From Baylor College of Medicine

Perspectives on "Sacred Moments" in Psychotherapy

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In this article, we describe a clinical experience and offer comments on it from the perspectives of a psychoanalyst, a psychotherapy researcher, and a historian of religions. The clinical context is a psychodynamic psychotherapy with a patient who is describing what she has tentatively thought about intellectually as a "paranormal experience," but she is concerned that it might be further evidence to support labeling her as an odd, weird, and "severely pathologic" individual. Our purpose is to encourage clinicians to be open to our patients' descriptions of anomalous experiences and to work with patients to construct meanings of these experiences that will promote health, positive coping, and growth.

A midcareer intensive care unit cardiologist had been in treatment for over a year when the following session occurred. Her DSM-IV diagnosis had been major depression. She was distressed by a series of disappointments in her personal and professional life. A simplified version of her developmental history is that she had a long series of severe, but not technically "traumatic," developmental interferences, beginning with rather extreme and odd failures of "self-object function" by both parents. Repeatedly, she would come to them with an idea, thought, or feeling to which they would respond dismissively, accusingly, or in other ways that made her feel foolish and "inappropriate." She had attempted treatment with several psychiatrists and other professionals before referral for a more intensive psychotherapy. We were meeting twice a week at the time of the following session. She was a faculty member of a department that included a well-known chairman, "Dr. Brown." In addition to his great scientific and clinical productivity, Dr. Brown possessed a legendary ability to make faculty, residents, staff, and students feel important and feel that they were valued members of "the Team."

Patient: I feel pretty good today. I don't have much to say....You keep saying that I don't trust you, but I think I'm trying as hard as I can to do that.

Therapist: It seems like you take my observations, especially those related to the difficulty of our project, as a criticism or a statement that you should be somehow different than you are.

Patient: I kind of interpret things negatively. I am feeling kind of scattered today. I usually try to think of what I need to bring to the table, but wasn't able to come up with very much for today. [Without much of a pause] A good thing that *did* happen today was that I submitted my article on end-of-life care. It made me feel good because my division chief actually *liked* it.

Therapist: Could you give me a thumbnail sketch of your article and your part in it?

Patient: Yes. I felt I had little choice about involvement with end-of-life care. This effort has been a pretty intense project of our division for many years. My particular article gives statistics on death in ICUs, attachment issues at times of loss, how to communicate with the family, and what should be done physically with the family at times of death. There is also a section on the grief process and bereavement, including material about cultural and religious matters. It took me nearly a year to do it. My boss liked it and hardly edited anything I wrote at all.

I guess I got interested because death was sort of ignored in my family. When my grandmother died, we hardly talked about it. I didn't go to my dad's father's funeral at all. I did go to my mother's mother's funeral, but my mother and her brother didn't even cry there. They had a memorial service. It seemed cold that my uncle stored my grandmother's ashes in his garage for a year until the service. I had a lot of feelings, but I was not supposed to talk about them.

Therapist: We talk about the current implications of that a lot.

Patient: I remember a terrible incident from about 5 years ago. I'm not even sure about just what caused the death of a young adult, but I was so focused on getting the time of death exactly right that I remember telling the family, "The time of death was—" whatever. My voice was really hard. I didn't really help things by being so stressed out about the death or by how I handled it.

I was with my fiancé when his father passed. Again, I got focused on the time of death. It's almost like I lost sight of the present and what was happening. I was with him when his sister called to say that his father had a stroke and was doing poorly. I insisted we go to Denver, where he lived. By the time we arrived, we learned that he had a huge hemorrhagic stroke and was intubated. His family is very Catholic. They looked to their physician son to lead and to make decisions. I did suggest that we bring in a priest first rather than immediately extubating

his father so that at least he could have the last rites while he was alive.

Now I want to improve family circumstances in the intensive care unit, but I am not sure—[Stops talking rather abruptly]

Therapist: You said you weren't sure and then you stopped yourself.

