TRANSFORMING A SLACKER IDENTITY: DYSTHYMIA AND ADULTHOOD

by

IMME KAROLA STAEFFLER

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

MERIDIAN UNIVERSITY

2014
TRANSFORMING A SLACKER IDENTITY: DYSTHYMIA AND ADULTHOOD

by

IMME KAROLA STAEFFLER

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

MERIDIAN UNIVERSITY

2014

This dissertation has been accepted for the faculty of
Meridian University by:

Melissa Schwartz, Ph.D.
Clinical Case Study Advisor

Justin Forman, Ph.D.
Doctoral Project Committee Member
ABSTRACT

TRANSFORMING A SLACKER IDENTITY: DYSTHYMIA AND ADULTHOOD

by

Imme Karola Staeffler

The clinical topic of this study, dysthymia as one response to an incomplete passage into adulthood, has meaning for depth oriented therapists, depressed adults, and adults identified with failure and loss who have strong, negative thought patterns. The client of this study, a 30 year old Caucasian man with dysthymia, experienced ambivalence and inner conflict about career choices, romantic relationships, and about how he approached goals in his life.

The literature review showed a link between loss, grief, ambivalence and depression or dysthymia. The traditional means to address these phenomena have been cognitive-behavioral approaches. However, depth oriented approaches show that soulmaking and reflexive pathologizing helped map out an initiate of adulthood which, in the transformative vessel of psychotherapy, began transforming a slacker identity.

Andrew sought therapy to help him find a more satisfying life; he identified with failure and being a slacker. Imaginal Process aided psychotherapy in a process aiming to meet, express, and engage hidden voices— including Gatekeeper voices—that uncover losses and grieve them. This allowed the client to begin grieving losses and become
gentler with himself. Furthermore, the client’s negative identification as a slacker became more fluid.

The learnings of this study show that prolonged and unaddressed losses and associated gatekeeping supported a dysthymic process.

The mythic lens in use to reflect on the learning of this study offers insights into slacker dynamics and how such are related to adulthood; this slacker identity is a version of the Puer archetype. In reflecting on dysthymia in early adulthood and the therapy examined in this study, a Puer Slacker emerges as a telling imaginal figure serving as an initiator in the client’s adulthood journey.
CONTENTS

ABSTRACT ................................................................................................................................. iii

Chapter

1. INTRODUCTION ................................................................................................................1

   Clinical Topic
   Exploration of the Topic/Subject Choice
   Framework of the Treatment
   Confidentiality and Ethical Concerns
   Client History and Life Circumstances
   Progression of the Treatment
   Learnings
   Personal and Professional Challenges

2. LITERATURE REVIEW ......................................................................................................17

   Introduction and Overview
   Biological Perspective
   Cognitive/Behavioral Perspective
   Psychodynamic Perspective
   Sociocultural Perspective
   Imaginal Approaches
   Conclusion
3. PROGRESSION OF THE TREATMENT.................................................................63
   The Beginning
   Treatment
   The Therapy Journey
   Legal and Ethical Issues
   Outcomes
4. LEARNINGS.................................................................................................96
   Key Concepts and Major Principles
   What Happened
   Imaginal Structures
   Primary Myth
   Personal and Professional Development
   Applying an Imaginal Psychology to Psychotherapy
5. REFLECTIONS...............................................................................................130
   Personal Development and Transformation
   The Impact of the Learnings on My Understanding of the Topic
   Mythic Implications of the Learnings
   Significance of the Learnings
   The Application of Imaginal Psychology to Psychotherapy
   Bridging Imaginal Psychology
   Areas of Future Research
Appendix

1. INFORMED CONSENT FORM.................................................................143

NOTES ........................................................................................................145

REFERENCES ........................................................................................161
CHAPTER 1

INTRODUCTION

Clinical Topic

This clinical case study examines dysthymia as one response to an incomplete passage into adulthood. The client “Andrew,” in this study, shared his story of leaving home feeling unaccomplished and lacking motivation to pursue adult life goals. He referred to himself using the derogatory term “slacker.” Andrew struggled. He was a bright, energetic, thoughtful young man and yet he experienced his life as lacking in power, assertion, and satisfaction.

Literature reviewed for this clinical case study shows relevant information for this clinical case study on dysthymia and young adulthood transformation. The literature review is divided into five sections: biological, cognitive/behavioral, psychodynamic, sociocultural, and imaginal perspective.

Literature reviewed from the biological cluster recognizes dysthymia and supports medication treatments. Cognitive Behavioral theorist Aaron Beck's theory of depression explains some of Andrew’s life experience, as Andrew held some negative views of himself, the world and the future, believing that he was at fault or defective, that the world was dangerous, and that the future was uncertain. Such beliefs about the self are quite common in long-term depression; the cognitive behavioral orientation is known for
relieving some of the worst ‘edge’ of these very painful self perceptions, albeit at superficial levels, relative to depth approaches.²

Psychoanalytic theories on depression point to two major issues: chronic ambivalence in the failure to reconcile negative experiences in early childhood and unresolved grief over real or imagined losses. For example, Melanie Klein's concept of the depressive position, an ambivalent relationship with one’s early caregivers at a pivotal time, results in adult depressive patterns.³ Andrew’s story of depression is a response to the unresolved grief of the loss in his earlier life compounded with a loss of direction later.⁴

At Meridian, the Psychology program’s approach to transformative learning, Imaginal Process, allows for, in Aftab Omer’s words, “The cultivation of human capacities through diversifying, deepening, embodying, and personalizing experiences. Imagination amplifies and integrates the sensory, emotional, and cognitive dimensions of our experience.” ⁵

A key concept from Imaginal Process is gatekeeping or the Gatekeeper. Omer explains, “Gatekeeping refers to the individual and collective dynamics that resist and restrict experience. The term Gatekeeper refers to the personification of these dynamics.” ⁶ The subjective experience of the Gatekeeper can be that of being attacked; the Gatekeeper is a psychic structure that attacks the person’s initiative in an effort to maintain the status quo and protect the person from reliving old injuries. If not challenged, the Gatekeeper limits psychological development and change. Omer's explanation provides another way of seeing Andrew’s self-attacking aspect.
The works of Erik Erikson and Thomas Moore convey the most relevant and significant points from the literature review on the topic.

Erik Erikson's theories on adult development are helpful in recognizing Andrew's struggle with achieving adulthood. Andrew’s aspirations for economic security and for finding a life partner and the related struggles are age appropriate and correspond to Erikson’s first and sixth stages of eight stages in the life cycle, intimacy vs. isolation and generativity vs. stagnation.\(^7\)

Thomas Moore’s words on depression provide a framework for holding dysthymia in a meaningful and life affirming manner. Moore adds to the understanding of depression as he differentiates depression from the “dark night of the soul.” He writes, “Depression is a mood to endure and try to get through,” while the “dark night of the soul” refers to “a process in which your coarse soul is refined and your intelligence deepened.”\(^8\) This study shows how therapy with soul holds an adult with dysthymia.

Next is a brief review of the most relevant and significant points to actual problematic issues. The symptoms of persistent depressive disorder, or dysthymia, according to the Diagnostic and Statistical Manual of Mental Disorders V (DSM V) are “poor appetite or over eating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulties making decisions, and feelings of hopelessness.”\(^9\) The DSM V states that the degree that this disorder impacts social and occupational functioning varies but the harm can be greater than those of major depressive illness.\(^10\) Dysthymia presents as a mild and chronic depression, and Andrew exhibited many of these symptoms.
The connection between Andrew's dysthymia and his struggle with adulthood resonated with me and I thought that therefore writing about this psychological territory would come easy. About half way through Andrew’s therapy, I began thinking that the therapy story might be an interesting backdrop for this clinical case study and considered finding a link between dysthymia and an incomplete adulthood passage, specifically in young adulthood or early adulthood, the ages 20 to 35.

Not being a disciplined and scholarly person, I dreaded writing this clinical case study. Writing long research manuscripts is difficult for me. Depression as a response to an incomplete transition into adulthood was an area of research I was familiar from personal experiences and reflections. Therefore, I thought, the work ahead would more palatable for me.

**Exploration of the Topic/Subject Choice**

Andrew displayed self-doubt and self-criticism, which I understood to be symptoms of dysthymia. Beyond the constellation of symptoms, a story about coming into greater adulthood echoed throughout the therapy as a search for greater aliveness and satisfaction stood out over his dysthymia.

Possessing dysthymic symptoms in response to an incomplete passage into adulthood is also a personal journey for me. In some elements, Andrew's story mirrored mine: graduation from the Fachoberschule Kulmbach in Germany, separation from my parental home and a consequence moved to the U.S. As a young adult, I responded to this separation by creating a unique way as a young adult. I sensed that my depression was the
result of losses during my teenage and young adult years. I experienced my life as if on two tracks: the track in which I live my life as many others, interested in becoming the most able and true to one's nature; and the other track in which I am depressed and sometimes feel that I cannot discern these attacking inner voices. One of my adult tasks has been to learn to manage a life on both tracks. James Keats states, “I am certain of nothing but the holiness of the Heart’s affections and the truth of the Imagination”, a verity that a person intuits but at times forgets. These personal experiences have set the groundwork for a deep curiosity about how humans negotiate adult lives, including aspirations, accomplishments, and failures.

Framework of the Treatment

The work with Andrew took place in a private practice setting in Oakland where I was working as a registered psychological assistant under the employ of Dr. Vernita Marsh, a licensed psychologist. Dr. Marsh (who I called by her first name, Vernita) worked as a general practitioner. I was registered with the California Board of Psychology as a Psychological Assistant. The office was located in a small suite with three therapy rooms. Two female marriage and family therapists rented one of the therapy rooms, the other two rooms were for Vernita and her interns. We met on a weekly basis for one hour of individual supervision. For the first year of my internship, there was only intern, then a post doctorate intern joined, and we enjoyed a collegial relationship with one another.
Andrew was Vernita’s client in another practice, an HMO in which the insurance only allowed ten sessions. In discussing options for ongoing therapy, Andrew chose therapy at a reduced cost with an intern of Vernita’s, and so she referred him to me.

The first meeting occurred on March 5, 2004. Between March of 2004 and October 2005 we met biweekly for individual, 50-minute sessions and a total of 39 sessions. We spoke on the phone on occasion when Andrew called to check in. We also had an agreement that on occasion the therapy included 20-minute phone therapy to assist Andrew with home assignments.

During my time as a Psychological Assistant in Vernita’s office, the internship provided opportunities for providing psychotherapy for up to three clients per week: Andrew, a teenage girl, and woman in her thirties. In addition, I prepared and facilitated one afternoon workshop for women.

Vernita supported my clinical growth, she provided both a challenging and safe learning environment. Supervision focused on structuring the therapy to prepare me to work with a variety of people and issues with the help of a repertoire of interventions and topics to support depth work. Some of these were exploring home assignments to support the work, listening to emerging themes and tracking transference and countertransference in sessions.

Confidentiality and Ethical Concerns

Research with humans requires the careful consideration of ethical and legal issues; consent and confidentiality are of particular importance. I took several measures to
protect Andrew’s confidentiality. First, throughout this clinical case study, a pseudonym disguises his true name. Second, Andrew’s biographical information and some other possibly identifiable details are altered. Changes to Andrew’s information were made carefully as not to distort the clinical picture.

In obtaining consent, attentive communication with Andrew about the consent assured proper consent. For ethical reasons and according to federal regulations and direction provided by Meridian University, Andrew was given a free choice to participate in the research and he was explained that he might withdraw the consent at any time. I made myself available to Andrew to discuss the consent for his participation in this clinical case study at any time during the duration of the study. We talked about the potential impact of becoming a subject in this study, including how the study might affect his therapy experience.

Andrew wanted to know who would read the study, the provided information explained that Meridian University faculty, staff, other students and my support team, such as colleagues and editors, would have access to the study. Andrew expressed an interest in reading the study and the reply explained how he might do so and how such access might negatively affect him due to the scholarly and creative nature of a clinical case study. I explained that as an author I would be motivated to satisfy the needs of the study and less his needs. We talked about what the study was about and what the study asked of him. 

It was anticipated that Andrew would respond with approval and curiosity to the invitation to become the subject in this study. A previous experience with Andrew gave me such an insight. In an earlier part of therapy, I shared with Andrew about taking notes
during the session for supervision purposes and Andrew responded positively. Andrew's response to my request that he serve as the subject of my clinical case study was that he felt taken care of and attended to.

Another potential ethical or legal issue relates to therapy termination before the therapy was completed. After two years in Vernita's employ, I decided to leave the internship for relocation to Sonoma County. Despite the termination, Andrew benefited from the completion of some major work. Yet, Andrew would have benefited from our continued work. Vernita and I assessed that a termination at this point in the therapy did not harm Andrew nor jeopardize other therapies. In talking with Andrew about the termination, he was encouraged to participate in a four month termination period and explained that a termination phase could potentially be very impactful.

He understandably declined to follow me to another internship in Sonoma County because of a long commute. I also offered to refer Andrew to another therapist and to meet with Andrew during the transition to a new therapist but, at the time, he declined working with another therapist. Andrew withdrew early from the termination phase of the therapy. He expressed that the termination provided a good, natural ending for him and that he appreciated the positive changes in his life. I would have wanted to participate and witness his further development.
Client History and Life Circumstances

Andrew revealed his story in his own time. Consequently, some information about Andrew’s life is not available; the information below was obtained in course of the therapy.

Andrew was 29 years old at the beginning of therapy. An unmarried, heterosexual, white male, Andrew lived in a shared apartment with a male friend near the south side of the city of Berkeley in Alameda County. He worked full-time as an office assistant at a national, nonprofit organization and he earned about $13 an hour. Andrew held a high school diploma and he had attended a couple of semesters at a junior college. His vocabulary was that of a college graduate. He dressed casually in fatigues and T-shirts and carried a tote bag. His long hair hung over his shoulders and his beard was neatly trimmed into a goatee. Andrew reported that he was in good physical health.

Andrew grew up in a Protestant home in a suburb of a large mid-western city. His father was the first born of five children, grew up in a mid-western farm, and went to seminary school. His mother had a Catholic upbringing, was the youngest of four children, and grew up in several northeastern small towns. Andrew’s father worked at a non-profit organization in an administrative position and supported a family if six with the help of additional assembly piecework at home. The stay-at-home mother began working part-time once the youngest children entered school. The father, an ordained pastor in a community church, left his position when Andrew was about six months old. Andrew assumed his father sought a higher paying position. His father remained involved with the church for the remainder if his life.
Andrew was the oldest of four children, and his parents were happy about starting a family. The siblings’ ages were as follows: a brother was two years younger than Andrew, and twin brother and sister were six years younger. Andrew described his childhood years as normal with regular church and family activities. His parents generally did not show much affection—somewhat typical for parents at the time. Still Andrew remembered that his father gave “good hugs.” As small children, they played with Legos building blocks and a play mobile in a basement room. He recalls family board games such as Shoots and Ladder, Candy Lane, and Risk. On Sunday afternoons, the parents napped and could not be disturbed.

Andrew also mentioned that, when he was a small child, his parents drank a lot of alcohol. Andrew mentioned that he observed the father and by then teenage sister making a pact to not drink alcohol when Andrew was a teenager. These statements contradicted other childhood descriptions. In therapy they remained largely unexplored because Andrew was not yet ready to do so.

When Andrew began therapy, all three of his siblings still lived in the larger geographical area of their parental home. His sister had problems with cocaine use. The sister’s twin, unmarried, came to Berkeley a few years prior and underwent a psychotic break. The “the middle brother” was a carpenter and moved in with Andrew during the therapy.

Andrew described himself as a “rebellious” and an “ignorant” youth. His parents encouraged him to do better in school and to attend college after high school. He was not interested in school and enjoyed spending most of his time with his friends. He, when at home, spent time in his room away from family interaction.
Andrew recalled no family problems until a couple of years before his parents divorced, when Andrew was about 15. Shortly after the divorce, his father started a household with a woman in the same neighborhood. Andrew did not recall in depth conversations with his father about the family life. His father died suddenly from heart disease in his early forties while Andrew was living with him. This was an additional shock for Andrew because Andrew was not aware that his father was deathly ill.

At age 17, Andrew entered therapy for a second time. An earlier therapy was discontinued because Andrew’s father did not believe in therapy; his father openly mocked the therapy. Andrew was admitted to an acute psychiatric youth unit for suicidality where he remained for three days. His mother easily became anxious and overwhelmed and was not emotionally available. Andrew's therapist had facilitated the hospitalization, and Andrew felt betrayed this. Andrew denied the need for the hospitalization.

After high school graduation, Andrew attended junior college for a couple of semesters and took on various short term labor jobs, one of them delivering cookies for a bakery. During these years, Andrew lived with roommates and with his mother or father. There existed little personal involvement with his parents at the time.

At age 23, Andrew left his family home and moved with a girlfriend to Seattle. This was his second significant relationship. He reported that his early west coast experiences were positive and expansive for him. After the break-up of their relationship in May 2000, Andrew moved to Berkeley. He still lived and worked in Berkeley. For the last year, he dated “Sara,” who lived in Chico 150 miles north.
Progression of the Treatment

Andrew initiated therapy; he wanted more satisfaction in his life. He appeared somewhat timid and guarded with much self-criticism about perceived failures in his life. He described himself as a “slacker” who did “not apply” himself. Yet, Andrew had great assets. He was compassionate, intelligent, and showed excellent verbal skills. He had a variety of interests and a sense of humor. Andrew wanted more satisfaction through meaningful and financially rewarding work, a life partner, and better self-care.

The initial therapy served in building trust and, later, therapy helped Andrew to be less critical of himself. Andrew’s presented goals deemed age appropriate. Andrew initiated a mourning process of his father. He engaged in a grieving process of sorting through conflicting memories of his father and deeply expressing how much he missed him.

During the later part of therapy, Andrew learned a process by which to identify the dysthymic voices and how to express them. Andrew had initially denied himself expression of feelings such as anger, conscious self-doubt, achievement, and satisfaction. As the therapy progressed, Andrew took increased risks and shared more of his previously repressed inner life. He examined his relationship with the use of drugs and alcohol. It remained difficult for Andrew to talk about the therapeutic relationship and his ambivalence. He also experienced increased stressors including family problems, employment loss, entering a new relationship, and falling in love.
The therapy was terminated because I relocated. In one of the termination sessions, Andrew stated that this 'forced ending' actually provided a natural ending for him. He expressed appreciation for the work completed.

**Learnings**

In reflecting on the therapy and the literature, I keep returning to some ideas I had during the sessions— that is, that dysthymia is embedded within the deeper structures of the psyche as a voice that always says, “Something is wrong with you,” or “You should have a partner (money, home),” or “Why are you not doing what you need to do?” Andrew was entrenched in self-judgment and self-attacks and yet, underneath, he had a sense that he could accomplish goals in his life and feel more satisfied. The work during therapy was informed by Omer's concept of gatekeeping. This study shows how long term gatekeeping contributed to dysthymia in Andrew.

The symptoms of dysthymia signaled that Andrew sought transformation into greater adulthood. That is his longing and imagination about a different life signified that he was seeking adulthood. His dysthymic symptoms of low self-esteem, brooding, difficulties making decisions, subjective feelings of irritability or excessive anger, and decreased activity with decreased effectiveness initially burdened him as he accepted the subjective experience of the symptom's initial messages and associated feelings. As Andrew began liberating himself from gatekeeping, the larger story became clearer: Andrew was undergoing a transformation from identifying with the *Puer Slacker* to an initiate on a healing journey, a journey of maturation.13
Personal and Professional Challenges

Some of the encountered challenges are summarized as the learning experiences of a beginning therapist. Andrew was my first client in a depth-oriented psychotherapy after completing the doctoral level classes for a Psy.D. at Meridian University. The work with Andrew was a time for me to discover how to be a depth-oriented psychotherapist in the practical application of long-term psychotherapy. As a novice therapist, I was very receptive to learn from a seasoned psychotherapist who in turn showed interest in Imaginal Psychology and Imaginal Process.

This internship offered an opportunity for me to articulate concepts and principles from *Imaginal Psychology* and to put its principles into the therapeutic practice. The curriculum at Meridian University explains,

> Imaginal Psychology is a distinct orientation to the discipline of psychology. This orientation reclaims soul as psychology’s primary concern. The soul expresses itself in images. Care of the soul asks that we pay close attention to the images we inhabit. This orientation to psychology has its roots in the transformative practices that are at the core of many spiritual traditions and creative arts.\(^{14}\)

I experienced some challenges related to this approach to psychotherapy. My background and training in Imaginal Psychology was not completely congruent with psychoanalytic psychotherapy, which emphasizes therapeutic objectivity and detachment from the client. In my training at Meridian University, the soul's passionate nature and how both the therapist and the client engage its true nature was seen as a central principle in the effective delivery of psychotherapy. When accepting Andrew as a client, I was not aware of the need for note taking. As note taking likely initiates distance, I counteracted through
transparency by offering Andrew examples of the notes. He listened to a few samples then declined to hear more. My awareness and pro-active measures lessened the possible negative impact of note taking.

It was new for me to structure long-term therapy in practice, including maintaining a therapy frame and fee setting with a client in depth therapy. Initially I timidly and cautiously approached fee setting or negotiating the therapy contract. I learned to track Andrew's story and my affectedness by it in a therapeutic practical application. Vernita's guidance in interpreting significant moments and planning and developing the sessions was instrumental in the therapy and my learning.

This study also challenged me personally. The psychotherapy and the research and writing process revealed personal meaning. Some of my reactions in the actual therapy mirrored my personal judgments about my own feelings of inadequacies. For example, I became annoyed with some aspects of the therapy. The therapy journey section of this study describes a “mule” shout-out in a session in response Andrew's brooding. At another instant, I grew impatient with a cookie business idea. My shying away from exploring sexual attraction in therapy also surprised me. These reactions taught me about my psychic structures, which were activated in the therapy.

My commitment and passion for this work remained unwavering, still my life as a student and intern included difficulties similar to Andrew's. At the time, I was in my forties and seeking more internship hours and income, not married, and had no children. In addition, I sensed losing a German or European connection; at the time of the therapy, it had been 25 years since leaving my home in Germany. My own status of being a “functional” adult was challenged. In the research and writing process that followed the
therapy, I questioned how I arrived at the current place in my life and who was I to write about maturation? Hence writing and researching on Andrew's dysthymia and transformation into adulthood became, at times, arduous because of my own inner conflict and beliefs. Still, this process confirmed the choice of a psychically energetic and worthwhile topic.
CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

This clinical literature review is divided into five sections: biological, cognitive/behavioral, psychodynamic, sociocultural, and imaginal. In these sections, general clinical concepts and principles on dysthymia, as well as dysthymia in response to an incomplete rite of passage, are reviewed. This literature review discusses the relevant literature in an attempt to convey a thorough clinical literature backdrop to this clinical case study.

The biological perspective section examines biochemical processes in the brain, genetics and the influence of stress and hormones on dysthymia. The cognitive/behavioral section offers the most relevant discoveries on how cognition and behaviors influence and are influenced by dysthymia. In the psychodynamic section are descriptions of concepts and principles on the inner life, unconscious motivations, and early life experience as relevant to the clinical topic of this study. The sociocultural section presents the most relevant social and cultural influences on and responses to dysthymia. Reviewed in the imaginal section are Carl Jung’s ideas on the human change process, story and myth, and ritual as relevant to this clinical case study.
In researching the topic of dysthymia in young adults, it is important to include research on depression because many researchers and scholars do not differentiate between major depression and dysthymia. Literature on depression and dysthymia is expansive and has grown out of a historical desire to understand such life experience. The wide body of literature available on dysthymia and depression, as appropriate to the topic of this clinical case study, was reviewed and only the most relevant information is extracted and included in the clinical literature review.

**Biological Perspective**

In the first half of the twentieth century, the classic model of depression held that emotional and mental stress causes psychiatric illness in an otherwise healthy person; more recent research found evidence of a biological basis of mental illness and depressive disorders. Biological research has led to important findings on the functioning of the brain, neurotransmitter regulation, and medication to treat depression. The idea that depression is a stress response is supported by earlier research— that is, emotional and mental stress causes depression including dysthymia. Genetic research has found genetic predispositions to depression and dysthymia.

The clinical case study examines early onset dysthymia as displaying intrusive and unrecognized symptoms. Klein, Daniel N., Alan F. Schatzberg, James P. McCullough, Martin B. Keller, Grank Dowling, Daniel Goodman, Robert H. Howland, John C. Markowitz, Christine Smith, Robert Miceli, and Wilma M. Harrison's findings support the presence of these symptoms in dysthymia. This implies that adults with
dysthymia are unaware of their condition. In a two-year longitudinal study Corrado Barbui, Nicola Motterlini and Livio Garattini learned that patients with early-onset dysthymia were admitted less frequently to psychiatric hospitals, this study claims that individuals with early onset dysthymia do not seek treatment due to the unrecognized nature of their symptoms.²

Dysthymia has biological, body based components and physical illnesses are associated with dysthymia. Studies show higher rates of medical illnesses are associated with the dysthymia: diabetes, irritable bowel syndrome, ulcers, and premenstrual syndrome.³ Individuals with dysthymic symptoms, who “complain of hopelessness and low energy,” and who are “the despairing but not depressed patient” incur the greatest cost upon physical health systems.⁴

Biological research makes a distinction between dysthymia and other mood disorders. Michael Maes Mariëlle Pier, Wouter Hulstijn, and Bernard G. C. Sabbe noted that, first, individuals with severe major depressive disorder show a decreased metabolic activity in the cerebral cortex and they experience less deep and restful sleep.⁵ Secondly, individuals with dysthymia show no psychomotor slowing in the fine motor tasks, while individuals with major depression show such slowed motor functioning.⁶ This study supports claims that individuals with dysthymia have fewer physical symptoms of depression than individuals with major depression.

