I think of myself as doing transpersonal psychotherapy although my clients most often present mundane problems (Boorstein, 1985) and my technique for working with them is conventional "talking" therapy. Of the three parameters—content, process, and context (Vaughan, 1979)—by which transpersonal psychotherapy is often defined, context is the most subtle. Transpersonal content, the discussion of spiritual dilemmas or "paranormal" events, is clearly recognizable. Transpersonal process, the use of non-traditional therapeutic techniques such as meditation or visualization, is also self-evident. Transpersonal context, the orientation out of which the therapist works (Vaughan, 1979), is less easily pinpointed. My experience is that the presentation of case studies is the most effective way of demonstrating transpersonal context and its effect on psychotherapy.

Acknowledging transpersonal context and its effects is particularly important to me. My own training as a psychotherapist, twenty years ago, stressed "anonymity of the therapist" and "self determination of the client." It was considered important, both from an ethical standpoint as well as an aid to establishing a transference relationship, to let clients know as little as possible about one's own point of view. My sense, however, is that there are many traditionally trained therapists like myself, who recognize that the way in which we choose to make responses conveys our attitudes, values and belief systems to our clients. Which of our clients' issues we seem to be most interested in, which interpretations we emphasize, the subtle
recognizing
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(or not so subtle) hints about our world view that show up in casual remarks we make, all may shape the outcome of therapy.

My view is that therapist anonymity is not really possible; it is also not helpful. People choose a therapist, form a therapeutic alliance, and continue to work well in therapy when they feel that the therapist has the understanding and skill to deal with their problems. This sometimes requires giving opinions and sometimes requires sharing world views. I certainly am not advocating imposing one's belief system on one's clients. What I am advocating is recognizing the possible effect our belief systems may have on the course of therapy (Shafranske & Gorsuch, 1984), and deliberately using this to best advantage.

The conscious introduction, on the part of the therapist, of a transpersonal framework—a larger than mundane interpretation of the issues being discussed into the therapeutic interchange is the precise area in which transpersonal context has the potential of being most significant. In both of the following case studies, transpersonal interpretations were offered, not only as another way of understanding the situation, but specifically to reduce the stress and alleviate the suffering the client was experiencing at that time. The transpersonal framework, in both instances, allowed the client to feel less trapped and less victimized.

It is important to note that in both situations transpersonal issues or interpretations were not successful until the most compelling symptoms which had brought these clients into therapy had been addressed in a traditional, interpersonal manner. After establishing some basis of therapeutic insight and symptom relief, it was possible to shift back and forth between personal and transpersonal levels of interpretation.

Ellen was 28 years old, had been married three years, and had a successful career in advertising when she sought therapy for her symptoms of insomnia and intense anxiety attacks. Both symptoms had begun abruptly one year previously when her mother had developed pancreatic cancer. Ellen's father, always the more indecisive and ineffective parent, seemed unable to cope with the decision-making and care arrangements necessary and much of this responsibility was shifted to Ellen. Her only sibling, a brother, lives some distance away and is only peripherally involved in decisions. Although both Ellen's husband and the company she worked for were tolerant about the time she needed to spend caring for her mother, Ellen felt her marriage and her career were both suffering. Her symptoms, by their very nature, were rendering her increasingly debilitated and demoralized,
Since Ellen appeared to me to be psychologically quite healthy with good ego strengths and ability for strong object relationships, therapy was largely interpretive in the style of traditional psychodynamic formulations. Ellen quickly became aware that although she indeed truly lamented her mother's illness and impending death, she resented the fact that the lingering aspect of her mother's illness was an ongoing strain and also wished her mother would die so that she would be free to continue her own life. In addition, she realized that she was angry that her mother's illness had revealed the truth of her father's childishness and ineptitude, a fact Ellen had tried to hide from herself all of her life. She felt guilty about her hostile impulses and dismay over the loss of her idealized image of her father. Finally, she felt that in one brief time span she had become parent to both of her parents and had lost her own status as protected child. She felt grief over this loss.

As Ellen allowed herself, within the safe atmosphere of the therapy situation, to become aware of her unconscious wishes and fears, her symptoms began to lessen. Probably what happened was that, as she was able to see that her impulses neither shocked nor frightened me, her superego, through identification, became less punitive. It became increasingly clear that her symptoms were directed defenses against the emerging into awareness, either in dream or in thought, of her "forbidden" desires.

Although I knew that Ellen and her husband practiced zazen and Ellen knew that I was involved in meditation practice, in the early weeks of Ellen's therapy there were no significant references to transpersonal issues. Since her symptoms were severe and since she correctly believed them to be intimately linked with her family situation, she and I both focused on the psychodynamics of the situation. In addition to her internal turmoil, the realities of her mother's medical situation presented daily crises with which Ellen needed to cope.

