# Seeking 'sacred moments' in psychotherapy and in life

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Summary

This paper describes a particularly powerful event in a long-term psychotherapy. A patient reports an experience which could be variously classified as sacred, paranormal, or anomalous. The importance of this event and the way in which it was handled in therapy seems confirmed by the subsequent evolution of the therapeutic work. The consequences are described by a series of vignettes from a psychoanalytic perspective.

Key Words: paranormal, anomalous, sacred, internalization, spiritual, psychotherapy, psychoanalysis

## Introduction

This paper describes a clinical experience with what could be variously described as an anomalous, 'paranormal', or sacred phenomenon, and then discusses it from a psychoanalytic perspective. This patient had been silently concerned that what she had thought of as a 'paranormal' experience provided further evidence of herself as an 'odd', 'weird', and 'severely pathologic' individual for over a year before the session in which she reported her unusual experiences. The evolution of this experience as an element of the therapeutic growth and increased personal capacity of the patient about a year later is also described. This clinical story illustrates the importance of achieving clinically useful understanding of unusual experiences. The purpose of the paper is to encourage openness to descriptions of anomalous experiences and to work with patients to construct meanings of these experiences which promote health, positive coping, and personal growth. 'Anomalous' is used as a generic term to describe statistically unusual experiences of connectedness that may be considered paranormal in some contexts, but 'sacred' in others. In longer term treatment relationships, the intersubjective/co-created construct by patient and therapist of these experiences has profound outcome implications.

## Clinical vignette

A mid career ICU Cardiologist had been in treatment for over a year when the following session occurred. Her DSM IV diagnosis had been major depression. She was distressed by a series of disappointments in her personal and professional life. A simplified version of her developmental history is that she had a long series of severe, but not technically 'traumatic', developmental interferences beginning with rather extreme and somewhat odd failures of 'self object function' (acceptance, mirror-

ing and affirmation) by both parents. Repetitively she would come to them with an idea, thought, accomplishment, or feeling to which they would respond dismissively, accusingly, or in other ways that made her feel foolish or 'inappropriate'. She felt herself to be particularly unloved and unappreciated in comparison to her younger brother. He was either favored or incomprehensively supported by both parents, but especially her mother, in spite of behaviors that ranged from disagreeable to quite dangerous for her and later for the family.

She had attempted treatment with several psychiatrists and other professionals before referral for a more intensive psychotherapy. We were meeting twice a week at the time of the following session. She was a faculty member of a department led by an internationally famous physician, Dr. C., who led a program with over $100 million dollar annual research income and nearly 600 members. Even more importantly to this story, however, Dr. C. also possessed an incredible, almost mythic ability to make not only faculty and residents, but also staff and students feel important and valued members of 'The Team'.

**Patient**: "I feel pretty good today. I do not have much to say...You keep saying that I don't trust you, but I think I am trying as hard as I can to do that."
**Therapist**: "It seems like you take my observations, especially those related to the difficulty of our project as a criticism or a statement that you should be somehow different than you are."
**Patient**: "I do kind of interpret things negatively. I am feeling kind of scattered today. I usually try to think of what I need to bring to the table, but was not able to come up with very much for today. (Without much of a pause) A good thing that **did** happen today was that I submitted my article on end-of-life care, *Death in the ICU*. It made me feel good because my division chief actually **liked** it."
**Therapist**: "Could you give me a thumbnail sketch of your article and your part in it?"
**Patient**: "Yes. I felt I had little choice about involvement with end-of-life care. This effort has been a pretty intense project of our division for many years. My particular article gives statistics on death in ICUs, attachment issues at times of loss, how to communicate with the family, and what should be done physically with the family at times of death. There is also a section on the grief process and bereavement, including material about cultural and the religious matters. It took me nearly a year to do it. My boss liked it and hardly edited anything I wrote at all.
I guess I got interested because death was sort of ignored in my family. When my grandmother died, we hardly talked about it. I didn't go to my dad's father's funeral at all. I did go to my mother's mother's funeral, but my mother and her brother didn't even cry there. They had a memorial service. It seemed cold that my uncle stored my grandmother's ashes in his garage for a year until the service. I had a lot of feelings, but I was not supposed to talk about them."
**Therapist**: "We talk about the current implications of that a lot."
**Patient**: "I remember a terrible incident from about five years ago. I am not even sure about just what caused the death of a young adult, but I was so focused on getting the time of death exactly right that I remember telling the family 'the time of death was whatever'. My voice was really hard. I didn't really help things by being so stressed out about the death or by how I handled it.
Now I want to improve family circumstances in the intensive care unit, but I am not sure." (patient stopped talking rather abruptly).
**Therapist**: "You said you weren't sure and then you stopped yourself."
**Patient**: "Well, I'm not sure it's ok to express emotions or my spiritual beliefs about it. (With hesitation) It's weird, but I have these '**paranormal**' experiences. When I was about 14 years old, I was babysitting for a girl named Caroline who was 14 or 16 months old. It was raining. I had put Caroline to bed and was watching TV and doing my homework. The phone rang and it was this man's voice saying '**I can see you and I'm going to kill you.**' I figured it was a prank call so I hung up. But I double checked the locks and closed the blinds in the room where I was studying. Then I heard Caroline start screaming. I could see her pointing through the crib rails towards the wall in the room where she had been sleeping. She kept on scream-

