Psychotherapy as a Rite of Passage

C. CHRISTIAN BEELS, M.D., M.S.†

Some psychotherapies may work because they resemble rites of passage. To explore this idea, this article describes an ''individual'' case of depression in which drug, cognitive, and narrative approaches fell short of effectiveness, and change occurred in a series of experiences that resemble a rite of passage. This resemblance is illuminated by examining two apparently quite different healing processes—Alcoholics Anonymous and multifamily group therapy in schizophrenia—to explore the elements they have in common with the case described: the acceptance of what Victor Turner called a liminal experience, and the importance of witnesses to the ritual support for that acceptance. The discussion contributes to a loosening of the distinctions between the processes of individual, family, group, and other social therapies and leads to questions about the expert knowledge the therapist provides.

Keywords: Psychotherapy; Ritual; Witness

Fam Proc 46:421–436, 2007

As I was thinking about psychotherapy as a rite of passage, two quite different images came to mind, one for psychotherapy and one for rites of passage. The prototype for therapy is the analytic couch in a closed private room, with the analyst as the sole witness. The prototype for a rite of passage is a public ceremony in a church, temple, or school—a wedding, christening, Bar or Bat Mitzvah, funeral, or graduation—a social ritual in which the witnesses, family, and friends are as necessary as the central characters. Family therapy contributed to the ritual of psychotherapy by adding other witnesses and asserting that those family witnesses were in fact essential participants in the therapeutic process—witnesses for one another. More recently, the narrative version of family work added an audience of ''outsider'' witnesses—a chorus, often a chorus of students, whose role is to comment, speaking from their own experiences, on the changes that the central characters are undertaking. Thus, a way has been opened for looking at the convergence of the traditions of therapy and rites of passage.

My purpose in this article is to carry this dialogue between the two traditions further and to suggest that some kinds of therapies work *because* the experience resembles a rite of passage. I am interested here in the role of witnesses and in the sometimes surprising ways in which they are recruited. Those of you who are familiar

†Ackerman Institute for the Family.

Correspondence concerning this article may be addressed to C. Christian Beels, 865 West End Ave., New York, NY 10025. E-mail: cbeels@post.harvard.edu

Family Process, Vol. 46, No. 4, 2007 © FPI, Inc.

with the work of Michael White (1992, 1995), David Epston (Maisel, Epston, & Borden, 2004), and Alan Rosen (1978, 1994) will notice how much I am indebted to them for some of these ideas. And like other students of ritual in therapy, I follow a path marked out by Evan Imber-Black, Janine Roberts, and Richard Whiting (2002). In her introduction to the first edition of that work (1988), Roberts made explicit many of the anthropological connections between healing rituals, rituals of passage, and psychotherapy. Many writers in different parts of the world were pointing out that a wide variety of familiar social situations have therapeutic potential—birthday parties and other celebrations, hospital discharge conferences (which could be turned into celebrations), spiritist consultations, and family therapy teaching conferences.

As I've said elsewhere (Beels, 2001, Chapter 11), Peggy Papp (1980), among other family therapists, brought the power of witnesses to bear on our work, although in those days, as throughout our history, we called it by other names, such as ''paradoxical.'' One of the many contributions of White, Epston, and their colleagues has been to get away from that earlier tendency to give brand names to our work, as if different practitioners were engaging in special guild practices. They have shown that the same ideas and tactics are being used in their individual, family, and community work, even their institutional consultation (Maisel et al., 2004). For me, this has led to a welcome fading of those traditional distinctions between individual, family, and community work. It led also to my presuming here to submit to *Family Process* what at least one reviewer regarded as an unsuitably ''individual'' case. This article is an effort to do something new with the distinction between family and individual therapy. By suggesting that both kinds of therapy are analogous to rites of passage, I raise the question, How is the witnessing in these rites constructed and perceived—whether the witnesses are family members, recruited others, as in AA, or group therapy or witness groups, or even imaginary witnesses such as historical figures? Putting the idea in its strongest form, suppose that what we are doing when we perform these professional services is providing a variety of occasions for meaningful rites of passage in the lives of the participants. Then what are the special kinds of knowledge or expertise that we bring to the occasion? What are we supposed to know how to do? I will try in what follows to keep track of the nature of expertise, at least of my subjective sense of what I was trying to do.

Two years ago, I met with a group from the Consultation Interdisciplinaire de Maltraitance Intrafamiliale in Lausanne, Switzerland. The director, Gerard Salem, and his colleague, Francine Ferguson, had read *A Different Story*, *the Rise of Narrative in Psychotherapy* (Beels, 2001), in which I take up the connection between narrative therapy and rites of passage. They agreed that I would work on this idea further for a talk in Lausanne.

I was also in the middle of consultation with a patient suffering from depression whose experience eventually suggested another application of the idea, though for a long time I did not notice the connection between the chapters in the book, the idea for the talk, and the story of the clinical work. I'll begin with that story, the story of Nora, who, when she first consulted me, did not think of herself at all as a member of a congregation of witnesses. As you will see, I believe that the way in which she became such a member influenced the outcome of our work.

Nora is a professor of literature, the author of several academic books, and the editor of a series of publications in women's studies. At the time I met her, she was 63, an age that she felt was nearing the fateful date in the Beatles' song, ''Will you still need me, will you still feed me, when I'm 64?''

