

Apologia Pro Vita Mea: An Intellectual Odyssey. Part Two

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Summary

The second part of my memoir deals with the evolution, over three decades of the turbulent last half of the 20th century, of two major aspects of my study of the human mind, psychodynamic psychotherapy (psychoanalytically oriented psychotherapy) and the treatment of the so-called borderline patient. I outline here the development of principles of psychodynamic therapy as I attempted to move from the research laboratory out into the field of human endeavor, which led me to a series of publications on the subject. At the same time psychodynamic psychotherapy shifted from being the central endeavor of psychiatrists to a very secondary occupation now mainly practiced by non-physicians. The same is true for the psychodynamic psychotherapy of the borderline patient that I had to learn how to do the hard way in order to survive and provide for my family, and that remains a very controversial subject even today.

“A sort of general atavism has set in; western man is in danger of relapsing to an earlier level of development which he has never properly overcome: crass, unfettered egoism is raising its grinning head and its fist, drawing irresistible strength from primitive habits, is reaching for the abandoned helm of our ship.”

Erwin Shrodinger [1, p.106]

I. Psychodynamic psychotherapy 1966–1996

So, George, I now began the full-time practice of psychodynamic psychotherapy and eventually psychoanalysis, averaging about 42 patient hours a week and almost always finishing in time to have dinner with my family and play with my children afterwards and on weekends, a matter I considered to be of prime importance to all of us. I taught residents at Evanston Hospital, at that time a branch of Northwestern University Medical School, and on the Chicago campus of that school, for a couple of afternoons a week for about 50 years. Later I supervised cases at the Center for Psychoanalytic Study in Chicago and conducted training analyses from there in my office. I began writing my thoughts and

teachings on what I called “intensive psychotherapy” that today would be called psychodynamic psychotherapy. In this second part of my Apologia I am going to review my work in the two areas on which I set out at that time, what I consider to be my contributions to the practice of psychodynamic psychotherapy and to the as yet unsolved problem of the so-called borderline personality disorder.

“What on earth is that?” asked George. I explained that my investigations of borderline patients catalyzed my thinking about psychodynamic psychotherapy over and over again. Borderline patients intently scrutinize the therapist and what he or she is overtly or covertly, consciously or unconsciously, communicating and attempting. So my publications in these two areas of our field came *pari passu* into being. But for clarity, and so that you can understand my approach to borderline patients, let me begin with reviewing my contributions to the yet unsettled field of psychodynamic psychotherapy, emphasizing both the technique and the dangers to the psychotherapist from just the kind of prolonged immersion in the practice that I was experiencing at the time.

For example, in 1978 I [2] discussed what I called the sad soul of the psychiatrist, dealing with the loneliness of the psychotherapist’s profession and the high incidence of depression among those who practice psychodynamic psychotherapy and among psychiatrists in general. I argued that these issues have not been sufficiently addressed by those of us in the profession. I also addressed these concerns to members of the ministry who were doing pastoral care. In a talk to the American Association of Pastoral Counselors [3] I argued that no person should be allowed to take the title of psychotherapist, whether a psychiatrist, a social worker, a psychologist or a minister unless they have accomplished three tasks. First, a thorough intensive psychotherapy or even better, a personal psychoanalysis that is successful, followed by inter-

views by experienced professionals to satisfactorily indicate that structural change has occurred and a reasonable degree of personal maturity has been accomplished. Second, a thorough training in the technique or craft of psychotherapy in an apprenticeship system where careful supervision takes place. This assumes the presence of a training program staffed by mature and experienced supervisors. Finally, a series of courses affording familiarity with a large body of knowledge of clinical psychology and psychiatry.

So, as Freud said, it is not a matter of first magnitude whether the professional psychotherapist is a psychiatrist, minister, social worker or psychologist. What is essential is the kind of training the therapist receives as a psychotherapist and above all, the personal, intensive, uncovering treatment of the therapist. I tried to defend this point of view in some detail to the pastoral counselors and in this paper I pulled together a number of my interests, including philosophy and creativity, and I tried to reinforce the difference between inspirational therapy and what I called psychoanalytically informed psychotherapy, currently referred to as psychodynamic psychotherapy to make it more palatable to American psychiatrists. In inspirational therapy there is the active establishment of object relations and massive identifications, whereas psychoanalytically informed psychotherapy works through spontaneous establishment of transferences and the minute tedious processes over a long period of time, of what I called at that time transmuting micro-internalizations, borrowing this from Kohut [4-6].

As the years passed I have become increasingly discouraged about the training of people who are daring to practice psychodynamic psychotherapy. I considered this rashly titled paper to the ministers one of my best papers even though it met with little response and appeared in a journal that most psychotherapists do not read. In a way it sums up a lot of my thinking on the whole topic of psychotherapy, who should do it, and how. Of course I wrote at length about this in a series of books and taped lecture series which were published between 1969 and 1985. In the first of the books [7] I tried to summarize my basic approach to the subject, covering the artistic and scientific aspects of the conduct of psychodynamic psychotherapy, the fundamen-

tal concepts of transference, resistance, insight, interpretation, the working alliance and the termination phases along with clinical vignettes. In the sequel to this book [8] I investigated failure in psychotherapy, focusing on the psychic field of the therapist and how to train and optimally prepare that field to be open to the patient in the consulting room. I gave two long taped cases to illustrate the many mistakes the beginner tends to make as a result of the inadequate immersion of his or her psychic field in the arts as well as the sciences, and I offered a curriculum quite unlike the one used today. For example, I could not resist another look back on Ezra Pound (see *Apologia: Part One*) [9]. I thought that the work of Yates, Eliot and Pound, and perhaps some of the contemporary confessional poets', could contribute greatly to the psychiatrist's insight and sharpen his or her tools of communication. I discussed each of these poets separately in an attempt to show what we might be able to learn from a study of their work.

"This seems very idealistic," interposed George, "How many psychiatrists do you know who ever read or studied poetry, or for that matter how many of today's doctors have ever done so, or had the time to do so? Certainly not in professional training!"

"I tried to combine science and the humanities in the field of psychodynamic psychotherapy and in the discipline of psychiatry in general," I replied, "And this has been a long-term goal of mine as manifest or implicit in many of my presentations and publications. I must admit it was completely undermined by the great psychopharmacological revolution in psychiatry." George looked troubled as he was having a hard time understanding why with all my training and experience I was not swept up the psychopharmacological revolution and the opportunities it offered to do clinical research.

Going along with my attempt to hook together science and the humanities in the spirit of Freud, this was followed by my more technical and updated formal presentation about the technique and practice of intensive psychotherapy [10], a book that has been reprinted a couple of times, and the introduction of therapists to the great ideas in psychotherapy presented by famous artists, thinkers, philosophers, and psychoanalysts, my most popular and unique book, first

printed in 1977 [11]. As I moved into philosophy, I added *Freud Teaches Psychotherapy* [95] to the list, presenting the many suggestions and ideas Freud offered for the practice of psychoanalytically informed psychotherapy, and placing Freud in the Kantian tradition in philosophy, as well as a little book introducing psychotherapists to the thought of Nietzsche [12].

Later [13], I described the technique and practice of listening in intensive psychotherapy, centering on psychotic, borderline, neurotic, narcissistic, and difficult patients. I suggested how to learn to listen and introduced my five-channel approach to psychoanalytic listening, which I will discuss in a later part of this Apologia, for by that time I was practicing psychoanalysis. Finally in my series of books on psychodynamic psychotherapy, I published a dictionary for psychotherapists [14], and, as an experiment, I imitated Galileo's famous treatise "Dialogue Concerning the Two Chief World Systems," juxtaposing a teacher, with a psychodynamically oriented resident and with a biologically oriented resident [15]. "That last one would be me," said George, "but why on earth did you do all this redundant writing on the topic?"

Remember, George, that I was doing a great deal of teaching and full-time practicing psychoanalytically oriented psychotherapy during those years. These books were generated out of the challenges I experienced from patients and students to clarify just what constituted psychodynamic psychotherapy. One of my greatest disappointments was that my little book on the topic modeled on the work of Galileo [15] was often overlooked, because by that time the psychodynamic approach was moving out of psychiatry. I thought it would have much appeal to residents and novice psychotherapists, but the blossoming of psychotherapy and psychoanalysis was over.

As I moved on I realized the premises of this work needed exploration and so I earned a PhD in philosophy in 1977 stimulated by a study of Freud, and shifted my practice more and more into psychoanalytic depth psychology. Here I was influenced by one of my most helpful and encouraging teachers, Franz Alexander, who did not see any basic difference between psychoanalysis and psychoanalytically oriented psychotherapy (psychodynamic psychotherapy). This is

in great contrast to the trend today to move the latter farther and farther away from the former so as to make it more palatable to American psychiatrists and, above all, to payment-by-insurance companies, who have a choke-hold on us all. This is a colossal difference from when I started out; psychoanalysis was then considered the basic science of psychiatry and insurance companies paid for long and difficult psychoanalyses without complaint.