Patient: Well, I'm not sure it's OK to express emotions or my spiritual beliefs about it. [With hesitation] It's weird, but I have these paranormal experiences. I remember something that happened to me in the eighth grade when I was about 14. I was babysitting for a girl named Caroline who was 14 or 16 months old. It was raining. I had put Caroline to bed and was watching TV and doing my homework. The phone rang and it was this man's voice saying, "I can see you and I'm going to kill you." I figured it was a prank call so I hung up, but I double-checked the locks and closed the blinds in the room where I was studying. Then I heard Caroline start screaming and I could see her pointing through the crib rails toward the wall in the room where she'd been sleeping. She kept on screaming, so I picked her up and walked her back to the room where I'd been studying, but the light was turned off and TV channel had been changed. That scared me, so I called a friend and asked her to come over. She came, but she felt weird too, so we walked to my house, which was only a few doors down, until the family I was babysitting for came home. I told them about what happened, but they sort of blew me off. You know, they never asked me to babysit again.

[Again, with a bit of hesitation] I have had other experiences that I am not comfortable talking about.

Therapist: What do you think is making you uncomfortable?

Patient: Well, they are strange and I don't know how to feel about them. Does anyone ever talk to you about things like that?

Therapist: I think you are afraid that I am going to make you feel worse, silly, or inappropriate.

Patient: Yes, and here's something weirder and I'm not sure I can talk about this. [Begins to cry] You know I felt very close to Dr. Brown. Before he died, we all knew he had cancer. Another member of our section also had metastatic cancer. He and I were talking about his relapse, but he said that, at least for him, the treatments were working. After that talk, I went right away to talk to Dr. Brown. I wanted him to know how much he meant to me. Actually, he spent most of that time comforting me! At the end, I told him I loved him and gave him a kiss on the cheek. He gave me a kiss back and said that he loved me also. As I left, I tried to help him with his chair. He laughed and said, "I'm not dead yet!"

Then on August 9 I was in Alaska with my fiancé. I didn't have e-mail access. About 2:00 p.m. that day, close to the time when Dr. Brown was dying in Houston, we were dog sledding out on a glacier with nothing but snow around us. I got off the sled and it felt like he was standing next to me. I felt him and heard something like his voice inside me saying: "Yes, I've died, but I love you. I will always love you, and you will do well." Of course I began to cry just like I am now, but I got back on the sled to finish the ride. I didn't say much of anything to my fiancé. I was concerned he would think it was too weird. Other people were teary because of the wind and snow, but that wasn't what was happening for me. We got on a helicopter and eventually returned to the cruise ship. The next day, I called my mother. She began the phone conversation by asking "if I had heard." I said, "Yes, I heard." She confirmed when he died, right before I had that experience. I still couldn't talk about it to anyone. [This event had happened months previously.]

After the ship arrived in Anchorage, my fiancé and I took a trip to Denali National Park. Mount McKinley is famous because it can be so difficult to see the top of the mountain. When we got there, the mountain of course was covered in clouds. I stood there and asked Dr. Brown to move the clouds off the mountain as a sign to me that he was all right. Of course, nothing happened immediately, but 2 hours later, the clouds cleared for 3 whole days. Everyone there said they had never seen anything like it. For me, that was very special.

Therapist: That was very special indeed.

Patient: [Crying a bit more intensely] I have never told anyone about this until now. Those moments will always be special to me.

Therapist: They should be. It's a very beautiful love story.

Patient: It's also surprising to me. Does this routinely happen?

Therapist: The sort of love that you had with Dr. Brown is hardly routine.

Patient: [Crying a bit more heavily] But do other people have experiences like this with people who have died?

Therapist: Only if they are extremely lucky.

Patient: I had lunch with my dad today. His Parkinson's is getting worse, and even a very small thing I say that could possibly be construed as a criticism makes him so labile. The conversation went well, but it took quite a bit of effort on my part.