Nora's second husband was also a professor of literature and a newly recovering alcoholic who had recently entered Alcoholics Anonymous after a stay in a rehabilitation facility. She found his enthusiasm for AA meetings puzzling, but she was grateful that AA was keeping him sober. Nora and her husband had no children; they had difficulty with conception, and after much discussion, they had decided not to adopt. The absence of children was a source of regret for which there was no consolation.

Her work was in many ways the most consuming part of her life. At the time I saw her, Nora was descending into a depression focused on the fact that she had not found a publisher for her first effort at a literary memoir—the story of her leaving home after college. She had already published two ''critical memoirs,'' which combined literary criticism and autobiography, but this book was her first attempt to speak to a general audience beyond academia. She took the book's failure to find a publisher as her own personal failure. Her status as a professor, her accomplishments as an editor and writer, knowledge of herself as an attractive, witty, intelligent woman with many strong and loyal friendships—all were of no use to her. When people asked, ''How are you?'' instead of answering, ''Fine,'' she wanted to say, ''I haven't published my book.''

Nora understood that the difficulty of finding a publisher was now a common experience for writers, especially those trying to reach new audiences. She knew that the publishing industry is notorious for its unpredictability and its frequent indifference to quality, and she understood that even the most successful authors may encounter problems with publishers, but she still took this failure as a judgment of her personal overall worth. ''Maybe I've waited too long,'' she told herself, ''maybe I just can't do this—maybe I'm finished.'' She was seized with envy when every week the reviews brought news of just-published authors, some of them younger women in her own field. These thoughts would not leave her alone, and they were only briefly countered when friends whom she trusted had read the manuscript and praised it with sincere enthusiasm. Nor did it help her to know that her agent was continuing to submit her manuscript to publishers.

In addition to this preoccupation with the book, she had a more general and longstanding depressed mood, painful feelings of low self-esteem from which she longed to be relieved, especially when she awoke in the morning with a physical sense of dread at facing the day. Nora had experienced episodes of acute depression before, most notably on returning home from Paris in her 20s. Like many Americans leaving college in the 1960s, she went to Paris to teach English and to study French—an academic and cultural adventure. But to Nora, it was more than that, and this was the subject of her unpublished memoir. For Nora, it had been an opportunity to establish a life and to forge a new identity in that glamorous and most storied foreign capital of American rebellion, epitomized for her by Jean Seberg's performance as the American girl in the film *Breathless*.

Her parents' plan was for her to become a conventional American wife with a good Jewish husband, perhaps a career as a high school French teacher. Instead, she found in Paris a fellow English teacher, an Irish American Catholic and an expatriate who had decided to make Paris his home. The marriage and her life in Paris were her declaration of independence. However, when the marriage very quickly ended in divorce, Nora was convinced that her attempt to establish herself as a Parisienne was a catastrophic failure, and on returning home, she experienced a profound depression.

But she did find a way of dealing with it. She found a job teaching French in a neighboring high school, the very thing that she had run away from, and then she found an apartment to share with a roommate. She forced herself to work and otherwise did little but eat and sleep. Her depression cleared significantly only when she began graduate studies in French literature. This improvement was strengthened both by her involvement in work and, most important, in my view, by her participation in some of the women's consciousness-raising groups that emerged in urban American life in the 1970s. I will say more about these groups later.

In talking with her about this time in her life, one thing that struck me was that she did not attach importance to her accomplishments. She had been a very effective teacher of English in Paris—indeed, she had used her profession to support her first husband—and she enjoyed the skill, humor, and natural authority that she experienced in the classroom. She was in demand as a translator of French texts, and when she returned to the United States, the exercise of her teaching skills helped get her out of her depression. Yet when she evaluated herself, these facts did not come to the front of her mind.

Both in Paris and on her return, she made strong, loyal friendships with other women. But her self-esteem depended more critically on new signs of academic recognition—on invitations to give papers at conferences, on important editorships, and, of course, on the publication of her previous books.

Nora had had two psychotherapies before coming to see me. One had helped her through the writing of her doctoral thesis. The second was an inconclusive psychodynamic exploration. Most recently, she had consulted a psychopharmacologist who, after other antidepressants had failed, prescribed the antidepressant drug Effexor (venlafaxine). This last drug was effective, but several months later, she developed doubts about medication as a treatment, suspecting that drugs mask rather than eliminate problems. She discontinued the medication during a sabbatical year in London, the year she used to begin the memoir that was now causing her so much disappointment.

I didn't get this story all at once, of course. The first step was to decide on the nature of the problem and how to deal with it. In fact, Nora had first come to me to ask my advice about her husband, who was enthusiastically embarking on a schedule of AA meetings following his return from a residential rehabilitation center. I met with them together, and we talked about how AA works, with the result that Nora was more confident in his choice. She then asked to return to see me about herself, and it was then that I heard about her depression. Having had one couple meeting already, I could easily have had more and begun a ''spouse-assisted'' depression treatment (Papp, 1999). But I decided against that. I had the impression that, although they were supportive of each other in their separate psychological careers, they would not easily undertake this project on Nora's behalf together. I also thought that the beginning of her husband's AA commitment was not a good time to ask something extra of him.

