From Poison to Medicine

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Once I heard a story called “The Poison Tree.” It represents three ways of dealing with adversity. All three attitudes described in the story can be applied to the meaning of symptoms in the therapeutic process.

> Three travelers on a pilgrimage come upon a poison tree. The first, alarmed by the dangerousness of the plant, wants to cut it down or destroy it. The plant is seen as a lethal threat to the continuation of his journey. For him it was imperative that the tree be destroyed in order to continue in safety. The second traveler is also distresses by the poison tree, but does not see it as an impassable obstacle in his path. He argues not to destroy the tree, but to fence it off with signs to “stay away,” so that its potential danger is contained. The third traveler sees the tree and exclaims, “Perfect! Just what I was looking for.” That person picks the poisoned fruit, investigates its properties, mixes it with other ingredients and uses the poison to create a medicine.

All three attitudes are relevant to the therapeutic treatment of symptoms. Ultimately in all three cases, the encounter with the poison tree belongs to each traveler’s journey. So it is with symptoms. Whether they manifest as physical, mental-emotional or behavioral disturbances, symptoms get our attention by disrupting the status quo of our lives. Symptoms require us to stop and pay attention to something that we would not necessarily choose to include in our travels through life.

Often, people come to psychotherapy because life has thrown up a poison tree in their path. In some cases therapy begins with few clues about the nature of the “poison.” James comes to therapy because of headaches that his physician told him were “stress related.” Sally

can’t sleep enough to maintain her daily functioning. Allen, who “never used to cry,” finds himself bursting into tears “for no apparent reason.”

THE FIRST TRAVELLER

Whatever the cause, symptoms are stressful and distressing. A natural human response is to get rid of them, to see them as obstacles to be removed so that life can return to its “pre-morbid” (i.e., familiar) state. From the perspective of the first traveler, the poison tree is a threat that is unbearable. It must be eliminated in order for him to continue his journey. This kind of phenomenon happens in therapy when the experience of a symptom takes over a person’s life. The proverbial dot on the wall becomes the wall, ad our entire sense of who ad how we are in the world is consumed by the experience of the symptom.

James couldn’t get enough relief from his headaches, and they were to the point of being insufferable. He experienced them as consuming his life “I want my life back!” he exclaimed, face contorted, hands tensed and shaking the air. As I took in his anguish, I could feel my own body tighten. I noted the degree of his desperation and my own proclivity for being drawn into it. Without realizing. I was feverishly searching my mental files for anything I knew about headaches. I felt overwhelmed by the variety of treatment approaches to this symptom, including potential referrals for acupuncture, consultations with a neurologist and a pain specialist, homeopathy, biofeedback, EMDR and a variety of other psycho-physical therapies with which I had varying degrees of familiarity. A red flag went up. I knew that as soon as I was focusing on the symptom, I had lost my sense of the person, James, and his experience of this phenomenon called “headache.” I had to stop myself and re-orient to James in order to see the headaches in the context of his history, his meaning, his life rather than my own urgency to be helpful.

Sally became sufficiently sleep deprived that she thought she was “going to lose her mind.” She was so tired that her judgement, her concentration and the quality of life became untenable. As I imagined what life was like for her, again I had to struggle with my own intense desire for her to find the relief for which she screamed. Sitting with someone who franticly demands change, I have to check myself that

my empathy doesn't seduce me into identifying with the patient's suffering, thereby losing the full range of my therapeutic perspective. At this point I do not yet know what approach is indicated. I need my countertransference to help me feel enough of what the patient is experiencing so that I can reflect it accurately. Yet I want to keep my focus on the symptom as "guide" to understanding what is being asked both of me and of my patient. To do this I must keep in mind all three approaches to symptoms as I concentrate on the priority of finding what would provide relief.

Allen's identity was threatened by the advent of uncontrollable eruption of tears. He came into therapy desperately determined to "stop this ridiculous crying" because it made him feel like a "frickin baby." His face reddened as he spoke of these emotional outbursts. I was not sure whether this body was expressing rage at the symptom, or shame, or both. My own skin flashed with the heat of humiliation as I listened to his accounts of being in professional situations when "all of a sudden" he started "bawling like a baby." I could easily understand how uncomfortable this might feel. Yet again I needed guidance from Allen's unconscious – through dreams, fantasy, associations – and my own intuitive/knowledge-based reactions in order to know how to approach symptom relief.

When a symptom poses such a great threat as to consume one's life, successful treatment must somehow restore the patient's life and sense of self to a state of being bearable. This can happen by eliminating what is intolerable as in the case of traveler 1, or by changing the experience of the symptom so that it becomes bearable as in the case of traveler 2.