Another study points to additional physical differences in dysthymia and other forms of depressions. Li-Shiun, Chen, W. W. Eaton and J. J. Gallo suggest that risk factors for dysthymia are more environmentally based and less genetically based than for other depressions.⁷ In the medical world, studies on the differences in dysthymia and
other forms of depression are generally considered insignificant. Current medical research is not interested in finding specific treatments for dysthymia.8

Dysthymia is generally considered a low level, chronic depression and research on the neurotransmitter regulation in dysthymia does not differentiate between dysthymia and depression. John O’Neal, John Preston, and Mary Tagala explain about antidepressant medication treatments. The basic neurotransmitter regulation processes are considered the same in both major depression and dysthymia.9 There are some differences, for example S. L. Brown, S. Steinberg and H. M. van Praag state that dopamine mostly controls mobilization and goal setting.10

In reviewing current and significant literature on the treatment of dysthymia, studies pose that medication therapy generally benefits patients. In one study, Richard A. Friedman, John C. Markowitz, Michael Parides, Leah Gniwesch, James H. Kocsis show that “social dysfunction in dysthymia responds to longer-term pharmacotherapy.11 Concerning a specific medication treatment, they found that social functioning remained impaired in patients who received desipramine as the only treatment. In this study, they found that a person receiving medication treatment might feel uplifted in their overall mood and be more active and willing to engage with others. They found that dysthymic individuals still need resolution about their experiences including the depression and the losses in their lives.12 In another study John. C. Markowitz, James H. Kocsis, Kathryn L. Bleiberg, Paul J. Christos, Michael Sacks determine that “pure” dysthymic disorders remains understudied.13 Still this study suggests that pharmacotherapy, medication treatments, may actually better benefit the dysthymic person that psychotherapy.14 John C. Markowitz, Kathryn L. Bleiberg, Paul Christos, E. Leviton in another study confirms
that interpersonal functioning shows improvement with medication treatment. Studies on the effectiveness of medication treatment as a primary remedy for dysthymia are not conclusive.

Today in the United States of America the main medication treatment for depression and dysthymia include: selective serotonin re-uptake inhibitors (SSRIs), selective norepinephrine re-uptake inhibitors (SNRIs), dopamine antagonists, tricyclic medication, and monoamine oxidase inhibitors (MAOIs). SSRIs and the SNRIs affect the central nervous system by reducing the natural action of absorbing neurotransmitters in the synaptic gap, a space between nerve cells needed to activate and stop cell communication, after the necessary nerve cell stimulation is completed. Tricyclic medications are inhibitors but are not as selective in what specific brain areas they affect. Monoamine oxidase inhibitors (MAOIs) work by the inhibition of monoamine oxidase, and monoamines lessen the availability of serotonin, dopamine, and norepinephrine. Through this action, MAOIs increase the availability of serotonin, dopamine, and norepinephrine throughout the central nervous system. Solomon also explains the use of these medications. Research shows that newer medication (SSRIs, SNRIs, and dopamine antagonists) and the older antidepressant (tricyclic) medication improve depressive symptoms at a similar success rate; however, the older medication produces a significantly higher rate of undesirable side effects. In one study, data was inadequate for deciding on the usefulness of newer antidepressants for “subsyndromal depression,” a mild form of depression.

The issue of medication treatment is somewhat controversial. Biological research studies neurotransmitter regulation in the brain and attempts to support medication
designed to influence specific neurotransmitter regulation processes. It is difficult to assert, however, that medication treatment should be the primary or sole response to dysthymia.

Henry Emmons suggests that depression is both a biological and a psychological illness; this suggests that both medication treatment and psychotherapy are appropriate in addressing dysthymia. He outlines three types of depressive behaviors and personality traits and links these to low levels of the three different neurotransmitters: serotonin deficiency manifests in anxious depression; deficiency of dopamine and norepinephrine manifests in sluggish depression; and serotonin deficiency in combination with a surplus of dopamine and norepinephrine results in agitated depression.

He claims that a therapeutic dosage of antidepressant medication lessens and can even extinguish symptoms of dysthymia. However, medication does not address the person’s desire for wholeness. Emmons, who states the “illusion of separation” is responsible for depressive feelings, also describes an example of how one’s psychology affects depressive symptoms. Emmons suggests that the illusion of separation in depression, which includes feelings of disconnection and loneliness, is an irrational belief. Emmons suggests a remedy for depression; depressed individuals need to counteract the depression’s pull towards isolation, a threat to their vitality, and actively engage in activities that foster and reinforce a sense of community and belonging.

Emmons also describes a biological predisposition to depression and a “biological, inborn resilience.” Biological predisposition to depression, heredity, and low levels of certain neurotransmitters set up a low resiliency in a person. This implies that a person with low resiliency returns less to normalcy after a loss compared to a
person with satisfactorily levels of neurotransmitters and without a depressive predisposition.  

John Preston, John H. O’Neal and Mary C. Talaga state that body-based symptoms are treated more easily than psychologically based symptoms. This indicates that medication positively influences the uplifting or mobilizing qualities of a person, which is useful, but the reflective, critical functions of the person cannot be engaged by medication. Reflection is a necessary function of modern humans. Preston summarizes this point:

It is important to underscore the fact that a number of the personal emotional and existential issues that make up the experience of a major depressive episode are not magically resolved by antidepressants. Even under ideal circumstances when medications work well, most patients must engage in a good deal of soul—searching, mourning and working through.

The authors write that 80% of adults who have a dysthymia diagnosis also develop major depression. The authors identify dysthymia as a minor depression and they follow the claim that minor depressions are of characterlogical issue and difficult to treat.

The new areas of research in depression study the role of stress. Peter Kramer explains that, under stress, a person with a low resilience is more likely to fall into depression. It is known that stress activates the central and peripheral components of the “stress system,” the hypothalamic-pituitary-adrenal connection and the sympathetic (arousal) nervous system. When this stress system does not respond adequately, “a sense of well being, adequate performance of tasks, and positive social interactions” suffers.

Not only does stress negatively impair a person’s functioning during times of stress, but also prolonged stress, particularly during childhood and adolescence, can
permanently change the stress system’s positive response and lead to mental illness.\textsuperscript{35} This is because brain plasticity slows down during childhood and puberty and reaches a plateau in young adulthood. Hormonal actions in early life and, to a much lesser extent, later can be organizational making the effects last for long periods, often for the entire life span of an individual. Hormones of the stress system and sex steroids have such effects, which influence the behavior and certain physiologic functions of individuals for life. Another study by Chen and others show a link between environmental stresses in childhood, such as high conflict in the family of origin, with dysthymia.\textsuperscript{36} Exposure of the developing brain to severe and/or prolonged stress may result in dysthymia.

Biological research shows that genetics also play a role in depression. Elliot S. Gershon’s study of biological twins growing up in different households attempts to explain genetic factors in depression. He explains that the rate of depression in twins growing up in different households positively correlates with the rate of depression in their biological parents. This study points to a genetic cause of depression and dysthymia.\textsuperscript{37}

In summary, the biological literature on dysthymia shows that biochemical processes, including the stress response and genetics, play a role in dysthymia. Some people have a biological partiality, which coincides with the occurrence of dysthymia. More research is needed to prove that dysthymia has a unique biological process, which differs from a general depressive process.

Therapists working from the biological perspective and supporting the use of psychotropic medication treatment assist their clients in relieving them of a variety of
uncomfortable symptoms; however, these therapies fall short in assisting their clients in relationship dynamics and understanding their role in life.

**Cognitive/Behavioral Perspective**

Among the wide body of literature on depression, cognitive-behavioral theories show important insights into dysthymia. Cognitive-behavioral therapists and researchers frequently work with the most current and well-known theories on depression. Psychologists from this perspective generally accept the biological aspects of depression; however, their greatest contributions lay in the work with thought and behavior patterns and associated feelings.

Aaron Beck’s influential and comprehensive cognitive theories of depression are widely quoted and incorporated into mainstream psychology. In summary, it states that negative cognition, thinking, triggered by life stress is the cause of depression. Beck restructures symptoms of depression into three sets of cognitive concepts: maladaptive self-schemata, cognitive distortions, and the cognitive triad.\(^{38}\)

The first major concept in Beck’s cognitive model *schemas* is cognitive structures, like *core beliefs*. Negative core beliefs fall into two types: helplessness and unlovability."\(^{39}\) This concept explains why depressed individuals maintain painful and self-defeating attitudes despite positive elements in their life. In this theory, maladaptive schemata are dysfunctional beliefs and are evident in automatic and distorted thought, which are reflected in themes of loss, inadequacy, failure, and worthlessness.\(^{40}\) According to this theory, stress activates these self-schemata and leads to specific
negative cognitions or cognitive distortions, the second major concept. The cognitive distortions are excessively pessimistic views of oneself, the world, and the future. Next, Beck’s concept of the cognitive triad consists of three major cognitive patterns that explain a client’s thoughts about themselves, their world, and their future. The first component, negative views of self, is noticeable in depressed individuals’ perceptions of themselves as defective, inadequate, or deprived. The second component relates to the patient viewing the world as making excessive demands on them and presenting overwhelming obstacles to reaching their life goals. The third component consists of a negative view of the future. The patient anticipates that his current difficulties or suffering will continue indefinitely. This person expects continuous hardship, frustration, and deprivation. When they consider undertaking a specific task in the immediate future, they expect to fail. These cognitive thought patterns in depressives are widely recognized and accepted. Considering this theory of depression, Beck developed a cognitive based therapy known as cognitive-behavioral therapy (CBT). CBT works well with clients who may be categorized as neurotic thinkers and who need to get in touch with their feelings. With these individuals, thinking serves as a defensive structure and CBT aims to counteract negative self-beliefs. CBT’s dialectic approach also helps high affect clients. Hence, another indication for CBT is for individuals who are ruled by affect and instinctual drive and who have little observing ego. CBT assists these individuals by decreasing overwhelm and emotionality.

CBT offers much to the work with depressed clients, but there are also limitations and omissions. For example, a part of CBT is assigning homework to further integrate therapy into the client’s life. Several problematic questions frequently arise in
association with this practice, such as why some clients do not complete their weekly homework assignments and why some clients do not get better despite regularly completing their homework.

Beck's cognitive theory of depression has provided a successful, widely accepted description of depressive thinking. A controversial cognitive concept is “depressive realism,” which contradicts Beck’s views that depressives tend to distort the facts and view their lives more negatively than the non-depressed. In a study by researchers Lauren B Alloy and Lyn B. Abramson asked two groups of test subjects (the depressives and the non-depressives) to “control the light bulb,” which was turned on and off by the researchers. The study found that depressives were significantly more realistic about their inability to influence the light bulb than their counterparts did, who kept attempting to turn on the light bulb over which they had no control.

Beck has contributed to the field of psychology by expounding on the cognitive processes associated with depressions, including dysthymia. Beck’s work with cognitive distortions and cognitive triads has been incorporated into popular psychological language and short-term therapies; entry-level clinicians now have psychological tools readily available, and advanced clinicians have means to affect immediate change with some patients.

Another, interesting model is Beck's evolutionary model. In this model, Beck asserts that depression is a reemergence of characteristics of some remote ancestor and that depression may have served a positive role in a prehistoric environment but that type of information processing is not adaptive in our current milieu. Depression having served
a different and useful purpose in another time is an interesting idea, which loosely relates to ideas on depression in mythology reviewed in the imaginal perspective section.

Another well-known cognitive-behavioral concept is Martin Seligman’s “learned helplessness.”\(^5\) He explains that as infants, we are born into a state of helplessness and we emerge from this state as we gain control over our lives under normal circumstances.\(^5\) Seligman originally perceived the origin of depression and the associated helplessness to stem from a sense of powerlessness and/or loss of control when exposed to overwhelming stress or a trauma; the individual experiences a loss of control in responding to a trauma–that is an inability to remove oneself or to stop the trauma.\(^5\)

Seligman later expanded his thinking from learned helplessness into a “helplessness theory of depression,” which states that the depressed persons believe themselves to be powerless, helpless, over an expected, negative outcome– and not an original, stressful event.\(^5\) The helplessness theory of depression asserts that three areas of functioning are negatively affected: motivation, cognition, and behavior. In the perceived state of helplessness, which can lead to depression, the individual expectation that desired outcomes will not occur, that undesired outcomes will occur, and that one cannot change this situation.\(^5\)

Lauren B. Alloy, Lyn Y. Abramson and Erika L. Francis findings in their research support that cognition, negative thinking patterns and information processing confer a vulnerability to “full blown” depressive episodes. They claim that cognitive theories as related to depression have been criticized as only applying to mild depressions, but their findings show differently. Furthermore, their research suggests that children may learn
depressive cognitive styles from the caretakers, which may or may not lead to adult depression.\textsuperscript{56}

Albert Bandura’s concept of \textit{self-efficacy} is similar to Seligman’s helplessness, as both concepts address people's cognitive patterns and beliefs in their capabilities to exercise control over their own functioning and over events that affect their lives. Personal efficacy, the belief that one has influence on one’s “life choices, level of motivation, quality of functioning, resilience to adversity and vulnerability to stress and depression” are key elements of Bandura’s theory.\textsuperscript{57} Depressed individuals perceive themselves to have social inefficacy, which increases a person's vulnerability to stress and depression. Bandura compared people who experience anguish about their perceived abilities with those who do not suffer from such problems and found that a sense of low efficacy to exercise control produces depression as well as anxiety.\textsuperscript{58} This is similar to Seligman’s ideas on learned helplessness as the cause of depression and anxiety. Bandura suggests that depression is a response to unfulfilled aspirations, a low sense of social efficacy and an inability to succeed with social tasks. This supports a self-fulfilling prophecy, a cycle of believing one cannot succeed, then becoming anxious, and hence withdrawing from the anxiety-producing situation even if these situations would lead to fulfillment of aspirations. This leads to low social self-efficacy beliefs and the depression cycle continues.\textsuperscript{59}

Albert Ellis developed another cognitive approach in treating depression called Rational Emotive Therapy (RET). Ellis's work emphasizes the role of irrational beliefs in maintaining depression. In treatment, the therapist attacks these beliefs and behaviors that lead to maladaptive, emotional consequences. The process consequently frees the client
from the negative beliefs and behaviors and provides an opportunity for the client to adopt positive beliefs and behaviors.\textsuperscript{60}

In general, the cognitive perspective shows that how an adult interprets and understands events in his life according to their cognitive styles affects their vulnerability to dysthymia or depression.

Exemplar of a behaviorist perspective is B. F. Skinner’s claim that depression is the result of a deterioration of behavior. According to Skinner, an interruption of the usual sequence of behaviors causes a deterioration of behaviors and the environment positively reinforces this deterioration of behaviors.\textsuperscript{61} For example, if staying in bed is a rewarding experience for the depressed person and that person receives positive reinforcement by avoiding difficult activities and staying at home in bed. Indeed, the deterioration of behavior of social withdrawal, for example, may provide a momentary sense of relief and reward to the depressed person and hence perpetuate further deteriorating behaviors. However, this theory leaves unexplained why some people respond to an interruption of the usual sequence of behaviors with depression and not others.

Cognitive-behavioral theories and their developed therapies have contributed greatly to the understanding of dysthymia and depression; however, cognitive-behavioral concepts, principles, and therapies have limitations. The relationship between thought and feeling and behaviors as elucidated in the cognitive triad, the self-schemata and cognitive vulnerability, learned helplessness, and self-efficacy are important to understand in working with the dysthymic client and are widely used. However,
cognitive-behavioral approaches lack attention in understanding the relationship between the client and the therapist and the origin of dysthymia.

**Psychodynamic Perspective**

While cognitive-behavioral theories generally focus on feeling, thought, and behavior patterns, psychodynamic theories generally state an understanding of the experience of one’s social life and personal history, and the unconscious factors in one’s life. This psychodynamic literature review section highlights the relevant and still applicable theories dating back to the earliest psychologists in the academic field of psychology.

In this section, the differences between dysthymia and depression are considered. In early psychoanalytic literature, dysthymia was understood as depressive neurosis, depressive personality disorder, neurotic depression (with duration of at least two years), and persistent anxiety depression. In the second half of the twentieth century, not much was researched and written about dysthymia. Joseph M. Schwartz conducted a quick search on depression in the Psychoanalytic Electronic Publishing Archive; he found only 19 entries for depression out of 6253 between the years 1989 to 1998. Despite non-popularity in the publishing community, he maintains that depression is part of most psychoanalytic treatment because clients frequently show sadness and grief. In this section, anger and attacks against the self, ambivalence, loss, grief, early development and therapies are highlighted.
In reviewing concepts, theories and principles on dysthymia information about the use of the terms dysthymia and depression are needed. The Psychodynamic Diagnostic Manual (PDM) Task Force concludes, “…the overlap and boundaries between dysthymia and major depressive disorder remain unclear.” The PDM claims some content validity in comparing the two depressions; the PDM allocates cognitive and affective symptoms to dysthymia and vegetative symptoms to major depressive illness. The question of whether dysthymia needs a category separate from major depression and depressive neurosis remains unanswered.

Dysthymia is distinguishable from other clinical depressions. Peter Kramer describes dysthymia as different from a minor depression. He explains that dysthymic experience a “chronic sadness,” which persists for more days than not, for two years with no two-month period symptom free. In addition, two or more other symptoms may exist, including problems with sleep, excessive guilt, or suicidal thoughts. Overall, dysthymia points to a less severe but more pervasive depression than major depression. The symptoms of dysthymia appear characteristic of the person’s usual behavior, while a major depressive episode can be distinguished from a person’s usual functioning.

According to the Diagnostic and Statistical Manual of Mental Disorders V (DSM IV), dysthymia is referred to as persistent depressive disorder. The DSM V states that persistent depressive disorder has an early onset in childhood, adolescence, or early adulthood. There are indication for temperamental, environmental, genetic and physiological risk, and prognostic factors. Interesting to this study, childhood factors include parental loss or separation. There are indications that individuals with this
disorder have a higher proportion of first degree relatives with the same disorder than do individuals with other depressive disorders.69

Intrinsic in the dysthymic experience is an unconscious confusion about who a person is: is it the depression or is it I? In dysthymic disorder, the experience is different because one identifies with the depression. Per Daniel Klein and others “complaints of depression may become such a fixture of people’s lives that is seems to be intertwined with their personality structures.” 70 In other words, dysthymia is related to personality rather than mood.

Another view comes from the unitary model. It suggests that all anxiety disorders and depressions are variants of the same disorder.71 Kremer supports the idea of a continuum of depression with sybsyndromal depression on one end of the continuum, dysthymia towards the middle, and major depression at the other end of the continuum.72 Despite this study not reaching a conclusive outcome on whether dysthymia is tied to personality or is a middle point along a continuum of illnesses, perceiving a continuum of depression has interesting implications. In much of the literature reviewed, dysthymia does not receive equal attention compared to other depressions and depressive symptoms.

Vanessa Cook’s research on a sense of well being (SWB) points to the relationship between affect and depression. She found that affect was the most significant predictor of SWB and distinguishes between major depression and dysthymia; people “high in duration and intensity of negative affect” will often experience depression, whereas people “high in duration and low in intensity of negative affect” are melancholic or dysthymic most of the time.73 In this study, the difference or likeness between dysthymia, major depressive illness, and depressive neurosis or depressive illnesses are
not a central theme. Hence, not much attention is given to the relationship between the various types of depression diagnoses

Sandra Buechler revisits early psychoanalytic theories on depression and finds them valid. She identifies two concepts as most relevant: anger toward the self and sadness over losses.\textsuperscript{74}

The psychological study of depression started with Sigmund Freud who recognized the gloomy outlook of depressives and made the connection to melancholia and grief. According to Freud melancholia is one response to the loss of a \textit{love object}. In his theories on the ego, superego and id, he explains that melancholic person wrestles with an overzealous superego. Freud describes depression as the \textit{turning inward of the aggressive} instincts, he continues to explain that the superego turns against the ego by setting itself over and against the other parts of the ego, which then dominate and judge, and punish the ego. He adds that, in maladaptive grief, the anger and disappointment previously directed at a lost person or object turn against the grieving person in the form of chronic and corrosive self-doubt and self-criticism.\textsuperscript{75}

By concurring with Sigmund Freud’s work with the super ego, ideas on the overzealous super ego continue. In depressed or dysthymic clients, Donald Kalsched recognizes that Freud’s super ego becomes \textit{sadistic} and has become a \textit{self-abusing aspect of the client’s psyche}.\textsuperscript{76} A. Almaas, recognizing the need of working with the superego, believes that \textit{dethroning the ego} is a necessary step in confronting an overzealous super ego. This is done by separating out and working with self-critical and self-limiting beliefs.\textsuperscript{77} Related concepts are Ronald Fairbairn’s \textit{inner saboteur} or \textit{antilibidinal ego} expressed in avoidance, self-hatred, and collapse.\textsuperscript{78} Fairbairn perceives that the
antilibidinal ego is formed to reject an attacking or intolerable indifferent object, caregiver symbol, or influential, powerful other. Many acknowledge a psychological self-attacking aspect of the person.

These observations of corrosive self-doubt and self-criticism relate to Karl Abraham’s interest in ambivalence, he referred to this as obsession neurotics. Abraham noticed increased ambivalence in the depressed person and noted that, in the depressed person, thoughts and experiences fluctuate and interfere with one another. In brief, conflicting feelings eventually block the person’s access to any feelings, which results in an experience of numbness and emptiness representative of depressive symptoms.

Melanie Klein built her ideas about depression on ambivalence. She developed the concept of the depressive position—an ambivalent relationship with one’s early caregivers at a “pivotal time” results in adult depressive patterns. Klein explains that the pivotal time in the baby’s life is when the baby first experiences the caregiver’s power either to nurture (offering touch or breast milk), or to be the source of pain (inflicting hunger, abandonment). In relation to these experiences, Klein coined the term good object. Klein suggests that, in the depressed adult, the ego failed to reconcile the person’s ambivalent relationship to the caregiver or the caregiver object. Instead the caregiver object is introjected into the person’s psychological make-up without discernment. Abraham also suggests a process of introjection in the depressed. The concept introjection is discussed later on. Consequently, the adult’s life experience vacillates between good and bad with difficulty in blending the two or resolving the split. The early depressive position can easily be re-activated in the adult’s life and result in
depression. According to Klein’s theory, the depressed client needs to work through the conflict of good and bad.\textsuperscript{87}

Besides linking ambivalence, introjection, and depression, Abraham was also the first to perceive depression as a response to a real or an imagined loss of a loved one or object. Abraham discovered that depression “contains a tendency to deny life” in response to loss experiences.\textsuperscript{88} After Klein, Nancy McWilliams confirms the validity of early psychoanalytic thought on depression relating to the un-integrated loss of a real or imagined love object continues. McWilliams argues that the origin of a person’s depression may not be the actual loss but the response to the loss by a caregiver. The loss may be a person, a developmental outcome, or even an aspiration— a child’s behavior that the child may not be ready to extinguish but is pressured to do so. If the child is not supported in accepting the loss and, hence, integrates the experience, the child could be left with chronic feelings of abandonment.\textsuperscript{89}

Adult depressives frequently identify fears of rejection and abandonment. Peter Kremer, who states that depressives experience rejection sensitivity.\textsuperscript{90}

Andrew Solomon studies the relationships between grief and depression. There are benefits to grieving, while depression is perceived of an expression of too much pain. Solomon writes,

depression is not just part of a lot of pain, but too much pain can compost itself into depression. Grief is depression in proportion to circumstance; depression is grief out of proportion...Grief is a humble angel who leaves you strong, clear thoughts and a sense of your own depth. Depression is a demon who leaves you appalled.\textsuperscript{91}

Solomon clearly writes about a deep, disabling depression in the sense of major depression, not dysthymia; however the role of grieving remains applicable to dysthymia.
Nathanson also links grief with depressive feelings and melancholy and perceives grief as a response to loss. He writes, “mourning and melancholy are common moods involving the affect distress and anguish,” and that long periods of distress after a loss experience lead to grief.92 The literature notes additional information about the differences between depression and dysthymia. Donald Nathanson describes that a person who experiences high levels of the fear and terror, distress and anguish, and anger and rage is more likely to develop depression than dysthymia.93 Nathanson links and delineates shame and guilt; he states that “classical depression” is characterized by excessive guilt while “atypical depression” is characterized by excessive shame.94 This is an important distinction, as guilt relates to having violated codes of conduct in our behavior and our actions, while shame relates to the sudden shut down of a positive affect and leaves a one doubting about the “quality of our person or the self.”95

Donald Winnicott provides important ideas about the transition period in which the child develops a sense of self as a separate from the caregiver. He supports the idea that a baby is first embedded with the caregiver and needs to develop boundaries; he calls this stage of development *symbiosis*.96 Winnicott’s concept of *transitional phenomena* (baby blanket) refers to a developmental task when the child first internalizes important external qualities.97 In transitioning from symbiosis into the next stage with the experience of being a separate, the child receives a sense of connection and comfort in its necessary loss experience. He explains that the child may successfully resolve the tension between constantly needing the caregiver and becoming a separate person by developing capacities in becoming a separate entity by the use of a transitional object. The transitional object provides a first experience of a connection with the caregiver even
when the caregiver is shortly not present. Before this stage, the child was unaware of a separation and his own experiences of himself and the world.  

Another way to think about early wounding is in terms of *introjection* is that in depression the external “bad” caregiver is introjected. McWilliams also refers to *dysthymic dynamics* as the nonphysical symptoms of depression. According to McWilliams, introjection is closely related to projection, as both are responses to “confusion” about an actual lack of a “psychological boundary between the self and the world.” McWilliams recognizes Klein’s introjection as the “most powerful and organizing defense” in depressed individuals. McWilliams explains that in the dysthymic process specific introjections are identified in clients’ assumptions about themselves. Dysthymic clients tend to takes sole responsibility for negative outcomes even when they clearly are not solely responsible. Interestingly, McWilliams explains when introjection and projection occur together, *projective identification* is a defense. Projective identification is a lack of psychological boundary –this is me and this is the other are fused into one internal structure.