ing so I picked her up and walked her back to the room where I had been studying, but the light was turned off and TV channel had been changed. That scared me so I asked a friend to come over. She came, but she felt weird too, so we walked to my family home which was only a couple of houses away till the family I was babysitting for came home. I told them about what happened, but they sort of blew me off. You know, they never asked me to babysit again.

(Again, with a bit of hesitation) I have had other experiences that I am not comfortable talking about."

**Therapist**: "What do you think is making you uncomfortable?"

**Patient**: "Well, they are strange and I don't know how to feel about them. Does anyone ever talk to you about things like that?"

**Therapist**: "I think you are afraid that I am going to make you feel worse, silly, or inappropriate."

**Patient**: "Yes, and here's something weirder and am not sure I can talk about this. (She begins to cry.) You know I felt very close to Dr. C. Before he died, we all knew he had cancer. Another member of our section also had metastatic cancer. He and I were talking about his relapse, but he said at least for him, treatments were working. After that talk I went right away to talk to Dr. C. I wanted him to know how much he meant to me. Actually, he spent most of that time comforting me! At the end, I told him I loved him and gave him a kiss on the cheek. He gave me a kiss back and said that he loved me also. As I left, I tried to help him with his chair. He laughed and said "**I'm not dead yet!**"

Later that month I was in Alaska with my fiancé. I didn't have email access. About 2:00 PM that day, close to the time when Dr. C. was dying in Houston, we were dog sledding out on a glacier with nothing but snow around us. I got off the sled and it felt like Dr. C. was standing next to me. I felt him and heard something like his voice inside me saying: "**Yes, I've died, but I love you. I will always love you, and you will do well.**" Of course, I began to cry just like I am now, but I got back on the sled to finish the ride. I didn't say anything about this to my fiancé. I was concerned he would think it was too weird. Other people were teary because of the wind and snow, but that wasn't what was happening for me. We got on a helicopter and eventually returned to the cruise ship. The next day, I called my mother. She began the phone conversation by asking '**Have you heard'.** I said: '**Yes, I heard**.' (but nothing else). She confirmed when he died and it was right before I had that experience. I still couldn't talk about it to anyone (This event had actually happened *months* before the session being discussed).

After the ship arrived in Anchorage, my fiancé and I took a trip to Denali National Park. Mount McKinley is famous because it can be so difficult to see the top of the mountain. When we got there, the mountain, of course, was covered in clouds. I stood there and asked Dr. C. to move the clouds off the mountain as a sign to me that he was alright. Of course, nothing happened immediately, but two hours later, the clouds cleared for three whole days. Everyone there said they had never seen anything like it. For me, that was very special."

**Therapist**: "That was very special indeed."

**Patient**: (Crying a bit more intensely) "I have never told anyone about this till now. Those moments will always be special to me."

**Therapist**: "They should be. It's a very beautiful love story."

**Patient**: "It is also surprising to me. Does this routinely happen?"

**Therapist**: "The sort of love that you had with Dr. C. is hardly routine."

**Patient**: (Crying a bit more heavily) "But do other people have experiences like this with people who have died?"

**Therapist**: "Only if they are extremely lucky."

**Patient**: "I had lunch with my dad today. His Parkinson's is getting worse, and even a very small thing I say that could possibly be construed as a criticism makes him so labile. The conversation went well, but it took quite a bit of effort on my part."