One day, in a lull between crises and with her symptoms somewhat abated, Ellen mentioned that she and her husband had attended a one day sesshin. I responded with something positive like:

"It's nice that you both share that interest, isn't it?" She said, "Yes, it takes away the edge of desperation." I said, "The Edge of Desperation, sounds like a soap opera..." She suddenly laughed and said, "The Cosmic Soap Opera, The Edge of Desperation. Tune in next week to find out: Will Ellen's mother survive this latest crisis? Will Ellen's father rise to the occasion!" We both laughed uproariously. Ellen continued, between laughs, to remark about...
how pleasant it was to be cheerful. All of her relatives, with whom she had constant contact in caring for her mother, were gloomy and pessimistic. I said that this was probably a reflection of their Eastern European cultural heritage and that her reactions were shaped by this as well. She said, "It's a culture of woe," and laughed again. "That's a soap opera too! The Edge of Desperation and The Culture of Woe!"

This was a turning point in the therapy. Having discovered, quite spontaneously, that there was a place outside her current crisis from which it appeared only as a passing show, Ellen experienced great relief. Although her symptoms would occasionally return and her daily problems were not solved, she felt much more at ease with the situation.

Once a transpersonal context was established, I was able to refer to it specifically when it seemed helpful. For example, when Ellen thought back to the onset of her symptoms, she was struck by the sense of how suddenly her life had changed. In addition to her understanding her symptoms as defenses against unconscious wishes, I suggested that the abrupt disorganization she had experienced was similar to the experience of the Buddha in seeing old age, sickness and death for the first time. Seen from this point of view, Ellen's sudden change could be understood in a positive way as the beginning of her own awakening rather than as a pathologic response to stress. Recognition of mortality, one's own as well as that of others, then becomes not only normal but also desirable. Ellen's mother's illness, leading as it had to Ellen's increased self-awareness, self-confidence, and emotional depth, could be seen by Ellen as positive events rather than as a disaster.

Transpersonal contexts do not preclude personal interpretations. One day Ellen arrived saying that she had awakened feeling "in a bad mood" without recognizing any specific antecedent cause. I suggested that if we wanted to be transpersonal about it we could say, "Bad moods come and bad moods go." Or, considering personal events, we could wonder if her mother's upcoming surgery, her brother's plan to visit, or her ongoing job concerns had something to do with this mood. I said, "What do you think? Personal or transpersonal?" She laughed and said, "This feels personal to me" and went immediately on to discuss a number of issues, the above-mentioned as well as others, that were troubling her.

The story of Ellen demonstrates several points. The introduction of the transpersonal context made Ellen much more comfortable about having her symptoms, less demoralized, and more confident in working in therapy. It also provided a
certain lightness which helped Ellen deal with a difficult family situation.

I believe this case history also addresses the criticism sometimes raised by traditional therapists that self-disclosure on the part of a therapist prevents the transference relationship from becoming established or distorts that relationship. Ellen gradually came to know quite a bit about my interest in Buddhism and my orientation based on that interest. However, I did not see evidence that this prevented a transference from being present, and interpretations based on transference manifestations continued to be effective.

Claire is a 75-year-old woman who sought therapy for depression. Although Claire had had periods of depression throughout her life, she had become acutely depressed following her marriage six months previously. It had been a third marriage for both Claire and her husband, a contemporary she had known only briefly before agreeing to marry him. Claire had been euphoric in anticipating this marriage as it had seemed the love relationship she had been seeking throughout her life. Her discovery, post-marriage, that it was not, had precipitated a major depression.

Claire had chosen me as the therapist because she knew I had taught courses in Buddhist psychology and in meditation. She, herself, has been a follower of various spiritual paths and spiritual teachers for more than 40 years. She was trying, somewhat desperately, to overcome her dismay with her new husband and his insensitivity to her needs by convincing herself that she had chosen him in order to learn some spiritual lesson.

Therapy with Claire, from the outset, moved back and forth easily between personal and transpersonal issues. I agreed that she might, indeed, have married her husband in order to learn forbearance, tolerance, etc. On the other hand, it was abundantly clear that there were personal, psychological reasons which had motivated Claire to move into this marriage without a great deal of careful consideration.

