

THE ABYSS OF MADNESS

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PROLOGUE

In my work as a psychotherapist exploring the far reaches of madness, I have discovered something completely unexpected: myself. Amidst the shattered hearts, the broken minds, the annihilations - it is as if the pattern of my own life and world has been somehow inscribed. Does this mean I should be diagnosed, medicated, and, perhaps, taken away? I certainly hope not. Another possibility is that the individuals we consider insane are simply human, all too human, and the pathways their lives have followed are also our own. What if the territory of the so-called psychoses is the mirror of our souls, given to us with extravagant clarity and drama? What if the task of studying and understanding madness is also an opportunity for us to discover who we actually are?

Extreme psychological disturbances often present themselves in obscure, incomprehensible forms. And yet, no matter how difficult the symptoms may be to understand, these conditions remain, in their essential being, human events arising out of human contexts. It is not just that. When we listen to the human stories told by our most disturbed patients, we inevitably also rediscover ourselves. A central aim of this book is to erase the sharp boundary that has been drawn to separate madness from sanity, returning the phenomena of severe psychological disorders to the circle of the humanly intelligible.

The viewpoint guiding this work is that of *phenomenological contextualism*, a perspective that has gradually come into being over the course of many decades of collaborative study, primarily with Robert Stolorow (Stolorow & Atwood, 1979; Atwood & Stolorow, 1984; 1993), but importantly as well with Bernard Brandchaft (Stolorow, Brandchaft, & Atwood, 1987) and Donna Orange (Orange, Atwood, & Stolorow, 1997; Stolorow, Atwood, & Orange, 2002). Born originally of studies of the subjective origins of psychoanalytic theories, this way of understanding has arisen out of our efforts over more than three decades to rethink psychoanalysis as a form of phenomenological inquiry and to illuminate the phenomenology of the psychoanalytic process itself. Our dedication to phenomenological inquiry, in turn, let us to a contextualist theoretical perspective, from which personal worlds of emotional experience are always seen as embedded in constitutive relational contexts.

This evolution has had profound consequences for our understanding of psychoanalytic theory and of the varied phenomena it seeks to address, including our conceptions of psychological structure, of the unconscious, of psychological development, of dreams, of trauma, of the phenomena of psychopathology in all of its variations and degrees of severity, and of the psychotherapeutic process. Phenomenological contextualism is a post-Cartesian viewpoint, dispensing with a view of the person as an isolated mind, a thinking thing having contents that looks out upon a world from which it is essentially estranged. Instead, the legacy of the philosophy of Descartes is replaced by a broadly based set of assumptions on which the person is seen as always inhabiting a world that provides the context for his or her experiences, a world itself understood as saturated by human meanings and purposes.

Traditional Freudian theory and its derivatives are pervaded by the Cartesian myth of the isolated mind (Stolorow & Atwood, 1992), which bifurcates the experiential world into inner and outer regions, severs both mind from body and cognition from affect, reifies and absolutizes the resulting divisions, and pictures the mind as an objective entity that takes its place among other objects. Freud's psychoanalysis greatly expanded the Cartesian mind to include a vast unconscious realm. Nevertheless, the Freudian psyche remained a Cartesian mind, a self-enclosed mental apparatus containing and working over mental contents, a thinking *thing* that, precisely because it is a thing, is decontextualized, fundamentally separated from its world. Phenomenological contextualism, by contrast, leads to a post-Cartesian psychoanalysis that investigates and illuminates emotional experience as it takes form within constitutive relational contexts. From a post-Cartesian perspective, all the phenomena that have traditionally been the focus of psychoanalytic investigation are grasped not as products of isolated intrapsychic mechanisms but as forming within systems constituted by interacting worlds of emotional experience.

The philosophical foundations of phenomenological contextualism trace back to the thinking of a number of post-Cartesian philosophers, most notably Soren Kierkegaard, Friedrich Nietzsche, Ludwig Wittgenstein, and especially Martin Heidegger (Atwood, Stolorow, & Orange, 2011; Stolorow, 2011). My purpose in this book however is not to focus on such historical origins (although they are touched upon in Chapter 9), but rather to give a more purely clinical exposition, illustrating the radical implications of this viewpoint for the practice of psychotherapy.

The book presents a series of specific clinical stories and includes detailed accounts of individuals in crisis and of the successes and failures that occurred in their treatment. This material reflects almost 50 years I have spent working as a psychotherapist, teaching, writing, and thinking about the problem of madness in all of its many aspects. The topics covered range widely, addressing the most extreme emotional situations human beings may fall into. I focus on different forms of psychosis, major depression and suicide, the impact on people of profound childhood trauma, the splintering of personality into systems of alternative selves, the psychotherapy of extreme states, the relation of madness to genius, and the importance of the philosophical premises of clinicians working with severe psychological disturbances. The final chapter approaches the philosophers whose thinking made phenomenological contextualism possible. By viewing these great thinkers as clinical cases, I have tried to point toward a future in which even their ideas are superseded. Throughout the discussions, an emphasis is always placed on discovering the inner truth of a life, and I do not think it is possible to read the accounts without being brought closer to the truths lying at the heart of one's own personal existence.

Chapter 1: Psychotherapy Is A Human Science
Much Madness is divinest Sense
To a discerning eye
Much Sense - - the starkest Madness
Emily Dickinson

When I was a student first entering college, in a burst of youthful enthusiasm, I had the thought that the psychotherapy of severe mental illness offered an opportunity to discover the secrets of the human mind and the depths of human nature. I have had the good fortune to actually devote my life to this quest, and the chapters in this book bring together some of the things that have emerged in the course of nearly 50 years working in the field.

I cannot claim that my journey has unveiled the mystery of the psyche, but I can say it has led to ideas and understandings that, to me anyway, seem interesting. The material develops in the form of a series of thought trains covering important clinical experiences and associated theoretical and philosophical reflections on the nature of the psychotherapy process.

THE CASE OF GRACE

Every psychotherapist has one early case that shapes his or her destiny as a clinician. The following account tells the story of a woman from whom I learned about psychosis, and about what is required of a therapeutic experience in order that the patient's devastation be addressed and healed. The work occurred as part of a postdoctoral fellowship in clinical psychology at Western Missouri Mental Health Center in Kansas City, Missouri, from 1969 to 1972. What made this institution of interest to me was that its director of clinical training was Austin Des Lauriers, a renowned psychotherapist and author of *The Experience of Reality in Childhood Schizophrenia* (1962). Des Lauriers was my clinical consultant in the unfolding of the experiences described.

First, a word about my initial encounter with the patient, a 28 year-old woman whom I shall call Grace: Early one morning – it was 3am - she came into the screening clinic at the hospital where I was being trained, shouting and carrying on. Her hair was disheveled, her eyes were wide with excitement, and perspiration drenched her clothes. She demanded to see someone important. I presented myself as that person and sat down to hear her story. A few hours earlier, Grace had experienced an invasion of her bedroom by dazzling flashes of golden light, and she said the flashes had also somehow penetrated into her body. I asked her what she thought this event was. She answered, in loud tones:

I had sexual intercourse with Jesus Christ! . . .

I am filled with His energy, and I am about to BUST!

For many years, the patient had carried the diagnosis: Schizophrenia, paranoid type – DSM II: 295.3. She fulfilled all the criteria: clear signs of thought disorder, inappropriate affect, hallucinations, delusions of grandeur.

Under Des Lauriers' guidance, I arranged to have daily meetings with the patient. I saw her 5 days a week. She was placed on phenothiazine therapy, and

while the drugs certainly slowed her down, they seemed to have no effect on the religious delusions she expressed. Her delusional life was quite involved, and in the early months of my work with her I made an effort to become acquainted with its full extent. I also collected a detailed history, from her and from various family members.

She was deeply entangled with God, the Catholic Church, and a special destiny she envisioned for her life on our planet. She considered herself to be the earthly incarnation of the Holy Spirit, a member of the Trinity, and saw her role as one of exercising a peace-making force upon the world as a prelude to the Second Coming of Christ and the End of the World.

From a logical point of view, this patient's delusions were inconsistent with one another in a number of respects, but if one looked at them symbolically one could discern the presence of repeating themes. She envisioned herself as a member of the Holy Trinity, incarnated to help bring about the coming of our Lord and Savior, setting the stage for her ascension into Everlasting Life in Heaven and the Resurrection and Salvation of all humanity. She believed that God the Father and God the Son had also taken on earthly form and were present in two individuals of her personal acquaintance. God the Father, she said, resided inside the Bishop of her diocese, a man for whom she had worked as a church volunteer in earlier years of her life. God the Son, Jesus Christ Himself, was present in another man who had served as her counselor during her late teen years. This person, also a devoted Catholic, had tried to help my patient with some very dark depressions that came upon her as a young woman. She had developed great love for this counselor, but their relationship ended when she was 19 and suddenly became psychotic. Although she had not seen him for almost a decade, she looked forward to a joyful reunion within the Trinity at the End of the World.

My patient seemed to entertain fantasies that she might be pregnant, often crying out in the mornings:

I feel nauseated, and I am in pain!

One day, I impulsively responded to this statement by telling her not to worry, because she was not pregnant. She reacted with gales of laughter. Although she never made overt claims to being the Mother of Christ, it was apparent that she was identifying with the Holy Virgin. She also believed she had a personal relationship with the Holy Father in Rome, often experiencing vivid hallucinatory flights through the sky to the Vatican, where she would descend from above and be gently deposited upon the lap of the Pope. The College of Cardinals, according to her further explanations, was giving consideration to canonizing her, and she eagerly awaited a proclamation from Rome that her sainthood had been declared.

Let me now turn to what I came to understand as a pivotal tragedy that occurred during her childhood. She suffered the experience of what is probably the single most injurious thing that a parent can do to a child: the suicide of her deeply beloved father. It took place when she was 10 years old, shattered her mother and really her whole family – there were also two brothers - and she had

no one to help her deal with its cruel aftermath. One afternoon, without any warning, her father had slashed his wrists and hanged himself from a tree.

An event such as this is indescribably destructive. In addition to constituting a traumatic loss, suicide retroactively invalidates the relationship the child had believed in prior to the death. Because it is a willful act, something the parent has chosen to do, a statement has been made as to the significance of the child to that parent. So the very reality of the child's world is attacked by a parent's suicide. All that was believed to be true has been suddenly rendered meaningless, faith in one's own perceptions and thinking is therefore assaulted, and the child is left with the knowledge, never before considered even as a possibility, that he or she was not worth living for. A child having undergone such an experience is in need of very significant support in finding a way to survive what has happened that will not progressively destroy his or her life. But generally the other family members are so traumatized by the death that they are completely unavailable to each other, and this greatly compounds and complicates the situation. All of these things came into play in my patient's early years.

How did Grace go from the tragedy of her father's death to membership in the Holy Trinity? How does someone move from a devastating loss to a messianic destiny to bring on the End of the World (Atwood, 1978)? As I listened to my patient's sad story, I wondered about these things. One could never ask her such questions though, because in her delusions she was not able to have any kind of ordinary conversation. Whenever the topic of these ideas came up in our meetings, she quickly became carried away with excitement and filled up with feelings of godlike power. If I was unwise enough to ask for example why she thought her counselor was the reincarnation of Jesus Christ - and in the early going I often asked very ill-considered questions - she would bound out of her chair and cry out:

I am the Truth, I am the Way, I am the Light, or

The suffering, the sorrow, the PAIN, or

It is the HUMAN side of Jesus Christ, not the DIVINE!

I learned to avoid such direct inquiries into the details of her religious life, and for short periods in our initial meetings I found it possible to engage her in fairly coherent discussions of her childhood background and of very concrete aspects of her program in the hospital.

The answer to the question as to how she went from the father's death to her delusions and hallucinations concerns the pathway she tried to find in the years following the tragedy. It was a pathway of inwardness, of secret prayer, of an attempted drawing close to God, of seeking comfort in the arms of Jesus. She made a kind of pact with her Savior: if He would accept her into a state of rescuing union with Him, she would transform herself and become a purely spiritual being. Telling no one living of her secret commitments, Grace tried to enact the planned union with God by entering a convent at age 17, with the idea of becoming a nun and a missionary and devoting the remainder of her earthly existence to works of self-sacrifice on behalf of the poor and the sick. She tried mightily, as an aspect of this striving toward oneness with her God, to purge herself of every trace of self-interest and personal need, including the whole of

her emerging sexuality. She was unable to complete the course of study at the convent, however, and after a year of struggle collapsed into a black depression. This was the time at which she began to receive counseling from a man who was a member of her church and who worked with many priests and nuns.

I am not going to go into the details of their sessions together, although she did describe them fully to me. Suffice it to say that she latched on to her counselor as her Savior, and without telling him what she was thinking began to entertain the notion that at last she had found Jesus – that a miracle had appeared in her life and her counselor was himself the Lord her God. But the spiritual attraction and joy she felt on having at last arrived in His presence was disturbed by other feelings: a confusing, dismaying sexual intensity began to color her tie to her counselor, and she was unable to suppress longings for physical, erotic contact with him. She also began to feel that he was not listening to her, and in spite of his exalted status as a quasi-deity that he did not care about her suffering. Never saying anything directly regarding these matters, one day, without warning or explanation, she arose in his office and shouted out these words:

JESUS CHRIST ABANDONED ME!

Following this announcement, Grace walked out and their meetings were discontinued. A few days later she was hospitalized for the first time, already deeply immersed in the delusional fantasies that were present when I first became acquainted with her. Her counselor made no effort to contact her and she made none to find him. There was nevertheless the fluctuating idea present in her mind that in him she had found God.

Over the course of the next 6 years, Grace went back and forth between relative stability and states of deep religious preoccupation. There were at least 10 separate hospitalizations during this period, some of them lasting months in duration. Finally, shortly after her 28th birthday, in the midst of the latest resurgence of her hallucinations and delusions, she and I found each other.

I spent a lot of time with her, visiting her almost every day for the first 6 or 7 months, sometimes for as long as two hours. I could see in the course of these meetings that she was becoming very attached to me – I always found her eagerly waiting when I arrived at the hospital each morning, and she was the last to say goodbye when I left in the evening. There was however no particular improvement that was visible as the streaming of her religious fantasies continued, sometimes becoming so intense as to preclude any meaningful conversation. Often she behaved in an imperious manner, barking out orders about what she wanted me to do for her, and promising that if I would comply she would repay my efforts by raising my consciousness and helping me become a spiritually powerful person in my own right. She once stared deeply into my eyes and cried out:

Doctor! I am going to raise you up, from here [gesturing toward her knees] to HERE [raising her hands high over her head and shouting]!

She became intolerant of any response I made to her words that did not seem to her connected with whatever she was trying to convey, many times angrily screaming out:

Stop cutting me off, you're cutting me off, STOP CUTTING ME OFF!

Such moments were extremely difficult, to say the least, especially because the ideas she was expressing were almost always matters of barely comprehensible, often incoherent religious revelations. In addition to her words, she presented a series of paintings she had completed some time before. These were chiefly concerned with religious themes, e.g., the Crucifixion, the Resurrection, the Holy Virgin, etc., but others displayed images of fire and destruction, with the words “I AM PAIN,” “I AM ANGER,” or simply “I AM,” scrawled across the canvases in large capital letters.

One day, many months into our relationship, she informed me that there was a secret project she had been working on for more than two years that was now on the threshold of completion. I asked her what this project entailed, and she answered, again shouting:

MY PLAN TO REACH MY GOLD!

At first I did not understand her words, and I asked: “Your goal?”

She then roared:

MY GOALLLLLLL D!

Seeming to condense the words “goal” and “God,” this plan involved, as I learned with great difficulty, a program of clandestine meditations and prayer she had developed that were producing healing, loving effects sweeping across the world. She was channeling, via the meditations, God’s Love, which then was being transmitted to all humanity. The purpose of this was to bring about world peace, and also to create the conditions for the Second Coming of Christ and the End of the World. In order for the Plan to be executed, she imagined it would be necessary for her to have a reunion with her old counselor, the man she had identified as Christ on Earth. Following their coming together, the two of them would then join with the Bishop and ascend into Heaven in a burst of radiant glory as the Trinity. The End of the World could then unfold, the souls of all mankind would stand in Judgment, and the Final Ascension of all into Heaven could then take place. “Reaching my gold” meant achieving union with God, the deity that had come to her many months before in the form of miraculous golden light. The patient then gave her instructions:

I want you to call Dr. S., my old counselor, and arrange for me to meet with him. YOU WILL DO THIS!

When I at first hesitated in the face of this demand, expressing doubt as to its wisdom, she furiously responded:

LISTEN UP, YOU! If you want to know me and be associated with me, you will be a part of my Plan and do as I say! NOW!

This was the crisis point in our evolving relationship: I had been given a choice between participating in her journey and following her orders, or refusing and therefore dropping out of her life. I found her to be almost irresistibly forceful in presenting this demand and was very unsure as to how to respond. I managed to put her off by promising to give her my answer the next day.

By this time, we had spent more than 120 hours together, increasingly it seemed to me, immersed in her passionate religious expressions. One day when I was playing a game of pool with another patient, she burst into the game room,

pushed us out of the way, and held the white cue ball high in the air. She cried out:

THIS IS THE HOLY GHOST!

She then shot the cue ball with great power, and showed intense satisfaction as a number of the balls flew off the pool table.

On another occasion, following a very difficult two-hour conversation with me on various religious topics, she ran into a room where other patients were playing a game of bingo. Standing before them, she announced in loud tones: *LORD I AM CURED! LORD I AM SAVED! LORD I AM JOY! DO YOU KNOW WHO HAS SAVED ME? THAT WONDERFUL MAN, DR. A. WHOOPPEEEEEEEEE!*

Some very serious thinking occurred the night following her instructions regarding the planned reunion with her old counselor. This included a short consultation with the gentleman at the hospital who had been guiding my work, Austin Des Lauriers, who believed psychotherapy was the most important of all things in the treatment of schizophrenia. He suggested standing up to her demands with a countering firmness, one that would more fully establish my presence in her world as the ground of her eventual healing and recovery. He thought that all her extravagant orders and threats were bids for a strength outside herself that she could finally rely on, and that it was up to me to help her find that strength in the connection she and I had been building now for many months. Des Lauriers told me it was time for me to rise and shine.

The next day, I saw her in the late afternoon, and this time our meeting was a very different experience, for both of us. When we sat down and she was about to launch into her Plan and its associated instructions, I stopped her by asking her to be quiet and listen to some things I had to say. When she shouted I was “cutting her off,” I answered that I was not; furthermore, now she was the one doing the cutting off, and she needed to stop and listen to me instead. Finally she was silent. I spoke the following words, trying to use a calm but very firm voice.

We have been spending time with each other for days and weeks and months, and I have listened to everything you have told me very carefully. Now I have something to say to you, and you must hear this clearly. There has been a lot of talk about a plan. I want you to know that I have a new plan now, a plan for you, and in my plan you are going to get well, and you will be able to return from the hospital and be with the people who love you. In terms of any meetings to be arranged, there are to be no meetings with anyone except for the ones between you and me, because it is in our work together that the plan I am telling you about will be fulfilled. There is only one person on this earth you need to be concerned about seeing. I am that person.

She tried at first to interrupt me as I gave this little speech, but each time she did so I stopped her and insisted again that she hear what I had to say. Then I repeated the presentation in somewhat different words. This had to occur perhaps three times. Finally she objected no more and, after a short period of silence,

began to cry. I had never seen her cry before this moment. She cried and cried, and then she cried some more. Half an hour passed, and, finally, she said:

Thank you. I am leaving now.

The next day I came into the hospital, curious, and worried, about what had transpired as a result of our encounter. My patient was not there; somehow she had persuaded the hospital staff to give her a pass to spend the day at home with her mother. I called her home to see what was occurring, and the mother, whom I had met and spoken to many times, said to me:

Doctor, what did you do? My daughter is herself again! She came home this morning and sat with me, drinking tea on the porch, and catching up on the latest news and gossip about our neighbors. What has happened? She is herself! She is the girl I used to know who disappeared a long time ago! This is a miracle!