**Therapist**: "That effort and love which is even more remarkable because you provide him empathy, attention, and love in a way that, for whatever reason, he couldn't consistently give you as a little girl."

**Patient**: (Getting up from the couch and smiling though still with a lot of tears) "I'll probably cry the

rest of the afternoon. Thank you for letting me tell you this. I may even tell my fiancé now." She did, but a year later.)

**Therapist**: "Stories like this get richer when told in safe relationships to the right person. Clearly today has been a major step and probably both of us are thinking about how you started the session with the protest that you didn't have much to say. (Patient chuckles.) Something like this is, of course, incredibly important. Try to capture wherever this session goes inside you to bring it back so we can know about it together." (Patient nods, says, "Thank you very much" and leaves.)

## History of 'paranormal experience'

In another paper on this topic (Lomax, Kripal & Pargament, 2011), Jeff Kripal provides a historical perspective on a paranormal experience. For the different purposes of this presentation, his work will be greatly summarized to say that experiences like the one just presented (a) are rather common and have stimulated scientific and scholarly discussions reflective of the time in which they occurred; (b) that 'paranormal' for the psychologist may be considered similarly to discussions of 'the sacred' for the sociologist or the historian of religion; (c) that 'the sacred' may not only refer to an encounter with the 'objective existence' of a divine other, but also describe a subjective experience that provides evidence of the fundamental structure of the mind or brain; (d) tend to be very meaningful for those who experience them; (e) often occur with the loss of emotionally significant figures and/or love relationships; and (f) if shared constructively, may help in the healing of traumatic loss.

## The sacred moment as a significant aspect of psychotherapy and psychoanalysis

In that same paper, Pargament suggests that: (1) sacred moments are in fact identifiable; (2) sacred moments have tremendous power in peoples' lives; and (3) by addressing sacred moments in treatment, practitioners may enhance the therapeutic alliance and, in turn, the effectiveness of treatment (Pargament, 2007). Below we define some terms and briefly summarize the research basis for each of these points.

### *Sacred moments are identifiable*

While we cannot verify the ontological reality of these spiritual or anomalous eruptions through scientific methods, it is clear that many people *perceive* sacred moments in their lives and those anomalous experiences are constructed as 'paranormal' by some people, sacred by others. Sacred moments include but are not limited to direct experiences with God or higher powers. They encompass any human experience of transcendence, boundlessness, and ultimacy (Pargament & Mahoney, 2005), experiences of the kind just described.

*Transcendence* refers to things set apart from the ordinary, the immediate, the everyday. We hear examples of transcendent experience in the vignette: the disturbing events she recalled when she was babysitting so many years ago, and the sign she requested and received from her mentor, Dr. C., following his death – the highly unusual clearing of clouds off the top of Mount McKinley. *Boundlessness* has to do with perceptions that go beyond the limits of ordinary time and space. In sacred moments, we hear the language of time stopping, space expanding, and boundaries fading. This is a shift from chronos, time and space understood quantitatively, to cairos, time and space experienced qualitatively. In the description of her death-transcending encounter with her mentor, the patient conveys this sense of boundlessness. She hears him tell her: 'Yes, I've died, but I love you, and I will always love you.' *Ultimacy* refers to perceptions of deep truth, what anthropologist Clifford Geertz described as 'the really, real'. Because they are perceived as absolutely true, absolutely real, sacred experiences have tremendous authority and legitimacy. They are written indelibly into human memory. Thus, the patient has no trouble recalling her troubled experience as a babysitter even though it occurred decades earlier. One would guess and *hope* that she will hold on to the memory of her spiritual encounter with Dr. C. for the rest of her life. In part, the chances of that resource enduring are determined because of the way it is told, received, and experienced in a treatment relationship.

The point here is that sacred moments are identifiable. We can articulate markers of sacred

moments, such as transcendence, boundlessness, and ultimacy, and even attempt to measure them. Research survey studies have shown that a majority of people who experienced the death of a loved one report a continued connection with them: hearing a voice, feeling a touch, sensing a presence, or catching a glimpse of the deceased (e.g., Sormanti & August, 1977). People spontaneously use the language of transcendence, boundlessness, and ultimacy to describe such occurrences in their lives (Hood, Hill & Spilka, 2009; Pargament & Mahoney, 2005). Of course, the language of sacred moments could be dismissed as simply poetic or overly-romanticized. There is, however, reason to believe that sacred moments have significant power for many people.

