareness, then they are unconscious of that aspect of their primary process. At the same time they may be aware that occasionally they are uncaring (their secondary process), even though they do not think of themselves as uncaring persons. In that case, they are conscious of their secondary process.

By identifying and supporting the primary process, the therapist builds trust, establishes rapport, and discovers the client's stated goals for being in therapy. By identifying the client's secondary process, the therapist discovers what is troublesome for the client, what lies beyond the client's present identity. The therapist also supports the client's secondary process, for although it is indeed a 'problem,' without it, there would be no challenge to develop.

The other aspects of the process structure that the therapist tries to discover are the client's occupied and unoccupied channels. Theoretically, experiences are occurring simultaneously in most, if not all,

of the channels, but we tend to focus on certain channel experiences and remain relatively unaware of others. If someone is identifying with a given channel, then this channel is occupied. An unoccupied channel is one in which an experience is occurring with which the person does not identify.

People tend to habitually identify with certain channels while not identifying with others. If someone consistently identifies with a particular channel, then it is referred to as the person's main channel. The primary process is generally experienced via a habitually occupied channel, while the secondary process tends to occur in a habitually unoccupied channel. Experiences in a habitually occupied channel are familiar because they represent the individual's most common way of perceiving. Experiences in a habitually unoccupied channel tend to be unusual and a source of new information. The channel experiences provide the therapist with vital information about how the client will develop and the approach the therapist must take in order to foster that development.

In Chapters 1 and 4, I have listed some of the sensory cues that can help a therapist determine a client's primary and secondary process and her occupied and unoccupied channels. C's specific behaviors in the psychotherapy session are analyzed accordingly.

The First Minute

In teaching seminars Mindell has often remarked that an attentive therapist may discover clues in the first few minutes (more or less) of a psychotherapy session which reveal the process structure of the entire session. This is an essentially holographic notion: that is, that a part can

accurately portray the whole. In this case, the structure of part of the session (the first minute or so) is the same as the structure of the whole session. This is also reminiscent of the Taoist notion that the unique convergence of events in the moment contains clues about more encompassing events. Let us see if the process structure is evident in the first few minutes of this session.

[0:11] When we look at C's first statement, we discover that she has two goals: (a) a general goal of finding out more about herself, and (b) a specific goal of working on two chronic body symptoms, that is, pain in certain points in her chest and back, and a constriction of her shoulders which makes her want to have more room. The pain and the constriction are the chronic body symptoms that will be examined as the session unfolds. These few statements reveal a good deal about C's process structure.

Primary and Secondary Process

In her initial remarks, C does not give much information about her primary process. This is due, in part, to the questions T asks, that is, ". . . did you have some part of your body you needed to work on? Did you want to find out more about yourself?" C responds directly to these questions, saying, "I want to find out more about myself, and I also have a specific part of my body to work on." If T had asked "What kind of person are you?" or said "Tell me about yourself," then C might have provided idlosyncratic information about her primary process, perhaps saying something like, "I am a student, and I like to ski," and so forth. Since T and C have known each other for several years prior to this session, they have probably

already established a degree of trust and rapport, so there is less need for T to discover C's usual description of herself, that is, more general primary process information.

Instead T begins by asking C about her presenting complaint, and she mentions the pain and the constriction. She does not identify with either the pain-producing process or the constricting, confining process. C's secondary process is, therefore, that of pain-giver as well as something that makes her feel that she doesn't have enough room. C's primary process, by implication, is that of someone who is in pain and feels constricted.

Unoccupied Channels

C says "I have a lot that hurts right here." This is a relatively passive description which is quite different from saying, "I hurt." C's description of her experience implies that something is causing her pain. She is not identifying with the pain-producing process, which means that proprioception is unoccupied.

C's other symptom is a constriction and, related to it, a sense of not having enough room. C's remark that "I have a constriction" (rather than, for example, "I constrict myself") indicates that she does not really identify with the constricting process. That is why she is always trying to get more room. A constriction process typically occurs in the movement channel, and she is, in fact, trying to counteract it by swinging her arms. Since C does not identify with the constriction process, she is not occupying kinesthesia.

Process theory assumes that there may be one or more dream figures in the background who are causing these unoccupied channel experiences. They are aspects of C's secondary process, outside of her identity, and are known to her primary process only as symptoms. For example, when C swings her arms, her movement is either toward or against an unseen figure. In other words, such a movement is made by C's primary process in relation to an unseen secondary dream figure. The fact that this is a chronic condition indicates that her relationship with this dream figure is a long-term one.

Occupied Channels

C speaks without any hesitations or stuttering, and the intonation sounds appropriate to the content of her words, indicating that her auditory channel is relatively occupied.

At this point, less than a minute into the session, T has sufficient information to deduce a considerable portion of C's process structure. He knows that C's primary process is one of being in pain and not having enough room, and that her secondary process is the pain-maker and confiner. In terms of the basic channel structure, C appears to be occupying her auditory channel. Proprioception and kinesthesia are unoccupied channels, with proprioception less occupied than kinesthesia. If C is to learn more about herself, it will be via the unoccupied channels.

There is still one important aspect of the process structure that is missing, and that is the next thing T tries to discover.

The Main Channel

[0:53-1:44] At this point T tries to determine C's main channel, that is, the one she occupies most readily. He does this by disrupting C's attention and then noticing how she accesses information.

C's sudden and complex reactions [1:16] indicate that she is at an edge. In this case the edge presumably has to do with her uncertainty about the intent of T's questions.

When C turns and looks out the window [1:28] she is using her visual channel to access information about the mountains. T then knows that vision is C's main channel. He metacommunicates to C about his line of questioning [1:44]. In response to a question, T [2:06] momentarily breaks his exclusive communication with C and explains to the seminar participants that it is helpful to know the main or strongest channel in order to integrate the material that emerges from less occupied channels during the course of the session. T is stressing that it is the relationship between the primary and secondary processes that is important. It is not enough to elicit secondary material through an unoccupied channel; the material must then be related to and integrated with the primary process via the main channel. After completing his explanation, T addresses C directly once again, with the goal of re-establishing rapport.

Confirming the Process Structure

[3:13] At this point, C states an additional goal: she is looking for something deeper in her life. C employs the active tense when she says "I've been looking," indicating that she is occupying her visual channel because she identifies with the process of looking. After she says this, C

stops talking for a moment, tilts her head forward and looks down. According to process theory, C's head and eye movements generally indicate that she is feeling something, that is accessing a proprioceptive experience. If T caught this signal, he could hypothesize that the deeper thing that C is looking for is a feeling. In other words, C is trying to use her main channel (vision) to access information that must ultimately come through an unoccupied channel (proprioception). C will eventually find the feeling she is looking for in the sequence from 25:48 to 32:43.

[3:49] When T asks, "What are you looking for?" he is following C's lead by phrasing his question in terms of the visual channel.

[3:52] C responds to T's request for more information by adding that she feels she needs a new direction, and that she is trying to move out of something. C's words ("I feel") and actions (tilting her head forward) indicate proprioception, but it is unclear whether she is identifying with this channel. Her statement that she is "trying to move out of something," along with her hand gestures, indicates that C is partially occupying kinesthesia. That is, she is identifying with the attempt to move, but at the same time there is an implied constriction—the thing she can't move out of. Since C identifies herself as someone who is trying to move but can't, this reconfirms the previous hypothesis that she is partially occupying kinesthesia. It is also reminiscent of C's attempt to "get more room" at 0:11. C's overall response underscores her reply at 3:13 by once again emphasizing that the experience she is seeking is proprioceptive and kinesthetic.

For a summary of C's process structure at this point, see Figure 8.

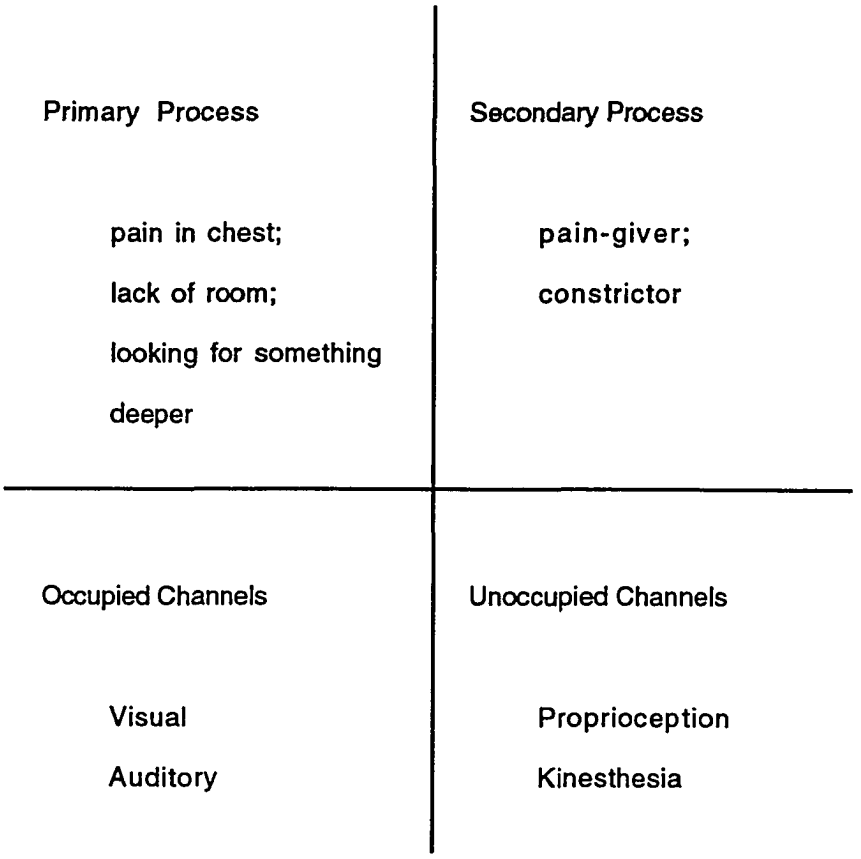

FIGURE 8. C's process structure at 3:52.

[4:18-4:40] T metacommunicates with C, explaining why he asked his questions. T is relating to C's primary process, that is, to her stated needs. T deliberately uses the same language that C has used to describe what she is trying to do, that is, *"moving out of"* and *"finding a new direction."* This is an example of channel-specific feedback.

Deciding How to Begin Working

[4:46-4:48] T recommends that they work on the sore points on the front of C's body, and C agrees. It is likely that T makes this suggestion because he realizes that proprioception is the least occupied of C's two unoccupied channels. It can therefore be assumed to be the source of the most valuable information.

Although T could assume (in accord with process theory) that there is an unknown dream figure who is causing C's pain, the figure is so secondary that it would not make sense to offer C this interpretation of her situation. Since C is aware of the pain in her body, they will begin by focusing in a channel-specific manner on her proprioception.

T then recommends that C lie on her back because it is a convenient way for them to work on the chronic sore point in her chest. C responds to T's suggestion before he has completed his sentence, which is an example of very positive feedback.

C's Shaking: Differentiating a Double Signal from an Edge

[4:50-5:32] C begins shaking, and says that she is nervous. There are two ways T can interpret C's behavior: as a double signal, or as edge behavior.

According to the double signal interpretation, T would assume that C's lying down and her shaking are contradictory messages, that on the one hand, she said she wanted to work, but by shaking, she is indicating she does not want to work.

But T regards C's behavior as an edge, not as a double signal. He is able to make this distinction because, although double signals and edges can appear very similar, there is a difference. As Goodbread has written:

> A double signal is usually persistent and remains in the background of both the client's and the therapist's perception as a constant and usually faint source of disturbance. Behavior around an edge appears suddenly, covers a broad range of phenomena, and is usually very apparent to both therapist and client. (1987, p. 207)

C's double signal, her "constant and usually faint source of disturbance," is the pain she feels in her chest, the constriction of her shoulders, and the feeling that she does not have enough room. In contrast, her shaking appeared suddenly and was obvious to both T and C. Edge behavior occurs when someone is at the boundary between their primary and secondary processes. The person has come to the edge of what is familiar to them, and is uncertain about how—or whether—to proceed. Goodbread defines an edge to mean the "total set of phenomena which happen when a person is brought to the edge of his awareness, or confronted by a secondary process" (1987, p. 204).

A therapist has two choices when a client is at an edge: the therapist can encourage the client either to (a) go over the edge, or (b) explore the nature of the edge. The more important the issue, the more necessary it will be at some point to explore the edge.

> Working at and around the edge is the most important step toward integrating secondary process material; effective work with edges means working with both sides until they come into relationship to one another. (1987, p. 208)

At [5:34-5:40], T recommends that C go to "the other side" of the edge, and C agrees. If C were simply being compliant, there would be a double signal. As the session unfolds, we will notice C reaching a number of edges.

Bodywork

Process-Oriented Psychology bodywork, in contrast with most other systems of body-oriented therapy, does not have an image of an ideal body which the therapist helps the client attain. Instead the current form and symptoms of the body are taken to be meaningful, and the therapist works with the client to decode that meaning.

Bodywork is mainly concerned with the proprioceptive and kinesthetic channels. Working with these channels tends to elicit powerful experiences because proprioception and kinesthesia are generally less occupied than the visual and auditory channels.

Process-Oriented bodywork is based on the notion that the body is constantly dreaming. The body's symptoms are the indications that the dreaming process is occurring. Since dreams and body symptoms (and, indeed, all other signals) are believed to reveal the same underlying process, bodywork and dreamwork are approached in the same manner, that is, by noticing what is trying to happen, encouraging (amplifying) it to happen more completely, and paying attention to what unfolds.

When doing bodywork, there are times when the Process-Oriented therapist may touch the client. It is beyond the scope of this discussion to outline the many issues related to physical contact between therapist and client. For a review of the general literature, the reader is referred to Willison and Masson (1986).

In this context, however, it is important to note that process theory does have a working guideline for what constitutes appropriate touch; namely, that touch is appropriate when to do so is indicated by the signals. For example, if the client is in the midst of a visual or auditory experience, then touch would not be an appropriate means of amplifying that experience. If, however, the client is propriocepting, then it might be appropriate for the therapist to touch the client in order to amplify proprioception. This is only a guideline, not a hard and fast rule, so that the therapist would have to take into account all other signals (such as those indicating transference, counter-transference, or dreamed up processes) before deciding how to proceed.

[5:45] T begins the bodywork by asking C if she would take off her sweater. It seems likely that T makes this request because it will be easier to find the sore point if C is wearing one rather than two layers of clothing. C says that this is all right and takes off her sweater.

[6:35] Then T asks C if it is okay that he touch different parts of her chest. Once again T is very careful to let C know what he intends to do and to receive permission before he begins. C gives him permission to proceed.

The Emergence of the Killer

The next sequence, which runs from 6:42 to 18:34, is a clear example of what Mindell refers to as "extraverting the unconscious" (described in Appendix C, Section 4). It is also an excellent example of the step-by-step amplification of a secondary process.

In *River's Way*, Mindell wrote that the most powerful tool of the Process-Oriented therapist is his or her ability to discover the process structure, which T has already done in this session. Mindell then went on to say that the process worker's

> second most useful tool is his ability to work with signals in their own various channels, to amplify these signals and bring them closer to awareness. The exact nature of amplification depends on the individual client, therapist, and the channel. There is no one set of techniques which will fit every situation. Part of the creativity of process work is learning the methods of amplification implied by the signals themselves. (1985a, p. 25)

Amplifying a symptom is like putting it under a microscope. At first it is difficult to discern much about the symptom, but amplification increases the resolution so that the details and fine structure of the symptom become apparent. Symptoms are holographic in that any secondary symptom, when amplified, can be shown to contain a great deal of information about the client's personality. We will see that C's sore point contains information about a psychological theme/issue that has been with her most of her life.

As he helps C amplify her symptom, T can expect one of three things to occur: (a) C will need to change channels in order for the experience to continue, (b) she will reach an edge, or (c) there will be a de-escalation of the signal. The first two options occur in the following sequence. De-

escalation occurs in a subsequent amplification sequence (28:15) and is described more fully at that time.

[6:42] T explains to the group and to C that he is "trying to find out more—through my hands—the nature of who she is." At this point T is accessing information proprioceptively, and at the same time he is amplifying C's proprioception. T invites C to direct him, and when he finds a point that he thinks is painful, T asks for and receives corroboration from C. This spot is the focal point of C's feeling, and is, therefore, the logical place to work with to amplify her proprioception.

[8:51-9:43] T and C begin to work with the sore point, which C describes as feeling like a bruise, and like a black and blue mark.

[9:54] The next step in the amplification occurs when C tells T that the point would be more painful if he pressed harder. T presses slightly harder, and C says that she feels a sharp pain.

[10:55] C takes deeper breaths, and T (11:17) encourages her to continue to do so. T is pacing C's breathing with his verbal description. Deeper breathing typically indicates a stronger proprioceptive experience.

[11:25] C notices that her thumb is pressing into the carpet. Only a sophisticated client would notice and comment on such behavior. This is the first overt action of the dream figure who is going to emerge from the amplification of the point.

[11:30] T alertly encourages C to work directly on the painful spot with her thumb. He starts to ask a general question about C's willingness to help ("Would you like to. . . ?"), but in mid-sentence incorporates the information C has given him and makes the question specific ("Would your

thumb like to. . . ?"). When C presses on her chest with her thumb (11:48) she is, for the first time, expressing in an overt manner the two polarized sides that her arm movements hinted at in 0:11: the secondary dream figure who is pressing on her and causing the pain, and primary identity of the victim of the pain.

[11:52] C further amplifies the pressing action by using both of her hands to press the spot. This further heightens the polarization, and she then experiences her chest as having strong walls, like a barricade. She is now beginning to be aware of the nature of the polarization: something is pressing on her chest, and her chest acts like a barricade to keep it out.

[12:47] T tries to find out what C is barricading herself against. According to process theory, C is barricading herself against an as yet unrevealed dream figure. This figure is still too secondary for C to be aware of it, so T (12:55) directs C back to her proprioception. At this point the answer comes from the proprioceptive channel, not from auditory or visual.

[12:55-13:18] During this sequence, T encourages C to feel the pain point. C's two remarks that "It hurts a lot" (12:58) and "It's just pain" indicate that she is still not occupying proprioception or identifying with the pain-causing process. On a physical level, C's chest is being hurt by the finger pressure being applied by C and T. On a psychodynamic level, process theory maintains that C's primary process is being hurt by a dream figure with which she doesn't identify. When C grimaces and lifts her shoulders toward her head (13:08), T interprets this as an indication that C is feeling pain. T responded in a similar fashion at 6:42. When T asks C

whether her pain is "like anything—?" (13:18), the question is in the form of a blank access. In other words, he does not refer to or direct C's response toward a specific channel.

Channel Change: Proprioception to Kinesthesia

[13:18] T asks C what the pain is like, and C (13:21) says that it is like a knife, while she makes a fist and raises her arm. This represents a channel change from proprioception to kinesthesia. It also represents the further emergence of the secondary dream figure who is pressing on C's chest. Mindell wrote that

> It is important to be able to notice these channel switches in the work because the dreambody seems to want one to develop awareness of the various channels. The dreambody signals in one channel and then switches channels because it realizes that you have either come to the limits of what you can bear in one channel or else that you are on the wrong track and need to perceive things in a totally new light. (1985b, p. 45)

In this case, it appears that C has, in the moment, reached the limit of her tolerance for the pain, so her dreambody has switched to the movement channel.

The concept of channel changing is derived from information theory. The Process-Oriented therapist is more concerned about the information emerging from the client's process than about the particular channel in which it is momentarily being expressed.

The therapist must pay close attention to determine if the same theme is continued when the client changes channels. For example, if C had made the transition from feeling pain in her chest to making fluttery movements with her hand which she described as a butterfly, this would be

a theme change. The butterfly would not represent the same information as the pain, and T would know that C had "edged out," that is, departed from the process they were working on together. If that happened, then T would try to bring C back to the original process. In this case the stabbing knife is thematically consistent with the pain C has been feeling.

[13:27-13:35] T asks whether C's experience of the knife is "Like a knife in you?" He is able to ask this pertinent question because he knows—from closely tracking C's process—that the pain in C's chest and the knife are different aspects of the same process. C reports that it is in fact "like being stabbed with a knife." C is now becoming even more aware of the two parts of her that are in conflict: her primary process, which feels like she is being stabbed in the chest with a knife; and her secondary process, which is doing the stabbing.

[13:37] T notices that the pressure he is applying to C's chest differs from C's subjective experience of the pain. Note that T does not deny C's experience; rather, he supports C and leads her more deeply into her experience.

[13:53] C's statement that "My hand went into a fist and it felt . . . " indicates unoccupied kinesthesia because of the passive description of the movement of her hand, and unoccupied proprioception because she refers to her hand as "it." She is not yet identifying with the "knife" process.

[14:00] Realizing that the process has shifted from proprioception to kinesthesia, T suggests that they focus on the knife rather than the painful point, and C agrees.

T is now faced with the task of helping C amplify her kinesthetic experience. The Process-Oriented therapist has a number of options for helping the client to amplify movement. These include providing resistance to the client's movement, having the client move in slow motion and study what the movement accomplishes, providing verbal encouragement, suggesting that the client express the movement with more of the body, moving with the client, and physically encouraging the client to continue with a movement.

[14:17] In this case T provides resistance to C's knife hand. C then increases the strength of her knifing movement, so that T's intervention has succeeded in amplifying C's kinesthesia. T then asks, "Who is this knifer?" because he wants to get more information about the dream figure who is doing the knifing.

[14:32] C adds an audible exhalation in a manner that is congruent with her arm movement. Whenever someone adds a channel like this it represents an amplification of the experience.

At 14:17 T asked C, "Who is this knifer?" Up to this point, C's primary process has been to identify herself as the victim of the pain in her chest. Here is an opportunity for her to identify—and potentially identify with—the pain-giver, a role which has been very secondary for her. C responds to T's question by providing an important piece of information: she identifies the knifer as a killer. C is beginning to reveal the personality of the secondary dream figure.

[14:42] C suddenly smiles, laughs, and puts her arm at her side. This is in marked contrast to the forceful stabbing motions she was making a

few seconds earlier. This thematic change clearly indicates that C is at an edge. She is reluctant to identify with the dream figure now that it has been identified as a killer. T remarks that "it's funny," tacitly supporting C for being at an edge. This is all the encouragement that C needs: a few seconds later (14:52), C goes over her edge and resumes the knifing movements. Once again T provides resistance to her arm, and C responds (15:00) by amplifying her movement and adding an auditory response (the exhalation).

[15:02] T tries to get more information about the "killer" by asking what the killer is after. T is making the teleological assumption that the killer's behavior is purposive. C then reveals that the killer loves violence. With this statement, C raises her head and sits up: the killer is no longer just in the right arm, and is getting off the floor.

[15:06] At 15:02, T referred to the killer as "he." It is not clear why T uses the masculine pronoun. T may have done so intentionally, or perhaps out of convention. At 15:06, C also refers to the killer as "he." The fact that she continues to do so as the session unfolds indicates that this fits with her experiential reality.

[15:19] By sitting up and facing T, C is further amplifying the polarity between the killer and its victim (soon to be played by T). C's eyes are still mainly closed. C's behavior after she says that the killer is only happy killing (i.e., looking down, spreading her arms, and so forth) indicates that she is at another edge.