At the annual meeting of the American Psychiatric Association in 1976 I presented a talk called "What Is Psychotherapy?" [16]. I tried to differentiate between psychoanalysis and psychotherapy by introducing the issue of the development of a workable transference. What I meant at that time was that the focus of psychodynamic psychotherapy needs to be on the transference whereas other forms of psychotherapy take whatever is there for granted and do not focus on it. So in the latter forms the psychotherapist presents educational techniques such as pacification, unification and optimal disillusion, and functions as an artificial ego or an artificial parent, whereas in psychoanalysis and psychoanalytically informed psychotherapy the shift is toward a primary use of transference, empathy and interpretations.

As time passed my interest in philosophy grew. Already in 1982 I published a paper on Socrates as the first psychotherapist [17]. At this point I was already an adjunct professor of philosophy at Loyola University of Chicago, having expanded my PhD dissertation into a book *Freud Teaches Psychotherapy* [95]. The Socrates paper was the talk I gave as the Grinnell College Scholars Convocation Lecture in 1981. In general, Socrates' approach was that the eye of the mind is not blind, but in most people it is looking the wrong way. To educate is to convert or turn it around, so that it looks in the right direction. If this is accomplished we will always know how to conduct ourselves and how to live, regardless of the social pressures upon us and the situations in which we may find ourselves in the unpredictable future.

George had listened to this quietly for some time and now he entered into the conversation. "What is this about philosophy?" he said, "How did you get into the quagmire of becoming a PhD in philosophy? What has this got to do with

medical practice? What on earth did you teach in the Loyola philosophy department?"

I replied, "I taught courses on Nietzsche (my notes were published as a book [12]), on Paul Ricoeur's Freud and Philosophy and on the hermeneutics of suspicion, and Jürgen Habermas' Knowledge and Human Interests, among others. The unwobbling pivot of my interests, as Confucius translated by Ezra Pound might say, has been the mysterious leap from the brain to the mind, known as the hard mind-brain problem, which intrigued me as early as the time I was getting a Bachelor of Philosophy at the University of Chicago. Many of the courses there were quite philosophically oriented. One of the greatest regrets of my life is that I refused an invitation to graduate with honors in mathematics by working with one of the mathematics professors on number theory because the pressure to get top grades in the regular courses in order to get into medical school was so overwhelming I dared not spend any time on anything else. In my study of philosophy I had hoped that the study of the brain, its chemistry and electrophysiology would throw light on that mysterious leap from the brain to the mind. But such studies did not seem to show much possibility, nor do I think they do today in spite of the great advances in brain research. Such practices as focusing on the amygdala to explain one's anxiety are committing a mereologic fallacy, as I have described it in a recent publication [18], one of my final contributions.

A meticulous study of Freud informed me that he clearly straddled between the mind and the brain in his early thinking. Finally, he left the issue of the brain entirely and it was that ingenious move that led to the invention of psychoanalysis. As you can see from the first part of these memoirs, I finally decided to follow the same path – from a study of the brain to a study of the mind.

"I don't see what the fuss is all about," grumbled George, "Bertrand Russell [19], in one of my favorite books, written when you were a young college student, jumped over what you are calling primarily an epistemological problem in his discussion of the limits of human knowledge."

"A wonderful book, George, and I remember when we first encountered and discussed it. But over the years I have learned that it is not just

an epistemological problem," I said, "Because the whole treatment of mental illness depends on it. Consider: we are trying to alter the mind without knowing what the mind is! Or where it comes from! Or how it is generated! It is all speculation and mystery. Later I want to go into greater depth on these matters but right now I want to continue my discussion of psychodynamic psychotherapy as I have learned to practice it over the years." George grumbled but he politely waited until we later could get into the philosophical discussion. He was obviously unconvinced by my response and not impressed that I had much knowledge of philosophy. I could see he was beginning to think of me as a sciolist.

I reviewed all the issues involving psychodynamic psychotherapy up to that time [20]. I started giving some courses on the overlap between philosophy and psychoanalysis. I studied the situation of social polemics involving existential complaints of patients and the question of whether these complaints were generated by society. I discussed the training of psychotherapists and fundamental philosophical issues in the field. I reviewed the choices that the therapist would have to make, the delineation, methodology and treatment of pre-oedipal disorders, and recent theoretical conflicts – areas that remain current issues in psychodynamic psychotherapy even today. I saw psychodynamic psychotherapy as a thrust towards the development of the individual and as a humanistic discipline and I described the dehumanization of our current dark age, which is even worse nowadays, as a powerful counter-thrust. The resident is caught in the dilemma between techniques stressing and promising "evidence-based" symptomatic relief and the possibilities of longer psychodynamic therapy that stands in stark contrast to these techniques.

Fundamental philosophical choices on the part of every practitioner are required regardless of the type of therapy he or she uses because the basic philosophical assumptions behind each of the various forms of psychotherapy regarding the mind and the brain are different and cannot be reconciled with each other. Following my teacher Franz Alexander, I attempted to delineate psychodynamic psychotherapy as a modified form of psychoanalysis, and so began

my focus in future work on the basic assumptions and clinical practice of psychoanalysis. I felt that the treatment of choice for pre-oedipal disorders, severe character disorders, borderline patients, and certain others, even some schizophrenic patients, was psychodynamic psychotherapy and today I believe psychoanalysis is the treatment of choice if the patient can tolerate it. The saddest problem at that time and still to this very day is the collision between irreconcilable views of psychoanalytic practice that force further choices on the therapist which, I am sorry to say, are always subdoxastic choices.

I found [21] an extreme and rigorous example of these assumptions in the views of Langs [22-29]. Langs tried to argue, in a series of books popular at that time, that we do not work in a vacuum simply with latent unconscious conflicts that show themselves through the patient's free associative material. Interventions and the adaptive context or situations involving the patient's life certainly do interfere with the production and nature of the patient's material, and it is incumbent upon us to keep these adaptive contexts in mind in order to properly listen to, and evaluate, what the patient has to say. He says embedded derivatives may be clues to this but because they are embedded, ambiguous and require decoding, they do not prove anything in the empirical sense.

"That is for sure," said George. I ignored this remark and continued that there are a number of assumptions Langs made that have not been generally accepted, but his is a very careful and intellectually worked out theory and it is worth attention. Perhaps because Langs was so very strict and intellectual or perhaps because it is so difficult to definitely locate the derivatives of what the patient Langs says is trying to use to comment on the interactive field, his approach tended to become neglected. Still, I have found it useful when I began to feel that the therapy was encountering an impasse.

Consistent with what we have just discussed, I presented the case of a 48-year-old woman to illustrate the dynamics frequently found in middle-life depressions that often form the basis for the so-called midlife crisis [30]. Drawing on notions of the soul found in the writings of Plato and Aristotle, I argued that these concepts are particularly important in orienting both psycho-

therapist and patient to a vital perspective especially helpful in dealing with midlife issues. I proceeded to present a failure in the psychodynamic psychotherapy of a schizophrenic patient [31]. The discussant of the case [32, p. 151] wrote, "Dr. Chessick certainly got further with this patient than did any of her previous therapists. He helped her complete college. He took quite a beating, allowing her rage against the bad mother transferred to him. I believe, though, that by doing this, Dr. Chessick helped her maintain, perhaps, a steady psychosis with the delusion that her real mother was good, and her therapist as well as others – former therapists and her real father – were all wicked. This might keep the patient from becoming fragmented again and fearful of a changing personality... In one sense, the case is not a complete failure, but a lesson in understanding the schizophrenic process."

"You must have reached some kind of a dead end", said George, "With all this writing on dynamic psychotherapy you seem to have repeated yourself again and again for different audiences."

"You don't understand what the situation was at the time," I told George. "Psychodynamic psychotherapy was going into an eclipse from which it has never recovered." "And perhaps it never will," interposed George.

For example, when I presented my paper on the sad soul of the psychiatrist [12], dealing with the loneliness of psychotherapists' profession and a high incidence of depression and burnout, at the Illinois Psychiatric Society, one of my colleagues raised his hand and stood up. He was a bright and mature classmate of mine in medical school at the University of Chicago so naturally I respected him most highly. He also happened to be an important official at that time in the Illinois Psychiatric Society in addition to being a successful clinical psychiatrist. He said, "Richard, I am disappointed. I came to this meeting hoping to hear about neurotransmitters, synapses, and new psychopharmacological agents. This is the future for modern psychiatry, not the re-introduction of ancient and obsolete philosophical notions of the soul."

I replied, "Dave, you suffer from a serious prejudice known to philosophers as belief in a mechanistic universe. This belief, the triumph of a scientific mentality in our day which has brought

us the neutron bomb, is a modern superstition." I quoted the physicist Heitler [33, p. 97], who wrote: "It leads to a general spiritual and moral drying-up which can easily lead to physical destruction. When once we have got to the stage of seeing in man merely a complex machine, what does it matter if we destroy him?" In the massive psychopharmacologic approach attempting to alter the mind through altering the brain, we tend to get into this mechanistic complication. If one is actually immersed in doing psychodynamic therapy, one has a different experience than that of brain scientists in their laboratory. The modern psychotherapist engaging in conversation with therapeutic intent has an affinity with the ancient Socrates, which is why I have written a couple of papers [11, 34] on Socrates as a psychotherapist. In fact, there is a close parallel between the intellectual goals and methods of modern psychotherapy and the fundamental premises of ancient Greek philosophy.