THE SECOND TRAVELER

In order to change the experience of a symptom, there must be some differentiation between the symptom and the rest of the person's identity. Then the threat posed by the symptom can be contained and is no longer insufferable. For each person at any given moment in our lives, certain behaviors, symptoms, etc., are manageable and others are not. For example, when a person feels supported by family and friends and is fulfilled with meaningful work, a physical symptom may be less threatening to that person's sense of well-being then if the

same symptom occurred at the time of divorce or just after being laid off work. A sense of general stability seems to be a positive factor that offsets the degree of upset of any given symptom.
Likewise, we all have different sources of well-being. They may be mental, emotional, social, spiritual, physical or any combination of these. A sense of accomplishment in one area of life, for example, can provide enough self-acceptance that we can take on the distress of a disturbing symptom without feeling as if the symptom is who we are. During the period he called “confrontation with the Unconscious,” C.G. Jung was flooded with disturbing thoughts, images, dreams and other unconscious material which rendered him unable to work. His major solace came from placing stones one on top of the other and knowing that he remembered his name and his address and the names of his family. For many of us, this meager ration of comfort would not suffice; yet for Jung they made his symptoms bearable.

The main psychological features of the attitude of the second traveler are that the poison tree (symptom) (1) is experienced as separate from the journey, (2) is no longer an intolerable threat to the journey and (3) can be contained. Herein lies the role of psychotropic drugs and any other tool that makes overwhelming symptoms bearable. For some patients, this alone is the treatment. They want enough relief from a given symptom to “get on with their life.”

James needed enough relief from his headaches to feel that the headaches were not taking over and becoming his life. He was not interested in talking about anything except what would provide immediate relief from the headaches. I referred hi for medication, then later for acupuncture and biofeedback in addition to our weekly sessions. For many weeks, he used our sessions to “unleash and unload” his anguish and anger about the headaches and to feel understood. I did little in the way of active intervention or explori9ng the etiology or phenomenology of the headaches. Once he was able to monitor and control pain levels, James felt that he “had his life under control again.” He could once again separate himself from his symptoms and “get a handle” (his words) on the symptom. In so doing he could “get on with his life,” which included frequent headaches. James began treatment to get relief from his headaches. When they became manageable, he felt his treatment was complete.

Sally needed to get enough sleep to function at a level that she could accept. She too turned to medication to “knock her out.” But the numerous medication she tried provided only minimal sleep and left her feeling “like a zombie” in the morning. This left her anxious and depressed, on top of feeling “impossibly exhausted.” At first I explored Sally’s capacity for relaxation. When it turned out that she was not able to relax for more than one minute, I wasn’t sure whether the problem was my limited skill with relaxation techniques or something in Sally that was preventing her fro relaxing. I referred Sally to a specialist with the intent that learning to relax might help her sleep, or at least provide some rest and rejuvenation.

This referral turned out to be “a waste of time” according to Sally. She couldn’t attain the desired states of relaxation and felt more like a “hopeless failure.” The therapist reported that she had been one of the most resistant patients he had worked with. He described her resistance as a “desperate need to ‘get it right,’” which resulted in an inability to focus on her sensate experience.

In addition Sally saw a homeopathic physician and began to receive weekly massage. The first night she took her homeopathic remedy she slept ten hours and awoke feeling “reborn into the land of the living.” She was ecstatically hopeful. Within a few days, however, the difficulties falling asleep and/or remaining asleep returned. This time Sally was in a panic. She reported feeling “cursed.”

After these “failed attempts at symptom relief we used our time like a “waking dream.” Since it took great effort for her to be coherent, I encouraged her to let her unconscious speak in its own language and not worry if it was logical (to her) or not. I had a sense that the extreme hypervigilance needed for Sally to be coherent when she was sleep deprived was a chronic coping strategy whose roots lay in early childhood. I felt that this hypervigilance needed for Sally to be coherent when she was sleep deprived was a chronic coping strategy whose roots lay in early childhood. I felt that this hypervigilance might somehow be connected to her difficulties with sleep. In her “semi-sleep” state, as she called it. Sally would close her eyes and immediately be in a dreamscape, which she would narrate.

In one such waking dream Sally saw a mother alley cat in a dark alley in a slum-like neighborhood. The cat was moving her litter of four kittens from one place to another. As soon as she had all four settled in one place, she would look around as if some danger was lurking and then, one by one, move the kittens to anew place. In each case there was one kitten that would not stay put, but would try to run back to the original location.

