

meditations to *elicit* the psychic remnants of the fault. Buddhist meditation, when properly adapted, can also have a critical impact on the other two components of Freud's therapeutic approach, what he called "repeating and working-through." It holds the key, in fact, to resolving the frustrating inability of psychotherapy to move beyond recognition and reconciliation to the far shore of relief.

CHAPTER 9

REPEATING

WE HAVE SEEN how meditation can be a vehicle for remembering and how this is the first way that its therapeutic potential can be tapped. But Freud quickly discovered that remembering was not sufficient to accomplish his purposes—that mere remembering was not always possible for his patients, nor was it always sufficient to clear them of their symptoms. Many people failed to remember anything of consequence from their early life, he found, no matter what modifications of technique he attempted. The "forces of repression," as Freud called them, were often too great to permit so simple a therapeutic process.

Yet there was another phenomenon that came into play in the therapeutic situation, one that Freud came to call "repeating." Rather than recalling a formative experience, most patients simply reproduced it, with one crucial and defining characteristic: they remained unaware of what they were doing. Thus, a patient whose father was relentlessly critical of her in her youth and who had been able to find no interpersonal satisfaction in her adult life might not know how critical she herself had become, but she might act it out in the relationship with the therapist. By bringing awareness to the criticalness in the

relationship, as it was being acted out *but not experienced*, the therapist might help the patient come to terms with the original criticalness that existed in her father.

The interesting thing about the phenomenon of repeating is that the material that is repeated is often just what we resist knowing about ourselves, that with which we are most identified but least aware, that which we are least able to remember consciously. "The patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out," wrote Freud. "He reproduces it not as a memory but as an action; he *repeats* it, without, of course, knowing that he is repeating it."¹

As Freud developed his technique, he moved from studying whatever was on the surface of the patient's mind to studying whatever was on the surface of the patient's way of relating. This required him to perfect a way of being that did not interfere with the patient's "acting out" but that would allow him to perceive it and interpret it back to the patient. This is the origin of what has come to be called the *analytic attitude* or *analytic neutrality*. It is a way of being, or perhaps a state of mind, that encourages the emergence of the transference, the special relationship between therapist and patient that contains the seeds of whatever the patient resists knowing.

Freud's primary method of wresting away the patient's weapons of resistance was through "analysis" of them. He hoped that if he could interpret to the patient what he or she was unconsciously repeating, the underlying conflicts or traumas could be brought to the surface and respite could be gained. In drawing on both the Freudian and the Buddhist traditions, however, I have found that relief does not often come through verbal analysis alone. As important as it is for the therapist to become aware of what the patient repeats, it is more important that the patient acquaint herself thoroughly with it. Interpreting the repetitions is not enough; the patient

must be helped to experience that which she repeats but remains unaware of. It is here that the Buddhist emphasis on fully experiencing each moment dovetails with the Freudian emphasis on attending to what would otherwise be ignored.

The psychotherapeutic environment is a unique domain; it permits the patient to manifest behaviors and feelings that would almost certainly be kept in check or ignored outside of the therapeutic relationship. As such, it presents a tremendous opportunity to put the kind of awareness that the Buddha taught to good use. When the therapist tries not only to interpret the patient's defenses verbally but also to help her *experience* those defenses as *hers*, then the lessons of Buddhist meditation can become therapeutic.

THE HERE-AND-NOW

Freud's discussion of repeating brings up a number of interesting issues vis-à-vis meditation and psychotherapy. With his technique, Freud perfected a method of examining *unaware* repetitions, ones that tend to intrude on and color present-day interactions. The Buddha's technique made the repetitive application of awareness the cornerstone of his successful practice. Freud strove to make his patients less unaware, whereas the Buddha taught his students how to become more aware. Buddhism does not attempt to work explicitly with the unaware repetitions that so fascinated Freud, and yet its method—the repeated application of mindfulness—is congruent with the attentional strategies that Freud found most useful. In developing an approach that draws on both traditions, I have found that each needs something from the other in order to work most effectively.