Therapist: That effort and love is even more remarkable because you provide him empathy, attention, and love in a way that, for whatever reason, he couldn't consistently give you as a little girl.

Patient: [Getting up from the couch and smiling, though still with a lot of tears] I'll probably cry the rest of the afternoon. Thank you for letting me tell you this. I may even tell my fiancé now.

Therapist: Stories like this get richer when told in safe relationships to the right person. Clearly today has been a major step, and probably both of us are thinking about how you started the session with the protest that you didn't have much to say. [Patient chuckles] Something like this is, of course, incredibly important. Try to capture whatever this session does inside you and bring it back so we can know about it together.

Patient: [Nods] "Thank you very much." [Leaves]

A Religious Historian's Perspectives on Anomalous Experiences (Dr. Kripal)

For a historian of religions, the question "But do other people have experiences like this with people who have died?" has a very easy answer: "Yes, indeed." It is precisely these kinds of uncanny, more than coincidental, experiences around the death of a loved one that have focused rigorous research and discussion of psychical and paranormal phenomena for about 130 years. A focus on historical genealogies and definitional discussions involves four originally technical but now largely popular terms:

the paranormal, the sacred, the psychical, and the telepathic. A historical context with precise definitions allows a better understanding, acceptance, and appreciation of the sacred moment of the clinical narrative.

The Paranormal

The patient explicitly invokes the term *paranormal*. This word dates back only to around the start of the 20th century. The earliest instances of its use were in a 1901 collection of French essays (1) and a 1903 French book by Dr. Joseph Maxwell (2) on "metapsychical phenomena"—that is, highly unusual psychological experiences that extend well beyond (*meta-*) the assumed boundaries of the psyche (*psychical*). The metapsychical and the paranormal were considered to be spontaneous, largely unconscious occurrences (the individual experiencing them was seldom, if ever, in control) that somehow "exteriorize" and radicalize the physical and sensory capacities of the human being (2). The highly controversial subject of telekinesis would be an obvious example of what Maxwell had in mind. Here, after all, individuals appear to be able to move physical objects as they would do with their hands, but with only their minds or wills. Similarly, with clairvoyance or clairaudience, the "seeing" of the eyes or the "hearing" of the ears are extended to great, seemingly impossible, distances. An even more dramatic example of such paranormal activity is the unbelievable but nevertheless well-documented phenomenon of the *Pöltergeist*, literally, the "angry ghost." Baffled observers of such events have long noted that they usually occur around highly distraught pubescent adolescents who appear to be able, again unconsciously, to exteriorize their pent-up emotional-sexual states to the point that objects around them move, fall, break, and even explode. We can, of course, question the reality or possibility of such events, but one thing remains indubitably true: that these alleged "exteriorizing" or "mind-to-matter" events are precisely the sorts of things to which the "paranormal" originally referred and around which it was first coined.

By the second decade of the 20th century, the term paranormal was well established in the English language. It became increasingly popular for those especially bizarre events that combine both a physical or objective and a mental or subjective component. Floating tables, ectoplasm, materializing bodies, and apports (objects that seem to appear or are "carried over" from somewhere else) could be considered "mind over matter," but *way* over. As the term escaped its original intellectual contexts and gravitated more and more into popular usage, it also began taking on more negative, sinister, or even quasi-demonic meanings, as featured in horror films like the recent hit *Paranormal Activity* (2009).

The Sacred

From the perspective of the comparative historian of religions whose focus is different temporal and cultural contexts, none of these recent developments are terribly surprising, since "the paranormal" in modern usage comes quite close to what sociologists and historians of religions mean by their own technical expression of *the sacred*. The sacred—technically, not colloquially—is not to be confused with the good or the ethical, although it certainly may contain such components. Rather, the sacred is, to use the famous Latin sound bite of the German historian of religions, Rudolf Otto (3), the *mysterium fascinans et tremendum*—that is, a human experience of mystery (*mysterium*) that is at once utterly attractive and alluring (*fascinans*) and utterly terrifying and potentially destructive (*tremendum*). The God of the Hebrew Bible, whom no human can see face to face, saved and killed and spoke through terrible floods and lightning as well as through healings and political liberation. Jung insisted (4) that the Devil is the other, shadow side of God. Angels and demons thus represent the sacred manifesting in both positive and negative ways.