I recognized the similarity between this waking dream and Sally's childhood. Sally was the eldest of three children. She grew up with an unemployed, alcoholic father who was violent and abusive. Sally often physically and psychologically herded her siblings and her mother away from her father who stayed at home day and night. She would, for example, tell her other that they all were invited to her friend's house for tea. Then Sally would get the younger ones out of the house. Her mother often came with them but soon returned home saying that she couldn't leave "poor father" alone.

I wondered if Sally's coping strategy of always having to know her father's whereabouts in order to protect herself and her family might have something to do with both her resistance to relaxation and her difficulties with sleep. When Sally returned to her normal waking (albeit exhausted) state, I asked her if she felt any connection between this childhood survival mechanism and them other cat. She reported that while I was asking the question her skin began to crawl as if there were a million red ants all over her. She wanted to scream and run out of the room. I went over and at beside her, talking to keep some aspect of her awareness in present time-space. Her breathing became rapid and shallow. She struggled to stay connected to me and to present time and place.

After some time, the acuity of her panic subsided; her breathing slowed and deepened. We were able to begin to talk about her feelings of always having to stay awake or "with one eye open" as she called it. Although Sally had told me about her childhood, the recounts sounded cerebral and detached. This time I felt that Sally was reliving and (in so doing) reconnecting with her life-long need to "stay awake to survive." She left the session and went home and slept for 12 hours.

This was not the end of the sleep disorder, but was a pivotal point in its treatment. After this, Sally made a ritual of “putting to bed” her learned experience that she had to stay awake in order to survive. She imagined putting this experience – its feelings, thoughts and images – into a scrapbook of her childhood and closing the book. Once she had separated the chronic danger of her past from her relatively safe present, she was able to employ relaxation techniques and rest if not sleep. Her chronic exhaustion slowly subsided. Her sense of identity included an increased sense of security both in herself and in her external situation (family, job, etc.). Sally said that she “felt like a new person – an improved version” of herself.

The second traveler stands on the ground of his/her identity and, from this place of connection with the Self, can contain the disease of the symptom. Allen had to regain his sense of identity so that he perceived his “crying jags” as his behaviors, not his Self. Specifically, he had to accept that, for whatever reason and potential purpose, he bursts into tears.

Allen’s sensitivity to shame demanded that I be meticulous in approaching the subject of his “crying spells.” On one occasion he rose to leave the office mid-session when I made premature interpretation. I remember my own heart beating rapidly when he stood up. I immediately knew that I had to better acquaint myself with the depths and magnitude of his shame or I would lose him. In order to help him accept the crying he hated, resented and feared, I revisited my own inner world. I crawled back into sources of my own shame and humiliation and traced my way toward tolerating the fact that they were a part of me.

In the course of our sessions Allen came to separate the crying from other parts of himself and his life. His crying became increasingly acceptable as he identified with and focused on parts of himself and his life which bring him comfort. Allen’s comfort lay in the fact that he was able to continue functioning at his job despite the crying. For Allen, functioning during what he called “being possessed by crying spells” gave him enough sense of an acceptable Self that he could tolerate the shame of his symptom. With the attitude of the second traveler, the symptom becomes tolerable if it can be clearly

differentiated from the rest of one's identity so that it is no longer an unbearable threat.

For all of us, there are issues that we need to treat in the way of the first and second travelers. In some areas of our life we simply must get rid of the intolerable threat. This can be done externally, e.g., getting a divorce or going on medication, or internally, through psychological defense mechanisms. Defense mechanisms can both banish what is intolerable from consciousness (e.g., denial) or separate and contain it (compartmentalization). Our survival requires that we have functional ways, both internal and external, of coping with what is insufferable.

THE THIRD TRAVELER

When symptoms are manageable, i.e., they do not interrupt our lives or our identity more than we can bear, it is possible to consider the approach of the third traveler. Headaches or sleeplessness that are not unmanageably debilitating might serve as examples. Here, we have the potential of using the symptom as a vehicle for transforming our learned assumptions about the world and ourselves.

Freud and Jung demonstrated that the Unconscious has an awareness of its own which is at variance with our own habitual consciousness and can even interfere with it (Whitmont, 1993, p. 15). From their perspective, symptoms are pieces of the unconscious trying ot get into consciousness, Jung saw that symptoms, the non-personal psyche operates as if it were directed by a central guiding entity or by a transpersonal field of information. The purpose of these symptoms, which are decidedly uncomfortable, inconvenient and life disrupting (yet still bearable), is to transform inaccurate and maladaptive conscious attitudes.