I saw the patient soon after these developments, and was astonished to find someone completely sane, very interested in the everyday world and without a trace of the religious preoccupations that had dominated her life and thinking now for many years. She spoke of interests in leaving the hospital, getting a job, and helping her mother in taking care of the house where she lived. It was shocking to witness this change. Overnight, as an apparent effect of 30 minutes of conversation, a raging paranoid schizophrenia, a volcano of florid symptomatology, had disappeared and been replaced by a perfectly normal person. I have never been able to see the phenomena of psychosis in the same way again. It also helped me to recognize that those who say so-called schizophrenia cannot be helped by psychotherapy don't know what they are talking about. One needs to have experiences like this in order to learn what is and is not possible.

Grace did fall back a number of times, sometimes violently, again becoming swept away in the religious imagery and the expectations of union with God in Heaven. In each instance though I reiterated my little spiel, with continuing good effects on her. She was able to leave the hospital a few weeks later, and in the ensuing years did well. She needed my support for a long period, and, during the first year following our breakthrough, often responded to me as if I myself possessed some sort of miraculous power and enormous significance. I did not comment on such attributions, because I thought they reflected her dependence on our connection as her shattered personal universe was in the process of being reassembled. But she really asked for very little. It was kind of odd that once I established the omnipotent plan I had for her, I didn't have to do much of anything other than remain emotionally available. I watched her in the years afterwards come into her own as her initial extreme dependence on our frequent contacts gradually diminished. I also saw her contend with the awful legacy of her father's decision to end his life. She spoke to me and to her family members at great length regarding her sadness and furious anger with him for choosing to kill himself. She did well for the next thirty years, but died suddenly as a result of a cardiac infarction at age 58.

The ending of the story is especially sad because Grace was one of the best people I have ever known. I had contact with her, sometimes sporadic, throughout the remaining years of her life, and I can say she was a joy to her

family and friends. She loved animals and was instrumental in rescuing a great many dogs and cats. She remained a deeply religious Catholic, attending Mass almost every day. This world would be a better place if there were more such people.

Reflections on Grace's Case

In its simplest terms, the impact of this clinical experience concerned my learning to view the phenomena of so-called psychosis as relative to a certain situational context, rather than as arising solely from a pathological process occurring somehow inside the patient. My understanding was that my patient had been seeking a response from her world to help her deal with the devastation flowing primarily from her father's suicide. Although I did not tell this part of the story earlier, when she was young she had tried to find help from her mother, her brothers, her teachers, and her priest. Her family members had closed down as a consequence of their own very profound trauma, and no one outside her family understood her cries for help. The abandonment space into which her life had fallen created the setting within which she turned to the Son of God. Having been deserted by her father, her family, and, from her point of view, everyone else, she looked for what she needed outside and beyond the world, to her Father in Heaven. Again however her unfolding journey through her teen years was punctuated by repeating abandonment shocks, as all her efforts to bring God into the heart of her being did not succeed and instead were rewarded only by a deepening loneliness and despair. These were the conditions within which a spiraling into a delusional reconstruction of a shattered personal world occurred.

Then comes the part of the story in which I was involved. When I finally recognized the importance of standing up to her imperious grandiosity, and found a way to do so that would help her see she was in the presence of someone she could depend on, the destructive course of events in her life began to turn around. Having discovered what she needed in our developing connection, the delusions and hallucinations receded. Very gradually, in the crucible of her initially extreme dependence, the healing process that had been aborted years earlier in her life now had a chance to occur.

Grace's 'symptoms,' therefore, were not just outward signs of an inward illness; they were reactions to an ongoing experience of continuous abandonment and devastation at the hands of an uncomprehending world. - they were desperate cries for help. It occurred to me that perhaps all the symptoms we see in the most severe ranges of so-called mental illness are analogously embedded in contexts of felt unresponsiveness, misunderstanding, and never-ending retraumatization. Such an idea leads to a far more optimistic view of these conditions as to the possibility of some sort of recovery. Maybe, I thought, an understanding of this could inspire us to rethink the problem of psychotherapy for our most extreme cases.

"SO CALLED" SCHIZOPHRENIA: THE CASE OF ANNA

Whenever I use the word "schizophrenia," I have found myself prefacing it with the words "so-called." The experience with Grace and many analogous ones with other patients subsequently have led me to this way of speaking. This term, "schizophrenia," meaning "split-mind," was coined one hundred years ago

by the Swiss psychiatrist, Eugen Bleuler (1911), who hoped to reinterpret the field of psychopathological phenomena previously grouped under the label, “dementia praecox.” This new diagnostic label in one respect was an advance over the older language: it highlighted an experience of the splitting apart of one’s sense of personal identity, a subjective catastrophe one sees often enough in those patients to whom this diagnosis becomes applied. One of my patients offered the original translation “torn soul,” reflecting her own feeling of inner fragmentation. So the diagnostic system moved in the direction of the patients’ phenomenology, which has to be counted as progress. But the word “schizophrenia” is a weird sounding term, and unless one knows Greek, it’s roots are obscure. What happened is that it became reified, imagined as the name of an internal illness in mental patients, and then psychiatrists’ thinking became captive to their newest brainchild. Today, when we pronounce someone ‘schizophrenic,’ that unfortunate soul is regarded as a defective, deficient, and disordered being, suffering from a dreadful illness arising from within. I resist such attributions, and so I speak of “so-called” schizophrenia. In my own clinical practice, I never use the term.

I had an experience with a very disturbed young woman, Anna, which contributed to my thoughts on this matter. She was a 19 year-old who had already been hospitalized for a number of years, and my work with her eventually spanned several decades. There was a central delusion in this case concerning a vicious persecution to which she had become subject. She believed evil “death rays” were emerging from the eyes of her enemies, and these rays crossed space and impacted against her face. Then they turned into tiny spinning, drilling machines that bored through her skin and skull, finally reaching the soft neural matter deep within. The persecuting rays/machines produced at her brain’s center a hardening, almost like a calcification, and the solidified tissues stopped her from having thoughts or feelings and made her feel she was dying. The deadly action of the rays was countered however by a special program of meditations Anna had instituted, intense mental focusing that “dissolved” the inner solidifications and freed her thinking and supported her feeling of being alive. She further explained that once the last solid particles in her nervous system were dissipated, she would undergo a breathtaking transformation she described as becoming “born.” The human world was according to her divided into the born and the unborn, and she intended, with my help, to become one of the “born ones.” I was, she declared, certainly one of the born ones myself and I was the individual selected by destiny to be her greatest “birth guard.”

It required a number of weeks to become familiar with the persecutory delusion and its details; Anna was mostly mute during this period of our work, quietly pursuing her meditations and explaining nothing to anyone. Once the awful experience with which she struggled finally emerged, the difficulty continued and grew harder still. I could not understand what she was talking about with all the references to birth, rays, machines, solidifications. Responding to this lack of comprehension, she began to experience the death rays as flowing out of my eyes as well. We had a series of meetings in which she would cry out: *Please, stop them [the rays]! They are killing me! I am dying! Oh God, George, you are killing me! Going, going, going.....Gone!*

At such moments all communication ceased, as she turned away and refused to speak to me any further. At the next meeting, however, I would be given another chance.

Since I did not understand the symbolism of her delusion at first, I am sure I showed my lack of comprehension in my eyes as she desperately tried to express the ongoing crisis of her life. This situation began to attack her, and she begged me again and again to make the rays stop. I had been drawn into her delusion as often occurs with such patients; but this does not mean that the possibility of a therapeutic outcome is lost. The therapist who has become the destroyer of souls might also turn out to have the power for their resurrection.

What helped us in getting through the impasse was a dream that Anna reported, one that occurred after a visit in the home of her mother. She dreamt she was standing before a tall mirror, looking down a long, tunnel-like hallway. At the other end of the tunnel, her mother appeared, with a loaded revolver. The two of them stood there, facing each other, and slowly the mother raised the pistol and aimed it. A gunshot rang out, the mirror behind Anna shattered into a cloud of tiny, swirling fragments, and she vanished. A disembodied voice then intoned the words: "*but a shadow on the wall, but a shadow on the wall,*" as a faint silhouette of something indistinct fleetingly appeared.

The dream and the delusion resemble each other if you look at them closely. In both there is a penetrating action from without, and its result is the killing off of my patient, the murder of her soul. The specific context was a short visit she made to her home on a pass from the hospital, to spend time with her mother. Much of this day had been filled with tension as the mother followed her daughter around the house, saying such things as:

Have you taken your medications yet today? The doctors have given you the medicine to help you! You know you are a sick girl, so don't forget your pills!

This mode of response, replicating the medically oriented treatment Anna also had been receiving in the hospital setting, she experienced as invalidating and discrediting. She did not believe she was mentally ill, and when told so felt attacked. She was someone of enormous vulnerability and sensitivity, who needed a very concrete mirroring and validation in order to feel that she was even present and in existence. Being viewed and responded to on the basis of a psychiatric diagnosis – schizophrenia, in this case – made her feel shattered and erased. The delusion symbolized this killing effect in a vision of penetrating rays from others' eyes that caused the petrification of her brain and the annihilation of her subjectivity. The dream expressed the killing off of the patient's soul in the image of a gunshot and in the vanishing of her body as she underwent a transforming reduction into nothing more than a fleeting shadow.

I responded to Anna's dream by telling her what I thought it meant, in simple, concrete terms:

What an awful dream, and what an awful visit it was for you. All the commotion with your mother made you totally blown away.

She was happy with these words, and dropped the subject of the dream.

Whenever I was able to speak to her in a way that connected to what she felt, she would give a little smile, and then move on to the next thing.

When Anna told me the dream of the gunshot, and I saw the context of its symbolic violence in her experience of her mother's verbal assaults and invalidations, it helped me to understand the delusion as well. I had the thought then that she had presented the dream as a gift to help me understand her. I realized that when she looked into my eyes and encountered my confusion, she felt invaded and undermined. Seeing my uncomprehending looks, she became an incomprehensible psychiatric object and lost all sense of her own personhood. I understood now as well that she was symbolizing this felt violence in the imagery of the rays and the deadly solidifications. She needed me to acknowledge the violence she was experiencing in a direct way; otherwise it could only continue. Here is what I said:

My dear, I have something important to say to you and I want you to listen to it very closely. I know that I have been hurting you, and it has been very, very bad. I see it clearly, and I did not before. Please know that I never intended to bring you harm; it has just been that I didn't understand. Now I do. I hope and I pray that you and I will find a way to undo the damage that has occurred.

The rays from my eyes then ceased to flow. In fact the whole delusion began to recede at this moment, because now she could look at me and know I had caught on to what had been happening to her. That was all that was needed. It is truly incredible how far a little human understanding can go.

To the extent that Anna's "schizophrenia" can be said to have consisted in her delusional thinking, her so-called mental illness here disappeared as a function of a shift in the intersubjective field constituted by our relationship. As in the case of Grace, a psychosis is seen to be relative to a situational context, in this instance one of intrusive, annihilating invalidation.

Another thought about the crisis of Anna's life then arose, stimulated by my friend Michael Gara's interesting suggestion. He offered the idea that the pattern of Anna's delusion concerning the invasive rays and the neural petrifications replicated the structure of the attribution that is made when one person diagnoses another as exhibiting schizophrenia, especially when this mental illness is assumed to include an underlying neurobiological disorder. In the delusion, rays emerge from the eyes of persecutors and enter into and render the core of Anna's brain inert, lifeless, devoid of subjectivity. In the diagnostic attribution, the expressions of the patient's experiences are ascribed to a physical defect, localized as an internal condition deep within her central nervous system. Could Anna's delusion, I wondered, have originally arisen out of her experience of finding herself relentlessly viewed as a chronic schizophrenic? Was her vision of her persecution a concretizing symbol of her experience of being viewed as crazy? Her astonishingly positive response to my validation of my own destructiveness with her would seem to be consistent with such an interpretation. Was her intersubjective situation prototypical of so-called schizophrenia in our time?

I do not want to give the impression that Anna's struggles were over as a result of this little intervention. Her severe difficulties and vulnerabilities continued, for a great many years. The delusion of the rays and the

solidifications, however, vanished and never returned. She was eventually able to leave the hospital where she spent so long and live with her mother and father.

PSYCHOTHERAPY AS A HUMAN SCIENCE

I was speaking a few years ago to a colleague in clinical psychology at my university, a woman who was the chairperson of my department at the time. She told me that the field of clinical psychology had moved decisively in the direction of “evidence-based treatment,” meaning psychotherapeutic methods that have been empirically substantiated as effective. The whole world of psychoanalysis and its derivatives, according to her, had been called into question as alternative approaches – such as cognitive behavioral therapy – increasingly were proving themselves out as effective. I was unsure how to respond to these claims, because I could see my colleague would have little sympathy for my viewpoint.

It is difficult for me to see how anyone serious could take such ideas seriously. Cognitive behavioral therapy, so-called, has two major problems, each of which is very serious. One is the defining term itself: *cognitive behavioral therapy*. It is almost an oxymoron: “cognitive” means having to do with thought, while “behavioral” refers to physical activity that has been divested of subjective meaning. Fusing the two terms creates a conceptual muddle from which I can see no escape. That would be the first reason I would not take such a thing seriously.

Secondly, the practitioners of cognitive behavioral therapy proceed as if it is possible to alter patterns of thinking without attending to the complex historical origins and meanings of those patterns. They try to skip over the hard work of discovering the events and circumstances that shaped the phenomena we encounter as clinicians, and this evasion is obviously problematic. To help a person, one needs to know what has brought that person to the miserable situation in which he or she is found. Cognitive behavioral therapy, maddeningly, turns its back on such considerations.

Still another problem arises concerning ‘empirically’ substantiating the effectiveness of ‘methods’ of psychotherapy. Is such a thing possible? What do these words even mean? Can there be any conceivable study of one method against another that has the remotest chance of demonstrating anything relevant? How does one measure effectiveness? Are ‘methods of treatment’ like fertilizing agents at an agricultural research station, something we can apply and then quantify and compare the effects of the application? Perhaps someone would answer that an effective method of therapy should at least provide ‘symptom relief.’ But then the use of the term “symptom” calls a medical-diagnostic language game into being, one that wreaks havoc with our efforts to describe and conceptualize psychological disturbances. This area of discussion lacks intellectual coherence, and it is a sad commentary on contemporary clinical psychology that it is caught up within it.

The clinicians and researchers currently enjoying popularity in academic circles are latter day positivists, insisting that one’s claims as to the efficacy of psychotherapy need to be tied down to hard, external data of some kind. The day will never come when this will be possible. Psychotherapy is a human science, and as psychotherapists we learn from the narrative accounts that are given of the

journeys we undertake with our patients. Principles of interpretation and intervention inhere in such accounts, and if these principles can be successfully communicated to others working in our field, then knowledge is thereby being disseminated and confirmed. We do our clinical work, and then we tell one another stories about it. The “evidence,” if you want to call it that, for there having been something positive that has occurred, lies inside the stories that are given. Sometimes the accounts are provided by our patients themselves. Read two magnificent, classic books: *I Never Promised You a Rose Garden* (Greenberg, 1962) and *Autobiography of a Schizophrenic Girl* (Sechehaye, 1954). These works describe two journeys in psychotherapy that were incontestably effective in helping the patients find new ways to live in this world.

THE FUTURE OF PSYCHOTHERAPY

Let me open our discussion up by asking what are the great issues that are challenging the field of psychotherapy today. Perhaps one can imagine a future in which scholars and clinicians will look back on our current situation. What will they say were the most significant questions and problems of our present age?

I picture future scholars looking back upon us as having created the foundation for a new golden age of psychotherapy practice, one that fulfills the latent potential of our field. I am aware that this idea is based on what many would say is blind hope. There are different aspects to it. One emerging theme in our field has to do with a growing attention to phenomenology, and a receding of extrinsic standards against which human lives are measured. A second aspect pertains to an extension of clinical practice to the most severe ranges of psychological disturbances. And a third is about what philosophically inclined analysts sometimes refer to as the ‘subjectivity’ and ‘intersubjectivity’ of our understanding and practice (Atwood & Stolorow, 1993; Stolorow, Atwood, & Orange, 2002).

First, let’s take phenomenology. Imagine a world of psychiatry and psychology that has escaped the hegemony of the medical model, one that grounds itself in the study of human lives as they are lived and experienced. The diagnostic systems we know today are based on an assessment of so-called “symptoms,” which are defined by their status as departures from a pre-established standard of normality or mental health. Imagine a diagnostic framework that instead groups individual worlds of experience, according to the content and themes which they show.

The word “diagnosis,” etymologically understood, means a separating and a knowing. I am speaking of worlds of individual experience that can be known and studied. One sees certain resemblances, and certain differences. Placing a descriptive word to indicate the similarities does nothing more than point out their presence. So one can note, for example, that some worlds are marked by a theme of personal annihilation, manifest in repeating experiences of being erased, rendered into nonbeing. Other worlds show a background of stability and substantiality, but within them there is an objectless foreboding, a feeling of being menaced but without any clear focus as to what the threat might be. A third group of worlds, differing from the first two, might be ones in which the personal sense of authenticity has been surrendered in an enslaving pattern of compliance

in order to secure otherwise threatened ties to emotionally important others. Noting the presence of these various distinguishing themes and developing a descriptive vocabulary for them places no one in a box and does not get lost in a system of reified mental illnesses. Imagine a future in which we will have a richly developed phenomenological vocabulary, and a wide and deep base of clinical knowledge about the life-contexts in which the various kinds of experiences encountered come into being and are magnified. Imagine as well the accompanying field of psychotherapy practice, in which our ways of approaching people would be uniquely tailored to the content of the individual world of the person turning to us for help.

In years and decades to come, I see our descendants, looking back, focusing on the best that exists already. This leads to the second of the aspects of my hopeful vision: the extension of psychotherapy practice into the most extreme range of psychological disturbances, those human situations currently grouped together as the so-called psychoses.

Our future counterparts fifty and a hundred years hence, as I foresee them, herald the efforts that are being made to devise psychotherapeutic strategies for patients currently labeled ‘psychotic.’ There have always been people working in our field who have undertaken the most difficult clinical cases – one thinks of Jung (1907), Federn (1953), Sechehaye (1951), Laing (1959), Binswanger (1963), Searles (1965), Des Lauriers (1962), Winnicott (1958), Sullivan (1953) Fromm-Reichmann (1954), Semrad (1980), Karon (1994; 2008), among others. But in our current world such efforts are still the exception, and the consensus is that psychotherapeutic intervention in the psychoses – in particular in what is called schizophrenia and bipolar disorder – is an enterprise destined for failure. In the more enlightened age that is to come, if my hope turns out to be fulfilled, such views will be widely regarded as without foundation.

We will be seen as mostly having lived in a dark age, but one sprinkled with points of light. The whole way of conceptualizing psychological disturbances will shift away from the ideas of illness and disorder, and toward the specific human experiences that are involved. We will speak of crises, catastrophes, and chronic dilemmas, and not of dysfunction and disease. Those things understood as symptoms of pathology will become reinterpreted as symbols of emotional disaster and as attempted restorative reactions in the face of extreme trauma. The emphasis, in other words, will become transposed from what is lacking in relation to an imagined ideal of normality, to an immersion in what is present as a lived experience.

Recall the story of the young woman with whom this essay began, Grace. Her admission to the hospital where I met her was occasioned by a set of visions: golden light had flooded into her bedroom and penetrated into her body. She interpreted this infusion as an experience of sexual union with Jesus Christ. Within the older thinking, the reported flashes of light would be regarded as visual hallucinations, symptoms of a psychosis. Our successors, by contrast, will see such experiences as restorative efforts, connected to the tragic circumstances of this young woman’s life.

The sexuality was itself a symbol of a coming together, a fusion in which the patient became one with her heart's desire. She was looking toward Heaven in a search for the strength underlying all of creation, and as the golden light flowed into her body and soul, she began to radiate its limitless power herself. It is a commonplace in the phenomenology of grief that one identifies with the person one longs for but has lost. An illusion of that person's presence is thereby generated, in his or her features becoming incorporated into oneself. I see the moment in which the divine energy of God became infused into my patient as symbolic of such an identification. It was a process in which she became the God for whom she longed, undoing her tragic losses and repairing her shattered world. Looking at it in this way, our focus is not on the departure of her experiences from our consensual definitions of what is real; instead we orient ourselves to the inner patterns of Grace's life as she was trying to reconstruct it.