The First Role Playing Sequence

There are three role playing sequences in the session. The first sequence, which we are in the middle of now, runs from 15:19, when C sits up and faces T, to 19:02, when there is an interruption in the tape. In this sequence, C is playing the killer and T is playing C's primary process.

In order to interpret the role playing sequences, it is important to understand how such interactions are viewed from the theoretical perspective of Process-Oriented Psychology. Process theory views dyadic interactions to be generated by individual psychology as well as by the properties of the field of which the individuals are a part. The systemic or field-like aspect means that the two individuals together generate a field that has properties of its own. The Process-Oriented therapist tries to understand the nature of the interactions by paying careful attention to the signals being generated.

It is the nature of any interactional field for specific roles to stand out and become polarized. As the client moves more deeply into the client's process, the client will begin to identify more completely with a particular role or dream figure. In other words, the client will begin to occupy that role within the field. The client will then begin to send out signals characteristic of that role. Because every system tends toward balance and completeness, the therapist will tend to respond to the client in a complementary manner. In that way the roles begin to become polarized. Deliberately engaging in role playing accentuates the polarization. Mindell refers to the principles governing the occupation and polarization of roles within a system as occupation theory.

When a therapist steps into a role, that is, deliberately begins to play one of the client's dream figures, several things happen simultaneously. First, the therapist will continue to have his or her own personal reactions to the client. And second, as noted above, the therapist will also begin to have reactions which are constellated by the signals the client is sending. In process terminology, by responding to these signals, the therapist becomes a channel for the client's process, that is, the therapist becomes "dreamed up" to represent one of the client's dream figures. (For a more complete discussion of dreaming up, see the section on the "Therapist--Client Relationship" in Appendix C, Section 1.)

It is not enough, however, for the therapist to allow himself or herself to become dreamed up: the therapist must also maintain an overall awareness of the process. In his writings on couple's therapy, this is what Mindell has referred to as the perspective of the "third person."

> The third person represents a special viewpoint. . . .The third person is the symbol of a consciousness which is impersonal as well as personal, Taoistic as well as emotional, distant from, yet engaged in, the relationship. The third person represents the capacity to get beyond the one-to-one situation, to see both people as individuals and simultaneously as a unit which is in the midst of suffering because its two parts are not communicating efficiently. (1987b, p. 10)

The therapist must be able to maintain the third person perspective whether working with a couple (in which the therapist is literally, to some degree, outside of the interaction) or as a participant in a role play between two of the client's dream figures. The third person perspective has been referred to previously as the ability to metacommunicate about a process.

Thus, the therapist must have the flexibility and awareness to express the therapist's dreamed up reactions, to differentiate them from the therapist's personal reactions, to continue to encourage the client to play his or her role, and to be able to step back from the interaction and comment about it.

As we will see in the role playing sequences, there is a process of mutual influence between T and C. As C changes, T responds to the new signals and changes also. The feedback C gets from T teaches C the direction she needs to go in order to deal with the dream figure.

[15:19-18:34] Returning to the transcript, C has just begun to play the part of the killer, and T is playing her primary process.

In addition to the skills listed above, in this role playing sequence, there are several specific behaviors that T adopts in order to be a realistic adversary. On a physical level, he offers enough of a struggle to keep things polarized, but is not so forceful as to physically overwhelm C and prevent her from playing the role of the killer. This type of challenge encourages C to amplify her experience of being the killer. T also adds verbal components to the role to make it more realistic and further heighten the polarization, as at 15:34 when he begs C ("No, don't do it") and when he gasps after being stabbed (15:38).

T must also be alert to the fact that playing the killer is not easy for C. As a consequence, she reaches an edge a number of times. Each edge is characterized by a clear theme change: C stops attacking T, puts down her knife hand, and engages in nonverbal behavior such as looking down, smiling, sighing, and shaking her head. In each instance, T encourages C to

go over her edge, using a variety of approaches to do so. At 15:31, T encourages C by lifting her knife arm; at 16:24, he lifts his own arm, thereby modeling the behavior; at 16:38, he offers verbal encouragement and lifts C's arm; and at 18:32, he offers verbal encouragement. In each of these cases, C responds by resuming the role of the killer.

At the same time that T is playing his role and encouraging C to go over her edges, he is also trying to elicit more information about the killer. That is why, as previously mentioned, T asked "Who is this knifer?" (14:17). This is the point at which C responds that the knifer is a killer. Then at 15:02, T asks, "What is he after?" and C responds (15:19) that the knifer loves violence, and is only happy killing. At 16:58, T asks, "Why are you doing this to me?" and C responds (17:11) that the only thing that makes the killer feel free is to kill. (Note C's use of the pronoun "me," an indication that she is more identified with the role of the killer. In that moment, it is the sad feeling that is keeping her from even more fully playing the role.) Each time T asks a question, he successfully elicits information. Each of these revelations further amplifies the relationship struggle, helping C to more fully identify the nature of the killer and more completely understand the conflict between her primary and secondary processes. T's line of questioning is further testimony to his teleological orientation, for he is assuming that the killer's actions are meaningful and purposive, and that it would be valuable to discover who this dream figure is and what it is trying to accomplish.

Another approach tried by T is to cover his head with a sweater (16:58) so that C can freely project onto the relationship struggle she is

having. It seems likely that T takes the sweater off his face at 17:11 either because C has responded to his question ("Why do you do this?" to which she replies, "It's the only thing that makes me feel free, is to kill") or because it has not proven to be a particularly useful intervention.

It is significant that when C is playing the killer (15:36 and 17:11), her fist—the knife hand—is on the same point on T's sternum as she had located on her own sternum

C's process structure has undergone a significant shift from the beginning of the session (see Figure 9). In many ways C's process structure is reversed from the way it was at the beginning of the session. Instead of identifying herself as the victim of pain and constriction, C is now identifying with the inflicter of pain, the knifer/killer. At the beginning of the session, C was occupying vision and audition, while proprioception and kinesthesia were unoccupied; now the situation is nearly reversed, with kinesthesia occupied, proprioception partially occupied, and vision unoccupied.

Finally at 18:34, C stands up and opens her eyes for first time. Both of these signals indicate that she is more congruently playing the role of the killer. What began as a sore point on C's chest has gradually escalated into C fully embodying the secondary dream figure who has been causing her the pain.

Primary Process	Secondary Process
Killer	Victim (person with chest pain)
Occupied Channels	**Unoccupied Channels**
Kinesthesia Auditory	Visual (her eyes are closed)
Partially Occupied	
Proprioception (17:11—feel free, sad)	

Figure 9. C's process structure at 17:11.

Tape Interruption

At this point, there is a brief interruption in the videotaping of the session. With the help of an associate, I role-played the interactions of C and T before and after the interruption. From this, I estimated that the missing segment was probably less than a minute in length. This estimate was independently corroborated by C in the post-session interview when she said, "In some ways it doesn't look like a broken tape to me. It doesn't look like you missed too much."

The Second Role Playing Sequence

From 19:07 to 21:04, T and C engage in what I am calling the second sequence of role playing. This sequence is probably an extension of the first role playing sequence, but because there is an interruption in the tape as well as a shift in roles, I am treating it as a separate unit of role playing.

[19:07] T says to C, "I think I'll have to kill you first. You're interrupting my life. Say good-bye to your friends. I'm going to kill you." He is standing straight and tall, so that his body posture is no longer that of a victim.

With these statements and change in body language, T is initiating a shift in roles. He is taking the language and behavior that C uses as the killer and then playing the killer role even more congruently than C has been playing it.

On one level it appears as though T is trying to initiate a role reversal, but I don't believe that T wants C to revert to her original

primary process role of victim. There are two ways T can help C to amplify her role as killer: by playing the victim, or by being an aggressor himself. In the first role playing sequence, T played the victim, and now he is beginning to play the aggressor. He is hoping that his actions will provoke C to amplify her own killer behavior so that she will play the role more completely than she has thus far.

[19:17] It is interesting that C, addressing T, asks, "What are you?" rather than, "Who are you?" Her use of the pronoun "what" rather than the pronoun "who" may be an unconscious acknowledgment that, as we shall see, her adversary is not human. C is not simply dealing with the introjected figure of someone she has known. Instead there is an impersonal or transpersonal aspect to the challenge that C faces in confronting her adversary. This is an indication that C is shifting to her primary process role of victim rather than amplifying her role of killer. As victim she is confronting a dream figure who is an unknown adversary, a presence, a "what" rather than a "who."

T displays the killer's behavior by twice raising his right arm over his head to make a knife stroke. The first time he does this, C replies by raising her own right arm. Had she continued in this vein, then she would have been staying with and potentially amplifying her own killer behavior. Instead, by the second time T raises his arm, C is in a defensive role and does not raise her arm in reply.

T also acts as the killer by twice stabbing to C's chest. C defends herself and does not counterattack in the manner of the killer, further evidence that she is not meeting the challenge that T is putting to her.

C's arm movements appear to be an amplified version of the arm movements she made at 0:11 when she was trying to get more room. Her arms are moving parallel to the floor, swinging from front to back, the difference being that she is swinging her arms alternately rather than at the same time. At one point at the end of a swing, both C's arms are behind her and her chest is forward. She repeats these movements at 21:04 and 21:46. She is still trying to have enough room, but now it is clear that she is making the movements in relationship to the killer.

[20:32-20:34] T has noticed C's intent stare and her exhalations, and checks to see if she has had a particularly strong experience. In order to question C, T resumes the role of therapist. In response to T's question, C (20:34) says that it's like a fight for her life. This is an indication of how seriously C is taking her interaction with the killer.

[20:44-21:04] T and C resume their struggle, with T as the aggressor and C making an energetic but not very effective defense (she is striking at the air and is rarely making physical contact with T). C's arm movements are once again parallel to the ground, as at 0:11, rather than the stabbing movements of the killer.

Metacommunicating About the Struggle with the Killer

In the sequence from 21:19 to 22:07, T and C step outside of the roles they have been playing to metacommunicate about their interaction.

[21:19] T steps out of his role and metacommunicates to C about his experience of playing the killer. This underscores the fact that T's own reactions are important. He notices that C's actions have not been enough to make him stop his attack, and that the two of them have cycled a

number of times, with T attacking, C counterattacking, and then repeating the same sequence. In process theory, a process cycles when someone is unwilling to go over an edge. This is important information for C; now she knows that she will need to do something different in order to stop the attack.

[21:46] C also wants to metacommunicate about the situation.

[21:58-22:02]. C believes that she is at a physical edge when it comes to dealing with the killer, and T agrees with her. Then C says, "I have all of your energy except at a certain point. Then I get weakened. My stamina goes."

C does not identify what it is that weakens her. It may be that C is in fact at an edge, that is, that her weakness is an edge to her strength, to feeling more energy and having greater stamina. As mentioned previously, I think that T was trying to provoke C to displaying greater strength by playing the role of the killer in this sequence.

It may be, however, that C needs to develop in a different manner in order to deal with the killer. There is not a pronounced theme change evident in C's behavior, so it is possible that she is not at an edge. Instead, it may be that C's weakness is an indication that something secondary is coming out. Perhaps she needs to be "weak," to develop in a different way. The question then becomes: in what channel will this development take place?

[22:07] T says, "This is the pattern of a chronic symptom: that you're up against a force that you are like stalemated with. That's a

chronic symptom." As mentioned above, the stalemate is evidenced by the fact that C and T have cycled a number of times.

T could, as he remarks, "do justice" to C's process by leaving it as a stalemate, since that is what is already happening. Instead T recommends that they resume working on the sore point on C's sternum. It is likely that he bases his recommendation on his analysis (0:11) of C's process structure at the beginning of the session in which proprioception was C's least occupied channel. This is the channel in which C is most likely to learn what it is she needs to know, so T suggests returning to proprioception and working on the chest point. C agrees.

The Missing Point

In the sequence from 22:42 to 23:00, T and C prepare to work on the sore point on C's chest. C's twitching hand (23:00) may be the killer still making his presence known.

T and C spend several minutes trying to locate the point again (23:38-24:53) but neither one of them can find it.

[25:05 and 25:38] T then responds to two questions from the group. In answering one of the questions T says, "The point is that if you start this processing in movement, or something like that, then the body changes, and if the body hasn't changed, then you haven't really processed the material that was there."

T is saying that C must have really processed the point because the point has changed. There are several indications that C has "really processed the point." One indication is the fact that by the time of the tape interruption, C had played the role of the killer to a significant

degree, from letting herself really feel the pain in the point, to knifing with her right arm, to using most of her body to be the killer. A second indication is that C does not play the killer again in the session, which suggests that she has processed that role as much as is necessary at this time. The implication is that playing the role of the "symptom creator" can change the nature of the symptom. The symptom has achieved its purpose: to make C aware of the secondary process which the symptom represents.

Phenomenological Attitude

[25:48] When T and C can no longer find the point, T says, "So I'm just going to follow the process. You go ahead and do what is right for you." At this point, T is still being guided by C's process structure, that is, by the fact that her proprioceptive channel was unoccupied in the beginning of the session. Beyond that T has no formula by which to proceed other than to notice and amplify whatever C does.

This is an excellent example of the phenomenological attitude that is characteristic of Process-Oriented Psychology. T's intent is to pay close and neutral attention to C's signals and base his interventions upon them, always changing his approach according to the feedback he receives. Although T has been maintaining a phenomenological attitude all along, this is the only point in the session in which he explicitly announces his intention to observe C's signals in a neutral manner and let them tell him how to proceed.

The Amplification of C's Primary Process

The sequence entitled "The Emergence of the Killer" involved the amplification of C's secondary process, beginning with the sore spot on her chest. The next sequence involves the amplification of C's primary process, the part of her that has been suffering in relationship to her secondary process.

From the standpoint of the process structure, it makes sense that this sequence should occur. In the discussion of C's shaking early in the session, the point was made that effective integration requires working on both sides of an edge. Until now, C has managed to amplify her secondary process; now, as a natural part of the unfolding of her overall process, she is about to amplify her primary process.

According to process theory, people have edges against both their primary and secondary processes. For example, a simplified way of describing C's primary and secondary processes at the beginning of the session would be to say that her primary process is to be in pain and her secondary process is to cause the pain. We have seen that C has had to overcome a number of edges before she could identify with and express the secondary pain-giver. If C were simply asked to feel and express her pain, she would also have an edge doing this, that is, she has an edge against her primary process. We are about to follow the process whereby C goes past this edge.

[25:48] T uses his hands to amplify the slight movements C is making, that is, her breathing and the tilting back of her head.

[27:31] C grimaces, clenches her jaw, tightens her arms, makes fists, and her legs begin to move. T puts his hand under C's arching back to amplify. In each instance, T's interventions are a response to what he observes C to be doing.

[27:54] T notices C's slight leg movements and encourages her to continue. C responds (27:55) by drawing her legs up further and raising her arms off the floor.

[27:56] T, again assuming that C's behavior is meaningful, encourages her to "know what this position is about." T is encouraging C to be aware of whatever she experiences rather than having her focus on a specific channel.

[28:15] When T places his hand under C's neck/upper back and his foot under her low back, he is amplifying C's movements by supporting her body where she is lifting herself. Looking for other ways to amplify C's movements, T provides some resistance to C's right hand (see Figure 5) to see if she will press against him, but she declines.

C has a very pained expression, continues to tense her body with her arms and legs off the floor. Then C relaxes, her arms and legs resting on the floor, no longer with an agonized expression on her face. She stays that way for 35 seconds, breathing more deeply than normal, and then goes back into a full contraction.

De-Escalation

It is important to understand why T does not intervene when C makes the transition from tensing to relaxing. I mentioned previously that

there are three possibilities when a symptom is being amplified: reaching an edge, a channel change, or de-escalation.

C's transition from tensing to relaxing is an example of de-escalation. De-escalation is what occurs when someone's behavior within a given channel reaches an extreme stage of expression and then makes an organic transition toward the other extreme. Jung, following Heraclitus, referred to this type of process as *enantiodromia*, by which he meant that eventually every process evolves into its opposite (Jung, 1971).

C amplifies her tensing to a degree in which her entire body is involved. It is only then that she begins to relax. C is completely congruent in both the tensing phase and the relaxing phase. Since C is not double signaling, and because there has not been a theme change, she is not at an edge. And since she is occupying proprioception (and, to some degree, kinesthesia) in both phases, she has not changed channels.

[30:17] T continues to probe for the reason for C's posture by asking, "Can you see your position?" In contrast with his open-ended suggestions at 13:18 and 27:56, this is a channel-specific suggestion. T realizes that C is currently occupying her proprioceptive and kinesthetic channels, two channels which are, for her, usually relatively unoccupied. C is, therefore, not as familiar with processing proprioceptive and kinesthetic experiences, so she may be in what T referred to at 1:44 as a "far out place."

T is hoping that by using her main channel—by seeing herself—C will be able to process her experience, and therefore discover the meaning of her actions.

[30:24] At this point, C's channel structure is reversed from the way it was at the beginning of the session. Now she is occupying proprioception and kinesthesia, and is only partially able to occupy her visual channel. The information she does provide visually—"see I can almost die"—is part of a life and death theme which is discussed in a subsequent section.

[31:20] When T says to C, "That's a great solution," he is referring to his previous remark, made at 22:34, that C's body contains the answer to the stalemate she is in with the killer. He believes that C's tensing and agonized expression constitute the answer supplied by her body. Moreover, C's proprioceptive experience is the "something deeper" she said she was looking for at 3:13. C's feelings represent a strong amplification of the suffering aspect of her primary process.

[31:23] C lies relaxed, then begins to tense again.

The Third Role Playing Sequence

At 31:39, T initiates the third sequence of role playing by once again taking on the role of the killer. T wants to see if C can use the solution she has found in direct confrontation with the killer. He announces to C that he is resuming the role, and, referring to her tensing reaction, says, "I'm going to kill you and see how you do that with me." He then "stabs" her in the chest.

Note that T refers to the killer as a "mythological figure." He apparently believes that C's process, in addition to being highly personal, also contains an impersonal aspect. In other words, the challenge of responding to a worthy adversary is a collective experience.

[31:59] C responds to the knife stroke by becoming even more tense and contracted than before (see Figure 6).

[32:35] T tells C that he can't play the role of the killer any more. From a systems perspective, by going over her edge and reacting so strongly, C has made it impossible for T to continue with his role. C has used her entire body as well as her facial expression to fully express her pain; in so doing, she has behaved totally congruently and has completely occupied her role. This is what the killer has been challenging her to do, and, now that she has done it, the nature of their relationship changes. There is no longer a need for a "killer."

As in the second role playing sequence (21:19), T once again metacommunicates with C about his experience of playing the killer, but this time his feedback is very different. At 21:19, T told C that her reactions were not enough to keep him from playing the role. This time, unable to play his role, T shares his personal, authentic reactions to her rather than the dreamed up responses of the killer. In so doing, T has entered the relationship channel with C.

[32:41] C sounds surprised that T can no longer play the killer.

[32:43] T explains in more detail why he can't play the role, sharing more of his personal reactions. T then makes one more attempt to play the killer but can't continue.

Integrating Primary and Secondary Process

At this point, C is no longer fighting with the killer. For most of the remainder of the session, C's task is to understand the killer and her relationship with him. In other words, C is working on integrating her

primary process (her sensitive or suffering aspect) with her secondary process (the killer).

The integration occurs in several stages. From 33:32 to 41:08, C relates to T as though he were still the killer. From 41:10 to 42:36, T and C talk about the killer. From 42:39 to 43:43, C sits up and faces T. From 43:58 to 45:19, C talks out loud to the figure of the killer inside of her. From 45:25 to 49:40, C draws the killer and T and C talk about him. And at 50:20, C realizes that the killer is like a missing figure from one of her childhood dreams.

There are several themes in the integration process that will be explored in detail: the use of C's main channel to foster integration, the stages of C's evolving relationship with the killer, drawing a picture of the killer, and remembering her childhood dream.

Using C's Main Channel to Foster Integration

T fosters the integration process at a number of points by suggesting to C that she use her main visual channel to interpret the secondary material.

For example, as we have already seen at 30:17, when C was lying on her back in the tensed position, T asked her, "Can you see your position?" In response, C was able to visually describe the process she was going through along with experiencing it proprioceptively and kinesthetically.

At 38:32, after C has been addressing T as though he were the killer while keeping her eyes closed, T invites C to use her visual channel by saying, "We've just been in physical contact. How about looking at me. Why not look at me?" C says okay and relaxes somewhat, but does not open

her eyes to look at T. This is a double signal: she is not yet ready to look at him. T then suggests, "Look at me with your inner eye," encouraging C to look at him (i.e., at the killer) with introverted visualizing. C follows this suggestion and is able to see the killer's nature, while mentioning that she cannot yet see his face.

A few minutes later (45:25), T tries to take the integration a step further by inviting C to draw the killer. This stage is discussed below.

The Stages of C's Evolving Relationship with the Killer

Interwoven with C's use of her visual channel for integration are a number of indications of her evolving relationship toward the killer.

Relating to T as Though He is the Killer

As mentioned above, from 33:32 to 41:08, C relates to T as though he were still the killer. At 34:14 and 34:24, T apologizes to C for playing the "mythological figure" and trying to kill her. At this point, T is speaking for the killer, but he is also expressing his authentic sorrow. C responds at 34:59 and 35:05 by saying: "I've given you everything I've got . . . and you make me go to the other world." The "other world" may be the mythological world, the world of the childhood dream.

C continues at 35:05, saying, "I gave you the best of me, the best of me, everything . . . . I gave every bit of blood I have, every ounce of my life, my energy, until you forced me to bleed. I matched you blow for blow." T replies that he (the killer) had to do what he did because C didn't react enough before. He is explaining to C how she prevented him from staying in his role, and at the same time he is implicitly supporting her in having her

feelings. C has trouble accepting T's answer and reacts as though she wants T to leave (36:04), but when he moves away (36:18), she calls him back (36:24).

A few seconds later (36:48), C says to the killer, "I love you. I love you." This is a significant shift in her way of relating to the killer. C is beginning to sense more completely the killer's nature and the deeper purpose of her relationship with him. She is realizing and appreciating that the killer has challenged her to develop, to feel and express her feelings, to test her strength. This theme is continued at 39:17.

At 37:18, T and C are pressing their arms together, and C says, "I like that you've been doing that. Why?" C's statement and her question are spoken in two different voices. The statement is spoken by the part of her that is beginning to appreciate the killer's impact on her. This is a new way of thinking about and feeling toward the killer, so another, more uncertain part of her asks the appreciative part, "Why?"

T, speaking as the killer (38:02), makes the assumption that the killer's intentions are benign, that is, that the dream figure is trying to teach C to react rather than harm her. C repeats (38:17) that they have been in conflict for many years. At this point they are beginning to cycle, so T invites C to use her main visual channel and look at him. This results in C being able to see the killer's nature (39:17), but not his face.

When C asks the killer how he can be both violent and loving (39:17), T notices that C is relating to the killer through her auditory channel, and, therefore, makes the suggestion ("You will listen and you will hear the answer") that she pay attention to her auditory channel in order that she

receive a reply (39:31). This is another example of channel-specific guidance.

At 40:39, C says to the killer: "You want to come in me" (40:39). The killer has wanted to come inside C, but until now, her chest has been like a barricade (11:52) keeping him out.

From 40:48 to 42:36, C expresses her ambivalence about her relationship with the killer, complaining that the small bones of her chest have difficulty accommodating the "big, strong" killer, and yet professing to be in love with him. It is during this sequence that C stops relating to T as though he were the killer, and instead they talk about the killer. C is beginning to metacommunicate about her process.