The process by which poison is transformed into medicine is analogous to the way that symptoms can serve as vehicles for personal transformation. The first two steps in this process include the attitudes of the first travelers: to transform the "insufferable" into a manageable part of self and life either by eliminating the "problem" or by changing one's relationship to it.

In order to examine or explore the meaning of a symptom, we have to be able to tolerate that symptom *and* we have to develop a sense of self separate from that symptom. In our case examples, James successfully used medication to manage his headaches and regain a sense of self separate from the headaches. Sally reduced her sleeplessness and changed her relationship with it through her insights connecting her childhood survival mechanisms with her sleep disorder. This insight motivated Sally's curiosity to further investigate the meaning of her sleep disorder. Allen referenced his sense of self through the areas of his life in which he functioned well. By compartmentalizing in this way his sense of self was no longer invaded and consumed by his symptoms. Only then was he able to investigate the meaning of his crying.

An experience of oneself as somehow acceptable is a prerequisite for exploring the meaning of (poison) symptoms. When we do enter the "poison tree" zone we may reexperience the degrees of fear, pain, anger and distorted assumptions about ourselves and our world which were so unmanageable that they created our primary psycho/physical defense systems in the first place. In other words, inviting the feelings, thoughts, images, body sensations and other associations that symptoms may bring into consciousness is like entering into contact with a known poison. As in dealing with such a physical threat, one must enter protected and be very clear what is dangerous and what is safe.

Our sense of identity provides the psychological ground to stand on from which we can examine this threatening material. It is part of our protection from the threat of the "poison" of restimulated shame or fear that, without a stable identity, can cause the past to be experienced as if it were the present. James needed enough relief from his headaches to be able to *consider* identifying stress factors in his life that might be contributing to the headaches. Sally required enough sleep to ve able to feel what else was going in her inner world aside enough to sleep to be able to feel what else was going in her inner world aside from exhaustion. Allen's crying, on the other hand, instead of being suppressed had to become acceptable enough to him that he could think and speak of it without feeling such shame that he had to make a joke or change the subject.

THE ROLEOF THE THERAPIST

Another source of protection from the “poison” of the symptom is the presence of the therapist. This experience of ally is built from the positive aspects of the transference. It can provide the psychological first aid of mirroring as an antidote to contamination by the poison. As the therapist reflects back to a more accurate image, the original distortions can begin to self-correct and heal. We can begin to perceive ourselves differently. That change in perception often effects concomitant changes in thinking, feeling and/or behavior.

According to C.G. Jung, “The role of the therapist is to discover the rationally insoluble problem toward which the patient’s unconscious is steering. Once these insoluble problems are found, deeper layers of the unconscious are activated and transformation of the personality can get underway” (Burstein, 1982). From this perspective, the symptom is seen as “insoluble problem.” In this way it is the poison that “when mixed with other ingredients” steers the therapeutic work. The steering guides the therapeutic process toward becoming the medicine for the transformation of the personality.

In the case of James, there was little interest and great fear about “stirring up” anything that would bring back the headaches. In order for him to experience me as ally, he needed to feel that I shared his intention for therapy, namely, to get his headaches enough under control that he could “have his life.” While our work together included references to his childhood inability to express anger. James did not want to “go back there.” He was quite receptive, however, to learning how to relate to his present anger. When this occurred and the headaches were under control, he thanked me and said, “I know where to come if I ever want to open the Pandora’s box of my childhood.”

In contrast for Sally, the therapeutic relationship was most valuable when I “witnessed and entered with her, into the hell realms.” A positive transference made it possible to invite in,” approach, handle and mix the poison. Her symptoms did not change until we explored the poisonous pain, rage and terror she experienced as a child and carried unconsciously into adulthood.

For Allen, the experience of shame was a decisive issue in our working relationship. We could approach the poison of his symptoms only as long as he did not feel criticized or judged. His treatment course included all three approaches. First, he needed to tolerate the fact of his crying (reduce the threat). Then he needed to develop an identity that focused on other aspects of his life without denying the crying. Finally, he became interested in the crying because he realized he “felt better” after crying despite his great resistance to accepting “breaking down.”

Feelings of shame did arise during our sessions. Early on in our work, I explained to Allen that this was likely to occur and was a necessary, though uncomfortable, part of our work. I told him his experience of shame from the past was a bitter part of the poison-becoming-medicine; it needed to come into the present in order to be healed. When shame did arise, my intention was to welcome, then investigate it. We then mixed it with the experience that this shame was somebody else’s reality imposed on him as “truth.” In this way Allen could develop a sense of himself separate from the person being shamed. We devised a signal for him to let me know when he was having a “shame attack” since it was not possible for him to talk about it when shame was occurring.