To illustrate further this changing focus, let me tell about some persistent auditory hallucinations of one of my other patients, and I will also recount a dream she reported that helped me to understand the meaning of her voices. This was a young woman in the throes of a bitter divorce from an emotionally abusive husband. There were child custody issues, bitter disputes about a financial settlement, and relentless mutual hatred and accusation. As the divorce process moved along and the cycles of attack and counterattack intensified, my patient began to hear voices calling her various insulting names:

She's a bitch from hell! She's a scumbag whore! She's a liar cunt!

A paranoid fantasy began to emerge in which conspirators were working against her and trying to destroy her sanity by broadcasting these awful messages on the radio.

Then she had a dream, which was important in understanding what the critical voices actually represented. In the dream, she stood alone in her home, and there were dozens of birds that had somehow gotten beneath the shingles on the roof, penetrating into the walls and the space above her ceiling. They were flying about and making a tremendous racket. It was immediately apparent to me what these terrifying birds symbolized: the hostility and ugly accusations in her divorce battle were finally getting to her, attacking her self-esteem and usurping the integrity of her sense of who she was. Each bird was one of her husband's disparaging attributions, and the felt pressure of his intensifying hatred was finally throwing my patient into an annihilation state. The attack, symbolized by the incursion of the birds into the very structure of her home, is dealt with in the auditory hallucinations by a kind of re-externalization of the usurping, invalidating opinions. Casting the invaders back into the outside world expresses a need to recover her own boundaries and re-establish the integrity of her own self-experience. The auditory hallucinations and the associated paranoia were thus not 'symptoms of an illness;' they were expressions of my patient's efforts to psychologically survive. This is the kind of thinking I envision as an accepted part of our field in its future development. People working with such ideas now are the points of light our counterparts to come will perceive in the vast darkness of our time.

What was my response to learning of my patient's voices? I told her what I thought they signified, that the divorce battle was getting under her skin. I also told her that there was only one voice she should really be listening to, and this all-important voice was none other than her own. I found that this helped with the hallucinations and the paranoia, which began now to recede. The power of my words was of course based on the emotional depth of my connection to the patient, whom I had worked closely with already for a number of years.

Why did the pressure of this woman's husband's hatred begin to usurp and annihilate her? The vicious attacks by the husband replicated equally vicious emotional assaults the patient experienced as a young child by her mother. She was a survivor of extreme child abuse, and the emotional violence and the invalidations of her early years were reawakened in her disintegrating marriage. When one sees such reactions there is almost always a current situation having effects that repeat and resurrect an earlier one.

"SO-CALLED" BIPOLAR DISORDER

Among the phenomena we conventionally see as 'symptoms' in severe psychological disturbances would be shifting, cycling mood states. Do these also become reinterpreted as restorative as in the case of many hallucinations and delusions?

So-called bipolar disorder is of course the crowning instance of such shifts and cycles. This quintessentially psychological phenomenon, as I would understand it, has in our time been wrongly ceded to the biological psychiatrists, the reductionists who are true believers in genetic and biochemical origins. Our friends in the future will shake their heads in dismay at the virtually complete disconnect between the medical certainties that are maintained about this matter and the poverty of supporting scientific evidence. There have been, however, points of light in the history of our field that concern the phenomenological basis of this condition.

There was a faint glow in the early observations and interpretations of Melanie Klein, who wrote about this topic (1934). The conflicts belonging to what she called the depressive position were central in her conceptualization, wherein the child suffers in an experience of his or her aggression being dangerous to the survival of the parenting figure. Unfortunately she was limited by an imprisoning theory of innate drives that obscured her phenomenological insight into what children in the midst of profound enmeshment feel about their own aggressive, self-assertive impulses. I think also of Frieda Fromm-Reichmann, who studied bipolar patients intensively (1954). She concluded that as children they were never treated as distinct persons, but instead were viewed as extensions of their caregivers. Then we have Donald Winnicott, who elaborated the idea of the manic defense (1962) – in particular he made the interesting suggestion that mania is a protection against not just depression, but against an underlying state of psychic death. Finally we come to my dear friend Bernard Brandchaft (1993; 2010), who had the luminous idea about manic-depressive patterns that they are concerned with a struggle against the experience of personal annihilation. Put most simply, the meaning of mania, according to him, is that it embodies a transitory liberation from an enslaving, annihilating tie to emotionally

important others, whereas the depression into which a manic patient collapses represents the reinstatement of that tie. There may be other pathways to bipolarity, but I have found Brandchaft's ideas abundantly illustrated among the many such patients I have observed.

I consider the psychotherapy of the so-called bipolar patient to be possibly the single most important contemporary frontier of clinical psychoanalytic research, but I cannot say that our knowledge in this area has advanced very far. I will offer a few thoughts that have come to me over the years in which I have given this problem consideration.

The Case of "Thomas"

A first idea appeared in a consultation with a colleague some years ago. My associate, a psychiatrist, sought my advice regarding what he thought was a sudden turn for the worse in a bipolar patient he had been treating for a very long time. This patient, a 45 year-old man whom I will call "Thomas," had shown a classic manic-depressive pattern, oscillating violently between the extremes of uncontrolled euphoria and suicidal depression. He had been hospitalized a number of times, there had been serious attempts to kill himself, and he had squandered all his family's money in spending sprees and hair-brained investments. My colleague had persisted with this man through a number of these crises, trying to help him basically by just being emotionally available and always maintaining their schedule of psychoanalytic sessions three times each week.

Now, however, in the aftermath of Thomas' latest bout of disruptive mood swings, something else had appeared. The man informed his analyst that he, the patient, had suddenly recognized that he was in absolute control of all his analyst's thoughts. Hearing of this reported mental omnipotence, my colleague concluded his patient was sinking into a delusional state. This was very depressing for him, because he had given of his time and energy to this man for a number of years. I asked him to say more about his patient, about what it had been like to work with him for this long period. Something interesting then appeared.

He told me that his patient's emotional life had always been strangely opaque, almost as if it did not exist. On the first occasion, near the beginning of their meetings, when asked how he was feeling, the patient had been nonplussed. He said no one had ever asked him such a question, and he did not have any idea about what his 'feelings' were. He said he did not know what the word 'feelings' even meant. He was familiar with the overwhelming rush of his manic states, and he knew about wanting to die. But he was a man who reported that there was no emotional life otherwise that could be described. He could not introspect or reflect, had no vocabulary for expressing what he experienced, and if pressed on the matter became very upset.

I wondered aloud about whether this absent inner life pertained to a developmental background that was an empathic vacuum, devoid of human understanding and offering nothing to help him develop a language articulating his emotions. This had not occurred to my colleague, who had seen his patient's opaqueness as some kind of congenital peculiarity that needed no further explanation. He confirmed however the idea that there had never been any talk

about emotions in the patient's family, because the parents had related to their son as a purely exterior being, almost as if they were some sort of strange behaviorists. They focused on his actions, and their approval of him was strictly conditional on whether or not he met their very high standards of conduct. There were indications, according to the psychiatrist, that the parents' avoidance of their child's inner life pertained to a terror of psychosis on their parts.

Then further questions arose in my mind, especially about Thomas' so-called delusion concerning having absolute control over all his analyst's thoughts. What if, I wondered, this seeming delusion expressed the arrival of a miracle in the patient's world: an experience of actually commanding the attention of another human being? What if the absence of an emotional life was the secondary effect of missing empathy, of profoundly absent emotional attunement in his family of origin? Maybe no one ever took the time to sit down and listen to him. A child who is never listened to is subject to annihilation.

What if, I continued to ask, this man grew up among people who saw him as the normal, conventional child they needed him to be instead of the one he actually was? What happened then to the person he might otherwise have become? My answer is: that person may have vanished, almost without a trace, as a life unfolded in a structure of compliance that embodied an identity borrowed from his caregivers' expectations.

Sometimes such a situation eventuates in an anorexic pattern, wherein the experience of the deprivation of emotional attention is symbolized in the repeating acts of self-starvation. The sense of agency that is given up in conforming to parental pressures and becoming the child that is wanted and approved of, in anorexia, reappears in an active refusal of the intake of nourishment. There the exercise of absolute control over what physical substances pass into the body stands in contrast to the passive compliance in which the child surrenders to being authored by the external human surround. Here again we see something conventionally regarded as a symptom of an illness that is better understood as an expression of a will to exist and survive. Obviously there is also a paradox, in that the agentic self-assertion implicit in the anorexic starvation project also often brings about biological death.

In other instances, as in the case of the patient about whom I was being consulted, a manic-depressive cycle springs into being, one in which the positions of surrender through compliance and of rebellion and protest alternate with each other. Keeping all of this in mind, the idea the patient evinced that he had absolute control over his analysts thoughts could be considered an amazing breakthrough, a first form of an experience of attunement heralding the possibility of an emotional life arising that belongs to the patient and that could result in a freedom from the deadly cycles of bipolarity.

I suggested to my colleague that he seek ways of validating, mirroring, and really celebrating the experience Thomas was now having of being in command of his thoughts. I told him that this feeling, being so utterly new, must also be a tenuous and unstable sort of thing, and that perhaps the need to hold on to this emergent sense was causing him to concretize and elaborate it in a seeming delusion. Unfortunately he was unable to follow my advice, focusing instead on

the disparity between his patient's new claims of omnipotence and the content, as he saw and defined it, of objective reality. A battle ensued between the two of them, and the opportunity to support the patient's apparent development was lost. I was told my advice made no sense, because it is not good clinical practice to encourage delusional thinking. He chose instead to interpret his patient's imagined control as a wish fulfillment, counteracting the effects of their separations between sessions of the psychotherapy. Thomas rejected this idea, and ceased to speak of controlling his therapist's mind.

I was able to follow up on this case a few years later when I had an opportunity to contact my colleague again. I asked him what had occurred in the period subsequent to the episode regarding which I had provided a consultation. He said that in the months following the remarkable claim of mental control, his patient had repeatedly accused him of trying to make him conform to some standard model of mental health, much as his parents had tried to mold him into an ideal child. A dream the patient presented at the time seemed to symbolize his struggle. In that dream he was being pursued by a gang of shadowy, frightening figures as he climbed the stairs to his psychiatrist's office. They seemed to be vampires or zombies, and they intended to kidnap and kill him. After a period of a year, Thomas abruptly terminated his sessions with his therapist.

My colleague, in interpreting the patient's seeming delusion, followed in the spirit of Freud's (1924) understanding of psychotic states as involving a turning away from a frustrating external reality in favor of a substitute imaginary world in which irresistible desires are fulfilled. Offering such an idea invalidates emergent modes of experience that, on account of being new and unstable, become cast into a language of concretizing symbols. So often the potential to move beyond the place of one's injury and imprisonment is subverted by the blinding certainties of those to whom one turns for help.

Nevertheless, I think it would be worthwhile to pursue the sort of thing this case presented. Perhaps other patients, followed intensively for long enough, could develop in a similar way, and one could discover whether an aborted developmental process could then be reinstated within the medium of the patient's experience of his or her therapist's empathy. This would require great dedication and long periods of time. One would have to be prepared to live through the crises, do what one could to avert the patient's complete self-destruction, and then hope that the needed underlying connection of empathy and validation could crystallize. People in our field today want quick results, so they turn to electroconvulsive therapy, lithium carbonate, and the like. In the golden age of psychotherapy that is to come, it will be understood that genuine healing is not likely to come quickly.

The Case of "Mary"

Some related thoughts arise out of more recent efforts I have made to help a young woman, whom I will call "Mary," who carried this diagnosis. She had experienced, in her late teens and early twenties, a number of manic episodes, requiring hospitalizations and eventuating in a high number of electroconvulsive treatments. She came to me when she and her family began to see that the ECT was having a devastating impact on her memory and cognitive functioning.

I was interested in Mary's description of the experience of her most recent mania. She explained that the chaos of her adult life had never bothered her much, because she had relied instead on the treasures of her own mind, on the fascinating intricacies of her rich imagination. She had been able always to escape her oppressive life situations – for example, of being a college student unable to complete her studies, or of being a young woman who was fast becoming a terrible disappointment to her parents – by turning to fantasy, to thrilling, exhilarating images of herself and her life in a world apart from this one. The problem was that when she gave herself over to this alternative reality, she also lost all control of her own thoughts and feelings. Glorious plans and dreams of unparalleled grandeur would materialize, and when she then was driven to enact these, disaster would occur, with hospitalization following along soon thereafter. As we spoke, I learned that she had, in her younger years, tried mightily to please her parents and other authorities, striving always for perfection and success. She had in fact become a slave to the goal of being a perfect golden child.

As she suffered under this imprisonment in her late teens, however, in the context of a series of disorienting changes and losses in her personal situation, a wonderful universe of freedom suddenly opened up before her mind, one she plunged into with joyful enthusiasm. This was a realm of liberation she had never known, and its intoxicating power became irresistible.

But then her newly crystallized plans and dreams led to catastrophe, and she was subjected to hospitalization, antipsychotic medications, and electroshock therapy. The child who had existed earlier and who had sought to please her family reappeared. Back and forth she went over the next several years, between uncontrolled manic highs and conformist depressive lows, and her electroconvulsive treatments and her lithium ultimately could not stop these oscillations, or they did so only at the expense of the functioning of her own mind. Then she and her family found their way to me.

I asked Mary what she wanted. She answered that she wanted to live for herself. That became the theme of our connection. She complained of there being “voices,” haunting, whispering presences that criticized and devalued her in every situation she encountered. I told her, as is my habit in such cases, that there was only one voice she should pay attention to: that would of course be just her own. She sat with that declaration for a moment or two, and then said to me: *You are a practitioner of ‘I-therapy,’ aren’t you? You seem like you are all for ‘I.’*

I answered that indeed I was one who believed in ‘I,’ and regarded ‘I’ as sacred and therefore to be protected and honored in every way possible. The young woman seemed at this point to relax in my presence, and told me much more about the voices she heard and the siren-call of the images that embodied freedom and glory.

A shared understanding seemed to appear in our long discussions of her adventures over the previous years of her life, one in which her extreme mood swings were viewed as alternations between trying to be perfect and pleasing to others on the one hand and seeking profound emancipation from such efforts on

the other. The lure of the manic states was very strong, always promising to deliver wonderful gifts, but leading in every instance to disaster. The depressions following her highs were very severe, filled with the critical voices, and often provoking a suicidal despair. She and I said to each other that the key to her recovery would be found in the achievement of a new balance between these polarized alternatives, an equilibrium which would not be one of perfection and which would also not require or involve infinite freedom. She said, and I agreed, that only she could establish and maintain this balance. She also suggested a metaphorical image for my role as her psychotherapist in this endeavor in search of a new personal center: I was to be her lighthouse, a point of reference in the night and in whatever storms might arise, one to which she could look in advancing her journey toward stability.

I have only known Mary for a few years. She has had her ups and downs in this period but we have succeeded in avoiding any further ECT. In the meantime she continues to experience her therapy as a lighthouse, one that helps keep her 'I' on its pathway, and we are hopeful that over time the stable life she seeks will become hers. I am thinking we will need at least a decade in this process, so we shall see.

Mary has increasingly assimilated my presence in her life as an ally and resource for the support of her sense of 'I-ness,' and I think this would be an indispensable precondition for the successful treatment of the so-called bipolar patient. Without a connection that is felt to be sustaining and supporting in this way, the psychotherapist can only be seen as an agent of society, one of the forces pushing the patient in the direction of normality and compliance. That is a recipe for psychological death in the lives of such people, who will then be condemned to the manic-depressive cycles without end.

Something has happened in the lives of bipolar patients to sever the connection between accommodative and individualizing trends in their personalities. In mania we see a roman candle shooting out the fires of pure freedom and uniqueness. In the depressions which ensue, one witnesses the extinction of the flames of liberty, as the darkness and despair of surrender to the agendas of family and society rush in. Something needs to occur to mend the rift that has opened up in the core selfhood of the patient, something that will bridge the two stark alternatives and establish a stability free of the bipolar swings. This something is the work of the therapy, and it can only occur as a result of the patients' own volitions. The effort of this work, in turn, can only be sustained in the facilitating presence of an other who can be a lighthouse for the journey. This would be an example of the principle that the 'I' can only come into being in relation to an answering and orienting 'Thou' (Buber, 1923).

The pathway of the journey will often involve creative works in some way. The act of creation, in all areas of art and literature and philosophy, offers abundant opportunities for integrating conflicting currents in our natures, for bridging rifts that have opened up in the warfares of bipolarity. My patient Mary, for example, made great strides in pulling herself together in a developing career in modern dance. Others I have known or studied found in poetry their pathways toward unification, or in musical composition, or in the elaboration of interesting,

integrative philosophical doctrines. This is an area in which there need to be continuing studies of all the ways people find to heal their fractured souls (Atwood, Stolorow, & Orange, 2011). Extensive knowledge of such matters, in turn, will prepare clinicians for their sacred roles as lighthouses in the stormy travels of the patients who turn to them for help. We are still at the beginning of the long process of developing this knowledge.

THE PLACE OF THE THERAPIST

This third aspect of what I hope I am seeing in the contemporary development of our field has to do with the radical engagement of the person of the therapist in whatever process of psychotherapy occurs. What does the term “radical engagement” mean in this context? It means that the therapist, as an individual, is implicated in everything that takes place within the psychotherapeutic dyad. It means that there is no such thing as detached observation. It means that the transformations that occur, if any do, include both participants.

My use of the term “implicated” might seem to indicate a crime of some sort has occurred. The things that happen in what is called psychotherapy or psychoanalysis often enough are crimes, emotional crimes committed against those we are entrusted to help. But that is not the connotation I want to highlight. It is more the idea that the imprint of the therapist’s subjectivity, of his or her personality, is everywhere present in the psychotherapeutic process. Psychotherapy, far from being any sort of procedure that is administered from a place of detachment, is always a dialogue between two personal universes, one that transforms both.

On more than one occasion at psychoanalytic conferences, I have been asked how it is then that we are to distinguish which of the people involved in an analysis is the patient. I become impatient with such questions, and once suggested that one can see which is which by determining which one is crying. Of course that doesn’t work when the patient does something so upsetting that the therapist breaks into tears. A psychotherapeutic dialogue, if it is in any measure successful, always illuminates and transforms the worlds of both of the people involved, and as far as I am concerned, this is actually self-evident.

Consider again my early clinical experience with Grace, my religious patient who visualized herself as part of the Holy Trinity. Her journey of healing utterly transformed my understanding of the whole realm of severe psychological disturbances and of the potential of psychotherapy to address them. Recall her promise that she would raise me up from someone small and weak into a position of strength and power. She certainly succeeded in doing that. I could also speak of the effect of witnessing her struggle with her father’s suicide as her mourning process unfolded. I could not follow these developments without a corresponding opening up of my own early experiences of trauma and loss. To see someone coming to the truth of his or her life is, inevitably, to be brought closer to the truth of one’s own. In the golden age of psychotherapy practice that is to come, this idea will be axiomatic. All the phenomena of psychotherapy will be understood as taking place within an intersubjective field, one that creates a constitutive context for the experiences and actions of both analyst and patient.

CHAPTER TWO: EXPLORING THE ABYSS OF MADNESS

Things fall apart; the centre cannot hold

William Butler Yeats

The girl with four imaginary children in her bedroom

I saw a 19 year-old woman a great many years ago, hospitalized, who refused to speak except to say that there were four children living in her bedroom. According to her parents, she had been entirely normal, reportedly perfectly delightful in fact, until just a few weeks before, but now she was in prolonged silence. The psychiatrist assigned to her gave her a diagnosis of schizophrenia, and she was begun on a course of antipsychotic medications. Her behavior remained the same: long stretches of silence, very occasionally interrupted by short statements that four children were in her room. She would not describe the children, explain their origin, or otherwise engage in any further communication on the matter. When asked if she believed the children were real, actual human beings, a look passed across her face of confusion and dismay. The doctor, after a period of weeks, recommended shock therapy, and a course of 12 electroconvulsive treatments then took place. Following these, she spoke just once to say there were now no children in her bedroom; otherwise the reign of silence continued. Finally she was discharged and her family took her home. We never saw her again. But I was haunted by what had occurred and always wondered about what happened to the young woman and what her behavior could have meant. In the following, I offer some hypotheses about this patient, and her story becomes a point of departure for a journey into the nature of madness.