On the one hand, the therapist's stare of mind—his or her ability to work exclusively in the present as the analysis of transference demands—has proved to be a tremendous stumbling block for psychotherapists. Most simply cannot command the kind of attentional presence that Freud found necessary for his work. There is no method for teaching therapists how to attend in this critical way. As a result, most therapists offer, at best, a watered-down version of what Freud was actually able to muster. On the other hand, meditation practitioners and their generally psychologically untrained teachers are often unambiguously unable or unwilling to handle the transference material that will inevitably emerge, as Freud points out, from careful attention to present-day activities and relationships. Meditation, as noted earlier, can bring up lots of emotionally loaded material, which, if not dealt with efficiently, may suffuse the entire meditative experience without ever being effectively put to rest. And yet, when the two traditions are able to work together, they can do so quite harmoniously. By offering the tools of *how* to stay in the present, meditation aids both therapist and patient; by teaching people how to identify and contain past material, therapy can free a meditation of emotional travail. Both work toward a greater ability to face life as it is; both begin, often enough, in silence.

SILENCE

My first experience of transference occurred not in the office of a psychotherapist but in the halls of an Eastern temple in a small northern Indian village called Vrindavan, said to be the birthplace of the Hindu god Krishna. I was attending the festivities at the opening of a new temple dedicated to the mem-

ory of a recently deceased holy man who had been the teacher of several of my friends. One of this teacher's chief disciples was a woman named Siddhi-ma, who was sitting on a cot in one of the temple rooms one morning casually giving *darshan*.

Darshan is a phenomenon of Indian religious culture in which devotees of a particular spiritual teacher come to that teacher simply to be with her for an instant. Talking is not a big part of the interaction, yet the experience is often highly esteemed and much sought after. The teacher is said to *give darshan*, or the devotee is said to *receive* it. While little oral communication occurs, the teacher's silence does not convey absence or lack of interest. The teacher is very much present, and her presence, conveyed through the quality of her attention, is a powerful emotional force that evokes a strong response. I am often reminded of this when I sit in my office doing psychotherapy. Freud spoke of psychoanalysis as the "talking cure," and yet what he first cultivated was the therapeutic use of silence. One thing I have learned through my study of meditation is how not to fear this silence. Nowhere in my training as a psychiatrist was this ever emphasized, and yet it has become one of the cornerstones of my work as a therapist. It is not that I endeavor to become a blank screen or a mirror or some caricature of the ever-silent and unresponsive analyst; in fact, I talk quite a bit when I have something to say. But I am not afraid to let there be silence, and I know that my silence does not have to be felt as an absent one.

Let me return to my experience in India: I was encouraged to enter the room, in which about fifteen people were sitting, some on the floor, some on the cot next to Siddhi-ma. I knelt down toward the rear of her chamber. I spoke no Hindi, she spoke no English, there was no one volunteering to act as a translator, and yet when she glanced over at me, I was filled with such a sweet, sad feeling that my eyes began to water. In

that moment I felt the wrenching loss of my childhood connection to my own mother. It was a preverbal memory that had been preserved in my body, but one that I had been previously unaware of. It was also the source, I can see in retrospect, of what I was to later repeat in the early days of my marriage.

Siddhi-ma's gaze had evoked this experience, permitting me momentarily to own an element of my personal life that I had been too undeveloped to understand when it had happened. I knew, in that moment, that my own capacity for love had, in fact, not been irrevocably damaged, despite the sadness that I was experiencing. After I had been sitting there a few minutes, Siddhi-ma glanced over at me again, smiled, and motioned to her attendants to give me some *prasad*, milk sweets wrapped in silver foil that had been blessed and were symbolic of spiritual nourishment. They forced me to eat quite a few while they all laughed.