This was one of several decisions I made at the beginning that were presented in my very un-narrative role of the doctor who knows what to recommend to the patient. A second was to introduce a cognitive approach to her depression. I assigned her reading in David Burns's *Feeling Good Handbook* (1999) and asked her to do the written exercises for correcting distorted thinking about depression. The effectiveness of these exercises has been well tested in research by Aaron Beck (Clark & Beck, 1999) at the University of Pennsylvania, where they originated, and by many others. Nora

put a book jacket over Dr. Burns's irrepressibly cheerful face on the cover and dutifully did the exercises. A good student, she quickly—in about 2 weeks—learned to detect her self-defeating thoughts and to search for alternatives. She wrote concerning this work,

> I had a very hard time separating the feeling from the thought. For me, if I felt it, it was true. So the feeling of depression was true—reality. The thoughts I experienced or voiced, expressing the depression—were true. I couldn't for the longest time separate the feeling of depression from the language of the thought. That distinction was for me the biggest breakthrough.

This cognitive change was valuable in that we were able to use the language and techniques as we went along, but it did not bring her the relief she was looking for. Another doctor-patient transaction, this one in response to her request, was to revisit her experience with medication. Because she had had such difficulty evaluating the role of long-acting antidepressants in her previous experience, I prescribed Ritalin (methylphenidate). This is a short-acting drug whose effects of improved alertness and concentration are time limited and thus very much under the patient's control. She liked the way this improved her ability to plan her response to periods of distress, which now came less often. I sent her for a second consultation with the specialist who had prescribed Effexor, and he prescribed low doses of Prozac (fluoxetine). To her surprise, this produced an improvement in her mood.

I now felt that we had a good medical-scientific foundation in place and were ready to start a narrative inquiry into her experience with depression. Ideally, this involves a shift from the doctor-to-patient transmission of expertise to a consultation in which the consultant interviews the person (no longer patient but co-consultant) to elicit experiences and language contrasting with the problem—in this case, depression. But there is a first step for which a little direction is still needed: introducing the language of externalization. Depression had to be gotten out of the center, not banished but put at arm's length, so that there was room to work. Dr. Burns's exercises were actually some help with this, but apart from separating language and feelings, Nora found it hard to move depression away from center stage. I suggested two kinds of imagery that might help. One was the biological description of depression as a conspiracy of neurotransmitters located in one part of her brain, with which the Prozac was presently doing battle. The other was Robert Burton's (1964) 17th-century idea, proposed among many others in *The Anatomy of Melancholy*, that depression was the work of the Devil. Nora liked both of these. Like many writers, she found the Devil an immediately recognizable presence opposing her struggle with her problem.

She was able, in this way, to externalize the voice of depression as an enemy rather than allow it to govern as the knowing internal voice that reproached her with failure, and a voice that seemed especially credible because it used the language of her own assessments. It was also helpful to see the depression as biological, located only in one part of her mind. She made use of this for a while but reinterpreted the biological metaphor to mean, ''This means I have always had it and will always have it; it will never go away''—a depressive turn. So we tested a spatial metaphor—moving the enemy into a different room. Nora could see that when she was busy in her office, the depression stayed away, it was somewhere else. She was also interested in the

neurological idea (Gazzaniga, 2005) that the brain has an ''editor'' that is in charge of selecting what receives attention.

So here, a year later, was a fair clinical result. Was it acceptable to her? No. And why not?

She didn't believe it. ''It was something like a truce or a reprieve,'' she said. She believed that depression was natural for her, her ''normal'' way of being, and that optimism would for her be untenable, no more than an attempt to kid herself. Happy feelings—even contented ones—were an illusory relief from what was ''really going on.''

At the end of the day, her own book was still unpublished despite her agent's best efforts, and something was still fundamentally wrong. She had constructed her own theory of depression: It was, for her, a kind of ''realistic pessimism''—a means of coping with anxiety and uncertainty. It is an essential defense against anxiety and uncertainty that fends off disappointment by deciding on failure ahead of time. Perceptive as this was, even her own insight did not lead to liberation. It can be easy, when working with such an intelligent, hardworking patient, to miss the fact that she is not getting better. Only in a much later conversation were we able to make use of this deep conviction of Nora's.

Following the narrative paradigm again, I searched with her through her experience for other states of mind or belief. Apart from work, what about play? Her gardening on weekends was dutiful and ambivalent. Cooking had been ruined for her as a pleasure by her experience with the demanding first husband in Paris. ''I am not a sensualist''—she summed it up. What about a different kind of work altogether?

Nora was very aware that she could not go on forever becoming an increasingly famous professor of literature and women's studies. We talked about the natural arc of a career, the need to think about retirement, retreat, and even—because it was on her mind—illness and death. Certainly between here and that horizon, something else needed to be imagined and planned. Though she had nursed her father in his final illness and death and even devoted part of one of her books to describing that experience, she had trouble thinking about her own retiring years.

The fact of her childlessness always led to negative comparisons: ''Everyone else has grandchildren,'' she said, ''and I don't even have children.'' Her second husband was able to be involved in his extended family and their children in ways that she didn't share. Our search for ways to try out alternatives to her present career, such as other kinds of service besides nurturing students, was not fruitful. After a trial excursion into that kind of activity, she felt she wasn't ready for it.

We looked at the cultural and family influences on her acquaintance with pessimism. I think of this as another kind of narrative approach, raising the question, ''Is there a story that has been handed to you by your family of origin, that you are continuing in a way that doesn't suit your preference?'' She attributed some of her suspicion of easy optimism to her ''Yiddishe Kopf,'' the value of a doubting, ''wised-up'' outlook that she shared not only with some other Jews but also with other immigrant groups that have faced uncertainty in a land of deceptive promise. So pessimism itself was not alien to her.