Looking back on this experience from the vantage point of all that I have seen since, there are five items that stand out: first, that she was, according to her parents, a “perfectly delightful” child prior to the transformation in her behavior; second, that the primary change was one of lapsing into silence; third, the sporadic statements regarding there being four children sharing her bedroom; fourth, her apparent confusion in response to being asked about whether she believed the children were real; and fifth, following ECT, her report that the children were no longer present in her bedroom.

Let us suppose that the perfectly delightful girl her parents knew her to be was the product of a surrender, rooted in very early experiences of great power, a deep-ranging accommodation in which she brought herself into compliance with agendas as to who she was and should be, transmitted to her by her mother and father. The identity that developed would then be one taken over from preexisting images they supplied, rather than from her emergent agency and spontaneous intentionality. The sudden disappearance of that delightful girl would thus be comprehensible as an act of rejecting the false self, of fighting back against the enslaving tie to the maternal and/or paternal agenda, and therefore an effort to rescue possibilities of her own being from annihilation. I would interpret the silence as a negation of her compliance, wherein the whole field of speech has been co-opted by the conforming trends of her personality and the only way to oppose them is to stop talking. She stops speaking, however, but not quite completely. The one little statement that remains is about the four children living in her bedroom. Let us assume that this bedroom is *a room of her own*, a space

within which whatever exists or remains of her authentic possibilities can live and survive. Why are there four? Air, earth, fire, and water come to mind – the fundamental elements of the universe. I have read in the Jungian literature that the quaternity is a symbol of wholeness. Here though one sees not wholeness but fragmentation, a collection of children rather than one coherent personality. Authenticity in the context of extreme pathological accommodation (Brandchaft, 2010) is at best a fragmentary, evanescent sort of thing, scarcely organized at all, lacking in the capacity to endure or coalesce. And yet this is what remains of the young woman's soul: four children, living in a room of her (their) own.

From a perspective valuing such authenticity, this young woman's breakdown into silence and delusion might better be considered an attempted *breakthrough*: to a life that, perhaps for the very first time, would actually belong to her. But such a possibility could not become actual without someone there to recognize and give it such a meaning, without a Thou to perceive the I trying to assemble itself out of its fragmentary possibilities.

Then we come to the so-called treatment of this young woman: medications, followed by electricity. The effect of these interventions was finally reflected in her statement that there were no children in the bedroom. This outcome might well be a tragedy, a sign of great and perhaps enduring damage having been done to this young person's chance to somehow pull herself together and have a life that could belong to her.

The apparent bewilderment she seemed to express when asked a question about whether she regarded the children as real also has importance. Of course the reason such a question would be asked pertains to the issue of her *reality testing*, the question as to whether she was in contact with all that her doctors consider true and real. From her point of view, the question would have to be enormously confusing, for it was her need above all that the children be real. If I am right in my speculations, the reason she concretized the fragmentary state of her soul into the image of actually living children is precisely that she could not at her center sustain any sense that she was an actually existing, alive, real person. But she was perfectly smart, and could see that her psychiatrist would react to any idea that the children were real as a sign of her serious mental illness, perhaps necessitating further drastic medical interventions. So: to say that the children were not real would be to embrace annihilation; but to claim that they were real would be to accept a pathologizing diagnosis and damaging medical intrusions. She was confused for the simple reason that there is no viable journey possible between this Scylla and this Charybdis.

This is a very sad story, and I hope that she arrived in some better situation once her parents took her away from the institution. I would like to think they found a setting for her in which she could perhaps follow an artistic pathway. The journey of creativity is very often one that supports a person's sense of being real. It even occurs to me that one could look at her descent into silence and what her psychiatrist saw as delusion as a piece of performance art, affirming her being in a rebellion against her family context and expressing to the world an indomitable life spirit within her. It would be extremely interesting to follow what might have happened had her analyst/psychiatrist taken such an attitude toward her so-

called symptoms. I suspect she would have found him to be someone she could talk to.

Was this young woman suffering from madness? I would say yes she was, in that madness is the abyss. Phenomenologically, going mad is a matter of the fragmentation of the soul, of a fall into nonbeing, of becoming subject to a sense of erasure and annihilation. The fall into the abyss of madness, when it occurs, is felt as something infinite and eternal. One falls away, limitlessly, from being itself, into utter nonbeing.

My students often ask me what is my opinion of psychiatry's understanding of madness, of contemporary diagnostic systems with their differentiations and classifications, with a view of the various forms of madness as disorders and diseases. I answer as follows: the ever-proliferating systems of nomenclature in psychiatry are among the field's most serious embarrassments, and nowhere as disturbingly as in the efforts that have been made in the study of madness. The notion of an orderly system that arranges and distinguishes this form and that form of infinite falling, nice little categories of a chaos that is beyond imagining and describing, is preposterous. It is human to try to bring order into disorder, but it is also human to be preposterous. The diagnostic systems that have been and continue to be generated lack all scientific foundation and are actually laughable. I am ashamed to belong to a field capable of such things.

Madness is not an illness and it is not a disorder. Madness is the abyss. It is the experience of utter annihilation. Calling it a disease and distinguishing its forms, arranging its manifestations in carefully assembled lists and charts, creating scientific-sounding pseudo-explanations for it – all of these are intellectually indefensible, and I think they occur because of the terror. What is the terror I am speaking of? It is the terror of madness itself, which is the anxiety that one may fall into nonbeing.

The abyss lies on or just beyond the horizon of every person's world, and there is nothing more frightening. Even death does not hold a terror for us comparable to the one associated with the abyss. Our minds can generate meanings and images of our deaths: we can picture the world surviving us, and we can identify with those that come later or otherwise immortalize ourselves through our works. We can rage against the dying of the light, and we can look forward to reunions with lost loved ones. We can think about the meaninglessness of human existence and its finiteness. We can be relieved that all our sorrows will soon be over. We can even admire ourselves for being the only creatures in existence, as far as we know, who perceive their own wretched destiny to be extinguished. The abyss of madness offers no such possibilities: it is the end of all possible responses and meanings, the erasure of a world in which there is anything coherent to respond to, the melting away of anyone to engage in a response. It is much more scary than death, and this is proven by the fact that people in annihilation fear – the terror of madness – so often commit suicide rather than continue with it. Death is a piece of cake compared to the abyss.

I think the reason so many in our society want to think of madness as a disease, perhaps localized in the brain and arising from organic predispositions, is that such ideas soothe the terror of the abyss. One must find some explanation

for the extreme claims people in the highest offices of psychiatry make in this connection, because the science to support those claims is not strong, nor will it ever be. The abyss is a potential inhering in every human life, and the dream of contemporary psychiatry is to pin down a tangible source or cause for this potential. Once this is successful, so goes the thinking, some intervention will become possible to eliminate it. It is a dream never to be fulfilled. We are stuck with the abyss as an irreducible possibility of our lives, and we would be better off to understand that. Psychiatry here reminds me of the person who has actually fallen into the abyss and then gone on to develop the idea that there is an influencing machine (Tausk, 1917) sending persecutory rays into his or her body and mind. You see, if there is such a machine somewhere, operated by one's enemies, a hope is held out that this machine can be found, turned off and finally destroyed, and one's malicious adversaries can then be brought to justice and disposed of. The biological sources of the so-called psychoses are miniature influencing machines, located in the molecular structures of who we are, and once these tiny machines are detected, we can turn them off, modify them, maybe breed them out of the human race. We as doctors can also reassure ourselves that our own organic constitutions do not include the predispositions, the little molecular machines twisted into our DNA, and we are therefore protected from the abyss. This is all illusion. The abyss is with all of us as a human possibility, forevermore, and so we will never be safe from it.

Am I saying that everyone, all of us, are forever on the threshold of madness? No. I am saying that the abyss is a universal possibility, which is not the same thing as claiming we all are always on its threshold. Most of us spend our lives in a stability and sanity that does not bring us, subjectively speaking, to the doorway to madness. Our sense of our own existence and security is steady, in fact is such a given of our lives that we never really think about it. That does not mean, however, that the sanity we enjoy in our cozy little worlds cannot be taken from us. It can, because we all are capable of falling into the abyss. Something might happen and then the center cannot hold.

Sometimes what happens in the fall into the abyss is that the sustaining events of our lives cease to occur. People often fall not because the bad happens, but rather because the good stops happening. Sanity is sustained by the network of validating, affirming connections that exist in a person's life, connections to other beings. If those links fail, one falls. The beings on whom one relies include, obviously, other people, sometimes animals, often beings known only through memory and creative imagination. In some instances it is the connection to God that protects a person against madness. Strip any person of his or her sustaining links to others, and that person falls. No one is immune, because madness is a possibility of every human life.

It might be asked, if a link to God shields some people from the abyss, why is it that the symptoms of madness so often circle around special relationships to God, delusions sometimes even of being God? One of the problems with such a question is that it speaks of *symptoms*, returning us to a medical and diagnostic viewpoint that cannot be helpful in our task of discovering the human meanings in what is expressed to us. Generally people claiming to be God or to have a unique

connection to the Almighty are resurrecting a sustaining tie that has been shattered. This was illustrated dramatically in the case of Grace, presented in chapter 1. The so-called delusion recreates a lost connection to someone lifegiving, and thus becomes comprehensible as an attempt to climb back out of the abyss. The signs and symptoms that psychiatry likes to arrange in its orderly diagnostic systems are pretty much efforts to return to sanity from madness.

For example, I once worked with a 7 year-old girl who heard God's voice speaking to her. She was so occupied with her conversations with the Creator that she was neglecting her schoolwork and ceasing to relate to her family members. I found out what had happened. She had been enmeshed to an extreme degree with her mother in her early years, adopting a role of comforting and soothing which helped the mother keep her emotional balance in a marriage that was full of strife. But then the mother became pregnant and had a hospitalization lasting months because of extreme complications of the pregnancy and a very difficult birth. The child was left with her father, to whom she turned then to replace the missing closeness with her beloved mother. Everything went well for the initial weeks, although there was great anxiety as to whether the mother was going to survive and recover. But then the father, evidently, felt sexually deprived by his wife's absence, and a period followed of molestation eventually culminating in full sexual intercourse with his daughter. The father, who had begun to replace the missing mother, in the sexual acts destroyed himself as anyone this child could rely on. She was eventually able to tell me, in her doll play, how the whole world "went wobbly" after the father's intrusions began, which was her way of saying she had begun to fall into the abyss. But the crisis of wobbliness was eventually made to recede by the appearance of a new active relationship in the child's mind: one to God in Heaven. Her celestial father replaced her earthly one and the stability of her world became resurrected. Her visible behavior became strangely incomprehensible to those around her, but inwardly she was finding her way. I worked with this child for two or three years, and she became less reliant on God and seemed to be doing well. Twenty years later she earned a doctorate in theology, which I thought was interesting. Why should she not devote her life to the one who saved her sanity?

Madness in this case did not lie in the symptoms that were shown. The so-called symptoms in fact were the sanity returning to her world, or trying to. People who have stumbled into the abyss do all kinds of things to bring stability and substantiality back to their worlds, and it is a tragedy of our field that these efforts are confused and conflated with the madness itself. This is also seen in the case of the young woman who said children were living in her bedroom. Those children, I suggested, may well have symbolized what remained of her psychological health.

One of the greatest challenges presented to those who have fallen into the abyss is the pervasive view in psychiatry that there is a disease process taking place within them. What a person in the grip of annihilation needs, above all else, is someone's understanding of the horror, which will include a human response assisting in the journey back to some sort of psychological survival. A person undergoing an experience of the total meltdown of the universe, when told that his

or her suffering stems from a mental illness, will generally feel confused, invalidated, and undermined. Because there are no resources to fight against such a view, its power will have a petrifying effect on subjectivity and deepen the fall into the abyss.

Objectifying psychiatric diagnosis is the antithesis of needed validation and mirroring. It leaves one with an attribution, offered up by a person invested with enormous authority, that can invade and usurp a person's sense of selfhood, that can operate like a nuclear tipped torpedo exploding in one's brain. Imagine the situation of a young man in the midst of a fall into the abyss, who has the misfortune to become incarcerated in an institution typical of the ones we have today in America. Perhaps the patient's doctor, directly or indirectly, communicates the view that he is suffering from *the brain disease* known as schizophrenia. The annihilating impact of such a view then becomes symbolized in the patient's unfolding experience that vicious, destructive voices are speaking to him over invisible wires and saying repeatedly that he should die. In this way a spiraling effect occurs, wherein the operation of the medical model further injures the already devastated patient, whose reactions to the new injuries in turn reconfirm the correctness of the diagnosis. Around and around we go, and this is generally the situation of madness in America.

Is it not diagnosis though to identify someone as having fallen into the abyss, which is what I have said madness is? The words are different, but here too don't we have a classification and a locating of the patient as a member of that particular class? To note that the particular experiences someone is having involve a fall into nonbeing involves a distinguishing and a knowing, and to that extent, etymologically speaking, one could say it is a diagnosis. But the word 'diagnosis' has been absorbed into an objectifying, medical language game, interlocking with all manner of terms and concepts about disease processes, biological roots, treatment possibilities. So I would not want to use the term to describe one's apprehension that someone has fallen out of the world. Also, my response will be a very different one based on this apprehension – certainly I am not going to tell the patient he is a schizophrenic. I am also not going to say he is mad.

The reason has to do with how such a thing will likely be heard, what terms like 'schizophrenia' or even 'madness' would mean to someone in an annihilation state. What I would want to do is communicate that I was listening, that I was understanding at least some part of what was being told to me, that I was prepared to do whatever would be necessary to be of help. I would always also try to express all of this in a language that would be understood in the spirit I intended.

Imagine a patient who comes, speaking of his or her complete personal destruction. How might one respond to such an individual? It will depend on precisely what is said and how it is said, on my understanding of the unique situation of this particular person at this particular moment. There are no general formulas here, but I could give an example or two. Suppose a young woman tells me, as someone once did, that she is having hallucinatory visions of a most terrifying kind. She reports being swept away, through space, then physically shrinking and being drawn into the bloodstream of her mother's body. She is then

tumbling helplessly within the coursing blood, trying not to drown, and her face and finally her whole body begin flaking away and dissolving. The vision culminates in a terrifying sense of disappearing altogether, having become indistinguishable from the blood. Again and again this vision came to her, sometimes it being other family members' bloodstreams into which she dissolved. She cried when she told me of these experiences, and begged me to tell her what was happening.

I did not tell her she was schizophrenic. I did not tell her she was mad. Such things had already been said to her by her psychoanalyst, a gentleman she had been seeing three times each week for the previous 8 years. When she complained to him about the hallucinatory immersions in her family's blood, he had responded by saying:

"You are experiencing a series of transitory psychotic episodes, most likely brought on by serious stress."

In essence her analyst was telling her she was crazy, and his reaction, unsurprisingly, was of no help. Unable to discern the core of subjective truth that was present in the strange experiences the patient was reporting, he focused instead on the ways what she felt happening to her departed from his definitions of objective reality.

In contrast, I let her telling and retelling of the frightening visions flow over my mind like a waterfall. A thought then came into my consciousness, which I decided to speak - for better or for worse. I said to the patient, calling her by her first name:

"Marie, is it possible that your whole family is nothing but a bunch of bloodsucking vampires?"

She was silent for ten or twenty seconds, and then said that no one had ever said anything like that to her before. This was the first conversation I had with this patient, the first of a great, great many. The hallucinations vanished, never to return.

The story of her life then began to emerge. It was a story of extreme trauma and enmeshment, and she needed a long time to tell it fully. This process was not easy; it was arduous, requiring many years.

The hallucinations vanished because the metaphor they contained had been understood and validated, because there was a new relationship to someone with whom the truth could be spoken. She did come from a family of vampires. The analyst she had been seeing was himself also a vampire. But she had never known this as anything that was real to her - in fact, the appearance of the hallucination could be considered a spontaneous and quite profound improvement in her situation, because it contained a reality never before seen. Of course she needed someone to understand what was being expressed; otherwise it would just have been something strange interfering with her functioning. Had it continued to be labeled and treated as a symptom of psychosis, I would imagine her situation would have grown even worse. I don't know if hallucinations in general can be handled so readily; but I do know that they often contain symbolic metaphors, sometimes expressing the very heart of the matter of what has gone awry in a

person's life. It is obvious that our patients will do better if someone is available to understand these things than if there is not.

Another case that comes to mind in a similar connection is that of Daniel Paul Schreber (1911), the German jurist whose *Memoirs of My Nervous Illness* were analyzed famously by Sigmund Freud (1911). Schreber said, to put it in its simplest terms, that he was the victim of a vast and deadly persecution, organized against him by God with the collusion of his own psychiatrist. His writings about this are highly elaborated, almost elegant equivalents to my patient's report of her hallucination of being dissolved into the bloodstreams of her relatives.

Let me imagine what one might have done with Schreber, and how he then might have responded himself. Of course the first thing would be to really try to hear what he was saying, and I mean *all* that he was saying, at every level of its meaning. I would listen to him as he told me of the *conspiracy* that had been directed against him. I would listen closely as he spoke of the horrifying *unmanning* to which he was being subjected by his psychiatrist and God, the final goal of which was to transform him body and soul into a *woman* and bring the process of *soul murder* to its terrible conclusion. I would listen attentively to his descriptions of the *divine rays* coming down from heaven and playing on his mind and body, and of the diabolical *miracles* taking place within him as a result of this supernatural activity. I would focus on his descriptions of the people surrounding him in the asylum as *fleeting improvised men*, simulacra apparently existing only for his benefit

Not only would I sit with him as he spoke, and carefully read over the manuscripts on which he worked; I would want to hear what he was saying and perhaps give him a sense of being listened to that he had never encountered before. Schreber may well have been a man that no one had ever listened to, at least not at the level of the deepest core of what he experienced. People in our field need to think about what it is like never to have been listened to - to have been raised in an empathic vacuum, or worse, a setting that closes out all one might authentically feel and then authors and reauthors one's experience according to the design of alien agendas. A family life that lays down layer upon layer of disqualification and invalidation, all the while insisting on total compliance. I see this man's background in such terms.

How does one accomplish such a level of listening? As in the case of the patient who was swept into her relatives' bloodstreams, I would let what is said flow over me like a waterfall and see what images and understandings begin to emerge. I picture listening to Schreber tell of God deforming and transforming his body, of the miracles and the rays, of the soul murder being carried out. I would try not to hear any of this as delusion; nor, if there were voices speaking to him, would I think of them as hallucinations. The concepts of delusion and hallucination arise because we are hypnotized by what we think of as the externally real, and once the fascination sets in, we cannot hear what is said to us without judging its degree of concordance with that external reality. It is possible though to set such thoughts aside and listen to what is being said, in and for itself.

In Daniel Paul Schreber, I see a child locked in a power struggle with a parent - there is evidence that it was his father (Shatzman, 1973; Orange, 1995) - a

struggle for existence itself. The ideas of unmanning and being made into a woman involve a stripping away of what makes this male child who he is. It converts him from someone who has a right to his own existence, who is in possession of his own masculine power to act and think, into a woman, which in this historical context probably means a passive vessel of pure receptivity and cooperativeness. This is another way of picturing the fall into the abyss, the erasure of one's very soul. The child to whom all of this has happened and is happening is telling his story in the so-called delusions and hallucinations, and if that story is heard, that might make all the difference for Schreber. I would want to let him know that I was listening, and that he was succeeding in making me hear what he was trying to say. I would also want to emphasize how I saw that his *Memoirs* constitute a kind of resurrection of his soul, a reclaiming of the life that had been stolen away from him.