Claire recalled in therapy, with as much clarity and poignance as if it had happened quite recently, the experience of having been “abandoned” by the untimely death of both of her parents when she was quite young. Her first marriage, while she was a teenager, had proved a disastrous failure. A number of unhappy relationships had followed. One of these relationships, an affair in which she had felt very much in love with a man who later left her, remained painful even until the present.
time. A second marriage, in her mid-40's, ended with the sudden death of her husband a few years later. This death precipitated a two-year depression, following which Claire had been able to resume full time work and a reasonably gratifying relationship with friends. The most salient feature of Claire's current depression, as she explored it in therapy, was not that her current husband was somewhat narrow-minded and insensitive. Indeed, although this was true of him, it was also true that he was genuinely fond of Claire and hoped to be successful in this marriage. Rather, it was Claire's recognition of how she had over-valued and over-estimated him during their brief courtship, and her realization that this misperception was conditioned by a lifetime of disappointments and deprivations. It was her realization of the depth of her neediness, coupled with her recognition that her need had not been met and probably would never be, that had triggered her depression.

Claire began therapy when all of her attempts to mitigate her distress with "spiritual" justification ("It's my karma," "It's my lesson," "I asked for it," etc.) failed. Early weeks of therapy provided Claire an opportunity to recall, and grieve over, the many instances of loss and hurt she had experienced in her life. Her acceptance of how unfulfilling and disappointing her life had been, although it caused her great sadness, relieved her of her feelings of embarrassment about how "stupid" she had been to have married her present husband. Although she was dismayed in her neediness, she was able to see that it was this, rather than stupidity, that had prompted her to hastily marry. As her embarrassment abated and she felt less humiliated, she found she was less angry at her husband, behaved more kindly towards him, and their relationship improved.

Another cause of pain for Claire was the sense that this had been her "last chance" for real happiness in life and that it had failed. In the most mundane sense this was probably true. It was unlikely that she could divorce and find a completely fulfilling marriage partner. Besides, she really didn't want to do that. Her sense of faithfulness and committedness precluded it. What saddened her was her awareness that her life would end without it ever being completely wonderful.

It was at this point that I reintroduced a transpersonal context with some reflections about whether life could ever be completely wonderful. Claire seemed very reassured to have me bring this up. She admitted that another source of embarrassment and depression to her was her belief that other people, more skillful than she, managed to achieve happiness while she had not. Her already low self-esteem, bruised by various
abandonments, smarted under this final insult. My acknowledge
ing that life, by the nature of its very impermanence, cannot ever be completely satisfying, was a great relief to her. She felt free from feeling guilty about not having "made a success" of her life.

As therapy continued and Claire's depression lifted, her relationship with her husband improved. Her energy level and her enthusiasm for social activities returned. In the therapy sessions the emphasis shifted from recapitulating past griefs to philosophizing about her current situation. The very same speculation, "He is in my life in order for me to learn acceptance and tolerance,” previously depressing and unsatisfactory, now seemed quite plausible and interesting to her. The more we talked about the fact that suffering is part of the inherent fabric of life, the more Claire was able to let go of feeling personally responsible (and guilty about) the suffering in her own life. As her guilt and its attendant anger abated, Claire was more able to recognize and appreciate the re-deeming qualities in her husband.

Claire's story is important because it demonstrates how, although she had had a transpersonal belief system for many years, her personal psychological distress outweighed any support this system had been able to provide. She felt comfortable with me as a therapist because she knew I shared her belief system. The therapy, however, was successful because it specifically addressed her psychological needs. Once these issues were attended to and her feelings of anger and guilt were somewhat resolved, the transpersonal context could be reintroduced for continued and additional support.

I prefer to think that my choice of a personal or transpersonal interpretation is always based on therapeutic discrimination, but it is probably more true that my transpersonal world view is obvious even in my casual speech. What is also true is that those clients not comfortable with, or not interested in, a transpersonal approach, will ignore my remarks and press on with a purely personal emphasis. The fact that the use of a transpersonal context was successful with Ellen and Claire was dependent, at least in part, on their being open to working with it.

In those instances where my choice of a personal or transpersonal intervention is a conscious decision, I have decided to label these interventions as "interpreting up" or "interpreting down." The use of "up" or "down" is semantic. I could use "broad" and "narrow," or "trans personal" and "personal," or "spiritual" and "mundane." I definitely do not mean "better"
"interpreting up" and "interpreting down"

and "worse." In Ellen's situation, "interpreting up" at a point in her therapy where conflict resolution was well underway facilitated her integration of the entire experience. Claire's situation required "interpreting down" so that personal conflicts could be addressed before a transpersonal approach was viable.

I believe that "interpreting up" prematurely is one of the clinical errors of which transpersonal therapists ought to be most wary. Our own belief systems, and a zeal to encourage these belief systems in our clients, may impair our ability to recognize when clients are using a transpersonal insight (albeit a genuine one) as a defense against confronting personal conflicts. In addition, the failure to "interpret down" when a personal issue is at hand may result in a missed therapeutic opportunity. In general, I find that it is my selection and application of the appropriate personal and or transpersonal interpretation, not the advocacy of my transpersonal worldview per se, that facilitates the progress of therapy in a transpersonal context.

REFERENCES


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