Much more alien was her struggle with her mother, who had conducted her childhood and adolescence as a series of dramatic and desperate battles over who was right. Her father, in the face of his wife's insistence on winning every battle, had acted as the go-between, begging Nora to give in to her mother for the sake of peace. It was to escape from continual defeat at the hands of this depressing coalition between her

parents that she finally fled to Paris and independence immediately after college. But she had learned by then to assume a defensive posture, repeatedly having to prove to her parents that she wasn't ''wrong.'' The only acceptable proof that she was right was, of course, the judgment of the world—the good grades, the recognition, the successful marriage, things that her parents would have had to recognize and concede. That was why, when her first marriage failed, she felt that she had failed utterly, and why, when the book didn't find a publisher, it was her failure. As she put it, ''I have to get an A, not an A minus.''

The discussion and interpretation of these psychodynamic matters had as little lasting effect as the cognitive, narrative, and pharmacological treatments. Each provided something that she described as ''palliative,'' but nothing lasting in the face of her abiding belief that there was something wrong with her, or at least with the way she was dealing with depression.

Now I want to introduce briefly the framework that I believe did eventually prove useful to Nora, because, in addition to the words with which she and I were trying to construct an alternative mental reality, it provided something more. It provided a concrete experience different from the judgment of the world that issued the grades. But first I will depart from Nora's story so that I can describe the ideas of the anthropologists Arnold van Gennep (1960) and Victor Turner (Turner, 1969; Turner & Turner, 1995) about rites of passage.

Van Gennep is famous for introducing the idea of the ''rites of passage'' to anthropology and popular culture. He wrote that the transitions of birth, adolescence, marriage, parenting, and death, are marked by rituals in all societies. These passages through life's big changes seem dangerous, at the very least because they are encounters with the unknown or uncertain. The purpose of the rituals we create to attend these changes is to protect the vulnerable individuals who are passing through them, and to give the others, the witnesses, a way of behaving in the presence of the instability in the social group that these changes would otherwise create. In a positive sense, a ritual blesses the change through the power of the group.

Victor Turner (1969) added illness to the list of passages requiring ritual protection. He noted the similarity between the rituals for illness and the rituals for adolescent initiation in an African society. He also added to a point Van Gennep made about the worldview of those caught up in a ritual observance, to which both of them gave the name ''liminal,'' meaning on the border, in-between, incomplete. Turner's point was that, modified by ritual, the outlook from one of life's precarious bridges was distinct from the worldview of those attending to the daily activities of the larger community. In that everyday world, the emphasis was on performance and results, on activities and accomplishments that might receive a grade or a price. In the liminal, transitional world of the rite of passage, on the other hand, attention is on the transition itself—the process of being born, of learning, of growing, of entering adulthood, of becoming married, of recovering from an illness, or, finally, of dying. These processes take place apart from the routines of our daily lives. Work stops for rituals, just as it stops on the Sabbath. To emphasize this, Turner called the world of the witnesses to ritual *communitas* to distinguish it from that larger working *community*. Communitas is a small congregation assembled for the purpose of teaching, supporting, healing, or sustaining—that is, an assembly that is concerned with process rather than outcome. Victor Turner had many other interesting things to say about ritual, but this summary will suffice to illuminate the rest of Nora's story.

When, in proper narrative fashion, I had tried to help Nora search through her life for *exceptions* to the dominant story of failure, of being ''second best,'' the exceptions we found were clearly examples of liminal process. One was the classroom, where, as a teacher, she had experienced satisfaction in the process of her teaching and her students' learning. Although schools exist partly to give grades, Nora, like all good teachers and students, knew that pleasure in the process of understanding provided something different from, something more collaborative than, and often more satisfying than, even a good grade.

The second liminal experience was in her women's consciousness-raising groups, where, during the 1970s, she and her friends helped each other develop alternatives to their experiences of oppression. This was a *process* of disclosure, exchange, and support quite apart from the daily experience of success or failure. It was, in fact, an antidote, a ritual alternative to that experience. It was a ritual attending their progress to the realization of themselves as women.

But further questions led to a surprise: The clearest example of liminal ritual, and the most meaningful to her, was her yoga class. She originally started yoga after turning 60, as a congenial form of exercise, but as we discussed it, she especially recalled the comments of her instructor on the more spiritual aspects of the practice. In particular, she remembered her saying, ''Don't look at the way the others do the pose.'' She understood this to mean that it's not a contest to see who is getting it right, who is getting a better grade. It is a process in which you discover something for yourself and your body. Thus, yoga introduced her to a real alternative to a world from which the negative judgments came.

A fourth experience was of great interest because it was unintentionally prompted by the therapy, mainly through our discussion of melancholy as a classical interest of writers like Burton. She went to Paris for a conference, and while there, she visited an art and manuscript exhibit on melancholia at the Grand Palais. When she returned, she brought the exhibit catalog to our next meeting and loaned it to me so that I could appreciate it. She had been fascinated by the artists and writers whose work was brought together there—Robert Burton, Albrecht Durer, Vincent van Gogh, Edvard Munch, and others, all of whom had transformed their experience of depression into a dark but majestic expression, into something transcendent as art. This was a different externalization from the biological ones I had suggested, and it occurred to me that the melancholia exhibit had added an indispensable ingredient in the construction of her ritual of reconciliation with depression. It had provided her with an audience of fellow sufferers, of fellow celebrants, of fellow witnesses.

The audience with whom a story or ritual is performed is as important as the content. What the melancholia exhibit had in common with Nora's women's support groups was a gathering of her peers, a congregation of other seekers, and often examples of people who have transcended their burdens through art. All the rituals of passage mentioned by Turner have a collective aspect, a joining in the liminal communion of the faithful or the hopeful. And in Nora's case, it was especially significant that this communion was with fellow artists and writers.