Regarding the "fleeting improvised men" Schreber said he witnessed around him, the following thoughts come to mind. If other people in Schreber's world are construed as a swirling of temporarily assembled appearances, then others are reduced to arbitrary beings having no real substance of their own. This amounts to the ultimate triumph of the will: the whole human world becomes subject to Schreber's subjectivity - in a way he becomes the only being who is real, an epistemological tyrant with absolute power over the very existence of all other beings. This is a reversal of his original predicament, in which Schreber the child is fashioned into a contraption that materializes his father's fantasy of the perfect child. So the original improvised man was none other than Daniel Paul Schreber.

I think of a contrast here. Another patient regarding whose treatment I consulted some years ago believed she had been kidnapped into the Truman Show, i.e., that her every act and even her every thought was being broadcast across our country for the entertainment of the population. Her life had thus become a television show and she had been stripped of her own autonomy and personal subjectivity. Here we have the sovereign power of the Other, in whose gaze the whole of one's being has become absorbed. She had come to feel she resided exclusively in the mass perception of the American people. Schreber is the reverse: he thought that the masses of people resided solely in his own perception, that they were little more than figments of his imagination, transitory little entities assembled to entertain or otherwise preoccupy him. And yet, still and all, Schreber was himself, in the beginning, a fleeting improvised child.

Working in the territory of annihilated souls is never easy. To really listen to someone, anyone, to hear the depth of what he or she may have felt, to work one's way into realms of experience perhaps never before perceived by anyone and therefore never articulated - all of this is as hard a task as one may undertake. Maybe I would try to listen to Schreber and tell him I was doing so by sitting with him, day after day, month after month, year after year if need be. I know I would never say to him he was mentally ill. I certainly would not inform him of his diagnosis of dementia praecox or schizophrenia. Those communications could only deepen his fall into the abyss. I am quite sure his psychiatrist, someone he considered his mortal enemy, spoke to him in precisely such a way, and contributed greatly to his destruction. I might even tell Schreber that he was

among the sanest people I had ever met, because I knew he was a man who spoke the truth.

It is possible that Schreber would be able to see in my eyes and on my face the recognition and acknowledgment he was seeking, and that nothing more would be needed. Often the simple presence of another human being who is actually listening to the story that is being told is all that is required. Schreber was utterly brilliant, with a sensitive understanding of other people and a penetrating intellect. If someone were really paying attention, it would not be lost upon him.

The Human Causes of Madness

If we approach madness as a human experience, then we would seek knowledge of what causes it in human terms. I had a colleague once who came to me and said he agreed with my thinking about this, explaining that he had discovered that people actually “choose” madness, or at least that it arises out of the decisions they make in the exercise of their freedom. I found I had to disagree with this individual. No one ‘chooses’ madness, and no one ‘chooses’ something that leads to madness. In fact the abyss includes the dissolution of choice itself, as all basis in self-experience for agentic action of any kind vanishes absolutely.

What then are the circumstances under which madness occurs? I already gave a partial answer to this, in the idea of a failure of the sustaining matrix of relationships to others that our sanity is based upon. This is not an environmentalism casting the person as passive victim. A failure in the sustaining ties one has to others is not external or environmental, and it is not internal or mental. We need to escape these snares of dualism. It is something that happens subjectively, something felt, lived, endured by the person in whose life the madness erupts. That is the beginning, the middle, and the end. It arises out of the utterly disastrous situational contexts in which we find ourselves. Obviously we have a role in creating our situations, favorable or unfavorable. But thinking about the origin of madness requires a different mindset altogether, one that highlights the specific sequence of events occurring in the subjective field of the person’s experience.

Let me offer another example. Picture a young man, a brilliant physicist and mathematician, someone whose thinking was beyond the minds of his contemporaries in most respects. Imagine further that this man never learned how to relate closely and sensitively with other people, in part because of his exceptional scientific talents and preoccupying interests. He remained, nevertheless, very vulnerable to others’ reactions and opinions, and felt searing shame and humiliation when his socially awkward ways led others to think he was strange and to withdraw from him. In the extreme if someone treated him with hostility and contempt he actually began to fragment, and avoided such terrible experiences by keeping almost entirely to himself.

Now picture this man, still in his youth but already working at a high level as a physicist, availing himself of the one experience that shored up his otherwise frequently crumbling selfhood: exposing himself to other young men in a public urinal. Here he was, a brilliant scientist, letting it all hang out in the restroom of a public park. Envision the police arriving in a sting operation, arresting him for

indecenty, and then communicating with his employer and colleagues about the crime he had been caught committing. Disaster upon disaster, catastrophe on catastrophe - - soon he was fired from his position at a prestigious science institute because of what was seen as unforgivable, intolerable moral depravity.

The story is not over. Our friend, the mathematician/physicist incomparable, experienced all this as the worst attack on his personal selfhood that had ever occurred: one defining him, seemingly irrevocably, as a sex pervert. An explosion took place in the center of his being, one in which all sense of coherent, cohesive identity was blown to pieces and all that was left was a need for unification. Time passed. Terrible, unspeakable agonies occurred. Then, as if brought to him by a magical cloud, an idea appeared that promised to solve everything. His destiny was to achieve the unified field theory, that structure of mathematical and physical concepts that will finally bring Einstein's theory of relativity together with the theory of quantum mechanics. Over the next period he poured himself into the search for the equations that would help the macroscopic universe make contact with microscopic phenomena in the quantum domain, a theory that will disclose the previously hidden variables that can unify gravity with the electromagnetic and other forces of nature. Anticipating glory, he celebrated in imagination the lecture he would give upon receiving the Nobel Prize. Thereby, in fantasy, he pulled the fragments together, displaying a shining coherence for all the world to see. The humiliated, devastated, annihilated soul thus moved toward its own redemption.

One minor difficulty: the scientific problem he had set out to solve is just too hard. Even though he was brilliant, unifying the foundations of physics required something he was unable to provide, and this no matter how hard he tried. Working late into the night, night after night, month after month, nothing came forward to bring the division together as innumerable pages of equations were written down, as all his efforts accelerated in the face of frustration and failure.

A vision finally supervened in the midst of this desperate activity: the world itself had become fractured and fragmented into isolated, often warring nations. Our friend now saw his future in even more glorious terms: to bring together the world itself, to heal the divisions that have torn it apart, to establish a unifying world government and usher in everlasting human peace. In this quest he appointed himself Emperor of the Earth whose sovereign rule would establish a human utopia. Guiding messages and confirmations of his destiny were received, telepathically, from advanced civilizations in other galaxies. At this point he actually traveled to various foreign capitals and tried to establish contact with the governing authorities so that his unifying dream could be fulfilled. His behavior now having become disruptive of the routines of ordinary life, however, the police were called and he was incarcerated in a psychiatric asylum. A very sad story.

He was trying to put the shattered world back together, but the human environment was not supporting his efforts on behalf of unification – it was instead attacking him, imprisoning him, and declaring him crazy. No man is an island, and so an intergalactic Thou crystallized, an Other to support and sustain his efforts to reintegrate and climb back out of the abyss. Here again we see how

the struggle to regain one's footing, to reestablish one's very being, becomes confused with an illness everyone thinks one is suffering from.

He was subjected to psychiatric violence, including involuntary incarceration, intrusive, powerful medications, and insulin and electroshock therapy. He was also told that he was mentally ill – specifically, that he was a schizophrenic. This did not help, in that it repeated and exacerbated the other things that had occurred to make him feel terrible about himself. The so-called treatment added to the fragmentation and deepened the fall into the abyss.

Finally, drawing on resources no one knew were available to him, he took matters into his own hands. Ceasing to speak of his mission to unify the planet and the inspiring messages from space, he focused his efforts on giving his doctors what they wanted to see: a man who was oriented to his surroundings, in contact with the externally real, intent on resuming a normal life. He was still getting his messages and inwardly had not given up on destiny; but he was teaching himself not to speak about it, and not even to think about it all very much. His doctors, in turn, stopped telling him he was crazy, and former colleagues began to express interest in him again. Finally he was pronounced dramatically improved and released from his long captivity. He subsequently worked on the periphery of his former field, and I understand did well for many years.

Madness comes about as a result of the failure of sustaining human relationships. It arises out of disastrous trauma that challenges the person's very capacity to experience 'I am.' Sometimes the precipitating events are present, clear, and dramatic; at other times, the inner catastrophes are hidden, perhaps lost in the mists of very early life. Whatever the details of the particular genesis, madness is a human response in a human context.

CHAPTER 3: PHILOSOPHY AND PSYCHOTHERAPY

*When my mother died I was very young
And my father sold me while yet my tongue
Could scarcely cry*

William Blake

I recently listened to a lecture in which the speaker said that every psychotherapist must be a philosopher. I think of philosophy as that domain of thought that brings us to an awareness of our deepest assumptions, and certainly psychotherapists should in this sense become philosophers. But in my old age, I find that I have become impatient with discussions that become too abstract. So I shall address this topic with a series of clinical stories, ones that to some extent relate to major areas of philosophy: metaphysics - the nature of the real; ethics – the nature of the good; epistemology – the nature of knowing; and aesthetics – the nature of the beautiful.

Metaphysics: the Nature of the Real

1. My first story concerns a 30 year-old man with whom I sat down a long time ago when I was still a student, a man who had been given a diagnosis of schizophrenia. He was silent, for a number of minutes. I asked him finally: “What are you thinking about, brother?” The answer that came back was: “*I don’t think. It thinks.*”

When I asked him what “it” was, he answered:

“The machine. It is. I am not.”

No matter what I said after this initial interchange, he kept repeating the statement that he did not think, was not there, and there was only a machine. What does one make of such statements? Most people would regard his words as in plain contradiction to all that is real. That would also be the view of contemporary psychiatry.

My encounter with this gentleman took place during my student days, at a time when I had not yet understood the phenomenology of annihilation states and the imagery often used to express and symbolize it. Instead I was still captive to a Cartesian view, in which this patient seemed to have traveled into an alternate universe, a world of his own which had lost contact with objective reality. Phenomenological contextualism had not yet been born. How, I wondered, is one to establish communication with such a person? Conversation between human beings, I thought, requires a shared basis of understanding, and here we had a rift separating his world from ours. What is one supposed to do with such a discrepancy? Do we suspend our own reality and try to enter his? Do we tell him he is wrong and try to draw him into ours?

There was no real guidance in the psychiatric setting where this was occurring, and neither I nor the other students and clinicians available were able to do anything constructive with this patient. He was eventually transferred to a long-term care facility for the chronically mentally ill. But I have never forgotten him, and I have tried to rethink what I experienced then in the light of my later training and clinical adventures.

I would now relate what this man said to the way I had initially addressed him. The question asking him what he was thinking about might have implied to

him that there was a 'he' or a 'you' within him capable of being spoken to. If there is no such being, the posing of the question opens up a gulf of misunderstanding and invalidation that might well have ended the communication even before it had begun. People carrying the diagnosis of schizophrenia often do not experience themselves as existing. They live in a felt state of nonbeing. As a result the customary ways of being addressed in our society cast them into a nowhere zone: unseen, unacknowledged. They then react to this banishment, and their reactions to the misunderstanding, in turn, are viewed as symptoms of the illness from which they are said to suffer. This is the situation of madness in America.

When I asked him about himself, and then persisted even when he has told me he was not there, I committed an act of infinite abandonment and invalidation. It would have been far better if I had simply sat by his side, quietly, knowing that he felt my presence.

Furthermore, when I addressed him as "brother," I made an attribution he cannot possibly have been able to make sense of. I was not his brother. He was no one's brother, in that he was no one at all. To be construed as such was to be swept into a controlling agenda that was unrelated to the nonbeing that was his authentic state. So the machine arrived: something that spoke, that had thoughts, that perceived. I, G.A., may well have been that machine, annihilating what little remained of his personhood by misguided friendliness. As the man told me, he was not - there was only the machine. Looking back now, I find that I like this man, because he spoke the truth as he saw it. There was hope for such a gentleman, but I was certainly of no help at the time.

People in annihilation states are not for that reason inaccessible to communication. One could have focused on the purely physical and directed the conversation to the way the patient was dressed, or to the heat or the oppressive humidity. One could have spoken to him in the third person - individuals in the midst of nonbeing do not experience 'I am,' and often therefore cannot tolerate being addressed as "you." It might have been a good idea to bring him a cup of coffee and doughnuts and talk to him about how good or bad they tasted. One could rest there quietly or take him for a walk.

This patient was someone living in a state of utter catastrophe, but opportunities were there to be with him without making his situation worse. If one ascribed something to him he was not able to experience, however, he was catapulted into the grip of the machine.

In approaching this man, it would have been good to start with the unremarkable idea that he, and I, and everyone, all live in a common world. Perhaps this is a philosophical assumption, but I don't see how one could speak to anyone about anything on any other basis. One would have needed not to overstress his talk about the machine and his absence - he was experiencing these things but they do not mean he lived in an alternate universe. They were just particular points at which his subjective life did not correspond to mine; there were plenty of other points at which there was no significant disparity.

If I wanted to relate to him, a space had to be created in which he could begin to feel himself in my presence and myself in his. A firm handshake and a

squeeze on the shoulder might have begun to establish this, and then could be followed up by a comment or two directed to our shared physical situation. Perhaps he would have said nothing in response, but he might have been listening.

I could have brought out the coffee and doughnuts and offered them to him. I might have warned him that the coffee was very hot and asked if he wanted any milk or sugar in it. If he still did not respond, I could pour coffee for myself and bite into a doughnut, then telling him how good or how bad it tasted. Who knows? A foundation might have been laid for a healing relationship with him.

What is it that might have happened though in this man's life? How do people come to an experience of not being there, and of there only being a machine? Those who feel they are not present, and who affirm the existence of a machine that controls their minds and bodies, are often the products of profound enmeshment with their caregivers in childhood. An accommodation has taken place at a very young age in which the agenda of the caregiver – it can be the mother, the father, or both – becomes the supreme principle defining the child's developing sense of personal identity. The experience of the child as an independent person in his or her own right is nullified, so that the child the parents wish for can be brought into being. Very often there are no outward signs of anything amiss, as family life unfolds in a seeming harmony. Somewhere along the way, however, the false self begins to crumble, and a sense of the degree to which the child has been absent from life arises. This emerging feeling of having never been there, of having been controlled and regulated by outside forces, is so unstable and fragmentary that it is given concrete form. What is seen from the viewpoint of others as a delusion then begins to crystallize, for example in the image of an influencing machine (Tausk, 1917; Orange, Atwood, & Stolorow, 1997, chapter 4). Within the world of the child, now perhaps chronologically an adult, the so-called delusion is a carrier of a truth that has up until then been entirely hidden and erased. What looks like a breakdown into psychosis and delusion thus may represent an attempted breakthrough, but the inchoate 'I' does require an understanding and responsive 'Thou' in order to have a chance to consolidate itself. This could well be the situation of the patient described in my little story, and the challenge to be faced by anyone who might have chosen to continue with him. It would unquestionably have been a very long journey.

2. I was walking with a young woman, a 24 year-old, on the grounds of a psychiatric hospital where she had been for a number of months. Like the last case, she had been diagnosed as schizophrenic. There was silence as we began our walk, but then she turned to me and said the following:

"You know, George, there is a cavern beneath this hospital, and there are assassins that hide it. At night they come out and murder the patients. I think they work for the CIA. Every hospital in America has a cavern."

I did not know how to respond. I think I just said, "Wow!" She stared into my eyes for five or ten seconds, and then shouted a series of questions and demanded answers:

"Do you believe what I just told you? Tell me if you think it is true: Is there a cavern, or is it just that I am mentally ill? Am I right about this, or am I sick?"

Which is it? Tell me right now, you bastard! Do you believe? I want to know: True, or Sick? Yes, or No?"

I knew better than to tell this patient she was mentally ill, but I could not bring myself to say that I believed her. We struggled for a few minutes with this and finally I tore myself away and left, with her screaming at me. It seemed that I was damned if I did and damned if I didn't. If I told her she was mentally ill, she would feel condemned and invalidated. If I said I believed her, she would see I was lying. That might be worse than saying she was crazy. Also, I could almost hear my psychiatrist colleagues telling me that believing the delusion would be a matter of encouraging psychotic thinking.

This story traces back about 30 years, at a time that my ideas about annihilation states and their connection to experiences of invalidation were first crystallizing. I happened at the time to pick up a paper written by one of my own former students, a clinician who was employed at a large public mental health center. She had worked for years as an outpatient psychotherapist, often with young men and women who were very seriously emotionally disturbed. The overall philosophy of this psychiatric institution was based on the medical model, and its primary mode of treatment was the provision of psychiatric drugs. My student had grown more and more appalled over the period of her employment by what she thought was damaging mistreatment and unforgivable neglect. I looked at the title of her paper, and it seemed to cry out to me:

"Contemporary treatment of young adults in community mental health centers: Are we murdering a generation of geniuses?"

My patient had been claiming murders were taking place in her hospital, and at all the psychiatric hospitals in our country. It occurred to me that she and my student were talking about the same thing. It was a symbolic metaphor, containing a deep subjective truth. I asked myself also why my patient was describing the assassins in the cavern as coming out only at night. She was saying they do their deadly work secretly, out of anyone's sight. The medically oriented treatment of her institution presented itself as a constructive, healing procedure. In the daylight world, it therefore manifested in a form that one would hope would be of help to those receiving it. But its invalidating, discrediting impact was hidden, and took its toll on the souls of the so-called mentally ill out of public view. In other words, it occurred in the dark.

The patient had been told repeatedly that she was a schizophrenic. I began to think about what it feels like to be seen in this way - to have anything and everything one does viewed as a symptom of the most severe mental illness that exists. One needs to imagine this experience, and take into consideration that the person being so viewed is also someone in the midst of personal disaster already. We have a human being for whom the bottom has completely fallen out, who struggles to maintain the most basic sense of integrity, perhaps even of existence itself. Then that individual becomes subject to an unrelenting experience of being personally discredited and pathologized. Psychiatric hospitals, which should be healing asylums, by and large are annihilation factories instead. The murders that are committed there are soul murders, and the medical model itself is one of the

primary instrumentalities of this infernal work. If one tells the patient she is mentally ill, one completes the killing.

Listening to my patient's words softly - symbolically and metaphorically - they convey a message about the emotional violence happening to her as a result of psychiatric objectification.

I began to see that what she was saying was, from her viewpoint, completely true. I also discovered something else that gave me pause: many psychiatric hospitals do have tunnels beneath the floors on which the patients are housed. These tunnels are often used for unobtrusively removing the bodies of those who have died or committed suicide. All of this helped me find a way to respond to the young woman that did not make the situation worse.

I decided, based on these reflections, that my patient was right, that there was indeed a cavern of assassins beneath the hospital, and that murders were indeed taking place each and every night. So I decided to tell her just that. The next time we met, she was waiting for me with those same urgent questions, repeated over and over. I asked her to listen to my response:

"My dear, listen to me. I have to apologize for running out on you the last time I was here and not answering your questions. The problem was that I did not understand what you were asking me, although you were being very clear. Now I do understand and I am going to tell you what I think. You are speaking the truth. Death is everywhere at this hospital, and you are also right that it is present at every hospital in our country. This is not illness; this is you speaking the plain, unvarnished truth. My answer to you is Yes, Yes, Yes!"

She was satisfied and the imagery of the cavern and the assassins receded. I never heard another word about it in the long and continuing course of my relationship with her. The incident I have been describing occurred very early in our work together, only a few months after I first met her. But there were signs that something very good had happened in the subsequent period. Perhaps a week after the discussions about caverns and murders had come to an end. I was walking with her again over the hospital grounds. I never knew what to say to this patient, so I would just say anything that came to my mind. On this day, I asked her:

"Tell me. What is the most beautiful thing you have seen today, on this lovely morning we are sharing?"

She answered with the following words:

"I saw a beautiful flower growing at the center of a cold, gray rock."

I had understood already that the patient had been subject to feelings of inner deadness for a number of years. She had cut herself really seriously two months earlier - deep slashes across her chest and on her arms performed with a coffee can lid. I had originally thought she was trying to commit suicide in this terrible act; but she informed me that she had wanted to feel the intensity of the pain and see her bright red blood flow. She had been in an experience of numbness and deadness and, rather than intending to die, was desperately seeking signs and sensations of life.