Whether or not Siddhi-ma actually was aware of what had happened to me in that moment or had had anything at all to do with it I do not know. In that very village, in fact, there was an ancient Hindu temple in which darshan was given by a piece of black volcanic rock that was kept behind a curtain at the front of the crumbling temple and that was dressed in a special cloth and attended to by Brahmin priests. The dimly lit temple amphitheater, like an auditorium but without seats, was filled with people round the clock. Several times an hour the curtains would be drawn open for an instant to reveal the black rock to the crowds, who would make all kinds of commotion and have all kinds of emotional experiences upon being in the presence of the rock. The experiences there seemed every bit as powerful as the one that I had undergone.

The lesson for psychotherapy is that the therapist may well have as great an impact through her *presence* as she does through her problem-solving skills. Especially when the root of the

patient's emotional predicament lies in the basic fault, in experiences that were preverbal or unremembered and that left traces in the form of absence or emptiness, the therapist's ability to fill the present moment with relaxed attentiveness is crucial. It is not just that such patients tend to be extraordinarily sensitive to any falseness in relating, but that they *need* this kind of attention in order to let themselves feel the gap within themselves. It is much too threatening otherwise.

It is through the therapist's silence, through his or her evocative presence, that this feeling can emerge in the here-and-now. The silence that I am referring to is not a dead silence, not a paralyzed one, but a silence teeming with possibility and texture. In the Buddhist tradition of Southeast Asia, there are twenty-one different words for silence: the silence between thoughts, the silence of a concentrated mind, the silence of awareness, and so on. Psychotherapy requires a silence that permits a patient to act out whatever she is otherwise out of touch with, or to say what she has not previously allowed herself to think. We are all hungry for this kind of silence, for it is what allows us to repossess those qualities from which we are estranged. Meditation practice is like a mine for this healing silence, which is an untouched natural resource for the practice of psychotherapy.

When a therapist can sit with a patient without an agenda, without trying to force an experience, without thinking that she knows what is going to happen or who this person is, then the therapist is infusing the therapy with the lessons of meditation. The patient can feel such a posture. This is most important during the patient's own silences, for when he falls silent, he is often just about ready to enter some new and unexplored territory. The possibility of some real, spontaneous, unscripted communication exists at such a moment; but the patient is, above all, sensing the therapist's mental state to see whether

such communication will be safe. A patient can be exquisitely sensitive to the therapist at such times.

It is this mental state, described in another form centuries ago, that makes psychotherapy interesting for the patient: "Do not think, scheme or cognize," counseled an ancient Tibetan meditation master.

Do not pay attention or investigate; leave mind in its own sphere . . .

Do not see any fault anywhere,

Do not take anything to heart,

Do not banter after the signs of progress . . .

Although this may be said to be what is meant by non-attention,

Yet do not fall a prey to laziness;

Be attentive by constantly using inspection.²

It is both tremendously difficult and a great relief for the patient to be "held" in this particular state of mind. It is difficult because this experience tends to force up the incomplete or unresolved material in the patient's psyche, her actual reasons for seeking therapy (as opposed to her stated reasons), and it is a relief because this kind of attention, or some derivative of it, is what we are all seeking. When I am asked how Buddhism has influenced me as a therapist, I am often tempted to assert that it has not: that when I do therapy, I am just doing therapy; that being interested in meditation has nothing to do with it. Yet I know that this would be a facile reply. Meditation has allowed me to be a functional therapist: it is through meditation that I have learned how not to interfere at the most critical junctures of the treatment.

W. R. Bion was one psychoanalyst who grasped the therapeutic power of this frame of mind. He also attempted to teach its use to an often confounded and sometimes hostile

audience of therapists. Although born in India, Bion did not admit to any influence from his native land. He developed his own idiosyncratic way of describing the therapeutic potential of his state of mind, as indicated in his book *Attention and Interpretation*:

It is important that the analyst should avoid mental activity, memory and desire, which is as harmful to his mental fitness as some forms of physical activity are to his physical fitness.

