Kraepelin had no confidence that his diagnostic distinctions were the final ones. Like Freud he went on revising his system up to the time of his death, trying to find his way between the need for structure, on the one hand, and the great elusiveness of almost all our knowledge of human nature, on the other. He welcomed Bleuler's nice epitomization of the dementia praecox symptoms; in fact he took Bleuler's major distinctions right into his own textbook. When the Wassermann test appeared, as I have indicated, he watched the number of patients diagnosed as de-

dementia praecox in the Heidelberg Clinic fall. The straggling, chronic, changeable dementia praecox, it turned out, had picked up in its net some syphilitic dementes, so that when there was a clear-cut test for the latter, the dementia praecox rolls shrank. It was not that the dementia praecox concept had proved empty, but that there were soft spots at its edges—some not far from its center—that had to be faced and reworked.

JASPERs

Karl Jaspers knew Kraepelin's work at first hand in Heidelberg, and psychiatric phenomenology, which was to a considerable extent Jaspers' creation, sprang from the limitations of Kraepelin's work. These limitations stuck out most noticeably with the paranoid patients. Kraepelin had put many in the dementia praecox category, but few deteriorated to the degree that catatonics and hebephrenics did; paranoid patients still, even on the back wards of the great state mental hospitals, keep the energy and often the clarity of their minds to the bitter end. Also, many of the paranoid cases, despite elaborate delusions, lived and worked in ordinary life, their illnesses undetected even by those closest to them. Thus if persecutory delusions meant dementia praecox, the category must include people otherwise unremarkable. Then there were paranoid patients whose illnesses seemed exaggerations of their original personalities, precipitates of their life situations, illnesses that seemed to grow bit by bit from their pasts: pathological personality developments. These stood in such contrast to certain other cases on which sickness fell, like a blow on the head, that the question inevitably arose: Were these the same illness? Did dementia praecox include both the personality paranoia and this abrupt illness that seemed to come out of nowhere? [1].

Jaspers undertook to distinguish the two, and the clearest difference that he found pointed the way from descriptive, objective psychiatry to psychiatric phenomenology. The two groups of patients encountered on the wards, examined and examined again, did not seem so different from the standpoint of the objective, outside observer, but their experience, seen from within, their subjective experience, did seem different.

In 1910 Jaspers [2] reported four cases of jealousy psychosis—two cases of abrupt origin and two suggesting pathological personality developments. As we review the details of one case, that of Herr Klug, watch how Jaspers continues the Heidelberg study of symptoms and signs over time, but now the pathological phenomena are being reported from within. Kraepelin and Bleuler had searched physical movements and the stream of speech for the external forms indicative of specific diseases. Jaspers now brings psychiatry a new field of data, the forms of inner experience, at the same moment psychoanalysis is exploring the content of inner life.

Julius Klug, a watchmaker, came first to the attention of the law. He told the district attorney that his wife was unfaithful to him with a number of men. He felt wronged, not ill, and therefore doctors were momentarily absent from the scene. Klug asked for a divorce and was instead referred for psychiatric help.

Typically, there followed threats, protests against the imputation of illness, further requests for legal help, a continuing preoccupation with his wife's alleged adultery, and voluminous correspondence with the authorities. (These patients have professors' minds: They write much, explain everything, and miss the plain points that "simple" people grasp.) The threats gradually became shriller. Klug talked of killing, and three years after the first complaint he was sent to an asylum.

Jaspers next gives the material from Klug's wife. She said he had always been stubborn and quickly excited, but hard-working and reliable; she said that she had made it a policy to
give him his way. For more than a decade he had been con­structing an immensely complicated astronomical clock, on which he pinned great hopes. Then, for the past three years, "ist es an ihn gekommen" [2, p. 576]: It had come to him; he had been seized. In bed alone with her, at the start of the illness, he felt literally squeezed and pressed by adulterous lovers. The German passive construction suggests a new, alien process.

One night, the patient himself described how, after an unsatisfactory party, he heard a noise, as of a door opening, felt a wet cloth over his face, then caught something like whispering or a kiss. There were feelings of bodily movement and pressure. This was "not a dream; the impression was too clear." Yet, he might have been "half-asleep" [2, p. 579]. The last points are vital. The "elementary experiences" being described must occur in a clear consciousness, or they can be dismissed as hypnoid and hysterical.