So I thought the rock might be a symbol of that deadness, an enclosing prison in which there were no feelings and there was no life. But she was telling me now

that life had appeared in the midst of death, and that it was a beautiful flower. This had to be a good sign for her and for our connection. I did not put my thoughts into any direct words, but chose instead to suggest that she and I compose a poem about that lovely flower. We sat on the edge of a pond in the morning sunlight and wrote one out, which she chose to entitle: “The Midnight Blue Rose.”

The patient did well in the ensuing years and was eventually able to leave the hospital and live with family members. Our work continued for many decades.

3. A well-established psychiatrist of my acquaintance was recently murdered by a young man who came to his office late at night. The patient was in a panic because he believed he was being poisoned in a vast conspiracy. He begged the doctor to help him find a way to rid his body of the toxins that had accumulated, crying out that this was his last chance to survive. The persecutors, as the man described them, were led by a number of psychiatrists and other mental health professionals, in league with various relatives who had turned against him. There was also some talk about a strange machine that was involved with his suffering.

The doctor, himself a respected but very conventional person working in Manhattan, made a diagnosis of paranoid schizophrenia, and gently but firmly advised the patient to begin on a course of antipsychotic medications he would prescribe. The patient listened to this advice, and pulled out a knife and plunged it into the doctor’s heart. I know what happened because I was able to look at interview material collected from the patient by the police shortly after the murder.

So here we have someone again living in what looks like a different reality, and in this case the effort to connect with him precipitated lethal violence. A clash of worlds occurred here, ending in homicide.

The psychiatrist in this awful story “knew” his patient was delusional, and he “knew” the so-called delusion was a symptom of a mental illness that could only be treated with medications. I have a series of thoughts about the calamitous situation that then developed.

Let us start with the antipsychotic medications. These drugs are actually poisonous, and I wonder about the patient’s complaints being the result of negative physiological reactions to their presence in his body. He claimed toxins had accumulated within him, and the chemicals likely to be involved here are known to be toxic. But the doctor responded not by addressing the possible validity of the patient’s complaints, but instead by prescribing more of what the young man said was poisoning him. This was a very bad decision on the psychiatrist’s part, and it led to him being killed.

As in the earlier examples, there are points at which the patient’s experience here departed substantially from all that this doctor believed to be real. The physician viewed his patient as engaging in paranoid distortions of efforts to help him on the part of other clinicians, for example, and it is likely he also saw the patient’s relatives as equally to have been drawn into a paranoid delusional system. The patient, by contrast, was in the midst of an experience of being plotted against and attacked by a whole range of individuals, some of whom probably were the people to whom he originally turned for help. It strikes me as

something of a miracle that there was still a particle of hope left inside this young man, as evidenced by his coming to my colleague in the middle of the night. What a sad and tragic thing it is that this court of last resort, as its first action, joined the conspiracy that was destroying the patient. A physician lies dead, and the young man is destined to spend the rest of his life incarcerated in mental institutions. It probably did not have to end this way.

What other way could have been found, and what other ending might have taken place? That leads to my second thought, concerning how the doctor might otherwise have responded, and what experience then the patient might have had in consequence. What if the first thing the doctor did was to ask about the specific poisons that had been introduced into his system by those that had hurt him so terribly? Let me imagine that the patient knew the names of the drugs that he had been given, and that they were the standard medications given by professionals in our field for psychosis.

I picture the possibility, not embraced obviously by the doomed psychiatrist, of having given the patient a specific, point-by-point summary of the destructive effects of his various medications. One could speak of the dangers of tardive dyskinesia, of diabetes, of various cardiac effects, of lasting alterations of the neurochemical environment within the brain, of excessive weight gain and its complications, of temporary and permanent interferences with cognitive functioning, of generalized emotional numbing that makes a person feel he or she has become a zombie.

I also imagine one could have instructed the patient about exactly what he needed to do in order to stop such effects and reduce any reliance there might have been on the tranquilizing action of the medications he had been taking. I might have said to him that if he wanted to detoxify his body and get away from these substances, he had come to the right place. I would promise him I would see that he received the help he needed and he would accomplish what he was trying to do. I seriously doubt a murder would have occurred, because what reason would there have been for it?

Someone like this is in a state of terror and despair. My goal would be to relieve him of the fear and provide a reason for hope on which he and I could build. The literal content of what I was suggesting is less important than the message of reassurance I would be trying to give to him. I would be speaking to him in a language that is the only one he was in a position to understand at this desperate moment of his destroyed life.

Maybe I should also say that if I had seen he had a knife, and suspected he might use it on me, I would have done everything in my power to physically escape the situation. I would have run out of the building and called the police. It is a cardinal principle of my practice never to allow myself to be killed, and there have actually been some close calls.

My third thought about this story, however, concerns what it meant in terms of the patient's probable life history. Here he was, feeling poisoned by persecutors, running to a man who was his last hope. The situation lends itself to an interpretation along the lines of the persecutors being symbols of maternal malevolence and the doctor being a rescuing paternal authority. This is a memory

of a little boy who runs to his father after being massively threatened by something happening with his mother. He seems not to have received much help from his father though, because how otherwise would he have ended up in this condition? Still and all, the presence of hope remains in the picture, however tenuously; that is, it remains until it is destroyed by the psychiatrist's response. I would expect the patient to want to kill himself after murdering the doctor – the violence is a sign of his despair having become absolute and everlasting.

My final thoughts concern the possible course of events in this case if a better response to the patient had been given. I will draw on clinical experiences I have had in a situation not dissimilar to this one. I would imagine seeing this young man on a very frequent basis, probably every day in the initial weeks. I treated such a person many years ago, and we met every morning in a local diner for breakfast. I had no openings in my regular schedule, so this was the only basis on which we could have time together.

My patient was initially very fearful of meeting me in public, saying his enemies were everywhere and intended to kill him. I answered these fears with a simple declaration:

“As long as you and I are meeting, your enemies will not hurt you. I guarantee it.”

This helped him begin to relax, but it was many days before he calmed down enough to join me in actually having breakfast. I did not wait, however, and so for the first week and a half he had to watch me consume cheese omelettes, french toast, pancakes, hash browns, and fruit, even as he sat there eating and drinking nothing. It was kind of pathetic to look at this poor, hungry, frightened man, while I was feasting. Eventually though he ordered some bacon and coffee, and things improved. A foundation was thereby created for a very long and productive relationship. This patient eventually weaned himself off the antipsychotic medications he had been taking and recovered essentially completely from a paranoia that had been present for many years.

So I would try to repeat this good experience by inviting the young man to breakfast over the ensuing period. I would certainly expect him to be suspicious, but I would disarm him by unrelenting friendliness and I would order food for him in the hope that he might accept it. In the mean time, he could be tapering off the medications he thought were poisoning him, and, who knows, maybe he could get off them entirely over the course of a few weeks or months. In pursuing this strategy I would be building on the spark of hope I saw at work in his first contacting me.

Where has this discussion left us with respect to the topic I began with: the role of philosophy in psychotherapy with a focus on metaphysics? Certainly there is nothing that has emerged to help us define the nature of the ultimately real. Here are three assumptions, and one can call them philosophical: first, we live in a common world; second, people are experiencing beings; and third, not everyone sees things in the same way. Adhering to these ideas helps us discover ways to respond to many of the otherwise incomprehensible and obscure things presented in extreme psychological disturbances.

Ethics – the Question of the Good

We are our brothers' and sisters' keepers. We are all siblings in the same darkness, as my friend Robert Stolorow likes to say. We are the guardians of the earth and all its living creatures. These are the tenets of my ethical philosophy, and in my professional work I have always tried to give it expression.

I can describe a case that appears to raise ethical issues and questions, and then discuss how my philosophical attitude plays out in a specific human context. The story involves a tragedy. This is the story of a suicidal patient, a woman of 49, who announced in a tone of certainty that she planned to end her life. It was only a question of when, not if. She showed an interest in the possibility of psychotherapy during the short period she would be remaining alive. She was without question going to kill herself, but considered it potentially beneficial to speak to someone nevertheless about her situation. No one was available to her, however, because all the clinicians she contacted said that they would work to avert her death. She had no interest in speaking to such a person.

What would I do if called upon by this woman? She insisted she was going to end her life, but asked for an opportunity for some counseling over the short period remaining to her. I have said we are our brothers' and sisters' keepers – how does this principle apply to someone who has elected to die?

Another feature of the situation was that she refused to speak to anyone who would form any sort of attachment to her – above all it was required that her therapist, if she could find one, be someone who would not be hurt by her suicide. The freedom to die without having to worry about her therapist's feelings was an absolute condition of her agreeing to undertake the counseling. So she was looking for someone to talk to who would neither interfere with her planned death nor be negatively affected by it when it occurred. This is obviously about something.

Two factors seem to have been involved in her decision: first, that she was the child of Holocaust survivors, and had in her childhood been made to feel the purpose of her existence was to honor the dead rather than live a life of her own; and second, that she had become massively addicted to a variety of drugs and alcohol, and saw no possibility of recovering from this. She said her life had zero meaning for her, was filled with suffering, and needed to end.

Why was it though that she was interested in some form of counseling before her death? She seemed to want to wrap things up in a conversation with someone, if she could find a person who would not obstruct her in carrying out her decision. She said only that she thought it might be useful. I think I see that this woman's life depended on the locating of that person. All that remained here of the will to live was her interest in a short period of so-called counseling. She wanted to talk about the meaning of her situation, and the life force resides inside such a desire. I would assume that if she could not locate anyone to provide this, she would carry out her suicide.

That is exactly what occurred: all the clinicians she contacted made it clear they wanted to help her recover a wish to live. These included two psychotherapists whom I, ill-advisedly, recommended. The therapists also responded in a way indicating to her that they would be very upset if she

committed suicide and would regard their work with her to have been a failure. This was intolerable to her, so she skipped the counseling and killed herself. The method she chose showed her absolute determination: she overdosed on a lethal amount of sleeping medications, drank a whole fifth of vodka on top of that, and put a plastic bag over her head so that she would suffocate. She really meant business. A very sad part of this story is that I had finally decided I would undertake the task of her counseling myself; but when I called her, she was already gone.

A person falls into despair, the world destroys her last particle of hope, and she kills herself. This woman turned to the professionals in our field for help, and they turned away from her. Suicides occur when hope is destroyed, and my philosophy includes the idea we should support hope rather than extinguish it. I would not however regard this as involving any ethical failure on anyone's part; the problem was their human failure, due to emotional stupidity. They knew not what they were doing.

I have said that I try to live by the principle that we are our brothers' and sisters' keepers, and yet this woman wanted a *carte blanche* on ending her life as a condition for even entering psychotherapy. How could one have reconciled the one aspect of this and the other? I would ask: why was it that she needed her therapist, if she could have found one, to be someone who would not oppose her suicide and be negatively affected by it? It is obvious from the brief story, as I think about it. There was no basis for continuing to struggle and suffer, since she had been slated for a life of honoring the already dead. Her parents harnessed her very being into their everlasting trauma and grief, and within this project there was no room for her existence as a person in her own right. She was one of those whose life was never her own. Such people often kill themselves.

I would have seen her life, what little there was of it, inhabiting her wish to find someone who would not be hurt by her suicide. This is, evidently, all that was left of this woman, and I would have wanted to communicate that I understood what she was doing and she was not to concern herself with protecting my feelings. In the meantime, perhaps we could have had some good conversations. If she felt free in my presence not to take care of me, and at liberty as well to end her life at any moment of her choosing, it is possible that a space would have opened up she had never known before, a space that belonged entirely to her. Who knows what could have happened then? If I had not been too late, a miracle might have occurred.

The ostensible care and concern of the clinicians she sought out precipitated her suicide, and what I have proposed would have been a chance for her survival. If we open our hearts and minds, a pathway might then be found to our brothers and sisters that otherwise would be lost to us.

This death might well have been inevitable, but at least she would have had the opportunity to talk her story over with someone before signing off. Even then I would have known I had been my sister's keeper, or done everything I could based on my understanding of her, and I could have lived with her death. I wonder how the clinicians who told her they wanted to preserve her life feel about it now. If I were one of them, I would be suffering very significantly.

Epistemology: The darkness of unknowing

The focus on philosophical themes seems to create opportunities for interesting discussions, so I shall continue by shifting to another domain of philosophy: that of epistemology. I have tried to think of clinical cases for which considerations bearing on the theory of knowledge would be germane. Epistemology asks such questions as: What is knowledge and what are its preconditions? The term, 'epistemological trauma,' arises.

An epistemological trauma is an event that undercuts someone's faith in what previously had been believed to be true. It is an event or situation in a person's life that contradicts what had been a matter of the given or even pre-given theretofore. The effect of such a trauma is the shattering of confidence in one's own mind. Such a collapse of trust in oneself can lead to terrible things, even, in the extreme, to an experience of personal annihilation. It makes a person feel he or she has been cast into the darkness of unknowing, and nothing can make it better.

Two clinical stories come to mind, both involving patients of mine from many years ago. These are the people who introduced me to the concept of epistemological trauma.

1. The first one involves a woman, 50 years old, who had been married for 24 years and in that period raised two sons. She came to me in a state of consuming anxiety, weeping uncontrollably, unable to sleep, desperate for help. Her marriage had not been perfect, but she and her husband had gotten along well enough and had cooperated for the most part in helping with the care of the sons. Their life together had been outwardly a conventional one – they belonged to a church, participated in community activities, had a number of friends they met during their children's school years.

Here is what happened: it suddenly emerged that for the entirety of their marriage the husband had maintained a secret homosexual life, one replete with sadomasochism, innumerable one-night stands, in the early years incidents of prostituting himself for rich businessmen visiting his area. He suddenly told his wife he had filed for divorce and wanted to explore the life that up until then had been kept secret. This was presented in a mood of joyful exuberance, as he felt he had finally broken out of a prison of secrecy to a glorious freedom he had never known. He gave his wife a detailed, X-rated account of all the activities he formerly had felt it necessary to conceal and asked her to join in the celebration of his joy.

She passed into unconsciousness in the face of her husband's revelations, unable even to understand what he was trying to tell her. It later seemed he had changed into someone she did not recognize and she struggled with the thought that he had been kidnapped and brainwashed into the ideas he was expressing. Then the bottom began to fall out, as she spiraled into a deep well of unknowing, losing faith in her ability to work, to relate adequately to her children and friends, to cook, even to choose her clothing in the morning when she got dressed. She told me in our first meeting that she felt she had lost her mind and was insane. She said as well that she had been mentally ill all her life and that terrible things

must have happened to her when she was a young child to cause her deep emotional problems. I also met her two sons, and they were exhausted from trying to deal with their mother's distress and asked for her to be hospitalized.

I did not hospitalize her – it seemed clear to me that this would have made the situation worse and would have totally failed to address the trauma that precipitated her struggles. She needed something to arrest the spiral of unknowing and reverse the associated collapse in her self-esteem. I spoke to her for an hour and a half about her marriage, her life, and her suffering, and at the end of that time she had recovered her balance.

This dramatic effect arose out of the following: after listening to her, I simply told her what I thought was going on. There is nothing more powerful than human understanding. I told her she was not insane, that her life did not show any mental illness at all, and that she should just forget about such ideas. I added that there was some madness in the picture to be sure, her husband's. It seemed apparent from the story that he had entered a prolonged manic episode, and that this had caused him to turn his life, and his family's lives, upside down.

I explained she was in shock because everything she had believed had suddenly been upended and this had made her lose faith in her own perceptions and feelings. I added that her reaction was normal in view of what had happened and I explained she would recover her balance as the traumatic shock gradually wore off. In the grip of her crisis, believing she had experienced a complete nervous breakdown, she had earlier requested antipsychotic and antidepressant medications. I told her she did not need anything like that, because she showed no trace of psychosis and no depressive illness either. I suggested that if the anxiety continued and interfered with her sleeping, she could have her physician prescribe a small dose of xanax to be taken before going to bed.

As I spoke in this way to my patient, and I had to repeat myself several times, she stared at me, blinking, at first not seeming to hear what I was saying. But then I saw my words were going in, and her relaxation was visible. She stopped fidgeting and looking around fearfully, and a deep calm seemed then to slowly materialize.

I know that it may be difficult to believe a simple conversation like this would permanently relieve this patient's confusion and suffering. I had to see her again a few times over the ensuing months and years, because the epistemological trauma continued to undermine the decisions she was making in reconstructing a life for herself after her husband's departure. For example, a year and a half later, she fell in love with a very kind gentleman, but she was terrified this move was setting the stage for a repetition of the disaster that had occurred in her marriage. She needed me to help her see that the doubt she was having was primarily based on the shattering of her trust in what she thought she had known, and that she was still on the pathway of learning again how to have faith in her perceptions and judgments. She eventually married again and things worked out well enough. Both she and her sons had, however, been deeply injured by the first husband's glorious breakthrough to freedom, and they suffered its destructive effects in other ways for a very long time.

2. My second experience that taught me about this form of trauma involved an 18 year-old student who came to me for counseling. He was a very bright young man with deep interests in eastern philosophy and religion, and although he was outwardly functioning well in his college program, he had begun to feel very depressed and wanted someone to talk to about his feelings. I asked him to explain what was depressing him, but he was unable to identify any situation or event that was relevant. He said in fact that really nothing specific was influencing his emotional state, because nothing in his life even seemed completely real. I asked him to explain further what this statement meant, and he said that he felt the world in which he lived was an illusion of some sort, that it lacked any independent reality, and that who he was, or where he was, in actuality, was completely unknown. He said he might be a catatonic schizophrenic locked up in a back ward of some psychiatric hospital, hallucinating his college career and even his conversation with me. Or it seemed possible that some unknown force or God-principle was generating a kind of world-story, and he was a mere character in this cosmic fiction with no independent reality of his own. This sense of everything being some kind of illusion was related to his fascination with the Hindu and Buddhist religions, which are predicated on the idea that the world we sense is Maya or Sangsara, illusory, something from which we need to emancipate ourselves.

The young man's feelings were obviously about something, and I wanted to find out what this might have been. A clue appeared when I asked him how he entertained himself, what he did in his spare time. He told me he liked to hang out in graveyards, by himself. Often late at night, when his family members were already sleeping, he would get in his father's car and drive to one or another of the cemeteries of his town. He liked to walk amongst the gravestones, reading the inscriptions and wondering about the lives of the people who had been buried there. After an hour or so, in each of these visits, he would get back in his car and return home.

How does this relate to epistemological trauma?. I let the young man's descriptions of his feelings and practices flow over me like a waterfall. And then I waited for a thought to occur that might take me toward the emotional truth lying inside what had presented itself. The first thought that came was that something must have happened to this person to render the world unreal. One does not come to such an experience for no reason, and so there will always be something that is involved. The second thought that arose was that the nocturnal visitations to the graveyards must be reactions to whatever the event was that turned the world to illusion. It seemed to me that he must be looking for something or someone in the cemeteries, so I asked him what or who this might be. He was not aware of looking for anything specific, however, so he was unable at first to answer my question.

I asked him then if anyone important to him had died, because as I thought about all he was telling me, the word "mourning" kept coming into my mind. He seemed like an aging widower returning to his beloved wife's grave. The sad story of what this was about then came out.

The patient, when he was seven or eight years old, had suffered the loss of his mother. He had been very close to her through his earliest years in a family consisting of himself, his mother and father, and three siblings. He was the second-born of the children and the family's life was one of emotional security and normality. The mother, however, had an undetected temporal lobe cancer. One day, as my patient was at school, a devastating cranial pain occurred, and she collapsed into grave, critical condition. When he came home from school, she was not there, and he was told she had been hospitalized because of a headache but that she would be coming home soon enough and he was not to worry. He had no reason to doubt what he had been told.

Days passed, the mother did not return, but the boy felt confident that in time everything would work out. Mommy would come back maybe tomorrow or next week when she got well, which again the next-door neighbors had promised him. Incredibly, the boy's father could not face his children and was absent throughout this short period. Finally, one day at school, another child approached the boy and teased him about the fact that his mother had died. My patient struck out at the child who made this seemingly sadistic statement. He was certain his mother was alive, even if not well, and that she would be coming home. After all, he had been told so, and, anyway, mummies don't die. They promise, implicitly and explicitly, that they will always be there.