*****

I began with Nora's story because her experience is so familiar. Indeed, it is the story of many in the academic and professional worlds. I now want to compare this

with the stories of some people who are more unusual, or at least whose experience society has defined as more alien: people afflicted with alcoholism and people afflicted with schizophrenia. Each of these groups has become associated with a treatment that is especially communal and ritualistic, and I believe that comparing them with Nora's experience will help us to understand what I mean by therapy as a rite of passage.

Alcoholics Anonymous is certainly one of the most famous and widespread treatments for alcoholism. It is a popular, unregulated movement dealing with a notoriously relapsing condition, so its effectiveness is very hard to measure. I am impressed with the great number of recovering alcoholics we meet in our work who attribute their sobriety to AA. I recommend Gregory Bateson's ingenious essay, ''The Cybernetics of 'Self': A Theory of Alcoholism'' (1972). Bateson was mistaken about some things, including schizophrenia, but about alcoholism he was absolutely right, in my opinion.

According to Bateson, the alcoholic's tragic error is that he believes that he can beat the bottle through willpower, that in the struggle for control over his drinking, he can win. Students of Bateson will recognize the distinctive difference he makes between symmetrical and complementary relationships (Bateson, 1958). The alcoholic is in a symmetrical struggle, believing that in the balance between winning and losing, winning is possible. The genius of AA is to turn this from a symmetrical contest into a complementary relationship—to make it not a contest but a resignation. Thus, the first of the 12 steps of AA begins, ''We admitted that we were powerless over alcohol.'' For AA to work, the alcoholic must accept that in regard to alcohol, words such as *self-control*, *willpower,* and *moderation*—and all those other words that might imply ''beating it'' or ''winning''—are illusions; that the only nondestructive relationship between the alcoholic and alcohol is complete abstinence; and that one is helpless with the addiction. But this resignation takes place within the sheltering arms of the group, the meeting, the fellowship of witnesses in AA, the witnesses who hear and affirm the opening declaration at each meeting, ''I am an alcoholic''—a necessary confession and understanding that is the beginning of recovery.

Now, notice the ritual and liminal aspects of the group experience as it proceeds. The meetings are reassuringly fortified by ritual, with an invariable format of introductions, storytelling, and reflections, so that participants need not contribute their own stories until they are ready; someone else somewhere in the room will have something to share. The 12 Steps of Recovery is a pilgrimage of stages that await each member, but there is no timetable. The accumulated wisdom of the AA—such slogans as ''one day at a time'' and the Serenity Prayer—often hang on the walls of the church basements where AA meetings are common, and they become omnipresent in the minds of the participants. The lessons are dramatized in the stories, blending horror and hope, that recovering alcoholics share with each other.

Recovery is forever ongoing; it is a never-finished process. A recovering alcoholic is always a *recovering* alcoholic, never recovered. This idea of a lifelong state of liminality, a process of development that never ends, is curiously liberating in the alcoholic's struggle, which, as Bateson noted, is so at odds with the mainstream world, in which images of triumph, of scoring a final victory, of release from the uncertain are pervasive. The alcoholic, before he enters AA, is frequently seeking victory over uncertainty, failure, and depression and is thus totally engaged in a dialogue about success, either achieving it or achieving anesthesia from its frustration. The paradox of victory through surrender is at the heart of AA. The similarity to Nora's experience

is what interests me here. She too was obsessed with a particular achievement, or rather with its frustration. I saw one goal of her therapy, like that of AA, as finding an experience of life in which that objective achievement is not the point—where instead something else, a process of development, is the point.

Victor Turner (1995) was interested in pilgrimage as an archetype of liminality. To him, a pilgrimage is a not-for-profit journey, a deliberate submission to a communal act of travel for its own sake and for the sake of the worship, submission, or discovery that is the only payoff. We still go on pilgrimages, but we call it travel. We still undertake journeys in which we suspend our daily getting and spending for the good of our souls, and a ritual for the sake of the process, not the outcome.

I want finally to describe another group of pilgrims on a lifelong journey, the patients and their families who struggle with schizophrenia. I say the journey is lifelong because the impact of schizophrenia on the order of the family's life plan is so profound. The illness strikes at just that youthful point at which the patient and parents are looking forward to a pivotal rite of passage: the launching of the patient's adult career of growing independence at high school and college, the transition to success in the world outside the family. The illness reverses or arrests whatever steps have been taken in that transition and brings the family and patient back into a state of dependence and care-taking that they all thought had been left behind in childhood. Typically, the project of independence, either from family or some other sheltering institution, does not effectively resume until decades later, when the patients themselves are beginning middle life, and the parents are contemplating the liminality of their own retirement or decline. So schizophrenia is, for both generations, a life-altering experience.

A group of family therapists over the last 25 years has devised a treatment called psychoeducation with multifamily group therapy (Anderson, Reiss, & Hogarty, 1986; McFarlane et al., 1995; Newmark, 1991). To understand how and why it works, consider the experience of the onset of schizophrenia.

First, for the patient, the experience of altered perceptions, uncanny, alien intrusions such as voices and other hallucinations, makes the person feel alone in the world, for surely, he believes, no one else could have had such experiences. Second, for the family and the patient, the available language—the words for describing what is going on, such as *crazy* or *delusional*—only increase the alienation, and so the situation seems to be impossible to talk about. No one wants to be accused of madness, and no euphemism makes the accusation acceptable. Third, the experience erases the provisional sketch that this young person and the family have begun to make of the future, not only plans for school and work but even for what will happen tomorrow or next week.