Otto and Eliade (5) were quite sophisticated about how they used the term "the sacred." They did not generally take a position on whether there was some sort of objective existence to the sacred. They were not doing theology. Otto, for example, made it very clear that he was studying a basic structure of human experience: a response to the experience or the *phenomena* of the sacred and not the *numen* of the sacred itself, which lies well outside any scientific, social-scientific, or humanistic method. Eliade, moreover, was adamant that the appearances or "hierophanies" of the sacred were always dialectical. They depend on the observer or human subject to appear at all. Eliade suggested that the sacred, whatever else it may or may not be, is a deep dimension or fundamental structure of human consciousness itself.

While this may appear merely academic, it is in fact quite relevant to the case at hand. First, such models give a very pointed answer as to why therapists and neuroscientists should pay close attention to spiritual experiences: such events likely give witness to some of the most fundamental structures of mind.

Second, it seems relevant that the patient intuitively or instinctively uses the term "paranormal" in a manner that resonates almost perfectly with what historians of religions mean by "the sacred." Hence, her early description of the "paranormal" events around the phone call and the babysitting scenario (a scene that could just as easily have happened in a horror film) occur within just a few sentences of her tear-filled, heartfelt, eminently positive descriptions of her uncanny connection to Dr. Brown's passing. The positive paranormal or the sacred continues with her story of the timing of the clouds' movement away from Mount McKinley.

Whether we ourselves choose to interpret any or all of these anomalous events as coincidence, cause, or correlation (such determinations are usually impossible to establish with any robust paranormal event), the powerful

emotional impact of the first experience and the therapeutic effects of the latter two sacred moments seem beyond doubt. And this is probably the real point and purpose of many, if not most, robust paranormal events: they are fundamentally about creating (or revealing?) meaning, narrative, and story to an individual in some difficult or even traumatic situation.

The Psychical

The key event of the case study is clearly the patient's inexplicable connection in the Alaskan snow to Dr. Brown's passing thousands of miles away in Houston. This extraordinary event happens to be one of the most common in the literature and is precisely the kind of traumatic event that resulted in our last two terms: *psychical* and *telepathic*.

The expression *psychical* goes back to the early 1870s, when Sir William Crookes, the pioneering British chemist, created a sensation by publishing the results of a series of experiments he had performed with the supermedium Daniel Douglas Home in the *Quarterly Journal of Science* (6). Crookes described what he called "a New Force" unknown to science. Since this New Force was obviously connected in some way to the human mind, "psychic" was quickly added to "force," and a new episteme was born.

Crookes's later collection of essays, *Researches into the Phenomena of Spiritualism* (6) attracted other intellectuals to the subject. In the winter of 1882, some of these intellectuals, many of them connected to Cambridge University, formed the London Society for Psychical Research. Alfred Russel Wallace, the co-creator of the evolutionary thesis with Darwin, attended the first official meeting on February 20, 1882. Wallace had already attended multiple séances and witnessed the full-blown materializations of various physical mediums (7). He saw the phenomena of Spiritualism as evidence for a separate, nonphysical line of moral or spiritual evolution (8). An American branch of the Society for Psychical Research was founded 3 years later, in 1885, with William James of Harvard University as one of its key founding figures. Indeed, the term *psychical* possesses elite intellectual roots.