Abraham, Klein, and Winnicott identify that an early childhood developmental task—balancing care and attention with the child's increased independence—plays a role in adulthood depression and dysthymia. Others focus on the grieving of missed opportunities to achieve well being and complete such necessary developmental tasks. Margaret Mahler recognizes that a person’s developmental losses need to be grieved. Mahler writes, “It must the loss of fantasy -- that is to say intrapsychic conflict...which is the cause for the occurrence of depression.”
Erik Erikson developed concepts and principles about developmental stages in the life of a person and these support the idea that dysthymia is a result of not completing a developmental phase. According to Erikson’s developmental theory, individuals face specific developmental tasks or crisis at various ages, which need successful resolution for a person's ability to complete next stages and become a more full person. Erikson perceives that such a crisis is an opportunity to develop psychological capacities, a turning point of increased vulnerability and enhanced potential. Erikson’s first of the eight developmental stages “trust versus mistrust,” parallels Klein and Winnicott’s pivotal time and occurs in the infant’s first year. According to Erikson, the unsuccessful resolution of this particular stage closely relates to an underlying depression in adults.\(^{105}\) Robert Kegan quotes Erikson on the crux of Erikson’s thinking— the main issue in a person’s life is to develop the “capacity to unify his experience and his actions in an adaptive manner.”\(^{106}\) In recalling an earlier idea on depression and dysthymia in response to not grieving the loss of a developmental task, it is reasonable to assume a person may become ensnared in a dysthymic process when not resolving any one of Erikson’s developmental stages.

Other factors in dysthymia and depression relate to familial responses to real losses within the family. McWilliams reviews the family’s response to losses within the family and finds that depressive tendencies in adults derive from the family of origin’s lack of grieving actual losses. She acknowledges that depressive patients’ families of origin frequently hold negative attitudes about mourning a death or “regressive reactions” to family disturbances such as the death of a family member. Families judge “mourning and other forms of self-care” and label such processes as unacceptable and even bad.\(^{107}\)
She found, in her own work, that depressed individuals generally exhibit more “emotional intelligence” than other family members do and therefore the family falsely labels them “hypersensitive” or “over reactive.” Individuals with these experiences and greater emotional intelligence are more likely to develop depression in their adulthood. The positive correlation between depressive caregivers and depressive offspring, from a psychoanalytic view, presents a counterargument to the biological theories. The concepts discussed in the biological literature review section contribute depression, in part, to a genetic predisposition whereas psychoanalytic theorists perceive the influence of depressive parents on the child as one of the causes of depression. Depressive parents lack the capacity to respond helpfully to their child’s grief, and the offspring is left with the same unresolved grief leading to depressive symptoms in adulthood.

In reviewing psychodynamic therapies, two distinct therapies are in use. Transference therapy maintains that healing occurs relationally; while Freudian therapy asserts that psychological change occurs through gaining an intellectual understanding of one’s maladaptive dynamics. Michael Gorkin relays that transference therapy works with the assumption that clients recreate their early crisis in the therapy sessions through a process called transference. In countertransference the “role-responsive” therapist experiences the client in session and draws parallels from this experiences. The therapist postulates how the client may relate to the world today and in his childhood. According to McWilliams, a depressed client transfers depressive structures onto the therapy: the client acts on the loss of unmet needs by being helpless and needy in therapy or by seeking approval of the therapist. The role-responsive therapist responds to assist the
client in completing a grief process of this loss by providing reparative experiences in the therapy session.

The therapists then interpret the transference process with a client. Several theorists believe that it is in how the client deals with the interpretation of the unconscious transference-countertransference process that is crucial for healing.\textsuperscript{112} Gorkin outlines how others work with disclosure of countertransference.\textsuperscript{113} Freudian therapists also appeal to the analytic functions in their clients: the analyst’s main aim is to learn the patient’s history, their unconscious fantasies, repressed materials as it emerges in dreams and other ways, and transference and countertransference. He then interprets these processes to the patient instead of providing a reparative experience in the therapy sessions.

In summary, psychoanalytic literature today mostly perceives depression as a response to the unresolved grief of the loss of actual objects and persons and perceived losses including developmental losses, especially in early life.\textsuperscript{114} The psychodynamic section of this literature review highlights several themes in relation to dysthymia. The main ideas are: dysthymia as a depression without the bodily, vegetative symptoms; an overzealous punishing super ego leading to depression and a turning inward of the aggressive instincts; ambivalence and depression; introjection; depression in response to real or imagined losses including the loss of developmental phases; specific ideas on depression springing from early, unresolved injuries; the need to grieve all losses, including developmental losses and depression due to a family’s inability to grieve.
Classic psychoanalytic thought puts much emphasis on personal experiences with the early primary caregivers, which proves to be somewhat limiting in understanding all psychic forces present in depression.

More research could sort out the differences and similarities of classical depression, atypical depression, major depression, and dysthymia in the psychoanalytical discussion. This study includes the assumption that major depression and dysthymia may be of the same origin. However, in dysthymia a person does not experience the vegetative symptoms often associated with depression and hence the depressive process goes unrecognized and the negative message in the environment are introjected without notice. The dysthymic experiences their depressive symptoms as intrinsic aspects of the self rather than as something foreign. The corrosive, self-doubting, and self-hating aspect of the psyche together with an unnoticed need to grieve seems of most significant in working with depressed clients.

Sociocultural Perspective

So far, this literature review on dysthymia has explored biological, cognitive/behavioral, and psychodynamic literature with the center of attention on the functioning of the brain, cognitive and behavior constructs, and experiences of personal losses. In contrast, the sociocultural perspective section elucidates important, non-personal aspects of dysthymia and how sociocultural factors affect a person. Lev Vygotsky recognizes that human development is situated within a social context and that the experiences between two people are not the only significant theme in the
development of a person. He states, “…the external, social world is central to
development.” 115 K. S. Kublin, A. M. Wetherby, E. R. Crais, B. M. Prizant corroborate,
learning is “embedded within social events and occurring as a child interacts with people,
objects, and events in the environment.” 116 Cook illustrates Kublin’s work and finds that
living in a depressive environment influences the person. Cook poses the rhetorical
question, “How can we live in this reality without becoming incapacitated by the
depressiveness and futility of life?” 117 The author writes about depressive environments,
such as famine or the problems associated with the pursuit of accumulation of wealth,
and she links depressive environments with depression.118

In showing of the role of depressives in our culture, this study broadens the
understanding of the dysthymic person. Andrew Solomon, Jeffrey Smith, and Lewis
Wolpert provide a summary of the history of melancholia, depression, and dysthymia in
western culture. According to their writing, mood disturbances date back before modern
times and the social and cultural context in which these mood disturbances occur have
undergone great changes over the past few thousand years.

Solomon states the ancient Greeks’ idea that depression was an illness of the mind
held true until the Dark Ages when depression and religious themes blended and
individuals who suffered from depression were considered to have fallen away from
god.119 By the time of the inquisition, depressives were fined or imprisoned for their sins,
called acedia or sloth – one of the original nine deadly sins.120 Solomon states that these
negative attitudes about depression have remained a fundamental structure of western
culture to this day.121
Sociocultural research on depressions shows how our culture differentiates between normal sadness and pathology. The depressed person holds negative beliefs and experiences about him or herself, the world and then encounters negativity reflected by the environment. Common phrases, “why don’t you stop complaining and do something?” or “pull yourself up, what’s wrong with you?” cement a dysthymic process. Today the stigma of and the resulting hidden identities of the depressed, exemplified by “the failure of the family” or “the chronically underemployed” are enormous in the public and the stigma further contributes to the depressive experience of the depression. Wolpert states, “Anthropologists … do not think of sadness, hopelessness, and demoralization as clinical disorders.” He finds that we misuse and judge emotions in a misguided effort to understand situations and relationships.

Other contemporary writers agree with Smith, Solomon, and Wolpert. James Hillman screened “Kind of Blue,” a British film by depressives discussing the benefits and drawbacks of depression. No American TV station, cable network, or cooperate sponsors showed interest in the film. Hillman explains that film critiques considered the film “too slow” and “not uplifting.” This is further evidence of a dismissive attitude towards depression and dysthymia, the negative affects, and dark emotion.

Smith provides a definition of dysthymia and offers a social critique about how Western culture relates to the symptoms of dysthymia and other depressive illnesses. He refers to dysthymia as the “poor cousin to the melancholic temperament - the state marked by chronic mild to moderate depression.” He calls our current times the “Age of Depression” or the “Age of Prozac,” while our cultural norms call for us to “maintain a sunny optimism.” He argues that depression derails the “efficiency” and
“productivity” of modern life, which goes against the needs of corporate capitalism and hence becomes pathology. Implied is, that in the “feel-good” environment of corporate capitalism, there is no room for the “darker emotions.”127 We as a culture have forgotten how to value the dark emotions and the negative affects and view them as abnormal and in need for correction. In contrast, Smith claims that European and aboriginal ancestors perceived melancholia as “an instance of grace, a nearly unmatched opportunity to learn to reach beyond the self to restore a lost soul.”128 He offers a solution by asking to give meaning to depression in a larger context, he writes the “isolated story of one invisible life, with its perplexing desires and compulsions” needs to expand into the larger ongoing story of unfolding creation.129

Smith goes so far as to blame the rise of suicide in the west on its imposed need for a feel-good atmosphere.130 Whereas, Nancy-Scheper-Hughes points out that such apparent increase of suicide may only be a result of our attending to depression in a different way by acknowledging depressives and recording suicides. She argues that depressive illnesses have caused deaths for thousands of years.131 In another long-term study, J. M. Murphy, N. M. Laird, R. R. Monson, A. M. Sobol and A. H. Leighton find that incidences of suicide have increased in Stirling County in Atlantic Canada since the 1950’s because of depressive illness.132 His research is inconclusive in determining if suicide rates have been on the rise in the twentieth Century.

Besides negative sociocultural attitudes towards depressiveness, other widely known sociocultural factors contribute to dysthymia and depression. According to John Mirowsky and Catherine Ross, gender has been associated with depression; women are
twice as likely as men to develop depression due to the phenomena of female oppression.\textsuperscript{133}

In addition, individuals living in poverty for long periods are more likely to develop depression than individuals of higher socioeconomic status. Income is a relatively poor predictor for dysthymia or depression but poverty is an indicator. David Futrelle’s research on the connection between money and happiness shows that having more money significantly increases the happiness scores of the poor, while people who already live in a measured economic stability range do not experience an increase in their happiness when they have more money.\textsuperscript{134}

The client in this study identified as slacker. Current cultural expressions, popular movies, agree with the existence of slackers and the depressive role of slackers. The movie comedies “Clerks” and “Clerks II,” released respectively in 1996 and 2006, bring to life the condition of Andrew’s dilemma. The dullness of the characters' lives reflects Andrew’s: minimum wage jobs, no future, unpromising romantic relationships, and other disappointments. The movie’s posters displayed slogans such as “with no power comes no responsibility” and “standing for truth, standing for justice, standing around,” mirror how Andrew felt when he began therapy.\textsuperscript{135} Another movie “Slacker” expresses similar ideas.\textsuperscript{136}

More research is needed to differentiate between the terms classical depression, atypical depression, major depression, and dysthymia. More research is needed to show how, the person with dysthymia, needs to resolve wounding that occurred when others or an incident suddenly disrupted their interest and excitement, or enjoyment, and joy.\textsuperscript{137}
Generally, studies show that specific social and cultural conditions positively correlate with the occurrence of dysthymia and depression and, depending on the study’s philosophical background, consider either the correlating dysthymia or depression as pathological or as a normal response to difficult situations. The sociocultural psychological perspective acknowledges the struggle of living in hardship and living an oppressed life and does not pathologize the individual’s emotional reactions to hardship and oppression. Furthermore, the ideas of engendered sociocultural literature promote an awareness of sociocultural influences of everyday life and intrinsically advocate for social change to avoid negative sociocultural influences.

**Imaginal Approaches**

The literature in Imaginal Psychology offers insight into dysthymia by focusing on the soul. Imaginal Psychology holds the soul as a central concept; generally, Imaginal Psychologists are interested in understanding individual, interpersonal, cultural, but most of all archetypal dimensions by “focusing on the soul.” In the literature, depression or dysthymia frequently are linked with soul. In this section, significant concepts and principles of dysthymia and therapy with reference to focusing on soul, image, archetypes, ritual and initiation, and adult development are reviewed.

The translucent concept of soul is an ancient one that has occupied philosophers and theologians for thousands of years. Plato viewed soul as a something that gives life and that gives people experiences. According to Plato, the soul is separate from the
human body and continues beyond the barrier of human death.  

Carl Jung explains, “Soul is the living thing in man, that which lives of itself and causes life.”

As related to this study, Jung also links soul to adult development; he describes that “meeting the soul” is a “master-task” in adult development. More about Jung’s ideas on soul, adult development, and maturation will be discussed later.

In writing about the soul, Thomas Moore establishes the soul as “a quality or a dimension of experiencing life and ourselves.” Following Moore’s thinking about the soul as a quality of experiencing life and ourselves, dysthymic experiences and adult maturation would also be of the soul. Moore’s words on depression provide a framework for holding dysthymia in a meaningful and life-changing way. He sheds light on the understanding of depression as he differentiates depression and a dark night of the soul. He writes, “depression is a mood to endure and try to get through,” while a “dark night of the soul” refers to “a process in which your coarse soul is refined and your intelligence deepened.”

Hillman’s ideas on soul are similar to Moore’s in that Hillman finds that we need to seek a relationship with soul. Using Hillman’s ideas, dysthymic symptoms can be understood as an expression of the soul’s need and the soul’s language. Jeffrey Smith gives an example of how depression can be a gateway into something greater than the depression itself. Smith values depressive symptoms as a “messenger” and he guards against dismissing the value of the depressive symptoms. He recognizes “pills and potion suppress something essential ...the “hidden knowledge’ of depression.”

Robert H. Davis reviews Hillman’s concept of pathologizing, he explains that pathologizing is a way of soul making. In Hillman's view of the world and human nature,
a “well-ordered psyche” does not exist. Any such seemingly successful lives are only personas and not genuine because the psyche generates illness and disturbances.\textsuperscript{145} Hillman’s work with soul implies that dysthymic symptoms are an expression of the soul’s need and the soul’s language. Hillman states that “archetypal pathologizing” goes beyond ridding oneself of unpleasant symptoms as promoted by general contemporary therapies. Our natural tendencies to pathologize reflect the soul’s inclusionary nature and the soul's desire to give expression and to find archetypal meaning in these expressions.\textsuperscript{146}

In pathologizing, an individual brings forth dysthymia in a unique way. The individual consciously engages with the symptoms, for instance, a client may state questions to the “brooding” of dysthymia or speak the voice of the “brooding.” In doing so, she establishes a healing relationship with the dysthymic symptoms and with soul. Hillman implies that in paying attention to psychological symptoms in such a way, in an imaginal way, the therapist and the client become witnesses of dysthymia as if they were the “voice of the soul.”\textsuperscript{147} A skilled therapist acknowledges the loss, the longing, the doubt, the self-hatred, or whatever may emerge in the therapy session.

Moore explores archetypal themes on depression; he compares the qualities of depression with the qualities of Saturn and he states that depression is as a way of being. According to Moore, over five hundred years ago, melancholy was equated with the Roman god Saturn, “the old man,” and a melancholic person was seen as a “child of Saturn.”\textsuperscript{148} Saturn signifies limitations within ourselves and our lives, yet in living a soulful life, Saturn may also govern a transformation. Moore writes:
It is difficult to let go of youth, because that release requires an acknowledgement of death. I suspect that those of us who opt out for eternal youth are setting ourselves up for heavy bouts of depression. We are inviting Saturn to make a house call when we try to delay our service to him.\textsuperscript{149}

Honoring the Saturn’s melancholy, one may reach maturity, acceptance, and wisdom.

In addition to recognizing the soul as a central organizing concept, Imaginal Psychologists call for an imaginal practice and for the care of symptoms; they also acknowledge the need for ritual. Mircea Eliade wrote about the loss of ritual in the modern world and in particular about the loss of initiation rituals. He states, “It has often been said that one of the characteristics of the modern world is the disappearance of any meaningful rites of initiation.”\textsuperscript{150} While of primary importance in traditional societies, significant initiations are practically nonexistent in the modern Western World. There are no literature references linking ritual or ritualizing and dysthymia but there are references linking ritual and depression.

One such practice is soulmaking. Moore’s elaboration on soulmaking in the case of depression helps understand what soulmaking is. The author points to an adult stuck in his fixated youth, the need for practice and ritual and how depression can be:

... transformed into a spiritual dark night of the soul that serves the soul, ... he (a client) remained literally stuck in his fixated youth ... a real dark night of the soul might have helped ... instead he avoided the seriousness of his life until it was too late...There is a crucial difference between confronting the darkness that gets a hold of you and simply letting it take over and ruin you..... The idea is to be affected by it emotionally and intellectually, but not literally destroyed.\textsuperscript{151}

In this passage, Moore calls for a spiritual dark night that serves the soul and that depressive symptoms receive the proper care and an initiation. Michael Meade supports Moore’s position on the need to care for symptoms; he reflects on ritual and the care for
symptoms. He writes, “Without ritual to contain and inform the pains of life, pain and suffering increase, yet meaningful change does not occur.”

Robert L. Moore proposes ritualizing as cure and illustrates how this position is contrary to classical psychoanalytic thought. Moore summarizes that Freudian Psychologists perceive the ritual in nature-based, “primitive” cultures as an outcome of pathology. He writes that Freudian Psychologists perceived that “the ritual processes were essentially defenses against a painful reality” and that the ritual process “represented pathological states and not a means for a cure.” Moore concludes that individuals in a nature-based society are deeply connected to a need for new boundaries and a new sense of self, and he highlights that ritual is the means for deep change.

Aftab Omer of Meridian University teaches that Imaginal Psychology, with its focus on soul, is shaping approaches to transformative learning and psychotherapy and that Imaginal Process is Meridian University's approach to transformative learning. Imaginal Process is a component of Omer's larger body of work, Imaginal Transformation Praxis. Another component is Imaginal Inquiry, which is a postmodern, participatory research methodology.

The image and ritual draw the soul and the individual to experience. Karen Jaenke quotes Omer, who states that, “soul thrives on experience.” According to her, Omer developed the four dynamisms of experience: personalizing, embodying, deepening, and diversifying for the development of human psychological capacities. Jaenke describes these to mean owning our experience and owning our projections, deep affective and somatic awareness, and connection, stepping into our multiplicity, and entering archetypal and mythical world. Working with the image is a way to work
with soul. Omer states, “the image both mediates and constitute experience.” Henry Corbin asserts that an image is “an organ of understanding mediating between intellect and sense.” One may extrapolate that, according to Imaginal Psychology, the work with image plays a crucial role in the therapy with depression and dysthymia.

Furthermore, in the psychological work, the Imaginal Process asks of a person or a group to speak from non-personal identity. Melissa Schwartz explains, “A key concept from Imaginal Process, a subjectivity, is a state of consciousness that has been personified, i.e. given voice as if it was a person.” A figure that one encounters in this imaginal work is the Friend. Omer explains that the Friend refers to “those deep potentials of the soul which guide us to act with passionate objectivity and encourage us to align with the creative will of the cosmos.” Gatekeeping or the Gatekeeper is another important figure in this work. Omer explains, “Gatekeeping refers to the individual and collective dynamics that resist and restrict experience. The term Gatekeeper refers to the personification of these dynamics.”

The subjective experience of the Gatekeeper can be that of being attacked; the Gatekeeper is a psychic structure that attacks the person’s initiative in an effort to maintain the status quo and protect the person from reliving old injuries. If not challenged, the Gatekeeper limits psychological development and change. It is known that depressives, including persons with dysthymia, struggle with much self-doubt and self-criticism.

Affects play an important role in the Imaginal Process as the process restores the relationship with affect and, in doing so, enters the world of the archetypes. The affects are a basic psychic structure that supersedes personal history; they are inborn and influence our behaviors. Omer proposes that the archetypes enter through deep affect.
Imaginal Psychology views psychological work in form as ritual, a place for suppressed and unconscious materials to surface and find new meaning. In examining what makes ritual, Omer explains that in ritual we “imaginatively deepen our participation in the necessities, meanings, and possibilities inherent in the present moment.” He continues that in *creative ritual* we may “surrender to the guidance of spontaneously emerging images.” Ritual “engenders a context and container for principled and imaginative transgression.” Omer states that the “exiled, rejected, devalued, and difficult parts of our experience ... express themselves in ways that have new meanings.”  

Malidome Some’s descriptions of ritual also provide insight into working with ritual. He emphasizes the need for sacred space as a place for ritual work:

…it is hard to create a ritual space without calling the spirits. Invocation…is a call placed upon a spirit. When you invoke the spirit world you initiate a different context or condition by bringing in witnesses that are non-human. This is why the space in question is sacred. Sacred means where the spirit occurs. We can’t make sacredness. The sacred is made by the spirits themselves. 

The space needs to be free to allow of full expressions of the unconscious, and the space needs to be protected and cared for so that unconscious materials and expressions of the soul may emerge like in an ancient *temenos* in classical Mediterranean cultures. In addition to discussing sacred space, Some explains about important ritual elements:
1. Invocational. Humans call on non-humans for a specific purpose. To meet a group without invoking the spirits means you are on our own.

2. Dialogical. We enter into a kind of solemn dialogue with the spirits and with ourselves. When we call in somebody who does not have a physical form, then we are giving a different contour to the place we are sharing with other people.

3. Repetitive. The actions (structures) in ritual are the same. When you pour a libation, the pouring stays the same.

4. Opening and closure. The ritual space is opened whenever the spirits are invoked. The ritual space is closed when the spirit is sent away. The spirit is sent away symbolically, not dismissed…

Akin to Imaginal Psychologists, who work with the image and the archetype as if they were their own entities, Some views spirits as “non-humans.” In the work of Imaginal Psychology (which will be explained later), the individual engages with entities, the image and the archetype, similar to Some’s dialogical element of a ritual.

Psychodynamic literature stresses the link between depression and loss; much is written about the need to grieve actual or perceived losses of loved objects, persons, and the loss of developmental phases. In reviewing the literature for the Imaginal Perspective section, Some’s work with grief rituals is relevant. In ritual, the death of a loved one triggers the grieving of previous, unintegrated losses. Some focuses on the need to express emotions in ritual. Some writes that the Western culture lacks “grief rituals” and “grief catharsis.” Hence the spirits of the dead linger and individuals suffer from a sense of disconnect from themselves and their community.

In thinking about how a dysthymic person may grieve his losses and complete a rite of passage into adulthood, modern day grief rituals are of interest. In one such example, Jewish grief rituals, the grieving person tears fabric to show the separation and loss of a loved one. In another example, women openly and loudly grieved on the streets
of Iran for the dead Ayatollah Komeni, a leader who had oppressed these women for years.\textsuperscript{171}

Much is written about rites of passages or initiatory rites and rituals from adolescent into adulthood. In these rites or initiations, the theme of death is reoccurring. Eliade acknowledges that death holds a special power that commands the person in ritual; he writes “to be created anew, the old world first must be annihilated.”\textsuperscript{172} Eliade continues to explain that, in initiation rites, the novice experiences a symbolic death and rebirth so that he may become an adult with adult responsibilities.

Imaginal Psychologists draw from story, myth, and archetypes to understand the human condition. Jung agrees that harvesting myth and story is important, as the archetypes express themselves through myth and story surrounding the archetypes.\textsuperscript{173} In discovering a dysthymic individual’s personified archetype, in unearthing the patient’s mostly unconscious yet life-guiding patterns, the imaginal therapist focuses on “rediscovering mythology in symptoms, finding stories in hurts, (and) transforming messes into variegated riches.”\textsuperscript{174} Dysthymic symptoms: feelings of inadequacy; pessimism; hopelessness; despair; generalized loss of interest or pleasure; social withdrawal; chronic fatigue; feelings of guilt; brooding about the past; irritability; excessive anger; decreased activity, ineffectiveness; lowered productivity; difficulty in thinking; poor concentration; poor memory; and indecisiveness become elements of a story about human nature and the needs of our times. In reviewing the literature, several stories and archetypes relate to dysthymia and to becoming an adult.

Jung offers a useful explanation of archetypes. He compares the collective unconscious with archetypes, “The contents of the collective unconscious ... are known as
archetypes.”  

The difference between the collective and the personal unconscious is important for understanding Jung’s thinking. Jung differentiates the personal and collective unconscious, “the unconscious is (was) limited to denoting the state of the repressed or forgotten contents.” Jung maintains that the personal unconscious is a more “superficial layer of the unconscious” than the “collective unconscious.” The collective unconscious, a deeper layer, is not personal but “universal” and “identical in all men.”

Next Jung elaborates on the importance of reflecting on the archetypes that one lives. The might of the archetype incites the individual resulting in an embodiment of the archetype. The individual may participate with the archetype consciously or unconsciously. According to Jung, the unconscious requires us to be “able to demonstrate its content,” which is his call for psychological work. A therapist working from this perspective engages with symptoms, the client’s stories, and the experiences in therapy in a way that supports the revelation of the hidden messages and the embodiment or personification of archetypes.

The archetype of Puer aeternus relates to the topic of this study. Marie-Louise Von Franz provides one interpretation of the Puer aeternus, the eternal child archetype. She believes that the Puer aeternus has an “outstanding mother complex,” with “too great a dependence on the mother” that overindulges the youth. According to Von Franz, the aeternus has trouble in bonding with women because the women never measure up to the youth’s perfect mother image.

Von Franz states that the Puer aeternus has an underlying inferiority complex with difficulties in developing careers and general problems with committing other
relationships. According to Von Franz, the Puer’s focus on heights, an upward movement, is a desire to escape the mother, and this escape into the heavens frequently means destruction to the Puer.182

Connie Zweig and Steve Wolf describe shadow elements of this archetype in which the Puer is naïve, caught up in fantasies, maybe seduced by drugs and alcohol, and unable to mature in conventional social ways. The Puer does not embrace adult responsibilities; like Peter Pan and the Little Prince, he resists ending a cycle of life in which he is free to live outside the boundaries of conventional adulthood. On the positive side, this archetype may reach genuine spirituality and is intellectual and charming.