That night he was informed of the truth by his family's minister. It was disclosed as follows. The minister asked my patient when he thought he would see his mother again. The boy answered, "I don't know, maybe next week or something." The minister then told him he would see her again, but that it would be longer and he would have to wait. The boy asked if it would be a month or more. The minister said no, that he would have to wait longer still. My patient then asked how long it would be. The reply was: "You see, you will be with her again in Heaven. She has died, but in everlasting life, you and she will be reunited." My patient's young heart burst at this point as the awful truth rolled in upon him.

The trauma was twofold. On the one hand he had lost the person to whom he was closest in his life, and continuing without her presence was unthinkable. On the other hand, he had believed and been led to believe that she would get well and return, and this faith in her was foundational for him. But this belief had been shattered, and all that he thought he had known now broke into pieces. It was a trauma of loss, and it was an epistemological trauma of the first magnitude.

Recurrent dreams then appeared as this grieving child lay sleeping. He dreamed dozens of times that his mother was running up to their house and joyfully shouting to everyone that it had all been a misunderstanding, a case of mistaken identity or some such. The dreams were enormously relieving, restoring his mother to life and reconfirming what he had believed was true with all his heart. Upon awakening, however, his beliefs and his mother were lost to him once again. He wept bitterly as he recounted the scene with the minister and told the story of his dreams.

During the weeks following his mother's death, he also tried to have some contact with her spirit, gradually accepting that she had vanished physically but

clinging to the belief she was still somehow present, however invisibly and tenuously. He asked her to give him a sign that she was there. Nothing occurred. He then set up a kind of spiritualistic experiment, taking a tiny, almost weightless wisp of cotton, carefully putting it on the surface of one of his mother's sewing thimbles turned upside down, and placing a clear glass over the display to keep drafts of air from disturbing the cotton. Then he waited for his mother's spirit to signal him by moving the wisp, however slightly. The cotton remained still, as motionless as death. Had the experiment worked, he would have known her presence was still real and at least a remnant of all he had believed would have been reconfirmed. Instead, the trauma only continued and deepened.

Within a few months after the tragedy, dissociation set in and the boy stopped thinking about his mother's death and life, throwing himself instead into his schoolwork and experiences with his friends. He wrote an autobiography at the age of ten for one of his classes and brought it to me during a session. It was remarkable. It recounted a series of incidents belonging to his very early childhood, and then another series belonging to his middle childhood years, but there was no mention of his mother's death, almost as if this part of his history had been excised. He remained aware of the raw physical fact of what had happened, but ceased giving it any thought. Eventually almost all of his memories of his mother's life and death faded from his recall.

I told the patient that I now understood why everything seemed so unreal to him. It was because all that he had considered real had been obliterated in the tragedy of his mother's death. To start with, it had never been conceivable that she could die, so that would be the first blow against what he had believed. And second, he had trusted the reassurances she would return during those anxious days following her hospitalization. So all that was real had been doubly destroyed, and this constituted an attack on the foundation of his world and on his ability to trust his own perceptions. I think this is a primary reason his mother's death had to be dissociated. It was not just the unbearable pain of sadness and missing her that was solved by this adaptation; reality itself was protected against a savage blow and he was able to continue his young life relatively intact. Intact, that is, until his late teen years as the realness of the world began to be called into question, as everything began to seem increasingly illusory. The walks in the graveyards were transparent efforts to refind his mother, to recover a world that was stolen from him by her death, ultimately to repair and restore an integrity to his own mind and faith in himself.

There had never been an opportunity to share his experiences of loss and invalidation with anyone, and so I tried to create a space within which he could come home to himself. I listened to him as he told of his lonely journey, I stayed with him through a great deal of the crying that occurred, and I told him what I thought had happened to him. That was about it. He understood himself better through this process, which extended over a number of years of our contacts, and he eventually did very well in his life. By the way, one effect of all our discussions was that the reality of the world was restored, and his fascination with Hindu and Buddhist thought receded. He eventually became a clinical psychologist, a very good one.

All trauma is epistemological trauma. My little stories are really just special cases of the more general principle that it belongs to the nature of traumatic experience that it shatters the reality in which the person has believed. It is an attack, in the phrasing of my friend Robert Stolorow(2007), on the ‘absolutisms of everyday life.’ The trauma survivor, in consequence, is always someone who has been cast into the darkness of unknowing.

4. *Aesthetics: the question of the beautiful*

Is there a place for the beautiful in how we understand people, perhaps including ourselves? Is the understanding in which we can have faith always beautiful? Are ideas that we develop that seem ugly to the viewer for that reason to be held in doubt? In what, exactly, does beauty in our field consist?

1. I will go into a specific case and a specific interpretation that emerged in the long course of the patient’s psychotherapy. It concerns a dream experienced recurrently by a child between the ages of 5 or 6 and 13. The patient was in her mid-twenties when she told me about it, but it was one of the most vivid recollections of her childhood. Here is the dream, in the patient’s own words: *“I am lying on my back, naked, in my front yard, staring up into the sky. There are five or six small men lined up on one side of my body, and five or six more on the other side. They seem like gnomes or elves or something. Each one is holding a piece of string in his hands, and on the end of each string, inserted into my skin, is a fishhook. There is one in my cheek, my neck, my breast, my waist, my hip, and down lower on my leg - and the other side of my body the same thing.. The men are pulling on their strings and hooks, and my skin, all up and down both sides of my body, is being pulled out and stretched, back and forth. It’s a tug-of-war. It’s creepy.”*

There is nothing beautiful on the face of this dream; in fact, it is in its imagery horrifying and ugly. I shall recount how my patient and I came to an understanding of its meaning. It required 13 years. The patient told me the dream on the first occasion I saw her but neither she nor I could penetrate its opacity. Other dreams she had were easier to understand, but this strange dream of the men with their strings and their hooks floated there for years without any clarification taking place.

The patient, as a small child, had been the victim of the worst sexual abuse I have ever seen. She was enlisted, at the age of 2 or earlier, to provide her father with oral sexual gratification. Two or three times each week, he came into her bedroom, secretly, while other family members were sleeping, and inserted his penis into her mouth. Then he gently encouraged her to stimulate him to erection and eventual orgasm each time. Following this, he would kiss her and tuck her in for a continued night’s sleep. The sexual abuse extended over a period of 11 years, at which point it stopped because the father was discovered by a relative in the act of anally raping my patient’s younger brother.

Although I knew much about the history of the father’s intrusions, I did not understand the connection to the dream until, one night as I sat with my patient, she cried out:

“I know what it is! The men, and the strings and the hooks!”

She then proceeded to explain that the two rows of little men were images of her two fathers, one of whom was completely normal and the other of whom was a sex maniac. The father of the daylight, as she put it, was a conservative gentleman who supported the family and tried always to represent the highest of moral values. The father of the night, in devastating contrast, was a strange, leering creature who insisted on sexual intimacy and made sure it repeatedly occurred. My patient had dealt with these opposing fathers by cordoning off the experiences in the night from the normal world of the day – when she was in the one she thought nothing about the other. Her development, however, was poised between the two, as she tried to achieve a sense of herself and a life that would have meaning to her in spite of the conflicting pressures and pulls imposed by her father’s madness.

I thought my patient’s spontaneous interpretation of her dream was beautiful. Perhaps I should say it was not the interpretation that was beautiful, but rather that the dream itself was rendered beautiful *by* the interpretation. Once one understands that the two rows of gnomes symbolize the two worlds of the patient’s childhood struggles, the dream becomes a structure beautifully expressing the impossible dilemma in which a young girl finds herself. How perfect the images are: naked and defenseless she lies there, pulled first to the right, and then to the left, and then again to the right, and the left, and back and forth, endlessly. These movements were the rhythms of her days and nights as she tried to inhabit incompatible realities, created by her father’s recurrent turning to her to serve his emotional and sexual needs. The dream is beautiful in that it captures the essence of a child’s experience, far better than any rational description could ever hope to. Dreams symbolize the subjective life of the dreamer, and this life was one of feeling forever pulled apart.

This patient also told me she had always felt she was in pieces, as if someone or something long before had pulled her apart. She said her sexuality, her religious beliefs, her humor, her sense of social responsibility, and her competence professionally were all somehow different “selves,” none of them connecting to the others in a cohesive structure. She obviously had been pulled apart, by the strange double binds implicit in her abuse

I saw her for 30 years, and she did exceptionally well, pulling herself together, marrying and bearing two sons, and progressively freeing herself of the awful legacy of her father’s crimes against her. It was in the space of the understanding she and I shared that her ability to surmount the impact of her abuse finally began to crystallize.

If the dream of my patient is made beautiful by the interpretation that sprang into her mind, what accounts for this beauty? In what, precisely, does it consist? The dream becomes beautiful because of the understanding that has emerged. Formerly opaque images that were nothing more than creepy and puzzling suddenly are rendered transparent and the life dilemmas that are symbolized shine through with breathtaking clarity. Beauty resides in this transparency, in spite of the events that are represented being so terrible. We can look at this strange recurrent dream and feel our hearts breaking in the face of the child’s impossible

situation. The tragic inner truth of this young life is inscribed in the dreams, and truth and beauty go hand in hand.

. When we understand something about someone, and what I have called ‘the inner truth’ of a life becomes disclosed, does this always entail an experience of the beautiful? I think the sensation of beauty resides precisely in the perception of truth. A case on which I consulted recently comes to mind, but really any time one reaches an understanding of a life one will find an instance of what I am talking about.

2. The story I think of involves another young man, a 22 year-old philosophy student pursuing his doctorate. I was called upon as a consultant by his analyst, herself a young woman. He was a self-described radical determinist. This meant that he felt and believed there to be no such thing as freedom. He argued, with great passion, that all talk of choice, of agency, of volition was nonsense, because the structure and content of our lives is controlled by our circumstances. Human beings are, according to the position he maintained, 100% in the grip of their history of conditioning and of their biological evolution.

Another aspect of what this man argued was that true communication between people is impossible, because everyone is locked up in his or her private subjectivity. One could not dispute any of this without becoming the target of a withering refutation.

A final feature of the case was that he said he expected to kill himself before his 30th birthday. There was absolutely no reason to live, as far as he was concerned, but he did find philosophical argumentation mildly amusing, and so his suicide was postponed for a few years while he pursued and promoted his determinism. He said he might write a book expounding his ideas, and then celebrate its publication by ending his life.

I saw no beauty in this young man’s thinking at first – in fact the ideas were rather ugly, and bleak. The analyst consulting with me had been drawn into debates with the young man about his philosophy, and the resulting arguments had become heated and disturbing. It was obvious that such an approach would be fruitless, in part because the patient was so brilliant and quick that he could run circles around almost anyone. Those whose intellectual positions he successfully countered became objects of scorn to him, and the analysis was at risk of failing before it even began. This was the reason for the consultation.

I told the analyst about certain feelings and images that came into my mind as I listened to the summary of the patient’s philosophical convictions. I was letting the waterfall flow again. The first feeling was of sadness, as I thought about the vision of people as isolated prisoners of their own private subjectivity. Sadness, and then an intense lonely feeling enveloped me, and I went on from there to a sense of powerlessness and helplessness, as I thought about his determinism. An image formed that was very clear, of a little boy, a miserable child whose isolation was profound and who felt unable to have any effect on the people in his surroundings. It was a picture of a depressed youth who was misunderstood and abandoned by his parents and other family members. I urged the analyst to let herself flow in a similar direction in an effort to find the emotional meaning of this man’s dark philosophy. An idea then came to us that his rigorous, aggressive

arguments on behalf of his thinking were highly intellectualized efforts to control and master an underlying life tragedy.

I asked about the man's mother and father. He had briefly explained in his first meeting with the analyst that he did not know his parents. He had lived with them, in their house, but they were people who never expressed any affection, physically or verbally. Wholly undemonstrative and uncommunicative, they had made their son feel like he was living with strangers. These same strangers, nevertheless, had been oddly involved and overinvolved with many of his experiences and choices growing up. His father, hearing of his early interests in philosophy when he was a high school student, contacted various colleges for him to consider attending. His father also arranged a summer internship after high school graduation where he could work in a philosophy professor's office.

There was more. A part of the family saga concerned what had happened to the young man's father when he, the father, had been a boy. He had shown signs of great talent in drawing and painting as a young child, and had made a very early decision that his destiny was to become an artist. This deeply held intention, however, had not gone over well with his own father, who after tolerating the artistic interests for a few years insisted that it was all effeminate foolishness and needed to be given up. When there was resistance against this decision, all the art supplies were taken away and the will of the boy was summarily crushed. The mother did not come to her son's defense. He never painted or drew again, and later became a certified public accountant.

The thought ran through my mind: what if the patient's father was, in his heart and soul, an artist though? Then it could be said that he was spiritually killed by his own father, because it is my view that an artist is nothing other than his art. I wondered if this man was somehow trying to reconstitute his own destroyed life in the journey of his son, my colleague's patient. What if the father had saddled his son with the task of living out his own unfulfilled life? The analyst said there had been some further features of the young man's history that were indeed consistent with such an understanding. The father had personally arranged multiple employment opportunities, college and graduate school admissions, and had even written his son's personal statements and resume. Although he was emotionally unconnected to the boy, he had done everything for him to such an extent that the patient needed only to flow into the slots that kept being prearranged for him. Hearing this, the philosophical determinism that had previously seemed so unattractive began to glow with a strange beauty in my eyes. His arguments that agency and volition are illusions and that people are deterministic pawns, perfectly crystallized the experience of a child whose life has been created for him, pre-scripted and therefore predetermined in every detail. Every detail, that is, except for one: the determinism itself, which now appeared to me to be the lonely cry of a soul in bondage.

I suggested that when the young man launched into long intellectual disquisitions, she tell him she had images of an isolated, lonely boy that came into her mind. When he told of how human beings are determined and how free will is an illusion, she could speak of a child who had no say in the unfolding course of his own little life. I suggested she could even make use of some of his fancy

vocabulary in this refocusing of their conversations, by telling him he seemed to have been raised by a couple of windowless monads. His parents were like that: people whose inner experiences were completely inaccessible. I would anticipate such reactions would bring a halt to the philosophizing and make contact instead with the underlying emotion. I would want to see the young man crying. If he could be brought into the feelings beneath his very depressing philosophy, there was a good chance that his planned suicide could be averted. People often need, above all other things, to cry.

It all came together more or less as I had hoped. The young man, when responded to on the basis of his inner feelings, dropped his intellectualizing philosophy and began to sob. He cried long and hard, for hours and days and weeks. Eventually an idea crystallized, out of all this sadness, an idea within his own mind about all that he had lost in the course of his journey from childhood to genius. He had lost the opportunity, reduced to its simplest terms, to be himself. He had lost the chance to grow into the person he might otherwise have become, the hopeful, creative young man who could give of his fundamentally loving nature to others. I don't want to make this sound all positive – there has been an enduring legacy of bitterness about the absence of support in his original family, and as well about the pervasive absence of support in our society for authenticity in the lives of its citizens. Still and all, he came out as someone who could support community rather than isolation, the expression of individual identity in a sustaining social world. I would say this was quite an achievement, in view of the cynical, deadly philosophy from which it began.

CHAPTER 4: DREAMS AND DELUSIONS

[In a dream, a delusion, or a work of art] a situation taken up into a metaphor loses its transitory, painful and unstable quality, and becomes full of significance and inner validity, the moment it passes wholly into an image

Rainer Maria Rilke

I first discovered the field of psychology, during my seventeenth year, in the writings of Freud and Jung. Among the many intriguing things with which these gentlemen concerned themselves, I discovered, was the world of dreams and dream interpretation. Nothing has ever been more interesting to me. What follows is a collection of ideas and clinical stories about the dreaming process and the use of dream interpretation in psychotherapy. I also take up the relationship between dreams and delusions.

The man whose head was crushed by Walt Disney

In a psychoanalytic seminar during the years of my training, the instructor presented the idea that one should always pay close attention to the very first dream a patient presents in psychotherapy. It was his opinion that this first dream will concern the deepest theme of the treatment that is to come, often forecasting or otherwise symbolizing the content of a process extending over many years. I found this idea interesting, and it has largely been borne out in my own clinical experiences. I shall begin with an account of one such dream, the terrifying nightmare of a young man who came to me for analysis a long time ago. This patient, 35 years old, was a teacher at a small college, and was suffering with a serious depression. After our first meeting, he sent a note describing his dream, which became a centerpiece of our work together. These were his exact words: *I watched a teenage boy walking into a large room. He had suffered a permanently damaging cerebral injury, in an earlier fall from a swing. He approached a table behind which sat an array of older men, and in the center, kind of like the chairman of the board, was Walt Disney. On the table were various small objects: pens, coffee cups, keys. The boy concentrated on these things and, psychokinetically, made them begin to whirl, levitate, and move up and down the table. It was a dazzling demonstration of paranormal powers. Walt Disney reached over the table and gently cupped the boy's head in both his hands. This affectionate holding continued for a few moments, but then Disney began to press inward. Very slowly the pressure increased, moment by moment, and finally, with an exertion of enormous strength, the boy's head collapsed and was horrifyingly pulverized.*

As I read the text, it became evident my patient was giving me his autobiography, a story in which severe trauma played a repeating role. Strangely, he had no understanding of this. He was someone who skated along the surface of his very painful experiences, unmindful of the extremity of the things he had faced.

Dreams are autobiographical microcosms, symbolizing the subjective life of the dreamer. They are representations, to ourselves, of all that we undergo and all

that we feel. Here a life is pictured involving a fall and injury, the appearance of magical powers, the finding of a loving embrace from a person of authority, and then a deadly crushing by that figure. My patient did not regard the dream as anything more than an odd puzzle of impressions and symbols, and the only remark he made was that the Disney figure might have represented the pressure he sometimes put on himself.

I told him what I thought: that it was a metaphorical account of his emotional history, of injuries that had occurred, of the lastingly disabling blow of something symbolized by the fall from a swing, and later something else, represented by the violence of Walt Disney. I did not know the specific events of this man's life, but I was sure I was seeing the effects of his history vividly portrayed. I asked him to tell me what had hurt him so deeply. He could not respond. Finally he told me that there was a strange pressure, like a soft elastic band or a cloth, drenched in warm water, somehow wrapped around his head, pressing gently and covering his eyes. It was the pressure of sorrow he carried in his heart, an indescribable sadness that was with him at all times. This man was one of the saddest people I have ever known, and it was interesting to me that he seemed not to be aware of it as such. His experience was just one of wet, warm pressure, as if he had been crying.

What was the history in this case represented by the events of this man's dream? There had been an early fall of a kind, a violent blow that made him feel changed forever. His mother, someone deeply beloved to him, had died very suddenly because of an undiagnosed brain tumor when he was eight years old. After long discussions with me, he was able to recall what he had felt upon learning of her death: he had been as if impaled on a pole, which some terrible force was swinging violently back and forth in the sky and slamming him into the ground again and again.

The dream included an idea that there had been a fall from a swing and a brain injury - an allusion to the impact of the death, which as a boy he had pictured as extreme violence. So the first part of the dream seemed to condense the early trauma history. I was unable to specifically decode the idea of a fall from a swing, until he remembered being swung through the sky and slammed into the earth. The paranormal powers which appear are a kind of inverse of his trauma; they create an image in which debilitating effects are undone by supernatural capabilities. As I contemplated this young man's impressive powers in the dream, a deep sadness came over me. He can move things around with his mind, but he cannot undo the injury that precedes it. He creates miraculous effects upon the small objects lying before him on the table, but he cannot bring his mother back from the dead. A binary crystallizes here: supernatural potency versus utter helplessness, the kind of thing one sees often enough with shattering trauma.