If the psycho-analyst has not deliberately divested himself of memory and desire, the patient can "feel" this and is dominated by the "feeling" that he is possessed by and contained in the analyst's state of mind, namely, the state represented by the term "desire."³

Bion was describing something that Freud had already recognized: the silences between therapist and patient can be either tremendously fertile or terribly destructive. There is a silent communication occurring during such times: the patient is sensing the therapist's mental state, and the therapist can intuit much from the patient. Freud believed that there was a direct communication between the patient's and the analyst's unconscious, in fact, and that it was up to the therapist to foster this environment.

NOT INTERFERING

While Freud aptly described this attentional stance, he emphasized only the value for the therapist in catching the drift of the patient's unconscious. What he did not describe is what Bion hinted at: the impact of this state of mind on the patient. The

state that Freud described is necessary because it is only in this state that the therapist's mind will not be felt as an intrusion by the patient. The therapist's expectations and desires, however subtle, create a pressure against which the patient is compelled to react or with which the patient is compelled to comply. The analogy with the intrusive or ignoring parent cannot be exaggerated.

Indeed, the French psychoanalyst Janine Chasseguet-Smirgel has explicitly referred to this capacity for nonverbal communication as a function of the therapist's maternal aptitude. Those who question its usefulness, she insists, must have hidden fears of their own feminine side.⁴ It is this fear of the feminine that also makes the meditative state so threatening to many psychotherapists. They refuse to offer the state of mind that, by its very nature of noninterference, allows patients to discover their own sticking points. The Buddhist word *myata*, or emptiness, has as its original, etymological meaning "a pregnant void, the hollow of a pregnant womb." When a therapist is able to create such a fertile condition, through the use of her own silence, the patient cannot help but come in contact with that which is still unfinished and with which he is still identified, albeit unawares.

I was reminded of this recently when sitting with a patient who had several years before, after an attack by a mugger, begun to remember sexual encounters with her father. As is common in such cases, this woman was filled with doubt about the truth of her own recollections, but she was gradually allowing herself to consider that they might, in fact, be true. She had had a dream the night before that her purse had been stolen and her wallet, with all of her identification, lost. She told me this at the beginning of the session, before she had really settled down, and she did not look at me much as she recounted the dream. This was not an unusual state for her at this time in

her therapy; an affair with an abusive man had ended recently and she often appeared distraught and frightened during these days, like an animal suddenly trapped by a hunter.

A long silence followed her report. Still uncomfortable, my patient also reported feeling suddenly very confused. I urged her not to discount this feeling of confusion but to stay with it, as she was clearly dissatisfied with the feeling and was treating it only as an obstacle to understanding the dream. It was confusion that had emerged out of the void of silence and with which she was still identified; the confusion was the unfinished material that the dream had brought into awareness.

Her next memory was of coming downstairs to the family dinner table after a frightening encounter with her father and seeing him sitting there presiding over the meal. "Now who was she?" she remembered thinking about herself as she looked around at her parents and siblings, all acting so normal. This was the seed of her confusion. Unable to reconcile the two pictures of herself and her father, she had for years denied the truth of what had continued to unfold secretly between them. Her dream, beyond the obvious connotations of rape symbolized by the loss of her purse, brought out the more insidious consequences of that trauma—the confusion that had plagued her and that she had been forced to act out in her repeated involvements with dishonest men, rather than experience consciously.

I was responding meditatively when I permitted my patient's confusion. I did not know what it signified when I urged her to attend to it; I knew only that it could be treated not as an obstacle but as an interesting phenomenon in its own right. My own training in moment-to-moment awareness prepared me for this approach, and my ability to maintain my attentional stance permitted my patient to go more fully into her own experience.