The Life and Death Aspect of C's Struggle With the Killer

From 37:40 to 37:52, C expresses surprise that she was not killed. The life and death aspect of C's struggles recurs throughout the session, beginning at 14:32 when C identifies the dream figure as a killer. Later, when T is playing the killer and T and C are fighting, C says that it is like a fight for her life (20:34). Again, at 30:24, C says that she can almost die. It is at this point (31:39) that T helps C "die" by resuming the role of the killer. This has the effect of amplifying C's proprioceptive experience, which is what she needs to do in order to effectively deal with the killer.

An important shift has occurred when C says that she is surprised that the dream figure did not kill her (37:40). In one sense, C did die: her primary process identity, the aspect of her that would not react enough, has died in order for C to be able to feel and express her pain. As Mindell wrote, "From the psychodynamic view, death comes when something new

is trying to happen and is split off. If we experience the inner figure representing this new element, our grieving abates as the concept of death disappears" (Mindell, 1989a, p. 95). By the time C expresses her surprise that she has not been killed, she is no longer identifying with her primary process, her victim body, and that is why she does not feel as though she was killed.

A few moments earlier (36:48), C began to move into a mythbody experience when she said to the killer, "I love you." From this perspective, the theme of life and death is no longer relevant. This is because, "from the viewpoint of the mythbody, death does not exist" (Mindell, 1989a, pp. 94-95). From the mythbody perspective, C's relationship with death changes, for she is in touch with the deeper part of herself that continues to exist even as individual dream figures live and die or transform. At this point, C is identified with the growth process represented by the childhood dream rather than resisting it.

Transition From Real, to Dream, to Mythbody

At 42:36, C puts her palms over her eyes. When T asks her, "What's rubbing your eyes do for you?" C says that it helps her to come back. In other words, she has indicated that she is ready to return from her internal experience. When C turns and faces T (43:05), T says, "This looks to me like the beginning of the second work . . . it's turned full cycle." C has "turned full cycle" because she has gotten fully into being the killer (her secondary process) and fully expressive of her feelings toward the killer (her primary process), and now she is once again facing T. The

"second work" could refer to the next stage in her process: either integration of this work, or an entirely different piece of work.

C requests more time to complete the session (43:58), and, after taking a few moments to reflect, C addresses the killer and says,

> I accept it. . . . I think we'll have some troubles, but I feel like you want me, you have me. . . . I'm ready to—I feel like you want me. Like you're important. . . . So I'm going to try to take you on. In that way, I accept you. (44:47-45:19)

C has gone from being unconscious of the killer, to fighting him in a life and death struggle, to accepting the challenge of her relationship with him. In process terminology, C has made the transition from an identification with her real body (experiencing herself as the victim of her symptoms), to an identification with her dreambody (the symptom creator), until now she is beginning to identify with her myth body (in which she recognizes and accepts the deeper purpose of her life). These transitions through the experiential bodies will be considered at greater length in Chapter 7.

Drawing the Killer

As mentioned previously, T's final suggestion to C to use her visual channel was for her to draw the killer. From 45:48 to 48:32, C draws the killer, and from 48:34 to 49:00, the picture is shown to the group members. This is a critical stage in the integration process.

(T remarks that the figure is *Zackig* looking. The dictionary translates *Zackig* as "jagged." It also has the connotation of angular, as in *Zackig Schreiben*, meaning to write in an angular fashion.)

When C completes the drawing, she can finally see the face and body of the killer. (Recall C's statement at 39:17 when she could see the nature of the killer, but not his face.) This is her most complete use yet of her visual channel, and two things happen as a result.

First, by looking at the picture, C is able to observe and talk about her process from an even more objective perspective than before. When C looks up at T (49:06), it is the first time she has made strong eye contact since T and C began their second attempt to process the sore point on C's sternum. C says, "The problem is you can't tie up your lifetime against a figure like that. You have to believe that it is something that is very real and not fight against it, but jump in with it and then you can fight with it. The deeper meaning is you can't push these things away forever." C is now more fully identified with the myth body, and is able to recognize and describe the deeper meaning of her experiences with the killer. This is what C was seeking at 3:13 when she remarked ". . . I feel lately like I've been looking for something deeper in my life."

From a structural perspective it is appropriate that C used kinesthetic terminology to describe her insights. At the beginning of the session, C used kinesthetic terminology to describe her wish to change, first when she said that she was "always trying to get more room" (0:11), and then when she said that she needed "a new direction" and to "move out of something" (3:52). Her pattern has been to "fight against" the killer, to push him away, at first unconsciously in her life, and then overtly in this session.

If we remember C's process structure at the beginning of the session, both proprioception and kinesthesia were unoccupied, with proprioception the least occupied of the two. Her behavior in the session shows that she was more comfortable occupying kinesthesia (recall her active embodiment of the killer, and her aggressive defense against T in the second role playing sequence). It was only after she had expressed herself though kinesthesia that she was able to return to proprioception and feel more deeply.

C needed to occupy kinesthesia, but that could only take her so far. Eventually she had to occupy her least occupied channel, proprioception. It was only when she allowed the killer fully inside (when she "jumped in with it"), felt her reactions completely, and expressed them congruently, that her relationship with the killer was transformed.

The second consequence of C's looking at the drawing is that she realizes the killer is a missing figure in one of her childhood dreams.

The Childhood Dream

At 50:20, while looking at her drawing, C says, "It's like a missing figure in my childhood dream—one of my childhood dreams. In one of my childhood dreams there is this kindergarten girl who is locked up in the bowels of the earth. And there are all these boulders. And I just recently found out who she was locked up by. I forgot that part of the dream when I was younger. She was always alone. And it was, like, this giant. And I could only hear him. I was terrified of him."

According to the hypothesis being tested in this dissertation, the fact that C has remembered this dream should be understandable in terms

of the process structure of the session. I shall attempt to determine whether this is true by using as a starting point a comparison of the process structure of the childhood dream and C's process structure at the beginning of the session.

As mentioned earlier in this chapter, the process structure of the first few minutes of the session theoretically reveals the process structure of the whole session. If this is true, then there should be a structural relationship between the beginning of the session and the dream which is remembered near the end of the session. In addition, process theory maintains that childhood dreams can anticipate future forms of the personality, appearing in adulthood in various forms, including as chronic body symptoms. If this theory is true, then the childhood dream should be acting as a kind of blueprint for C in this session, so that there should be a structural relationship between the dream and, not only the beginning of the session, but the session as a whole.

There are several ways of comparing the childhood dream and the structure of the session. The first is to determine whether C's chronic symptoms early in the session are an indication of the presence or influence of the childhood dream. The second is to compare the process structure of the dream to the process structure of the session in terms of three structural elements: C's primary and secondary process, her channel structure, and the dream figures.

C's Chronic Symptoms as an Indication of the Childhood Dream

The first symptom that C mentions is the pain in her chest. Initially we discovered that this was the place C felt she was being knifed by the

killer. Considering proprioception in light of the childhood dream, the painful point in her chest (0:11) can now be understood to be the childhood monster's point of contact with C.

C's chronic experience of not having enough room (0:11) and of "trying to move out of something" (3:52) makes sense when we realize that she is still carrying the experience of being confined in the bowels of the earth. The movements she makes with her arms in an attempt to get more room (0:11), previously understood to be in relation to the killer, can now be seen as also being in relation to the giant in the childhood dream.

Finally, when C says that she is "looking for something deeper" in her life (3:13), there may be more to this phrase than the previously offered interpretation that she is looking for a feeling. C's phrase may be a reference to the fact that in the childhood dream she is locked in the bowels of the earth, a place that is metaphorically deeper than sitting on the floor of a room. From this perspective, the something deeper that C said she was seeking may not have been just a feeling, but also a point of reference, that is, she was seeking a feeling she had while in the bowels of the earth.

In sum, these signals clearly indicate the influence of the childhood dream. At the beginning of the session, C is not just describing her momentary condition; she is also describing proprioceptive and kinesthetic experiences which have their origin in her childhood.

Primary Process

C's primary process in the childhood dream is that of a fearful, confined child. What is secondary for her is the aspect of her dreambody

that is confining her and causing her fear, that is, the giant. See Figure 10 for a schematic comparison of C's primary and secondary process in the childhood dream and at the beginning of the session.

The structure of C's primary and secondary process in the childhood dream and at the beginning of the session are virtually identical. C's primary process in both the childhood dream and at the beginning of the session is to be experiencing pain and constriction. Her secondary process in both cases is the dream figure who is constricting her and causing the pain. In the childhood dream this figure is the giant, while in the session the figure is the killer.

The only difference is in C's primary process at the beginning of the session when she mentions that she is looking for something deeper. This is C's way of describing her intention to become more aware. C does not know it at the time, but she is unconsciously expressing her intent to reconnect with the childhood dream. A more signal-based explanation would be that C's primary process is responding to signals sent by her dreambody through the proprioceptive and kinesthetic channels.

Channel Structure

Channel structure is the next factor to consider in comparing the process structure of the childhood dream and that of the psychotherapy session.

Thus far we have seen that C's chronic symptoms indicate the influence of her childhood dream, and that her primary and secondary process early in the session and in the childhood dream are

Childhood Dream

Primary Process	Secondary Process
fearful, confined child	fear-causing, confining giant

Beginning of the Session

Primary Process	Secondary Process
pain in chest; lack of room; looking for something deeper	pain-giver; constrictor

Figure 10. C's primary and secondary process in the childhood dream and at the beginning of the session

structurally nearly identical. Clearly C is being influenced by her childhood dream, but without the awareness that this is occurring. What is it that keeps her from being aware of the dreaming process? The answer lies in C's symptoms (pain and constriction) and the channels in which they appear (proprioception and kinesthesia, respectively).

Analyzing the channel structure of the childhood dream we see that C has three occupied channels: proprioception, audition, and vision. Her proprioceptive channel is occupied because C says she felt terrified, her auditory channel is occupied because she can hear the giant, and her visual channel is occupied because she is aware of the boulders. It appears that proprioception is more occupied than audition because simply hearing the giant is a more passive description than feeling terrified. Vision may be the least occupied of these three channels because C says "there are all these boulders," which is a relatively passive way of saying that she sees boulders.

Kinesthesia is the one channel that C is not occupying. This is because she is "locked up in the bowels of the earth."

See Figure 11 for a schematic representation of the channel structure of the childhood dream.

At the beginning of the session, C was occupying her visual and auditory channels, while proprioception and kinesthesia were unoccupied. Figure 11 also displays C's channel structure at the beginning of the session.

Childhood Dream

Occupied Channels	Unoccupied Channels
Proprioception	Kinesthesia
Auditory	
Visual	

Beginning of the Session

Occupied Channels	Unoccupied Channels
Visual	Proprioception
Auditory	Kinesthesia

Figure 11. C's channel structure in the childhood dream and at the beginning of the session.

Comparing the channel structure of the childhood dream with C's channel structure at the beginning of the session we arrive at the following:

	AUDITORY	VISUAL	KINESTHESIA	PROPRIOCEPTION
DREAM	occupied	occupied	unoccupied	occupied
SESSION	occupied	occupied	unoccupied	unoccupied

As mentioned in the beginning of the chapter, the process structure in the first minute of the session showed that if C was to learn about her symptoms—and about the dreaming process that underlay them—she would have to do so via her unoccupied proprioceptive and kinesthetic channels. At that early juncture, proprioception appeared to be C's least occupied channel, and thus the one that would convey the most critical information for her development. The unfolding of the session has born out this prediction.

Now let us see whether what has occurred in the session makes sense in light of a comparison of the channel structure of the dream and the first minute of the session.

As the chart above shows, three of the four channels are structurally similar in the dream and the session. C is occupying her auditory and visual channels in both the dream and the session, and she is not occupying kinesthesia in either one.

The key structural difference between the dream and the session is in the proprioceptive channel. C's experiences in this channel are reversed:

in the childhood dream, proprioception is occupied, while at the beginning of the session, C's proprioception is unoccupied. This contrast is even stronger when considering that proprioception appears to be C's most occupied channel in the dream and her least occupied channel in the session.

This comparison underscores the role of proprioception as the most critical channel for C. The principal reason that C is not aware of the influence of the childhood dream throughout most of the session is that her primary process, which is relying mainly on her visual channel, has its strongest edge against proprioception. Since proprioception is an essential element of the childhood dream, it is no accident that the dream was so secondary for C. It is only by occupying proprioception that C can access the experience of the childhood dream.

The other key channel is kinesthesia, which C does not occupy either in the dream or the session. C accomplishes several things when she occupies her movement channel. It is by occupying this channel that C becomes more aware of the killer, initially by becoming the killer, and then by fighting with him in the second role-playing sequence.

As mentioned earlier, according to process theory, C's arm movements at 0:11 are occurring in relation to an unseen dream figure who is confining her. At one point in the session (the second role playing sequence), C makes these arm movements in relation to the killer. C's primary process is trying to have enough room in relation to her secondary process, represented by the killer. It is only when C remembers her

childhood dream that we understand the true nature of the constricting process: she has been locked in the bowels of the earth by a giant.

In addition, it is through her encounter with the killer that C becomes aware that she is in a life and death struggle. The impact of this realization is probably a proprioceptive experience as well as a kinesthetic one, and may subsequently have helped C to more fully occupy proprioception.

This raises the issue that, although I have generally referred to them as separate processes, proprioception and kinesthesia are, in fact, intimately related for C. For example, in the sequence called "The Amplification of C's Primary Process," T helps C to occupy what I have labeled proprioception by amplifying C's subtle movements. The solution she finds in her encounter with the killer may be largely proprioception, but also includes kinesthetic elements. Ultimately, C needed to occupy both of these channels in order to access the childhood dream

Finally, from a structural perspective, it makes sense that when C begins to work on her unoccupied channels, she stops accessing information through her visual channel. Evidence of this is that she keeps her eyes closed during most of the session, only opening them when she stands up while playing the role of the killer (18:34), in the second role-playing sequence, and then finally when she describes the deeper meaning of her relationship with the killer (49:06).

Dream Figures

From a structural perspective, the killer and the giant are, for all intents and purposes, virtually identical.

First, the killer and the giant are each secondary figures, relatively far removed from C's primary process, so that C only knew about them indirectly. C was unaware of the killer until the session, and the only clues she had of his existence were her symptoms. C had forgotten for a number of years that there was a giant in her childhood dream, and even when she remembered, she could only hear him, not see him. (The fact that C had remembered the giant prior to the session can be seen as a step toward an increased awareness of the role that the childhood dream was playing in her life.)

Second, as mentioned in the analysis of C's primary and secondary process, the killer and the giant each had the effect of creating strong proprioception and kinesthetic experiences (i.e., terror and pain in proprioception, and constriction in kinesthesia).

Third, neither the killer nor the giant is human. This is probably why T refers to the killer as a "mythological figure" (31:39), and it underscores the impersonal or transpersonal nature of C's relationship with these figures. (This will be discussed at greater length in Chapter 7.) In process theory, C's relationship with the giant in the dream is not considered to be an aspect of the relationship channel because the giant does not exist out in the "real" world, apart from C's imagination. The same is true of C's relationship with the killer during the session. In either case she is having a relationship experience, but not a relationship channel experience. These are examples of what Mindell refers to as introverted relating: "Introverted relating appears in dreams where one

feels badly or is dealing with a dream figure in an inappropriate manner" (Mindell, 1985a, p. 21)

Fourth, initially neither the killer nor the giant were accessible through C's visual channel. When C does draw the killer, she realizes that he looks like the giant in her childhood dream. Thus, the appearance and identity of the killer and the giant are, for practical purposes, nearly identical.

To summarize, the key to C's development was to occupy proprioception, which was occupied in the dream but not in the beginning of the session, and kinesthesia, which was not occupied in the dream or the beginning of the session. C partly occupies proprioception when T and C amplify the pain point. Then she occupies kinesthesia, first by becoming the killer, and then by encountering the killer. She then returns to proprioception and occupies this channel more completely.

At this point, having occupied both proprioception and kinesthesia, C was able to represent her experiences in these channels through her main visual channel by making the drawing. It was only then that C was able to connect the killer and the giant, which enabled her to remember her childhood dream and relate it to her current experiences and symptoms. As the process structure indicates, the dream was in the background, patterning her experience in the session, but C only became aware of this when she could access it through her main channel.

Conclusion. The Angular Movements

From 51:30 to 51:50, T tells C that all his arthritic patients make drawings like hers, that is, that they have the same zackig quality in their bones that is in her drawing.

C responds (52:02) by saying "That's what I feel my experience is though—is very much like this" (making a slashing motion with her right arm, then her left arm). And a few seconds later (52:12), she says, "And I feel over the years, my body has become very angular. And like this: (making direct, angular movements with her arms). I only enjoy making movements like that."

C identifies with being angular, so at the moment, this is her primary process. She contrasts angularity with being rounded: "I feel like I should be more rounded" (making soft, curving movements with her arms), so to be rounded is a secondary process.

"Angularity and roundness" is another way of characterizing C's primary and secondary process at the beginning of the session. Angularity corresponds to her secondary process of being the killer and making sharp movements such as the knifing motion, while roundness corresponds to her primary process of being sensitive and in pain. At the end of the session, though, C is identifying more with the angular killer process; whereas, at the beginning of the session she was identifying more with her roundness process.

There are several possible explanations for this. The simplest is to say that processes are fluid, so that what is primary in one moment may be secondary the next. C's identification with her angular and round

processes changes at various points during the session, and this is another instance of such a shift.

Another, somewhat more involved explanation is suggested by the fact that C is not only identifying with the angularity but saying that it is normal for her to do so. It is possible that C's usual primary process is to be angular, in which case she has been unconsciously identifying with and integrating the killer's quality of directness. In that case roundness would be her usual secondary process. If this were true, then C's tendency to identify with the angularity would force her secondary process to accentuate her symptoms so that she would have to pay attention to her pain. Perhaps this is what happened prior to the session, so that she was more identified with pain (or roundness) than with angularity when the session began. This may be why C became the killer before she fully amplified her pain; it was easier for C to go over her kinesthetic edge to be angular than her proprioceptive edge to be in pain.

The session concludes (52:43) with T saying that "They (meaning the dream figures) take over after a while." He is referring to his own experience, and to his observation that C has been signaling the presence of the killer/giant both by referring to and by demonstrating her proclivity for angular movements.

Results of the Follow-up Interview

The purpose of this section is to compare the information gathered in the follow-up interview with the data contained in and interpretations generated by the videotape transcript. The interview took place in Waldport, Oregon, in October, 1990, approximately 4 1/2 years after the

original psychotherapy session, and is reproduced in its entirety in Appendix B.

The most relevant information from the interview falls into the following categories: chronicity of C's symptoms, the amount of time that elapsed during the interruption of the taping, the nature of the interaction between T and C after the interruption in the tape, the childhood dream, and the integration process.

When asked about the chronicity of her symptoms, C says that she has always associated a lack of stamina with her chest area, that she remembers wanting more room and noticing the sore point in her chest in her early 20s, and that her shoulders have always been a little rounded forward as long as she can remember. From the perspective of Process-Oriented Psychology, the chronicity of these symptoms would go along with their association with a childhood dream. Process theory maintains that recent body symptoms tend to correspond to the dreams of the past few days, while chronic body symptoms are usually associated with older dreams.

It is interesting to note that in the interview, C describes her shoulders as being "rounded" forward. This points to another instance of the "angularity and roundness" theme mentioned above. In her first statement (0:11), C mentions two chronic symptoms: a "constriction" which she demonstrates by accentuating the roundness of her shoulders, and the need to get more room, which she illustrates by swinging her arms in a linear, forward-and-back, angular motion. This is an example of how

the contrasting qualities of angularity and roundness are making themselves felt in C's experience of her body.

As I have quoted previously, when asked about the amount of time that elapsed during the interruption of the taping, C said, "In some ways it doesn't seem like a broken tape to me. It doesn't look like you missed too much."

When asked about the interaction between T and C after the interruption in the videotape, C reviewed the transcript and said,

> It seems like he's challenging me, trying to deal with me by challenging me. And it looks like we see that that intervention isn't the one that's going to work. This is what I think: he's imagining that I need to pick up this power (19:07) to defend myself, but that's not going to be the way to work with this figure.

C's opinion supports my interpretation that T began acting like the killer in an attempt to provoke C to amplify her own killer-like behavior.

C revealed that the childhood dream was a repetitive nightmare, which she dreamt between the ages of 5 or 6 until approximately 14. She recounted the dream as follows:

> It was a repeated nightmare of a little girl, a kindergarten girl, and she was locked up in the bowels of the earth. It was mostly a feeling. Very isolated, down under the ground. And I would hear the footsteps of this giant. And there were a lot of boulders.

An analysis of the process structure indicates that this account of the childhood dream is similar in most respects to the version C provided during the psychotherapy session. Proprioception is the most occupied channel because C emphasizes that the dream was "mostly a feeling." Audition is occupied because she can hear the giant. Vision is occupied

because C mentions the boulders. Kinesthesia is unoccupied because she is locked up in the bowels of the earth.

The one significant difference is that in the interview, C emphasized that it was "very isolated, down under the ground." In this version, then, it appears that C's relationships with others were important, and that because she was very isolated, she was not occupying her relationship channel.

The difference between the two versions of the childhood dream underscores the point that there are many, many lessons to be learned from such an important dream. A slightly different version will emphasize a different lesson that must be learned, and sometimes, as in this case, the lesson is in a different channel. As C remarked during the interview:

> Well, every time I find my childhood dream and chronic symptoms are fluid things. So whenever I work on them I always understand something more. It's not like I have one particular breakthrough and then I've understood the dream. I always feel there is always a lot more that I can learn from it. Once it will be important learning about the little girl part of the dream and other times about the giant, and other times about the relationships, and different channels.

When asked about the angular movements, C said, "I enjoy those movements, those angular movements. Actually I think I have integrated it, like a Zen master. I mean I feel like I have that inside of me. I can be very direct now. And in my practice, I can go to what's important. Part of me is like a no-nonsense kind of person. Really direct. This contributes to our understanding of what it means for C to be "angular." In addition to being a quality of movement, it also refers to C's ability to relate to

people in a very direct, no-nonsense manner. Like the killer, C is learning to have a direct and powerful impact on people.

C adds that now she has an edge against being round. Her statements would tend to support the speculation that angularity is more often her primary process than is her process of being sensitive and "rounded," so that she has been working more deliberately to integrate the angularity and now is trying to go over her bigger edge to develop her roundness.

CHAPTER VII

SUMMARY, ANALYSIS, AND IMPLICATIONS

Summary of the Purpose and Hypothesis

According to Process-Oriented Psychology, childhood dreams reveal fundamental life patterns or life myths. These fundamental patterns may manifest in adulthood in a variety of ways, including as chronic body symptoms.

One of the tenets of Process-Oriented Psychology is that there is a process structure to all experience, including childhood dreams and chronic body symptoms. In Process theory, this structure has been classified in terms of an individual's primary and secondary process, occupied and unoccupied channels, edges, and dream figures.

One way of testing this theory is to study a psychotherapy session, conducted in accord with the principles and methods of Process-Oriented Psychology, in which the client works on both a chronic body symptom and a childhood dream. According to process theory, the childhood dream and the chronic body symptom should have structural correspondence in terms of the client's primary and secondary processes, occupied and unoccupied channels, edges, and dream figures. This is the research hypothesis, and the purpose of this study was to examine its validity.