The wife said he claimed that even passing male visitors had had intercourse with her, that their children were a whore's children; he had beaten her, begged her to confess the adultery, but then run away from the men he accused. For his part, he said that she had told him a suggestive dream, there had been rumors, some coincidence of names among the men she knew, and various ambiguities of phrasing. He had tested her by a nighttime visit when he was assumed to be away; she opened the door in her nightgown.

Then Herr Klug is described as he appeared on the asylum ward. Polite, obedient, understanding, he was an exemplary patient, orderly in his habits and willing to answer questions. Little could be suspected from casual observation. Perhaps he was a trifle superior. He dropped hints now and then of feeling that he might fall apart or go crazy, and the poems he wrote repeated the theme of being rescued from situations of great danger: "God does not leave his people" [2, p. 580].

There was a naïve eagerness, too, in his descriptions of the astronomical clock. However, he insisted that he had not been jealous before, and there was nothing remarkable in his family history or the accounts of school, work, or marriage until recently. All these areas are reviewed almost curtly. Jaspers is making the case for an intact personality upon which a pathological process fell.

It was not until the patient and his wife were interviewed together that the psychosis revealed itself. Klug quickly became excited, abused her, and threatened violence. Then his limbs hurt and he had to go to bed.

Jaspers takes us directly to the patient's written accounts, which were later supplemented by an autobiography. These emphasized the unexpectedness and severity of the evening's hallucinatory experiences; the latter were worse than "the worst of murders." In the morning he believed himself poisoned at breakfast, heard a "roaring of waters" [2, p. 583], and had more physical discomfort. The plastic quality of the discomfort is underlined, as were the sensations of pressure in bed. The "elementary experiences" are, above all, alien to everyday life; there must be some miraculous power and intelligence behind their occurrence.

The diagnosis was paranoia, and the patient's further course bore it out. The suspicions continued but never extended. No treatment was recommended, only constant observation. He was soon released and returned to watchmaking and his family. Apparently he had learned not to mention his convictions, which burst out only a few times. Once he accused the burgomeister of preventing him from finishing the clock. However, it was finished, even written up in the newspapers. Then he encountered fresh difficulties in selling it, which he blamed on the charge of insanity. The court intervened, praised his extraordinary skill, and awarded him money. There were public discussions of whether the clock should be bought for a mu-
seum. The German welfare state of 70 years ago practiced a social psychiatry fit to shame some more recent efforts!

Jaspers finds in Klug's autobiography the combination of grandeur, naïveté, and piteousness so characteristic of the syndrome. (He does not make clear whether these are results of the alien process or the soil on which it grew.) Throughout he emphasizes that the patient's work capacity never suffered, nor did he show any mental weakness. There were no further "plastic" experiences. The ferocity gradually disappeared from his complaints about the wife; she had become old and a "churchgoer," leaving far behind the alleged life of sin [3].

It is the plastic, elementary, vivid, bodily experiences that represent the alien pathological process, Jaspers is arguing. These comprise the indelible nucleus that is elaborated into delusions. Elementary experiences are not continuous with personality development. They break unintelligibly upon it. Personality must be warped and twisted to absorb the manifestations of process.

One lets the patient give a detailed story of himself and his experiences; one enquires when some point is obscure and in this way proceeds through his life, and particularly through the years which are suspect, for the beginning of an illness. As one participates in this experience with an inward understanding, one notices at first that connections are obscure and finally quite incomprehensible. One makes a note of these, compares them together, and eventually may find that they can be understood or on the other hand they accumulate and cluster together at some particular time. In that case one has found the most vivid and striking characteristic of the mental illness proper which cannot be demonstrated in any single symptom but which, as one lives into the patient's experiences, impresses itself forcibly on one's understanding [4, p. 829].