MEMORY AND DESIRE

As explicit as Freud was about the critical importance of evenly suspended attention, therapists ever since have had great difficulty in accepting his advice. "It is too difficult," they complained. "How is it to be done?" they asked. "A strain of this kind scarcely occurs otherwise in life," sighed Sandor Ferenczi.⁵ What about intellectual activity, "critical scrutiny," "problem-solving thinking," or "cognitive processing," they asked? Otto Fenichel, who single-handedly codified much of psychoanalytic technique in his still-influential little red book of 1938, *Problems of Psychoanalytic Technique*, dismissed the efforts of those who struggled to implement Freud's original recommendations by accusing them of merely floating in their unconscious and by doing "hardly any work at all."⁶

What all of these analysts failed to understand—and it is hard to blame them, since they had had no experience in meditation—is that a single state of mind, a poised and balanced state of bare, or evenly suspended, attention, can encompass both nonverbal *and* rational or intellectual thought. The cognitive processing does not have to be initiated by the therapist; there is more than enough of it happening of its own accord. When there is something meaningful to say, it is more than apparent. More often than not, however, intellectual activity in the therapist is a defense against experiencing the patient's silence, a refusal to enter the jointly experienced not-knowing that makes discovery a real possibility.

What is ultimately therapeutic for many people is not so much the narrative construction of their past to explain their suffering, but the direct experience, in the therapist's office, of the emotions, emotional thoughts, or physical remnants of emotional thoughts with which they are stuck. These feelings

peek out of the silences and manifest their presence when the room becomes quiet. Often in the form of an angry neediness, a sullen hurt, or a hopeless rage, they are the evidence of the basic fault that has people repeating destructive behavior without understanding why. The American Zen teacher Charlotte Joko Beck describes the essence of Zen as learning how to *melt* the "frozen blockage of the emotion-thought."⁷ Meditation has a dual influence in this regard: it can teach the therapist how to let these most private feelings emerge in the therapeutic communication, *and* it can teach the patient how to be with them once they do. Only then can there be the possibility of bringing the endless repetitions of emotion to a close.

APPLYING BARE ATTENTION
IN THERAPY

Once the therapeutic relationship is well enough established to permit the patient to begin repeating the unresolved emotions of the past, the task of therapy shifts to one of learning *how* to be with those very feelings. It is here that meditation, once again, can be specifically of use. Just as the therapist is never really taught how to pay attention in the most effective way, the patient is never taught how to pay attention either. As therapists, we expect our patients to free associate, but we do not teach them how to do it. In particular, when a patient is experiencing a difficult emotion, the method of bare attention can be extremely useful in countering the usual tendencies to act out or hide from the actual feelings. Much of my work as a therapist with a meditative perspective involves teaching people, in the context of therapy, *how* to pay attention to what they are repeating in a manner that is both meditative and therapeutic.

The emotions that we repeat are those we are most identified with and least aware of, they are what we resist knowing in ourselves and what we are in the most need of applying bare attention to. As the well-known behaviorist Marsha M. Linehan described it in a panel that I was a part of in 1988 entitled "The Buddha Meets the West: Integrating Eastern Psychology and Western Psychotherapy,"⁸ even the most emotional or suicidal "borderline" patients turn out to be essentially phobic toward their own emotions. They display—or, in Freud's words, repeat—plenty of emotion, but they are simultaneously estranged from and fearful of those very aspects of themselves that are so apparent to everyone else. As Linehan found, the principles of bare attention can be distilled and taught in a behavioral mode with such patients to desensitize them to their own emotions. A similar process is necessary within the parameters of psychotherapy.