Summary of Findings, Interpretation and Literature Support

In this section I analyze the case study, the follow-up interview, and the literature in an attempt to:

1. Determine whether the case study confirms or refutes the hypothesis;

2. Evaluate the accuracy of the predictions made by Process-Oriented Psychology about the case study; and

3. Discuss the theoretical implications of the confirmation or refutation of the hypothesis.

Evaluation of the Hypothesis: The Structural Relationship Between the Chronic Body Symptoms and the Childhood Dream

As described in Chapter 6, an analysis of the process structure of the case study revealed a number of relationships between C's chronic body symptoms and her childhood dream.

C described two chronic body symptoms in the beginning of the session: a pain in her chest and a sense of not having enough room. The painful place in her chest was first seen to be the knifer/killer's point of contact with C. When C remembered the childhood dream, a more fundamental pattern was revealed, and we saw that the painful place in her chest, the focus of her unoccupied proprioception at the beginning of the session, was actually the dream giant's point of contact with her.

The same interpretation is possible in reference to C's chronic experience of not having enough room (0:11) and of ". . . trying to move out of something" (3:52). At first these movements can be understood as being in relation to the killer, but when C remembered the childhood dream, it

was clear she did not have enough room because she was still cycling in the experience of being confined in the bowels of the earth, and the arm movements were being made in relation to the giant who confined her.

An analysis of C's primary and secondary process also revealed a structural relationship between the childhood dream and C's process structure in the beginning of the session. Her primary process in the childhood dream and the beginning of the session was to be experiencing pain and constriction, and in both cases her secondary process was the dream figure who was constricting her (the giant and the killer, respectively).

A comparison of the channel structure of the childhood dream and the beginning of the session showed that C was occupying her auditory and visual channels in both the dream and the session, and that she was not occupying kinesthesia in either one. The only difference was in proprioception, which was C's most occupied channel in her childhood dream and her least occupied channel in the beginning of the session.

This meant that C's proprioceptive experiences were the key for her to re-access her childhood dream. The inherent difficulty in doing this was that C's primary process in the beginning of the session, which was relying mainly on her visual channel, had its biggest edge against or resistance to proprioception. From a structural perspective it was no coincidence that C's childhood dream was so secondary for her, since some of the key information about the dream was carried in a channel that was relatively foreign to her primary process.

Because it was not occupied either in the dream or the beginning of the session, the other important channel for C was kinesthesia. Occupying this channel brought her into relation with the killer. In the beginning of the session, C made specific arm movements in an attempt to have more room, and in the second role playing sequence she made similar movements in relation to the killer. When C remembered her childhood dream, we understand that the experience of being confined had its origins in the dream experience of being locked in the bowels of the earth.

The figures who were doing the confining—the killer and the giant—were structurally virtually identical, insofar as neither was human, both created strong proprioceptive and kinesthetic experiences, both were secondary figures for C, and neither was accessible through C's visual channel.

This analysis clearly indicates that there is a correspondence between C's childhood dream and her chronic symptoms in terms of each of the elements of the process structure. C's primary and secondary process, her occupied and unoccupied channels, her dream figures, and the way in which she experienced her chronic body symptoms are evidence that the childhood dream was in the background patterning her experiences in this session. C's body symptoms are evidence of her childhood dream, but it is only when she processes the symptoms completely that she becomes aware of the dreaming process.

To summarize, the case analysis clearly shows that there is a structural correspondence between the body symptom and the childhood

dream in C's psychotherapy session. Thus the case study confirms the research hypothesis.

The Accuracy of the Predictions Made by Process-Oriented Psychology

Chapter 4 lists six predictions made by Process-Oriented Psychology in reference to C's process structure.

Prediction Number 1

The first and most fundamental prediction was that there would, in fact, be such a structure consisting of C's primary and secondary process, occupied and unoccupied channels, edges, and dream figures. From the analysis that follows, it is evident that the prediction is supported.

Prediction Number 2

The second prediction was that it is often possible to determine a client's process structure within the first few minutes of the session. This was true in this case study. After C's initial remarks (0:11), T could have deduced the following information about her process structure: that her primary process was to be the victim of chest pain and constriction, while her secondary process was to be pain-giver and constrictor; and that she was occupying her auditory channel, while proprioception and kinesthesia were unoccupied. T then tried to determine C's main channel, and by (1:28) he knew that it was vision.

It is interesting to note that Pittenger, Hockett, and Danehy (1960) demonstrated that a detailed analysis of the first 5 minutes of a psychotherapy session revealed information about the presenting complaint, the diagnosis, and the prognosis.

Prediction Number 3

The third prediction of process theory was that knowledge of C's process structure early in the session would allow T to make predictions about (a) the channel(s) in which C would access the information she needed in order to learn about her symptoms, and (b) the channel(s) which would be most important to C as she attempted to integrate the new material.

Regarding (a), in this case T could have predicted that the information that C needed in order to learn about her body symptoms would be experienced in her two unoccupied channels, proprioception and kinesthesia. Since proprioception appeared to be somewhat less occupied than kinesthesia, the most critical information or experience could be predicted to occur in proprioception. These predictions matched what happened in the session. The events most critical for C's development were that she occupied kinesthesia by becoming and then encountering the killer, and that she occupied proprioception to some extent in the initial sequence of amplifying the pain and then more completely in the sequence that began at 25:48. Proprioception was the most difficult channel for C to occupy, and doing so was the final step in learning how to deal with the killer.

Regarding (b), the other prediction that T could have made based on C's process structure in the beginning of the session was that C's main channel would be of vital importance in order for her to integrate the information obtained through the unoccupied channels. This process, as described in Chapter 6 (in the sections on "using C's main channel to foster

integration" and "drawing the killer"), was, in fact, a critical stage in C's development during the session.

It is important to note that Mindell maintains that there are certain limits as to what can be predicted in terms of C's primary and secondary process and her channels. As he wrote,

> The maximum amount of information which we can give someone about their process involves the channel in which they are functioning, the probable new channels which may open up, and the patterns of their present behavior in terms of primary and secondary phenomena.
>
> That which cannot be fathomed in terms of . . . the channels or their opposites, is, according to the *I Ching*, the 'spirit.' . . . . The 'spirit' is the unfathomable aspect of process work. It is the speed and exact form of future processes, the moment when channel changes occur, or when total awareness of the Tao will happen. Thus processes contain an uncertainty principle which implies that their predictability is limited. We cannot guess when or exactly how things will manifest. (1985a, p. 98)

Thus, T could predict the role to be played by the visual, proprioceptive, and kinesthetic channels, but he could not say exactly when the experiences would occur or the exact form they would take.

Prediction Number 4

The fourth prediction of Process-Oriented Psychology was that there might be one or more dream figures in the background who cause unoccupied channel experiences. The first indication that C had such a figure was when she talked about feeling constricted and then made her arm movements (0:11). As mentioned in Chapter 6, from process theory we would hypothesize that C made these movements in relation to a dream figure who was confining her, and this proved to be the case.

Prediction Number 5

The fifth prediction was that there are three possible outcomes when a process is amplified: the client may change channels, reach an edge, or de-escalate. All three of these outcomes occurred in the session. C changed channels from proprioception to kinesthesia at 13:21 when she made a fist and raised her arm. She reached an edge a number of times during the session, most noticeably when she was attempting to take over the role of the killer. And she de-escalated when she went through the tensing and relaxing sequence beginning at 27:31.

Prediction Number 6

The sixth and final prediction was that as C's perspective changed, her experience of her chronic body symptoms would also change.

As described in Appendix C, Section 2, Process-Oriented Psychology is in accord with the view of modern physics that the observer's psychology affects that which is observed. Mindell has applied this principle to the individual's subjective awareness of the body, and has differentiated four different "bodies of experience" (see Figure 12).

One of the implications of Mindell's theory is that, experientally speaking, the idea of health varies according to the psychology of the observer. In other words, as the subjective experience of one's body changes, so does one's relationship to body symptoms.

This theory accurately describes the stages C went through during the psychotherapy session.

At the beginning of the session, when C describe her chronic body symptoms, she was experiencing what Mindell refers to as the "real body."

	REAL BODY	DREAM-BODY	MYTH-BODY	IMMORTAL BODY
Imagery	the body	recent dream figure	big dream or saga	etheric body
First body description	upset	symptom	nothing unless aided	distant feeling
Processed body experience	victim	creator of symp-tom, no pain	sense of purpose, no pain	freedom, wholeness, completeness

Figure 12. Body Experience Spectrum

(Mindell, 1989a, p. 90)

The real body is the way a person's primary process experiences the body. C's case is typical, insofar as she experienced her body symptoms as intrusions upon her primary process. From an experiential standpoint she felt as though she was the victim of the symptoms, which is why Mindell also uses the term "victim body" as one which is synonymous with "real body."

C's experience of her body changed as the session proceeded. By becoming the killer (sequence 15:19 to 19:02), C identified with the secondary process that was creating her symptom (in this case the sore point in her chest). According to Mindell's schema, at this juncture C was experiencing herself as the dreambody. The dreambody is generally first experienced as an intrusion on the real body and is noticed as one or more symptoms.

What is important to note here is that by identifying with the symptom creator, C's experience of her body changed. She was no longer the victim of her secondary process, and, as a consequence, was not complaining about and may well not have been feeling pain in the point on her chest. We do not know for certain that C did not feel the pain because T did not ask about and C did not volunteer this information. However, she was certainly not acting like the victim of her symptom, and, as mentioned in Chapter 7, one interpretation of the "missing point" is that playing the role of the symptom creator may have changed the nature of the symptom.

C began her shift toward a mythbody experience when she said to the killer, "I love you. I love you" (36:48). Her identification became stronger when she said that she accepted her relationship with the killer (44:47),

and another significant stage was when she had drawn the killer and could see what he looked like. At this point, when C spoke about the deeper meaning of her struggle (49:06), she was not experiencing pain and she had identified a sense of purpose. These are the qualities of the mythbody experience.

In addition to C's report of her subjective experience, there were two other indications that this was a mythbody experience. The first indication was the nature of the pain point that C felt in the beginning of the session. According to Mindell, the body feelings that are associated with the mythbody are usually outside of the individual's awareness. In the follow-up interview, C said that the point on her chest was "something that you'd only really discover through touching it." In other words, as a rule, the point was below the threshold of her awareness, and it was only when she pressed on it directly that she became aware that it hurt.

The other indication that C was having a mythbody experience was the childhood dream itself. In a personal communication, Mindell wrote that

> Dreams to which we have no personal association, to which we can not connect in our everyday life, are mythbody dreams, they are far from consciousness. Usually, elements of our childhood dreams are mythbody experiences, especially if we can find no particular relationship to those elements or dream figures.

This is an accurate description of C's childhood dream. Although the dream was influencing C's experiences, it was far from her consciousness because she was completely unaware that the dream was having this kind of an impact on her. It seems fair to say that C had "no particular

relationship" to the giant in her dream, since she would have no personal associations to him because he was not someone she had met in "real" life.

Through her experiences in this session, C moved closer to an identification with what Mindell calls the *immortal body*.

> The immortal self is the Self, the larger personality behind our dream and mythbodies. Our ordinary and mythical dreams, symptoms, and trance states are all aspects of this larger personality, what Jung would have called the Self. This is our wisdom center, the greater being behind the personal one. The more we become our total selves, the more we come to resemble this figure, the more it becomes our double. (Mindell, 1989a, p. 93)

By the end of the session C is no longer completely identified with the concerns of the moment or with a purely personal focus. She is identified, instead, with a much larger sense of her Self.

Results of the Six Predictions

To summarize, analysis of the case study indicates that each of the predictions made by process theory was accurate. C's process was understandable in terms of her primary and secondary process, occupied and unoccupied channels, edges, and dream figures. This structure was evident within the first several minutes of the session, and made it possible to predict that (a) C would learn the most about her symptoms from proprioception and kinesthesia, her unoccupied channels, and (b) that vision would be the most important channel for C as she attempted to integrate the new material. C's unoccupied channel experiences did involve dream figures, that is, the killer and the giant. The three predicted outcomes of amplification—reaching an edge, changing channels, or de-escalation—all occurred in the session. And, finally, as C's perspective

changed (from victim to killer, and so forth), her experience of her chronic body symptoms also appeared to change.

Theoretical Implications of the Relationship Between the Childhood Dream and the Chronic Body Symptoms

As noted above, the analysis of the case study supports the hypothesis that there is a structural relationship between C's childhood dream and her chronic body symptoms. In this section, I discuss the theoretical implications of this finding by focusing on possible explanations for the relationship between the dream and body symptoms.

Process-Oriented Psychology describes the relationship between childhood dreams and chronic body symptoms in three different ways: from a unitary perspective, as a developmental issue, and as a field phenomenon.

The Unitary Explanation

As described in Appendix C, Section 2, recent developments in the field of physics describe the universe as an indivisible whole in which the notion of separate parts is illusory. Process-Oriented Psychology subscribes to this viewpoint, maintaining that there is an underlying process that relates all events which is more fundamental than the events themselves. As this process manifests, it does so in the form of patterns, and a key task of the Process-Oriented therapist is to discern such patterns.

From the unitary perspective, a childhood dream and a chronic body symptom are not separate phenomena. They only appear to be separate so long as we fail to perceive the fundamental pattern or process which links

them together. Mindell addressed this issue when he wrote: "In process work there is no connection between dreams and body phenomena, since both are two aspects, two channels of the same process which is trying to unfold" (Personal Communication, January 9, 1990).

There is evidence to support the unitary perspective in the case study as well as the literature review of dreams and illness.

At first glance C's childhood dream and her chronic body symptoms appeared to be separate phenomena, but a deeper analysis demonstrated that they were clearly linked through the process structure. The dream and the body symptoms were conveying the same information, albeit through different channels. Thus, they were united by both being expressions of the same pattern or process.

Support for the unitary explanation also comes from the literature review on dreams and illness. The review indicated that, as a general phenomenon, dreams and illness often appear to be manifestations of the same underlying process. In addition, several references were cited that specifically connected childhood dreams and illness developed later in life. Once again, in these latter studies the dream and body symptom appeared in different channels but conveyed the same information.

The Development of Chronic Body Symptoms from Childhood Dreams

Process-Oriented Psychology maintains that childhood dreams may develop into physical symptoms because there is some aspect of the dream that is incompatible with the waking personality.

Using the case study as an example, the etiology can be theorized to proceed in this manner: as a child, C dreamt a "far-seeing" dream that contained important information about her character and potential. Faced with the need to adapt to the external world, she developed a personality that allowed her to cope with daily challenges. As she developed, her personality did not fully take into account or integrate the information conveyed by the childhood dream. As time passed, and C relied increasingly on her visual channel, her primary process developed more and more of an edge against the, by now, secondary childhood dream material with its strong proprioceptive focus.

Although the information contained in the dream may not have been compatible with C's primary process, it did not cease to exist. Mindell wrote that "Edges which continue for long periods of time, develop into blocks and are associated with psychosomatic problems, apparently because information not consciously picked up is always re-routed through the body" (1987a, p. 182). This is an example of what Mindell calls the conservation of information.

Mindell believes that the body (or proprioceptive channel) is a likely conduit to hold or store the information because there is a cultural edge against feeling. He wrote that:

> The biggest problem I encounter is that people have not learned how to work with their feelings . . . our whole culture is against feeling too much pain. People have still not learned to love themselves, and they have to learn it, they must make a different relationship with themselves toward their bodies. There is no way around it. It's important to accept pain, to sit with it and feel it. (1985b, p. 33)

As noted above, C shared the cultural inhibition against occupying her proprioceptive channel.

According to this theory, as the years went by, the information about C's childhood dream began to broadcast its message from her proprioceptive channel. As she continued to ignore the signal or leave it unprocessed, it increased in strength, until finally it was broadcasting often enough and with enough strength that it became identified as a chronic physical symptom.

> The less aware you are of your dreambody, or the longer you avoid making changes that your body is asking of you, the more insistent your dreambody becomes. It is a self-amplifying system and continues stubbornly until the moment when you get seriously ill and are forced finally to heed its message . . . . (1985b, p. 69)

As was true in the case of C, the development of a chronic body symptom from a childhood dream can take many years.

The literature review of Dreams and Illness (Chapter 2) supports the developmental theory of Process-Oriented Psychology in several ways.

First, it is clear beyond any reasonable doubt that dreams can affect physiological processes. For example, the rapid eye-movement studies of gastric secretion rates (Armstrong et al., 1965), nocturnal angina pectoris (Nowlin et al., 1965), and asthma attacks (Ravenscroft & Hartmann, 1967) each showed that dreams have an immediate impact on physiological functioning. In addition, the impact of dreams on physiology appears to increase when the dream is recurrent. As noted in Chapter 2, recurrent dreams are associated by Sabini (1981) and Lockhart (1977) with cancer, by Epstein (1964, 1967) with epilepsy, by Lippman (1954) with migraines,

by Saul and Bernstein (1941) with migraines and hives, and by Levitan (1981) with susceptibility to psychosomatic illness.

These studies support the hypothesis that C's childhood dream could have had an immediate impact on her somatic processes, and that, through repetition, that impact could have become more pronounced.

The second aspect of Mindell's theory that finds support in the literature is the idea that an edge against proprioceptive experience can lead to the development of body symptoms. As mentioned in Chapter 2, Levitan (1978, 1980) observed that some people who become ill have difficulty recognizing and identifying with their feelings. He theorized that a diminished awareness of feelings delays the implementation of the defensive functions of the ego in dreams.

> It is postulated that the failure of the protagonists to fully perceive their own feelings played an important role in fostering the development of the traumatic events. Feelings such as anxiety and sadness are key signals which incite the ego of the dreamer to set protective operations into motion. The diminution of awareness of these feelings, may, therefore, delay the implementation of protective operations to a point which allows the traumatic events to progress dangerously far. (Levitan, 1978, p. 137)

In the terminology of Process-Oriented Psychology, what Levitan refers to as a diminished awareness of feeling would be called unoccupied proprioception. That is, the person would be feeling something, but the individual's ego (or primary process) would not be identifying with the feelings and could be completely unaware or unconscious of them. This is what is happening in Levitan's studies (1978, and especially 1980) in which a dream character other than the dreamer experiences strong feelings.

C's case differs slightly from those described by Levitan. In her childhood dream, C was the one who was having the strong proprioceptive experience, and it was only after she awoke that she did not want to identify with what she was feeling. The principle is the same, that is, that a reluctance to perceive feeling can lead to the development of physical symptoms.

Field Theory

A third way of describing the relationship between the childhood dream and the chronic body symptom is to say that each is a field phenomenon. This is similar to the unitary explanation insofar as both dream and body problem are considered to be symptomatic of a more fundamental process. The emphasis is upon systems theory, and the recognition that everyone is simultaneously an individual and a part of an encompassing system which includes family, community, nation, and the organic and inorganic world.

From this perspective, C's childhood dream, her personal myth, can be seen as an expression of the larger field of which she is a part.

> Personal myths are to people as magnetic fields are to individual metal filings. The overall collective field seems to me the essential thing. This field then moves us in individual ways, depending upon our personal characteristics. Nothing is either personal or collective; again the two are intertwined. Every development we think is personal, is for us, unconsciously satisfying the demands of the entire universe. (Mindell, Personal Communication, January 9, 1990)

So long as the condition persists in the field that gave rise to C's childhood dream, then there is still the need for C to develop in the way

the dream requires. Eventually it is a chronic body symptom that attracts C's attention, reminding her of the task at hand.

> The study of proprioceptive signals borders on medicine and parapsychology; symptoms are part of the total communication field . . . . A body symptom is a signal to the individual asking to be expressed to the collective. Thus, one way to see a body problem is as a collective dream, as a spirit in the field we live in. (Mindell, 1987b, p. 44)

C's body symptoms are a part of a collective process, for as C integrates the lessons that her symptoms are teaching her, she will begin to express herself in new ways. She will impact the field around her through the expression of her ideas and feelings, and she will be modeling this kind of behavior for others.

Theoretical Implications Summarized

From a unitary perspective, C's childhood dream and her chronic body symptoms are not separate phenomena, but are each reflections of a more fundamental process. From a developmental perspective, C's body symptoms may have resulted from an unwillingness to identify with and process the proprioceptive experiences of the childhood dream. And from the perspective of field theory, C's body symptoms are her individual expression of a collective process.

Each of these theories offer a plausible explanation for the structural relationship between C's childhood dream and her chronic body symptom. They point beyond the familiar but illusory separation of mind from body, past from present, and individual from world. And they remind us that, besides being a "problem," a symptom is also an opportunity to re-discover the complexity and inter-relatedness of life, and our place in it.

The Results in Perspective

There are a number of variables to consider when evaluating the results. These may be classified under two general headings: data gathering, and the impact of the research design on the interpretation of results.

Data Gathering

As I mentioned in Chapter 1, the mechanical aspects of the data gathering were limited by the quality of both the audio and visual portions of the videotape. Access to visual data was limited by the fact that there was only one camera recording the session, by the proximity and focus, and by the brief interruption in the filming. Access to audio data was limited in several instances by the clarity of the soundtrack, and by the interruption in the filming.

In addition, transcribing a videotape is an unavoidably subjective process. I followed a detailed procedure (described in Chapter 4) to transcribe the videotape, and had my results corroborated. However, it is all but impossible to incorporate all of the data available in a videotape in a transcription. For example, unlike Pittenger, Hockett, and Danehy (1960) in *The First Five Minutes*, I did not transcribe all of the paralinguistic sounds, such as changes in inflection and throat clearings. All researchers make decisions, both consciously and unconsciously, about what it important, and focus their attention accordingly. This was certainly true in this study.

The Impact of the Research Design on the Interpretation of Results

The case study research design severely limits the degree to which the findings can be generalized. Yin differentiated between analytic generalization and statistical generalization when he wrote:

> . . . case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes. In this sense, the case study, like the experiment, does not represent a "sample," and the investigator's goal is to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization). (Yin, 1984, p. 21)

Clearly the results of the case study cannot be generalized to include other client populations. The subject of the case study was a Caucasian female in her mid-20s with specific body symptoms. The further a subject deviates from these attributes, the less one can assume that the results of the case study are applicable.

The fact that Mindell was the therapist must also be taken into account. This was not simply a psychotherapy session conducted according to the principles and methods of Process-Oriented Psychology; instead it was a psychotherapy session conducted by the originator of Process-Oriented Psychology. There is no way of knowing whether another practitioner of Process-Oriented Psychology could have achieved the same results with this client.

In addition, the question remains as to whether Mindell or another Process-Oriented therapist could replicate these results with different client populations. There is anecdotal testimony that such replication has occurred, but these cases have not been the focus of a formal study.

In terms of expanding and generalizing theories (analytic generalization), the findings of the case study have implications for Process-Oriented Psychology, and for the way in which we view the relationship between dreams and body phenomena. The implications for Process-Oriented Psychology are outlined in the following section on Practical Implications, while the implications for dreambody theorizing are described in the preceding section on the Theoretical Implications of the Relationship Between the Childhood Dream and the Chronic Body Symptoms.

Practical Implications

The research in this dissertation has a number of practical implications.

The first practical implication concerns the field of health care. The typical attitude for a patient is to feel victimized by physical problems, particularly those problems that are chronic. And the common mind-set in much of the health-care community is to pathologize the patient, to view the symptom only as evidence of what has gone wrong and needs to be fixed.