I believe that in our society [35], as in many other cultures before us, two of the greatest character defects that interfere with living a life devoted to the disinterested pursuit of knowledge are greed and vanity. These are essentially derivatives of a narcissistic personality problem and obviously lead to pretentious and ineffective psychotherapeutic work. The patient is no longer heard and responded to as a human being but as an object for the aggrandizement of the therapist, a selfobject, as Kohut [5] would say. There are no shortcuts. The unavoidable task of rebuilding and restructuring the personality is a tedious working-through, requiring a long period of exposure of the patient's damaged personality patterns to the hopefully healthier therapist's patterns over and over again.

Psychiatry and psychotherapy demand a large body of clinical knowledge. Psychotherapy is no longer an emerging and primitive discipline. The psychotherapist who mucks about in peoples' lives without his or her own proper intensive psychotherapy and training is analogous to the barber who attempts brain surgery, and that therapist is every bit as dangerous to the patient. It is indeed a curious modern fact that a procedure with such far-reaching consequences for the whole life of a person as well as the person's family is undertaken by the untreated and untrained therapist with such a casual attitude,

whereas the same therapist will tremble with fear at the very thought of picking up a scalpel and cutting into the brain of the same patient. Yet the consequences can be equally as lethal, and over many years I have experienced numerous clinical examples where there have been disastrous consequences with so-called therapists attempting to work with fragile patients.

I have seen a number of student therapists as well as some successful practicing professionals who have never really asked themselves, "What is a mental disorder? What is a patient? Why is the patient coming to me at this time? What curative fantasy does the patient bring into the treatment? What is my curative fantasy for this patient?" It is human narcissism that constantly throws everything off in our thinking and this discovery represents the fourth great blow to our human self-centered position of thought. The first blow was from the discovery that the earth is not the center of the universe, the second from the discovery that we are descended from the animals and are animals ourselves, and the third was from Freud's discovery that we are governed primarily and relentlessly by unconscious mental processes from our childhood.

We now know that all our mentation is some kind of phase of brain function from which it emerges. It is the appearance of mentation in the universe that represents what is really important and amazing. We know that when a system such as the human nervous system reaches a certain critical point, new and unexpected possibilities appear, such as conscious mentation, the emergence and development of which cannot be predicted on the basis of the previous more primitive states. These new states become self-enhancing and they even follow different natural laws. Copper [36] explains what he calls the concept of the third world, a vast system of organized thought and its products such as libraries, microfilm knowledge (and now computers and iClouds) in which men now must move and have their being. In depth psychology a complex mental state is unthinkable without our ability to know via empathy what the inner life of man is and what we ourselves and what others think and feel, where we are going and where we hope to go.

"I am sorry for you," said George, "because the mechanistic explanations and the histochem-

ical studies that I have indulged in are so simple compared to the immense complexity of what you are tackling here. I am beginning to understand why you are objecting so much to the effect of the culture and the faith in science and mechanisms that have an interference with understanding of mentally ill patients. But Richard, isn't there an element of greed and vanity in your tackling subjects of this magnitude that have puzzled philosophers for thousands of years?"

"There undoubtedly is," I said, "But we must all follow our star, the star consisting of the early compromise formations that formed our personality." George was not at all satisfied with this answer, but out of politeness deigned not to press the matter further.

I have suggested there is a background, a basic generally accepted structure that nobody questions, in which people present themselves and live their brief lives, all too soon to be forgotten. Here I have been much influenced by carefully reading and writing about Heidegger [37-55]. This generally assumed or taken for granted background really has a profound influence on the foreground and, as Heidegger pointed out, even the future influences the present. Translated into the psychoanalytic process, the intrapsychic fantasies and compromises that the patient brings determine both what the patient says and what he or she hears the therapist say and therefore profoundly affects the intervention or interpretation, no matter how well intended. Technical interaction, therapist statements and office ambience form the foreground which falls on the patient's unique intrapsychic background that cannot be taken for granted. If, through proper listening to the patient, that background has not been carefully investigated, then it is impossible to understand why the patient may respond so paradoxically to what appears to be a simple rational intelligent statement made to that patient.

The response of the patient simply makes no sense unless the therapist becomes aware of background aspects that are ordinarily not attended to. In opposition to those who devalue psychoanalysis as a science, the patient's responses are actually quite predictable much of the time, and with this knowledge of the background such predictions no longer appear to be

magic. The problem for the teacher of psychodynamic psychotherapy is to jar the student out of assuming that the simple background of an ordinary doctor-patient interaction is going on and to call attention to everything he or she can think about aspects of the intrapsychic background of both participants. Background practices are not based on the empirical sciences but rather underlie them! If the student cannot be jarred out of the blind cultural background worship of the scientific approach, he or she will never understand each patient as constituting what with Foucault we might call a transcendental/empirical double and will therefore never really develop empathy with patients. I explained Foucault's notion that the human seen as a set of facts to be studied is also the human who forms the transcendental condition of knowledge for any culture at the time of the study [53]. So if we reduce the human to the empirical, we cannot become clear about how to obtain knowledge. This is because the question "Where do the assumptions about the validity of empirical knowledge come from?" cannot be answered by empirical study. As I wrote [56], the true effectiveness of the teacher is to get the student therapist to listen to people in a way he or she has not listened to them before. The real expertise of the psychiatric professional shows in a two-person relationship where he or she can actually hear what another person is trying to communicate in the midst of background practices, intrapsychic preoccupations, self-states and interpersonal relations, and in addition to this, the scientific and empirical and mechanistic aspects of the patient's mentation.

"What is the point of all this amorphous pondering? Why not work with man as a chemical and physiological organism and interfere with his various disorders by the introduction of chemicals, electroshock, and so on?" asked George, who was by now running out of patience. "Let's use a decent sensible approach with these difficult people, let's use common sense therapy, explanation, education, cognitive therapy, behavioral modification, rational therapy, and medications and appeal to man's reason. These are amenable to ordinary scientific validation or non-validation and can be touted as 'evidence-based'. Don't you remember what Abe Wikler told you in the first part of this memoir?"

There was a true scientist, even in the muddy field of psychiatry!"

"George," I replied, "In psychoanalytically oriented psychotherapy we attempt to reach a depth beyond the level of symptoms. Your suggestions are aimed at symptom removal but they do not primarily affect the underlying disorder and personality structure. In order to enter the world of another person to such an extent that we can actually alter the way that person has learned to perceive and subsequently deal with the world, we have to be able to listen to the patient at what I call 'transcendental' or empathic [56] as well as at an empirical level."

"Where is all this going to lead?" asked George irritably, "You are immersed in a culture of scientific background practices and trying to rise out of it into something rather ethereal it seems to me."

"I believe that the two most important papers that I wrote on this subject are the one with the sardonic title I mentioned before [3], and my much more modern "The frantic retreat from the mind to the brain: American Psychiatry in Mauvaise Foi [57]."

"Don't you realize that you are going in the opposite direction from modern neuroscience?" asked George. "They would not interpret the move from the mind to the brain as a retreat but rather as an advance!"

"This is probably the crucial issue in my writings on this topic," I replied. "And my complaint is that the movement from the mind to the brain results in a mechanistic view of human mentation and behavior that loses sight, as Husserl would put it, of the lived life of man. There is simply no agreement on this topic but I would agree with you George that the massive movement at present is away from continental philosophy and the notions of ciphers and souls, and towards an increasingly simplistic and mechanistic model of human emotions and intellectual functioning. Much of this of course has been stimulated by the spectacular success of computer science. There is a strong contingent of psychiatrists and neuroscientists that would like to look on the brain as a computer, although there are powerful arguments against that idea. The fact that the computer can beat the world champion chess player does not imply that the computer thinks the way the world champion chess

player thinks or even as you or I think, and this is the danger of anthropomorphizing these implements."

I carried this more into the ethical and philosophical area in the publication mentioned above [57]. In this rather sweeping paper I have noted that the higher income that accrues to the practitioner of reductionist biological psychiatry compensates him or her for any fleeting suspicions of inauthenticity. And so I maintain that the final question is an ethical one. Should the leaders of American psychiatry embrace the biological paradigm that will make certification and testing easier and more quantifiable, and reward us with the material things of this world, or should psychiatry press forward as a revolutionary and humanizing force calling attention to inequities, racism, sexism, and all the innumerable ills of which society is capable, at the risk of political opprobrium, financial loss, and even in some dictatorship-led countries, brutal repression? Should the leaders of American psychiatry commit our profession to an amelioration of those psychological and sociological factors that enter into the very fabric of society, or should they constrain our discipline so that it wears the trappings of internal medicine and thus gains respectability in a culture where drugs are used for everything, to the ecstatic joy of the giant international pharmaceutical corporations that saturate our advertising media and even our professional journals and meetings with their simplistic sales messages?