There is no understanding Klug's hallucinations, Jaspers insists—no exterior cause, change in circumstances, or even minor occurrences. Later in life no new "connection-points" (to the alien process), no new elementary experiences occurred. The elaboration of ideas and twisting of personality all led back to the original hallucinations. Surely if paranoia were a personality disorder, its development would not remain bound to events of barely 12 hours' duration. Finally, in his last, contrasting case illustrations, Jaspers described personalities much more obviously and earlier disordered. Their illnesses did appear to flow without break from their attitudes, wishes, and experiences and did have the isolated plastic hallucinations of the first two. To the psychoanalytic complaint that Jaspers appears largely ignorant of his patients' sexual lives or fantasies, ignores the unsatisfactory party that preceded Klug's hallucinations, makes little of the symbolic significance of the astronomical clock, and fails to develop a relationship between the rigidities of character and psychotic developments, he replies that any relationship of similarity, temporal contiguity, or psychic forces that could be established among these elements would still not explain the vivid bodily experiences, would not explain the form which the illness took. To invoke the "unconscious" or a breakthrough from the unconscious is simply to invoke words. Worse, to try to explain such phenomena in psychological terms is to overlook the nature of the inner experience, to ignore that one can establish an intellectual explanation but no "inward understanding."

Some experiences cannot be "felt into." The patients themselves experience them as alien. When we get close to the patient, we do not thereby get close to these experiences.

... A young man suffering from schizophrenia lived with a woman hysterical who shared many of his hallucinations and anxieties. The patient said of her, "If one gets caught up, one is nervous; once one has the actual experience, one is not at all nervous;
in my case the whole thing is much quieter and clearer" [4, p. 132].

"The 'shouting miracle' is an extraordinary occurrence; the respiratory muscles are put into motion, so that I am forced to shout out, unless I make an enormous effort at suppression, which is not always possible in view of the suddenness of the impulse, or rather I have to concentrate relentlessly on it. . . . At times the shouting is so repetitive that my state gets unbearable . . . since words are shouted, my will is of course not altogether uninvolved" [4, p. 124].

Jaspers is arguing, do not impose an intellectual formula on the material. Respect the differences in experience reported. No one doubts that there are pathological physical processes which can break in on mental life. Are not these psychotic experiences more like physical processes than the vast bulk of personal experiences reported? If these arguments carry no force, try achieving an "inward understanding" of the experiences, try "living into the patients' experiences." I tried in the case of Klug, Jaspers says, and I could not.

Jaspers' contribution does not turn on his success or failure with Herr Klug. Perhaps a more empathic observer could have reached an "inward understanding" of Herr Klug's psychosis; some therapists appear to have done so with very similar illnesses. The great point is the test applied. There is no deciding between unconscious process and alien or physical process on the basis of external observation, whether of the brain or the mind. A fresh method is needed, and that, Jaspers suggests, should be one of "inward understanding," "living into the patients' experiences." The physical cases should not allow it; the psychological ones should. This is the first step toward the existential method.

Paranoid cases provided the royal road to the exploration of psychosis for both the Heidelberg school and psychoanalysis. These articulate, self-conscious patients, with their great penchant for explaining, served both schools; in fact Jaspers and Freud each used Schreber's memoirs. Paranoia was like an extraordinary insect fixed in the clear glass of a seemingly intact person. Again it is the accessible material, as with hysteria, that shapes the development of scientific ideas. The paranoid patients did feel they were subject to an alien influence. Had Jaspers been "taken in" by the psychotic material or were the patients right—subject in fact to an alien process that the psychosis was only an attempt to explain?

The difference between Jasperian and Freudian explanations comes to less and less as the more closely we study them. Jaspers would not say that the alien process was physical; he did not know what it was. Of the two, Freud was the one prone to physical explanations. He would have been the one more likely to locate the unconscious in the midbrain, for example, and to call psychosis a disturbance of the midbrain. He was forever leaping back and forth between the mind and the body. Jaspers tended to remain on one side or the other.

However, what should interest us about Jaspers is not his ignorance of the cause of psychosis. That he shares with a large and humble company who have learned to be at home with psychiatry's early victories as we work toward larger ones. What Jaspers did was to make clear a fresh difference between psychosis and normal or neurotic life. He did so by studying carefully patients' reports of their experience, as Kraepelin had studied their physical movements, stream of speech, and hand-writing, and Freud their mental content. And just as the objective schools of descriptive psychiatry and psychoanalysis fathered detailed methods, so the study of inner experience fathered its own technique.

