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Several years ago a man in his early 30's came to me for psychotherapy following his release from a psychiatric ward of a Toronto hospital. His older sister, who was taking my psychology class at the time, had approached me after class and asked if I would be willing to see her brother after his stay in the hospital. She was quite distraught and very concerned for her brother who had been living with her and her husband and young children at the time of his hospitalization. I met with Omar several days later. He was a landed immigrant from rural Africa and had been in North America for about 4 years at the time of his breakdown. He was very anxious and quite deferent towards me when we met, and was in despair about his current situation and his future. When I asked him about his recent experience in the hospital, he told me that the psychiatrist who had been treating him for the two weeks said that he had a biochemical disorder called schizophrenia which was not curable but was treatable with medication. He was told that not only was it likely that he would have this disease for the rest of his life, but also that if he ever had children, there was a strong possibility that they would develop it as well. This diagnosis left him in absolute despair.

When I asked him to tell me something about what brought him to hospital, Omar said that his sister and brother-in-law had taken him because he was hearing voices that were frightening and confusing him. These voices came mainly through the walls of his bedroom from the people next door who were talking about him. Often this talk expressed a sexual interest in him. He was quite anxious telling me about this and added that he didn't know if it had really happened or if he had imagined it because of his disease. He said that the pills the psychiatrist had given him were helping with this, and that since coming home from hospital the voices were not so loud and clear and he couldn't really tell if they were talking about him or not. I said that he must feel relieved that the medication was helping him with this. He agreed but was quick to add that the pills themselves caused him to feel strange. (He was on a heavy neuroleptic medication to control psychotic symptoms.) He said that it put a kind of curtain between him and the world. That as he spoke to me, for example, it was like I was not quite in focus; as if our words had to pass through something like a gauze or thin cloth that prevented a direct and vivid connection between us. He found this very distressing, and the thought of having to live in this kind of fog made him feel frightened and hopeless.

I began seeing Omar twice a week and soon determined that the psychiatrist had shown virtually no interest in learning anything about him beyond his symptoms and his responses to the medication. It seems that his medical training had done nothing to make him curious about the circumstances of Omar's current life or personal history. Indeed, if he were as certain of his diagnosis as Omar's account led me to believe, questions about the patient's interpersonal life and its history would have had little relevance and not much to contribute towards the treatment of the disease.

The fact that Omar's father had regularly beaten with sticks, at least once to the point of unconsciousness, had not entered the picture. Nor had the fact that from the time he was 8, he was left completely on his own for weeks at a time in remote pastures. His formative years were lived as a tribal boy in a village where it was still common practice to sew pre-pubescent girl's labia together and leave them that way until their wedding nights. The fact that Omar was a gifted student and that his family was prosperous, resulted in his acceptance into a prestigious American university, and a rather sudden departure from his rural African life. Against his own wishes he found himself in a major North American city, carrying the huge expectations of his family who had invested everything in him. It must have been like landing on another planet. It seems it was enough to crash what was quite likely already a fragile self.

I draw your attention to the fact that the psychiatric system did not concern itself with the circumstances of Omar's life, not because I want to take cheap shots at psychiatry or the mental health system. Working within the system means dealing with patient loads and constraints that we generally don't face in private practice. I do so because it's a graphic illustration of how theory

shapes ones perceptions and responses to a human experience. It also does much to determine the psychic distance one takes from another's experience. We might say that in this case the medical theory, which shaped the psychiatrist's perception of what Omar was going through, provided a kind of maximum distance between the giver and the receiver of the treatment. One had a biochemical disorder, which caused him to have bizarre experiences and to act in meaningless ways, and the other did not. The theory did not require, or in any way encourage the doctor to identify with what was happening in Omar's subjective world. In fact, getting involved in the subjective realm of these events might only serve to cloud a clear scientific diagnosis.

And the symptoms were, in fact, treated. The troubling voices were quieted and sent to the background. What took their place, the "veil" that distanced Omar from the world, was a side effect. But it is also a metaphor for the treatment and the theory of human functioning that informed it. The fact that it left Omar with what we might describe as an existential impairment, a reduced capacity to feel emotionally and psychologically connected with others, seems somehow outside its frames of reference. If an individual speaks to us of the experience of being emotionally connected to, or disconnected from another, he is speaking in subjective terms, of an interior phenomenon, which has meaning for us only if we bring ourselves subjectively close enough to identify existentially with that experience.

But being able to identify with this experience and being of some help with it are certainly two quite different things. In the beginning, being with Omar was quite troubling for me. The severity of his disturbance and the level of anxiety he brought into my office were somewhat overwhelming. What could I possibly do for this man that a psychiatric unit could not? Where do I begin? What can I do or say to reduce his anxiety and relieve him of some of the despair he was experiencing? Was my agreeing to see him implicitly making promises I could not possibly keep?" This man needs someone with years of experience with psychosis", I thought," not a fraud working in an office in the basement of his home"!

If the psychiatrist's medical theories had led him to *under-identify* with Omar's situation, whatever theories I might or might not have been holding during those first sessions were certainly doing nothing to prevent me from temporarily completely *over-identifying* with his distress! The state I entered while in his presence put me too close to his subjective world; I needed to adopt a theoretical position that would help me draw back enough to be capable of something closer to an objective perspective on the situation if I were going to be of any help at all. In order to gain this, the first thing I did was to meet with a couple of colleagues and mentors. They were quick to point out that my feelings of helplessness arose largely from the fact that I was, in a manner of speaking, standing *too close* to my client. He did need me to be with him in a way that the psychiatric system could not, but he also needed me to stay in my therapist's chair instead of, as it were, pressing my ear with him against his bedroom wall to hear what the voices were really saying. He needed my attention and genuine care, but being with him on an ongoing basis would also require me to be O.K. with the fact that I could not do or say something that would take away his anxiety and distress.