*Sacred moments have power in people's lives*

Empirical studies suggest that the emotions related to the experience of sacredness have a variety of implications. Vaillant (2008) considers these same and related emotions as part of an adaptive, evolutionary impetus for spirituality. These positive, spiritual emotions (such as love, awe, joy, etc.), have been linked with significant psychological, social, and physical benefits. For instance, Schnall *et al*. recently reported that the feelings of elevation elicited by watching another person perform a good deed resulted in tangible increases in altruistic behaviors (Schnall, Roper, & Fessler, 2010). Perceptions of sacredness serve as vital resources for many people, especially in difficult times, offering the capacity to sooth, comfort, inspire, and empower (LaMothe, 1998). At a deeper level, they can provide individuals with a way to find meaning in life, a way to connect themselves with the past and future, and a way to link people together in larger communities. Several studies have shown that people derive considerable satisfaction from sacred experiences and moments (Pargament & Mahoney, 2005). Finally, sacred moments can become organizing forces that lend coherence to disparate thoughts, feelings, actions, and behaviors. Sacred moments can serve as pivotal points in time that lead to fundamental, life-changing transformations. Consider again the message received by the patient from her former mentor – "I will always love you." A message of this kind is likely to have a profound and lasting impact for a woman with a history of troubled relationships with her primary attachment figures.

Although sacred moments are often experienced positively, they also have the potential to elicit spiritual struggle and strain, for they may trigger fundamental questions about an individual's self-definition, worldview, and ultimate goals and values in life. Spiritual struggles may be especially problematic when compounded by a history of insecure attachments with parental figures which leave the person ill-equipped to examine extraordinary experiences with curiosity and openness. It is not surprising that this patient, following some gentle prodding on the part of the therapist, admits that she is uncomfortable discussing her sacred moments. Repeated experiences of rejection and disapproval by her parents throughout her early years had left her unable to trust her own perceptual system. Powerful experiences of potentially remarkable value became, instead, sources of doubt, turmoil, and confusion. Unless resolved, these spiritual struggles could have exacerbated the patient's depressive condition, as empirical studies have shown (Exline & Rose, 2005; Pargament, Murray-Swank, Magyar & Ano, 2005).

*Extraordinary moments should be addressed directly in treatment*

It is paradoxical that patients are often most reluctant to discuss those experiences that hold greatest power. This patient's discomfort likely reflected, in part, her history of ambivalence towards authoritative experiences (as well as authoritative figures) in her life. However, it also grew out of fears about how others, including her therapist, would respond to these experiences. These fears are not ungrounded, given the history of antipathy of mental health professionals to religion and spirituality. Surveys indicate that many patients would like to be able to discuss spiritual issues in therapy if their disclosures were met with support rather than criticism (Rose, Westefeld, & Ansley, 2001). Commenting on the patient's experience of the spiritual sign of a parting of the clouds on Mount McKinley, the analyst begins by saying, "That was very special indeed." When his patient went on to ask whether other people have similar

experiences with people who have died, "Only if they are extremely lucky," provided an affirmation that helped move the therapy to a deeper, more profound level. In fact, it helped bring the sacred moments the patient had experienced outside of therapy into the therapeutic relationship itself in what might be considered a 'corrective emotional experience'. Such therapeutic experience can heal developmental interferences from unfortunate experiences at earlier 'critical periods' of developmental vulnerability/opportunity. ***In this sense, sacred moments occur not only within individuals, but also between people.***

Empirical evidence suggests that more explicit attention to spirituality may promote the effectiveness of treatment (Pargament, 2007; Smith, Bartz, & Richards, 2007). Pargament concludes that such 'sacred' moments are potentially critical ingredients in the recipe for successful treatment and, as such, deserve serious attention and therapists should nurture or 'seek' them in treatment relationships. The challenge is for researchers and practitioners to delve more deeply into sacred moments and develop greater awareness of their place in life. In doing so, we may foster our understanding of our patients, their understanding of themselves, and our ability to stimulate meaningful growth and change.

## A psychoanalytic framework for anomalous sacred experience

The primary clinical role of the therapist listening to a description of anomalous, sacred, spiritual, or religious experience is to understand and to respond to the mechanisms and the mediation of the experience by the mind and the brain. That understanding allows us to detect problems and psychopathology and to promote meaning and health. This is the same clinical role we have with the other domains of human experience. The quite personal, often highly emotional nature of these experiences – in a manner quite analogous to human sexuality – makes this topic worthy of special attention and focus.