At first everything depended on finding cooperative, articulate patients in touch with their inner lives. The investigator did little more than ask the patients how they felt and then hope for an intelligible answer. The answers seemed generally to concern symptoms, that is, some discrete pain, anxiety, or
peculiarity of experience that caught the patient's attention. (We have already seen how the objective schools also began with these bits of experience.)

A large number of these "subjective experiences" were collected and categorized under a variety of headings. One result was a greater appreciation of how varied human experience is. Phenomena that looked largely identical from the outside were found to have all kinds of inner differences. For example, hallucinations, illusions, fantasies, true perceptions seemed to describe an adequate spectrum until patients developed in more detail what they "saw" or "heard."

In describing sense-experience in false perception, we distinguished illusions from hallucinations and similarly we draw a clear distinction between sense-phenomena and the phenomena of imagery (i.e., between hallucination and pseudo-hallucination). This does not prevent us from finding actual "transitions" in that pseudo-hallucination can change over into hallucination and there may be a florid sensory pathology in which all the phenomena combine. We cannot reach any analysis, however, unless we attempt sharp distinctions of this sort which provide us with some kind of standard [4, p. 70].

We are given a series of phenomena, with some features in common and others not, a much richer variety of experiences than objective methods revealed. One result was the collapse of neat sortings by the psychological faculty involved; plainly there lie between thinking and perceiving, for example, intermediate or transitional phenomena which defy simplistic categories. The richness of inner life encourages still wider and deeper investigations. What will we find if we extend our interest beyond symptoms, ask questions meant to plumb the whole range of inner experience, place ourselves where we can share the patient's experience, minute by minute? These are the next steps in the development of phenomenology and then existential psychiatry.

I pass on to another case history, which occurred in 1923. At this time a happy circumstance or, more precisely, the vicissitudes of life obliged me to spend two months with a patient as his private physician. I was with him continually, night and day. It is not difficult to imagine the annoyances that such a symbiosis can cause, but on the other hand it creates special conditions for the observer. By allowing him to constantly compare the patient's psyche with his own, it gives him the opportunity to note certain details which usually escape attention.

Briefly, here is the clinical picture. It concerns a man 66 years old who exhibited a depressive psychosis accompanied by delusions of persecution and extensive interpretations. . . .

The patient expresses delusions of ruin and guilt. Being a foreigner, he reproaches himself for not having taken out French citizenship. He sees this as a terrible crime. He claims also that he has not paid his taxes and that he no longer has a penny. An atrocious punishment is in store for him as a result. Someone will cut off the arms and legs of the members of his family and will then leave them exposed completely naked in a barren field. The same thing will happen to him. They will hammer a nail in his head and pour all kinds of filth into his stomach. Mutilated in the most appalling way, he will be led in a large procession to a fair and will be condemned to live, covered with vermin, in a cage with wild beasts or with rats in the sewers until he dies. The whole world knows of his crimes and knows the punishment which awaits him. Also, everyone with the exception of his family will be involved in one way or another. People look at him in a certain way in the street; servants are paid to watch and slander him. All the articles in the newspapers are aimed at him; books are printed expressly against him and his family. The Medical Corps is at the head of this vast movement directed against him [5, pp. 180-181].

Although my patient's case is relatively commonplace from the clinical point of view, the circumstances in which I observed him were not. I have already said that I lived with him for two months. Thus I had the possibility of observing him from day to day, not in a mental hospital or sanitarium but in an ordinary environment. His manner of reacting to normal external stimuli, his ability to
adapt to the demands of daily life, the variability of his symptoms and their particular nuances are set out more clearly under such conditions. This circumstance is accompanied by another. We cannot maintain a medical point of view 24 hours a day. We react to the patient as do other people around him. Compassion, gentleness, persuasion, impatience, and anger appear in turn. Thus, in the above circumstances, I not only observed the patient but had the possibility of projecting his psychic life on mine at every moment. It was like two melodies being played simultaneously; although these two melodies are as dissonant as can be, a certain balance becomes established between the notes of the one and the other and lets us penetrate a little further into our patient's psyche. The findings thus noted were psychological on the one hand and phenomenological on the other [5, p. 182].