"This is really very idealistic, almost foolishly so" said George, struggling to stay polite. "What has it got to do with helping patients on an everyday basis and practicing psychodynamic psychotherapy, and who on earth do you think will listen to this kind of talk, except a small fringe of socially conscious intellectuals? These kinds of problems did not arise in my research because we took biological reductionism for granted; there was no arguing with the appearance of histochemical stains. I think you have gone into an area that may be of philosophical interest to you but it is obvious from history and today's culture that it is not of real interest to anybody else or at least to very few people."

"I'm well aware of that George," I said, "but I learned a lesson from the history of psychiatry as it was taught by Zilboorg. How many residents

read his book any more [58]? I still remember the conversation when he took a group of us as residents to dinner. Regardless of some of the personal difficulties he got into later, there is a lesson here for senior psychoanalysts and psychotherapists about just how important it is to take a group of beginners to dinner and converse informally with them; they much need idealization figures while they are in training, and human interaction with their professors, not just lectures. Here is what Zilboorg [58, p. 524-5] teaches us:

“The whole course of the history of medical psychology is punctuated by the medical man’s struggle to ride above the prejudices of all ages in order to identify himself with the psychological realities of his patients. Every time such an identification was achieved the medical man became a psychiatrist. The history of psychiatry is essentially the history of humanism. Every time humanism has diminished or degenerated into mere philanthropic sentimentality, psychiatry has entered a new ebb. Every time the spirit of humanism has arisen a new contribution to psychiatry has been made.”

“Richard, you are riding off again in too many directions,” said George. “When will you settle down and go intensively into one area of research and study? Now you are going off into the sociology of psychiatry!”

“I did try to put a lot of this together George, for example in my third paper [59] on psychoanalytic listening. This is an attempt to pull together the various theories about psychoanalytic listening and the competing models of those factors central in bringing about change in psychoanalytic treatment. We know these models are epistemologically incompatible and yet all are useful so we are in the situation that existed in physics when there were competing wave and corpuscular theories of light. In our postmodern situation it is recognized that no one of these models can be determined to be definitively the correct model; some thinkers even argue that in principle there will always be competing and irreconcilable theories in the human sciences.

Five-channel theory of psychoanalytic listening

So this is where I introduced my five-channel theory of psychoanalytic listening that I have re-

vised repeatedly in subsequent publications. Although no attention has been paid to it, I come back to this theory again and again. The attempt to listen to patient material from five different channels, approaches, stances or models which are not compatible with each other requires a discontinuous jump in the mind of the therapist from one channel to the other. I begin with the drive/conflict/defense model of Freud, attempting to identify derivatives of the core infantile fantasy life of the adult that generates conflicts, the transference, and the compulsion to repeat. At the same time, as the material of the patient suggests it, one remains open to viewing the material, both verbal and nonverbal, of the psychotherapeutic process from an object relations point of view, from a phenomenological point of view, from the self-psychology point of view, and from the loosely defined interactive point of view. These imply different incompatible stances or approaches of listening to the patient and generate different kinds of interventions and interpretations.

“My hope is that as the patient experiences the therapist’s understanding and communication at a level he or she finds meaningful, trust is increased, and the ego is strengthened, allowing the patient eventually to communicate more derivatives of the infantile fantasy life and achieve greater depth of psychoanalytic understanding, because increasingly the therapist can employ Freud’s drive/conflict/defense/listening stance and approach the psychoanalytic ideal of proper transference interpretations.”

George: “This is pushing now into the actual area of psychoanalysis and is a step beyond psychodynamic psychotherapy, is it not?”

“Yes George, it is, but there is a continuum in my opinion between psychodynamic psychotherapy and so-called pure psychoanalysis, which depends primarily on the transference and countertransference interaction and whether this is addressed as a central issue in the therapy or not.” In 1968 the final part of my experimental work at the Veterans Administration Research Hospital was published [60]. In our laboratory Bassan and I found a number of areas of positive physiological correlations between patient and therapist that might be termed “physiological empathy”. Using this definition we were able to demonstrate an increase of physiological em-

pathy with time over each session and over the whole therapy process in long-term cases. There is also some indication that the evaporation of physiological empathy was related to the consistent bombardment of the therapist by primitive devouring demands from the patient. That is to say, there was a rated decrease in the therapist's attentiveness, intellectual understanding, gentleness and permissiveness over the therapy process with patients who were rude, uncooperative and obstructionistic even though the therapist was still trying to understand and interpret what was going on.

As I moved into the area of philosophy and the background foundations of psychiatry, I pointed out that the basic stance of postmodern thinking constitutes a challenge to what is called foundationalism, which dominated scientific and philosophical thought until recently [61]. In answer to such luminaries as Derrida, Rorty, Foucault and Lyotard, who questioned the possibility of whether any form of interpretation can be thought of as related to reality or the truth, my point of view is that an intermediate position is necessary rather than a binary opposition between nihilism and foundationalism or, more specifically, between postmodern and traditional psychodynamic psychotherapy. I believe that careful attention to the patient's material following an interpretation can provide clues about the validity of our conception at the time but the horizons and historicity that we have discovered delimit all truth reduce the authority of the stature of the analyst and make him or her less of an arbiter of what is reality. But the notion of social constructions as constituting the psychoanalytic process suffers from the lack of sufficient attention to the historical determinants of how a given individual reacts in given situations. A patient will react differently to different therapists, depending on the transference or projective identification that the patient brings to the treatment, regardless of the interpersonal interaction and the personality of the therapist.

I described the dangers of postmodern thought disintegrating into nihilism and surely all of this has a meaning and application to the clinical practice of psychodynamic psychotherapy because of the unresolved issue of whether these procedures represent science or hermeneutics. If postmodernists are to be believed, the human

sciences, to whatever extent they rely on texts or narratives that arise in the psychoanalytic situation, are subject to deconstruction and continuing reinterpretation. In this sense it is no longer possible to speak of truth or reality as Freud once did when he repeatedly presented psychoanalysis as uncovering "scientific facts." But in one of my final publications I tried extensively to establish that psychoanalysis is indeed a science with its own methods, its own area of investigation, different from any other science today [18]. I referred to Aristotle [62, p. 535], who began *De Anima* with: "To attain any assured knowledge about the soul is one of the most difficult things in the world... If there is no such single and general method for solving the question of essence, our task becomes still more difficult; in the case of each different subject we shall have to determine the appropriate process of investigation."

This paper [18], which was given by invitation as the keynote address at the 58th annual meeting of the American Academy of Psychoanalysis and Dynamic Psychiatry in New York on May 2, 2014 to a disappointingly small audience and generated very little discussion, constitutes my final words on the status of psychoanalysis and psychodynamic psychotherapy. It apparently incensed the editors of the journal so much that the three of them published their disagreement in a paper that appeared right after mine. I guess I was lucky my paper was accepted for publication; I had spent a full year working on that one paper as my farewell to the field. They felt apparently that my view (and Freud's and Franz Alexander's) on the subject of psychodynamic psychotherapy was now obsolete and they hope to integrate it with neurosciences, research, Kraepelinian descriptive psychiatry, and so on, a view that I am sure is much more acceptable to the American Psychiatric Association. For example, I taught an all-day course at the annual meeting of the American Psychiatric Association for about 11 consecutive years, returning each year because of the popularity of the course. The result was my book *What Constitutes the Patient in Psychotherapy: Alternatives to Understanding* [53]. But when some years later I offered a symposium to the American Psychiatric Association meeting on Heidegger's contribution to psychotherapy, having as a member of the Heidegger Circle rounded up three Ger-

man professors of philosophy and two from the United States, all of whom were noted experts on the work of Heidegger, it was turned down. No reason was given and I was shocked and embarrassed in front of my colleagues.

"Well I can tell you the reason," said George, "Psychiatrists are not considered scientists in the medical profession and they are trying very hard to shape their discipline so it resembles other branches of medicine. There is no room for Heidegger in that. Don't you remember in part one of this memoir how the dean of your medical school responded when you told him you were going into psychiatry?"

In "The silence of Socrates" [34] I emphasized the humanistic and phenomenological approach to the mind and contrasted it to the era of the brain that is so idealized by psychiatry today. I outlined the debate between those who expect science to explain everything sooner or later and those who believe there are certain essential aspects of the world such as the qualia of consciousness that cannot be reduced to material factors. I concluded as follows:

"In our age Socrates is essentially silent. The great dialogues of Plato, in which Socrates employs the maieutic method in a never ending quest to approach the central truths, eternal forms, and the essential self, have been replaced in our time. Ours is the era of the brain, the orientation of Timaeus in the Platonic dialogue of that name that concentrates on craftsmanship, technology, and hence in our days pragmatism, and symptom removal... The roads of hermeneutics and science all eventually lead to two mysteries. These are about the inexplicable and unique presence of human consciousness and about how the 'singularity' that apparently existed led to the creation of the universe. It is entirely possible to argue that the answers to these two mysteries are beyond our human capacities just as one cannot expect a dog to master calculus. But should we give up the struggle and sink into a nihilistic materialism? Must the 21st century be like the 20th century? Must we stay in the cave or can we emerge, as Plato thought, guided by philosophy and the humanistic disciplines?" [34, p. 418-9]

To illustrate the clinical importance of long-term psychodynamic psychotherapy, I presented a treatment of 15 years in which the thera-

py essentially enabled the patient to function for all that time [63]. It illustrated the deep, partly conscious and partly unconscious interaction between a patient and her analyst over many years of treatment and the profound effect this has had on the outcome. It underscores the importance of patients being allowed to heal in their own way and in their own time without intrusion or interference from the analyst or from insurance companies. I tried to demonstrate the crucial importance of long-term psychodynamic psychotherapy as a lifesaving procedure in cases where it is appropriate in spite of the great amount of time and expense involved.