Different psychological models have been developed around the term and the vast array of anomalous experiences it encoded for these researchers (9). Most famous of these models was Frederic Myers's subliminal psychology (10). Myers posited a vast unconscious or superconscious field of consciousness below the threshold (*sublimen*) of the social ego. Psychical cognitions, for Myers, took place below the same threshold. In short, they were generally unconscious. Hence the most likely setting for a telepathic or precognitive experience was sleep and the space of the dream. Freud, by the way, suspected the same and wrote no fewer than six papers on telepathy or what was called "thought-transference." He eventually counseled his followers to avoid the subject, however, lest it bring the entire psychoanalytic house down.

The Telepathic

What focused the psychical researches of the Society for Psychical Research was what was originally called the "crisis apparitions" or the "veridical hallucination." These were similar to "the sacred moment" of the present narrative. An individual would be asleep (the usual scenario) or awake (less common, but well attested) when a dream or vision of a loved one would enter the field of awareness. Perhaps it was a grandmother standing at the end of the bed waving goodbye, a brother dripping wet, or a friend appearing in the window. Days later, the person would receive the news that the grandmother had died, the brother had drowned, or the friend had passed away at that time. The first major publication of the Society for Psychical Research, Edmund Gurney's massive *Phantasms of the Living* (6), contained 702 cases of such "crisis apparitions."

It was cases like these that led Myers, a trained classicist, to coin a new word in 1882: *telepathy*, literally, "profound feeling" (*pathos*) at a "distance" (*tele-*). Telepathy was not about some vague magical power or fantasy. It was about the profound, partly conscious, largely unconscious, emotional connections that are formed between human beings who love one another and that later result in mysterious communications that violate our usual understandings of space and time. As originally conceived and employed by Myers, the telepathic was all about love and trauma, and it often served an explicitly therapeutic or healing function. It was meant to console, to provide meaning, and to assure connection.

"Sacred moments," events like the clinical encounter described here as healing but also confusing, are common and well documented in the scholarly literature. Terms like the sacred, the paranormal, the psychical, and the telepathic could be very helpful in therapeutic contexts such as this, but only if we can become more familiar and comfortable with their technical uses and historical origins. Such genealogies and definitions show us that this analyst and his patient are not alone in their experiences and attempts to understand. On the contrary, they take their place in a long line of thoughtful researchers, psychologists, and historians of religions.

Research Perspectives on the Sacred Moment as a Significant Aspect of Psychotherapy (Dr. Pargament)

Sacred moments in psychotherapy of the kind described in this case may represent an aspect of the clinical encounter that is rarely mentioned by theorists and researchers but is a vital ingredient of the psychotherapy process and relationship. Numerous evaluative studies pitting one type of therapy against another have led to the conclusion that differences between types of treatments account for only about 1% of the variance in treatment outcomes (11). This finding has been called the "dodo bird effect," drawing on the words of Lewis Carroll in

Alice's Adventures in Wonderland: "Everybody has won and all must have prizes." If the effects of treatment cannot be explained very well by differences in types of therapy, then what does account for treatment effects? The answer seems to lie in part in the relationship between the patient and therapist. Some have estimated that as much 50% of the variance in treatment effects can be attributed to the therapist-patient alliance (12). Sacred moments may be one important marker of an effective therapeutic alliance.

The term "sacred moments" may be off-putting to some, suggesting a "touchy-feely" view of psychotherapy at best and a paranormal view of clinical practice at worst. After years of efforts by clinicians to gain respect for psychotherapy among skeptical scientists and health professionals by establishing evidence-based treatments, some therapists are reluctant to turn back the clock through conversations about a spiritual dimension to the psychotherapy process. Others, though, might be willing to consider broaching spirituality in treatment if they knew how to address this seemingly elusive process. I would like to suggest that: 1) sacred moments are in fact identifiable; 2) sacred moments have tremendous power in peoples' lives; and 3) by addressing sacred moments in treatment, practitioners may enhance the therapeutic alliance and, in turn, the effectiveness of treatment.