This was very apparent in the work I did with a woman named Eden, who, for a long time, gave no indication of making any progress in her therapy. At the age of forty-two, for example, Eden could not be in the same room with her mother for more than twenty minutes without berating her for her failings. Eden was not happy with herself when she acted this way, but she could not help herself; her behavior was the expression of a deeper pain. Resentful over the paucity of interest that her mother had been able to offer her in her youth, Eden would lash out every time her mother made a vaguely disparaging, questioning, or intrusively demanding remark, which was quite often. Thus, when her mother raised such questions as, "Who is staying with the children when you go out?" or "What did you give the kids for supper tonight?" or "Why is the little one upset today?" Eden interpreted those as critical commentary on her own abilities as a mother, which they probably were. Her rage at these questions, however, was of an ado-

lescent nature; she could not muster any of the maturity that she evidenced in other dimensions of her life in her interactions with her mother. Her demand, always frustrated, was to be treated *differently* by her mother. Her need for reparation was so strong that after leaving a holiday dinner at her mother's home one time, she called to confront her mother for not bothering to give her a hug good-bye. Much to her amazement, her mother had actually embraced Eden on her way out. Eden was completely unaware of the gesture.

Of course, Eden had reason for the strength of her feelings. Her memories painted a picture of a mother-daughter relationship that had much closeness but remarkably little warmth. Her anger at her mother's failed gesture suggested some early and ongoing temperamental mismatch, at the very least. Her later memories bore out her mother's difficulties in sensing or responding to Eden's needs. Between the ages of twelve and fifteen, for instance, while Eden's body was changing and developing in adolescence, her mother had ignored these changes and had sent her to school in her childhood clothes. Eden had felt ashamed of her body and had been unable to ask her mother for help, fearing that she would be further ignored. At the same time, her mother was overinvolved in other aspects of Eden's life, since she commented repeatedly on Eden's weight and eating habits, which encouraged Eden to hide from her mother what she was eating. Finally rescued only by a visit to the family doctor, who ordered Eden's mother to clothe her properly, Eden continued to feel ignored and unseen, and as if there was something terribly wrong with her. She once wrote her mother a letter telling her of her pain and her feelings of being invisible, and left the letter on her mother's pillow. Her mother never responded.

As an adult, Eden was drawn to the philosophy of Buddhism, but she resisted formal meditation practice. She

couched her resistance in the language of independence: she did not want to submit to some kind of artificial structure, she could mediate her *own* way, and she did not trust some other imperfect teacher to tell her what to do. But Eden came to see in therapy that she was actually afraid of her own pain. Her troubled relationship with her mother had led her to feel so unworthy and so hurt that she could never allow herself to be with those deep feelings about herself. Instead, she kept throwing herself at the original problem in a vain attempt to receive some other message from a mother who must have been feeling equally alienated from her.

In therapy, Eden did not act out her anger, as she did with her mother. For a long time, she simply described the details to me without much emotion. Then, one day, she just cried. This continued for many weeks with neither of us knowing what she was crying about. She would just sit down and, sooner or later, start crying. She did not always seem sad when she cried, but nevertheless she sobbed, with intense shame at what she was doing. Not only was she experiencing the hurt and pain of her unsatisfactory relationship with her mother, it turned out, but, probably more importantly, she was letting herself dissolve in my presence. It was this dissolution, which occurs in love and joy as well as in sorrow, that Eden had been denied. Her mother had simply been too uncomfortable with Eden's emotions to permit them to be expressed, as reflected most dramatically in her failure to respond to Eden's letter. The shame that Eden felt around her emotional expression reflected the shame she had always felt at not being what her mother had wanted her to be. She had been forced to erect her ego boundaries prematurely to deal with her mother's demands and had always felt that it was too dangerous to surrender to her own feelings. Her uncontrolled rage at her mother in her adult years only reinforced that perception of her feelings as dangerous and out of control.

Eden's mother had been concerned about preparing Eden for the outer world; she had never thought to reach out to her daughter's inner world. Therapy allowed Eden to stop expecting anything different from her mother, and to accept the hurt, the pain, and the unworthiness as the natural consequences of the imperfect relationship that she had with her. The work here was in some way the opposite of the Tibetan practice of seeing all beings as mothers. Eden had to stop seeing her mother as *mother*: she had to treat her as just another person, and so tolerate the minor insults that had previously been too redolent of her childhood experiences. My most helpful contribution, however, lay not in any analysis of Eden's predicament, but in my ability to create an environment in which it became safe to experience the forbidden feelings of the past.