### *Spirituality as attachment seeking*

From a psychological perspective, the 'spiritual' dimension of religious participation can also be seen more specifically as an expression of 'attachment behavior'. Of course, the term 'spiritual' is used to mean or modify very different things including 'beliefs', i.e. cognitions. At least one definition of spirituality, however, in both the medical/scientific and religious/theoretical literature is to refer to a type of 'seeking behavior' satisfied by relationships of a particular quality. The term seeking behavior is here used in the manner of Jaak Panksepp, an Experimental Psychologist who describes an animal model of 'seeking behavior' in his text *Affective Neuroscience* (1998). Spiritual pursuits in this sense involve seeking a connectedness with God, other people, or nature. In developmentally mature, healthy individuals (those with mature 'object relationships') such 'seeking' is characterized by an interest in and valuation of the 'other as separate, important, and distinct from 'self'.

One very important contribution to a discussion of spirituality as attachment was provided by the Jesuit Priest and Psychoanalyst, William Meissner, in his development of Winnicott's concept of the 'transitional phenomena' (Meissner, 1984). The Soothing Teddy Bear of childhood becomes the unopened anxiolytic prescription or even our phone number carried 'faithfully' by a patient with panic disorder. Growth-producing illusions have ties to reality, but also measure the capacity of the person to transform reality into something reflective of inner significance and hope – 'creative illusion formation' in Meissner's terms. In our conversation of spirituality as attachment, 'sacred objects' are meaningful because they reflect the 'inner significance and hope' of the religious or spiritual person who has 'transformed' an ordinary material object into something that represents an emotionally significant relationship with a powerful and desired other – parent, healer, or God.

### *Religion as individual and group 'cognitions'*

In contrast to spirituality-as-attachment, formal religious organization and particularly religiously-based moral or ethical reasoning can be considered as expressions of the human tendency to order experience and to understand the meaning of experience. Mentalization, as described by Peter Fonagy and Jon Allen (Allen & Fonagy, 2006), includes the concept that such cognitive ordering of percep-

tion includes affective states and allows us to create a set of working theories about the minds of other peoples' intentions, motivations, and plans. This ability to 'keep an other's mind in mind' allows us to function successfully in a complex, interdependent society. Mentalization based psychotherapy is the structured use of this concept and one of the evidenced-based treatments for borderline personality disorder (Allen & Fonagy, 2006) and Posttraumatic Stress Disorder (Allen, 1995).

*Religious acts and activity*

For clinical purposes, a third 'variety' of religious experiences may be considered to be the domain of religious activity and community participation. Active religious participation is more likely to be health promoting than passive religious participation. Activity which reflects the psychological capacity for 'generativity' seems to be of particular value in this regard (Burgener, 1994; Vaillant, 2002). Not only the 'being in' community, but also 'doing for' others seems health promoting. Thus, knowing what our patients 'do with' their anomalous, religious, or spiritual experience is important in assessing the healthcare consequences of such experiences.

## Clinical consequences of a 'good enough' understanding of a paranormal experience

To be truly worthy of our attention, there should be significant treatment outcome implications of how the therapist deals with a report of a paranormal experience. Our shared experience of her 'mystical' / paranormal encounter with her mentor during the snow storm in fact was an important element in building our therapeutic space and foundation. A bit over a year after that event, several things occurred over approximately a six week period which revealed an important and clinically useful extension of the therapeutic relationship which had been consolidated at that time. These events were precipitated when she came upon an article, *The Gift of Depression*, written by a patient with depression when she inferred was also a patient of mine (Goddard-Finegold, 2009). My patient found this article irritating and somewhat threatening, particularly a comment made by the author that a psychiatrist might need to refer a patient to someone else if over stimulated (positively or negatively) by the patient. This made her worry whether she was "too competitive" (both in general and particularly as was being revealed by her response to the article). She feared that her response to her discovery would make me "like her less" – especially if I was aware that, in her fantasies, the amount of rage she felt in general and at specific times in our relationship made her want "to use curse words and throw things." In short, although she was pretty confident that our treatment relationship had resulted in steady, positive developments in both her personal and vocational life, she was also consciously concerned that revisiting a developmental 'critical period' within our treatment relationship might result in a repeat of the rejection, dismissiveness, and abandonment-in-favor-of-others that she had experienced in her childhood. This 'resisting' of problematic aspects of developmental interferences within the therapeutic relationship is simultaneously a threatening crisis and also a critical opportunity for therapeutic growth.