The psychokinesis also stands in relation to the third part of the dream, wherein Walt Disney cradles, and then pulverizes the young man's head. These images, I saw immediately, tell a further story of something that had happened, something crushing. I told him that I thought someone had hurt him really badly,

and I asked who it was. He answered that he didn't know, and wondered again if this concerned terrible demands he put on himself. Again I posed my question: *"Who is it that first of all showed a protective, supportive love, but then exerted some kind of brutalizing pressure on you?"*

He finally answered differently, describing a recent letter from an admired older man, someone who had been his beloved mentor but who had turned on him and on his work and teaching at his college. Years earlier, my patient, a brand-new Ph.D., had met a senior faculty member in his department, a gentleman who was an internationally recognized scholar in my patient's field of study. An intellectual love affair had developed between them, in which the scholar mirrored and nurtured the emerging talents of my patient, and my patient devoted himself to supporting the creative work and thinking of his mentor. The first years of this relationship were idyllic, and the native capabilities of the young man began to unfold into important ideas and writings. It is possible that the dream picture of paranormal abilities alludes to these evolving capacities, which, to the young man, seemed like miracles brought into being by his inspiring mentor. Again and again he found that in the presence of the older man, in dialogues about various ideas and developments in their shared field, insights would come into his mind that he could never have achieved while working alone. As he continued to develop under this nurturing guidance, he began to publish on a number of topics, and his field began to recognize a new voice that had appeared in its midst. Here is where the problem arose: the older man could not tolerate the success of my patient, when he had sown the seeds of that success but was now receiving no public credit. My patient saw clearly his indebtedness to his mentor, and even tried to coauthor a number of essays and books with him. But the older man did not approve of all the directions in which the work was going, and a collaborative enterprise turned out not to be possible. In the meantime, the mentoring professor's own scholarship had become paralyzed, and he had published nothing over a period of many years. But now he was witnessing the development of ideas he had participated in inspiring, in the works of the young man he had nurtured. A paranoia began to crystallize, in which the older one visualized the younger one as a kind of vampire, feeding off of his thoughts and stealing all his most important concepts. Finally, in a rage, the mentor fired off a long letter filled with ugly accusations, telling my patient he had cannibalized a treasurehouse of original ideas in order to satisfy a pathological need for fame. He also communicated his suspicions to important figures in his field, and this began to come back over the grapevine to my patient. The accusation of intellectual robbery, spread across the country, was experienced as a crushing personal blow, and this is certainly what is symbolized in the horrible violence with which his bad dream comes to an end.

I worked with him closely, and he eventually did reasonably well. He found it possible to partially heal the breach, basically by flooding the older man with letters and phone calls of love and gratitude. After a number of years, things improved between them and the mentor finally expressed forgiveness and regret for how he had reacted. This softened the blow of the trauma significantly. It also helped my patient to learn that other students of his mentor had experienced

the same thing: an initial period of nurturance followed by accusations of robbery and extreme hostility when the students sought to break away and find their own pathways.

Why was it that the person in the dream administering the crushing blow was Walt Disney? I don't know. My patient disliked Walt Disney, and regarded his lifework as plastic and artificial – although he said he did have a fondness in his heart for Scrooge McDuck.

It occurred to me that Walt Disney fed the fantasies of the young, entertaining them with all manner of stories having magical and supernatural qualities. But he was also a man exploiting the sense of enchantment among children to achieve commercial success. In this respect he was rather like the Wizard of Oz, appearing magical, until one discovers his all too human failings. Similarly the mentor figure was idealized, until he too revealed his own personal limitations - by attacking my patient for stealing away fame and recognition. He continued to love his mentor for many years. He also continued to feel a certain amount of pain about the events that had transpired, being haunted in particular by the “forgiveness” that had been granted - implying he was still being seen as having committed a crime.

I did not focus on this young man's associations in determining what the dream imagery might concern. Is this not a cardinal principle of psychoanalytic dream interpretation? Here is what I think, after half a century of studying dreams and their meanings. Interpreting a dream is a matter of locating the context of experience to which it belongs – sometimes a dreamer's associations can assist in this, but often the associations are misleading. My patient's thoughts went in the direction of the harsh judgments he placed on himself. This was not entirely unrelated to the dream, but strayed from the heart of the matter: that he had been terribly hurt by what had happened to him. An ongoing issue for him was that he seemed to move along the edge of his own painful feelings. The dream, in contrast, presents two images involving great violence: first a fall, leading to irreversible brain damage; and second, the crushing of a person's head. So we could say the dream stands up for the extremity of his historical experiences, correcting or compensating for his conscious attitude of unmindfulness.

The electrocution of a baby girl

I will now tell a story about a second patient's initial dream in a long psychotherapy process that occurred. The account concerns a 31 year-old woman who sought help because of paralyzing feelings of being a frightened child, lost in a world of high-powered grownups. These disruptive states stood in contrast to her external situation, one of having achieved great financial success and of having earned the respect of numbers of people who followed her leadership. She was an impressive adult by every objective criterion; but her feelings were of being a terrified little girl. Here is the dream as she presented it, which occurred the night following our first meeting:

I am walking down a long corridor toward a brightly illuminated room. As I approach the doorway, I see a baby girl, not more than a year old. She is sitting on a blanket in the middle of the floor, and there is a strange metal contraption on

her head. It seems to be a helmet of some sort, with coiled wires coming out of the top and connecting into a wall. A horrible realization: the baby is about to be electrocuted, and the helmet and wires are part of the apparatus that will kill her. Doomed.

The dream was one of terror. I understood it as her picture of her situation in entering into a psychotherapy relationship. She felt she was submitting herself to something that would end her life. What this awful expectation came from only became clear when she added a detail regarding the dream, some weeks later. The infant on the blanket had been naked, facing the door, with her little legs spread apart. This baby was wide open to some kind of sexual attack.

She had undergone a terrible sexual exploitation, perpetrated against her by an earlier psychotherapist. The story was this: she had known, loved, and trusted a man, who had helped her during her late teen years with deeply buried feelings arising out of extreme neglect and abuse in her family of origin. But then, having earned her devotion over a three-year period, he changed the terms of their tie: it now became her responsibility to keep him sexually satisfied. He presented the new arrangement with an explanation that their sexual interaction would help her crystallize her emerging identity as a mature woman. She had absolute faith in this gentleman, who she believed had saved her life, and therefore complied. For more than a year she provided oral gratification on a regular basis, and even paid for the opportunity, because of its ostensible purpose of solidifying her flowering womanhood. Finally, when she began to express doubt and confusion, he became angry and denounced her for being too childish to appreciate the incomparable gift she was receiving. She then fled the relationship, vowing never again to depend on anyone.

She reburied the child within her, along with the deep hurt to her soul. Although she knew she could never return to him, she maintained an idealized picture of their relationship that encapsulated all the good things he had given to her before the sexual interaction commenced. In the ensuing years, she completed her education and rose within her profession to a very high level of competence and responsibility. It was at this point that the injured child began to resurface, in the form of feeling like a little girl surrounded by scary grownups. She needed help in the worst way, but to seek help from a psychotherapist was to reenter the danger zone that had already nearly killed her. She was afraid that by entering into a new psychotherapy she was signing her own death warrant.

As in the case of the young man I described earlier, I told the patient what I thought the dream meant. I explained that I found the terror in her heart was understandable, in view of what had happened in the other psychotherapy. I also suggested that she might have begun to trust me already, and that this was what was causing the surge of fear. Look at what trusting an analyst before had brought into her life. She was telling me that if the same thing happened this time, it would be the end.

Working with such patients is always difficult, because trust needs to become established; but trust has become a deadly enemy. So one goes back and forth,

often for a long time; eventually though things tend to work out if there is a shared understanding of the storms of fear that arise.

Why did she have this dream? Why not just say how afraid she was? The dream was her way of telling me of her fear. The original experience of having been injured by her therapist had actually never fully developed. It was dissociated after her departure from the relationship, and in the early months of our work she still idealized this man. A positive picture of his meaning in her life was indispensable to her continuing survival and progress. The fullness of his damage to her life became real to her only very slowly. But the dream registered that damage vividly right at the beginning. There is an old idea in our field that the disaster one fears in the future is actually a memory of a catastrophe that occurred long ago. This would seem to apply here, in the frightening picture of the impending murder of a baby girl.

If my patient had been in touch with how deeply hurt she was, I think there would not have been a need for a dream. Dreams capture something that is incomplete in one's conscious life. Impressions, feelings, memories, thoughts all in a swirl, not worked out, insufficiently articulated, incompletely thought through: this is the stuff of dreaming.

Freud (1900) gave us the formulation that every dream fulfills a wish, or attempts to do so. How would my own formulation about the general features of dreams relate to his? Freud was hypnotized by the image of the unfulfilled wish. One could reinterpret his proposal as a special case of the more general principle that dreams are attempts to resolve subjective tensions. They express a need to come to terms with issues that are problematic in the waking life of the dreamer. There are obviously many situations that are laden with tension other than the one involving an unfulfilled wish.

In my youth, enamored of Freud and Jung, I had the idea that the study of dreams and their meanings might disclose profound truths about human existence. Here are my thoughts on this matter, after dwelling on the issue for a very long time.

It is human nature to dream, which means to create systems of symbols representing our ongoing subjective life. Our consciousness itself, in consequence, becomes immensely more complex than would be the case if we lived only in unsymbolized immediacy. In our evolution, humanity came to itself when dreaming began. It is a foundational manifestation of the symbolic capacity, and it is this that distinctively defines human nature. One may ask if dreams can somehow teach us the secret of human nature. The fact that dreams exist is human nature showing itself.

What is my understanding of the relationship between dreams and language? Many have thought that it is language that defines the uniqueness of human beings. Dreams and language appeared together. They are coequal manifestations of the symbolic function. I place the capacity for creative

symbolization at the center of human existence, and dreams are a cardinal expression of this capacity.

Returning to the dreams discussed earlier, the first about the young man whose head was crushed, and the second about the infant's electrocution, can it be said that these images are matters of creative symbolization? The creativity involved in those two instances is breathtaking, transforming emotional injuries into dramatic events. In one case someone's devastation at the hands of his beloved mentor is represented as the sadistic crushing of a boy's skull. In the other, the searing transformation of a therapist into an exploitive monster is visualized as the impending murder by electrocution of a baby girl. Dreams are quintessentially creative, which is one of the reasons I think they are central sources of culture itself. Also, dreams are not just a matter of the play of images in discrete intervals during our hours of sleeping; we are continuously dreaming, daydreaming, fantasizing, playing, and symbolizations of subjective life are always crystallizing, interlacing, and interacting with one another.

Dreams and Delusions

Let us turn to a different question: What is the relationship between dreams and delusions? Are they the same thing? Is a delusion a dream from which one cannot awaken?

Engaging with these questions requires first of all a definition of the term, 'delusion.' The conventional definition is that it is a false belief someone clings to in spite of all contrary rational argument and evidence. Drawing on the principles of phenomenological contextualism, I would say a delusion is a belief, any belief, about the validity of which there can be no discussion. The evaluation that the belief is false requires a comparison between what is real to the person and what is real according to some objective, external standard – a dilemma one can avoid by staying with the idea that there can be no discussion of the validity of the so-called delusional belief.

So what then can we conclude from a comparison of dreams and delusions? A delusion is similar to a dream in that it is an enveloping experience with little or no reflective awareness. One can compare and contrast the two with regard to the contexts involved. The context of dreaming, whether in sleep or in reverie, is one in which attention becomes unfocused, thought frees itself from the constraints of logic and reason, experiences are cast into concrete perceptual images, and everything becomes more-or-less interchangeable with everything else. Freud offered an idea about this in his theory of the so-called primary process. I prefer not to use his terminology, but he was right to emphasize there are differences in the organization of our thoughts and experiences in different states of mind.

So-called delusions share certain features with dreams: they partake of the concretizations dreams show, their organization follows no logical or rational schema, and things become interchangeable with each other in all kinds of complex ways. A delusion though is a generally stable structure, and in this respect is like a dream from which one does not awaken. Another resemblance has to do with memory: delusions, when they recede, tend to be forgotten, almost

as if they had never been there, like a dream that lingers for a while but then fades into oblivion.

Delusions form, generally speaking, in a context of very severe threats against a person's sense of existing – they belong to the psychology of annihilation states. By casting the danger to a person's sense of being in highly concrete, particular images, the delusion expresses an effort to resurrect oneself and be protected from the possibility of obliteration. Someone in the midst of these struggles may have a dream that essentially does the same thing, and that dream may carry over into a relatively permanent structure, which we would then call a delusion. So a delusion could be understood as a long-lasting dream, elaborated in the context of personal annihilation.

The story of Anna returns to mind, whose experiences I touched upon in chapter 1. She was the young woman who had a terrible dream of being shot by her mother as she, Anna, stood before a large mirror. The result of the shooting was that the glass of the mirror disintegrated into a swirling cloud of fragments and the patient became nothing more than a fleeting, vanishing shadow. This dream, vividly symbolizing an experience of personal annihilation, was helpful in decoding the subjective truths inhering in the patient's persecutory delusions about penetrating, killing rays attacking her from the eyes of her enemies. These rays, it will be recalled, began at a certain point of the therapy to emanate from my own eyes, producing all manner of difficult reactions from Anna and threatening the work in which she and I were engaged.

The dream and the delusion displayed an isomorphic relation to one another: in both instances, an invasive, penetrating action from without was followed by a sense of being killed and erased from being. There actually was an array of other similarly structured images Anna became afflicted by in this early period of her therapy. For example, she repeatedly became convinced that tiny insects, perhaps ticks, had somehow crawled into the canals of her ears and were voraciously eating their ways deep into her brain. Medical examinations revealed no problems in her ears or in her brain. Her drawings at that time also seemed to reflect experiences of being intruded upon and invaded. She produced dozens of images showing a person with his face pressed up against hers, in such a way that the other's long, pointed nose was piercing her face and head, intruding into the inner structure of her brain. The drawings were horrifying to look at: they seemed to depict a bizarre, brutalizing rape of my patient's head. All of these representations – in her dream, her delusion, her fearful fantasy of the invading insects, and her artwork – gave concrete form to a feeling of being usurped and annihilated by the intrusive, invalidating perceptions and attributions of others. Perhaps the worst of these experiences occurred in a psychiatric context, wherein she was relentlessly viewed as a deeply disturbed schizophrenic.

The ultimate extreme of the destruction materialized in her psychotherapy with me, when my uncomprehending reactions to her delusional preoccupations made her feel herself turning into an incomprehensible psychiatric object, a dead thing composed of neural solidities produced by the rays flowing out of my eyes. With the help of her dream, as well as of her other images, I finally saw the impact of my invalidations on her capacity to feel an ongoing sense of being. This in turn

made possible a new response to her devastation and, finally, our relationship became something that began to sustain rather than destroy her.

The dream of the obliterating gunshot and the delusion of the petrifying rays from others' eyes thus were equivalents of each other, concretely depicting her failing struggle to maintain a sense of being alive in the midst of forces that, from her point of view, made such survival impossible.

In this story, a dream and its context helped to decode the metaphor present in a delusion. I shall now tell another one in which the relationship between a dream and a delusion can again be illuminated. Is there a general principle that can be stated connecting the one to the other? Let us consider the dream and principal delusion of the famous patient Renee, the author of *Autobiography of a Schizophrenic Girl* (Sechehaye, 1952, p. 21). I will quote the young woman's words describing her dream.

“A barn, brilliantly illuminated by electricity. The walls painted white, smooth – smooth and shining. In the immensity, a needle – fine, pointed, hard, glittering in the light. The needle in the emptiness filled me with excruciating terror. Then a haystack fills up the emptiness and engulfs the needle. The haystack, small at first, swells and swells and in the center, the needle, endowed with tremendous electrical force, communicates its charge to the hay. The electrical current, the invasion by the hay, and the blinding light combine to augment the fear to a paroxysm of terror and I wake up screaming.”

It seems to me that Renee was identified with the needle, and the engulfing hay that fills the brightly illuminated barn was a symbol of the annihilation experience she was undergoing. The surrounding passages in her book describe a progressively deepening derealization experience, in which everything around her began to appear mechanical, separated into isolated single elements – it was a breakdown of the coherence of her world and a loss of the sense that anything was real. The swelling, engulfing hay expressed a feeling of being consumed by unreality.

Why did Renee use the image of the needle? The thought that comes to mind is that the needle must have been phallic, masculine, and probably symbolized what remained of her sense of agentic selfhood. A female's representation of herself as male also suggests an active disidentification with the feminine, a distancing from the figure of the mother, and therefore alludes implicitly to maternal disasters in her family of origin.

The electrical current inside the needle is almost certainly the sensation of pure terror in the face of the annihilation that was occurring. That is what terror feels like: an intensifying electrical current passing through one's body, and its communication to the hay shows that her universe was becoming completely pervaded by it. This was an experience of a fall into the abyss of madness.

One could ask what would be the circumstances in a child's life that could produce the annihilation state from which Renee was suffering. If someone feels his or her world and selfhood are being destroyed, then something has happened to produce that. Such feelings do not emerge from nothing; they come about in a

human context involving an absolute catastrophe. One would need to look at her early years, at the qualities of her relationships to caregivers – although I don't think anyone gave her much care based on looking at this dream and its probable meanings. I would expect to find a story of neglect, of rejection, of abuse, of invalidation, perhaps of exploitation. Such a state could only come about because of some truly awful things having happened.

Consider now Renee's delusion and let us see if some further formulation of the relation between dreams and delusions emerges in our discussion. I will give a description, again in her words. It concerns a machine that became a relentless persecutor.

"I constructed an electric machine to blow up the earth and everyone with it. But what was even worse, with the machine I would rob all men of their brains, thus creating robots obedient to my will alone. This was my greatest, most terrible revenge" (Sechehaye, 1952, p. 35).

There was an all-engulfing feeling of guilt, without definition and focus. A crime had been committed, but one had no idea what it was, and the punishment for this crime was a feeling of everlasting culpability. Although the electrical device began as a weapon against others, it quickly transformed into a malign entity that attacked Renee.

She described the source of her guilt, which was somehow equivalent to the machine, as the 'System:' the supreme persecutor of her world. All humanity was the victim of this persecution, and those who became aware of this she referred to as 'Enlightened.'

The System also began to exact punishment by ordering her to burn her hand. To obey such orders, according to her account, would not bring an end to the persecution however; it would only increase its power and intensify the agony of her guilt. So what about this so-called System? What exactly is it, and how can we understand the relationship between its persecutory action and her dream of the needle and the hay?

Renee's delusion of the System is a counterpart to the engulfing hay in the dream. The hay threatened to swallow up and obliterate the electrified needle, which is a symbol of the annihilation of all sense of personal identity by the onrush of unreality that was afflicting her. The System also surrounded Renee and threatened to disrupt and erase her personal individuality, by usurping her will and inducing actions of extreme self-destructiveness. The System reminds me of Kafka's *The Trial* (1925), which is also about a strange, all-consuming guilt.

I would say Renee's crime, like Kafka's, was that she tried to exist as a person in her own right. There were experiences in her background that undermined her chance to develop a sense of her own selfhood and of her own world as real. Perhaps in addition to whatever abuse she suffered, there were pressures to make her serve the needs of caregivers. Then we could understand the System as a concretization of the actual family context, including Renee's compliant surrender to the agendas that were imposed. Within such a system to claim a life of one's own is indeed a crime. Often though this sort of thing takes place silently,

unnoticed, and even the developing child whose soul is being taken does not see the violence that is occurring, that is, until suddenly there is a hostile persecutor engaging in unspeakable acts. The violence against the child thereby breaks into consciousness, in the form of strange paranoid visions like Renee's – or in great works of art, such as Kafka's famous novel. The delusion therefore carries the subjective truth of a young woman's life history, and expresses her fight to prevent that history from destroying her.

This shows again, as in my other example, how the annihilation experience in a psychotic state appears in dreams and obviously also in a patient's so-called delusions. Sometimes they are closely similar to each other; in other instances the imagery is very different. I would not want to make too much of a distinction between these classes of experiences – for all I know Renee's electric machine that turns into her persecutor may have originated as a dream to start with. Dreams depict the subjective life of the dreamer, and so do delusions.

Given the nature of Renee's struggle, what sort of psychotherapy approach can we envision? The book tells the story of the treatment, which was completely successful, and I could not improve on the process that is described. Renee's analyst, Margarite Sechehayé, made a profound commitment to her patient and worked closely and lovingly with her over a period of many years. That is what is needed in such cases.