Here is one of the moments of passage for psychiatry, from the objective, descriptive reporting of Jaspers' informants to the existential encounters that Minkowski begins to experience. The report starts out traditionally; the paranoid and depressive delusional content was familiar enough from a thousand previous examples. However, the necessary materials for preserving the outward, objective position have already been thrown away. The patient is at home, not in a hospital; the doctor does not visit, he stays; there is no desk or instruments or examinational procedures to maintain distance between doctor and patient. Minkowski is able to preserve his professional attitude for a little while, assisted by the "far-out" nature of the patient's communications; in the last paragraph he switches from I to we, and back to I again, taking refuge for a moment in the impersonal plural, but then.

When my children came to visit me one day, I was supposed to have purposely had them bring a change purse with some coins in it. These coins now would be put in his belly. It was shameful to have involved one's children in such an inhuman scheme. Finally he called me a murderer and bestowed on me the name "Deibler." At that point everything fell apart. All that remained were two people who did not understand each other at all and who, as a result, were hostile toward each other. I became angry; he translated his anger in his way by adopting a completely antisocial attitude. He accused me of the most evil deeds and then purposely went into the garden and gathered all the strings and matches that he could find [5, p. 183].

Minkowski does not tell us how he, the doctor, expressed his anger over this silly quarrel, so like a domestic quarrel in its triviality, in its made-up quality, and in one partner's going off to "pick up" compulsively afterward. There is still this professional reticence about the feelings and actions of the doctor. He does tell us that in a calmer confrontation than this angry one he wanted to tell "my partner," "Come on, let's make peace." Again he does not indicate that he did say it. However, following this desire of the doctor, the patient underwent a sharp change.

He would react by a fit of simple depression. He would complain of his misfortunes, appeal to our compassion; on the other hand, the interpretations scarcely played a part. It was as if he drew from the arsenal of his pathological attitudes something with which he could establish a certain contact with his fellow men [5, p. 183].

That is not quite right. His delusional, interpreting attitude had also established "a certain contact," such unmistakable contact that Minkowski had gotten angry. However, by contact Minkowski means something positive, a greater feeling of liking, sympathizing with the patient, in contrast to the hostility that he had aroused earlier. For a little while Minkowski had been able to stay closer to the patient, break up his endless harangues. For a moment they seemed even to like each other, although it was a liking that did not last long. "As he repeated his melancholic complaints, his moanings, they ceased to move us" [5, p. 185].

Ironically this favorable change had been accomplished by
the collapse of the objective, professional attitude. That brought the two onto fresh ground. Minkowski was not able to see that the breakdown of the traditional attitude and the establishment of a new attitude, which might become professional in its turn, was necessary for the favorable change. Nor did he remark that perhaps the essential point was his having been for a while moved. The insight he had was essentially phenomenological. He knew that living with the patient, encountering him day after day, gave a richer picture of his inner life, that such changes in the position of the observer made it possible to feel more of what the patient felt, almost "experience" the patient's world. The two melodies that Minkowski wrote of might become for a moment one. The phenomenological interest was investigative. The gradually emerging existential interest was therapeutic; it aimed at the changes which Minkowski in his exasperation forced upon his clinical relationship, against his own will. We remember that a similarly great change occurred in psychoanalytic technique when therapists found themselves locked in transference situations that their repeated, steady being with the patient had brought to birth. A clinical "accident," you might say, developed a concept, which in turn shaped changes in technique.

Minkowski wrote that he not only observed the patient, in the traditional objective way; he also compared "his psychic life with mine." There is not a great deal of evidence for this assertion. We do not learn much of Minkowski's psychic life from this report. Nor do the phenomenologists and existentialists often make good, or at least overt, this claim of comparing. Again, we must suspect that the old privacy of the doctor was being put first, despite the existential claim. However, there was a stated willingness to compare, which, in principle at least, marks a radical departure. The doctor was to bring his psychic life beside the patient's—not his knowledge of disease beside the patient's symptoms, as in objective psychiatry, nor his listening ear, his readiness to grasp hidden connections, as in psychoanalysis, but his own psychic life. This was a degree of equalizing, of egalitarianism, that invites comparison with the great political aspirations of today.