The basis of the Process-Oriented approach is to regard all symptoms, including physical ones, as positive in the sense that they carry information which, if processed and integrated, furthers individuation. From the teleological perspective, a repeating pattern occurs for a reason, and that reason can lead us to an important understanding of who we are. The more chronic the pattern, the more it says about who we are. By assuming that the symptom is trying to tell us something, the patient

becomes an active, curious participant in a process of discovery rather than a re-active, depressed victim of a process of pathology. This is a positive attitude for any patient, and, as evidenced by the case study, can make it possible to access parts of ourselves that are essential for our development. A further practical implication is that discovering and acting on the meaning of the symptom may have a positive effect on the symptom itself.

To the extent that they shed light on persistent patterns of thought and behavior, both childhood dreams and chronic body problems address the deepest levels of meaning in an individual's life. I have referred to these persistent, deeply meaningful patterns as the 'life myth.' Processing a childhood dream or a chronic body symptom is a way of accessing the life myth, and could lead to making changes in seemingly intractable cycles of thought and behavior. Knowing this has practical value for anyone who is plagued by chronic patterns, and for therapists working with such clients.

This dissertation underscores the general importance of childhood dreams in accessing the life myth, as well as the specific teleological function they may serve in anticipating the subsequent development of chronic physical symptoms.

It was not my intention in this dissertation to try to prove the general validity of the theories of Process-Oriented Psychology. There are, however, a number of practical implications to psychotherapy in using this approach. The Process-Oriented approach gives the therapist a tool for analyzing the client's process structure and predicting (a) the channels that will be most important for the client's learning, (b) which channel is

most important for the integration of the new information, and (c) the kinds of behavior to expect when the client is at the edge of learning something new. Unlike most systems of psychotherapy, Process-Oriented Psychology easily shifts focus from body symptoms to dreams to movement processes, and so forth. Such a fluid and signal-specific approach allows the therapist to more closely track the client's experiences, which is an invaluable aid in providing treatment.

In the case study, Process-Oriented Psychology proved to be very effective in helping the client understand the psychodynamic underpinnings of her chronic physical symptoms. To the extent that this was valuable to the client, Process-Oriented Psychology has practical implications as a treatment modality. And finally, the process approach was very useful as an explanatory model insofar as it permitted a consistent and relatively complete description of the events of the psychotherapy session.

Suggestions for Further Research

A number of the authors cited in the literature review on dreams and illness have made attempts to correlate specific dream themes or images with specific body problems. Only one article, however, correlated themes from childhood dreams with illness that developed in adulthood (Lippman, 1954), so this remains an open area for research.

Another approach to investigating the relationship between childhood dreams and chronic body symptoms would be to interview in depth a number of people each of whom has some awareness of a dream and a body symptom. The interview could include questions such as at what age the person had the dream, whether the dream was recurrent, whether

there were any dream figures in the dream, and, if so, whether they were human. The results from such a survey could be generalized in a way that is not possible with the case study methodology.

In this dissertation, I deliberately focused on childhood dreams and excluded childhood memories. Jung and Mindell both mention that early (often the earliest) memories can also serve a prophetic, teleological function. Research could therefore be done on the relationship between childhood memories and chronic body problems that develop in adulthood.

An interesting theoretical study could relate Process-Oriented Psychology and chaos theory. Gleick has written that "To some physicists, chaos is a science of process, rather than state; of becoming rather than being . . . . It is a science of the global nature of systems" (1987, p. 5). This would also be an accurate description of Process-Oriented Psychology.

In chaos theory scientists from disciplines as diverse as mathematics, biology, chemistry, and physics have been investigating the irregular side of nature. They have looked beneath the apparent order described by the "laws" of nature and discovered that randomness is emerging from it, and then, when they looked further, the have discovered that the randomness has its own underlying order. This is closely aligned with the perspective of Process-Oriented Psychology. The apparent order corresponds to a person's primary process. The emerging disorder corresponds to the accidents, symptoms, synchronicities, and Freudian slips that a Process-Oriented therapist would take as indications of the client's secondary process. Finally, the process worker presumes that

there is a deeper, underlying order even in seemingly chaotic human behavior, and refers to it as the Tao, archetypes, or individuation. A thorough investigation of the parallels between chaos theory and Process-Oriented Psychology would lead to psychology being included in the disciplines listed above.

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APPENDIXES

APPENDIX A

TERMINOLOGY OF PROCESS-ORIENTED PSYCHOLOGY

TERMINOLOGY OF PROCESS-ORIENTED PSYCHOLOGY

AMPLIFICATION

Amplification refers to the various methods used to increase the strength of a signal in a given channel. Amplification increases awareness of the underlying process by accessing the information contained in the signal. The methods used to amplify a signal vary according to the client, the therapist and the channel.

CHANNEL

A channel is the way in which a signal is represented.

Signals may appear in a number of different channels. Each channel represents a different way of perceiving.

Process-Oriented Psychology recognizes four basic channels and two composite channels. The basic channels are vision, audition, proprioception, and kinesthesia, while the two composite channels are relationship and world.

The visual channel refers to any perception that is based on sight. The auditory channel refers to any information that is noticed as sound. Proprioception consists of internal body sensations such as pain, pleasure, temperature or pressure. Kinesthesia is the sense of movement or lack of movement of any part of the body.

The relationship channel is a composite channel which refers to experiences in which a familiar person is the central object of awareness. The world channel involves focus upon perceptions of unfamiliar people,

and upon collective groups of people such as community, country, and foreign nations. It also includes the individual's relationship to nature and to inorganic phenomena such as physical objects and the universe.

An individual may experience any channel either introvertedly or extravertedly, depending upon the nature of the signals.

See also **"main, occupied, and unoccupied channels."**

CONGRUENCE

Communication is congruent if all of the signals being sent simultaneously in the different channels convey the same meaning. If the signals convey different meanings, then the communication is incongruent.

CONSCIOUS AND UNCONSCIOUS

Conscious (or consciousness) refers to reflective awareness, that is, to those moments when an individual is not only aware of a process, but is also aware that he is aware. Consciousness implies the ability to metacommunicate, that is, to reflect upon or talk about one's experiences.

Unconsciousness refers to any process of which the individual is not conscious.

The **primary process** cannot be equated with being conscious, nor can the **secondary process** be equated with being unconscious. It is possible to be either conscious or unconscious of both primary and secondary processes.

DOUBLE SIGNAL

Double signaling occurs whenever someone simultaneously sends two **signals** with contradictory meanings. Generally the individual is aware of one of the messages and unaware of the other. The term double signal specifically refers to the message of which the person is unaware or with which he does not consciously identify. Such messages are related to a secondary process.

DREAM FIGURES

The concept of dream figures is a way of organizing and making sense of collections of signals over time. It is based on the observation that in many cases, signals, particularly secondary ones, appear to be generated by independently operating subsets of the personality. In Process-Oriented Psychology, these independent parts are referred to as dream figures. Dream figures act as though they have personalities of their own, with accompanying voice tones, expressions, postures, and so forth. Dream figures correspond to Jung's autonomous complexes.

EDGE

The edge is the boundary that separates the primary and secondary processes. The edge represents the limits of an individual's primary process identity, that is, the limit of who the individual imagines himself or herself to be and what theindividual imagines that he or she can do.

THE EXPERIENTIAL BODIES

Mindell has differentiated four experiential bodies.

At any given moment an individual is processing experiences in all of the channels. Typically people are identified with the experiences occurring in one or two channels.

The *real body* is the way in which a person's primary process experiences the body. The real body generally experiences body symptoms, such as pain or illness, as unwanted intrusions and a form of suffering. That is why the real body is often referred to as the *victim body.*

An individual who is identifying with the experiences occurring in most or all of the channels is experiencing the *dreambody.* The dreambody refers to the total personality as it exists simultaneously in any given moment in all of the channels. The dreambody is generally first experienced as an intrusion on the real body and is noticed as one or more symptoms.

The *mythbody* is the transpersonal dreambody. Experientially the feelings associated with the mythbody are generally below the threshold of the individual's awareness. Mythbody themes usually have more to do with personal myths than with the ongoing events of daily life.

The *immortal body* is experienced when an individual lives closer to his or her personal myth. The immortal body corresponds to what Jung called the Self. This is the total self, the encompassing sense of being that transcends identification with the concerns of the moment or with a purely personal focus.

FEEDBACK

Feedback refers to the way in which a person responds to a stimulus. In a psychotherapeutic setting, it refers to the client's response to the therapist. Feedback can be either positive or negative. The nature of the feedback from the client guides the therapist in making interventions.

MAIN, OCCUPIED, AND UNOCCUPIED CHANNELS

People tend to focus on certain channel experiences and remain relatively unaware of others. If someone identifies with the experiences that are occurring in a channel, then that channel is considered to be occupied. If someone is not identifying with a channel experience, then that channel is unoccupied. The main channel is the one a person usually occupies.

PROCESS

Process refers to the flow of signals in channels as perceived by an observer. Process emphasizes movement, change, and the dynamic flow of relationships in an interactional system.

All processes are believed to have some kind of structure. Process is regarded as more fundamental than structure, and is to be contrasted with fixed **states**. See also **primary and secondary process**.

PRIMARY AND SECONDARY PROCESS

Process can be differentiated into primary and secondary process.

Primary process refers to all of the body gestures, ideas, and behaviors with which a person readily identifies, or with which, it could safely be assumed, the person would identify if asked.

Secondary process refers to all of the experiences with which a person does not identify. Secondary processes tend to be experienced as intrusive, as not belonging to oneself, as invasions or interruptions of the primary process.

NOTE: It is important to distinguish Mindell's use of the terms primary and secondary process from the meanings assigned by Freud.

In psychoanalysis, primary process thinking refers to unconscious mental activity in which there is an uninhibited discharge of instinctual impulses without regard to reality or logic. Typical examples include dreams, fantasies, and the magical thinking of young children.

Psychoanalysis defines secondary process as conscious mental activities that are under control of the ego and guided by the reality principle. Secondary process thinking is a rational, logical attempt to effectively meet the external demands of the environment and the internal demands of instincts. Systematic, rational thinking (such as problem-solving) is an example of secondary process thinking.

In general, then, Process-Oriented Psychology assigns nearly the opposite meanings to the terms primary and secondary process as does psychoanalysis.

SIGNAL

A signal is any specific piece of information that is perceived by an individual.

STATE

State refers to a static aspect of a **process**. State-oriented thinking and perceiving is a function of dividing a process into discrete parts and creating a fixed description of the parts.

APPENDIX B

FOLLOW-UP INTERVIEW WITH THE CLIENT

FOLLOW-UP INTERVIEW WITH THE CLIENT

This interview took place in Waldport, Oregon, in October, 1990, approximately 4 1/2 years after the original psychotherapy session. The interview was designed to elicit information about six topics:

1. General background information;
2. The chronic body symptoms;
3. The childhood dream;
4. The drawing which the client makes during the session;
5. Subsequent integration of the work; and
6. The interruption in the videotape.

The interview was conducted in two separate sessions. This Appendix contains a complete transcript of each session.

Session #1

Q--How long before the seminar began were you aware of your symptom? The symptom was your posture, and the sore points in your chest, and the feeling of not being able to get enough room.

A--I think I've always felt a lack of stamina associated with my chest area. Growing up I was very athletic and very physical and I always felt that stamina was my weakest point.

Q--And it felt associated particularly with your chest.

A--And it felt in my chest, and I think as I got older I think I especially remember, in my early 20s, when I was writing my dissertation, I

remember especially at that point. I remember sitting at my desk and making this motion . . .

Q--Spreading your arms out, moving them back and forth.

A--Not being able to get enough air. Wanting more air than I was able to get or something.

Q--So the wanting more room in your chest seems like it was a long time thing.

A--It seems like a chronic thing, yeah.

Q--And the sore point in your chest—were you aware of that?

A--I only remember that so much in my 20s. Something you'd only really discover through touching it. I remember during my thesis period I remember very acutely that. I remember breathing and how it hurt in there.

Q--It's like it got more focused somehow.

A--Yeah as far as the pain goes.

Q--Had that affected you posturally too? The not getting enough room? You talked about how your shoulders would kind of round forward. It seemed that there was not only the experience of not having enough room but your posture followed that.

A--I don't know if I would have made that connection myself, that it has to do with the pain itself. But my posture—my shoulders have always been a little rounded forward as long as I can remember. And it's probably also—my mother and grandmother also have a similar posture. It's a family thing. My grandmother has asthma and

bronchial troubles in that area. So I've always felt that that particular symptom is connected to the women in my family.

Q--I'm curious whether you'd tried to process that symptom, the not having enough room and the pain in your chest? Had you tried processing it before the workshop or was that really your first attempt at doing it?

A--I think I'd worked on it before.

Q--With Arny?

A--With Arny. It had come up also in different ways. I remember particularly working on it in a relationship seminar. Some one had injured me, really badly, really hurt my feelings, and I was at an edge and I felt as if I could almost die at that point. And I had a pain in my chest. I think that happened before that particular workshop (in Tschierv). But I've had experiences that didn't necessarily begin with a body symptom. This was relationship work, and then the body symptom entered in so strongly. It's like I could almost die when someone was so mean to me.

Q--It affected you athletically, it affected you when you were working on your dissertation, it came up in a relationship context, and you saw it in terms of your family history. It seems that there are a lot of connections you are making to it. What made you think of your childhood dream?

A--I have two childhood dreams that remind me of that picture. This one—I used to only remember it years ago. It's this girl who was locked up in the bowels of the earth. And then from that seminar and

probably from different meditation seminars, I realized who was locking me up and it was a giant. And that picture reminded me of that giant. And then I had another childhood dream. Actually that dream was a repetitive dream, that I had for years.

Q--The one of being locked up?

A--Yeah. I had that dream for years.

Q--From what ages? Do you remember?

A--Well, maybe like 5, 6 till like 14 or something. It was a repetitive nightmare. The first dream that I remember, though, happened when I was 4. In that dream was also a crazy guy, a guy who came out from the sewers. He came out from the sewer system and came to my window and terrified me.

SESSION #2

Q--Could you tell me the dream again, the one where you were in the earth and the monster . . . .

A--It was a repeated nightmare of a little girl, a kindergarten girl, and she was locked up in the bowels of the earth. It was mostly a feeling. Very isolated, down under the ground. And I would hear the footsteps of this giant. And there were a lot of boulders.

Q--When you say it was a feeling, I'm curious in what part of your body you felt the feeling. In the session, you said it was terror. Do you remember where you felt the terror in your body?

A--It's hard to think of it as a past thing. I can feel it now actually.

Q--Where do you feel it now?

A--I feel it in my chest, my shoulders, my arms. I notice I move back.

Q--You move your torso back.

A--I move my torso back.

Q--And kind of scrinch your shoulders.

A--Um hum. Scared.

Q--So it's hard to tell whether that's what you felt then but that's what it makes you feel now.

A--I probably did but I just never thought of it then.

Q--The reason I was curious is that I was wondering if what you felt then in the dream was related to a body part that you developed a symptom in.

A--It sounds like it could be.

Q--Did that session help you to understand your childhood dream?

A--Well, every time I find my childhood dream and chronic symptoms are fluid things. So whenever I work on them I always understand something more. It's not like I have one particular breakthrough and then I've understood the dream. I always feel there is always a lot more that I can learn from it. Once it will be important learning about the little girl part of the dream and other times about the giant, and other times about the relationships, and different channels. That particular time I remember being really struck by the pain I was in and showing that pain. I remember the emotional pain and the thing that stopped the giant was the intense agony. That was really strong for me. I remember also looking at that on video tape and how powerful that was. There was

something about the agony and showing that pain and that that could actually stop such a powerful figure. Could stop an attack. Maybe I was needing at the time to react more to critical things, or difficult attacking things. At that time in the work, I wasn't experiencing the figure as very friendly. [laughs] It was only at the end that I thought maybe he was a nice guy.

Q--Do you feel like you've integrated your ability to respond, to show your pain or agony in situations where it's appropriate?

A--Huh! I do think I have a big edge in showing my hurt. I think I'm very sensitive, and hurt a lot. Sometimes I'm not as fluid in it as I'd like to be. I think more and more (fluid). I don't always show it as expressively. That was what it was in the particular tape I was very expressive.

Q--So I think I hear you saying that there is still room for growth but that you have grown since that time.

A--Yes.

Q--I'm curious whether you still experience the physical symptoms in the same way. Do you still experience the lack of room in your chest and the rounding of your shoulders. Has that changed at all?

A--It really depends. It's hard because it changes a lot. There are times I do and there are times I don't. . . . I'm trying to feel it. I still feel like I have a symptom there. One of these days I'd like to work on it again. It's just not acute. I don't have a lot of pain with it. At that time in my life, I was probably experiencing it more. I don't have, for example, I remember at that time sometimes stretching

and feeling a little pain in here [indicates her chest]. Sometimes if I press in my chest, I can maybe find little points that are sore. It's not a big—I have to search for them. But I do feel like the roundness of the shoulders is not, feeling like I don't have enough air or like I don't have enough stamina, I feel a general weakness in that area. In my upper body; I just generally feel weak there.

Q--It sounds like some of the symptoms have changed a bit and others haven't.

A--Yeah.

Q--And it's not really up as a focal issue.

A--It's not really up but the past 5 months I've really thought of working on it again. I haven't gotten around to it. I would describe it now as a weakness. And at that time I did have trouble—I remember feeling that I had to really grieve a lot to get the air that I wanted. I haven't had that symptom.

Q--So the grieving comes much easier.

A--Yeah.

Q--Let me ask you if you can remember the section in the tape where nothing happens—the tape went out.

A--I think it's pretty much an organic role switch. I think he just switched roles. . . . Because I haven't changed when that goes on.

Q--You haven't gone into your agony.

A--I say, "I'm not going to stop." He tries to pick up my energy here, and I don't change. But I think maybe he's trying to do that. I think he just responded. In same ways it doesn't seem like a broken tape to

me. It doesn't look like you missed too much. I can imagine what went on here was that I just went on, "I'm not going to stop." I imagine I just went on with this thing. "I'm not going to stop, I'm going to kill you.' I was just really into it. And I think he's trying to find a way to interact with me.

Q--Or it may be that once you stood up then you were really congruently beginning to act the killer, and at that point then you could reverse the roles. You'd really gone over your edge a number of times, and so maybe that was the point at which it would be appropriate for you to switch roles.

A--Except to me this role seems the same, the same energy. It seems like he's challenging me, trying to deal with me by challenging me. And it looks like we see that that intervention isn't the one that's going to work. This is what I think: he's imagining that I need to pick up this power [19:07] to defend myself, but that's not going to be the way to work with this figure.

Q--So at the 19 minute mark, he's thinking you're going to need to pick up the power to deal with the figure and tries the role reversal and you go on and try being powerful but it still doesn't work.

A--Yeah. I mean, I think the fight was beneficial. That was important.

Q--It was. You were making those kind of angular movements that you were talking about at the very end.

A--Yeah. It's so interesting because those are really archetypal for me. They really work on the same stuff. My motions are very similar

and often have those angular kinds of motions. It's something that needs to come out more.

Q--So at the end you were talking about needing to develop your angularity. Do you feel that's something...

A--I said that there? I don't remember that.

Q--At the very end, you were talking that you feel you should be more rounded. That over the years your body has become very angular, and that you only enjoy making movements like that. Do you feel like you've continued to integrate. . .

A-- I probably have because now I'm thinking I'm fat instead. Like now I'm really round. Now I have an edge against being round.

Q--Do you have any idea how you did that? Do you think it was a movement thing, or a relationship thing, or . . . ?

A--I enjoy those movements, those angular movements. Actually, I think I have integrated it, like a Zen master. I mean I feel like I have that inside of me. I can be very direct now. And in my practice, I can go to what's important. Part of me is like a no-nonsense kind of person. Really direct.

Q--So you've integrated it a lot more and now you're saying your body is changing and now you can let yourself be rounder, in a way.

A--I don't know if I let myself, I'm not into it. [laughs] Now I think I'm becoming a lazy slug.

Q--Integrating laziness.

A--Yeah. I'm totally not into it but I feel like . . .

Q--It's happening anyway.

A--That's another thing I want to work on.

Q--It's like the wheel just keeps turning. Up here you are integrating angularity, down here integrate being a slug.

A--Yeah, like I feel my muscle tone is flabbing out. And I feel it's a process. It has to do with detaching, taking it easy, becoming like a fat Buddha. I have a total edge against it. There's a part of me that could stay in bed all day.

Q--Is there anything else?

A--I was thinking something about my personal myth, since you're working on chronic symptoms and childhood dreams here.

Q--What about your personal myth. I'm curious how you understand it right now.

A--So many things. If I think of that I think of something very wild and earthy inside of me.

Q--If you think of this work?

A--Yeah. I think that figure has always haunted me and been around. And also at the same time there is the other part of it which is this little girl. She's very sensitive, and shy, and quiet. Part of my myth might be bringing those two parts together in myself.

Q--How to be wild and earthy and also sensitive and shy.

A--Yeah.

Q--That's a real challenge.

A--There's something very fine feeling about me, and sensitive and artistic. Then I have this other incredible, passionate, earthy,

wild, let-loose fiery kind of creature. And I think they sometimes are in conflict with each other.

Q--I wonder if there is a story that connects them. If you were going to have a life story or life myth, I wonder what it would be? It's the pattern that connects the characters.

A--As I said, when I work on these things, different things are important to me. Sometimes it's important for me to bring out the really shy, sensitive one, to show my fear. Then other times I have to be very radical. I think that's also part of my myth, is that I have an incredibly radical nature.

Q--You have a big range. And that's part of your myth is how to deal with that range. In the session, you talked about having fine bones, and yet there is this monster that wants to come out. How can a body like that, how is it supposed to have a monster in it? How can you contain it or express it? That's the challenge of bringing the archetype into the human form.

APPENDIX C:

THEORETICAL FOUNDATIONS OF PROCESS-ORIENTED PSYCHOLOGY

SECTION 1

The Analytical Psychology of C. G. Jung

Introduction

After receiving a master's degree in physics, Mindell went to the Jung Institute in Zurich to study Analytical Psychology. He became a Diplomate and a training analyst, and, as a result, the influence of Jung's work runs very deeply through Process-Oriented Psychology. Mindell writes that "I call process-oriented psychology a daughter of Jung's because even though she is now growing up and carrying her own name, she comes from his household. His blood, spirit and history are hers as well" (1988b, p. 2)

In this section, I highlight the principle concepts of Jung's work that have a direct bearing on Process-Oriented Psychology: the teleological perspective, the therapist-client relationship, the body in therapy, historical foundations (Taoism and alchemy), and common terminology.

Teleology

The history of epistemology has been characterized by the contrasting attempts of determinism and teleology to explain natural phenomena. Determinism is the philosophical doctrine that every event, act, and decision is the inevitable consequence of antecedents that are independent of the human will, while teleology is the use of ultimate purpose or design as a means of explaining natural phenomena.

The deterministic orientation explains an event by looking for the prior events which lead up to and cause it. The assumption is that there is an unbroken chain of events, one leading to another, which explain the event in question.

In the field of psychology, Freud's orientation was largely deterministic. His approach was to psychoanalyze a symptom by uncovering the relevant personal events that preceded and presumably caused it. In practical terms, this often meant tracing symptoms back to their origins in childhood.