Zweig and Wolf describe the flight of Icarus in Greek mythology as a youth who, with much desire, flew too close to the sun to despite his father’s warnings and plunged into his death.183 Zweig and Wolf explore the Puer’s flight and state that “He has suffered all his life from feelings of isolation and alienation; he often had dreams of flying high above the earth, free and unattached, soaring away from the limits of the responsibilities of daily life.”184

Both Bly and Hillman refer to the Puer archetype, and, Bly suggests that the Puer shows a yearning for a lost or darkened father and not an attempt to get away from an overbearing mother.185 Bly writes about a “hunger for the king, in a time without father.”186 Hillman perceives the flight as a spiritual “call for perfection.”187 In interpreting Hillman’s ideas, Zweig states that the Puer “is not meant to walk but to fly.”188 The escape of the mother or the seeking of the father are perhaps secondary to Von Franz, Hillman and Bly’s implicitly state that more mother than father psychic energy is available to young adults.
Next, some popular fairytales highlight the lack of rites of passages into adulthood. Bruno Bettelheim points out that Jack, from Jack in the Beanstalk or Jack and the Giant, seeks a relationship with the father. In the story, Jack trades the family money for magic beans that allow him passage into another world in the sky. There, Jack meets up with a threatening giant with a huge appetite. It seems that this giant, perhaps a type of heavenly father, is more threatening than helpful to the young Jack. Bettelheim points out that Jack learned from the Giant about the dangers of worldly desires and obtaining them in illegitimate ways.

This is a story of a boy or young man, who was raised without a father and who seeks adult initiation. Bly’s ideas on a “sibling society” assert that Jack in the Bean Stalk is one of many of today’s expressions of a parentless society with half adults, who lack proper maturation into adult roles.

James Matthew Barrie’s original fairytale of Peter Pan tells the story of a boy who refuses to grow up. The boy is the leader of the Lost Boys Club on the island of Neverland, where he meets other children. The other children eventually acknowledge the need to grow up, but Pan does not relate to their ideas and remains a boy lacking adult qualities.

Terry Apter illustrates the young adult’s need to venture out into the world while needing reassurance from home with the story of The Wizard of Oz. Apter writes that the story of The Wizard of Oz “taps into this common dilemma of the threshold years: the longing for independence and adventure, and the constant search for a way home again.”
The stories of Inana and Persephone are applicable to this study as well with their themes of a descent into the dark underworld (depression) and getting help from the upper world (therapy, friends, or something that is helpful). Inana’s self-imposed departure from her home is motivated by seeking something she does not yet have.\textsuperscript{193} Inana, a grown woman and the “queen of the upper world,” yearns for a greater satisfaction than the upper world can offer her. As a young woman Persephone is taken against her will into the underworld.\textsuperscript{194} On their journeys through the depths of the underworld, they are forced to give up maladaptive patterns. They enter the wilderness of their internal unknown and eventually arrive at home again with greater knowledge. Both women eventually return to the upper world with greater maturation. In thinking about dysthymia as part of a maturation process, these stories confirm that dysthymia equates with being lost in the wilderness and underworld that is within oneself. With the right care and ritual, a person’s transformation may occur in the underworld within, come out from despair and be whole.

Jung’s ideas on individuation and depression show some similar themes of a descent and ascent for the purpose of maturation or individuation. Jung, perceived psychological transformation and change as alchemy and calls the union of the opposites conjunctio.\textsuperscript{195} In achieving individuation, the prima materia (unconscious material being worked on) in the individual goes through purification before individuation, which is maturation. The resulting purified state is known as albedo, or whiteness.\textsuperscript{196}

The process, according to Jung, usually begins at the nigredo stage, which is characterized by self-reflection and a state of dissolution. Albedo follows nigredo.\textsuperscript{197} According to Jung, transformative depression corresponds to the alchemical stage of
nigredo, or blackness. Alfred Adler quotes a letter written by Jung that addresses the state of nigredo, and elucidates Jung’s view on depression and the role of the nigredo:

Depression means literally “being forced downwards.”...excessu affectus [in an excess of affect or passion]...I would wrestle with the dark angel until he dislocated my hip. For he is also the light and the blue sky which he withholds from me. ...But for you too there is an instinct either to back out of it or to go down to the depths. But no half-measures or half-heartedness.¹⁹⁸

To Jung, this means that a person gradually gains insight into prima materia until the person’s inner life becomes integrated. In men the anima is a critical phenomena. The “unconscious personification as anima” arrives at a new personality. The new personality is the self, a uniting symbol and a union of opposites. Jung states that the integration of the self appears after mid life.¹⁹⁹

One may interpret that the alchemist is a therapist who has sessions and is in relationship with the client. In a sense, the depression Jung speaks to is a stage in becoming mature, individuating one’s own sense of self; in part, separate from early teachings in life and, in part, accepting of early teachings in life. One may not reach maturation and instead remain in the nigredo stage, depression, for a long time.

In reviewing imaginal literature on dysthymia as a response to an incomplete rite of passage into adulthood, Jung’s writing on depression and individuation are applicable and significant. Jung does not differentiate between depression and dysthymia. His perception of depression as a turning towards the unconscious, or in Robert F. Hobson interpretation of Jung, “an attraction of the libido to the unconscious,” incorporates Jung’s major ideas on individuation, the shadow, and the collective unconscious.²⁰⁰ Individuation is adult maturing. In Jung's thinking, the path to individuation is characterized by the constant conflict of opposites, of conscious and unconscious
materials (shadow and collective unconscious), that produces psychic energy. While bringing the opposites into a complete union, the individual matures and individuates. In other words, the conscious and unconscious materials integrate and work together rather than existing in opposition to one another.

In summary, the imaginal perspective works with symptoms of dysthymia as expression of something larger than the individual’s personal relationships and history. The impact of personal history of losses on the adult functioning are not negated but are understood as part of a larger story of humankind. Stories about the nature of Saturn and eternal children teach about the need for solitude and change. In tapping into the larger stories by acknowledging the soul as an organizing principle in dysthymic young adults, the hope is not to merely eradicate depressive symptoms, but to move through the symptoms, toward individuation and wholeness.

**Conclusion**

The literature shows a variety of ideas on dysthymia. Biological perspectives examine biochemical processes in the brain, genetics, and the influence of stress and hormones on dysthymia. Cognitive/behavioral theories offer the relevant discoveries on how cognition and behaviors influence and are influenced by dysthymia. The psychodynamic section describes concepts and principles on the inner life, unconscious motivations, and early life experience as relevant to the clinical topic of this clinical case study. The sociocultural section shows the most relevant social and cultural influences on
and responses to dysthymia. In the imaginal section, the ideas reviewed of Carl Jung on
the human change process, story and myth, and ritual are relevant to this study.
CHAPTER 3

PROGRESSION OF THE TREATMENT

The Beginning

Andrew was the first client in my internship as a registered psychological assistant in private practice. At the time, all of my previous work had been in public mental health settings with mostly cognitive-behavioral approaches, so I was eager to draw on the teachings of my training at Meridian University and chose a psychoanalytically oriented psychologist because I wanted to explore unconscious material.

Vernita referred Andrew, who had originally begun therapy with her for a limited number of brief psychotherapy sessions as permitted by Andrew’s health insurance. He now sought long-term therapy and appreciated the idea of a sliding scale fee. He had expressed interest in continuing therapy with an intern of Vernita so that he would have less disruption of his treatment than if he sought therapy elsewhere.

Our first meeting occurred on March 5, 2004. I learned from Vernita that Andrew was dissatisfied with life and that he wanted make changes. There was no immediate crisis in Andrew’s life. His goals were to be “more motivated” in his professional life and he saw himself as a “-slacker” who “should and could do better.” He also expressed discomfort with a romantic relationship and about which he did not elaborate at the time.
Overall, Andrew was anxious and slightly depressed. His thought process was clear, his thought content and communication were coherent with appropriate range of affect. His intellectual and language capabilities were above average. He was cooperative and somewhat emotionally distant and he sparingly provided information about his life history. I noted that he avoided speaking about early family dynamics and significant childhood events.

Andrew examined my trustworthiness and, in a story about his youth, he shared about a therapist’s betrayal. The therapist hospitalized Andrew without disclosing concerns or intentions in the sessions leading to the hospitalization, Andrew recalled, “My therapist did this awful thing…He told me to go to a clinic for an anti-depressant medication, and instead it was for a hospitalization.” After the hospitalization, he returned to the therapist and was referred to a trainee; his therapist declined contact with Andrew. In Andrew’s explanation, the therapist felt too uncomfortable about the hospitalization process and consequently avoided him. Andrew felt that his therapist was not genuine and Andrew felt utterly alone.

Vernita thought that the distrust might also be a reflection of her work with Andrew, since she referred him to her intern just as his previous therapist referred Andrew to a trainee. In his words, Vernita “pawned me off to Imme.”

Taking notes during the sessions was challenging because my training in Imaginal Psychology did not support note taking in sessions as it is thought to create distance between the therapist and the client. When I first began working with Vernita and accepted Andrew as a client, I was not aware of the need for note taking and met this task with transparency offering examples of the writing to lessen negative transferences.
Andrew listened to a few samples then declined to hear more, he communicated that he trusted me. This resulted in development of a note taking technique that minimized writing in sessions by taking shorter notes with much open space to add on after the session.

I was pulled to prove my trustworthiness to Andrew. These early sessions working with trust set the stage for subsequent unfolding work. In early sessions, a few inquiries about Andrew’s personal history revealed his discomfort with such inquiries— which he deflected with “things are fine.” I contributed his withholding to self-protection and ambivalence, sensed to respect Andrew’s timing, and did not press him for details of his childhood or experiences.

Andrew did not experience any immediate crisis but his ambivalence about therapy quickly became a treatment focus. The ambivalence was expressed in a lack of committing to weekly sessions, not paying for sessions, tardiness, and missing sessions. Vernita first recognized the ambivalence and recommended that the issue of ambivalence be incorporated into the treatment plan. She elaborated that the therapeutic work needed to maintain the therapy framework. She interpreted Andrew’s missed sessions and payment as non-commitment to the therapy and wanted me to make Andrew's ambivalence explicit by exploring his ambivalence and its parallels with Andrew’s relationships in his current and past life. Throughout therapy, I was keenly aware of Andrew’s general ambivalent stance and drew on these impressions throughout treatment.

During the course of treatment, a crisis emerged; Andrew threatened the therapy by the use of drugs and alcohol. Until that time, I had become aware of Andrew’s
recreational use of marijuana and alcohol and I shelved this information for a later exploration. In the early part of the therapy, I posed various assessment questions and gently challenged Andrew’s assumptions and beliefs about the use of addictive, mood altering substances.

**Treatment**

The treatment plan was developed and changed over the course of several supervision sessions.

Andrew negatively identified as a “slacker,” and this identity caused emotional pain. He experienced dysthymic symptoms. The long term goal of the treatment plan was to better understand this identity, how it served him, and how it did not serve him. Furthermore, the goal included better understanding how dysthymia affected him. This could lead to a greater openness for self-examination and the perspectives of others, greater capacity for emotional intimacy, and lessen defensiveness.

The treatment plan also considered Andrew’s the betrayal of his previous therapist and Andrew’s demonstration of a heightened degree of ambivalence about therapy. The treatment plan focused on building trust and on increasing a commitment to the therapy. Additionally, the treatment plan included education on how therapy works, the therapeutic process, transference, resistance, and difficult feelings to counteract likely withdrawal reactions in response to uncomfortable feelings that may arise as part of the therapy.
Identified in the treatment plan was Andrew’s feeling of helplessness with career development and romantic relationships. The plan supported Andrew accessing control in his life and taking responsibility for feelings, behaviors, and accomplishments by bringing deep awareness to the planning and execution of tasks. Andrew was to reframe perceived failures as a normal part of living and to redefine what normal meant to him.

The treatment plan incorporated ongoing drug and alcohol assessment to distinguish between addictive or problematic use from recreational use of mood altering substances and to assess the need for further interventions. The plan was to observe mood and behavioral changes, explore the role of mood altering substances in Andrew’s life.

**The Therapy Journey**

The story of the therapy begins with a referral from Vernita who described Andrew as a bright, young man, with self-deprecating behaviors. Andrew saw himself trapped in a low income earning job at a national non-profit agency. He wished for more aliveness and meaning in his life. Andrew expressed a desire for long-term therapy, longer than the ten sessions allowed by his HMO. In discussing options for ongoing therapy, he expressed that he did not want a disruption of treatment by changing to another therapist. Vernita offered an intern at a reduced cost, and Andrew liked that idea because of the continuation.

I gladly accepted and was ready to begin providing psychotherapy and felt that I could readily relate to Andrew’s issues of depression and his dissatisfaction with life and career. Per arrangement with Vernita, Andrew left a phone message and then, in a brief
conversation, he expressed wanting long-term therapy and that he was eager to start right away. We scheduled an appointment for later the same week.

Friday afternoon March 5, 2004 I met with Andrew for the first time in the down stairs foyer and noticed kindness and a tentativeness that was beyond the expected initial anxiety. I extended a greeting and invited him to come my office. He was casually dressed in green fatigue pants, a small tailored shirt with a T-shirt underneath, and mirror sunglasses hiding his eyes. He had long, straight, light brown hair and he carried a contemporary tote – the appearance I would become accustomed to.

We quietly walked up the two short wooden flights of stairs in the old building and into a small suite and a newly and sparsely decorated office. I offered to talk and explained how therapy worked; it was important for him to understand that the therapy was a collaborative effort. Then I initiated a conversation about taking notes in the sessions, Andrew thought it was a great idea because this way I could more accurately share with Vernita. He expressed that it made him feel more attended to. We reviewed the consent for treatment, the counseling policies, and payment. He generally listened and was friendly, asked some clarifying questions, and agreed to attend weekly sessions. We reviewed and signed a written therapy contract.

In the second session, Andrew switched from weekly to bi-weekly sessions due to “financial difficulties.” I did not readily agree to change the frame of the therapy and challenged Andrew’s decision. He declined the option of another therapist for a lower fee. I gently encouraged him to express his thoughts and feelings about my preference for weekly sessions, but he declined to share and eventually his insistence on bi-weekly sessions won. I believed that allowing Andrew this choice aided trust building by
negotiating power in the therapeutic relationship, Andrew had the power to decide how often he wanted to attend therapy. In reviewing the process about bi-weekly sessions with Vernita, she pointed out that Andrew had broken the therapy frame. Vernita and I also agreed that Andrew’s insistence on bi-weekly sessions showed courage.

Andrew initiated talking about his inner conflict with his girlfriend Sara. He referred to himself as having self-deprecatory behaviors; “I beat myself up” about the relationship with Sara. Andrew felt guilty for dating Sara because he could not conceive of a long term relationship with her.

Then Andrew self-identified as a conflicted person and linked this to his father, who was also “hard on himself.” Andrew criticized how his father begrudgingly followed doctor’s orders to change life style habits for a healthier heart instead of feeling the desire to do so himself. I encouraged Andrew to speak in his father’s voice in form, an Imaginal Process, from the place of the father, instead of talking about him. Then Andrew quoted his father who “had to work out per doctor’s orders” and “because of a life threatening illness.” Andrew gave life to how his father openly and harshly putting himself down during recommended exercise. In form Andrew yelled, “You are stupid. Go get the ball. Try harder!” Afterwards, Andrew, while feeling the impact of this form, realized how much his father’s self-attacks emotionally hurt Andrew.

In the third session, I felt the need to provide reassurance to Andrew and pointed out that he had done “good work” in therapy so far and provided more education on how therapy worked. My intuition was confirmed, Andrew was surprised by the praise and accepted it; he looked pleased with himself. Andrew responded by tenderly sharing more personal information, which I interpreted that trust was developing. He shared that his
youngest brother experienced a psychotic episode while he was visiting Andrew. The brother displayed odd behaviors, such as going through the housemate’s belongings and hiding objects. Andrew wanted to better understand psychosis. Andrew trusted me and opened up about family problems. I learned that the grandfather drank a lot (alcohol) and had committed suicide. Andrew liked telling his story and he liked me listening to it. He fantasized that sessions could last as long as he wanted while he stretched out on the couch across from me, head back, and his feet resting on the other end of the couch.

Andrew feared losing his best childhood friend and current roommate Billy because they argued. Andrew felt that he contributed more to the upkeep of their apartment and their friendship and he blamed himself for avoiding an open dialogue with Billy. When he did raise issues, he did so in frustration. Billy thought Andrew’s concerns stemmed from possible homosexual interests. Andrew identified as a heterosexual man and was confused about Billy’s statement. Andrew wondered if Billy was gay; it was an unsettling experience for him.

Still, Andrew described his younger childhood years as normal and uneventful. I had a sense that he was protective of his family and that by speaking about them he was violating an unspoken family agreement. I sensed that Andrew experienced psychic injury as a child but that he was not ready yet to work with these issues.

Andrew found it easier to confide about his difficult teenage years when the familiar life he had known fell apart. His parents divorced and his father moved from the family home to a house with a “new woman” down the street. Andrew felt betrayed by his father’s behavior and he felt alone and confused; he experienced neither his father nor
his mother as helpful in understanding and adjusting to the family changes. His father was physically not available, and his mother was too anxious to respond effectively. In addition, Andrew’s father, then in his early forties, suddenly died from heart disease. Andrew deeply regretted that he never had a chance to reconnect with his father before his death.

Andrew was entrusting me with some of his secrets. I usually listened to the stories with a curious mind and empathic presence, tracked the content of the conversations and the affect. I allowed Andrew to initiate the direction of our conversations.

The work also focused on Andrew’s reservations with his job and with Sara, his girlfriend. Andrew felt unrecognized at work. His work had become more complex over time and he received no official recognition in the form a new job description or a salary adjustment. Andrew felt that he needed to stand up for himself and speak to the management or leave the job. Doing neither was a sign that he was a failure. Andrew also questioned if Sara really cared for him and he described a time when she did not make time for him while he was house sitting. This could have been an optimal time for the two to spend some time alone as both had housemates.

In the therapy, I further elaborated on a form from the Imaginal Process so that Andrew could more easily express his internal world and to make a space for the unconscious. I was hoping that the form would bring us closer to the subject matter, any subject matter, and disengage the ego functions that hinder the emergence of unconscious materials. I explained about the subject, the Gatekeeper and the Friend positions in the form. Since a third person was missing to complete all the positions, an empty chair with
an object on it served the purpose. Either Andrew or I could become the third position at any time by taking the object in our hands. However, the form had only two active participants, the third, the Friend position, remained silent.

I had previously explained the form and its purpose to Vernita who supported this type work; she appreciated the focus on engaging the unconscious in such a way. Vernita understood that I valued my training at Meridian University and that I was eager to learn how to put my learning into my practice with Andrew and future clients. She was curious about how I would introduce the form to Andrew.

Andrew offered to do some work with an introjected father voice, whom Andrew called Ben. Ben was not his family father but an imagined father. In form, Andrew did not speak from a personal identity but instead he consciously enacted a derogatory attitude about therapy. Ben mocked therapy with “therapy is mumbo-jumbo” and “voodoo happens” while one “sits in a room with a shrink.” I participated in the form as a therapist who marveled about the usefulness of therapy. Andrew stayed in form for several minutes before he became more vulnerable than he could tolerate and stopped. In the debriefing after the form, Andrew felt the need to clarify that Ben’s voice was not his own. This form began a dialogue about the introjected and critical father voice. Andrew disliked Ben and his need to separate was a sign of healing.

Andrew continued the relationship with Sara; they saw each other a few times a month. Andrew believed that his girlfriend disguised her true feelings; he feared that she missed him much less than she stated. In session six, I suggested a form to work with Andrew’s feelings about his girlfriend. In the form, Andrew was the subject experiencing being missed. I was to participate as the voice, “I missed you.” It took a few trials before
we sank into the form. For a few moments, we only silently held a gaze while I was looking for cues of what might be going for Andrew. I decided to push a bit further and spoke the words “I missed you.” Andrew listened and sat in silence, and then he ended the form. In the debriefing, he explained discomfort with the form; he experienced role confusion about the therapist and his girlfriend, the form did not work as intended.

Andrew suggested an alternative by inviting me into his life in a different way. He wanted me to be a fly on a wall in his home and observe him in his social circle, and then we would talk about my observations. At the time, I experienced this fantasy an invitation for more emotional intimacy in the therapy but clearly not as his girlfriend.

In session seven, Andrew dove into a sexual conflict; he liked his girlfriend but did not see a future together. He enjoyed their sexuality and yet felt guilty about it and wanted to end the relationship. Andrew’s participation made me believe that the therapy was moving along, that things were happening in the sessions. Andrew now free associated; he described his dream girlfriend: a tall, opinionated woman, with dark hair and horn rim glasses. He liked her to be taller than him, so he could nestle in her shoulder while walking down the street with her. He was comforted by this image.

In session eight, I addressed a small treatment crisis, Andrew had not paid for a few sessions; he forgot to bring payments and missed a session without notice. I referred to the nonpayment and cancellation policy but I did not charge Andrew the cancellation fee. Andrew was apologetic and seemed embarrassed, which confirmed my sense that confrontation created distance in therapy. He wanted me to know that he was not thinking about leaving the therapy. I felt as if I had scolded him.
In the next three sessions, Andrew talked more about sexuality and that he ended the relationship with Sara. I felt glad that he felt comfortable sharing about satisfying sexual urges with masturbation and that he considered potential lovers but did not act on his ideas. I suggested that he had conflicted feelings about sexuality. Andrew agreed and elaborated that sexual contact with another person could lead to catastrophes. He warned on the dangers of sex—“HIV and syphilis” and of a “death sentence if you catch it.” He argued that we no longer lived in his parents’ generation when “things were safe.” I was surprised by his presentation and the catastrophic thinking on sexuality; it felt immature to me.

In supervision, I learned that, after having had several rich sessions, Andrew might withdraw due to increased anxiety. Vernita helped me see metaphors for Andrew’s distance and fear of intimacy. She suggested that Andrew’s anxiety blocked access to his affect and his emotional world. Vernita expressed that Andrew might be attracted to me, an idea I declined to explore in the therapy.

After these rich sessions, Andrew’s life outside the therapy was changing. He expressed excitement for having begun a yoga and breath practice and regular physical work out sessions. Then he missed a session. Vernita's insight into Andrew's psychology, his need to back off from intense sessions, proved right.

The work continued, Anthony shared in session about hoping for a promotion or some sort of recognition for his years of service but such was not forthcoming. He felt that in his work was contributing to a society. He liked the idea of different employment but did not engage in seeking employment despite his dissatisfaction. Andrew needed to
feel that some changes were happening in his life. He identified two concrete positive changes in his life: Sara and a yoga practice.

Session 12 in December 2004 marked the eleventh year of his father’s death. Andrew grieved his father and in his sadness, he recalled previous death anniversaries. His siblings were more intensely affected by their father’s death because they were younger. This brought to my attention that Andrew felt responsible for his younger siblings and that he was negating the impact of his father's death on himself. With support, Andrew stayed with his feelings and he imagined his father's struggles as a young man with a family. Andrew experienced the loss of his father as a constriction in his life, as something was missing: a loss. Andrew wanted to cry but held himself back shielding against the painful impact these emotions. He explored a father substitute, a father figure and suggested that a father-in-law could serve that role for him.

I sensed Andrew emotionally distancing when he shared that a girl could never find a father figure in an in-law family because of the “dirty old man stuff.” He then jumped to the taboo of getting close to the opposite sex of the in-law parents particularly for women with in law fathers. I fell short in exploring the issue while following Andrew's tangent about the overpopulation of the planet, disease, wars, ecology and our destructive relationship with the earth. Listening and noticing an absence of emotion, I did not feel connected with Andrew and trusting the therapeutic process, I did not point out the emotional distance and tangents.

In the subsequent sessions, Andrew showed his pain. It was important to express his anger and self-criticism, about feeling like a failure and being a weak human. I listened to hours of perceived failure experiences in all areas of Andrew’s life, careful not
to validate his misguided beliefs about himself. Andrew wanted to use all his resources and strengths, he was passionate about and his family, friends, and sense of responsibility about the world, but he felt ineffective. He included paying for therapy as a sign of his failure because he should not have to pay for therapy. He believed that what one gets in therapy should be given by life, and paying for therapy made Andrew feel he lacked community. In an ideal world, this would be so; I understood Andrew.

Vernita thought that Andrew experienced ambivalence in and out of therapy. She, again, encouraged me to help him remain engaged in the therapy so that he could have a reparative experience. I recalled Andrew’s wish for a “tall woman, with thick glasses, who was opinionated” and wondered to myself if he wanted me to be a strong and powerful woman who would pull him out of his pain by witnessing his stories.

Vernita wanted ambivalence to be a more central focus in the sessions. Therefore, I attempted to talk about ambivalence, and Andrew responded by sharing lengthy, self-negating descriptions of his failures. The idea of Andrew as ambivalent made him feel even worse, I lacked a good approach and decided to think about how to integrate a talk or offer a form about ambivalence.

Andrew stayed in therapy and opened up about family problems. One time, he identified his father as an alcoholic and talked with dismay about the pizza and beer parties in their home. Still, he denied any hardships or stress in the family due to the drinking. I experienced a disconnection by Andrew with his past. According to Andrew, his parents loved each other and that they never fought until the separation. They were “old world parents” involved in church, family, and work. I felt the work was calling for working with early childhood injuries but that the time had not come.
In another session, Andrew projected himself into the future and shared about who he would like to be in a few years, “I like helping people ... but I don’t have things to offer to people ... but I am good at moving things.” I replied unexpectedly, “Like a mule” and instantly felt embarrassment about my response and was relieved that Andrew joined me in silence. After a pause, a talk about a mule’s positive qualities followed, such as patience and strength carrying large loads from one place to another. I left out the part where I thought that a mule lacked initiation, creativity and most of all the ability to have intimate human relationships. Nothing else was ever spoken about this incident and it left me feeling unresolved.

During supervision after the fourteenth session, Vernita suggested to make more process remarks and generally be more active. Per Vernita's suggestion, I assured Andrew that I would not abandon him and introduced concrete, tangible therapy concepts, such as naming thoughts, feelings, and behaviors. I linked current and past feelings and drew parallels between occurrences outside of the therapy with events in the session.