The purpose was not political, however, not equality as a principle of justice or social right. Its end was investigative and medical. Minkowski hoped to understand more by comparing the two psychic lives. It was uncertain how this greater understanding would come about. He wrote metaphorically that there were two melodies being played simultaneously. That by itself does not suggest understanding, or even harmony. But then "a certain balance becomes established between the notes of the one and the other and lets us penetrate a little further into our patient's psyche." He was claiming that the "balance" permitted a movement inward. What is this balance and how does it permit the movement?

At times, after the confrontations and during the brief depressions the patient seemed more normal.

The alternating of symptoms, the diverse forms under which they were presented, establish a current between normal life and the pathological psyche; like a succession of rising and falling waves, sometimes there is an intermission, an attitude of contact prevails, and we cannot help hoping again; at other times the waves mount, everything breaks up, we are submerged once again [5, p. 183].

However, even during the patient's delusions Minkowski caught glimpses of "more normal" attitudes, a "hint of life," and "reality." There was a great deal of intellectual activity involved with the delusions, much to figure out, calculate, which interested Minkowski: The patient realistically perceived that swallowing everything must be very expensive, so he decided to absorb "only parts of the objects in his body; then, with what was left, they would install him in a sideshow at a fair so that he could be the object of public derision." Min-
kowski could appreciate this concern for economy and the patient's nice ability to reach and accept a compromise.

Yet Minkowski was not concerned with what he could "understand," that is, sympathize or identify with. His own psychic life was being used only for comparison with the patient's, so that whatever matched could be thrown aside. (In watching the development of psychiatry we come to expect this assumption of the observer's normality in the early stages of every psychiatric school.) That leaves for study what does not match, whatever seems to lie outside the doctor's familiar mental life. Here is a dramatic example:

From the first days of our common life, my attention was attracted by the following fact. When I arrived, he stated that his final execution would certainly take place the next night. Anxious, he could not sleep and kept me awake. I was consoled by telling myself that the next day he would see that his fears had been without basis. But the same scene was repeated the next day and the next, and after three or four days I had given up all hope; his attitude had not changed at all. What had happened was that I, a normal being, had very quickly drawn a conclusion concerning the future from observed facts. He, on the other hand, had let the same facts go by him without being able to profit from them concerning the same future. I knew now that he would continue to claim that he would be executed the next night— which he did, without any thought of the present or the past. Our thought is essentially empirical. Facts are interesting only insofar as we can base our future behavior on them. This propulsion toward the future was completely lacking in the patient. He had no tendency to generalize and arrive at an empirical law. When I said to him, "Look, you can believe me when I assure you that nothing threatens you; up until now my predictions have always been correct," he would answer, "I admit that up until now you have always been correct, but it doesn't follow that you will be right tomorrow." This reasoning, against which one feels defenseless, represents a serious disorder in the general attitude toward the future. Here time is split up into isolated elements. In normal life they conform to a completely normal integration [5, pp. 185-186].

We must put aside our habit of thinking the doctor and patient meet only now and then and read this passage remembering that not only the patient but also Minkowski was being kept awake all night. Minkowski then discussed the patient's disordered sense of time to raise the complicated issue as to whether his lack of sense of the future sprang from his delusional belief that execution was imminent or the delusion sprang from the lack of a future; he wanted to decide which was more fundamental. This proved to be an insoluble dilemma, but there was nothing insoluble or a dilemma about Minkowski's experiencing the patient's time sense. He did that in the most intimate and painful way possible. He might well have cried out that neither the loss of a future nor the delusion is the basic fact. The basic fact is the loss of sleep, and all the hopelessness and confusion that spring so regularly from that.

How are we to know what is primary, fundamental? Listen to Minkowski wrestling himself toward his own answer.