The value of this orientation is that it encourages the therapist to uncover any prior events that are relevant to the problem at hand. The potential drawback of a strictly deterministic approach is that problems tend to be reduced to constituent elements and fit into convenient categories. A given experience will tend to be seen as pathological, as a problem caused by specific events, and its potential value ignored. The meaning of a symptom is derived from the events that gave rise to it.

The teleological orientation approaches a symptom by attempting to discover its underlying purpose or meaning. Teleology assumes that a symptom is an indication of a process that is still unfolding. The advantage of this approach is that it automatically places a constructive, growth-oriented value on any problem or symptom. The potential drawback is that a strictly teleological orientation may overlook important antecedent events that have a bearing on the situation.

The Teleological Perspective of Jung

Jung believed that there was evidence of teleology in the purposive behavior of neurotic symptoms and complexes, in synchronistic events, and in the individuation process generally (Jung, 1933, 1953b, 1969). For example, he wrote that ". . . It is correct that neurotic symptoms and complexes are also elaborate 'arrangements' which inexorably pursue their aims, with incredible obstinacy and cunning. Neurosis is teleologically oriented" (Jung, 1953, p. 39).

Jung's teleological orientation meant that he viewed problems and symptoms as meaningful. Even in his work with 'incurable' institutionalized patients, Jung assumed that there was a germ of meaning in their hallucinations and paranoid ideas. By investigating and trying to understand the world of his patients, Jung discovered that a life history and a pattern of hopes and desires lay behind the psychosis (Jung, 1963, p. 127). Discovering the meaning of the symptoms made communication possible and improvement more likely.

Jung did not try to replace causal explanations with teleological ones. Rather he thought that both were necessary in order to have a complete understanding of a situation. Thus, he wrote that "In psychology one ought to be as wary of believing absolutely in causality as of an absolute belief in teleology" (1953b, p. 289).

The Teleological Perspective of Mindell

Mindell has been greatly influenced by Jung's teleological perspective. In *Coma*, he wrote that "My background in process work is

based upon the finalistic philosophy applied by Jung to psychological situations" (1989a, p. 27).

Mindell considers all symptoms as positive in the sense that they carry information which, if processed and integrated, furthers individuation. His writings repeatedly underscore the importance of the teleological orientation to Process-Oriented Psychology. *Dreambody* and *Working With the Dreaming Body* are concerned with finding the meaning behind physical symptoms. *Coma* describes methods for discovering the purpose and aiding the unfolding of comatose states. The thesis of *River's Way* is that the accurate observation of the client combined with the ability to support that which is being observed will promote a useful development of the client's process. *City Shadows* is an exploration of the process structure and underlying meaning of conditions such as psychosis, catatonia, depression, and mania.

Mindell's commitment to the teleological perspective is one of the main ways in which Process-Oriented Psychology is different from most other schools of psychology. Even the most subtle or unusual signals, from the flutter of a comatose patient's eyelid to synchronistic events, can be regarded as meaningful. This means that the Process-Oriented Therapist must be prepared to notice, support, and try to understand any experience of the client. The teleological approach challenges the therapist to maintain an attitude of open-mindedness and caring, to have faith that something useful will develop by taking such an approach, and to be willing to develop along with the client.

The Therapist-Client Relationship

Jung's Views of the Therapist-Client Relationship

In his essay entitled "Problems of Modern Psychotherapy" (1966a), Jung wrote that the process of psychotherapy has four main components: confession, elucidation, education, and transformation.

The goal of **confession** is to bring to awareness material that the client has repressed. Jung used the term 'shadow' to refer to the personal material that is unacceptable to the client's conscious identity, or persona. Recognizing and admitting shadow material to the therapist often has a cathartic or cleansing effect. The principle underlying confession is that awareness is healing, that is, that secrets that remain unconscious are more likely to cause problems than those that are consciously acknowledged.

Moving deeper, the stage of **elucidation** involves the resolution of the transference, or the projection (or transfer) of unresolved unconscious material onto the therapist. Jung believed that the transference was not only the projection of the client's original, unresolved issues with the parents (as maintained by Freud), but that in addition, the client's projections could contain the seeds of unrealized psychological growth which were constellated around the archetypes of the collective unconscious. Thus in Jung's view the transference material could be either personal or archetypal, and the therapist had to be prepared to deal with either eventuality.

In the **education** stage, the therapist and client address the issue of how the client is to integrate his or her newfound awareness into social

fabric of his or her life. At this point, the client must learn how to apply the inner work in such a way as to be adapted to society.

It is in the final stage, **transformation**, that Jung truly addressed the nature of the therapist-client relationship. This is the stage in which the client must consider if it is enough to be a 'normal' and adapted social being. Jung wrote that, for many, social adaptation is easy, but that it may not address all of the individual's needs. Those who cannot adapt without sacrificing essential and important parts of themselves must learn to become "appropriately non-adapted" (1966a, p. 72).

The therapist faces two challenges in the stage of transformation. The first challenge is to support the client's unique path of growth, and the second is to be willing to change along with the client.

First, Jung believed that the therapist had to learn to recognize and support the individual needs of clients. This meant the therapist had to make every attempt to follow the individual client's process, repeatedly discarding hypotheses in order to be faithful to what was actually occurring:

> It is enough to drive one to despair that in practical psychology there are no universally valid recipes and rules. There are only individual cases with the most heterogeneous needs and demands—so heterogeneous that we can virtually never know in advance what course a given case will take, for which reason it is better for the doctor to abandon all preconceived notions. This does not mean that he should throw them overboard, but that in any given case he should use them merely as hypotheses for a possible explanation. (Jung, 1966a, p. 71)

By not following a predetermined formula, Jung placed his faith in the client's individuation process to ultimately determine the direction of

the therapy. Thus, he wrote that "In dealing with psychological developments, the doctor should, as a matter of principle, let nature rule and himself do his utmost to avoid influencing the patient in the direction of his own philosophical, social, and political bent" (1966a, p. 26).

Here arises the second challenge for the therapist, for it is inevitable that in the course of therapy the therapist's own unresolved issues, the counter-transference, should emerge. In addition to the professional relationship between therapist and client, Jung believed that the mutual influence that gives rise to the transference and counter-transference also made the encounter a very personal one.

> For, twist and turn the matter as we may, the relation between doctor and patient remains a personal one within the impersonal framework of professional treatment. By no device can the treatment be anything but the product of mutual influence, in which the whole being of the doctor as well as that of the patient plays its part. (Jung, 1966a, p. 71)

According to Whitmont (1969), Jung was the first to break with traditional psychoanalysis by eliminating the therapist's couch, preferring instead to sit face-to-face with his clients. This practice heightened the personal nature of the interaction.

In order to cope with the counter-transference and therefore better serve the client, Jung believed that the therapist had to be continually willing to work on the therapist's own issues. To this end, Jung was the first to require that aspiring therapists receive personal psychotherapy as part of their training: "The analyst is blind to the attitude of his patient to the exact extent that he does not see himself and his own unconscious problems. For this reason, I maintain that a doctor must himself be

analyzed before he practices analysis" (Jung, 1970a, p. 235). In addition, while conducting a psychotherapy session the therapist had to be willing to constantly examine himself or herself, and to do so while remaining aware of the client's process.

> The analyst must go on learning endlessly, and never forget that each new case brings new problems to light and thus gives rise to unconscious assumptions that have never before been constellated. We could say, without too much exaggeration, that a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient. (1966a, p. 116)

It is not enough to maintain an impervious facade and apply techniques from a safe psychological distance. Instead the personality of the therapist, the range and depth of the therapist's humanity, is a significant factor in the treatment of the client. This takes psychotherapy out of the medical model, for it is no longer simply a case of the healthy doctor treating the sick patient. At a more fundamental level it is an encounter between two human beings, both of whom become transformed.

Mindell's Views of the Therapist-Client Relationship

Mindell tends to describe therapist-client interactions in terms of process structure rather than as transference and counter-transference phenomena. He has included in the channel structure of Process-Oriented Psychology a composite channel termed "relationship." Relationship can refer to any one-to-one relationship, including the interactions between therapist and client. In this section, I consider first the client's reactions to the therapist and then the therapist's reactions to the client.

The client's reactions to the therapist fall into three general categories: either complete projection, wholly accurate observation, or a combination of the two.

If the client is projecting, Process-Oriented Psychology, in accord with Jung, maintains that the material can be either personal or archetypal. When the client is projecting, the therapist can point this out and the nature of the projection can be explored. This is a standard exchange between therapist and client in Process-Oriented Psychology as well as in many other schools of psychotherapy.

But what of a situation in which the client's reaction is a partially or completely accurate description of the therapist? In such a case, the therapist must decide whether or not to admit that the client has made an accurate observation. In making this decision, the therapist will be influenced by his or her psychotherapeutic model.

In some schools of psychotherapy, the therapist would always reflect the client's remarks back to the client, and would never admit that there was some truth in what the client said. This approach maintains a hierarchical split between therapist and client in which the client is regarded as always projecting and the therapist is a perfect mirror who never has anything personal to reveal. This type of exchange does not acknowledge the relationship aspect of the client-therapist interactions.

In Process-Oriented Psychology the therapist examines himself or herself to discover whether the client's remarks are accurate. If so, then in some cases, it is appropriate to tell the client what is projection and what is not. Mindell described a hypothetical case of a women who noticed

that she is mentally criticizing herself. Encouraged to listen to the internal critic,

> Then she might say, "Oh, my stomach hurts." Now she's switched to the proprioceptive channel. "What does that feel like?" I might ask. "Well, it feels bad," she says, making a fist at the same time. So we focus on the fist, which is a kinesthetic or movement expression of the same process. Then I might have her amplify the fist by making a muscle in her bicep, tightening her neck, and tensing her face. Suddenly she says, "Now I look like my father." "What does he look like?" I ask. "He looks like you!" At this point, I would probably say, "Can't we take this inward? Does it really have to be projected outward. Are you really criticizing me?' . . . Then as a therapist I have to look inside myself and see whether a part of me isn't in fact critical of her. There may be, in which case, I need to recognize and talk about that part. We may go back and forth until the person realizes that I'm not like her father, but the fatherlike part is in her. (Bodian, 1990, p. 69)

This is an example of therapist and client working in the relationship channel. The therapist's willingness to engage in this way provides a reality check for the client, who would otherwise have to doubt either her own beliefs or the therapist's honesty. Such a disclosure by the therapist promotes trust and can deepen the rapport between them.

In this example, the therapist tracked the signals from internal auditory (hearing the critic) to proprioception (stomach) to kinesthetic (fist) to visual (seeing her father) to relationship. By closely following signals and analyzing the underlying process structure, the process worker has a rationale for making interventions with the client. In this case, the need for relationship work emerged in an organic fashion as the therapist followed the client's process.

As this example indicates, in Process-Oriented Psychology the therapist must consider all sources of information as potentially relevant,

including the therapist's own reactions to the client. Mindell has differentiated two categories of reactions that the therapist may have toward the client: counter-transference and being "dreamed up."

Counter-transference, as defined in the preceding section, refers to those instances in which the therapist's unresolved personal material is projected onto the client. The Process-Oriented therapist is expected to notice and work internally with his or her own counter-transference reactions while at the same time tracking the client's process. As in the example described above, the signals and process structure will indicate whether it is appropriate to disclose counter-transference material.

The second category of therapist reactions to the client consists of what Mindell calls "dreamed up reactions." For example, imagine a psychotherapy session in which a male client is describing how he was betrayed by a business associate. He says that although the associate was a close friend, and betrayal was devastating, he has thought it through and decided that business is business and it is best to put the event behind him. As he recounts the incident and his thought about it, he is very rational and his voice is measured. At the same time his face is slightly flushed and he appears to be somewhat short of breath. As the therapist listens to the account, the therapist begins to get angry, and it is all the therapist can do to keep from denouncing the business associate and suggesting ways of remedying the situation. The therapist is being dreamed up to have this reaction.

Analyzing the process structure reveals that the client is sending a double signal. On the surface (the primary process), he is calm, rational,

and accepting, but underneath (the secondary process), he is furious. The therapist is unconsciously noticing the facial flush and shortness of breath and is reacting to these signals by feeling the anger that the client is expressing indirectly. At the moment, the client is unaware of his anger; it is like a dream that he is having unconsciously. The therapist unknowingly begins to react like the client's secondary or dream-like part, that is, the therapist is "dreamed up." The therapist has become a channel for the client's secondary process.

It is very helpful if the therapist can differentiate between counter-transference and being dreamed up. Mindell wrote that

> As long as the therapist has a reaction which is short-lived and lasts only as long as he is in the vicinity of the client, we can speak of a purely dreamed-up reaction. If, however, this reaction lasts longer than the time of the interview, we must also consider the possibility that the therapist is unconsciously projecting something of himself onto his client . . . We speak of dreaming up when the therapist has no affects before, after, or as soon as the dreamer has integrated and understood his dream material. (1985a, p. 43)

If the therapist suspects that he or she is getting dreamt up, the therapist can fairly safely assume that he or she has missed a double signal. The task is to discover the signal and encourage the client to express the unconscious material more congruently. As the client takes over the client's secondary process, the therapist's urge to express this aspect of the dreaming process will diminish.

The fact that dreaming up and projection can happen simultaneously in both therapist and client can complicate the interaction enormously. The therapist's ability to unravel such complex interactions will be greatly enhanced if the therapist can differentiate counter-transference

from dreaming up, and is able to attend closely to the complex, subtle, and ongoing flow of signals.

The therapist's awareness and flexibility in relating to the client is determined by the therapist's edges, that is, by the limits of the therapist's identity. Goodbread (1987, 1989) has categorized the kinds of edges that the therapist may encounter. Two of these—personal and professional edges—have been alluded to previously. The personal edges include the therapist's unresolved characterological issues and his or her least accessible channel. Professional edges vary according to the therapist's psychotherapeutic model and affect attitudes toward therapist-client interactions, including counter-transference phenomena. In addition, every therapist is influenced by cultural edges in which the habitual and typically unconscious acceptance of cultural norms limits awareness.

In summary, it is apparent that Mindell has been influenced considerably by Jung's views of the therapist-client relationship. This may be an important reason why Mindell developed a relationship channel as part of the theoretical and practical structure of Process-Oriented Psychology.

Some of the areas of overlap include the emphasis upon identifying and supporting the needs of the client; discarding hypotheses if they do not accurately describe the client; recognition that the transference projections may be either personal or archetypal in nature; the need for the therapist to work on himself or herself both between and during sessions; and, when appropriate, going beyond the role of therapist to

convey personal information or feelings. Implicit in Mindell's approach, as with Jung's, is a trust in the client's individuation process to provide guidance for both therapist and client. Both Jung and Mindell refer to psychotherapy as a process of observing and following nature.

Although Mindell's basic philosophy of and approach to the therapist-client relationship is similar to Jung's, there are some important differences.

One of these differences is the degree to which Mindell has integrated an information theory perspective by focusing on signals, information flow, and feedback. On one level this gives Process-Oriented Psychology a behaviorist flavor. Some behaviorally-oriented models of psychotherapy, such as Neuro-Linguistic Programming, do not regard relationship work between therapist and client as necessary or appropriate, but Mindell has not taken this approach. Instead, he has used awareness of the signal flow as a rationale for and a means of focusing upon the nuances of relationship work between therapist and client.

Mindell's other major contribution to therapist-client interactions is his theory of dreaming up. This concept allows the Process-Oriented therapist to differentiate the therapist's own counter-transference projections from reactions that are triggered by the client's double signals. This in turn enables the therapist to focus on and help the client access the material being expressed through the secondary signal.

Thus a signal-based awareness of therapist-client interactions combined with a willingness to engage the client in a personal manner help the Process-Oriented therapist to know when it is appropriate to discuss

counter-transference reactions with the client, and to know when personal reactions are in fact a "dreamed up" aspect of the client's process.

The Body in Therapy

Jung and the Body

References to the body appear throughout Jung's writings.

Jung conducted word association experiments in which he established a connection between psychological complexes and physiological changes. In one of these studies, he used a galvanometer to measure electrical skin resistance. ("On Psychophysical Relations of the Associative Experiment," Jung, 1973) In another study, he used a galvanometer and a pneumograph designed to measure the frequency and amplitude of breathing. ("Further Investigations of the Galvanic Phenomenon and Respiration in Normal and Insane Individuals," Jung & Ricksher, 1973).

Due to their autonomous nature, complexes manifest as both psychological and somatic symptoms. The physiological effect of complexes is not limited to changes in breathing and electrical skin resistance; in addition, they can "disturb the conscious performance . . . produce disturbances of memory and blockages in the flow of associations . . . temporarily obsess consciousness, or influence speech and action in an unconscious way." (Jung, 1969, p. 121).

In an article on "The Psychology of Dementia Praecox" (Jung, 1960), Jung hypothesized the presence of a toxic factor in the pathogenesis of schizophrenia. He suggested that such a toxin could play a role in the

fixation of the complex, thereby contributing to the perseveration of symptoms.

Jung often studied the body language of his patients. His first psychological study included observations of unconscious body movements (Jung, 1970b). While working at the Burgholzli Psychiatric Clinic in Zurich, he studied the perseverating gestures of regressed patients (See Jung, 1963). One of his techniques was to closely watch silent, withdrawn patients, even those who had not spoken for years. When they moved or changed expression, he would imitate them, note his inner experience, and put this experience into words. In a number of cases, the patient would respond, a dialogue would be established, and the patient would improve (Van Der Post, 1977).

Jung recognized that for some patients, movement was the ideal mode of self-expression. His writings contain a number of references to body movement as a form of active imagination (Jung, 1969, 1976).

When appropriate Jung encouraged his patients to dance the mandala symbolisms which emerged in therapy:

> Among my patients I have come across cases of women who did not draw mandalas but danced them instead. In India there is a special name for this: mandala nrithya, the mandala dance. The dance figures express the same meanings as the drawings. My patients can say very little about the meaning of the symbols but are fascinated by them and find that they somehow express and have an effect on their subjective state. (Jung, 1967, p. 23)

A similar reference is also contained in *Dream Analysis* (Jung, 1984), while Van Der Post described Jung's dance movement interactions with a patient in a different context (1977).

Jung frequently theorized about the nature of the mind-body relationship (Adler, 1975; Jung, 1966a; 1969,; 1967; 1959b). His perspective is summarized in the following quotation from *Modern Man In Search of a Soul*:

> The distinction between mind and body is an artificial dichotomy, a discrimination which is unquestionably based far more on the peculiarity of intellectual understanding than on the nature of things. In fact, so intimate is the intermingling of bodily and psychic traits that not only can we draw far-reaching inferences as to the constitution of the psyche from the constitution of the body, but we can also infer from psychic peculiarities the corresponding bodily characteristics. (1973, p. 74)

In addition to Jung's consideration of complexes, he formulated a number of other concepts that addressed the issue of mind and body.

Jung theorized that archetypes bridged the mind-body dichotomy at the psychoid level. The psychoid is the deepest level of the unconscious and is completely inaccessible to consciousness. It has properties in common with the organic world, and is therefore both psychological and physiological in nature. Jung imagined a spectrum of consciousness ranging from an infra-red or physiological pole to an ultra-violet or spiritual/imagistic pole (Jung, 1969). On a theoretical level, the archetypes span both poles, and can thus be understood to bridge the mind/body dichotomy. On a practical level, the archetypes can manifest in behavior and physical symptoms.

Jung's idea of synchronicity also addressed the mind/body connection. In the broadest sense, synchronicity refers to a connection between subjective, psychological realities and events in the external, material world.

> . . . it is not only possible but fairly probable, even, that psyche and matter are two different aspects of one and the same thing. The synchronicity phenomena point, it seems to me, in this direction, for they show that the nonpsychic can behave like the psychic, and vice versa, without there being any causal connection between them. (1969, p. 215)

A number of Jung's followers have applied the concept of synchronicity to the relationship between psychological events and organic illness (Lockhart, 1977; Meier, 1986; Ziegler, 1962).

In the Tavistock Lectures, delivered in 1935, Jung described how the psychological concept of the shadow can manifest as body symptoms:

> We do not like to look at the shadow-side of ourselves; therefore, there are many people in our civilized society who have lost their shadow altogether, they have got rid of it. They are only two-dimensional; they have lost the third dimension, and with it they have usually lost the body. The body is a most doubtful friend because it produces things we do not like; there are too many things about the body which cannot mentioned. The body is very often the personification of this shadow of the ego. (Jung, 1976, p. 23)

Finally, Jung pointed out that the ancient traditions of alchemy, Taoism, and the *Tibetan Book of the Dead* refer to a *corpus subtile*, a "subtle body" or "breath body" (Jung, 1953a, p. 408). The subtle body is a transfigured and resurrected body, that is, a body that is comprised of both matter and spirit.

To summarize, Jung was aware of and flexible enough to incorporate body-oriented approaches into the practice of psychotherapy. He discovered complexes by means of galvanic skin response, attended to movements and facial expressions, and encouraged clients to dance when that mode of self-expression seemed most appropriate. On a theoretical level, Jung's consideration of mind/body phenomena included concepts such

as complexes, archetypes, the psychoid unconscious, the shadow, and synchronicity.

Jung did not make body-oriented approaches a formal, explicit aspect of analytical psychology. If he systematized his approach, he did not write it down for others to follow. However, his approach to psychotherapy and the scope of his theorizing created a climate which was sympathetic to the integration of body-oriented approaches with traditional forms of psychotherapy. One indication of this is the subsequent development of Jungian dance-movement therapy; another is Mindell's Process-Oriented Psychology.

Mindell and the Body

Mindell's studies at the Jung Institute in Zurich trained him to work with dreams and to be able to work on himself through active imagination. Excited about working with dream material, Mindell began to wonder

> whether what I now knew about dreams could be used also in working with the body and with relationships. I became frustrated with just sitting and talking; I was fascinated with gestures, symptoms, odd or insistent physical sensations, and the different ways clients (for instance couples) had of relating to me and to each other. (Mindell, 1988b, p. 2)

Mindell's motivation to discover how to work with body symptoms increased when he became ill. His readings in psychology and Western medicine left him thinking that there were many methods of manipulating the body, but that he still did not know how to discover what his body was trying to say.

He began to take careful notes on the body language of his clients, and soon noticed the tendency of many people to amplify their symptoms,

actually making them more acute. He worked with terminally ill patients, encouraging them to amplify their physical symptoms, and discovered that illness is a meaningful condition and that amplification is a way to discover that meaning.

While working with a dying patient, Mindell realized that the man had had a dream that conveyed the same information elicited by amplifying his physical symptoms. Extrapolating from this, Mindell realized that dreams mirror body symptoms, and body symptoms mirror dreams, a discovery that he has subsequently corroborated with many other patients.

From this insight, Mindell had the idea that there must be a 'dreambody,' an entity that was simultaneously both dream and body. Inspired by Jung, the dreambody is a reformulation of concept of the subtle body mentioned in the preceding section.

Mindell's study of body language has ranged from overt signals such as posture, movement, and facial expressions to minimal cues such as pupil dilation and changes in skin color. Awareness of body language is a critical component in the Process-Oriented therapist's ability to detect many double signals, in which, for example, the verbal content conflicts with nonverbal behavior. In analyzing the process structure of a psychotherapy session, it is very common to discover that the secondary process (i.e., the process that is further from consciousness and therefore contains the seeds of growth) is located in proprioception or kinesthesia. This fact increases the importance of being able to recognize and work with somatic processes.