In session 15, I further explained about Imaginal Process of the Gatekeeper triad. Andrew took to the Gatekeeper triad; he experienced the Gatekeeper as an angry and hateful internal voice. When thinking about an upcoming family reunion and how he did not measure up to his relatives outside the immediate family, he acknowledged a shadow voice that said, “I want to rain on other people’s parade, I am angry, other people should not be happy.” His Gatekeeper criticized him harshly for these feelings. He appreciated being able to separate the Gatekeeper voice from other internal experiences; this allowed greater expression of shadow thoughts and feelings without a shame that muted Andrew.
This work helped Andrew gain insight into how he can intellectualize his feelings, in particular anger, as he feared others could not hold his anger. This was a major shift in the therapy.

In session 17, I taught Andrew to engage inner voices by writing a journal. The next session, Andrew excitedly announced that he had “much to talk about” and that “stuff is happening.” He worked on his journal and felt he learned a tool to free himself from Gatekeeper’s attacks. Andrew’s access and expression of feelings deepened and widened and he tolerated emotional discomfort better. Andrew initiated more in his life. The direct results of the initiatives were not usually what he had hoped for, but the experience of taking initiative was liberating for Andrew. For example, he pursued a woman from work without experiencing ambivalence, doubt, or guilt.

He remained dissatisfied with work and felt good about voicing his dissatisfaction; it was a liberating experience for Andrew to ask for a raise even though he was turned down. The rejection motivated him to seek other employment. However, the employment search was an agonizing and slow process; it created many opportunities to practice working with the self-attacks. Life brought further challenges. Andrew felt angry at himself and at the world. He lost a phone service for non-payment, he stopped his yoga practice and his ex-girlfriend Sara contacted him creating further stress and confusion. I encouraged Andrew to go with his desire to take risks while practicing a special awareness of current life events— that is, to notice his experience, his internal and external world, what the Gatekeeper spoke, and to engage self compassion.

He completed home assignments and he brought in topics to talk about. In a home assignment, “mindful resume writing,” Andrew located self-attacks and linked these to
situations in his life. He experienced more internal self-attacks when not asserting.

Another time, he experienced anger and he engaged the anger by listening and dancing to loud, hard music— that time in a different way than before. That time he danced and listened with permission and awareness as he moved with his anger. The sessions felt rich, and it seemed that Andrew’s life was shifting.

Andrew shifted between various subjectivities. In session 20, he presented as defeated and depressed. He stated that he lacked discipline to take charge in his life and he could not challenge his beliefs that something was wrong with him. Andrew illustrated with a story about the Chief Executive Officer (CEO) leaving the company and drew a parallel: disciplined, well adjusted adults leave bad situations, while Andrew, who lacked motivation and did not live a satisfying life, stayed in bad situations. Andrew brought another example of his faults; he missed “the right woman” in his life. At end of this session, Andrew shared that he had been drinking with a friend before the session and he wondered if that influenced the session. I questioned to myself his reasons for this behavior and explained that I preferred him not drinking before sessions and he agreed.

From the on, Andrew initiated the topic of drug and alcohol and was ready for further self-exploration. I gently challenged Andrew’s assumptions and beliefs about use of mood altering substances and decided against a too active pursuit of Andrew’s use, as I believed it would counteract his openness. We took inventory of his use and established previous patterns of use and associated feelings. He tracked the fluctuations between using mood-altering substances and intentional non-use. He talked about how he felt when he drank or smoked and he used terms like “liquid courage” or “a relaxed state of mind.” During non-use, he engaged in healthy lifestyle practices, such as a good diet,
meditation, yoga, and exercise. He learned that he sometimes uses alcohol or marijuana to ward off anxiety. Vernita and I felt that the work with Andrew’s drug and alcohol issues progressed nicely. He did not wish for additional help when such was gently offered.

Andrew kept transgressing with the use of marijuana and alcohol. Andrew missed a session because he “was high” and called after the session and he acknowledged that his behavior was problematic. A few weeks later, Andrew came to the session noticeably under the influence of alcohol. At first Andrew's intoxication went unnoticed but with continued contact I became aware of his glassy eyes, slightly slurred speech and bravado attitude. The following sessions focused on the therapy frame (no alcohol). Andrew agreed to not repeat a session like that. I reviewed these occurrences with Vernita who agreed that a client should not be intoxicated during a session because of the impaired brain function under the influence of alcohol and marijuana and how that negatively affected the session. However, why was Andrew behaving like this? Andrew feared that he might become addicted or be addicted like his family members and he decided to actively examine his own relationship to drugs and alcohol. He decided that using responsibly was important; he stopped these transgressions realizing that he wanted to learn to cope with anxieties, depression, and feelings of defeat in ways that were more constructive.

In session 22, Andrew revealed that he had been afraid to grow up because he felt that he had never been successful at anything. In his fear, he wanted to remain a child and “play with finger paint.” Now on a path of self discovery, Andrew recognized Gatekeeper voices and, during his meditative practice, he first experienced a loving internal voice.
Andrew believed that he had the power to affect things. He also initiated a plan for his brother to live with him. Andrew, as the oldest child of four, felt responsible for his siblings.

Andrew described himself as an “ignorant and rebellious” youth, who, after leaving the parental home, went through several mind-opening experiences. He described how he came to terms with homosexuality in the world after being homophobic all of his life. Having gone through such a change, he now sought other changes and believed that he was in the midst of such a change.

In sessions 23 and 24, Andrew had the realization that his brother was “an alcoholic.” This reminded him of his own mood altering substance use and brought attention to it with heightened importance. Andrew continued to plan a future with this brother and considered buying a home with him in a few years.

Andrew requested help with tracking his dreams. I felt he did so in part to please me or to demonstrate that he was happy to be in therapy, that there was hope, that he was “worth the investment,” and that he could be accountable for himself.

In another session, Andrew decided that opening a cookie business would solve his employment problem. He no longer wanted to focus on finding employment or writing a resume. For a couple of sessions, Andrew reported about the details of recipes and potential customer markets. I was concerned for his well being and felt that I was losing Andrew while he was flying away with a fantasy. After the drinking and after the realization that he was accountable to himself, the cookie business seemed not to fit.

Andrew's pain drove these behaviors. He wanted a respite from the difficult feelings that he was having. When sitting with Andrew in these times, I focused on grounding work.
Andrew needed to slow down his cognitive processes and sink into the sensations of his body as if he was flying away and needing to pull into himself. This way of working with Andrew was based on the ideas of Focusing. I encouraged Andrew to share what was occurring at any given moment following his awareness from one sensation to another while focusing inwardly.

In sessions 26, 27, 28 and, Andrew expressed anger that personal belongings were stolen from him twice. Items taken were his bag, a wallet, a phone, personal memoranda, and some other items. The thievery initially disappointed Andrew. Then he became angry and a sense of lack self protection fed this anger. I was able to help him respond to the situation by giving permission to express his anger outwardly instead of turning anger against himself. Andrew engaged visions of drinking until intoxication to drown his anger. I held Andrew's anger.

In session 28, Andrew wanted to discontinue treatment due to the thefts. He talked about coming only because he did not want to pay for a missed session. His unreflected and freed anger now leaked unconsciously into the sessions. I offered to reduce the fee by 50 percent for an agreed upon length of time. Andrew initially declined and then accepted the reduced fee for three sessions at $30 per session. With some probing, Andrew described two feeling states. In one state, the “therapist takes advantage of client” because therapy does not work and he called this state his cynical self. In the other feeling state, he felt good the therapy and that therapy was helping. He talked about inner rage and brought an example of wanting to toss an ottoman across a room to feel the anger physically. In summary of this session, Andrew expressed that he was glad he expressed himself in a “civil way,” and “not by acting out.”
In session 29, Andrew described how he became intoxicated with alcohol and realized that he was seeking release from feeling angry about the thefts. Therefore he decided to release anger in other ways by exaggerated movements in a new martial arts practice. Andrew also processed a friend's request to purchase Codeine via the Internet. Andrew admitted that he debated about this. On one hand, he could make some money and then use that money to help his codeine addicted friend and help himself. On the other hand, he wondered if his friend should enter drug treatment. Andrew unconsciously invited me to be his superego to call his reasons rationalization and a bad idea. Andrew agreed with me and decided against the drug purchases.

With Andrew trusting me, more direct approaches followed. I responded to his invitation to become his parent, to re-parent him, by guiding and helping him plan his day and by offering alternative ways to think about situations in his life. I openly spoke about my intentions of not punishing or criticizing him and encouraged him to locate his inner guidance. In one session, we enacted an angry child and he screamed out in anger.

In session 30, I learned that Andrew’s brother arrived and that the brother was burglarized. All the tools of his trade were stolen from his car resulting in more money worries for Andrew. He thought that he could help his brother. Andrew also worried about his sister’s pregnancy because she was an active cocaine user. Andrew did not think highly of her boyfriend as he had a long history of cocaine use. This child would be the first one born in his family of siblings.

In session 31, Andrew was in touch with his desire for change and was sad about losses. “Sometimes I am stricken with grief about a life already lost.” He was glad to be in therapy and expressed mental torment and sadness about feeling lost and not wanting
to waste his potentials. I held this pain in loving attention. He felt that he wanted to help his sister. He stated, “I love my sister to death. I will build a heaven and earth to make sure her baby can grow up healthy. Maybe I can send money from time to time. Maybe the boyfriend has to leave or straighten out.”

I wanted to explore more addiction family dynamics, and Andrew acknowledged his discomfort with this. He was now able to state that he felt guilty for talking about family drug and alcohol problems. To me, this event marked a turn towards greater self-awareness and self-understanding. Previously, Andrew had held back from disclosing such painful experiences. He usually shielded from disclosure or exposure to this disturbing awareness with stating that everything was “fine.” Per his request, I wrote down his ideas for the next sessions: living with his mother until he was 23; a physical relationship with women vs. a potential life partner; and other ideas related to family history and significant moments in his earlier life.

Next Andrew missed a session; he forgot. I thought about the unconscious communication of “forgetting” sessions or payment. Vernita perceived Andrew’s action as an unwillingness to commit to the therapy: missing sessions and not attending weekly session. The operating assumption was that for therapy to work, enough therapeutic contact in the form of weekly sessions was needed for the unconscious material to be active and available in the therapy. Andrew only attended therapy sessions every other week, and, with additional missing sessions, the therapeutic effect likely lessened. Perhaps this is how Andrew unconsciously moved away from the therapy, was leaving therapy, even though, in the therapy sessions, he mostly stated that he wished to be in therapy– demonstrating an ambivalent dynamic.
In a session, I attempted to explore this issue of forgetting. In response Andrew surprisingly laughed off my comments, “Ha-ha, do you think I might not come back to therapy or something like that ...oh, no, I would not do that.” The exploration in the session did not lead to immediate fruition, and I felt that I annoyed Andrew with my inquiry. Vernita tuned into Andrew’s frustration with life and the need to commitment to therapy and any system: work, a clean an apartment, paying bills.

It is noteworthy that, at this time, I began evaluating whether to end the internship, I wanted to balance the responsibilities in my personal life. After beginning the internship, I unexpectedly moved two counties north, to Sonoma County, for employment and further internships. By then I had been enduring a long commute with much traffic to meet with Andrew for over one year.

During sessions 30, 31, 32, Andrew spoke about his family’s drug and alcohol use. This was one year and four months into the therapy. His brother excessively drank, which disappointed and embarrassed Andrew. He also felt that he could not longer rely on his brother; Andrew took care of him. Additionally, he felt badly that he could not make things better for his sister.

Vernita encouraged weekly sessions in response to Andrew’s recent comments that sessions ended too quickly. I talked with Andrew about attending weekly sessions, and he declined. Vernita thought of Andrew as someone who felt desperate and had a difficult time with attachment. The alliance between Andrew and me was strong but faltering at the time. Andrew needed to be therapeutically and emotionally intimate with me and that was frightening for him. Vernita wondered if Andrew carried narcissistic needs, as he was the oldest child. The assumption was that oldest children occur more
narcissistic wounding than their younger siblings do. According to Vernita, oldest siblings have a tendency to feel more easily attacked when receiving any criticism from a therapist.

Then in session 33, Andrew shared about his growing feelings for Angelica, a woman he had met. He questioned his sanity because his “infatuation or love” made him “feel crazy,” and he experienced jealousy. Secretively he sought a romantic involvement with Angelica, but he decided to not initiate such contact in order to get to know her better first. In session, he examined his previous relationship with Sara and he feedback that he was “aloof” and “not emotional.” He examined if his focus on Angelica was a way to avoid his personal problems. Overall, he felt satisfied with the budding romance.

At this time in therapy, Andrew explored how he was always waiting for something to happen in his life. He longed that someone would claim him in a “coming home” type of way. He identified as a dreamer who was learning how to live life and how to manifest these dreams. He made use of therapy; he sought advice, he processed feelings, and he sorted out how he wanted to respond in situations with his family and the new woman in his life.

In session 34, Andrew shared that his position at the non-profit agency was eliminated. He would be receiving unemployment benefits and severance pay. Andrew appreciated this lay-off as it meant change that he did not need to initiate. Among other things, he planned to have breakfasts at home, read in the mornings, and spend time with Angelica. He experienced the lay-off as an opportunity and made plans to take classes or get ready for university to become a teacher or a therapist. He still considered the cookie business idea. After much effort by Andrew, the plans for an apartment with his brother
did not actualize. The brother moved out and all plans to support one another, to save money, and possibly to purchase a home in a few years were abandoned. Andrew separated himself from the worries about his family with the statement that they “were living their lives.” Concerning Angelica, Andrew felt that she was returning his affection and was looking forward to deepening their relationship.

Before speaking with Andrew, I had spoken with Vernita about my plans to leave the internship. She was disappointed and enjoyed working with me, but she understood my reason and accepted my decision. Our focus shifted to Andrew and how to best serve him. We planned for a long termination period of a minimum of four months, perhaps more if needed. Vernita explained about the possibility of powerful endings as people sometimes experience great comfort in knowing that therapy would end. We were hoping that this termination would allow for further work. The idea that something fruitful might come out of termination lessened my guilt over leaving Andrew. We also considered that Andrew might drop out. We decided that in the next session I would speak with Andrew.

In session 35, Andrew began with reflecting on how work dissatisfaction led him to begin therapy over one and half years ago. I wondered if Andrew intuitively knew that I was planning on leaving. He then updated me on the latest developments with Angelica. He learned from mutual friends that Angelica wanted Andrew to “make a move;” Andrew had held back because he wanted to give enough time for the friendship to develop.

I decided to talk about my plans for leaving and explained to Andrew the reason as stated earlier. I offered to continue working with him in Santa Rosa at my other internship site at an even lower fee; the agency’s lowest fee was $12 a session. Andrew
declined. Andrew listened and understood about a meaningful ending in a four month termination period. I asked Andrew to share his internal reactions, his feelings and the angry voices as I assumed the termination might trigger a previous therapist betrayal. Andrew sat for a moment and stated with an angry affect, “It has happened before that a therapist left me “ He then criticized therapy from the cynical father place, “Well therapy. What is that anyway?” I felt awful and relieved that Andrew brought the voice of Ben into the session; it gave hope that there would more work ahead. At the end of this session, Andrew reflected that the “time spent with you was very well spent.” He elaborated that I helped him be gentler with himself and he agreed to participate in a lengthy termination process.

Andrew arrived at the next session noticeably upset about an occurrence just outside the therapy and he began telling a story about him and Angelica. The couple decided to become sexual and planned for a special first time. In their sexual act, they both became vulnerable both emotionally and physically. Andrew emphasized that they were in love and how much he appreciated the intensity and honesty of their feelings.

Andrew did not show for the next session. In reflecting on the previous intense session, I took note that Andrew decided to attach himself to Angelica in response to my speaking to him about my plans to terminate therapy. After a general check-in in session thirty-seven and offering time to reflect on the previous session, Andrew declared that he was ending therapy that day. He came prepared with three reasons for his decision: he felt better, his guilt and fear had lessened, he had learned a lot about himself, and it felt like it would be a good and natural ending. I thoughtfully posed the question of whether there
might be other, not so visible reasons for this ending today. I wanted to share about my thoughts about shifting intimacy from therapy to Angelica, but it felt wrong.

We sat in silence, then Andrew responded and he listed his first, second, and third therapist. The first therapist only stared at him, and his father eventually stopped the therapy because he saw “no use in it.” The second betrayed him with a hospitalization as explained earlier. About me, he said, that we figured some things out together, and, as a result, he was no longer sad. He pointed out that he did not like the drug and alcohol related questions that I posed throughout the sessions; it made him feel antagonized. He was speaking a truth he otherwise could not have.

At the end, Andrew stated that it meant a lot for him to be open in session today. He stated that this was a good ending and that he had Angelica now to be close to and talk to.

**Legal and Ethical Issues**

A therapist needs a heart to heal and provide a service that is defined and valued by ethic, laws, and contracts. This study offers several interesting ethical and legal issues.

The issue of therapist initiated termination deserves a mention here. I worked as a Psychological Intern with Vernita for about two years. When deciding to leave the internship with Vernita, I had been Andrew’s therapist for one and half year. I had relocated from the East Bay to Sonoma County. Vernita understood my reasons and asked that to give at least a four months notice to Andrew. Andrew also had the choice to
follow me to another office. I addressed this termination and offered referrals. Andrew initially agreed to attend the termination sessions but then changed his mind.

At the beginning of the work with Andrew, I did not foresee leaving the internship in a couple of years and did not discuss expected length of the therapy with Andrew. Vernita and I did not have a formal agreement about this, but there was an assumption that the length of my employ would be at least a couple of years and also negotiable depending on needs. This decision to end my employ did not come easy, as I felt an obligation to the work with Andrew and a need to simplify my busy schedule. At termination, I offered Andrew a variety of referrals including drug and alcohol problem resources and low cost counseling centers. In addition, I offered to meet him during a potential transition period in case he decided to continue therapy with another therapist.

Another issue that sprang from the work relates to differences in approaches to therapy and note taking in sessions. I was trained in imaginal approaches, so I thought of the note taking as potentially interfering with the quality of my work. Initially the note taking appealed to Andrew as he experienced such as care and attention. Later he indirectly criticized the note taking; Andrew recalled a supervisor who wrote while Andrew was speaking about sensitive issues. I interpreted this to mean that the writing could take away from the therapy.

The option of audio recording and transcribing each session in preparation for the supervision was another option, which I declined. A good system for note taking and for transparency, that is sharing the notes, naturally limited what I wrote. Increased skills in note taking allowed me to write less during the sessions and add to notes afterwards. Vernita was satisfied with the quality and usefulness of the notes.
Another ethical and legal concern is that Andrew did not attend weekly psychotherapy sessions. Andrew reported that he could not afford the fee every week but that he would commit to bi-weekly sessions. I accepted Andrew into therapy with bi-weekly sessions. Believing that Andrew could better benefit from weekly sessions, I was ethically obligated to provide the choice of a low cost clinic and allow Andrew to make an informed decision on the issue, which I did. Contrary to this ethical obligation is the illegality of providing wrongful therapy due to the therapist’s lack of scope of practice and competency. I am certain that the provided therapy was within my scope of practice and competency.

Another practice and competency issue is important to review. I continued therapy with Andrew when Andrew’s drug and alcohol consumption became of concern. Addressing this treatment issue, I used good judgment and acted ethically and legally. Andrew benefited from this level of drug and alcohol intervention. There was no indication that Andrew required residential treatment, partial hospitalization, or medical attention. When Andrew came to a session noticeably intoxicated (I smelled alcohol), I made assured that he was not driving a motor vehicle away from the session (a legal concern). My supervisor pointed out that seeing Andrew while intoxicated presents an ethical issue because Andrew may not benefit from the therapy while intoxicated. Many therapists would not see an intoxicated client and postpone the session. I sensed that Andrew was able to productively partake in the session and that the topic of intoxication in session would lead to fruitful consequent sessions. Vernita agreed with my decision.

In this next situation, ethical issues around setting policy, fees, clinical effectiveness, and not adhering to agreements are illustrated. According to Jeffrey A.
Kottler therapists’ anxieties around fee setting may result in therapists acting unethically or potentially be considered at risk for illegal practices. Interns, frequently feeling that they charge too much for their clinical skills and capacities, may not hold clients accountable for non-payment and hence blur the ethical and legal treatment contract. To exemplify, an intern may harbor resentments for not receiving adequate payment, which may lead to not providing good therapy or acting-out harmfully abandoning the client.4

The next situation is an example from the work with Andrew of what Kottler describes. Working with low-income people, a 24-hour cancellation policy might be more fitting, however at the beginning of my internship I simply adopted Vernita’s 48-hour cancellation policy. When Andrew first missed a session without a 48-hour notice, I waved the fee. Feeling sensitive to Andrew’s limited income, I felt uncomfortable requesting the fee. Vernita pointed out my discrepancy in not upholding the policy and agreement between Andrew. Wanting Vernita to feel confident in my work, that I would uphold the therapy frame, I enforced the policy from then on and Andrew adhered to it.

The careful consideration of policies and agreements is important.

I also learned about my tendency towards low fees including an unconscious belief that my low fee would compensate for any possible shortcomings as a novice therapist. I learned that this belief might set up the message: the therapy is not good or that if the therapy is good then client is indebted to me because the client pays a low fee. I examined the value of my work and consequently became more comfortable with fee setting.

These legal and ethical trepidations offered opportunities to examine my motivations and the value and purpose of therapy. In thinking about what motivates me in
working with Andrew and the role of therapy contracts, I am better able to appreciate the role of a therapist.

**Outcomes**

In assessing the outcomes, it is useful to consider how Andrew changed psychologically and how well the treatment plans and goals were accomplished.

The relationship between Andrew and me was dynamic, events and internal changes occurred inside and outside the therapy container, which are indications that the therapy was effective in mobilizing psychic materials.

In therapy, Andrew acknowledged and grieved the loss of his father.

Andrew’s identification as a “slacker” and Andrew’s main concerns at the beginning of therapy lessened, and he eventually perceived himself as an able person. Andrew became conscious of how this slacker identity had a grip on him.

Andrew benefited from therapy by expressing his emotions and his secret, self-doubting, and self-attacking aspect. He learned to separate the dysthymic symptoms. Andrew’s capacity to tolerate uncomfortable feelings increased and he located the inner critique, which is essential in working with dysthymia. He expressed more confidence after learning to recognize some of his Gatekeepers – the internal, oppressive aspect that previously endorsed his sense of self-worth. Andrew engaged in an inner dialogue that allowed him greater freedom in feeling and thinking about himself and the world around him – a move away from a repeated and unexamined acceptance of the inner critique’s voice about Andrew’s personhood and the world.
Andrew adopted a way of “freeing” himself from the inner critique rather than engaging this internal aspect and with it, he dismissed uncomfortable feelings and responsibilities. On occasion Andrew stated, “The Gatekeeper is wrong and needs to be quiet.” It was my hope that Andrew would recognize this error and find the courage to explore his discomforts further instead of repressing these feeling, what I feared might have happened.

Another indication that Andrew benefited from therapy is his increased interest in examining his relationship with drugs and alcohol. In therapy, he learned that he had a mild obsessional relationship with mood altering substances and that taking mood-altering substances is one way of coping with his uncomfortable feelings. With the help of therapy, Andrew learned to make use of these uncomfortable feelings by first tolerating them, then developing a curious attitude towards them as if these uncomfortable feelings held some important messages for him. The therapy ended before full fruition of the benefits of this skill.

In review of the benefits and indications if the therapy was beneficial, the overall therapy was beneficial to Andrew. At the beginning of therapy, Andrew had not experienced a positive treatment outcome and he demonstrated a high degree of ambivalence about therapy. Positive change occurred in addressing this ambivalence. Andrew attached to the therapist and gained trust in the therapeutic process. By internalizing the therapist’s encouragement and care, Andrew afforded himself greater suppleness in his self-exploration as evidenced by practicing therapeutic principles outside the therapy hour. At the ending of therapy, Andrew expressed genuine appreciation of the therapy and deemed the therapy helpful. Despite Andrew’s rejection
of referrals during the termination phase, it is likely that Andrew will continue his therapeutic work with another therapist in the near future because of the positive treatment outcome.

Additional therapy is recommended.
CHAPTER 4

LEARNINGS

Key Concepts and Major Principles

The ideas, concepts, and principles used in the interpretation of what happened in therapy draws on Imaginal and Psychoanalytical Psychology.

When applying concepts from Imaginal Psychology, I mostly draw on James Hillman, Thomas Moore and Aftab Omer. Hillman refers to the pathologizing and listening of voices of the soul, Moore identifies soulmaking and care for symptoms and Omer’s work expands on the Imaginal Process and Gatekeepers. In his explanation on suffering, Hillman views pathologizing as central to the soul and describes “autonomous ability to create illness, morbidity, disorder, abnormality, and suffering” of the soul.¹ Omer’s work with expressing affects and the Gatekeepers in transformative practices supported the work with Andrew in liberating penned up psychic energy that Andrew was carrying.²

Psychoanalytical concepts in use relate back to Freud, who explains the role and action of the punishing, self-attacking and overzealous superego in depression.³ Instead of breaking down ego functions and defenses as a sole method for bringing about change, the main work in the therapy involved engaging Andrew's complaints and worries. These were not analyzed but seen and witnessed as the soul’s necessity.
Aiding the interpretation are Karl Abraham and Melanie Klein’s observations on ambivalence and depression. Abraham first connected loss, ambivalence, and depression. Later Klein suggested that in the depressed adult, the child’s ego failed to reconcile an ambivalent relationship to the caregiver object. The ambivalence is then continued into adulthood, reactivated in the depressed adult and transferred in various ways. Furthermore, McWilliams’s ideas on depression state that depression is a response to a real or an imagined loss of a loved one or object and that these losses need to be grieved. Environments not meeting the need to grieve these losses initiate a dysthymic process.

Erikson's developmental stages describe how a person resolves psychosocial inner conflicts as part of maturation.

Beck’s influential and comprehensive cognitive theories of depression are widely quoted and incorporated into mainstream psychology. Beck restructures symptoms of depression into three sets of cognitive concepts: maladaptive self-schemata, cognitive distortions, and cognitive triad. In summary, it states that negative cognition, thinking, triggered by life stress is the cause of depression.