After reading the article, she soon had what she referred to as two "exposition dreams". In one of those dreams she had signed up for a class in college but did not attend it. Now it was time to take the exam. At a cognitive level, she recognized this as a fairly common dream in our culture. She thought this dream had to do with her being uncertain about her efforts to "be more of herself" and to express herself. However, regardless of those useful and accurate bits of cognitive self analysis, the article had made her emotionally quite anxious.

The second dream involved her being on a trip with her mother and brother on a mountainous, winding road. They passed by "motorcycle crashes" that her mother "minimized" and bypassed. In the dream she wanted to help the crash victims. She thought this dream was connected to her wishes to deal with her "family carnage." She reminded me that she had been quite frustrated by her parents' discouraging responses to her efforts to find out about their disputes and fights. She was concerned I was seeing more progress in our project than she was (minimizing dangers) or at least than she felt confident about. She also questioned whether I

saw her often (three times a week at this point) in order to pay off "debts to Barnard College" – which she had deduced after fortuitously following my car (with a Barnard sticker) into our parking garage. These "exposition dreams" were indicators that something was brewing in our project that was of great importance. Based on her past experiences with attachment figures, she was concerned whether either of us were up to the task at hand.

From time to time my patient had begun to send me "musings" that she had written in response to various things that had come up in our sessions. She slowly came to know (with some relief) that I was quite interested in her essays and not afraid of her creative reflections upon and constructions of our experience. We discussed them in ways that let her feel that I thought the "musings" elegantly captured some of our struggles within the analysis. I would ask her to tell me how the stories were evoked and how they developed inside her. During this particular period, she wrote one essay entitled *Aster* about the tentative and fragile blossoming of the small flower. The essay was somewhat surprisingly (especially to her) positive and reflected her sense of growth and some increasing tolerance of her unruly wishes. As we discussed this essay, she noted that the "permission" of analysis allowed her to potentially become something beautiful (like an Aster), but it also involved an experience of herself which was far less "controlled," albeit more authentic or "real". She was quite concerned that the unfolding of that "new" self could be dangerous for both of us. She noted that sometimes she felt more like "a blot on a white sheet" instead of the more positive image of an Aster-in-bloom.

However, as we worked through her concerns about her unseemly aggressiveness historically, in current relationships, and in the transference, her urges became less frightening and she became more curious about them. She reported even feeling "peaceful with herself."

As this evolved, she "found myself praying again after a long period of time." Her prayers included requests for "protection of the persons she considers closest." She also noted that she felt "closer to God" and was somehow a bit less worried about her new found happiness "being destroyed" (by God). She furthermore reported during this time that she had the thought that I wanted her to have a baby in spite of her frequently expressed concerns about not wanting to "torture a baby the way she felt tortured as a little girl." This thought about my wishes seemed to be an important affirmation that she (and what she might produce) was loveable and worthy of continuation – a positive internalization of our therapeutic relationship.

As these things were occurring, an event at her workplace led her to feel justified and vindicated: an aggressive and devaluating superior was severely reprimanded. However, her excitement about this serendipitous event was somewhat dampened by a series of memories of wanting to hurt herself as a child when negative things happened to others she disliked. In spite of the mixed elements of this experience, she was able to take on new opportunities that became available to her as a result of this workplace change.

As we explored how it was that her childhood fantasies often involved religious ideas, she recalled and reported newly available, positive memories about her relationship with her maternal grandmother. This grandmother was "very religious and very kind to me." She recalled how they would read religious picture books and the Bible together. While the relationship was quite comforting and a solace, she remembers also being confused about their discussions of "right and wrong." She specifically recalled the story of Elijah's ascension in the dessert. Her fantasies about the story quickly included her own childhood wish to be rescued (mostly from her nuclear family) like Elijah was in a picture she found from her childhood Bible – whisked away in a chariot with elegant, muscular horses. These memories seemed connected to the hope that our treatment relationship would – a bit more dramatically than possible – help extract her from the enmeshed misery she experienced with her family of origin.