In short, the awareness and incorporation of somatic phenomena is an integral aspect of the theory and practice of Process-Oriented Psychology. While Jung included body-oriented approaches in his methods of working with patients, and clearly created a climate that encouraged further exploration, Mindell has explored somatic phenomena in far greater depth. Mindell's application of the channel system, his use of amplification, and his development of the concept of the dreambody has created a psythotherapeutic system that is precise and adaptable when dealing with the spectrum of body/mind experience.

Historical Foundations: Taoism

Introduction

In his acknowledgments for the book, *River's Way*, Mindell wrote that he was indebted to Jung for introducing him to alchemy and Taoism, and that these two bodies of knowledge represent the historical foundations of Process-Oriented Psychology. According to Mindell, "Alchemy is based upon cooking what is incomplete and Taoism encourages one to discover the patterns behind reality and to follow their unfolding with appreciation and awareness" (1988a, p. 27). In this section, I briefly describe Jung's interest in alchemy and Taoism, and outline their respective importance to Process-Oriented Psychology.

Taoism: Jung

Jung was well into his career before he discovered parallels between the Chinese philosophy of Taoism and the theory and practice of analytical psychology. His writings on Taoism are primarily focused on

Lao Tsu and on two Chinese texts: the *The Secret of the Golden Flower*, and the *I Ching*, or *Book of Changes*.

Jung believed that *The Secret of the Golden Flower* contained a description of the same process of individuation that he had observed in his clients. Jung saw this as evidence to support his theory of the collective unconscious, which he defined as the common substratum of the psyche that transcends all differences in culture and consciousness.

According to Jung's theory, if consciousness becomes estranged from the archetypes of the collective unconscious, then a breakdown of the personality is likely to occur. What is then needed is a re-unification of the personal and collective elements of the psyche. Jung believed that such a unification of opposites was the issue that is addressed by Taoism generally and by *The Secret of the Golden Flower* in particular.

In his commentary on *The Secret of the Golden Flower*, Jung described the essence of the Tao from a psychological perspective:

> If we take the Tao to be the method or conscious way by which to unite what is separated, we have probably come close to the psychological content of the concept . . . . There can be no doubt, either, that the realization of the opposite hidden in the unconscious—the process of "reversal"—signifies reunion with the unconscious laws of our being, and the purpose of this reunion is the attainment of conscious life or, expressed in Chinese terms, the realization of the Tao. (Jung, 1967, p. 21)

Thus, for Jung, the Tao is the process whereby opposites are reconciled within the psyche. In Jung's Analytical Psychology, this reconciliation is brought about by the transcendent function. Over time, the transcendent function fosters the individuation process, which is the tendency of the psyche to move toward wholeness and balance.

It is important to note that the unfolding of the Tao and the process of individuation take into account not only intrapsychic processes but also meaningful events in the world. In Volume 7 of his *Collected Works*, Jung wrote:

> From a consideration of the claims of the inner and outer worlds, or rather, from the conflicts between them, the possible and the necessary follows. Unfortunately, our Western mind, lacking all culture in this respect, has never yet devised a concept, nor even a name, for the union of opposites through the middle path, that most fundamental item of inward experience, which could respectably be set against the Chinese concept of Tao. (Jung, 1953b, p. 203, first emphasis added)

In the *I Ching*, Jung found an approach to understanding the world which was closely aligned with his theory of synchronicity. He observed that Western science is almost exclusively concerned with establishing causal connections between events, whereas the *I Ching* is concerned with meaningful coincidence. This type of coincidence is the essence of Jung's theory of synchronicity.

The Taoist conception of the relationship between the "inner and outer worlds" is easier to understand if we realize that "The achievement of Taoism is not merely that of the concept of unity of dualities or the identification of opposites. For the Taoist there is also a unity in multiplicity, a wholeness in parts" (Chang Chung-yuan, 1970, p. 33). This holographic conceptualization of the world means that Taoism maintains there is a meaningful pattern which underlies the multiplicity, a hidden unity which ties together diverse elements that may have no apparent causal relationship.

Furthermore, for there to be a wholeness in parts means that the configuration of local events in a given moment contains information about the nature of the larger whole. That is why the yarrow stalks may be used for divination when consulting the *I Ching*: the seemingly random alignment of the stalks are in fact ordered by nature and may, to the discerning inquirer, reveal aspects of the world.

For Jung, as for the Taoist, the coming together of inner experience and outer circumstance is a meaningful, though not necessarily causally related, event. Thus, following the Tao and the process of individuation each require the reconciliation of conflicting parts of the psyche as well as an awareness of and a harmonious blending with the rhythms of nature.

The information revealed by consulting the *I Ching* or by synchronistic events is not accessible strictly through intellectual analysis; rather it must be gained through direct, intuitive experience. When the distinction between subject and object vanishes, or when intrapsychic opposites are united, then one understands the Tao.

Taoism: Mindell

Mindell considers Taoism, particularly as presented in the *I Ching* and Lao Tsu's *Tao Te Ching* to be the most complete process theory of which he is aware.

In his workshops and books, Mindell often likens Process-Oriented Psychology to Taoism. Both are concerned with the fundamental process underlying events; both advise paying attention to any clue (even and especially unlikely ones) which might reveal the presence and direction of the Tao; both advise harmonizing oneself with the Tao, however

mysterious or irrational that path might appear; both suggest that a 'beginner's mind' is necessary to stay open to the ever-changing flow of events.

The Process-Oriented therapist attends to discrete signals or bits of information and then classifies them according to the channels in which they appear. Mindell noted that channel structure is an arbitrary means of classifying the information flow, and that such a classification should not be mistaken for the underlying reality, or Tao: "Using process language we can say that the Tao is the flow of events in and between channels. Tao signifies a process which simultaneously manifests in a number of different channels" (Mindell, 1985a, p. 91). Along with Jung, Mindell also likens the background process, or Tao, to archetypes:

> The archetype is the connecting pattern organizing spontaneous events. Thus dreams would be a channel of the archetype since one has minimal control over them. Body problems which cannot be influenced in a causal manner would be another channel of the archetype. Spontaneous acts of fate also belong to the description
>
> of the archetype. We see that the archetype is a total picture of the spontaneous phenomena occurring in all possible channels. (1985a, p. 101)

In the *Tao Te Ching*, Lao Tsu wrote that "The Tao that can be told is not the eternal Tao" (1972, Verse 1). This statement, which cautions us not to mistake our ideas about reality for reality itself, is a key directive for the Process-Oriented Therapist. Rather than view the client through the filter of preconceptions, the process worker must maintain a beginner's mind. This is the only way the process worker can hope to track the ever-changing flow of signals, and thus gain an understanding of the flow of the Tao, or the archetypes shaping the over-all process.

This does not mean that the Process-Oriented therapist neglects analysis in favor of direct experience. At one point, it may be appropriate to simply experience the Tao, while at another point the Tao may call for critical analysis. By maintaining awareness and a flexible approach, by balancing action and nonaction, the process worker strives to recognize and support the Tao as it manifests in the client's process.

> . . . Understanding and being open to all things,
> Are you able to do nothing?
> Giving birth and nourishing,
> Bearing yet not possessing,
> Working yet not taking credit,
> Leading yet not dominating,
> This is the Primal Virtue. (Lao Tsu, 1972, Verse 10)

Historical Foundations: Alchemy

The Historical Background of Alchemy

Alchemy has been practiced for several thousand years, and flourished between the 9th and 17th centuries. Practitioners came from all segments of society, ranging from common laborers to kings, and including such notables as Roger Bacon, St. Thomas Aquinas, and Isaac Newton.

The outward or exoteric practice of alchemy consisted of attempts to create the *philosopher's stone.* This stone was believed to have the power of transmuting the base metals lead, tin, copper, iron and mercury into the precious metals gold and silver. In addition, alchemists attempted to create a liquid, the *elixir vitae*, which could indefinitely prolong the human life. The innumerable attempts to create the stone and elixir were the tentative beginnings of the science of chemistry.

Along with the activities that centered around alembics and melting pots, there was also an esoteric form of alchemy. Esoteric alchemy gave rise to mystical treatises in which the authors used the language of exoteric alchemy to describe philosophical and religious beliefs. It is this aspect of alchemy that was of interest to Jung.

Jung's Approach to Alchemy

Jung believed there was a psychological and spiritual significance to the alchemical philosophy. In his essay on "Individual Dream Symbolism in Relation to Alchemy," Jung (1953) recorded a series of dreams produced by a patient who had no previous knowledge of alchemy. For nearly every dream, Jung was able to produce an alchemical plate that closely duplicated the symbolism of the dream. He concluded from this that the alchemists, as they conducted their experiments, were unknowingly projecting the contents of their unconscious onto the material world (Jung, 1953a).

The dream images of Jung's patient were similar to the alchemical plates because they both portrayed a process of psychological transformation. Jung referred to this process—the integration of conscious and unconscious, of the 'noble' and 'base' aspects of the psyche—as the transcendent function. In psychological terms, the creation of 'gold' is the ongoing integration of the personality. In other words, Jung believed that the symbolism employed by the esoteric alchemists paralleled the stages of the individuation process.

Jung incorporated a number of the terms employed by the alchemists into the standard terminology of Analytical Psychology. Thus, he referred

to the analytical work as an *opus*, the analytic relationship as a *vas* (vessel or container), and the goal of psychotherapy as the *coniunctio*, or the union of opposites. The stages of individuation were also described with alchemical terms.

Jung was fascinated with the symbolism of esoteric alchemy for a number of reasons. First, the fact that similar symbols could emerge from his clients substantiated his belief that there is a collective level to the psyche. And second, the descriptive language of the alchemists proved to be a rich source of imagery for describing the kinds of transformation that occur both in psychotherapy and in the individuation process generally.

Mindell's Use of the Alchemical Paradigm

In *River's Way*, Mindell wrote at length about the stages, symbolism, and philosophy of alchemical transformation. He drew extensive parallels between the opus or work of the alchemist and the "art" of practicing Process-Oriented Psychology. And in teaching seminars, Mindell has often used the symbolism of alchemy when he has talked about the importance of allowing a client's process to "cook."

Briefly summarized, Mindell wrote that the alchemist works on the *prima materia* (defined as the 'imperfect body' or the 'constant soul'). For the process worker the prima materia refers to signals that indicate a secondary process.

Having noticed the prima materia, the alchemist then waits for the *ignis nonnaturalis*, natural spark in processes which makes them evolve. The process worker waits for the signal to perseverate, for this indicates that it has sufficient 'spark' to be worth pursuing.

The alchemist then hermetically seals the prima materia into a philosopher's egg. In process work, this means bringing an intense focus of attention—both mind and heart—upon the process at hand. The focus of attention, like an egg, distinguishes the prima materia from all that surrounds it, thereby, creating an area within which the prima materia may safely grow.

The alchemist then puts the egg into an oven so that it can cook at a constant temperature. In process work the 'heat' is provided by the various techniques of amplification.

Mindell then went on to describe various aspects of the stages of transformation, from conflict between opposites to the eventual discovery of 'gold.'

If Jung's assumption is correct that the alchemist pursued his or her quest unconsciously, then this underscores a basic difference between the opus of the alchemist and that of the Process-Oriented therapist. The task of the process worker is to identify and nurture transformation in a deliberate and conscious manner, and to recognize and integrate any projections the therapist may have as this process unfolds.

This, then, is the 'art' of the process worker: the ability to gently cook a process, using whatever ingredients and utensils happen to be available, taking care to neither burn nor undercook, not knowing precisely what is being prepared, but trusting that the outcome will ultimately be as good as gold.

Common Terminology

One of the clearest areas of overlap between Jung's Analytical Psychology and the Process-Oriented Psychology of Mindell is in terminology.

Mindell uses many terms which are derived from Jung, including complex, archetype, collective unconscious, amplification, self, shadow, individuation, and synchronicity.

Mindell retains basically the same meanings ascribed by Jung, although there are a few exceptions. The most important exception concerns the use of the term amplification.

Jung referred to amplification as one of several approaches to understanding dreams. The first step was to have the client freely associate to the various contents of the dream. These associations established the personal context of the dream. The next step, symbol amplification, drew upon mythological, historical, and cultural parallels in order to emphasize the universal imagery in the dream. Amplification thus emphasized the archetypal basis of the dream, and made possible another level of understanding.

For Mindell, amplification is a method of working with signals in the various channels. The Process-Oriented therapist begins by identifying the channel in which the client's dream or body experience is attempting to manifest itself. The therapist then works with the client to amplify the strength of the signal in that channel. This has the effect of increasing the availability of the information contained in the signal, in much the same way that a microscope allows a scientist to study the details of

microorganisms. The added detail creates the possibility of further intervention and development.

For a comparison of Jung's and Mindell's definitions of the terms listed above, the reader is referred to the glossary in *City Shadows.*

For definitions of process terms that are not derived from Jung, please see Appendix A.

SECTION 2

Modern Physics

Introduction

At first glance, the sciences of physics and psychology appear to be at opposite ends of a continuum. Traditionally, physics is the ultimate objective science, probing into the essential nature of the universe at the atomic and subatomic levels, the pillar upon which all other branches of sciences rest. It is the ultimate "hard" science.

Psychology is the study of subjectivity, of the elusive, invisible, ever-changing landscape of perception, emotion, and cognition. In some ways it is the ultimate "soft" science.

The Cartesian and Newtonian paradigms support this dichotomy, but the perspective of modern physics does not. According to neuroscientist Karl Pribram, the convergence of physics and psychology is necessary if we are to understand the nature of the mind and the universe in which we live:

> Thus modern physicists and modern perceptual psychologists have converged onto a set of issues that neither can solve alone. If the psychologist is interested in the nature of the conditions which produce the world of appearances, he must attend to the inquiries of the physicist. If the physicist is to understand the observations which he is attempting to systematize, he must learn something of the nature of the psychological process of making observations. (Pribram, 1978, p. 15)

One of the unique aspects of Process-Oriented Psychology is the degree to which Mindell has integrated the discoveries of modern physics with the theoretical and practical aspects of process work. Mindell earned

an M.S. in Physics before studying Jungian psychology, and has been working on this integration for over 20 years. In the foreword to his Ph.D. dissertation in psychology Mindell wrote:

> . . . I concentrated my studies in college on physics, only to become dissatisfied with the scientific lack of concern for the personal aspect of events. Hoping to find a more holistic approach, I studied depth psychology. I still remember one of my first dreams in analysis. I was sitting listening to a lecture by Dr. Jung. After the lecture he approached me and said: "Don't you know what you should be doing with your life?!" "No," I replied. "Find the connections between psychology and physics," he declared. (1976, p. i)

In creating Process-Oriented Psychology, Mindell has relied to a great extent upon the theories of modern physics. In the following sections, I describe several themes Mindell has pursued, including process as a unifying concept, the incorporation of relativity theory, the adoption of a phenomenological attitude, the perspective of modern physics on the body, and the individual's relationship to the world.

Process as a Unifying Concept

Mindell conceives of "process" as a common focus for physics and Process-Oriented Psychology, and as a unifying concept for physics and psychology generally.

There are several ways in which modern physics takes a process-oriented approach. Physics, like information theory (described in Chapter 4, Section 3), evaluates phenomena from a systems perspective, and systems theory emphasizes process over structure. Modern physics thus emphasizes relationships rather than individual, separate objects, and conceives of the relationships as being inherently dynamic. For example,

atomic and subatomic "particles" are now conceived to be bundles of energy, and energy is continually active, or in process .

Process-Oriented Psychology also takes a systems perspective. Clients are not viewed as individual, separate objects, but rather as imbedded in a complex web of systemic relationships. The fundamental nature of these relationships is that they are dynamic, ever-changing, and always in process.

As process unfolds, it does so in the form of patterns. In physics, these patterns are described in terms of the probabilistic wave equations of quantum mechanics. In Process-Oriented Psychology, patterns are attributed to the organizing function of archetypes. Both archetypes and wave functions are attempts to describe the creation of patterns out of underlying process. In *River's Way*, Mindell wrote that

> . . . dream work indicates that outer events are not haphazard phenomena, but conform to patterns and have meanings. The course of inner and outer processes conforms to the patterns or archetypes found in the dreams of the observer. These patterns create the essence of process, 'process logic.' This logic gives coherence to all spontaneous perceptions. For example, apparently dissociated dream fragments are not independent pieces of some chaos, but cluster around a particular archetype. (1985a, p. 60)

Modern physics no longer considers space or time to be absolute qualities. Physicist David Finkelstein considers process to be more fundamental than either space or time: "classical quantum mechanics is a hybrid of classical concepts (space, time) and quantum concepts (states, tests). A more consistently quantum mechanics is proposed, with space, time, and matter replaced by one primitive concept of process" (quoted in Mindell, 1985a, p. 67).

In Process-Oriented Psychology, Mindell referred to this "primitive concept of process" as the *Unus Mundus*, or one world, a term borrowed from Jung: "The Unus Mundus is the world of archetypes in contrast to the world of archetypal manifestations such as dream processes and synchronicities . . . . (and) reflects a level of existence from which the manifest world is created" (Mindell, 1985a, p. 63).

Finally, in addition to linking physics and Process-Oriented Psychology, Mindell also considers the concept of process to be a bridge between physics and psychology generally:

> . . . in a post-Einsteinian universe, where telepathy, synchronicity, dreams, and somatic body trips occur, the concept of process unifies events which move from psyche to matter, imaginations into the body. This concept allows psychology and physics to come together and allows the process worker to deal with post-Einsteinian signals and channels, regardless of their inner mechanisms or superluminal nature. (1985a, p. 68)

Bringing Relativity into Psychology

In *River's Way*, Mindell wrote that Einstein's theories inspired him to relativize the channels in Process-Oriented Psychology.

Just as Einstein's theories established that neither space nor time are absolute, in Process-Oriented Psychology, the channel structure is not absolute. According to Einstein, there is a space-time continuum, and in Process-Oriented Psychology, there is a continuum of experience which has been differentiated into the auditory-visual-proprioception-kinesthesia-relationship-world channels. None of these channels has an absolute value relative to the others, and no channel exists apart from the others: they are all part of the same continuum of experience.

Many systems of psychotherapy appear to favor one type of channel experience over another. Depending upon its orientation, a school of psychotherapy may favor internal body experiences, verbal expression, movement, or visual imagery. In Process-Oriented Psychology, it is the information value of the experience that is important, not the channel in which it occurs.

In addition to relativizing the channels, Einstein's theory of the spacetime continuum has influenced the attitude of Process-Oriented Psychology toward what is "real" and what is not. As Capra has observed,

> We have no direct sensory experience of the four dimensional space-time, and whenever this relativistic reality manifests itself—that is, in all situations where high velocities are involved—we find it very hard to deal with it at the level of intuition and ordinary language. (Capra, 1988, p. 89)

In fact, we sometimes do appear to have direct sensory experience of four dimensional spacetime, and occasionally these experiences may occur within the context of psychotherapy. The process worker cannot simply dismiss experiences that are unique or unusual, such as telepathy or a synchronistic event, but must be receptive to them for at least two reasons. First, because they may be meaningful and helpful to the client; and second, because our commonsense notions of space and time are, after all, only relative.

The Phenomenological Attitude

In *River's Way*, Mindell wrote that Process-Oriented Psychology is derived in part from "the phenomenological attitude of theoretical physics" (1985a, p. viii). Traditionally, the phenomenological method is a

way of dealing with the information that presents itself to human experience. In Process-Oriented Psychology, the therapist takes a phenomenological approach by examining the facts of perception with an attitude of neutrality.

> One of the advantages of process science is its neutral basis. Since process work is based upon a phenomenological viewpoint, terms such as psyche and matter, inner and outer, psychology and physics, are replaced by the experiences, awareness, and observations of a given observer. Thus the physicist's approach to 'purely material' events is, in principle, no different that the process worker's approach to body, dream, or relationship experiences. (1985a, p. 55)

Psychotherapists display the natural tendency to classify perceived facts into specific categories. Once this is done, the inclination is to ignore any new facts that do not fit preconceived beliefs. The Process-Oriented therapist also categorizes experience, but attempts to remain neutral by remaining willing, moment by moment, to incorporate information that runs contrary to expectations. In so doing, the Process-Oriented therapist tries to stay as close as possible to the actual phenomenon without distorting it through interpretation. This is true whether the phenomena fit within a Newtonian framework of clearly delineated cause and effect, or within a relativistic framework of acausal, superluminal signals.

Although Process-Oriented Psychology strives for neutrality, it does not claim to be objective in any absolute sense. Mindell agrees with the perspective of modern physics which maintains that the observer's psychology affects that which is observed. This means that the therapist will always alter what is observed, no matter how close the therapist manages to get to the actual phenomenon.

The phenomenological attitude does not mean that the Process-Oriented therapist remains uninvolved. On the contrary, ideally the process worker is able to participate fully in the ongoing flow of events even while observing what is happening. This is far from easy, for whenever the therapist finds himself or herself at his or her own growing edge, the tendency is to lose awareness. As Mindell has noted, someone who could continually maintain the balance between experiencing and phenomenological awareness would "correspond to a psychological ideal, the integrated or whole individual, someone who is simultaneously involved and clear about his involvement" (1985a, p. 66).

Modern Physics and the Body

Mindell's understanding of modern physics has influenced the way in which he conceptualizes body phenomena.

Modern physics maintains that an observer affects that which is observed. Just as light resembles either a particle or a wave depending upon the nature of the observational process, so too the body takes on different appearances according to the way in which it is viewed. For example, if blood is drawn and analyzed, then the body is perceived in terms of blood chemistry. To an athlete running a race, the body consists of a medley of proprioceptive and kinesthetic sensations.

Mindell has referred to the body observed through objective physiological measurements as the 'real body,' while the body observed through individual experience is the 'dreambody.'

Typically, the measurements of the real body are considered to be more objective and valid than the body as perceived by individual

experience. And yet the real body can no longer be considered to be absolute, for several reasons. The first reason is that the subjectivity of the observer affects all observations, so that every measurement becomes relative. Secondly, if physicists view matter as energetic fields of varying intensities rather than solid, clearly defined particles, then we can no longer assume that the 'real body' is simply a solid object with objectively measurable qualities.

Just as a physicist must be able to view light as both particle and wave, so Mindell considers both the real body and the dreambody to be equally valid:

> Both real body and dreambody descriptions are valid within their own observational realm. Confusion arises only when one body description is treated more importantly than the other or when questions pertaining to one body are asked about the other body. (Mindell, 1982, pp. 10-11)

Mindell thus recognizes the 'real' body of objective physiological measurements as well as the dreambody of individual experience, and does not consider one to be more important or 'real' than the other. Valuable information would be overlooked if either the real body or the dreambody is not thoroughly investigated.

Applied to the practice of psychotherapy, this means that if a client reports that the client has high blood pressure, and also remarks that the beating of the client's heart is like the pounding of an anvil, then each of these statements reveals something about the nature of the client's body. Taking the first statement seriously might mean encouraging the client to continue to have the client's blood pressure monitored. Taking the second statement seriously might mean having the client amplify the client's

experience of the pounding anvil, and thereby discover more about the nature of the dreambody.

In a later work, Mindell (1989a) further differentiated the categories of body experience. These categories are described in Chapter 7.

The Individual's Relationship to the World

The theories of modern physics maintain that individuals do not exist in isolation from all other people and from the world. Mindell has used field theory and the analogy of the hologram to explain how the consciousness and destiny of the individual is inextricably linked to global and universal processes.