The multifamily group addresses all three of these problems immediately. It introduces these people to a community of families who have been through the experience, who have a language for talking about it, and who have come part way on the journey into the future. The staff who guide the groups provide an education for the family members (that is why it is called family psychoeducation) about subjects such as causation, outlook, medication, and management, and then, as the groups form to meet every 2 weeks, a ritualistic sequence of activities is performed.

The ritual part is called *experimental problem solving*. It is a simple device borrowed from the bag of tricks of the behavioral psychologists. It has a special effect on this particular group, in the context that I have been describing. First, the experience

is marked off from the everyday life of the families by starting each meeting with a period of chatting about that life—how the journey getting to the meeting was, news about other members of the family, and so on. Then the leaders announce the start of work by asking if anyone has anything to report on the problems that were discussed at the last meeting. These are noted in writing on the board, questions are asked, encouragement is provided, and small successes are recognized. Even if nothing has occurred in 2 weeks, that is progress, and the members of the group understand that we are on a slow journey, one step at a time. Next, the leaders ask for a new problem from a different family. This is written on the board, possible solutions are invited from anyone in the group, and these are also written down and *not* evaluated. Pros and cons are then suggested—*not* argued about, but written down—and finally an *experiment* to be tried during the subsequent weeks is agreed on by the family, and written down.

This slow, objective *written* process makes it possible to concentrate on the rational steps of problem solving, a concrete procedure that overcomes two difficulties. One, it helps patients who find learning new skills confusing, because they are distracted by the interfering noise from their symptoms. And two, for the family members, it sets a pace of progress that can be observed in spite of frequent reversals. Even though this pace is agonizingly slow, it is progress. The families are there to encourage each other, to remind each other that it is a journey, or a pilgrimage, that cannot follow a schedule. They are thus members of a distinctive group in a society in which everyone talks about their children.

*****

I told Nora that I was interested in the parallels between her experience and the book chapter about ritual, and I added that I would like to include a description of our work in my talk in Lausanne. She agreed, chose her pseudonym, read an early draft of the talk, and provided many corrections. This gave her an opportunity to edit out anything she did not want made public, and it gave us a chance to discuss a number of things further. I should say here that my work with Nora involved writing, reading, and rewriting from the very beginning. She had brought to our second meeting the typescript of her rejected memoir, and I read it with pleasure. So I not only gained an understanding of some of her experiences, but I also joined the group of readers who liked it and thought it should be published. She in turn read my book (Beels, 2001), and it helped her to understand the ideas we were talking about. She made notes on all our sessions, which she copied for me in preparation for my talk. I gave her, as I do with most of my patients, copies of the notes I make during sessions. I try to make notes that are for them, more than for me, and following in the steps of White and Epston, I often try to correspond between sessions, referring to what was said in the office. I find that this goes a long way to overcoming the change of consciousness that leads to forgetting what was said in the office. In Nora's case, we also sent each other excerpts from readings by regular mail and e-mail and, as you will see, this written conversation arrived at a place of unexpected resolution.

Some time before I was to leave to give that talk in Lausanne, Nora's story took an important turn. She arranged a kind of ritual for herself, perhaps unintentionally, or perhaps following a profound intention that she discovered in the course of performing it.

In the early summer, she told me that she had decided to accept a suggestion from Jeanne, her yoga teacher, that she attend a 5-day country retreat where she and a group of students would take special training in the practice and philosophy of yoga. She knew that Jeanne conducted this retreat every year, but she had never thought of going before, so this decision seemed to her a little impulsive. And she had not done anything like it since she was a girl going to summer camp, an experience she had very much enjoyed. But as the time for this retreat approached, she became anxious, and she was not at all sure why she was going. She made plans for escape if she found herself trapped in the country having a bad time with a group of people she didn't like. She reassured herself that at least she would be able to improve her handstand, the pose with which she had the most difficulty, and if she still did not like the experience, she could always come home.

Her anxiety, and the beginnings of depression, increased during the first days of the meeting at a beautiful mountain retreat center. There were two practice groups. One was for beginners, led by an older woman who also lectured on yogic philosophy of daily-life discipline. Nora disliked both the lectures and the idea of attending a beginner's class, so she joined Jeanne's group to work on her handstand.

And finally, there were groups for the purpose of sharing experience and for reporting and discussing dreams. Nora did not at first contribute to these sharing groups. She had many more private discussions with others about how unhappy she was feeling, how dissatisfied she was with her practice, which she felt was not improving. She started to realize that she had gone to the retreat imagining that she would magically be able to do all the poses that had eluded her.

Then one night, she had a dream in which she got a D-minus as a grade. She was so humiliated by the dream that she skipped the group the next day in which she could have talked about it. Shortly after having this dream, she was approached by a young novice instructor, who suggested to her that she might get more out of joining the beginner's group that was being led by the other teacher. Nora was taken aback by this suggestion—a novice instructor! the beginner's group!—and she went to consult with Jeanne about it.

She told Jeanne that she wanted to leave. Jeanne encouraged her to stay and also to try the beginner's class. With great trepidation and embarrassment, she joined the beginner's class, and instead of attempting the handstand, she returned to fundamentals. In particular, she realized that she would have to strengthen her shoulders, the beginning of a long and indefinite process.