"Well that does it," said George, "You have certainly managed to swim against the tide of current economic, sociologic, political and psychiatric thought."

II. Intensive psychotherapy of the borderline patient 1966-1996

At this point, George, I would like to go on to discuss the type of patient that I worked with the most in psychodynamic therapy, the patient with the so-called borderline personality disorder that sometimes was called pseudoneurotic schizophrenia and at other times ambulatory schizophrenia, but is now given a Kraepelinian description in DSM-5 [64] as displaying a pervasive pattern of instability in interpersonal relationships, self-image and emotions, as well as marked impulsivity. This disorder usually is quite marked, sometimes beginning in early adulthood. Such patients make frantic efforts to avoid real or imagined abandonment, and suffer through unstable and intense interpersonal relationships. They manifest an identity disturbance with sudden dramatic shifts and have a precarious sense of self. Above all they show impulsivity in areas that are potentially self-damaging, sometimes recent suicidal behavior gestures, threats or self-mutilating behavior, affective instability, and often complain of a chronic feeling of emptiness. What makes them especially difficult people is their inappropriate, intense anger, difficulty controlling it, and sometimes transient paranoid ideation, but they do not have schizophrenia.

"They sound like the kind of patients nobody wants," remarked George.

"This is very true," I replied, "Because when I started out in my practice and I went around with my hat in my hand begging for referrals, everyone sent me the patients they did not want and sure enough, these turned out to a large extent to be borderline patients. Whether I would starve or not therefore depended on whether I could work satisfactorily with such patients, and so I had to learn, and I allowed them to teach me the hard way. And teach me they did, because such patients are extremely sensitive to any failings or mistakes or absences of the therapist, complaining bitterly and being quite manifestly angry and demeaning in their response, which they continue for a long time."

My first major paper [65] was based on face-to-face psychodynamic therapy over 5 years [1960-1965] of 15 patients who had received various forms of treatment with no noticeable results. At that point I called them "borderland patients" because they seemed to lie on the periphery of patients amenable to psychiatry, on the periphery of schizophrenia, on the periphery of society, and on the periphery of penology. Some of them had been in and out of prisons as well as mental hospitals. Although the symptoms of these patients were many, variegated and fluctuating, the dynamics were similar. They all had been subjected to severe damage in the so-called mother-child symbiosis during the first year of life. In my view the initial and basic repair of this preverbal disaster arises out of the eventual building of a symbiotic relationship with the psychiatrist. If this can be established, the psychiatrist can become a bridge to true object relations by helping the patient to give up the sense of narcissistic entitlement and of living around secret narcissistic consolation fantasies, exchanging these for adult gratifications are true object relations and living in a mature realistic object related way.

A long period of working through is necessary for the extrusion of archaic and malevolent parental introjects from the ego and the superego. I emphasized the dreadful loneliness which pervades the lives of borderland patients. I worried about the effect of a psychotherapist's greed and vanity on the patient, especially these very disturbed patients [66]. The patient receives a dou-

ble message from such therapists. On the one hand, there is lip service to the classical Socratic ideal of the disinterested pursuit of understanding the patient. On the other hand, the life patterns of the therapist can demonstrate an entirely different set of values. I was amazed at how quickly even the sickest patient catches on to the life patterns of the therapist regardless of his or her effort to maintain "neutrality" or "anonymity." There are of course unavoidable personality traits of any therapist and unfortunately borderline patients, for example, detect any trace of therapist greed and vanity and, because such patients are so needy and grasping, they tend to stir up a countertransference of defensiveness and loss of neutrality. I have consulted on cases where the therapist became so enraged at a borderline patient that he literally chased him out of his office. Only being in a continuous, disinterested, lifelong striving for understanding himself or herself can the therapist attain the state of unselfconscious alertness required for empathy with patients and the ability to really listen. Unanalyzed psychotherapists have tended to get into serious trouble, especially in enactments involving borderline patients.

In a second major article on "borderland" patients I attempted to identify the crucial dilemma the therapist has to confront in their psychodynamic therapy [67]. Every psychodynamic therapist has to walk a tightrope in this "crucial dilemma" in the treatment of borderline patients. On the one hand, it is clear that direct ministering to the patient's needs, such as caressing or feeding or giving gifts to the patient, constitutes a form of "acting in" and is undesirable except in the most minor and socially acceptable forms because it prevents ego expansion by fixing the patient on the omnipotence and beneficence of the therapist. On the other hand, a therapy without parameters [68] in my experience cannot hold the patient in treatment. The crucial dilemma that the therapist always faces with such patients is where to draw the line. The therapist soon finds himself or herself facing this crucial dilemma, the choice from session to session between staying with the strict technique of psychodynamic psychotherapy, or following an inner attitude which may even at times result in temporary abandonment of previously learned techniques of psychotherapy. There is a

great deal of disagreement in the literature as to how strict one should stay with techniques rather than following one's intuition. The latter carries great danger of sliding down the slippery slope of destructive enactments, but at times it makes all the difference.

For example, I offered a case report that indicates great care should be taken in diagnosing "hysterical blindness", especially in severely disturbed patients, for these patients come with all kinds of symptoms and complaints that can exhaust the therapist [69]. The appearance of any visual disturbance in psychotherapy should call for immediate careful ophthalmological examination, since if angiospasm has taken place with the resultant infiltration of serum into surrounding tissues, the patient deserves the trial administration of prednisone and tranquilizers under carefully controlled medical conditions in order to prevent permanent tissue damage as much as possible. Winnicott [70] speaks of the borderline patient as breaking through the barriers of the analyst's technique and professional attitude and forcing a direct relationship of a primitive kind even to the extent of merging. In his view, holding by the therapist is presented primarily by interpretations with empathic understanding and soothing terminology and by a consistent and reliable psychotherapeutic setting in which the therapist behaves himself or herself. Without these factors, treatment of the borderline patient is impossible.

In another case presentation [71], I described at length how everything depended on the recognition by the therapist of the insidious and all-pervasive externalization unfolding itself underneath the patient's repeated claims of existential despair. The outcome hinged on a race between the patient's capacity to develop an observing ego and check the externalization and other defenses against affectual contact, and the patient's profound anxiety and fear of human closeness. The greatest problem is again the therapist's frustration and temptation to do more and more that is tangible and touchable for the patient. In this case, perhaps because of my empathy with her overwhelming needs so common in borderline patients, I was able to sit with this patient through countless hours of complaining and raging, patiently interpreting again and again how the process of externalization was at work in her

setting up the situation in the consulting room and in many aspects of her life.

"This is all pretty foggy", said George. "And what do you mean by externalization?" I explained that it is one of the common defensive systems used by borderline patients, a combination of projection, followed by selective perception and manipulation of other people for the purpose of verifying the initial projection. Other people are experienced wholly in terms of their value in verifying the initial projection and only those aspects of other people which have this value are perceived at all. So the most benign therapist approaching the borderline patient finds himself or herself transformed into a horrible monster very quickly by the patient's selective perception. We hope that the therapist is aware of this danger, since he or she is normally inclined either to retaliate or to quarrel with the patient's extremely unflattering image, which usually contains a kernel of truth and is a direct assault on the therapist's narcissistic self-conception as a benevolent physician.

Borderline patients often expect and bring about their own failure, and adapt to life by feeling beaten in an unpredictable and ungiving world. When the therapist presents the patient with a consistently benign environment, the patient cannot trust the lack of frustration. Instead of risking the inevitable disappointment that he or she expects, the patient prefers relating in a setting in which he or she has learned to adjust. If the analyst is mature and benign, the patient's psychic balance is upset. This leads the patient to make every effort to reconstitute ego equilibrium by repeatedly attempting to make the analyst just another representative of the allegedly hostile and ungiving world that is familiar to the patient.

George complained, "You are using too many words and I suspect you created too many publications on this subject too. For example, what does 'parameter' or 'introject' mean? I get the general idea, but there is a lot of 'psychoanalyses' here, if I may use that term." I suggested to George that if he wanted details he could consult my Dictionary for Psychotherapists [14], where these terms are carefully spelled out in response to many queries. But George said he was not interested in the details. He pointed out that our conversation is not a textbook of psychoanalysis

but an inquiry into my intellectual career since he had passed away with hopes for my future as a scientist, perhaps in his laboratory as a successor. He was shocked and disappointed but courteously tried to keep this to himself. Nevertheless, it popped out from time to time.