**What Happened**

Giving attention to the significant moments in therapy helps in relating them to a larger context of the therapy story, in which one begins to understand the psychological story about a therapy. This section of the Learnings Chapter describes significant moments and elaborates on their psychological meaning.
As Andrew’s therapist, I easily felt drawn to support him to accept that he was a capable young man on a journey to greater adulthood, and that he was capable to find his strength and inner guide. My description of Andrew is contrary to how he experienced his transition into adulthood. He self identified as slacker and saw his life filled with conflicts, failure, and a desire for something different. Andrew felt stuck in the much younger life style of an adolescent boy who just “grew older.” He derogatorily called himself a “slacker,” who “should and could do better.”

Beck’s cognitive model describes *schemas* or *core beliefs*, which fall into two thematic types: helplessness and unlovability. This concept explains why Andrew maintained self-defeating attitudes despite his strengths. In this theory, maladaptive schemata are dysfunctional beliefs as evident in Andrew's automatic and distorted thinking: themes of loss, inadequacy, and failure. Beck's cognitive triad holds other patterns of Andrew's thinking and behavior: negative view of self, the world, and the future. According to Beck's theory, Andrew's early cognitive vulnerability led to dysthymia and cognitive distortions: a pessimistic view and experience of self and life. However in the therapy, the Gatekeeper work addressed what is described as Beck's cognitive distortion. Andrew's cognition improved. Overall Andrew's cognition and experiences became less negatively affected by previous Gatekeeper attacks. More is written on the work with the Gatekeepers in later passages.

Andrew identified not maintaining a household with being a slacker; however, the language of the soul communicates something different. Early in therapy, Andrew described a frustrating process of completing routine household tasks. He described that after having washed the laundry, he left dirty and clean clothing mixed up in his bed. He
stated, “I sleep with my laundry!” The image of Andrew sleeping in his bed at night with clean and dirty laundry mixed together was that of a nesting place in Andrew's unconscious. To me, it meant that therapy served Andrew's initiation and that therapy was serving Andrew's initiation into a something new.

Jung has soulful ideas on depression, viewing it as a first step in individuation—that is, depression as nigredo, a shadowy place characterized by self-reflection and a state of dissolution. In alchemy, the prima materia, the clean and dirty laundry within Andrew, nested in his unconscious, represents another important step in transformation. The bed symbolized the fermentation of his soul so that Andrew would gradually gain more insight and wisdom. Andrew mostly believed that change was possible for him and that therapy could help with his desired change. In a later session, he said, “I am changing, I am growing, I can take initiate.” Andrew found that he could initiate and step forward into his life, into fuller adulthood.

Andrew had experienced losses in his life. The unfolding story shows loss of a secure home, his father, and Andrew’s idea of himself as a capable man. Andrew responded to his ungrieved losses with anger, which was primarily focused on himself. The psychodynamic section of this study highlights several ideas that apply to Andrew’s story. One way of holding Andrew’s story of depression is as a response to the unresolved grief of the loss of actual objects and persons as well as perceived losses that include developmental losses especially in early life.

He was raised with protestant family values: his father was the breadwinner, his mother stayed at home and the family was involved with church. Andrew did not necessarily perceive his desires as in alignment with those of his family of origin; instead,
he plainly accepted these goals as his. Andrew experienced these adult tasks asked of him as worthy, but saw himself as shying away from the tasks for reasons unknown to him. Beck’s ideas on a depressive’s view of the future filled with frustration support Andrew’s move away from engaging in his life, as he feared failure.

Erik Erikson’s ideas point to markers of adulthood that are helpful in thinking about adult development. We live in a time of diminished cultural ritual containers that support life events, such as leaving home, starting a home, entering a profession, childbirth, and marriage. Andrew’s life was further affected by loss and disruption of family life at time when parental guidance and support could have made a big difference—that is, early adulthood, the time when one leaves home to find one’s way in the world.

Erikson lists a progression of three major psychosocial crisis adults or adolescents may experience to various degrees of awareness, intensity and types of outcomes. The timing and sequence of Andrew’s yearnings and crisis presented differently than Erikson delineates. For Andrew, the young adulthood psychosocial crisis Intimacy vs. Isolation and the adulthood stage correlating with Generativity vs. Stagnation lived simultaneously in the foreground of his consciousness. The crisis of Intimacy vs. Isolation was evident in Andrew’s search for a life partner, a wife. He examined his needs for emotional intimacy and sexuality with a woman. Andrew, when faced with sexual urges, decided against having casual sexual activity, as he sought to build a long term and intimate relationship with one woman. The Generativity vs. Stagnation crisis was in the forefront of the therapy. Andrew had a strong sense of commitment for wanting to contribute through his work and private life, and he felt that he had too little generativity and the sense of stagnation left him feel like a slacker. Andrew was in the process of creating a
home and imagining the beginnings of his own family with children and a wife. When he try to reach out to his family of origin— the nuclear family he knew as a child—they could not provide meaningful and effective support with these adult tasks. On the generatively side, caring for others motivated Andrew: the community in which he lived and family—that is, his siblings and future children of his siblings. The adolescent stage of Identity vs. Identity Confusion crisis also occurred in the therapy.\textsuperscript{12} I met the adolescent Andrew, perhaps during regressed state, when Andrew seriously considered child-like solutions to his problems, such as making money quickly with a cookie business or when he rebelled against therapy.

Behind the veil of his church upbringing and his desires for an adult life, I sensed a shadow side. I took note of Andrew’s initial shying away from sharing about his family. He initially protected his family from the therapist who might judge or perhaps remind Andrew of his own inner demons—a family who cannot provide assistance in his passage into adulthood. Later on in the therapy, Andrew’s disillusionment with this family indicated that he needed to separate from them. He declared that his “family will live their lives,” and “I need to find mine.” Modernism is keen on individuation from the nuclear family, but this leaves out an ancient longing for collectivism. Freud observed,

\begin{quote}
From the time of puberty onward the individual must devote himself to the great task of freeing himself from the parents; and only after this detachment is accomplished can cease to be a child and so become a member of societal community.\textsuperscript{13}
\end{quote}

Vernita pointed to Andrew’s ambivalence about therapy, which was evident when he expressed his father views on therapy as being a place where “mumbo jumbo happens.” Another time Andrew introduced “a friend” who expressed a negative attitude about therapy. Andrew brought in the general cultural belief that only ill people go to
therapy. Andrew’s courage in giving voice to these cultural Gatekeepers created space between himself and the cultural Gatekeepers; he learned to engage these voices rather than have the voices be experienced as an integral part of himself.

The Gatekeeper work extended beyond the cultural gatekeeping against therapy; it involved the Gatekeeper that attacked Andrew when he sought relief and solutions to his problems. The Gatekeeper work lessened the impact of Beck's cognitive distortions and allowed Andrew to gain greater freedom from this internal and self-oppressive process.

Andrew learned that he had mixed feelings about his relationship with his girlfriend, Sara, and not morally inept. The work in the sessions, giving expression to this conflict with a compassionate witness, began a process of releasing pent up emotions about intimacy and helped him separate from the oppressive, self attacking voices.

Andrew fell in love with another woman and, in a stream of consciousness, the inner conflict lessened in intensity. He says, “I wanted to approach the girl, but I didn’t. I could not tell if it was me or my defeated self who did not approach her . . . I am capable … why hold myself back. It’s silly.” This passage indicates a change, Andrew’s internal life with self-doubt and wanting but lacking initiative now laid open. Andrew could see his process, which was previously embedded in a sea dysthymic feelings of depression and self blame. The structures that kept him in a tight grip softened. Andrew was now capable of deeper self examination: “was it me or my defeated self?” His belief, that he was faulty, “something is really wrong with me,” changed to a light hearted self examination, “…why hold myself back? It’s silly that I do this thing.”

Andrew presented with some catastrophic thinking about sexuality— that sex could lead to death by means of sexually transmitted diseases. In Andrew’s pathologizing
about sex, his Protestant Christian background, which cautions against pre marital sexual
counters, became visible. More so, Andrew expressed this catastrophic thinking about
sex after the break up with Sara when he was faced with sexual longing and no partner.
Having sex outside a relationship was not an option that he liked. My supervisor, Vernita
thought of Andrew’s tangents and ostentatious ideas as mother wounds and defense
structures in response to intimacy and exposure, which for Andrew could lead to
catastrophes. In sessions, I approached the topic of “the mother” a few times, but the pull
was always to the father. At the time, Andrew did not hold a therapeutic charge to work
with the mother.

About twelve sessions, while lying on the small couch underneath sunny
windows, Andrew playfully shared about qualities that he desired in a life partner; he
described an image of a “tall woman, with thick glasses, who is opinionated.” She would
be so tall that she “could put her arms around my shoulders while walking down the
street.” The tall and strong woman figure can be seen as a personification of Andrew's
unconscious feminine, the anima. In session, I held the image as a wish for rescue from
his conflicted and unhappy self.

After about the tenth session, my supervisor encouraged me to explore sexual
phobias and suggested that Andrew might be sexually attracted to me. Even though
Andrew spoke of sexual fears, the idea of sexual phobias did not resonate with me or
with what was occurring in therapy. I was surprisingly uncomfortable with idea that he
might have a sexual attraction. In a session I initiated the form, “I miss you.” Here I felt
drawn into an imaginal dialogue about being missed because Andrew doubted that his
girlfriend really missed him. At the time, I thought this form would be helpful in working
with Andrew’s ambivalence, but the form took us to the place of romantic, sexual, physical attraction in therapy—a place neither Andrew nor I felt comfortable working.

The theme of “the father” was clearly woven into the therapy. Early on, Andrew shared about grieving his deceased father. It was a complicated wound: grief that held sorrow, betrayal, and anger. I became acquainted with a harsh and self-critical father within Andrew. He recognized a connection between his internal conflicts about his life, work, and relationships and his father’s trait of “being hard on him.” In a form, Andrew yelled to his own dismay, imitating his father playing tennis, “You are stupid. Go get the ball. Try harder!” Here something happened: Andrew felt alive and angry about how one can work against oneself.

Sessions later, I learned about the father’s betrayal: the divorce, the possibility of infidelity, and an overall insensitivity to the son’s needs. When Andrew recalled his father’s emotional distance and the sudden death, he simultaneously wanted his father and was angry with him. In a grief stricken moment, Andrew longed to have his father’s life experience and wisdom. On such an occasion he quoted the lines of a song, “Didn’t leave a message, no way to say good-bye.” At another time, Andrew, angry with his father, yelled, “You left me twice,” referring to the betrayal and then sudden death. Through therapy Andrew was able to reconnect with his father and forgive him for the betrayal. Andrew loved lingering in his imaginings of his father and how he might respond to Andrew today.

The search for father is an archetypal theme. Luigo Zoja writes about the son’s search for the father: “wants to know him from the inside out, just as once he knew him from the outside.” Zoja’s writing also supports the idea that Andrew was on a journey
into adulthood, a journey where a son wants to know the father “who lives within him: he [the son] wants to become an adult.”

The literature review shows that loss, ambivalence, and depression are linked. Andrew had experienced great losses that affected his adult development: he had lost a secure home base by the betrayal of trust and the unspoken promise that his father would guide him into his adult life, the mother’s incapacity to act and unacknowledged family problems. Beyond the influence of the family, our collectivist culture is deteriorating and families, work units, communities, education, rites of passages, kinship, and religion that used to offer forms to hold our libido, our affects, our human needs are now in flux.

Andrew could not look for guidance in his nuclear family, in an extended family, nor in the culture. Andrew consciously grieved the loss of his family, in particular his father. In the literature review, a link is shown between loss, ambivalence, and depression. Andrew had lost a secure home base by the betrayal of trust and the unspoken promise that his father would guide him into his adult life, along with his mother’s incapacity to act as well as other previously unacknowledged family problems.

In addition, cultural institutions and communal life do not offer means to assist in one’s maturation as our collectivist culture is deteriorating. Kinships, work units, living communities and religion no longer offer meaningful rites of passages or rituals that hold libido, our affects, and our human soul needs. Andrew’s dysthymia was an undifferentiated mass of negative emotions, negative life experiences, and a desire for an adult life. All this contributed to his negative slacker identity. With the help of therapy, he reconnected with libidinal energies, freed repressed anger, and he could work on his
life tasks with more ease and less ambivalence and self-doubt. He saw himself on life journey.

Next, I briefly mention about the process of taking notes in sessions. As described earlier, I took notes in the session. Andrew questioning whether I was tape-recording the sessions prompted a conversation about disclosure, confidentiality, and trust. In another session, Andrew said that during a meeting with a superior, the superior “typed while I talked ... I didn’t not know if she was listening.” This lead me to believe that he questioned whether I paid enough attention to him while taking notes, so I responded, “This scenario reminds me of our sessions, I write while you talk. How do you feel about me writing?” Andrew’s reply was dismissive, “Oh, no that’s fine…I am not even sure if she, the superior, was writing about me. You write about me!” I noticed vagueness and suggested that perhaps something else was going on, that indeed it was not “fine.” In session this passage was followed by a long silence, which I regretfully interrupted by introducing another topic.

My intuition told me that Andrew might have felt dismissed by the writing activity. The note taking supports the idea of therapist as an expert, which makes it more difficult to challenge the therapist and to get close to her. Andrew likely wondered what I was writing and tried not to judge it or pay attention to it.

Andrew expressed dysthymic states. When dwelling in dysthymia, one is not connected to the world; it is a place of depression and isolation. With so many depressed in our modern world, it must be an issue of soul, not a personal problem or a personal illness. It is so very American to be optimistic; perhaps this enculturation to optimism has created blindness for the meaning of the darkness, pessimism, and depression. This
attitude leads many to take anti-depressant medication; they see no reason for wallowing in the darkness of depression.

At times it was slightly unsettling or annoying to be present with Andrew’s circular and repetitive negative self talk when he expressed from a dysthymic state. I reminded myself that not having hope, not participating in change and expressing the dismay of what is happening in the world or to oneself has a right of its own and a place among all things. It is up to me to build capacities to recognize and further the meaning and contribution of one’s suffering.

Yet, just in one such moment, I referred to Andrew as a mule. At the time, he was sharing about who he would like to be in a few years: “I like helping people … but I don’t have things to offer to people … but I am good at moving things.” In response I blurted out, “Like a mule,” and I instantly felt embarrassment about my response. Calling someone a mule is an insult in my native language, German. Why call him a mule and not a horse or a tiger (which means a mature adult to me)? Animals like horses and tigers can make noise and take initiative, and consequently “help others” in less passive ways than an immature mule. I intuitively caught that the image of the mule expressing that Andrew grew tired carrying other’s loads.

Towards a later part of the therapy, I experienced disappointment and even some annoyance with Andrew’s idea of opening up a cookie business as a solution to his unemployment. I found myself not wanting to listen and became physically restless. His more typical presence of brooding, feeling stuck and faulty was such a contrast to the cookie business idea. I wanted to believe that the cookie business would be a success, but it seemed more like an escape fantasy. Andrew was excited about his idea, I was going to
betray him with a confrontation. The countertransference I experienced was Andrew’s employment anxiety. I felt a pull to become his parental figure, gently confronting his lofty ideas while still allowing him be this excited about the project.

The therapy ended unexpectedly. I initiated the termination of the therapy for personal reasons, feeling the need to simplify my own life of balancing long commutes, full time work, an internship and my commitments to compete a clinical case study. At the time, my reasons felt practical and not psychological, but after some time I realized that my actions might have been affected by some unconscious dynamics of the therapy. From the beginning, Andrew was ambivalent about therapy. Because therapy was helpful, he could not leave it. Andrew had also entered a new intimate relationship and, as Vernita previously had predicted, he would likely end therapy. It seems that by ending the therapy in a projective identification, I responded to Andrew’s unconscious wish or fantasy to end therapy.

Vernita and I decided that the ending was good enough. Andrew did not want to have a termination phase, he declared the end of therapy in the first termination session. Andrew genuinely thanked me for the help and the change in his life. He astutely recapped highlights from the therapy: he no longer felt depressed and asserted himself more. The Gatekeeper work helped gain emotional and mental space for self-development—development previously hindered by self-loathing and self-attacking inner voices. Andrew unconsciously acknowledged that he was replacing the intimate relationship with the therapist by the developing relationship with Angelica with the statement, “I can talk with her now.”
Imaginal Structures

Both Andrew and I affect the therapeutic process and both are affected by the therapy. This section of this study provides an in-depth look at transferences in the therapy— the lens that helps the therapist recognize and work with the significant moments of the therapy as described in the above section.

How I Was Affected

I quickly liked Andrew. He presented as thoughtful, warm and slightly depressed; I easily feel empathy with depressed people. He reminded me of myself when I first sought therapy as a young adult learning processes and practices for self-awareness and becoming more compassionate with myself. I easily related to Andrew’s financial and social struggles. Andrew sought a life partner, gratifying work, and economic sustainability—all these are typical theme for those in their 20s and 30s. I knew the psychological territory and therefore I easily experienced openness and patience with Andrew.

I was impressed with his intellectual and language capabilities; Andrew expanded on descriptions with a large vocabulary. I have always felt that language capabilities have inhibited my expression and academic work, and so I admired this in Andrew. He was also charming.

I generally wanted to be closer to Andrew and I experienced him as shying away from emotional closeness and a deeper connection with me. His affect on me led to the
experience of an internal tug in the center of my body to not abandon Andrew even while he kept me at arms length. As the therapy progressed, Andrew's ambivalence reminded me of my own anxious attachment and avoidance structures. My personal life experience with ambivalence and discomfort with intimacy was mirrored in the therapy with Andrew. I accepted his movement away from me and away from a deeper emotional connection and concluded that, perhaps, I was expecting this closeness rather than Andrew was seeking it. I learned that deep moments are not necessarily a part of therapy.

Being a new therapist, I naturally underwent uncertainty about my competency as a therapist. Appreciating the work with Andrew and feeling honored that he came to me for help and inspiration about life, I still sometimes wondered if I was up to the task, whether I would come up with the right word or gesture or if I was open and receptive to a diversity of experiences inherent in this work.

I noticed myself more drawn into the therapy when the work turned towards Andrew’s deceased father as I quickly found connectedness with the archetypal longing and grieving for the Father, an Imaginal Structure that emerged in this study. When Andrew revealed such Imaginal Structures, I felt excitement about the possibility for work with related subjectivities.

I was affected by my response to romantic or sexual attraction in therapy declining Vernita’s invitation to explore Andrew’s attraction to me in a session with him. In considering my inexperience in depth work, I felt that I could be treading on dangerous territory. Instead of welcoming such work, I forbade or stopped entrance into an open exploration of sexual transference in the therapy.
I experienced guilt for initiating termination of therapy and the internship and examined whether I was unconsciously avoiding some aspect of the internship or something that was emerging in the therapy. I reviewed these feelings in supervision but did not bring my own process into the session, as the therapy would have not benefitted by focusing on such an exploration. Instead I attended to Andrew in our last sessions.

While working with Andrew, much of my therapeutic focus and energy was directed towards him. Overall, I trusted that the meta-message would emerge and that I would be able to meet Andrew’s unconscious, archetypal expectation and role assignments in the unfolding story of the therapy. Overall this was an exciting opportunity to engage with another in this way. The therapy with Andrew confirmed my choice of becoming a therapist.

**My Imaginal Structures**

Next is an examination of my Imaginal Structures that appeared during the psychological work. Imaginal structures are the lens, or a type of sense organ through which we are sensitive to one another. Another way to think about Imaginal Structures is in the context of transference—that is, the Imaginal Structures are in the transferences. Robert Romanyshyn corroborates, “others in the work, who are imaginally real” point to such Imaginal Structures. To follow is a review of some my Imaginal Structures in the work with Andrew.

I was an inquisitive child with curiosity about the universe and the origin and purpose of people and God. I have always been philosophically interested, early
childhood questions such as “where do we come from?” and “why are we here?” were met with life encouragement at home and the world outside family life. With that came a psychological sensitivity about the feelings and viewpoints of others. This early disposition overlaid with life experiences created some of the qualities of a therapist—someone curious and caring of others and who wants to understand human dilemmas.

Sometimes my natural curious state was not in alignment with the world. I recall when I was five years old, my mother was upset with me. In response, I felt powerful and heroic, and I Can Do and ran circles through the house while being chased by my frustrated mother.

However, I Can Do is a forceful response and cannot sustain its position. Eventually it collapses—the collapse is the defeated victim position: Little Imme Victim. Suspicious, even paranoid, the Little Imme Victim sees the world as a hostile place where people do not care; it is place where one worries much about one’s own existence. This is a place of depression. Melanie Klein describes this place as a paranoid-schizoid position with paranoid insecurity as the root of loneliness. It is from this life experience of living with these Imaginal Structures that I can understand some of Andrew’s struggles.

As an adolescent, my psychological inclinations led me to think about the human character, the relationship between God and evil, and on a persona level, what defined me, what sort of adult I would be, and what societal responsibilities I felt drawn to. I have an array of memories of conversations with family and teachers on religion and philosophy. I wrote letters of concern to cultural leaders. I also felt that my voice was an alternative to the voice of my parents and that my voice was important.
Along with my early inquiries about the world and developing sense of responsibility for our world and myself, I recall the emergence of anxieties about who I was. In my early teen years I listened to Cat Steven’s “The Wind” not yet comprehending the impact of such a life lived, “I listen to the wind, to the wind of my soul. Where I'll end up, well, I think only God really knows.” I held a deep trust in a balancing principle, something that heals and restores, so the Cat Stevens’ lines held something about a faith in being carried by something larger than myself. I was part of a different path, not willed by success strategies but found by heartfelt seeker of a good life for one self and world.

In my early twenties, I first noticed that one of my subjectivities held a negative worldview that I will not achieve certain dreams and not ascertain some milestones. Others do not understand me or misread me. Perhaps it was foretelling of a negative Puer life restricted by an unconscious desire to avoid adulthood and to not be overburdened with a too large and an out of balance sense of responsibility. There was no felt desire to avoid life, but rather a sense that my plans did not manifest. The worries and anxieties still accompany me today and, over the years, my relationship to the anxieties shifted many times. The accountable voice from this place holds hope and seeks meaning.

In my work with Andrew, my personal work with the victim, hero, and philosophical subjectivities allowed me to recognize and have compassion for Andrew’s sense of failure, fears, and worries. David Herbert Lawrence lines, “Not I, not I, but the wind that blows through me! A fine wind is blowing the new direction of Time” teach me about letting go of my personal identities and to listen to the stories beneath the stories so that I may capture the essence life for my work in therapy and in my life.19
As Andrew’s therapist, a few times I questioned whether I was up to the task of offering therapy. The Imaginal Structure of the Little Imme Victim confused and lacking self assertion, questioned whether I would come up with the right word or gesture at the right time. This line of self-questioning by the Little Imme Victim did not lead to a conclusion, but rather it went in a repetitive circular motion without a vertical dimension. The I Can Do aspect questioned how I would be present with Andrew during times of the activated victim. I Can Do’s questioning moved me along in my work. Both lines of questioning were part my experience of a beginning therapist, however only the later was useful.

The Holding and Protective Mother Imaginal Structure is a vehicle for holding the life experiences of hopes and dreams, hurts, and disappointments. My image of the mother and the father is a singing bowl, the mother being the bowl and the father the striker.\(^{20}\) The archetypal mother gives loving attention, she comes to me as a generous being that welcomes strangers and provides safety. The Holding and Protective Mother allowed me to sit through the hours of therapy with an open and alert heart. Andrew’s expressed father grief, and longing for the father tapped into my own psychological work—my own longing for father. My personal father maintained a picture of a traditional well-to-do family to the outside world, but at home I lost and missed our mutual father daughter relationship. Father longing enters the archetypal world and has been in my consciousness for many years. Zoja writes that father longing and the search for the father is archetypal, and if one longs for father, one goes on a journey and is looking for adulthood. For both Andrew and me this statement holds true.\(^{21}\)
The shadow side of my Holding and Protective Mother becomes apparent when she gets tired of holding and dismisses what she had been holding and caring for. I wonder if this shadow process made the projective identification at the end of the therapy possible or at least contributed to it some way. Was I unconsciously tired of holding the idea that Andrew should stay in therapy? I was aware of my tiredness with a full schedule and long commute, but did a tired mother Imaginal Structure drive this? This is a new edge for self exploration.

An early Imaginal Structure is identified in the relationship with my personal mother. I was born shy preferring to sit in my mother’s lap instead of playing with the other children. Entering kindergarten was a difficult separation; I did not want to be with the other children and away from my mother. My mother left me screaming and kicking. It was also difficult for her, as she believed kindergarten would enhance my development. She negotiated special arrangements for me—that I would attend the kindergarten only very part time and with a flexible schedule sensitive to my tolerance.

In my work with Andrew, I readily recognized Puer dynamics; we both lived in a place of becoming more adult. I was about ten years older than Andrew was, and my journey looked different from his but also shared some common threads. As young adults, we both felt that something was missing in our adult lives. We both identified with lack of parental involvement and we both longed for guidance. When I was in my twenties, friends and therapists allowed me to enter into new and enriching relationships that supported my journey. University life provided a psychological home. During those years, I benefitted from several “older sisters” whose lives were interesting, and I wanted to be like them. These experiences helped me become an elder for Andrew. In a parallel
process, towards the end of therapy, Andrew decided that he would like to become a teacher or therapist and was planning to enroll into college.

**Client’s Imaginal Structures**

Andrew experienced dysthymia and an incomplete rite of passage into adulthood, leaving him with structures of a half adult and half adolescent. The Dysthymic One recognized the half adult half adolescent dilemma. Andrew presented with dysthymic symptoms believing that something was wrong him and he longed for a different life and believed that he could achieve such but just did not know how. He derogatorily referred to himself as a slacker. Even though this experience of dysthymia was painful, dysthymia also helped him recognize his incomplete passage into adulthood. Dysthymia was an adaptation that showed him that his way of life was not achieving the fruition of his dreams for adulthood. Andrew’s desire for change showed that he had been thinking about himself, his purpose, and his shortcomings. He developed ideas about politics, had a circle of friends, employment, and his own apartment. He functioned separately from his parental home. He was a sensitive and intelligent young man who needed help with finding his place in the world.