It was after making this move that she began to realize that she had not only been harboring negative feelings, but she had also unwittingly been communicating them to others since she had arrived at the retreat. She had been doing what she had done to her mother, demonstrating over and over how inconsolable she was, by insisting on doing the one thing she couldn't do—the handstand, the source of the D-minus. She decided then to talk to the sharing group about her dream, and the others immediately responded that they were so glad that she had spoken; they had been aware of her silence and her unhappiness. She began to respond more to the sharing groups and became interested in the lectures on yogic philosophy and practice, which she could now see had practical application to her own life. For example, spreading negative thoughts had been a topic of the lectures from the start of the retreat, but somehow she now understood it for the first time. It was a form of violence toward both self and others, in opposition to the yogic principle of *ahimsa*, nonviolence. She also saw this as

a piece of the ''negative thinking'' defined as a problem by the exercises in Dr. Burns's book. The point, I think, is that although many of the ideas that now caught her attention had been present in her previous reading and in her own reflections, and certainly in the discussions she and I had had together, she now had a different experience brought about by what a great student of ritual, Jerome Bruner (1987), has called ''a performance of meaning.''

Nora and I had one meeting between her return from this retreat and my departure for a long vacation. After she told me this story, we had to laugh at what a good ending it would make for the talk I was going to be giving in Lausanne. She had been helping me to edit the talk since I started to write it several months before. In this way, the audience at the talk became her witnesses in this ritual process, a process that brought together experience, telling stories about it, and asking questions.

One good question, or exception, came up in the audience's response in Lausanne: Someone asked, What is the effect of the all-or-none quality of Nora's transitions? Gradual changes, such as healing, therapy, or the achievement of sobriety, are naturally subject to halts and reversals. Marriage, however, is a famously all-or-none transition (which is why it needs the before-and-after prolongations of engagement and honeymoon). Unfortunately for authors, book publication is like marriage, or at least engagement: One is either chosen or not chosen by the potential publisher or the potential spouse, and the event either happens or it doesn't.

Since then, Nora continues to struggle, sometimes more effectively, with her memoir, her depression, and her handstand. Concerning her handstand, she says that her strength is increasing and that she has achieved many postures in yoga that are coming closer to it—achievements that surprise her. Summarizing her experience, Nora said that she came to see the lifelong liminality of AA as the model for her struggle with depression. From talking to her husband, she understands that ''alcoholics always know they are vulnerable.'' This is better than her previous model of illness followed by cure, for which the alternative is the *failure* of cure, an all-or-none response like the failure of publication. I wonder, in retrospect, if she felt that she was getting a bad grade in therapy because of her inability to banish depression from her experience—a hunch that is consistent with what happened next.

We dropped the frequency of our meetings to once a month. Nora hated being still ''in therapy'' for depression because it was a constant reminder of the unresolved aspects of the problem. Then her symptoms renewed their attack with a vengeance, partly because she precipitated the final agonies of the publication failure by firing her agent and taking the decisions on herself. This seemed to both of us a sensible tactic, but it was a confrontation with a failure of a sort. At the same time that she was suffering from grief revived by the terminal illness of a close woman friend, an experience she knew would remind her of another very close friend a few years previous.

This time she did not suggest more frequent meetings but intensified our correspondence. Her first letter cited a newspaper article about the difficulty depressed people have in seeing their moods and behavior problems as villains to be defeated. To them, therapy was part of a continuing adaptation, not a decisive battle. But even this article, she wrote, failed to grapple with ''the resistance to telling or believing a different kind of story.'' A day later, she wrote that she disagreed with both William James and Dr. Burns on their pragmatic view that depression is something that can be influenced by belief. ''My default mode is depression,'' she wrote, ''no matter how hard I fight against it, it's always there lurking.''

Shortly after that, she sent in the mail a photocopy of the opening pages of Chapter 10 of *Peaceful Mind: Using Mindfulness & Cognitive Behavioral Psychology to Overcome Depression* by McQuaid and Carmona (2004). The book had been sent to her by a friend with whom she had been corresponding about these things. The chapter was entitled ''Acceptance Is Not Defeat.'' Across the cover page she wrote,

> The way I take the notion of ''acceptance'' is what I was saying a while back—I often feel I'm being urged to negate my negative feelings and thoughts—and that ends up making me feel ''crazy''—i.e. acting as if my frustrations and disappointments aren't real, or are distortions that need to be corrected. Now I'm feeling as bad as I ever do despite yoga, etc, etc., because of my writing block and panic on top of three years of rejection. It feels to me as though I need to leave room for these ''facts.''

I replied by e-mail that I was looking forward to hearing more at our next meeting about what she wanted to retain from her experience. I also said that I liked the pages from the book she had sent, among other things because it had expounded the philosophy of Marsha Linehan, someone I admired for harmonizing cognitive behavioral methods and yogic mindfulness. I went online and found that Linehan has coedited a book, *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition* (Hayes, Follete, & Linehan, 2004). Clearly I have some more reading to do in this area.

When we did meet, Nora was unaccountably (to her) feeling much better, and for the most part, we talked about how the ideas in the book had been helpful to her. I did point out that I had not set a goal of banishing or curing depression—in fact, getting it into a separate room where she could keep an eye on it while she worked was the way I had put it. And certainly, there would be times when it moved back in on her, and the question would be, what to do then? Practicing mindfulness and acceptance certainly seemed like a good place to start.