Sacred Moments Are Identifiable

In his classic work *The Sacred and the Profane*, historian of religions Eliade (5) described sacred moments as "hierophanies," times when the sacred reveals itself to people by "erupting" into the profane world. While we cannot verify the ontological reality of these spiritual eruptions through scientific methods, it is clear that many people *perceive* sacred moments in their lives. Sacred moments include but are not limited to direct experiences with God or higher powers; they encompass any human experience of transcendence, boundlessness, and ultimacy (13)—experiences of the kind described in the vignette.

Transcendence refers to things set apart from the ordinary, the immediate, the everyday. We heard several examples of transcendent experience in the vignette, including the disturbing events the patient experienced when she was babysitting so many years ago, as well as the sign she requested and received from her mentor following his death—the highly unusual clearing of clouds off the top of Mount McKinley. *Boundlessness* has to do with perceptions that go beyond the limits of ordinary time and space. In sacred moments, we hear the language of time stopping, space expanding, and boundaries fading. This is a shift from *chronos*, time and space understood quantitatively, to *cairos*, time and space experienced qualitatively. In the description of her death-transcending encounter with her mentor, the patient conveys this sense of boundlessness. She hears him tell her, "Yes, I've died, but I love you, and I will always love you."

Ultimacy refers to perceptions of deep truth, what anthropologist Clifford Geertz described as "the really real." Because they are perceived as absolutely true, absolutely real, sacred experiences have tremendous authority and legitimacy. They are written indelibly into human memory. This patient has no trouble recalling her troubled experience as a babysitter even though it occurred decades earlier. One hopes that she will hold on to the memory of her spiritual encounter with Dr. Brown for the rest of her life in part because of the way it was told, received, and experienced in the treatment relationship.

The point here is that sacred moments are identifiable. We can articulate markers of sacred moments, such as transcendence, boundlessness, and ultimacy, and even attempt to measure them. In fact, a few researchers have already begun to do so in ways that may eventually be considered "standard practice." They have found that sacred moments of the type experienced by this patient are not at all unusual. For example, studies have shown that a majority of people who experienced the death of a loved one report a continued connection with them: hearing a voice, feeling a touch, sensing a presence, or catching a glimpse of the deceased (14). Large numbers of people also report mystical experiences and use the language of transcendence, boundlessness, and ultimacy to describe occurrences in their lives (13). The language of sacred moments could be dismissed as simply poetic or overly romanticized. There is, however, reason to believe that sacred moments have significant power for many people.

Sacred Moments Have Power in Peoples' Lives

Empirical studies suggest that perceptions of sacredness have a variety of implications. They are tied to a powerful complex of emotions that Otto (3) labeled the *mysterium*—awe, uplift, gratitude, reverence, fear, and dread. These emotions, particularly positive spiritual emotions, have been linked with significant psychological, social, and physical benefits. Schnall recently reported (15) that the feelings of elevation elicited by watching another person perform a good deed resulted in tangible increases in altruistic behaviors. Perceptions of sacredness serve as vital resources for many people, especially in difficult times, offering the capacity to soothe, comfort, inspire, and empower (16). At a deeper level, they can provide individuals with a way to find meaning in life, to connect themselves with the past and the future, and to link people together in larger communities. Several studies have shown that people derive considerable satisfaction from sacred experiences and moments (13). Finally, sacred moments can become organizing forces that lend coherence to disparate thoughts, feelings, actions, and behaviors. Sacred moments can serve as pivotal points in time that lead to fundamental, life-changing transformations. Consider again the message received by the patient from her former mentor—"I will always love you." A message of this kind is likely to have a profound and lasting impact for a woman

with a history of troubled relationships with her primary attachment figures. These findings suggest that we should be careful not to dismiss talk of the sacred and spirituality in treatment as merely flowery language. There is power in the sacred moment, and it makes good sense to address these experiences more directly in treatment.