I mentioned two publications in *Medikon*, published by the European Press in Belgium [72-73]. In the second of these, I reviewed the whole concept of the borderline patient again and in the first I tried to discuss the ego weakness of borderline patients. The predominance of higher- or lower-level, primitive or less primitive sets of ego operations, the capacity for mobility along an ego axis and the remarkable capacity of borderline patients to shift back and forth from very regressed states to adult autonomous ego functioning are described. But the capacity of the patient for autonomous ego functioning has to be carefully distinguished from re-instinctualized situations in which the ego functioning is apparently autonomous but actually in the service of resistance; the relative presence or absence of intrasystemic conflicts eventually may determine an actual or potential disintegration of the personality. Evidence from the treatment of borderline patients clarifies and defines four different and vital ways to approach the assessment of so-called ego weakness or ego defect in every patient: (1) the predominance of higher- or lower-level (primitive or less primitive) sets of ego operations; (2) the remarkable capacity to shift back and forth from very regressed states to autonomous ego functioning; (3) the distinction between autonomous ego functioning and re-instinctualized situations in which ego functioning is apparently autonomous but actually in the service of resistance; (4) the relative presence or absence of intrasystemic conflicts that contain the capacity for disintegration or at best identity diffusion.

Borderline patients can manipulate and torment their therapists in many ways. I discussed the so-called countertransference crises that typically come up in the treatment of such patients [74]. This clouds the therapist's consciousness and often blurs sound clinical judgement. The most difficult problems to deal with are the erotization and seduction of the therapist and the acute or chronic rage characterized by attacks on the narcissism of the therapist. These are the

most stressful because of the extreme intensity of the feelings hurled at the therapist and because often they are in an unconscious fashion calculated and parceled out in small amounts so they are not obvious and overt. Borderline and narcissistic patients suffuse relationships with intense pregenital aggression to which the therapist, despite his level of training or self-understanding, is not totally immune. Even their seductive maneuvers are in the service of aggression and narcissism, not genuine object relatedness. In one case I heard of, when the patient successfully seduced and had an affair with her psychiatrist, she remarked triumphantly, "I always wanted to get a psychiatrist to f-k me!" Therefore acute vigilance against repetitive sadomasochistic interactions is a necessity in such therapeutic processes with borderline patients. The simplest rule of thumb is "Do not do what you would not have known."

Perhaps the most difficult to manage is the chronic rage against the therapist because he or she cannot provide all the gratification of the patient's infantile wishes from the ideal parent. It requires great fortitude to tolerate the constant little pricklings that the patient produces hour after hour when he or she spots the minor narcissistic weaknesses of the therapist. This can easily begin to shift the unwitting therapist's benign attitude toward the patient into a countertransference that becomes increasingly aggressive and sadistic. It is often at this point that the therapist begins to react argumentatively, force interpretations, exhort, advise, sermonize, or reach for a prescription pad. This critical period can have a more lethal outcome if the therapist actually begins to manipulate to get rid of the patient!

The manner in which the therapist establishes and maintains the basic rules of the therapy and the boundaries of the therapeutic relationship is an important manifestation of the therapist's identity, the state of his or her ego functioning and for the therapist managing his or her own intrapsychic conflicts, including handling the stirrings within one's self evoked by the patient, and for avoiding pathogenic interaction.

"This all seems pretty self-evident to me," said George, "I don't understand why so much fuss is being made about it."

I answered, "Because in the day-to-day dealings with patients such as these there is an insid-

ious development of countertransference problems which, unless the therapist is well aware of them, can slide the therapy into a pathological interaction and failure. You have to experience this sort of thing, George, to actually grasp what it is like to go on with somebody day after day who is very hostile, critical, silent, seductive and self-centered, efficiently and effectively producing many hours of what appear to be a lack of progress."

"It must be very hard on the life of the psychotherapist to have to deal with patients of this intensity and unpredictability", said George.

"Yes it is, and as I worked with these patients, I began to concentrate more and more on the quality of the physician's life [75]. I felt that it was very important for physicians, especially those who are under a lot of stress, to be warned. We are all unduly caught up in the world of production and consumption and a clue to the understanding of our patients with psychosomatic disorders who are similarly immersed comes from this. It is clear that leisure time must be allocated for the purpose of cultivation of what is truly human in us. The three basic aspects of this are keeping up with and contributing to scientific progress, contemplation of the humanities, and thoughts about the first principles of things. I felt this leisure was necessary in addition to liberal amounts of loving interaction with friends and family and that a lack of it indicates a gap in the maturity of the individual at the very least, and a danger."

"Now you are sermonizing," said George, "I led a much more simple life I had no children, married late in life, had very few possessions, not even a car, and spent most of my waking life in the laboratory. On the other hand I was quite gregarious, had many friends, was generous, and even lent you the money to begin your training psychoanalysis, and, above all, I did not complain."

"And you died of a coronary occlusion at the age of 51, at the height of your career," I replied, "And we will take that up in the next part when we discuss psychosomatic medicine." George was getting so irritated now he could not resist a final thrust: "At least I kept up to date with my scientific knowledge in medicine and histochemistry," he responded, "And it is clear you are not au courant with psychoanalysis since

you still rely on a one-person psychology, the so-called ego psychology school in which you were trained, and you have not made the popular fashionable shift to the two-person psychology and relativism that pervade psychoanalytic thinking today."

"I will take that up in the final part of this memoir," I said, "But let me continue please." My excited discovery and reading of Heidegger helped me to understand the defective ego feeling and the quest for being in the borderline patient [76]. Borderline patients typically complain of the meaninglessness of life and a vague sense of being "alive but not alive" often relieved by tactile contact or drugs and nothing else – this produces an enormous challenge to the resources of the psychotherapist. The intense suffering of these patients becomes more intelligible and less puzzling when one reviews the dramatic and lifelong preoccupation with Being of the philosopher Heidegger, even though he was personally a very flawed and repugnant man. "He couldn't have been more different than Bertrand Russell, my favorite thinker," added George firmly, "And I think his Nazi sympathies disqualify him as a philosopher."

In psychodynamic terminology borderline complaints are traced to the lack of good-enough holding in infancy, resulting in what Federn [77] described as a defective ego feeling. The obsessive quest for Being or of "meaning" in life and the vague sense of inner deadness are symptoms of defective ego feeling. This defect also feeds into the classical difficulty of borderline patients, their deficient sense of relating to both the human and non-human environments in spite of apparent superficial efficiency of ego function. Federn introduced his concept of ego feeling, the capacity to develop a secure relationship to the non-human environment as well as an I-thou relatedness that is grounded on a healthy ego feeling. It is this healthy ego feeling that is lacking in the borderline patient. Because the cause for this disturbance can be traced clinically to a lack of good enough-holding in infancy, the physical sensation of holding at an extremely primitive level offers a temporary sense of relatedness to the patient. Ego feeling that is basically missing cannot be replaced with any kind of intellectual or verbal exchange. Giving in to the patient's wish to be held, as all too often happens, is use-

less. It produces temporary relief but contributes to fixing the patient on primary process gratifications and avoids the working through of etiologic factors and, in my clinical experience, increases the patient's rage. Patients suffering from defective ego feeling are uniquely sensitive to countertransference manifestations in the therapist, especially when they involve a lack of psychological presence or of "being there" with the patient. It is the experience of the therapist's personality and the encounter with the therapist as a human being who is truly present, rather than any verbal exchange that makes the fundamental difference in therapy of such patients.

Ego feeling is difficult to define clearly. It has to do with the feeling that one has of one's own self, a kind of subjective experience, the sensation of one's ego. The ego, says Federn, is more inclusive than the sum total of the usual ego functions that psychoanalysts talk about. It includes the subjective psychic experiences of these functions with a characteristic sensation. As long as the ego functions normally one may ignore or be unaware of its functioning just as normally there is no more awareness of the ego than the air one breathes. Only when respiration becomes burdensome is the lack of air recognized. The subjective ego experience includes the feeling of unity, contiguity and causality in the experience of the individual. In waking life the sensation of one's own ego is omnipresent, but it undergoes continuous changes in quality and intensity.

"Aren't you taking a rather long leap there?" asked George. "To take a jump from Heidegger's quest for Being to Federn's ego feeling seems to me a jump that would not be approved of by Heidegger. It is difficult to assess Heidegger's thinking because his writing is very confusing, his thinking is muddled, and it is all infested with his Nazi and anti-Semitic sympathies. This is especially clear in the recent publications of his Black Notebooks. So let us go back to your clinical work and try not to bring Heidegger into the discussion."

I replied, "It is true there are many complaints about Heidegger's thinking and personality, and I would be the first to agree with them but he did have a startling idea here, although it is very difficult to pin down. I do think he was on to something extraordinary [11, p. 405-26] and that

it does relate to Federn's notion of ego feeling. I hope to discuss this later, along with Winnicott's [70, p. 54] remarks and his others on the 'continuity of being'."

Around this time, my book *The Intensive Psychotherapy of the Borderline Patient* was published [78], offering in detail what I have summarized here and including case presentations. I went on to publish three papers on the practical aspects of the psychodynamic psychotherapy of borderline patients. The first of these [79] was a straightforward description of my work, which then had lasted over 15 years, on the diagnosis and treatment of the borderline patient with special emphasis on the problem of transferences, the middle phase and so on. The ordinary practicing psychotherapist tends to be confused by the number of conflicting theoretical formulations regarding the so-called borderline patient. As a general rule of thumb, intensive psychodynamic psychotherapy with such patients begins with a working alliance and prevention of dangerous acting out. In the proper atmosphere with an uncovering stance, a working alliance forms, and characteristically narcissistic transferences, transitional object transferences and certain disruptive affect-laden transferences appear. Careful handling of these contributes to the uncovering of the patient's childhood disappointments, profound rage and consolation fantasies.