Field Theory

Mindell's inclusion of a world channel in the channel structure of Process-Oriented Psychology is critical to his theoretical explanations of synchronicity, dreaming up, and the nature of mental illness. The world channel includes the individual's relationship to unfamiliar people, and to collective groups of people, such as community, country, and foreign nations. It also includes the individual's relationship to inorganic phenomena such as physical objects and the universe.

Mindell has included a world channel because he noticed that different aspects of the world sometimes behave as though they are part of an individual's process. Information can be transferred to the individual via the world channel in a number of ways. In the case of dreaming up, the information is transmitted by another person. In the case of some synchronistic events, the information appears in the form of animals or

natural phenomena. In some cases, such as telepathy, the transfer of information from the world to the individual does not obey the principle of local causes.

The behavior of the world as a channel for the individual has led Mindell to speculate about the field-like properties of the human mind. As the examples above indicate, "our mind can be spread over space at any given moment" (Mindell, 1989b, p. 56). In other words, whereas the physical brain is located in the human skull, the mind behaves like a field of consciousness that extends throughout both local and nonlocal space. Each person is an individual whose field includes other individuals and the world at large.

This same field-like quality is also characteristic of the world itself, so that the "world is a field, organized by patterns, not by time and space" (Mindell, 1989b, p. 56). The world's field is inextricably linked with the fields of individuals. Just as the world can be a channel for the individual, so to is the individual a channel for the global field, which Mindell refers to as the global dreambody. Every person is simultaneously an individual dreambody and part of the collective dreambody.

> Thus an individual can be considered as the unconscious or the split-off and dreamed-up part of another person or group just as the group can be understood as a part of the individual. If we switch our viewpoints and no longer consider the individual and his dream as the center of the universe, but the universe's process as the central phenomenon organizing the behavior of its individual parts, we enter that part of psychology which borders upon relativistic physics. (Mindell, 1985a, p. 54)

The Hologram

In addition to having a field-like aspect, another way of describing the interrelatedness of the individual and the world is by using the analogy of the hologram.

Hologram theory was originally developed in the late 1940s by Nobel physicist Dennis Gabor, but it was not until the invention of the laser that it became possible to create holographic images. A hologram is a special kind of optical storage system in which an image of the whole is encoded in each of the parts. For example, suppose a holographic photograph is taken of a tree, and then the image of a branch is cut away. If the image of the branch is then enlarged to the size of the original photograph the resulting picture will be of the entire tree, not just an enlarged branch. In other words, each individual part of a holographic image is a condensed representation of the entire image.

In physics one of the leading proponents of a holographic model of the nature of reality and consciousness is David Bohm (1980). Bohm's theory is an attempt to account for the difference between the manifest world of appearances, in which objects appear separate and distant, and the underlying, hidden reality, which is indivisible and connected. Bohm refers to the phenomenal world, in which objects and events that appear to be separate and discrete in space and time, as the explicate or unfolded order. The explicate realm is contained within and generated by a more fundamental realm of undivided wholeness which he terms the implicate or enfolded order. Because the implicate whole is available to each explicate part, Bohm's model is a holographic one.

A holographic model of the universe depicts the relationship of a part to the whole in a very different manner than the Newtonian, mechanistic model. The Newtonian model emphasizes substance and quantity, so that there is a clear difference between, for example, a single cell and the entire body of which it is a part. The holographic model emphasizes information, so that a single cell, through its genetic code, contains information about the entire body.

Mindell has applied the holographic model to various aspects of human behavior and experience:

> The world we live in behaves, in many respects, like a hologram. It's broken up into little segments: nations, cities, religions, groups, or families, and each of these smaller segments carries the same pattern found in the world as a whole. (1987b, p. 99)

In discussing the treatment of the mentally ill, Mindell noted that according to hologram theory the inner personal situation of the client is a reflection of the outer situation in the environment, and vice versa. This perspective gives the therapist several treatment options:

> Seeing the world through the analogy of hologram theory helps you understand how you can change the individual by working with the world or change the world by working with the individual. Thus there are two ways of working with hopeless situations, extreme states, and impossible clients. One is by improving the psychotherapy of the individual and the other is by working on the world situation. (1988a, p. 101)

Synchronicity, dreaming up, and projection can also be viewed as holographic phenomena since each of them involve the mirroring of an inner psychological situation by an external event.

Finally, from a holographic perspective, our individual problems and joys are also an expression of a more global process. Mindell wrote that

"Your dreambody is yours, yet it's not yours. It's a collective phenomenon, belonging to nature and the world around you. Your dreambody is you, but it's also the entire universe" (1985b, p. 71).

Thus both field theory and holographic theory point to the same conclusion: that the separation between the individual and the world is in some essential way an illusion.

SECTION 3

Information Theory

Introduction

In his introduction to *River's Way*, Mindell wrote that process science is derived in part from electronic communication theory. Communication theory is also known as cybernetics, information theory, or systems theory. In this section I use the more common term information theory.

One way of describing Process-Oriented Psychology is that it is a signal-based system of psychotherapy. According to Goodbread, a signal is "any discrete piece of information which is perceived by the client, the therapist or both" (1987, p. 154). The integration of information theory into Process-Oriented Psychology is of central importance in understanding how a process-oriented therapist classifies and interprets perceived signals.

There are a number of ways in which information theory is integral to the theory and practice of Process-Oriented Psychology. These include a recognition of the fundamental importance of process, emphasis upon principles of organization, acknowledgment of the systemic nature of any therapeutic exchange, focus upon the informational value of events, and recognition of the significance of feedback.

Recognition of the Fundamental Importance of Process

As indicated by its very name, in Process-Oriented Psychology as in information theory, the processes are regarded as more fundamental than structure.

Mindell defined process as the variation of signals experienced by an observer. He contrasted process with the idea of a fixed state, which is "an unchanging description of a situation which has been broken up into parts" (Mindell, 1985a, p. 11).

A state-oriented psychology would tend to create fixed descriptions of subsets of human experience, and would then be inclined to perceive clients in terms of these descriptions. The drawback in this approach is that, for example, a state-oriented therapist might insist upon a specific procedure for curing a client, and would be likely to miss or ignore signals indicating that the procedure was not accurately recognizing or addressing the uniqueness of the client.

The process-oriented therapist forms hypotheses about the nature of therapeutic interactions, but must be prepared to discard the hypotheses immediately when they do not match what is occurring in the session. It is important to recognize the value of following a fixed routine when it is appropriate to do so, and then being alert enough to notice and respond to any anomalies in a routine pattern. In this way the process-oriented therapist attempts to recognize and respond to the dynamic and changing flow of events.

Emphasis Upon Principles of Organization

Information theory focuses upon the principles of organization of a given system. Process-Oriented Psychology does this by attempting to determine the process structure of a therapeutic interaction.

A process worker follows the flow of information by noting specific signals and classifying them according to the channels in which they are occurring. The process worker notes what the client does and does not identify with and classifies it in terms of primary and secondary process. By emphasizing process structure, and by employing terms such as channel and signals, Mindell is utilizing the language and epistemology of information theory.

The Systems Perspective

For many years, modern psychology did not attempt to take a systems view, in part because it emerged from and relied upon the epistemology of the predominant scientific disciplines. In the 18th and 19th centuries, physics and chemistry used the Cartesian-Newtonian epistemology to great effect. In the early years of this century, psychology sought to be equally rigorous, and the results were reflected in both the assumptions and language of psychotherapy. Influenced by Descartes, psychotherapy generally referred to "mind" and "body" as though they were distinct entities. The emphasis was upon internal psychological processes as distinct from somatic processes or from interactions with the environment.

For example, classical psychoanalysis is essentially a description of intrapsychic phenomena. Psychoanalytic terminology reflects this bias in

that the only term that bridges the gap between intrapsychic events and external behavior is projective identification. This approach maintains the mind/body split, represents the individual as isolated from the environment, and portrays mental illness as an individual problem. It was not until Bateson (1973), employing an information or systems theory perspective, that schizophrenia was clearly described in terms of interactions (double binds) between individuals.

Influenced by Newton, psychoanalysis made reference to psychic "objects" being acted upon by "forces" or "energy" in a causal, linear fashion. Adopting the notion of "energy" as a determinant of behavior was problematic. Even Jung, who attempted to incorporate a systems perspective into his view of the psyche, was hampered by his use of the term energy as an explanatory principle.

Information theory maintains that a system is an integrated whole. Process-Oriented Psychology clearly approaches psychotherapy from a systems perspective. In *Working With the Dreaming Body*, Mindell wrote:

> Looking at my client and understanding his dreambody from his point of view is a very meaningful experience for him. Yet it is also important for me to understand and to see what my dreambody is doing in my dreams, body and environment.
>
> However, now as I talk to you about the dreambody's information system, I'm able, for a moment, to step outside the situation long enough to notice something. Namely, that the two of us form a unity, an inseparable system whose parts can be defined,
>
> but not divided from one another. The two of us, the therapist and client, or the two partners of any couple, form the basic particles of a system.

> These particles cannot really be taken out of the system and analysed separately from the field in which they live. You cannot take a child out of its family and understand the child completely. You have to see this child within its family structure to understand it as fully as possible., When there are two people, there are three things happening. There's you, your partner and there's also the system or couple which you create and which behaves differently than the mere sum of its parts. (1985b, p. 75)

Mindell has applied a systems perspective to working with body symptoms (1985b); small group, community and global processes (1989b); relationships (1987b); mental illness (1988a); comas (1989a); and general process theory (1985a).

The Significance of Feedback

By paying close attention to signals, the Process-Oriented therapist is very attentive to feedback received from the client. For example, suppose a client tells the therapist that the client wants to change some aspect of the client's life. The therapist may then make a suggestion to the client about how this change might be achieved. The utility of the suggestion is determined by the feedback from the client.

Feedback can be either positive or negative. According to information theory, negative feedback maintains a homeostatic or steady state condition. Homeostasis is a way of achieving and maintaining stability and predictability in relationships. If the client responds negatively to the therapist's suggestion, then the process-oriented therapist recognizes that he or she must try another alternative if he or she is to support the client's desire to change.

If the client responds positively, then the therapist knows that this is the correct route to follow. According to information theory, positive feedback leads to a loss of equilibrium and results in change.

Feedback from the client indicates the most appropriate way for the client to change. Feedback tells the process-oriented therapist how to adapt his or her approach to the idiosyncratic needs of the client. This is in contrast to a "state-oriented" approach in which the therapist follows a set program without regard for the client's feedback. In addition, by noticing and responding to feedback the process worker is modeling an open system for the client.

The Information Value of Events

Information theory is concerned with the information value of events rather than the events themselves.

Mindell's emphasis on information enables him to avoid relying upon terms such as energy when discussing the nature of psychotherapeutic interactions. Focusing on information and identifying a wide range of channels in which signals occur allows the Process-Oriented therapist to track a process as it manifests in different aspects of the interactive system.

The appearance of an information-laden signal in successive channels is known as "channel switching," and is an example of what Mindell has referred to in teaching seminars as the conservation of information. For example, a Process-Oriented therapist may observe that a client is having a strong proprioceptive experience. When the proprioception has proceeded as far as it can in that channel, it may then

switch to a vision. This may in turn switch to a movement, and so forth. The information content of the original signal is being conserved, even while the channel in which the information is occurring is changing. It is the information being "carried" by the feeling, vision, or movement that is of primary importance. This approach is extremely flexible and allows the process worker to track the client's process as it shifts in focus from mind to body, or from individual to society.

As noted above, a key concept in information theory is that the more improbable an idea or event is, the higher its informational value. In process terminology, the signals of the primary process represent that which is ordinary and to be expected. Typically at some point, the client will begin to double signal, that is, will send a signal that contradicts the ongoing message of the primary process. These secondary signals, because they are relatively unusual and unexpected, have a greater information value than the primary signals. The attentive process worker will notice the secondary signals and encourage the client to amplify them so that the information they carry will become more accessible. Information theory provides a clear rationale for investigating the secondary signals.

SECTION 4

Gestalt Psychology

Introduction

In *River's Way*, Mindell wrote that Process-Oriented Psychology rests in part upon gestalt-oriented process work, and that "Fritz Perls encouraged me through his games with the hot seat to extravert the unconscious and try to get away with it" (1985a, p. vii). In this section, I briefly explain how several of the techniques of Gestalt Therapy succeed in extraverting the unconscious, and outline the significance of this approach for Process-Oriented Psychology.

Techniques of Gestalt Therapy

Perls utilized a number of psychotherapeutic techniques for working with clients. The two techniques that Mindell found useful in 'extraverting the unconscious' are psychodrama and the 'empty chair.'

In psychodrama, the client re-enacts specific, emotionally-charged situations by playing the roles of the various participants in the situation. The roles are re-enacted through verbal exchanges as well as movement. Many variations are possible, including the therapist acting out a role in the psychodrama, role-reversals, and so forth.

In the 'empty chair' technique (which Mindell referred to above as the 'hot seat') the client imagines that a significant figure in his or her life is seated in an empty chair. The client then has the opportunity to speak and act toward the figure in any way that the client needs. After

doing so, the client can then take the role of the imagined person and speak for him or her. This kind of dialogue continues as long as necessary.

These techniques are very effective in extraverting the unconscious. First comes the awareness that the client has two parts of his or her personality which are polarized. Each introverted, internalized part is then externalized; it is given a voice, posture, and movements. As both parts are acted out, the polarity between them is heightened. This has the effect of increasing the client's awareness of each part, and of the relationship between the parts. As awareness increases, and the needs of each part are expressed, there is a greater likelihood that the parts will learn to live in some degree of harmony, and that the client will learn to integrate their wishes into daily life.

Each of these techniques relies upon the willingness of therapist and client to regard the client's dream or memory as something that is happening in the present. All memories are expressed through the present moment. Instead of simply talking about the memory, the therapist and client work together to enact it, to make it come alive.

Gestalt Therapy and Process-Oriented Psychology

Mindell has incorporated these techniques into Process-Oriented Psychology with great effectiveness. In Process-Oriented Psychology, as in Gestalt Therapy, a great deal of emphasis is placed upon recognizing internalized figures (which Mindell refers to as dream figures) and identifying the polar figures with whom they are in relationship. When both figures are identified, then the polarity that exists between them becomes more explicit to consciousness.

Simply recognizing internal, polarized figures is useful. But it is even more useful to externalize and amplify them, to give them a chance to express themselves in the different channels of speaking, hearing, feeling, and moving.

If a process needs to remain internal, then a process-oriented therapist will support that. But if the client gives positive feedback about externalizing a process, then the process-oriented therapist has the option of using the role-playing techniques described above. In this way, the techniques used by Perls have become an integral part of Process-Oriented Psychology.

SECTION 5

Neuro-Linguistic Programming

Introduction

In *River's Way*, Mindell wrote that "Behaviorists such as Grinder and Bandler challenged me to discover the unconscious in their behaviorist's reality" (1985a, p. vii). In this section, I describe some of the ways in which Mindell has incorporated the basic principles and approaches of Neuro-Linguistic Programming (NLP) into Process-Oriented Psychology, including use of information channels, emphasis upon sensory-based information, methods of establishing rapport, recognition that people favor certain channels, and emphasis upon awareness as a way of distinguishing between conscious and unconscious.

Channel Structure

The concept of information being conveyed in discrete channels was developed as part of information theory (described in Appendix C, Section 3). Bandler and Grinder applied the channel concept to psychotherapy. In *The Structure of Magic*, Vol. II, Bandler and Grinder wrote that

> There are three major input channels by which we, as human beings, receive information about the world around us—vision, audition, and kinesthetics (body sensations). (The remaining two most commonly accepted sensory input channels—smell and taste—are, apparently, little utilized as ways of gaining information about the world.). (Bandler & Grinder, 1976, pp. 4-5)

Mindell appears to have followed NLP in applying the use of the word and the general concept of "channel" to psychological phenomena. Along

with NLP, Process-Oriented Psychology recognizes the visual and auditory channels and does not emphasize either smell or taste. The NLP focus on the kinesthetic channel has been differentiated by Mindell into the proprioceptive (body sensations) and kinesthetic (movement) channels. Mindell also acknowledges two composite channels which he refers to as "relationship" and "world."

Writing about the relationship channel, Mindell observed that "Modern neurolinguistic programmers practice Freudian theory in so far as personal relationships between the individual and therapist are avoided because they create dependence" (1985a, p. 40). Bandler and Grinder described their relationship with the client as 'uptime.'

> We know what outcomes we want, and we put ourselves into what we call "uptime," in which we're completely in sensory experience and have no consciousness at all. We aren't aware of our internal feelings, pictures, voices, or anything else internal. We are in sensory experience in relationship to you and noticing how you respond to us. We keep changing our behavior until you respond the way we want you to.
>
> Right now I know what I'm saying because I'm listening to myself externally. I know how much sense you're making of what I'm saying by your responses to it, both conscious and unconscious. I am seeing those. I'm not commenting on them internally, simply noticing them and adjusting my behavior. I have no idea what I feel like internally. I have tactile kinesthetic awareness. I can feel my hand on my jacket, for instance. It's a particular altered state. It's one trance out of many, and a useful one for leading groups. (Bandler & Grinder, 1979, p. 55)

Bandler and Grinder are attempting to stay within a strictly behaviorist stimulus-response model, one in which only the client is acknowledged to have an internal reality. Such an approach limits the range of information considered by the therapist, and, therefore, the range

of available interventions. In this respect, the NLP model is radically different from Process-Oriented Psychology, in which the relationship channel is acknowledged and is considered critical (to varying degrees) to most if not all therapeutic encounters.

A further difference is that Mindell, following the Jungian model, has differentiated each channel into introverted and extraverted aspects. Mindell has described this aspect of the channel system in *River's Way.*

Emphasis Upon Sensory-Based Information

Another connection between NLP and Process-Oriented Psychology is the degree to which both emphasize the role of the therapist in gathering precise sensory-based information, both verbal and nonverbal, in the different channels. This is a central focus of Process-Oriented Psychology, as it was in NLP, and many of the specific information-gathering approaches (such as attending to eye movements and the predicates a person uses to describe her situation) appear to be derived from NLP.

Methods of Establishing Rapport

In both systems the therapist uses the information gathered to establish rapport on both verbal and nonverbal levels with the client. In NLP this is known as "matching":

> To effectively gather information or beginning a process of change, it will always be important to establish rapport between yourself and your client at both the conscious and unconscious level. An invaluable technique for doing just this is to generate verbal and nonverbal behavior which matches that of your client. This is called "matching." The client's subjective experience becomes one of being really understood. (Cameron-Bandler, 1978, p. 64)

This process of joining the inner world of the client is an essential aspect of Process-Oriented Psychology. NLP provided many insights about how to match with precision, and these are an implicit part of Mindell's system.

Awareness of the Channels

A fourth parallel is the fact that although information is being processed in all channels simultaneously, people have different degrees of awareness of the separate channels. Bandler and Grinder wrote:

> How many here now see clearly that they are visually oriented people? How many people see that? How many people here feel that they are really kinesthetically oriented people in their process? Who tell themselves that they are auditory? Actually all of you are doing all of the things we're talking about, all the time. The only question is, which portion of the complex internal process do you bring into awareness? All channels are processing information all the time, but only part of that will be in consciousness. (1979, p. 34)

People tend to be aware of or favor certain channels over the others. In NLP, this favoritism is referred to as the person's lead system and representational system. In Process-Oriented Psychology, Mindell refers to it as the main and unoccupied channels.

The Importance of the Lesser-Used Channels

Both NLP and Process-Oriented Psychology maintain that experiences that occur in lesser-used channels tend to be quite powerful. Bandler and Grinder described this phenomenon as follows:

> If you use guided fantasy with your clients, there are some clients you use it with automatically and it works fine. Other people you wouldn't even try it with. What's the criterion you use to decide that, do you know? If they can visualize easily, you use visual

> guided fantasy, right? We're suggesting that you reverse that. Because for people who do not normally visualize in consciousness, visual guided fantasy will be a mind-blowing, profound change experience. For those who visualize all the time, it will be far less useful. (1979, p. 44)

In the same fashion Mindell wrote that

> The main and unoccupied channels are important for the process worker for if he can determine which channel is a primary one and which the unoccupied or secondary, then the main channel can be use to integrate irrational secondary processes. An unoccupied channel will bring the client the most powerful and uncontrolled experience. (1985a, p. 24)

Conscious and Unconscious

Finally, in both systems there is an emphasis on awareness as the key to distinguishing between conscious and unconscious. Bandler and Grinder advised people not to

> . . . get caught by the words 'conscious' and 'unconscious.' They are not real. They are just a way of describing events that is useful in the context called therapeutic change. 'Conscious' is defined as whatever you are aware of at a moment in time. 'Unconscious' is everything else. (1979, p. 37)

Mindell made the same distinction when he wrote that " . . . consciousness refers only to those processes of which you are completely aware . . . .unconsciousness refers to all other types of signal processes" (1985a, p. 13).

Conclusion

At the beginning of this section, I quoted Mindell as saying that Bandler and Grinder challenged him to discover the unconscious in their behaviorist's reality. The behaviorist reality of Bandler and Grinder focuses with precision upon a wide range of verbal and nonverbal cues.

Attending to these clues enables the therapist to construct an accurate model of the client's (often unconscious) inner world. Ideally the therapist is then able to enter that world to facilitate change.

Mindell's greatest debt to NLP is derived from the range and precision with which Bandler and Grinder attended to the client's signals and the use of the channel concept as a means of categorizing the signals. This approach has been critical to the development of Process-Oriented Psychology.

The way in which Mindell has developed signal awareness and the channel structure differs considerably from the NLP model. For example, the inclusion of relationship and world channels makes Mindell's model a more encompassing one, so that Process-Oriented Psychology operates from different premises and allows a greater range of interventions. Consequently the way in which a Process-Oriented Therapist interacts with a client could—and likely would—differ in many ways from a Neuro-Linguistic Programmer. Since my purpose here is to describe what Mindell appears to have derived from NLP, it is beyond the scope of this section to emphasize the differences between the two systems in greater detail.

APPENDIX D

CONSENT FORMS

CLIENT CONSENT FORM

1. I, _____ , freely participated in a psychotherapy session which focused on chronic body symptoms and a childhood dream. The session was held in Tschierv, Switzerland, in April, 1986.

2. In addition, I freely participated in an interview related to the psychotherapy session, conducted in October, 1990, in Waldport, Oregon.

3. I hereby authorize Alan Strachan, M.A., of the Institute of Transpersonal Psychology, Menlo Park, CA, to use the material and insights he gained from a videotape of this psychotherapy session and an audiotape of the interview in his dissertation, to use what is written in that dissertation in talks or other written forms, and to allow others to copy and use parts or all of the dissertation.

4. I understand that my identity will be kept in confidence by Alan Strachan so that I cannot be identified in any way as having participated in the case study.

_____ _____

Client's Signature Date

THERAPIST CONSENT FORM

1. I, _____ , freely conducted a psychotherapy session with the client of this case study. The session was held in Tschierv, Switzerland, in April, 1986.

2. I hereby authorize Alan Strachan, M.A., of the Institute of Transpersonal Psychology, Menlo Park, CA, to use the material and insights he gained from a videotape of this psychotherapy session in his dissertation, to use what is written in that dissertation in talks or other written forms, and to allow others to copy and use parts or all of the dissertation.

_____ _____

Therapist's Signature Date