Over time Allen became increasingly familiar and comfortable with the fact that his sense of shame was in fact not “his” but someone else’s reality. The feelings of shame gradually became a signal for him to investigate further his own identity separate from that which was imposed in childhood. We could not begin to explore the meaning of his crying spells until his shame about them was manageable.

WHICH MEDICINE?

It is not possible, or even desirable, to look at every poisonous symptom as a potential ingredient of a medicine. In our travels through life, some aspects of ourselves get transformed and others remain fixed “givens” of the journey. Part of the mystery of life is that only at the end do we get to see what has been transformable” and what has not. In the course of living we have only one sense of

satisfaction with our lives as a guide to inform us about a need for transformation.

In cases described herein as well as throughout my practice, I do not begin knowing which approach to symptoms is indicated. I take my cues first from the patient's stated purpose for therapy. The patient's experience of the symptoms guides the course of treatment. In the division of labor within the therapeutic dyad, I view the patient as the ultimate authority on his/her truth. Part of my job is to midwife the delivery of hat truth into conscious awareness. I can do this only to the extent that I accurately read the cues and clues provided by the patient. This includes relying on my working partner-patient to let me know how valid are my interpretations and other responses. The matter of recognizing one's own truth is a large part of my personal working style.

For example, layer upon layer of learned coping responses obscure truth from recognition. The facts if the patient's reality are often held prisoner in the unconscious. It is often a moral dilemma whether it is in the best interest of the patient to release these inaccessible contents into conscious awareness.

I recall a case of a supervisee who responded to a patient's dream by asking whether or not the patient remembered being sexually violated in childhood. The patient, a lawyer, became irate and tore out of the consulting room; the next week the therapist was sued for malpractice.

In the realms of symptoms and psychic poison, a patient may not be able to communicate truth consciously or verbally. When, for example there is resistance to exploring the meaning of symptoms, I take the "resistance" to be the communicator of truth, which is as yet unavailable to consciousness. I understand the resistance as an indication to address symptom alleviation or reduction. Resistance can mean that we are treading in territory experienced as too dangerous to approach directly at this time. Often, as in the case of Sally, when further investigation (third traveler) is appropriate, the approaches of travelers 1 and 2 will be ineffectual.

At other times, I might ask the patient whether he or she wants to focus directly on the symptom or use it as a vehicle for exploring issues of individuation. I have also recounted the poison tree story and asked the patient for reactions to these various approaches to the symptom at hand. In some cases the course of treatment does not follow the stated preference, because the interference of the unconscious dictates a change of direction.

Countertransference reactions can also be useful in assessing “which medicine” to use in a particular case. Many times I have noticed that my own felt responses to a patient accurately expressed feelings that the patient was unable to communicate directly, or feelings that were not yet in his/her awareness. For example, on several occasions I have felt enraged as a patient was describing a situation in a matter-of-fact way. I monitor my reaction in these moments by checking into my inner life to see if this anger belongs to my own values, biases or wounds.

Often I have found that I feel the rage that the patient is as yet unable to feel. Experiencing my reaction can offer permission for the patient to feel previously intolerable feelings. In other cases the patient might unconsciously elicit my hatred of him/her in order to feel the genuine love that is available only when hatred is embraced.

When working with dreams, I might ask myself, “How much of my reading of the dream came from my own need to provide symptom relief?” To answer this question I again embark on a meticulous investigation of my own biases.

The symptoms that are presented in the consulting room evoke a variety of responses both client and therapist. Each attitude can be translated into a treatment approach. Three such attitudes are (1) to get rid of the symptom, (2) to separate and contain it, and (3) to use it as a guide to explore the as-yet-unknown areas of unconscious conflict.

Each of these approaches has its place in the unfolding treatment process. In each case, however, it is the need of the client and the therapist’s ability to read that need accurately that will ultimately dictate which approach or approaches is indicated. Nonetheless,

symptoms remain part of the ultimate mystery that is a human life. As such they serve to remind us of the paradoxical and inseparable relationship between poison and medicine.

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Though patients come to psychiatrists with a multitude of problems, I shall consider their difficulties here, in a gross oversimplification, under the heading of one common problem: the sense of helplessness, the fear and inner conviction of being unable to “cope” and to change things.

--Hilde Bruch, *Learning Psychotherapy*