REPARATION

While any of the difficult emotions (anger, desire, excitement, shame, or anxiety, for example) may become the focus of this kind of therapeutic bare attention, the constellation that is particularly common involves the striving for reparation that Eden's story is so evocative of. What many of us cannot adequately remember, but instead repeatedly act out, are the consequences of a childhood drama in which, as we have seen, we are left like Oliver Twist, belatedly asking for more. The feelings involved are of being prematurely detached or disconnected, of feeling unreal or forgotten. A common consequence is to feel, as one of my patients described it recently, as if "everybody hates me" or as if one is intolerably alone. Another is to clamor for attention from someone who has proved over and over again to be incapable of providing it.

As Freud found out rather quickly, we rarely are able to remember or experience the traumatic events of our childhood directly, either through meditation or psychotherapy. It is much more likely that we will repeat behaviors that are in some way an attempt to repair or deny the original deprivations. As Eden demonstrated in her relationship with her mother, it is much easier to angrily demand complete parental attunement than it is to tolerate the imperfect relationship that actually has always existed. We make these demands for reparation relentlessly, hoping against hope that we can fix our relationship with our parents, achieve the kind of wordless surrender with a loved one that we never experienced, or reach some kind of rapport with those who have disappointed us in which they will no longer be disappointing. The drive in these behaviors, however, is always to change the other person, never oneself.

My work as a psychotherapist is about how we can change ourselves. In cases like these, people must learn first to look at what they are repeating (the rage, the attempts to destroy the separateness that disappoints, the sullen yearnings for attention) and then to feel the inner emptiness that is behind the demands for reparation. It is this emptiness, with which those who are scarred by the basic fault are so identified, that must be held in the attentional space of bare attention. It is often fought against with all of the fury of a rejected lover, but by helping people work their way back through defensive feelings of outrage to the direct experience of that terrifying hollowness, the fear that so permeates their perception of themselves can be slowly divested. This is a goal that psychotherapy has long cherished, but it is one that is made more approachable through the contributions of meditative awareness.

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THE GAP

During my earliest days as a therapist, I was taught this lesson about the urge for reparation when a young woman named Paige entered therapy with me after dropping out of college and threatening suicide. She felt empty, without direction or support from her family, and she was afraid of being humiliated in relationships that she both craved and feared. In the beginning, she was tortured by frightening dreams in which she was recurrently chased, threatened, accosted, or pursued. She began calling me often between sessions, sometimes pleading despairingly for help and sometimes expressing indignation and outrage at the ways I was failing her, demanding that I call her back, schedule additional appointments, and drop everything to take care of her. I very quickly began to feel as if I could never do enough, although I tried my best to be helpful, to placate her, to explain the limitations of my role, and so on. All of these attempts at being reasonable did very little to help Paige. It was only when I was able to see that she was, in effect, trying to destroy me, that she did not want to experience the boundaries between us, that her need for me was also mixed with rage, and that she was terrified at the intensity of her fury and needed help with her fear, that I could begin to be a "good enough" therapist.

Paige was repeating, in her relationship with me, much of the fury that she felt over her parents' unavailability to her as a small child. But she was experiencing that fury with me and had no immediate interest in tracing it back to her early life. My first task was to help Paige find a way to experience her feelings without merely acting them out. As angry as Paige was, she was not completely aware of herself. She was possessed of a righteous fury; she felt entitled to make demands on me,

and she actually was more in touch with her righteousness than with her rage. Her dreams contained her fury, but always in a turned-around form: people were chasing and threatening *her*, never the other way round. Paige saw her anger as a faucet that could not be turned off, and she was scared to simply be angry, to be with her feelings in a tolerant way. When I forbade her to call me between sessions, when I made clear boundaries that I adhered to, Paige felt a curious kind of relief—and a more circumspect kind of anger at me—that enabled her to begin to focus on the shadowy pursuers of her dreams as her own dissociated angry feelings. Paige was able to take possession of her anger by learning what it meant to *feel* angry, and she became much more human, no longer dwelling in a realm of hideous projections.