The Party Guy is one adolescent Imaginal Structure. In a session, Andrew shared his excitement about preparing for a party. He fantasized about the therapist attending his party as a fly on the wall — inconspicuous to all except him. His excitement about the idea showed me who he was when he was “partying with is friends.” The Party Guy says,
“Look at me, I am cool!” As his therapist, I imagined hoards of drunken young men, or boys, being boisterous and exploring their budding manhood in a drunken manner.

The Rebellious One is an adolescent structure as well. Andrew’s parents wanted him to do well in school, but he did not apply himself and skipped school to be with is friends. Andrew talked about never having “stood up” to his father and instead acting out his frustration with an “I don’t care attitude” in his teenage years. In this rebellion, he personified the teenage rebel with “I will show you, I won’t do anything.” He rebelled against the frame of therapy by forgetting about a session because he was high on marijuana.

The Disempowered One relates back to Andrew’s earlier childhood. The literature review shows that early childhood stress leads to depression in adults, depression leading to disempowerment. Andrew’s guardedness revealed that he was not ready to share about early childhood wounding; I, however, sensed such injury. The associated intense gatekeeping created disempowered and defeated structures. Andrew was anxious and passive, he wanted a different life and believed such to exist, but he felt that he could not create such a life as exemplified by the statement “I could and should do better but don’t.”

The Imaginal Structure Rescue Me appeared as a woman figure. Andrew fantasized about a girlfriend who was opinionated, tall, strong, and with thick horn brim framed glasses. He could rest his head on her shoulder while walking down the street and through life. I integrated the tall and opinionated woman as an unspoken role or contract between Andrew and I— I was to be strong for Andrew. Andrew transferred his need for strength as he felt helpless and that he could not meet his own needs in life. The required
work was just too hard, and he wanted to be rescued. McWilliams corroborates that a depressed client may present helpless and needy in therapy or by seeking approval of the therapist. It is typical for depressives to transfer depressive structures onto the therapy; the client acts on the loss of needs not being met by original caretakers. Andrew’s image of the tall, opinionated woman with glasses expressed his longing to be released from the ambivalent, mad dysthymic hold in his life. Andrew experienced the woman as a relief, as friend or helper, and he felt comforted by her.

**New Learnings about My Imaginal Structures**

Next a summary of how the work with Andrew and the research shaped me and how my Imaginal Structures were altered by this work. One way I was affected is that I am more receptive to personal avoidance structures and this change is in response to learning about passivity in the therapeutic relationship with Andrew.

The evocative mule imagery discussed in earlier sections points to avoidance structures and the Imaginal Structure, the Mule. In an embarrassing and guilt-ridden moment during a session when Andrew was describing a passive aspect of himself, I compared him to a mule. I then questioned myself: Did I add to the situation with my impatience with Andrew? I thought naming the Mule as unhelpful and the result of a mistake by a novice.

These feelings lingered past the sessions and into the research writing phase. Today I believe the mistake was not so much in my speaking of the Mule but rather my avoidance of the image in therapy; I was actually relieved that Andrew did not want to
talk about the Mule. Today I want to know how Andrew held the image of a Mule; what did he feel and think? What work did not happen because of this avoidance?

Over time, the Mule presented unexpected materials into my consciousness—the potential abuse of power by a therapist. In my exploration, I arrived at the question whether I unconsciously needed to attack Andrew and, if so, why? Did I feel the need to relieve myself of my own slacker and so seized the opportunity through my actions? Did my own slacker react to the Andrew’s self-neglect and passivity and so punished him by calling him a mule? I have felt grief over my own missed opportunities and losses in life and working with Andrew reminded me of them, but I do not believe my feelings created the need to attack Andrew in such a way.

Next, the Mule image morphed into an image of a Tyrant inflicting pain and suffering onto people. I was born in 1963; eighteen years after Hitler capitulated in 1945. How could I not be affected? I am curious about how I and other Germans are affected by these traumatic events in history. I wondered if my impulsiveness was in response to totalitarian and abusive structure—my impulsive rebelling against my own unconscious tyrant providing relief to the self. In addition, I believe that, in tyranny, impulsiveness allows for some new experiences and brings novelty into ones life.

In staying with the tyrant image, I think of the Nazi regime with its murderous followers—a terrifying image that leaves me paranoid. It is dangerous to show weakness because the Tyrant scoffs at weakness. I even wondered if my impulsiveness was in response to a totalitarian and abusive structure—my impulsive rebelling against my own unconscious Tyrant providing relief to the self.
My nature is towards introversion, whereas life called me to develop extraversion. I believe some of what I think of avoidance is actually introversion. Being introverted I fit in well in my former village life in Germany, former West Germany, but that changed when I moved to the United States when, as a young adult, I was pulled into extraversion. My process of enculturation into the American ways was learning to be extraverted and what I experienced as uncomfortable self-promotion.

When growing up in Germany, I learned that belonging to a place and a community holds a person’s identity and sense of belonging. The communities in which I grew up typically were comprised of extended families and neighbors of generations going back 100 years, as well as church, work units and schools. To illustrate, I grew up in an over 300-year-old mill, the Muehle Niesten, which in 1922 my paternal grand parents purchased and operated as a small country retreat for city vacationers from northern Germany. In such a place time seems longer.

I learned that both my introversion and extraversion can serve the therapy: the introversion supports deep thought and reflection and listening; and extraversion supports engaging the other person in the room, who rightfully expects of a therapist to participate and move the therapy forward through actions, verbal expression, and overall active participation.

I have chosen the path to not live in my home country, not to marry and have children, and, consciously, sometimes less consciously, I withdraw from situations and tasks. For example, the completion of this study has been a process of dipping into the work and then retreating from it. Throughout the process, I have returned to the image of transformation: something unique and meaningful has been occurring. The Gatekeepers
shout at my ebb and flow patterns of engagement and call it a sign in my own failure to mature. I reconcile this two-track life experience by knowing that I have applied myself. The echoes of failure are introjected energies from consumer driven and soulless environments.\textsuperscript{24} My work continues in reflecting on how and when I connect and disconnect from others, what my reasons are, what does it feel like, and what are the options.

My desire for greater connectedness and abilities stand in opposition to avoidance. Remembering Andrew's desire for greater maturity and Erik Erikson's stage Generativity vs. Self-absorption and Stagnation, I know what I must do.\textsuperscript{25} In a way, I am moved by fear of self-absorption, and that fear moves me into action, into writing, and into a renewal of my relationships. The released energy is focused on my work of creating community and connection with life.

\textbf{Primary Myth}

The overarching mythology of the therapy tells the story of a modern day Puer, Puer Slacker. At the time of therapy, Andrew’s soul was active and pushing Andrew into a new direction; he was on a road to greater maturity, but, overall, he felt unwell and uncomfortable in his life at age 30. Andrew identified as a semi-adult and ambivalently experienced a bleak adult existence. Andrew, his life permeated by the shadow side archetype of the Puer, sought transformation into a more able and complete being.

Louis Von Franz appreciates and criticizes a Puer existence and sees the Puer resisting the ending of childhood in which he is free to live outside the boundaries of
conventional adulthood. Von Franz’ words describe the Puer as living “…encircled by the music of the stars, Giver of comfort, Sparkling free and beautiful.” She writes the Puer is the “eternal youth encircled by the music and the stars.” Von Franz describes the Puer as not embracing adult responsibilities, which include routine and commitment. The Puer, like Icarus, dreams of “flying high above the earth, free and unattached, soaring away from the limits of the responsibilities of daily life.” Andrew’s cookie business and intoxication with drugs and alcohol show Andrew's attempts to soar like Icarus.

Life pulls the Puer forward into adulthood; he suffers and gains awareness. The light of the Puer cannot last. Connie and Steve Wolf exemplify in their finding that the Puer has “feelings of isolation and alienation.” Icarus falls from the heavens into his death; Jack fears for his life when meeting the giant, and the Puer meets up with adult life experiences creating opportunities for transformation. As he learned about himself, Andrew's dysthymia echoed failure, fear, and it also informed him that he was in an important stage in his life.

Examined next is the role of women, the feminine in the Puer’s life. Andrew bonded carefully with women, as he was ambivalent with women. The Puer identified male has trouble attaching with women, and, according to Von Franz, women never measure up to the male youth’s perfect mother image. In her interpretation, the Puer has a mother complex excessively depending on the mother. Von Franz explains that the Puer focuses on heights in an upward movement. This is seen as a desire to escape the mother even when the escape into the heavens frequently means destruction to the Puer.

However, it is not certain that Andrew was fleeing the mother. He felt unease about commitments in general, and yet, with therapy, he committed to a girlfriend and his
female therapist. In therapy, the figure of the tall, opinionated woman was positive for Andrew. Andrew interacted the least with the female relatives and he longed for his father.

Examined next is Andrew’s relationship with the father. He grieved the loss of his father in two ways: biologically, as his father died; and emotionally, through his father’s betrayal. In therapy, Andrew connected with loss of his father and a desire to reach back to his father and engage on a journey of sharing and healing. The therapy afforded such opportunities by imaginal play in the forms. Andrew’s experiences with father loss are reflected in Hillman and Bly’s ideas about the Puer and the father. According to Hillman and Bly, the Puer’s flight relates to a yearning for a lost or darkened father, and not an attempt to get away from an overbearing mother. Andrew indeed sought a lost father.

Andrew wanted psychotherapy as a means to bring change in his life. He wanted transformation for how and who he was in the world. The archetype of the Puer does not seek maturation, the Puer fears facing what all adults must face. We are not perfect; the adult learns this in his contact with the world and this matures him and makes him wiser. Psychotherapy guided and supported this transforming from a Puer life into a new and more mature way of being.

**Personal and Professional Development**

As a novice therapist, I was naturally motivated to learn about therapy and greatly benefited from the work with Andrew and the clinical reviews and discussions in supervision. After my doctoral studies, I was prepared to sit with many expected and
unexpected small and large moments in the therapy and I was excited to transfer my
skills and capacities from a doctoral program environment into praxis.

As a student trained in the Imaginal Psychology and interning with a
psychoanalytical Psychologist, I learned about clinical formulations and the work in
sessions from the perspective of depth psychology. In previous clinical work I had
provided supportive counseling to adults with the experience of what is commonly
referred to as mental illness and addictions. The operating therapeutic characteristics of
my work with Andrew required other capacities—those in service of depth work and the
Imaginal Process.

The therapeutic work asked me to be present, receptive, and reflexive. In response
to the work with Andrew, I became more comfortable and effective in navigating the
therapy process and stating the obvious—that is, I acted on or spoke more explicitly
about the process in the dynamic field of the therapy. With this came an increased trust in
my ability to recognize and to act upon significant moments in the therapy.

I was pushed out of my comfort zone when working with his ambivalence,
especially when Andrew needed to be pulled into the therapy through active engagement.
In working with Andrew, I learned to suggest activities, provide explanations, and offer
home assignments. The internship taught me how to structure sessions: creating an
opening and closing, taking inventory of the therapeutic field, ascertaining themes and
psychic energies, checking Andrew’s presentation, deciding on activities and forms,
thinking of home assignments, and tracking the need to engage and attract participation
with Andrew. The risk taking included pointing out the unspoken and thinking about the
archetypal forces in therapy. I learned the usefulness of having a repertoire of therapeutic activities to support the various turns in the therapy.

The work with Andrew provided opportunities to explore feelings of inadequacy and uncertainty. Vernita’s validation of clinical skills and judgments positively supported my development. I was able to take helpful risks and learned that the therapy benefits from a therapist who draws on the experiences in the session. For example, I was able to examine how my own discomfort with talking about fees or missed sessions could negatively affect the therapy. Still, the most beneficial teaching was on the structure of the therapy and practical applications of theory in therapy.

Vernita supported imaginal approaches in the sessions, which allowed me to design sessions based on my training at Meridian University. I designed forms to support the therapy and explained how therapy worked with soul as the central concept of the work. I developed a rhythm in the sessions with openings, deep listening and exploring the field, directing forms, and engaging soulful conversations.

I enjoyed the relaxed and rich supervision sessions—a place to practice what might happen in a session and a place to share openly about my experiences in the sessions. Vernita offered helpful and interesting ideas to hold what was occurring in the therapy, and I thought that she was interested in and informed by my contribution and participation in our supervision meetings.

I am grateful for the experience of working with Vernita and her support of me as a new therapist. I felt that she was invested in my becoming a therapist. Even though our psychological orientations differed, my internship prepared me well for more depth work. I learned a better understanding of the application of psychoanalytic concepts.
I have changed as a person because of the work with Andrew. My awareness and sense of responsibility outside the therapy was affected by taking on the responsibility of being a therapist. I have always considered myself a psychologically sensitive and accommodating person who just sometimes fell short. Today I want to be more available and put aside my own needs for the benefit of connection with others.

One day, I was in a grocery store and noticed that I did not greet a cashier and only focused on the immediate task of paying for something. My actions did not feel right. This was a profound moment for me. My desire for greater connection with others grew out of the guilt for ignoring the cashier. The image of tending to Andrew in this way helped me: it is calling me to act with the highest integrity, pulling me towards the depth and more insight into the realms of the soul. The overall positive experience of providing therapy and receiving the supervision helped me in becoming a therapist. I feel affirmed that I can positively influence a transformative process as a therapist.

**Applying an Imaginal Psychology to Psychotherapy**

The application of Imaginal Psychology supported the therapy with Andrew. In the work with Andrew, I structured the therapy to include Imaginal Process. As a result, I was challenged to be a teacher of the Imaginal Process and to articulate its concepts and guiding principles. In the session and in supervision, I introduced Imaginal Process as a way to access material from the personal and collective unconscious. The expression of these materials in forms makes the invisible visible and moves the unconscious materials that affect our conscious selves. After a warm-up period of first taking on easier figures
and voices, such as a client who wished for free therapy or general fears associated with therapy, Andrew enacted his father’s—named Ben—derogatory attitude about therapy. Ben’s voice spoke of “therapy is mumbo-jumbo,” and “voodoo happens,” while the young Andrew “sits in a room with a shrink.” In the form, the therapist assumed the role of a therapist marveling about the usefulness of therapy in a provocative manner. Andrew stayed in his father’s character for several minutes before he became too vulnerable and stopped. Afterwards, in a debriefing about such experiences, I usually praised Andrew for taking the risk and for participating and I invited him to think about its meaning as it applied to him and his environment.

In another form, exploring the state of “I am sleeping with my laundry,” I encouraged Andrew to let the symptoms speak, to be the slacker, to express what came alive for him. After some initial hesitation, he moved into the form. In the debriefing, I learned that Andrew’s initial hesitation was about overcoming the inner critique, which initially and quickly attacked Andrew for acknowledging the inner slacker.

The therapy included Gatekeeper work with triad forms—consisting of the Gatekeeper, the subject, and the Friend—that showed Andrew his own insistent Gatekeepers. The work allowed Andrew to examine how these figures kept him imprisoned, and he learned that, by collaborating with these voices and figures, they lessened their powerful grip on him. Andrew’s dysthymic voice was a Gatekeeper voice. Over the years, Andrew had internalized his perceived failures in being an adult, and these voices affected his self confidence, self esteem, focus and concentration, decision making, and effectiveness—all clinical symptoms of dysthymia. The Gatekeeper accepted this way of being as a norm and warded of Andrew’s adult attempts for a different life.
Ben, mumbo jumbo, and voodoo intervened with Andrew’s change process but they did not stop Andrew as he was learning tools to achieve their collaboration.

The idea of home is not so much a place where one sleeps and keeps one’s necessities, but rather where one seeks solitude and invites in friends and family grew out of the work with Andrew. The otherwise mundane objects of home can become projections of one’s internal world. Hillman includes the household and items of the home as part of the family. In thinking about how Imaginal Psychology could support an early adult’s transition into fuller adulthood, a form that evokes home images could be beneficial. For example, in form, participants could be asked to bring objects—or representations of such—from the home in which one grew up, the current home, or the ideal home. The work in form would include a dialogue with these objects aiming at engaging unconscious materials to help with individuation. As an example, the bed with dirty laundry could become the place of unknown, the fears of adulthood, or an unwanted adulthood; a high school diploma or college degree may be one’s hopes and dreams.

Since the culture does not relate thoroughly with depression, a therapists needs to. Moore brings describes a place for depression in our cities, “a dark, shaded, remote place where a person could retire and enter the persona of depression.” The therapist could create such places in the therapeutic setting with imaginal figures: the shady place away from others, away from the center with attachment and community, or the hopeful and the hopeless, and so on. Home assignments would include building a “depressive” place in the client’s home as a means for giving permission to be depressed.

After the therapy with Andrew, I developed an activity to support integration of the therapy during the termination phase. It is a form is based on curriculum at Meridian
University. In an assignment students were asked to state significant moments of in class work and its meaning. In this termination form, a client becomes the therapist and shares what happened during the therapy: the important moments, the meaning of these moments, psychological changes, and work that is left. The form offers opportunities to initiate a conversation about unfinished business or risk taking in the safety of the end. It support further self exploration.
CHAPTER 5

REFLECTIONS

Personal Development and Transformation

The experience of researching and writing this clinical case study has been a meaningful challenge. I see that my relationship to researching and writing has shifted: I have gained in the capacity of responsibility for writing—that is, a response-ability in writing.\(^1\) In the process of researching adulthood, transformation, and depression, my own woundedness and ability to express in language became a matter of priority and completion of my work became a must.

Linda Sussman’s ideas on speech of the grail illustrate transformation in the speaker, instead of the writer like me. She states, “Less burdened now by heavy defense, the initiate speaker can become more sensitive to time and timing. Exquisite attainment to time - knowing when to speak, just how much to speak, and when not to speak.”\(^2\) These ideas hold true. In a parallel to Sussman’s work, I ask what to write, how much to write and what not to write. As a result of this study, I trust the heart more and I relinquish the head and I know that the writing process leads to new connections and understanding.

Beyond the desire to obtain a doctoral degree, I have been drawn to learn through transformational research and writing and to gain insight into the matters of the soul. For
years, my own Gatekeepers have combated my expression, saying that what I wrote was not meaningful or good enough. Sussman describes a process of laying claim to the world, and, for me, this has meant completing the research work so that I may take the next step towards my future work in psychology. In my engagement with the Gatekeepers, I encountered intense emotions; I call this Emotion Gatekeepers. The intense emotions from the Emotion Gatekeepers bring on feelings states of fear, anger, envy, or betrayal of imaginal others.

Robert Romanyshynt describes the idea that research with soul is a spiral process, a hermenic spiral.⁴ According to Romanyshynt, one repeats experiences and ideas in a seemingly circular fashion when researching with soul. In this process, a third dimension—a spiral axis—takes the researcher deeper into the subject matter and the soul. My writing shows circular patterns of many rewrites and stand stills along with bursts of creativity and productivity—an ebb and flow of attention and presence. I wanted to tap into the creative process and assert a voice in the midst of soul material, a hermenic task.⁴

Kjell Erik Rudestam and Rae R. Newton describe the importance of “claiming your authorship” in the dissertation process.⁵ They also write that developing a voice is an important step.⁶ My author’s voice developed as I imagined an audience that I was addressing with my writing.

The research and writing process took a long time. My Aries’ courage to initiate without necessarily knowing how to complete—while demonstrating an uncannning strength born from stubborness to hold on when many let go—supported the work as well. By initiating my Aries nature, I unleashed great energies that could carry me beyond the
limits of my ego, my patterns, and with which I thought I needed to be attached. At a time when feeling detached from things in the world, such as family, a clan, or the school as an elder figure, the clinical case study process proved to be worthy of being attached to. But now, after years of researching with soul, I wish to be attached differently. Today I stand firmly in middle adulthood with experiences of settling into a life, grateful for the next generation in my family members that have begun their adult journeys. My parents’ generation is aging, and I project toward my elder years. In the fermentation process of this clinical case study at Meridian University, I feel that I matured.

Transformation, deep change in people takes time. I am forgiving myself for the years it took to complete this clinical case study. A casual observer could easily see them as lost years. I wish to share an image of physics proton collision research, which holds one value of time. A decade-long, multinational search for what’s been labeled the *God particle* or the Higgs particle, which might provide insight into the origin of all matter. In 1964— one year after I was born—that scientific researchers proved their theory. Two neutrons collided in the Large Hadron Collider in Switzerland in 2012, which is 48 years after the original quest for two neutrons to collide. It was the vastest and most expensive experiment in history. The research restored physical conditions that existed immediately after the Big Bang, the beginning of our universe. In 2013, researchers received the Nobel Prize in physics for these findings. In my quest for psychological meaning of life, I am not looking for great rewards. This study has confirmed my choice in becoming a psychologist despite, or perhaps because of, the time it took. I now feel that I am deserving of a doctorate degree;
moreover, that I am ready to take on more work in the field of psychology, a field that I am passionate about and have given my time to.

**Impact of the Learnings on My Understanding of the Topic**

My understanding of the clinical topic of this clinical case study—dysthymia in response to an incomplete passage into adulthood—changed through the research. Originally, I perceived Andrew’s situation in relation to a loss of cohesion in the family unit and that hindered his young adult development, as the losses created a lack in external and internal resources. Later I focused more on the effects of chronic frustration and gatekeeping.

The psychoanalytic literature suggests that adult depression is an outcome to real and imagined loss and such losses were evident in Andrew’s life. Loss and grief played an important role in Andrew psychic life. Through the experience of grieving his losses as he understood them, Andrew became gentler with himself.

The clinical case study shows that Andrew’s Gatekeepers, the internal self-attacking voices, led to dysthymia. I sensed that his early childhood development was not as perfect as he wanted to believe; it is likely that early childhood events already influenced him earlier in his life. Over many years of not being witnessed for who he truly was, failure experiences built upon more failure experiences. The resulting intense gatekeeping voices became more powerful and eventually developed into dysthymic structures that readily responded every time Andrew initiated, took risks, or wanted intimacy. A similar idea is Seligman’s learned helplessness, in which infant humans are
born helpless, but learn otherwise through the proper care and attention of a supportive
environment.\textsuperscript{10}

In the therapeutic work Andrew engaged consciously with Gatekeepers and re-
connect with the losses in new ways that allowed an expansion into a new life.

\textbf{Mythic Implications of the Learnings}

More implications of the clinical case study are located in the mythic realm. The
dark Puer Slacker's journey of seeking guidance and seeking anew is a story of our times
about adult maturation and a spiritual journey.

Romanyshyn, in his writing on researching with soul, describes necessary and
often surprising psychological dialogues, and the conversations in therapy and the
associated reflections brought such surprises. Romanyshyn’s suggests to apply the
collective archetypal level when researching with soul. Aiding the process of entering the
mythical level, he asks, “For whom is this work being done? Who are the ancestors who
are direction this work? Whom does this work serve?”\textsuperscript{11} In thinking about these
questions, mythical stories of young men and women seeking guidance and new ways
come into relationship with this study.

This study already shared the stories of Icarus and Jack in the Bean Stock seeking
new heights. Icarus' flight with waxwings towards the sun against the advice of his father
unfortunately led to his death. The death may symbolize the end of the conventional life
Icarus had known. It is a spiritual quest. Hillman perceives the flight as a spiritual “call for
perfection.”\textsuperscript{12}
The death could also be perceived as a failure to mature which would align the story of Icarus with a Puer Slacker story similar to Andrew's story at the beginning of the therapy. These types of death experiences are natural elements in the maturation process. Adults are pulled to come to terms with failure experiences and limitations in life. Typically these deaths are associated with the tasks of mid life. Jung explains about the integration of the nigredo and albedo forming a more cohesive self, which, according to Jung, appears after mid life.¹³

Fatherless Jack meets a giant in the heavens who wants to eat him after he gave away the family savings in exchange for magic. Bettelheim believes that Jack seeks a relationship with the father.¹⁴ Perhaps Jack valued something greater than the conventional, earthly goods, Jack sought the gods. In Greek creation stories, giants proceeded gods on the earth, they created the gods who in turn created humans.¹⁵ In a parallel, the hungry giant is overwhelming to humankind and needs the gods as intermediaries.

Andrew identified as a slacker, who rejects the conventional ways—a life defined by the values of a consumer society that offers only secondary satisfactions and lacks true meaning. Yet a slacker does not go into action; he is not necessarily politically, intellectually, or an artistically active. Instead, the slacker endures the shadow, he drifts along in a mixture of wanting and not know what is he seeks. His life makes a statement about the emptiness and pain of such a life and teaches us about the need for change.

To find answers to the questions—For whom is this work being done? Who are the ancestors that are directing this work? Whom does this work serve?—is a brief description of a modern day Puer quest by the East German rock band Puhdys.¹⁶ The song entitled...
'Icarus' was released before the *Wende*, the process of changing the political and government system of the former East German Democratic Republic in 1989/1990. I used to listen to this song at night on the East German radio station as it appealed to my young teenage heart. Today the image of Icarus flying is disturbed by a newly discovered egocentric, heroic theme in this song. Still, the lyrics also express that the value of Icarus is reaching the new place, the unknown, the dreams of a generation, so that others may follow. In the 1970s in the former East German Democratic Republic Icarus was a symbol of new possibilities even under bleak circumstances.

The Puer Slacker archetype seeks new possibilities, new space for mutual support, creativity, and greater life satisfaction for a generation and in doing so, the person initiated through this archetype, enters a spiritual journey.

Our world today with its large and small crises and all of our daily challenges need adults who cooperative well, create good ideas and put them into action. The work is to move into action, unfold potentials, and create new solutions beyond the conventional. On a mission with loving attention to address current problems, this archetype is guided by the generations who have gone before.

**Significance of the Learnings**

This study links psychoanalytic ideas on dysthymia and loss, adult developmental ideas by Erikson, and Imaginal Psychology concepts of archetypal pathologizing and gatekeeping. This study is important to Imaginal Psychology, the study validates that the work with Imaginal Process and gatekeeping and shows how to bring about deep change,
Andrew disidentified as a slacker and began seeing himself as a capable man. The study also claims that long term unaddressed gatekeeping led to dysthymia in Andrew.

Young adults mature into greater adulthood in interplay of culture and personal choices and needs. The literature review hints that adult developmental theories do not thoroughly describe the variances of deeper experience for adults who mature in different ways: adults who are grieving developmental losses.