"Easier said than done," remarked George.

Most of the middle phase of treatment, however, is characterized by focus on problems of mistrust and adaptational failures as they appear in current life problems and as they developed at an earlier time of life. It is help with understanding the origin of these problems and the subsequent formation of a stronger ego that is the crucial task of treatment of these patients. At this point I felt that it was problematical whether the notion of borderline patient would ever become a theoretical or metapsychological entity. The value of the concept lies in the clinical descriptive diagnosis of DSM-5 with the implications of poor ego structure and consequent requirements for the proper therapeutic approach.

I published a long case presentation [80] in which I illustrated some of the issues I have been talking about. I fully realize the existence of a whole literature by numerous authorities who disagree with each other and who also would

disagree with some of my contentions and approaches to the patient as presented in these papers. Part of the problem is due to the variety of patients characterized as borderline but I do not think that interpretations in the early phases of the therapy are as important as the actual human encounter between the patient and the consistently unanxious therapist. I focused on the therapeutic alliance in which searches for object replication appear, and emphasized attunement as the basic technical tool [81]. I thought Fromm-Reichmann [82] was correct when she said that the patient needs an experience not an explanation. To provide such an experience and form a working alliance with such patients, regardless of the theoretical controversy over them, along with finding some effective procedure for limiting the patient's dangerous acting out, is the first task in the intensive psychotherapy of such patients, common sense tells us. I offer details of how this alliance can be formed: consistently and frequently being at the service of the patient, at a time arranged to suit mutual convenience; being reliably there, usually on time; for a contracted period, keeping awake and being professionally preoccupied with the patient and nothing else, such as note-taking, telephone calls, tape recorders, and so on; the expression of love in the positive interest taken and "hate," as Winnicott [83] called it, in the strict start and finish and in the matter of fees; the sincere and dedicated attempt to get in touch with the mental processes of the patient, to understand the material presented and where the patient is at, and to communicate this understanding by properly timed and formulated interpretations; the use of a method stressing a non-anxious approach of objective observation and scientific study with a sense of physicianly vocation; work done in a room that is quiet and not liable to sudden and unpredictable sounds, and yet not dead quiet; proper lighting in the room, not a light staring in the face and not a variable light; keeping out of the relationship both moral judgement and any introduction of details of the therapist's personal life and ideas; staying, on the whole, free from temper tantrums, free from compulsive falling in love, and so on, and in general being neither hostile and retaliatory nor exploitative toward the patient; maintaining a consistent clear distinction between fact and fantasy so that the ther-

apist is not hurt or offended by an aggressive dream or fantasy. All this adds up to the therapist behaving himself or herself as a relatively mature adult and showing a realistic and consistent dedication to the work of the treatment. Unanalysed acting out by the angry or narcissistic therapist – so common these days when everybody claims to be a "therapist" – stirs up a veritable storm of trouble and emotion in a borderline patient.

"Easier said than done," said George again, "It does not seem to me that this is a technique that would reliably be successful, and I think you are again being very unrealistic." It is not always successful; I went on to publish three papers giving examples of how it does not work out. The first of these [84] pointed out that the practical situation Greenson ran into by trying to treat Marilyn Monroe is similar to the practical situation we run into when treating narcissistic and borderline patients. If we are strict with the patient and insist on hospitalization for drug withdrawal, for example, or for protection of the patient against self-destructive acting out, or even try to place some limitations on the patient's behavior, the patient declares that we are not compatible and goes elsewhere. If the patient encounters a therapist who denies the seriousness of the situation and tries to treat him or her like a conflicted neurotic, the patient may remain in therapy for a while but nothing happens at all. Then there arises a gradual frustration on the part of the therapist with the danger of sliding into a therapeutic misalliance or countertransference acting out. The patient is in a sense manipulating the therapist as a selfobject in the service of a narcissistic disorder and refuses to tolerate even the minimal restrictions and the narcissistic disappointments incumbent on not having their way at all times. This must be interpreted to the patient and if the patient cannot accept this insight he or she becomes by definition untreatable by the method of psychoanalytically oriented psychotherapy.

I do not know that Marilyn Monroe was such a patient because I never had the chance to confront her and I have no evidence that anybody ever did. Unfortunately, we have only very sketchy information about the details of any of her treatments. I do feel that the case of Marilyn Monroe demonstrates the power of the psychol-

ogy of the self in explaining and bringing together the diverse phenomena of severe narcissistic personality disorders, and it best explains why, in spite of the tremendous commercial and popular success of Marilyn Monroe, a state achieved by very few movie stars, she remained an empty depleted self who died of a regressive attempt to cure her central defect. Some of the behavior of her analyst, a highly respected senior professional, indicates what a tangle one can get into, such as taking the patient home with him to be with his family, cutting his vacation short when she was upset, and so on. I personally remember one instance when we were invited by a good friend, a senior psychoanalyst, for dinner at his home. When the family sat down at table, I noticed an individual there whom I had never seen before. It turned out he was a patient of the analyst whom the analyst brought home to live with his family. I did not really believe these things happened until that incident, although I did know of some cases where the analyst divorced his wife and married one of his patients. But this seemed even more extraordinary, although at the table the patient did not participate in the conversation. My guess is he was schizophrenic and the analyst was trying to maintain him in remission somehow.

I moved on, perhaps stimulated by the experience at the analyst's table, to discuss one of my favorites in the operatic literature, Richard Wagner's *Der Ring des Niebelungen* [85]. In my opinion the relationships in the Ring, seen as a drama of pre-oedipal destruction, are associated with the kind of problems we run into with borderline patients. The drama of the Ring is not primarily associated with anything oedipal or the subject of normal feminine sexuality and development. It lies in the deeper struggle that must be gone through in every pre-oedipal child, involving the eventual giving up of childhood narcissism and the acceptance of one's limitations without being consumed by narcissistic rage. Adults like Wotan, who have entered middle age immersed in fantasies of being all-knowing and all-powerful, usually end up like Wotan, with despair and depression. These are the middle-aged men who make wars that young men must fight.

From the operatic literature I went on to study Strauss's *Elektra* [86], and later Kundry in *Parsi-*

fal [87]. In the case of *Elektra* I tried to show that the unique and remarkable impact of the opera rests not only on its dramatic portrayal of the oedipal theme but also on an inspired expression of our archaic emotions, pre-logical thought and pre-oedipal concerns. It serves as a warning to clinicians confronted with manifest oedipal material to be sensitive to the diagnostic implications when the oedipal material is permeated with more primitive expressions and affects, producing a curious and eerie ambiance and much disquiet in the therapist. The pre-oedipal disorder portrayed in *Elektra* is similar to the borderline personality disorder and shows an oscillation between manifestations of madness, paranoid pseudo-rationality, psychic fragmentation and organized paranoia, so the oedipal theme becomes suffused with archaic elements, magic thinking, ecstatic states, narcissistic rage, and primitive transitivity with blurred ego boundaries. This produces a clinical picture and disruptive ambiance quite different than that of a neurotic patient with a nuclear Oedipus complex, in spite of the similarity of the manifest drama to the play of Sophocles' *Oedipus Rex*.

It is a good warning to psychotherapists that, when they feel disturbed by such patients, just as audiences were quite disturbed by Strauss's opera, they ought to consider they might be dealing with individuals suffering from pre-oedipal disorders. The same is true about Wagner's Kundry in *Parsifal*. The problems of feminine rage, feminine psychology and feminine self-destruction must be understood as multiply determined and not simply an appropriate manifestation of social inequality in a male-dominated culture. This is illustrated by a study of pathological and borderline women. Wagner's female creation from *Parsifal*, Kundry, suffers from unresolved intrapsychic splitting, in which she oscillates from mature service to hatred, seduction and destruction of men. What is most emphasized is her misery and guilt, which are consequences of her reality testing being sufficiently intact for her to be aware of this splitting and the consequences of it for her. She receives no understanding from the men around her. The fact that her guilt and conflict are emphasized has a hopeful prognosis for her imagined psychodynamic therapy, as in the opera it makes her redemption possible.

"You are really getting far out," said George, "and making some wide speculative generalizations which no scientist would dare to do."

"Wait until you become acquainted with my next publication, George, 'In the clutches of the devil' [88]." Here I tried a different sort of experiment in communicating with my colleagues. I was scheduled to give a regular presentation to the department of psychiatry at one of the local hospitals and I decided to do it in a different way so they would remember it and not sleep through it as most people did at these presentations. I wrote a play that was later enacted at the 1987 annual meeting of the American Psychiatric Association and at a number of other professional meetings. It consists of a short and preliminary attempt to weave together the themes of cultural pressures, individual life pressures and personal psychopathology impinging on a psychiatrist, all potentially leading ultimately to fragmentation in middle age. Because of his inferior training and lack of personal psychoanalysis the psychiatrist in this clinical example is unprepared and unable to cope with these disintegrating forces and succumbs to using a borderline patient to treat himself. It also illustrates the phenomenological approach, letting the facts speak for themselves without classifications and formulations, in an attempt to generate a more genuine encounter with the patient, who in this play is the psychiatrist. Borderline patients are all too eager to get into tangles like this with their psychiatrist, which gives the patient a narcissistic victory, demeans the professional man, and makes treatment impossible. They are also very skilled at it.