As she and I were discussing her memories of Biblical stories, she wrote and sent the musing *Stealth* with a cover note: "This one just came out of me in response to our talks regarding my aggressive nature. I thought you would enjoy it": "Like an observer of the fete, I stand apart and watch hoping for a center-cut chop of roast human served on a sliver platter. I grasp the offering and my tail

quivers with delight beneath my skirt. I devour the offering politely savoring the clandestine capture of forbidden fruit." In the following session, she reported being pleased with herself and the essay. She noted this piece had to do with her "sort of liking our discussion about my aggressiveness." The musing had "come to her" while she was preparing a dinner involving a "center cut pork chop." She described the essay as "writing about herself as a cat devouring people in authority." She recalled how as a little girl she had wanted to be a vegetarian (to be like her mother who unfortunately also seemed quite conflicted about and chronically wallowing in miserable ambivalence about her own aggression). She connected this wish to be a vegetarian to her "belief" that her aggressiveness made her a bad person and should be either removed or denied. However, she also noted that in spite of her concerns about aggression, she gets "really aggravated" when she is "not allowed to participate." Reflecting on her observation, she decided that her aggressiveness and competitiveness is often "borne out of feeling unworthy." With some embarrassment, she then revealed her wish for me to greet her for our sessions with, "How nice to see my favorite patient!" instead of my more tepid version of "Won't you come in?"

The imagery of *Stealth* revealed important elements of her fantasy life and specifically imaging herself "morphing into a big cat or dragon" and stalking or killing "self-centered people" who excluded her or treated her as undesirable. In her fantasy life, she would have the power to seize what she longed for (both "things" and special relationships) when those were denied her. She noted such thoughts were sometimes followed by a sort of "verbal tic" in which she would repeat the names of the intrapsychically "endangered" others in a private setting, like her closet. We were eventually able to discuss this "tic" and other behavioral retreats as an attempted "undoing" of her aggression.

Our discussion of the essay seemed lively and quite facilitatory of our work, but was soon followed by another email with the subject line: *Apology*. In this note, she "confessed" that she had looked up an "Introspections" piece I had published in the *American Journal of Psychiatry* (Lomax, 2004) about how I had become a psychoanalyst after failing in my attempt to become a professional baseball player. She also confessed that she found my story "confusing" but discussed it with her "rather athletic" physician husband. (By this time, she had married her fiancé who had been with her in Denali.) Her husband "understood it right away" and "explained" that both baseball and medicine involved extensive persistence and careful strategic planning. She had felt "really badly" that she had even wondered about (been disappointed by?) the history of my professional development, which she was sure is "none of my business anyway."

*The next day after sending me the* Apology, she asked if I was mad at her. I asked her if I should be. She elaborated her concern about her wish to "cross boundaries" and not being sure of "her place." I responded that she seemed hungry to know more about me, but afraid that her curiosity would somehow hurt me or our relationship. She noted that she felt like she shouldn't ask too much and observed that I didn't really disclose very much in response to her questions. My version of therapeutic anonymity was indeed frustrating and anger-provoking for her. It felt like I was excluding her and that provoked her doubts about her desirability. Our exchange led her to acknowledge a wish she found embarrassing to reveal: "That I could start over and you could be my dad and I would have a healthier start in life."

Eventually, we connected our exchanges about her preemptory wishes for affirmation and curiosity (that had seemed to her to be evidence of her badness) to our previous exchanges about her use of religious language in her relationship with her grandmother. This conversation led me to ask her about her little girl experience of communion (a question in part influenced by my own associations to *Stealth*). With a pleasantly bemused giggle, she recalled how as a little girl she was not allowed to participate in communion at her church. However, she had frequently been able to "steal the crackers" and eat them later. This "stealth" attack was her effort to "know" (cognitively, but also as in the Biblical euphemism) about what she was missing and to participate in a relationship from which she felt excluded. Of course, we connected this bit of healthy, albeit covert, expression of cu-

riosity and aggression as a part of her motivation to do research about a currently important attachment figure upon whom she placed great hope. She took some solace from appreciating how her personal "hunger" to seek union with an idealized other in the transference relationship was not all that different from the Christian sacrament expressing the desire to "take in" or "seek union" with the body and blood (bread and wine) of Jesus in the world's most practiced religion.