As my own balance gradually restored itself and I settled in to listening to Omar's story, it became evident that what I was able to provide was to be with him in a way that he had not likely ever experienced before. What this required was not that I know everything about schizophrenia, but that I attune myself as closely as possible to the minute fluctuations in the level of his anxiety. These *readings*, separated as best as possible from my own anxiety and dread, would help me establish and maintain an optimal distance between him and me. A distance that would provide him with the experience of feeling understood by another human being, without the threat of being taken over or invaded by the other. But an optimal distance needed to be a kind of fluid continuum, not a static position. (A wave, not a particle, to borrow from physics). To achieve this, even the most nuanced and finely tuned theory is of limited help. A theory can't accurately map this landscape because by its nature it's constantly shifting. What we must rely on is something much more simply human; our ability to let ourselves *resonate* with the emotional state of another and our capacity to be guided by what we feel when we allow that to happen. To be aware of our feelings and allow them to inform our responses without losing ourselves to them is a difficult achievement. Like a happy and successful marriage, we do it imperfectly, and it's only easy on T.V. or in the movies. Theories about human functioning, no matter how sophisticated or brilliant, can't prepare us for this. I believe our best

preparation is our own history of repeated honest and direct encounters with others. Unfortunately, most of our daily social and professional contacts don't really afford us the opportunity to exercise our capacity for direct and open expression of strong feelings. So most of us are not so well practiced at this. The stirring of intense feelings is usually experienced as a threat to most relationships. Blunt honesty can, in fact, be used destructively.

So how do we learn to do this? To be with another in a way that invites him to enter disturbing feeling states while at the same time allowing ourselves to feel how disturbing this can be for us. The best way I know is to put ourselves in a context where we can practice exposing ourselves to this over and over again. It requires a context that is safe but also free of many of the expectations that govern most of our usual interactions. This is, of course, the purpose of our psychotherapy training groups and why they have such a central place in our program. This is also why it's the Centre for *training* in Psychotherapy, as opposed to the Centre for the *Study* of Psychotherapy. We study a range of theories, and our ongoing exposure to this evolving discourse is essential to our learning and practice. But as important as these ideas are, they should remain as guidelines and sources of inspiration: not a source for formulas. Hopefully, what we are training in ourselves, our capacity to be as conscious as possible of our own feelings and motives will help us hold our favourite theories lightly and enable us to surrender them when they start shaping reality instead of explaining it. Otherwise we impose our own version of the veil that Omar talked of. We need theories, and I encourage you to pursue the ones that really capture your imagination with all your intellectual vigour. But I also encourage you to use the more experiential contexts, primarily your groups, with all the courage and honesty you can muster.

Last week I watched the film **The Cell.** (I highly recommend it for those of you who have a tolerance for disturbing movies) Its underlying structure is the myth of Orpheus. It's about a descent into hell and the rescuing of a soul. In this case hell is the truly hideous and terrifying landscape of the inner world of a psychopathic serial killer. He's caught while his most recent victim awaits a horrifying death that he has electronically programmed to take place in several hours. However, just before the police track him down he slips into a coma from which he will never recover, so the police aren't able to interrogate him about the location of the doomed woman. Jennifer Lopez, who plays a therapist who's been using an experimental technique for treating coma victims whereby through a hook-up of their brain waves is able to travel in a kind of trance state literally into the victim's mind, is called in. At the risk of being permanently trapped there herself, she enters the killer's mind. Among the many horrors she encounters there, is the psychopath as a terrified and abused child whose trust she tries to gain. But presiding over this kingdom of horror is a grandiose and utterly sadistic version of the killer whose only motivation is to dominate and indulge his sexual sadism. In this place where he is king, shapes shift at his will and another's fear or compassion fuels his cruelty. Although he and the boy are the same person, and were themselves victims of unspeakable cruelty, to treat him with compassion is to encourage his sadism and become his victim. There is no singular way to be that will enable her to negotiate this territory; she can't tame or heal the murderer with loving-kindness any more than she can force the boy to trust her. Her responses have to be informed by what she herself feels in their individual presence in the moment.

When we're working with our clients, the splits we encounter in them are usually not so extreme or dramatic. How close we should get is determined by much more subtle shifts and indicators. Sometimes our natural warmth might be experienced as too cloying or even smothering, and we need to back away. Our normal friendliness might be regarded as naiveté, so we need to be cooler. When we're presented with a client's more everyday version of the grandiose tyrant, moving close and holding him in our therapeutic empathy only encourages the grandiosity and disregard for others. And we make a mistake in the opposite direction if we stand back from the frightened boy and expect him to reveal feelings that terrify him. But how do we know whom we're talking to when these are all aspects of the same person? I think we can never *know* for certain, but I believe our best guess is taken when we know and trust our own feelings enough to base our response on the question, "what does it feel like to be with this person in this moment?" And it's this ability, rooted in self-knowledge, which we should continue to train and develop throughout our practice. An ability that we develop when we risk direct and open encounters with others.

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