We may tend to contribute depression because of childhood experiences or the loss of a loved one, however, causes of suffering do not reside only in the personal realm. Along with personal shortcomings, we may look to how our suffering may teach us about larger cultural issues at hand, issues outside family of origin, our relationships, or work environments. Andrew’s self critical stance about his life as a slacker teaches us about culture. Andrew mostly felt that he was solely responsible for his slacker existence, yet, there are many who share his experience. The study exemplifies how Andrew held his coming of age and adulthood in his twenties as an individual experience rather than a collective, shared experience.

The clinical case study made a connection between dysthymia, slacker experiences, and transformation. This is important to the developmental literature, which is interested in psychological maturation, adult capacities, and life stages. This study could be of interest to developmental theorists, who wish to study the development, influences, and expressions of adult maturation across different generations. Andrew identified with the Generation X (Slackers), which is couched between the Baby boom Generation (Baby boomers) and Generation Y (the Millennial Generation): each generation represents different values and motivations.
The Application of Imaginal Psychology to Psychotherapy

By trusting that work with soul is a transformative process, a psychotherapist may navigate soul territory by working with others with depression. This study shows how a common constellation of symptoms, or dysthymia, may unfold into a larger transformation story of becoming adult. Psychotherapy with a young adult with dysthymia, a mild and often unrecognized depression, was helped by Imaginal Process, which is a process to meet, express, and engage hidden voices—including Gatekeeper voices—that uncover losses and grieve them. This clinical case study is one story of Slacker transformation. Andrew’s transformation is not complete; the therapy shows the beginning of Andrew’s change. The Puer Slacker in this study seeks new adult roles.

Bridging Imaginal Psychology

This study shows how Imaginal Process supported the work with dysthymia and adult development with the overarching story—the myth that carried this study—the Puer Slacker. I am certain that my training at Meridian University and the experience researching and writing this study is only a beginning of my future work drawing on the Imaginal Process and Imaginal Psychology principles.

Future work could focus on the field of psychiatry: adults who have experiences in the public mental health field. Adults with, what is referred to as, mental illness remain an unseen segment of our population. Many of young men and women continue to arrive
in psychiatric emergency rooms. While therapy could help, current treatment options typically do not include psychotherapy. Adults with the experience of mental illness undergo a death of life: they struggle to hold on to their ideas about life only to eventually lose touch with who they are. Imaginal Process and Imaginal Psychology informed therapy approaches could meet some of the psychological needs of these young adults.

This work is not limited to adults in extreme and chronic conditions only, in a sense we are all orphans of the world. This study applies to all adults who are seekers of truth and meaning, in particular adults who identify with early adulthood and the issues of establishing their own adult lives. Early adulthood seekers have a unique opportunities to be initiated into a more truthful life that bears soul fruits instead of cementing feelings of lack or disconnection, which so many adults face today in a rapidly changing global world life.

Areas of Future Research

Aaron Beck's *evolutionary theory* on depression offers an interesting viewpoint that is not explored in this study. Beck asserts that depression is a re-emergence of characteristics of remote ancestors and that depression may have served a positive role in a prehistoric environment. However, the type of information processing involved is not adaptive in our current culture. In other words, a dysthymic life experience once supported a life but today dysthymia is not useful.
A psychoanthropological study of dysthymia might reveal surprising findings, and new ideas about depression and adulthood are useful. Pre-historic times or ancient times, cultures relating more directly with nature and gods could reveal new findings about dysthymia. I can only speculate on new ideas: isolation is a means to get closer to the gods or ambivalence honored as a sacred container for a polarity that otherwise could shatter relationships. These questions arise: How did the proximity with nature affect loss, grief, and depression? Did they suffer from depression in response to unresolved grief, did they have unresolved grief? How did our ancestors perceive of a person who “suffered” psychologically? Many questions are exciting to contemplate but researching is tricky. Imaginal Psychology's research paradigm Imaginal Inquiry, that is researching with soul, would further such research.

A therapist, who is sensitive to these evolutionary potentialities, will receive the inhabiting images of the interactive field and is more likely to connect with archetypal materials. Research into evolutionary models of depression could aid therapy.

This study opens to many areas of possible research. The connection between loss, grief, and attachment are of interest to this study. The therapeutic work with Andrew showed that his growing edge was on issues related to ambivalence and attachment, which is committing to others, a career, potential life partner, or the therapy. This study did not examine concepts and principles on dysthymia and attachment as such seemed unnecessary among the many areas of exploration available on the topic at the time. However, in looking back, gaining a better understanding of the relationship of attachment and the Puer life could be beneficial in understanding adult life passage and maturation.
Another topic for further exploration grows out this study. Andrew had experienced losses that he had not grieved. The literature review mentions some background on grief and the potential transformative power of grief work but it could use further exploration. The literature review takes into account grief of imagined losses as well as actual ones. Further research into the loss experiences of today’s generations could show surprising findings in the areas of transgenerational loss experiences and the loss of home or sense of home, and the establishment of a new home. It would help expand our experiences, which are frequently limited to ourselves and our family of origins, to new visions within larger contexts.

In chapter 5, the reflection chapter of this study, I shared about personal transformation due to this study and the research and writing process. Further research that flows from this work would also focus on the transformative aspects of writing with soul. I took note how this work affected me and how this expressed itself in the writing. There are some initial ideas and hints. For example, contradictory statements or style inconsistency in the text show a relationship to initiation, individuation, and integrating. The writing research writing process naturally mirrored my personal journey, such was evident in tone of written and mood of myself. Another interesting observation takes note of different levels of disclosure and intimacy with the audience and within myself, this relates to the experience of urgency or priority and associated integration.

Many ideas flow form this study, immediate are listed here.
APPENDIX
APPENDIX I

INFORMED CONSENT FORM

Date: ___________________

Dear ___________________________________,

You are invited to be the subject of a Clinical Case Study on dysthymia, which is a professional terminology for mild, yet lasting, depression. The study’s purpose is to better understand the dynamics and issues involved in this form of depression.

For the protection of your privacy, all my notes will be kept confidential and your identity will be protected. In the reporting of the information in published materials, all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to adults and may benefit the understanding of dysthymia.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing that you are the subject of the study could affect you in ways that could potentially distract you from your primary focus in the therapy. If at any time you develop concerns or questions, I will make every effort in discussing them with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason up until the publication of this study. Please note as well that I may need to terminate your being part of this study at any point and for any reason; I will inform you of this change, should I need to make it.

If you have any questions, you may discuss them with me, or you may contact the Clinical Cast Study Coordinator at the Institute of Imaginal Studies (now Meridian University), 47 Sixth Street, Petaluma, CA 94952, telephone number (707) 765-1836.

I, ___________________________________, understand and consent to be the subject of, or to be referred to in, the clinical case study written by Imme Staeffler, on the topic of dysthymia. I understand private and confidential information may be discussed or disclosed in this clinical case study. I have had this clinical case study explained to me by Imme Staeffler. Any questions of mine about this clinical case study have been answered, and I have received a copy of this consent form. My participation of this study is voluntary.
I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for the disclosure of all information about me including, but not limited to, information that may be considered private or confidential. I understand that Imme Staeffler will not disclose my name or the names of any persons involved with me in this clinical case Study.

I herby unconditionally forever release Imme Staeffler of Institute of Imaginal Studies (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causes of action whether known or unknown, arising out of the mention, use and disclosure of my clinical case history, and all information concern me including, but not limited to, information which may be considered private or confidential. The Institute of Imaginal Studies assumes no responsibility for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors, and assigns. The term and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this ___ day of _____________, 2006, at Oakland, California.

By: ___________________________________

               Client’s Signature

_______________________________________

               Client’s name in print
NOTES

Chapter 1

1. *Clerks II*, directed by Kevin Smith (New York: Miramax, 2006), DVD.


5. Meridian University, Meridian University Course Description on website, Petaluma; [http://meridianuniversity.edu/index.php/psychology-course-descriptions;](http://meridianuniversity.edu/index.php/psychology-course-descriptions;) (accessed April 4, 2014). The full text states, “Imaginal Process is a distinct approach to transformative learning. In this approach, human capacities are cultivated through diversifying, deepening, embodying, and personalizing experience. Imagination amplifies and integrates the sensory, emotional, and cognitive dimensions of our experience. Through the labor of imagination, it is possible to craft our experience towards truth, joy, and effectiveness. This approach reflects an emerging multidisciplinary and multicultural synthesis which can be applied to education, therapy, coaching, organizational change, and the arts. Transformative and initiatory experience requires courage, curiosity, and compassion. Listening deeply to each other’s stories is at the heart of this process. Good listening requires that we inhabit vulnerability, mystery, and complexity. This way of listening engages the empathic imagination in ways that catalyze mutual individuation. This course sequence is an opportunity to experience how a group of individuals, through participation, becomes a collaborative learning community and how each individual becomes more of the person they desire to be.”


10. Ibid., 170.


I created the term Puer Slacker based on Andrew's archetypal presentation of a shadowy Puer and his self-identification as a Slacker. For more on the Puer archetype, please refer to the primary myth section in chapter 4.

Meridian University curriculum, Meridian University, Petaluma, CA; http://meridianuniversity.edu/index.php/component/content/category/58-psychology-overview; (accessed April 3, 2014). Meridian University curriculum defines Imaginal Psychology, Imaginal Psychology is a distinct orientation to the discipline of psychology. This orientation reclaims soul as psychology’s primary concern. The soul expresses itself in images. Care of the soul asks that we pay close attention to the images we inhabit. This orientation to psychology has its roots in the transformative practices that are at the core of many spiritual traditions and creative arts. In the last one hundred years modern depth psychology has rediscovered these sacred potentials. Imaginal Psychology traces this vein of gold through its ancient and modern manifestations in ways relevant to our contemporary lives, enabling a distinctly postmodern psychology to emerge.

Chapter 2


6. Ibid.


8. Ibid.


12. Ibid., 284-286.


17. Ibid., 171-172.

18. Ibid., 170.


23. Henry Emmons, M.D., *The Chemistry of Joy. A Three-Step Program for Overcoming Depression though Western Science and Eastern Wisdom* (New York: Fireside, 2006), 44. The author writes that “I believe too deeply in the profound interconnection of mind and body ever to think that depression is ‘all in your mind’ or that it can simply be willed away. Nor do I believe that diet, exercise, meditation, and other techniques described in this book are always sufficient, or that they work equally well for everyone.”

24. Ibid., 24-29.

25. Ibid., 13.

26. Ibid., 13, 247, 253-254.

27. Ibid., 200.

28. Ibid.


30. Ibid., 85.

31. Ibid., 78.
32. Ibid.


35. Ibid.


42. Beck, Cognitive Therapy of Depression, 99, 188.

43. Ibid., 188-194.

44. Ibid., 215-216.


46. Clinical supervisor at Chrysalis Counseling Services, Santa Rosa. Personal Communication from Cynthia Weissbein, Summer 2006. Cynthia did not supervise any clinical work with Andrew.


50. Aaron T. Beck, “Cognitive Models of Depression,” *Journal of Cognitive Psychotherapy: An International Quarterly* 1, no.1 (1987), 215. Beck describes the other five models. The cross-sectional model states that the systematic negativity that permeates the cognitive processes is a necessary component of depression. The structural model specifies that certain negatively inclined schemas become pronounced in depression and shift the cognitive processes sufficiently to produce a systematic partiality in the abstraction of data, interpretation, short-term memory, and long-term memory. The stressor-vulnerability model suggests that specific patterns of schemas make a person sensitive to specific stressors. The reciprocal-interaction model focuses on the ways that interaction with key figures is relevant to the
predisposition, precipitation, aggravation, prolongation, and recurrence of depression. The psychobiological model integrates genetic, neurochemical, physiological, psychological, affective, and behavioral aspects of this disorder.


54. Ibid., 46-56.

55. Ibid.


62. Joseph M. Schwartz, “The Cartography of Melancholia,” *Contemporary Psychoanalysis* 38, no. 1 (2002): 156. The author states that the Psychoanalytic Electronic Publishing Archive includes articles from eight major publications in the field of Psychoanalysis. Furthermore, he points out that between 1989 and 1998 he conducted quick searches for “trauma” and “gender” and found that each word showed 62 entries. In conducting a quick search for “depression” during the years 1959 to 1968, the numbers showed 34 entries for “depression,” ten for “trauma,” and three for “gender.”

63. Ibid.

64. P.D.M. Task Force, *Psychodynamic Diagnostic Manual* (Silver Spring, MD: Alliance of Psychoanalytic Organizations, 2006), 671. The P.D.M. is explained on its website www.pdm1.org/intro.htm. “The Psychodynamic Diagnostic Manual (PDM) is a diagnostic framework that attempts to characterize the whole person--the depth as well as the surface of emotional, cognitive, and social functioning. . . . The goal of the PDM is to complement the DSM and ICD efforts of the past 30 years in cataloguing symptoms by explicating the full range of mental functioning. The PDM is based on current neuroscience, treatment outcome research, and other empirical investigations. Research on brain development and the maturation of mental processes suggests that patterns of emotional, social, and behavioral functioning involve many areas working together rather than in isolation.”

65. Ibid., 172.


68. Ibid., 168.

69. Ibid., 170.


76. Donald Kalsched, *The Inner World of Trauma* (New York: Routledge, 1996), 81. The author describes Freud’s concept of the id, the ego, and the superego, a sever superego with sadistic traits. Freud acknowledged that in “melancholic” persons, the superego’s worst aspect is the superego attacking the ego, the self.


79. Ibid.

80. Karl Abraham, “Notes on the Psychoanalytic Investigation and Treatment of Manic-Depressive, Insanity and Allied Condition,” *Selected Papers of Karl Abraham* (London: Hogarth, 1927), 139. In this article, the author’s focus on manic depression, however, the author’s descriptions of depression and depressive processes seem applicable to the concepts reviewed here.


83. Ibid., 97.

84. Ibid., 100-111.

86. Likierman, Melanie Klein, 104.

87. Ibid., 105-106.

88. Abraham, Selected Papers of Karl Abraham, 138, 140, 418-419. The correlating chapters are named “Notes on the Psychoanalytic Investigation,” and “A Short Study of the development of the Libido.”

89. McWilliams, Psychoanalytic Diagnosis, 234.


93. Ibid., 92-106.

94. Ibid., 21-22.

95. Ibid., 19.


97. Ibid., 4-5.

98. Ibid., 6, 14, 98-99.

99. McWilliams, Psychoanalytic Diagnosis, 233.

100. Ibid., 107–112. The author’s explanation of projective identification is worth noting. She writes that when introjection and projection occur together then the defense is referred to as “projective identification.”

101. Ibid., 231.

102. Ibid. The author explains that when introjection and projection occur together then the defense is referred to as “projective identification.” It is a lack of psychological boundary, that this is me and this is the other are fused into one internal structure.


104. Margaret S. Mahler, The Selected Papers of Margaret Mahler: Separation–Individuation, Volume II (New York: Jason Aroson, 1979), 64.


McWilliams, *Psychoanalytic Diagnosis*, 235.

Ibid., 236.

Ibid.


McWilliams, *Psychoanalytic Diagnosis*, 232.


McWilliams, *Psychoanalytic Diagnosis*, 233.


Cook, “Subjective Wellbeing.” The following passage brings attention to some disturbing cultural issues and questions, which may influence individuals. “The reality of the world can be harsh and depressing. In the Western world, people’s lifestyles and opportunities are somewhat dependent on their wealth. People need money to afford food and shelter and are judged and influenced by how much money and social status they have, and most people spend the majority of their lives trying to earn as much money as possible. On a global level, the world is filled with disease, war, famine and tragedy, and in many ways it can be said that humans are their own worst enemy. We live in a reality where children starve in the streets whilst others cruise in luxury cars; where a huge proportion of the nation’s health care budget is used to remedy the consequences of almost epidemic proportions of our self-imposed sloth and gluttony; and where there is such hate and mistrust in the world that tragedies such as September 11 are becoming common threats. How can we live in this reality without becoming incapacitated by the depressiveness and futility of life?”


Ibid., 293.

Ibid., 285-296.

123. Ibid., 33.


125. Ibid., 145.

126. Ibid., 113.

127. Ibid.

128. Ibid., 219.

129. Ibid., 208.

130. Ibid.


135. Clerks II, directed by Kevin Smith.


137. Donald L. Nathanson, Shame and Pride, 73-82. The positive affects were taken from this chapter.

138. Aftab Omer. Integrative Seminar. Author's notes at Meridian University, 1999. Omer points out that the soul is a central concept to Imaginal Psychology, the same way the unconscious is a central concept of Depth Psychology.


141. Ibid., 29.


143. Moore, Dark Night of the Soul, 29.


Ibid.

Moore, *Care of the Soul*, 138.

Ibid., 139-140. Moore's passage continues:

The Saturn’s depression will give its color, depth and substance to the soul that for one reason or another has dallied long with youth. Saturn weathers and ages a person naturally; the way temperature, winds and time weather a barn. In Saturn, reflection deepens, thoughts embrace as larger sense of time and the events of a long lifetime are distilled onto a sense of one’s essential nature.


Moore, *Dark Night of the Soul*, 206.


Ibid.


The term image is defined later in this chapter. Meridian University website explains that the image is language of the soul. It states “The soul expresses itself in images. http://meridianuniversity.edu/index.php/component/content/category/58-psychology-overview; (accesses April 3, 2014).


Ibid., 6.


163. Ibid.

164. Ibid.


168. Ibid., 93-119.

169. Ibid., 65-74.

170. Ibid.

171. In a modern day Jewish grief ritual, Anne Brener notes that the mourning person tears fabric to express outwardly the inner feelings of ripping away of a loved one by death. Anne Brener, *Mourning and Mitzvah A Guided Journal for Walking the Mourners Path Through Grief to Healing* (Woodstock, VT: Jewish Lights Publishing, 1993). Another example of a grief ritual occurred in 1980 Iran when Ayatollah Komeni died. Previously oppressed women came out into the streets and publicly poured out their grief. Westerners looked upon these events with puzzlement because here were women seemingly grieving their oppressor. This example of the soul’s need to grieve in this instantaneous street ritual was more important than expressing rage over the oppression or relief over the oppressor’s death. Baqer Moin, *Khomeini. The Life of the Ayatollah* (London: I.B. Tauris, 2000), 312. After eleven days in a hospital, Khomeini died of heart attack on Saturday, June 3, 1989. Iranians mourned Khomeini’s death in a “completely spontaneous and unorchestrated outpouring of grief.”


176. Ibid., 3.

177. Ibid., 3-4.

178. Ibid., 3-5.

179. Ibid., 4.

180. Ibid., 160-181. For a detailed description of the child archetype and its functions refer to Jung.

182. Ibid., 3, 5.


184. Ibid., 96.


186. Ibid., 92-122.


188. Ibid.


196. Ibid., 111-112, 119, 141.

197. Ibid., 111, 119.


Dear N.,

I am sorry you are so miserable. “Depression” means literally “being forced downwards.” This can happen even when you don't consciously have any feeling at all of being “on top”? So I wouldn't dismiss this hypothesis out of hand. If I had to live in a foreign country, I would seek out one or two people who seemed amiable and would make myself useful to them, so that libido came to me from outside, even though in a somewhat primitive form, say of a dog wagging its tail. I would raise animals and plants and find joy in their thriving. I would surround myself with beauty - no matter how primitive and artless - objects, colours, sounds. I would eat and drink well. When the darkness grows denser, I would penetrate to its very core and ground, and would not rest until amid the pain a light appeared to me, for in excessu affectus [in an excess of affect or passion] Nature reverses herself. I would turn in rage against myself and with the heat of my rage I would melt my lead. I would renounce everything and engage in the lowest activities should my
depression drive me to violence. I would wrestle with the dark angel until he dislocated my hip. For he is also the light and the blue sky which he withholds from me. Anyway that is what I would do. What others would do is another question, which I cannot answer. But for you too there is an instinct either to back out of it or to go down to the depths. But no half-measures or half-heartedness.


Chapter 3

1. Omer, Imaginal Process, 1996. From the author's notes from Imaginal Process class. The subject focuses on the experience of being attacked by the Gatekeeper and the Friend assist the subject in doing so and in engaging and negotiating with the Gatekeeper. The Gatekeeper triad is a form from Imaginal Process. Here, three positions— the subject, the Gatekeeper, and the Friend— engage, experience, and express in service of transformation.

2. McWilliams, Psychoanalytic Diagnosis, 107–112. The author explains when introjection and projection occurring together, the defense structure is named “projective identification.” It is a lack of psychological boundary, that this is me and this is the other are fused into one internal structure.

3. Eugene T. Gendlin, Focusing (New York: Bantam: 2007), 11-13. The author explains about focusing as a bodily knowing or a felt sense; it is done by focusing on body images as they emerge in process and a person's awareness.


Chapter 4


2. Omer, Integrative Seminar, 1996.


4. Abraham, “Notes on the Psychoanalytic Investigation and Treatment of Manic-Depressive, Insanity and Allied Condition,” 139. In this article, the author’s focus on manic depression, however the author’s descriptions of depression and depressive processes seem applicable to the concepts reviewed here.


6. McWilliams, Psychoanalytic Diagnosis, 234.


12. Ibid.


“Song of a Man Who Has Come Through”

Not I, not I, but the wind that blows through me! A fine wind is blowing the new direction of Time. If only I let it bear me, carry me, if only it carry me! If only I am sensitive, subtle, oh, delicate, a winged gift! If only, most lovely of all, I yield myself and am borrowed By the fine, fine, wind that takes its course through the chaos of the world Like a fine, an exquisite chisel, a wedge-blade inserted; If only I am keen and hard like the sheer tip of a wedge Driven by invisible blows, The rock will split, we shall come at the wonder, we shall find the Hesperides.

Oh, for the wonder that bubbles into my soul, I would be a good fountain, a good well-head, Would blur no whisper, spoil no expression.

What is the knocking? What is the knocking at the door in the night? It is somebody wants to do us harm.

No, no, it is the three strange angels. Admit them, admit them.


22. McWilliams, *Psychoanalytic Diagnosis*, 232
23. Armand Volkas, Internship at the Living Arts Center, Oakland, CA, 2005. In a workshop, Volkas works with the implications of cultural trauma. The generational effect of culturally traumatic events, like the Holocaust or the holocaust in Armenia, takes seven generations for healing.


27. Ibid., 185.


29. Ibid.

30. Von Franz, Puer Aeternus.


33. Moore, Care of the Soul, 147.

Chapter 5

1. Omer, Intergrative Seminar. Author's notes at Meridian University 1996/1997. Responsibility is described as one of several human capacities. Transformative learning at Meridian University fosters various capacities, others are: reflexivity, empathy, collaborativity.


4. Ibid., 219.


6. Ibid., 159.


9. McWilliams, Psychoanalytic Diagnosis, 234.


16. Wolfgang Tilgner with the Pudhy, “Ikarus”

“Ikarus”
Einem war sein Heim, war sein Haus zu eng
Sehnte sich in die Welt.
Sah den Himmel an, sah wie dort ein Schwan
hinzog.

Er hieß Ikarus und er war sehr jung,
war voller Ungeduld.
Baute Flügel sich, sprang vom Boden ab
und flog
und flog.

Steige Ikarus! Fliege uns voraus!
Steige Ikarus! Zeige uns den Weg!

Als sein Vater sprach: “Fliege nicht zu hoch!
Sonne wird dich zerstören.”
Hat er nur gelacht, hat er laut gelacht,
und schrie.

Er hat's nicht geschafft und er ist zerschellt
Doch der erste war er.
Viele folgten ihm, darum ist sein Tod
ein Sieg,
ein Sieg!

Steige Ikarus! Fliege uns voraus!
Steige Ikarus! Zeige uns den Weg!

Einem ist sein Heim, ist sein Haus zu eng,
er sehnt sich in die Welt,
Sieht den Himmel an, sieht wie dort ein Schwan
sich wiegt.

Er heißt Ikarus und ist immer jung,
ist voller Ungeduld.
Baut die Flügel sich, springt vom Boden ab
und fliegt
und fliegt.

Steige Ikarus! Fliege uns voraus!
Steige Ikarus! Zeige und den Weg!

English translation:

“Icarus”
One in his home, his house was too small
Longed for the world
Looked at the sky, saw a swan flying
across.

He was called Icarus and he was very young,
full of impatience.
Built himself wings, jumped off the ground
and flew
and flew.

Climb Icarus! Fly ahead of us!
Climb Icarus! Show us the way!

When his father said, “Do not fly too high!
Sun will destroy you. “
He just laughed, he laughed aloud,
and shouted.

He did not make it and he shattered
But he was the first.
Many followed him, because his death is
a victory
a victory!

Climb Icarus! Fly ahead of us!
Climb Icarus! Show us the way!

One in his home, his house is too small,
he longs for the world,
Looks at the sky, sees there a swan
swaying.

He is called Icarus and is always young,
full of impatience.
Builds the wings, jumps off the ground
and flies
and flies.

Climb Icarus! Fly ahead of us!
Climb Icarus! Show us the way!

REFERENCES


______. “The Breath of the All-Merciful: Towards a Chart of the Imaginal”;
http://philosophiaperennisetuniversalis.blogspot.com/2013/01/towards-chart-of-
imaginal.html; (accessed December 10, 2013).


Eliade, Mircea. Rites and Symbols of Initiation: The Mysteries of Birth and Rebirth. New


Emmons, Henry. The Chemistry of Joy: A Three-Step Program for Overcoming
Depression through Western Science and Eastern Wisdom. New York: Fireside,
2006.


Eysenck, H. J., R. A., Friedman, J. C. Markowitz, M. Parides, L. Gniwesch, Sr., and J. H.
Kocsis. “Six Months of Desipramine for Dysthymia: Can Dysthymic Patients
Achieve Normal Social Functioning?” Journal of Affective Disorders 54, no. 3

Freud, Sigmund. An Autobiographical Study. With a foreword by Peter Gay. New York:

_____ “Mourning and Melancholia.” Edited by D. J. Strachey. The Standard Edition of
1957.

_____ General Introduction to Psychoanalysis. New York: Washington Square Press,
1960.