"I do not understand," said George, "Are you writing a play and acting in the play?"

"I hired an actor to take the role of the psychiatrist and presented him to the audience as a visiting consultant on a particular case that he was going to present. During the case presentation he breaks down and reports that he has become utterly enamored of the patient to the extreme of throwing everything in his life away for her. This is not as rare as it sounds, for borderline patients can be extremely seductive, and impaired therapists provide dramatic examples of what such patients can do. After the affair is over the psychiatrist is left in ruins and the patient brags she has seduced a psychiatrist and

therefore all psychiatrists are simply men pretending to be something more than they really are. I often have suggested to residents and therapists alike that they read the story *Rain* by Somerset Maugham, which is not so different from this play."

"Well, how was the play received?" asked George.

"It was hard to tell because the play was rather shocking and something that had never been done before in any of the psychiatric grand round presentations, although one or two psychiatrists remarked, 'This is what you can expect from a presentation by Chessick,' a statement that can be interpreted in several ways. Whether they got anything out of the play, I was really not convinced. I could see that the play produced a lot of anxiety in the audience of psychiatrists; also a psychiatrist friend of mine was tipped off in advance and asked to observe the audience, and he agreed. It was an attempt to communicate in a different way with my colleagues about the problems in the treatment of borderline patients."

I closed my series of papers on the psychodynamic psychotherapy of borderline patients with a review of many of the aspects of the treatment that I have now discussed [89]. Whether this has a genetic or environmental origin, their profound volatility and anger and their extraordinary capacity for seductiveness produce what Kernberg [90] has labeled a global countertransference that he considers a diagnostic indicator of the condition. In contrast to Kernberg's more technical and highly specific views of the dynamics involved, I argue there are no pathognomonic systems, no specific personality constellations, and no compelling evidence for a definitive stage in infant development when this disorder is fixed; all stages are involved, from faulty foundational to oedipal periods. Therapy is long, tedious, and requires our willingness to patiently catalyze the patient's resumed development and to endure the periodic and at times frightening disruptions – and they can be very frightening, such as threats of violence or suicide. Narcissistic rage can become so overwhelming that a critical value is crossed; previous compromise formations such as obsessional rituals or masochism are suddenly overshadowed by a massive projection and projective identification. This pro-

duces an emergency and can break up the treatment and it constitutes an ever present danger in the treatment no matter how long the treatment has been going on and how confident the therapist might be that he or she has formed a good "working alliance" with the patient.

Continuing my study of borderline patients, the next step was experimenting with the use of the couch in the psychodynamic therapy of such patients, to get closer to the psychoanalytic situation. I found right away that three types of patients could not be placed on the couch under any circumstances: adolescents, borderline patients with obvious depressive, suicidal or paranoid tendencies, and severely affect-starved or anxious borderline patients [91]. In the series of 14 patients that were transferred to the couch a definite improvement occurred in 6, no detectable change in 2, and a worsening in 4. Two of the patients left therapy. Some patients who improved when switched to the couch seemed to be unbearably frightened by the closeness aspect of the face-to-face treatment and consequently were forced to retreat into silence, whereas on the couch they could speak more freely. Another type of patient, overwhelmed by sexual and dependent longings in the face-to-face position, found that using the couch enabled them to relax and use the psychotherapy better. The increased distance between patient and therapist the couch seemed to produce by placing the therapist out of the line of vision led to the improvement.

On the other hand, an immediate but reversible deterioration did occur in four patients, illustrating the dangers of the procedure. Some borderline patients experienced the couch in terms of visual deprivation, which led to an increase in their already overwhelming affect hunger. The therapist has to determine, depending on the aims of the treatment and psychodynamics of the patient, when to use the chair or couch. In my experience the couch is a sophisticated tool which demands experience, good training, alertness and self-understanding, along with continual reassessment from the therapist, so it is not the couch but the therapist who uses it that counts.

After many years of doing psychodynamic psychotherapy with borderline patients, I began to place a number of them on the couch and approached a more formal psychoanalytic

stance. With some I had success and with others I had failures, even though many of the patients whom I chose made progress. Already in mid-career I was more and more impressed with the longing for the pre-oedipal mother which never goes away in borderline and addicted patients.

Perhaps by looking very carefully at this, I thought, I could learn more about it from my patients. This defect manifests itself in longing, hunger, restlessness, depression and self-abnegation and is unanalysable in the sense that although it can be painfully faced, it is not a conflict but rather a deficit inside. Many patients have to learn to live with it in some fashion that is not self-destructive. Discussing the more formal psychoanalytic treatment of borderline patients I noted the controversy as to whether they can form therapeutic or "working" alliances [92], but I argued that the problem with borderline patients is not whether or not they can form a therapeutic alliance. Instead, the problem is how to get them to come 3 or 4 times weekly for psychoanalysis, since most of these patients are unsuccessful or even being supported by family members and, in this age of managed care and unbelievably greedy and heartless insurance companies, they receive little support from third-party, corporate, so-called healthcare payments. This is a catastrophe for a substantial segment of our patient population, since without intensive long-term psychoanalytic treatment the life situation of borderline patients tends to deteriorate, lurching from crisis to crisis and often involving drug addiction, alcoholism, episodes of self-mutilation, and suicidal attempts that are sometimes successful.

Our society is deliberately throwing these patients onto the trash heap, along with all the unfortunate occupants of our public mental hospitals who have been ejected to live in our streets, alleys and doorways. Foucault was certainly correct when he said that every society should be judged by how it treats the poor, the sick, and the mad. Their capacity to be successfully analyzed is a function of what I called nothingness, meaninglessness, chaos, and the "black hole" in these patients, which I have also frequently observed in addicts [93]. The emergence of an unendurable state in these patients is often described by them as a sense of nothingness, meaninglessness, chaos, or a "black hole," a falling

through space into a void. Previous discussions in the literature have emphasized the relationship of this to an infantile catastrophe, a failure in the initial nursing couple with all this implies for core psychoses or impaired ego functioning or a faulty sense of self. I concluded that the interacting combination of parental failure and the child's contribution, both in fantasy and from innate biological factors, is followed by the escalation of these failings into the formation of a closed system of horror. This central system of horror which the patients are trying to tell us about by invoking such phenomena as black holes, chaos, void, meaninglessness and so on, is extremely refractory to therapeutic influence because it is such a closed system, like a walled off abscess, around which the rest of the personality defensively develops in pre-schizophrenic, borderline, addicted and other personality disorder patients. To breach this wall there is a danger of reopening the abscess with a flood or miasma of malevolent elements drowning the ego. I offered some case presentations and discussed them mainly to illustrate that the emergence of such "black hole" material should not automatically be attributed to any one underlying intrapsychic situation but can have many meanings in one patient as well as a variety of different meanings in different patients.

"Well, you have had a lot to say about borderline patients," said George, "But I don't see how they are much amenable to improvement by the ordinary practicing therapist. As I understand it, these are very difficult patients and you have sort of painted yourself into a corner by running out of further recommendations and repeating yourself too much. In addition, there is total controversy about the topic, what a borderline patient is, how one becomes a borderline patient, and how one treats a borderline patient, and there are no ways of producing reliable experimental evidence about who is right and who is wrong. This is not my idea of research and it is more in the area of speculative philosophy. The only difference from philosophy is that these are patients who are suffering and need all the help they can get; it is not a matter for simply philosophical discussion. To my mind you have left the area of scientific research entirely and you should resign your membership in the Sigma Xi

research fraternity, which at one time you were so happy to obtain."

I tried to point out to George and other traditional scientists that philosophers have long considered these matters [94]. The basic problem of 20th-century man has been presented by Kierkegaard as an anxiety or restlessness or anguish that increases as science demolishes systems of belief previously thought of as inviolable. Man with his increased leisure remains unhappy because successful creative and altruistic activity must occupy that leisure if psychogenic tensions are to be released. It is the task of modern psychiatry to point out these facts to modern philosophers but they very often do not do so. It is the paramount task of philosophers not to recommend regressive "leaps of faith" to us or to take refuge in mystical "systems", but to help us examine human value systems in order to guide us toward those forms of humane activity that are most effective, most gratifying, and most beneficial to humans, both as individuals and as a species that I regard as now endangering its own existence. All my life I have wondered how it is that a species that can land a man on the moon, and even soon on Mars, is so completely unable to stop its members from killing other members, regardless of the rationalizations for the killing, which invariably are appallingly stupid. I do not understand why as a species we have been unable to conquer the "death instinct," as Freud [95] described it, and to base all human activity everywhere in the world on a reverence for human life.

Forthcoming: part three will present parerga and paralipomena [with apologies to Schopenhauer] to parts one and two.

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