Once Paige learned how to be with her own anger, she became much more able to grieve the irrevocable loss of her childhood. Instead of perpetuating conditions in her present life that would reinforce a sense of isolated and alienated bereftness, as she had been doing with me, Paige began to learn how to accept those feelings as a consequence of her childhood experience. By repeatedly applying meditative awareness to those bereft feelings, by slowly desensitizing herself to them, Paige was able to come to terms with who she had become and to reach out toward that which she wished to be.

GHOSTS INTO ANCESTORS

The therapeutic process, then, is one that encourages just this kind of grieving. The psychoanalyst Hans Loewald wrote of transforming the *ghosts* that haunt patients into *ancestors*, in through tasting what he called the "blood of recognition" in

the relationship with the therapist. He asserted that the ghosts must be led out of the unconscious, reawakened through the intensity of the therapeutic relationship, and then laid to rest, relegated to history, thus allowing the person more flexibility and intensity in present relations.⁹ In a similar vein, the British psychoanalyst Michael Balint, in his discussions of the basic fault, wrote of helping the patient change "violent resentment into regret,"¹⁰ helping her to come to terms with the scarring that has been established in her psyche. Implicit in these widely cited analogies is the recognition that the difficult emotions generated by the original deficiencies do not actually go away; they may be enshrined on a shelf above the doorway as in a Confucian home, but they must be afforded great respect.

Once the scarring is identified, once the fault is recognized, once the anger is transformed into grief, the opportunity then exists for meditation to be used in a new way. Precisely because the scarring does not go away, the person then has the opportunity to zero in on the defect around which so much of the feeling of a substantially existent self has coalesced. Westerners who are subject to the basic fault cannot begin to explore Buddhist selflessness without looking first at how they are identified with their emotional pain. This is rarely a process that involves *only* therapy or *only* meditation; it is one that requires as much help as possible. Once cleared of the "violent resentment" that so clouds the observing mind, however, the process of working through can actually begin.

When Freud imagined *how* to make the therapeutic relationship a vehicle for working through these repetitive emotions, he said some interesting things. The emotions must first be given the right to assert themselves "in a definite field," he maintained. The relationship must then become like a "playground" in which "everything that is hidden" can reveal itself. What happens in therapy must be like an "intermediate

region" between illness and real life, "a kind of twilight zone of the soul.

While many would consider Freud's musings overly idealized, his major omission lay in his failure to teach his followers *how* to create the kind of environment that he imagined. Meditation is indispensable in demonstrating to both therapist and patient how to maintain Freud's "intermediate region" and how to let an emotion or action "assert itself in a definite field." The Buddha's vehicle of bare attention is one means by which Freud's playground can be constructed.

CHAPTER 10

WORKING THROUGH

I REMEMBER ONCE, not so many years ago, sitting in my therapist's office, telling him of an argument that I had had with someone close to me. I can no longer recall the details, but I had done something to get my friend upset with me, and she had become quite angry—unjustifiably and disproportionately, in my view. I was still obviously angry, too, but I remember feeling upset and frustrated as I recounted the events to my therapist.

"All I can do is love her more strongly at those times," I insisted somewhat plaintively, drawing on my years of meditation practice and the sincerity of my deeper feelings in the hope of freeing my mind from the anger that was brewing.

"That will never work," he snapped, and it was like being hit with a Zen master's stick. My therapist would look at me somewhat quizzically at such times, as if amazed at my foolishness. "What's wrong with being angry?" he would often say.

This interaction has stayed with me because, in some way, it crystallizes the difficulties that we face in trying to integrate Buddhist and Western psychological approaches. *Is* there something wrong with being angry? Can we get rid of it? What does it mean to *work it through*? I have to address questions such