How would I myself account for this leveling off of symptoms, tentatively labeled improvement, that puzzled her? I think Nora changed our relationship into a ritual form much more congenial to her than ''therapy''—a form of writing and relating personal experience to reading and (in this case yogic) philosophy as a guide to understanding. This had been the form of her work and preparation for her published books, each of which had been about changes in her life. So instead of terminating the therapy (which we had discussed before, pro and con), she changed my role to that of one of her many correspondents and coreaders. She was pointing out where I had not been ''right,'' and was marshaling other witnesses. Certainly, what she is developing at this point is a practice that will fortify her for this next stage of her life, because she already knows *how* to do it.

A month later, we met for the last time before the long summer vacation. I had sent her the final draft of this article to review before I submitted it. She suggested several corrections and then said that reading it had made her feel better about the therapy. In particular, she realized that what I meant by ''alternatives'' was not ''exclusive alternatives'' in the sense that a different activity had to replace depression and get rid of it. It meant a different place to stand. Acceptance, for example, could lead to viewing negative thoughts with some compassion. That would be like viewing her younger self with compassion, which some readers had suggested on reading her memoir. She added that the writing she is doing now requires tolerating the uncertainty of experiment because she doesn't know how it will come out. But this

experiment is of a manageable size. ''When I was young, as I was in that memoir, I was betting my whole life on an experiment.'' As she left, we agreed to meet again in the fall and talk about how to proceed.

What is the place of expertise in arranging these ceremonies? Obviously, I did not arrange this last one—she did. If I had a part in it, it was through being available as an especially informed correspondent. I think of the work of psychotherapy as a sort of expert witness. Knowing how to do it requires embracing the contradiction between ''expert'' and ''witness.'' If you think of yourself as an expert handing out treatments for well-diagnosed conditions, you lose the all-important creative contribution of the patient.

On the other hand, being *only* a helpful witness (such as a friend or an appreciative reader) does not describe how a therapist is ''influential,'' to use White's word. As Nora said, ''I wouldn't pay a friend.'' What was I being paid for? I would say, for knowing how to change tacks between recommending, explaining, and asking questions—specifically questions that point to alternatives to the problem-saturated experience, openings in the thicket. This is the great contribution of the narrative writers about psychotherapy, who I think have described this in the cleanest form: a form that presumes the least possible expert knowledge about *who* the patient is, and what's wrong with her, and the most expertise in knowing *how* to help her invent her own process. Along the way, essential witnesses appear and need to be recognized—sometimes actively recruited to attend, even if only in the imagination.

REFERENCES

Anderson, C.M., Reiss, D.J., & Hogarty, G.E. (1986). *Schizophrenia and the family*. New York: Guilford.

Bateson, G. (1958). *Naven*. Stanford, CA: Stanford University Press.

Bateson, G. (1972). The cybernetics of ''self'': A theory of alcoholism. In G. Bateson, *Steps to an ecology of mind* (pp. 309–337). New York: Ballantine Books.

Beels, C.C. (1989). The invisible village. *New Directions for Mental Health Services*, *42*, 27–40.

Beels, C.C. (2001). *A different story: The rise of narrative in psychotherapy*. Phoenix, AZ: Zeig, Tucker & Theisen.

Bruner, J. (1987). Life as narrative. *Social Research*, *54*, 11–34.

Bruner, J. (1990). *Acts of meaning*. Cambridge, MA: Harvard University Press.

Burns, D.D. (1999). *The feeling good handbook*. New York: Penguin.

Burton, R. (1964). *The anatomy of melancholy*. London: Dent.

Clark, P.A., & Beck, A.T. (1999). *Scientific foundations of cognitive theory and therapy of depression*. New York: John Wiley and Sons.

Gazzaniga, M. (2005). *The ethical brain*. Chicago: Dana Press.

Hayes, S.C., Follette, V.M., & Linehan, M. (Eds.). (2004). *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition*. New York: Guilford Press.

Imber-Black, E., Roberts, J., & Whiting, R. (2002). *Rituals in families and family therapy*. New York: W. W. Norton.

Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York: W. W. Norton.

McFarlane, W.R., Lukens, E., Link, B., Dushay, R., Deakins, S.A., & Newmark, M., et al. (1995). Multiple-family groups and psychoeducation in the treatment of schizophrenia. *Archives of General Psychiatry*, *52*, 679–687.

McQuaid, J.R., & Carmona, P.E. (2004). *Peaceful mind: Using mindfulness and cognitive behavioral psychology to overcome depression*. Oakland, CA: New Harbinger Publications.

Newmark, M. (1991). A practical model for treating schizophrenia in the real world. *The Dulwich Centre Newsletter* [Adelaide, Australia], *4*, 28–34.

Papp, P. (1980). The Greek chorus and other techniques of paradoxical therapy. *Family Process*, *19*, 45–57.

Papp, P. (1999). Gender differences in depression: The his or her depression. *Journal of Pastoral Counseling*, *36*, 5–22.

Rosen, A. (1994). 100% MABO: Decolonizing people with mental illness and their families. *Australian and New Zealand Journal of Family Therapy*, *15*, 128–142.

Turner, V. (1969). *The ritual process*. Chicago: Aldine.

Turner, V., & Turner, E.L. (1995). *Image and pilgrimage in Christian culture*. New York: Columbia University Press.

van Gennep, A. (1960). *The rites of passage*. Chicago: University of Chicago Press.

White, M. (1995). *Re-authoring lives*. Adelaide, South Australia: Dulwich Centre Publications.

White, M., & Epston, D. (1992). *Experience, contradiction, narrative, imagination*. Adelaide, South Australia: Dulwich Centre Publications.