Sacred Moments Should Be Addressed Directly in Treatment

It is paradoxical that people are often most reluctant to discuss those of their experiences that hold the greatest power. In their book on human transformation entitled, *Quantum Change*, Miller and C'de Baca (17) describe how common it is for people to keep their most profound, life-altering epiphanies to themselves. This seemed to be the case with this patient. She was uncomfortable talking about her spiritual experiences and had never shared them with anyone before. But the discomfort may reflect fears about how others, including the therapist, will respond to these experiences. Will the patient be seen as childish, weak, or just plain crazy? These fears are not ungrounded, given the history of antipathy of mental health professionals to religion and spirituality. But surveys indicate that many patients would like to be able to discuss spiritual issues in therapy if their disclosures were met with support rather than criticism (18). This is precisely the way Dr. Lomax reacted to his patient's disclosures. Commenting on the patient's experience of the spiritual sign of a parting of the clouds on Mount McKinley, he responded by saying, "That was very special indeed." When his patient went on to ask whether other people have similar experiences with people who have died, his response was even more poignant: "Only if they are extremely lucky." This kind of affirmation helped move the therapy to a more profound level. Additionally, it helped bring the sacred moments the patient had experienced outside of therapy into the therapeutic relationship itself. Sacred moments occur not only within individuals, but also between people. These moments of sacredness shared between people—what Buber called I-thou encounters—may be the most important spiritual experiences of all.

"It is paradoxical that people are often most reluctant to discuss those of their experiences that hold the greatest power."

There is a small but growing body of empirical evidence suggesting that more explicit attention to spirituality may promote the effectiveness of treatment (19, 20). In spiritually integrated treatment, where such moments are accorded interest, respect, and affirmation, they strengthen the therapeutic alliance. Perhaps it is time to treat sacred moments not as "incidental findings" but as potentially critical ingredients in the recipe for successful treatment that deserve serious attention. The challenge is for researchers and practitioners to delve more deeply into sacred moments and develop greater awareness of their place in life. In doing so, we foster our understanding of our patients and our ability to stimulate meaningful growth and change.

Conclusions (Dr. Lomax)

This patient had experienced a series of developmental interferences leading her to regard herself with varying levels of disrespect, contempt, and dread. The interferences frequently involved significant attachment figures, which compounded the injuries. She suffered from clinical depression and unfortunate life-complicating choices. Psychoanalytic psychotherapy and psychoanalysis often involve a reliving and reexperiencing of such "critical moments and periods" in the treatment relationship. At such moments, there is a potential both for healing and for significant retraumatization.

Unfortunate distractions from the therapeutic task are likely to result if the therapist's focus is impaired by his or her belief or unbelief in the reality of such an experience. This patient's experience was a real and important affirmation for her and a growth-promoting dimension of her relationship with a key mentor—a healing relationship and an important exception to disappointments with other attachment figures.

A clinical framework informed by more positive perspectives on religion and spirituality (21, 22) allows an openness to such experiences and creates the potential for an intersubjective construct that promotes a more positive self-representation, a more stable mood, and a greater facility in negotiating attachment relationships. While this was only one session in a long therapeutic relationship, both patient and therapist considered it a key building block of their therapeutic foundation. The patient's foundation of respect and interest in the treatment relationship was steadily articulated into the rest of her professional and personal world, eventually including marriage with a very suitable man who was quite in love with her, as well as a more satisfying vocational life. The therapeutic relationship helped her to see, nurture, and express her perceptions and ideas with progressively less anticipatory shame and doubt.

There is a neurobiological perspective on any human experience as well as the historical and psychological ones addressed in this article. Investigators from Penfield through Damasio have studied the limbic system mediation of awe, but that would be a quite different focus. Our hope for this case conference is that the types of interdisciplinary dialogues and discussions that led to this article will expand the therapeutic repertoire of clinicians to the benefit of patients and lead to a more positive anticipation of psychotherapeutic help by the general public.

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