As what seemed like an attempt to take solace from her efforts to achieve tolerance of imperfections in herself and others, she wrote the third essay of this series, *The Beauty of Ambiguity* about her experience of falling asleep and her "imagined flight in white air without wings to the you I need you to be (father, brother, husband, son)." Significantly, the essay concludes that "With trepidation I trust" ***(both herself and her therapist).***

## Conclusions and a Caveat

So what does the experience of this particular patient and therapist tell us about the broader human experience? Using the notion that spirituality might be an expression of attachment phenomena, what my patient described as a "paranormal experience" at the death of her mentor seems characteristic of some other people who lose a loved one. Some paranormal experiences follow an intimate and involved relationship loss. Sometimes, a more distant but emotionally significant loss is involved. For my patient, her mentor was also a father who saw her gifts and treasured them in a way her own father could or did not. Her wishes to be desired, pursued, and sought are pretty human. In secular music, George Gershwin wrote and Willie Nelson sings poignantly about the importance of "Someone to Watch over Me." In religious organizations such longings are also captured in hymns and rituals. An example in the Hebrew Bible is Psalm 42: ***"As a deer longs for flowing streams, so my soul longs for you, O God! My soul thirsts for God, for the Living God. When shall I come and behold the face of God?"*** Christians celebrate the sacrament of communion as a symbolic taking in of the blood and body of Jesus. For some Catholics, the bread and wine actually become the body and blood of Christ. While some adults process this ritual on a symbolic level, it is probably confusing for many children in the way in which my patient felt confused by some of her readings and discussions about right and wrong with her beloved maternal grandmother. The ritual of communion is sometimes accompanied by hymns like *Jesus Thou Joy of Loving Hearts*, attributed to Bernard of Clairvaux. The not so subtle third verse of this hymn is: ***"We taste Thee, O Thou living Bread, and long to feast upon you still; We drink of Thee, the Fountainhead, and thirst our souls from Thee to fill."***

In this framework, my patient's expression in *Stealth* of her "hunger" to know more and to be known, desired, and included seems to capture in words a natural attachment appetite mediated by what Panksepp describes as the seeking system of mammals. Unfortunately, a series of little girl experiences led her to feel "weird and inappropriate" when her appetites for contact, union, communion, or even a "simple" understanding of her parents and their relationship were met with dismissive and abrupt rejections. The apparently far more favored status of a difficult, disruptive, and demanding brother in spite of her nearly desperate efforts to be the good child who strove to alleviate the family misery has been a lifelong source of frustration and confusion.

As an adult, she had suffered from clinical depression and had made some unfortunate, life complicating choices. A 'good enough therapeutic relationship' allows the reliving of such developmentally 'critical periods' in ways that help our patients to feel more confident and curious about their dispositions and their experience with important others. One desired product of a treatment relationship is the internationalization of a more supportive, less critical partner with whom to face the ambiguities of life – a soothing, gratifying, and encouraging internal object relationship instead of a persecutory, humiliating, and punitive one.

For better and worse, a therapeutic relationship inevitably involves a series of slippery slopes which involve the personal and professional boundary continuum. Unfortunate distractions from the therapeutic task can result if the therapist's focus is impaired by his/her 'belief' or 'unbelief' in the 'reality' of an emotionally significant, unusual experience. Whatever its 'ultimate meaning', her

'paranormal' experience in Denali was a 'real' and important affirmation which reflected a growth promoting dimension of her relationship with a key mentor. Theirs was a healing relationship and an important exception to disappointments with other attachment figures. It would be both a clinical and ethical error and distraction to take a disclosed position within the treatment relationship on the ultimate reality of her experience – whether her 'paranormal' experience actually 'revealed' afterlife.

A clinical framework informed by more positive perspectives on the paranormal or the sacred allows an openness to such experiences and the creation of an intersubjective relationship that promotes a more positive self and object representation, a more stable mood, and a greater facility in negotiating inevitable problems within important attachment relationships (Akhtar, 2001; Lomax, 2006).

My patient's foundation of respect and interest in the 'practice field' of our treatment relationship was steadily articulated into the rest of her professional and personal world eventually including marriage with a very suitable man, who is quite in love with her as well as a progressively more satisfying and generative vocational life. The therapeutic relationship helped her to see, nurture, and express her perceptions and ideas with more confidence and curiosity and progressively less anticipatory shame and doubt. To return to the title of this paper, if the alliance is adequate and the treatment relationship survives the inevitable tests of safety and security, "imagined flights" like those of my patient are put into words first in the treatment relationship and then in life in ways that can lead both to trust and to blossoming growth.

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