... Isn't the disorder pertaining to the future a perfectly natural consequence of the delusional idea of imminent torture? This is the crux of the problem. Could we not assume, on the contrary, that the disorder in our attitude concerning the future is of a more general order and that the delusion of which we spoke is only one of its manifestations? [5, p. 186]

Probably someone will say that basically this is the outlook of a person who has been condemned to death and that our patient reacted this way because of his delusion that he and his family were condemned to death. I doubt it. I have never seen a person who has been condemned to death. I willingly admit that the description we have just given corresponds to the idea that we have of the experience of someone who has been condemned to death. But don't we draw this idea from ourselves? Don't we have it because, at moments, we are all condemned to death—at precisely those moments when our personal clan weakens and the door to the future is shut in our face? Can't we assume that the patient's attitude is determined by a more lasting weakening of that same
impulse? The complex idea of time and of life disintegrates, and the patient regresses to a lower level that is potentially in all of us. Thus the delusion is not completely a product of the imagination. It becomes grafted onto a phenomenon which is a part of our life and comes into play when the life-synthesis begins to weaken. The particular form of the delusion, the idea of execution, is in fact only the attempt of that part of the mind which remains intact to establish a logical connection between the various sections of a crumbling edifice [5, p. 187].

The delusion is a secondary or reparative effort in the face of a fundamental breakdown of synthesis, or dissociation, Minkowski argues. The dissociation is the fundamental phenomenon, and its direct expression is the breakdown of the sense of time. We are familiar with both these concepts, of primary dissociation and secondary symptoms, from Bleuler, Janet, and Breuer. We will confront them again in the more modern concept of a weak ego. Do not dismiss either the earlier or the modern version because Freud was able to show that conflict in the case of Minkowski’s patient was probably a conflict between destructive impulses toward his family and both his love of them and his conscience. This conflict or crack in the integrity of the personality may be the weakening or disintegrating agent—and therefore more primary than the dissociation. Do not dismiss the earlier concept, for in fact Freud’s idea, too, will prove insufficient. It will not explain why the patient’s personality was not able to contain the conflicting elements; psychoanalysis itself had to take refuge in the concept of a weak ego, which is hardly more than a return to Bleuler’s and Janet’s idea by a fresh route. No, it is only when we reach the ground of either social experience or biology that we pierce the dilemma. But that is a later step.

Almost every psychiatric discovery is given etiological significance at the time of its discovery. Everyone hopes that he has reached the bottom of things, but he had enlarged the range of observables—and by a method at once new and surprising. He had really experienced the new datum; he really knew what the patient meant. Perhaps his discovery was not as impressive as the discovery of the cause might have been, but we learn to live with our disappointment in that. The discovery was modest, but it was real and very human. The dissociations that Kraepelin and Bleuler had observed from the outside were now being experienced from the inside—a great confirmation of the importance of this concept. We are not surprised to find the breaks reaching through to the inner experience: If it had been possible to imagine such data before Jaspers and Minkowski, the depth of the fractures might have been predicted. But that would have been speculation. Minkowski had come upon something empirical, convincing.

The development of the method by which he reached the patient’s inner experience was not predicted either, any more than the development of psychoanalytic method from hypnosis to head-pressing to free association to analysis of the resistances was predicted. Jaspers had taken the first step in making explicit the area of investigation: inner experience. Minkowski now took a second step by staying close enough long enough to the patient to secure more than the fragmentary reports that Jaspers had received. Once trapped with the patient, he found another step perhaps inevitable. It does not seem possible that anyone could have maintained the traditional objective, aloof attitude of Kraepelin under such circumstances; the doctor had either to get out or give in to the feelings so insistently aroused by the patient, who was again and again irritating and then pitiable. This acceptance of the doctor’s feelings and open conveyance of them to the patient was a third step toward the full existential method—and the one at sharpest variance with the ideals of traditional practice. We can therefore understand the guarded language with which Minkowski describes it. He
hardly acknowledges what he is doing. Certainly, doctors had often found themselves annoyed with patients. A good part of the humor among doctors about medicine expresses that fact. However, to elevate the doctor's emotional response to a principle of investigation and treatment was to fly in the face of a fully accepted tradition.

Psychoanalysis would also acknowledge the doctor's feelings about the patient, the so-called countertransference reactions. But psychoanalysis typically saw those feelings as distortions of the clinical situation, carry-overs from the past, rather than natural outgrowths of the present. Nothing was more typical of the existential attitude than its acceptance of the spontaneous, emotional responses to the patient, the incorporation of such reactions into the heart of the method. Where the objective schools saw the emotional reactions and relationships between doctor and patient as disruptive, existentialism was to claim that such reactions and relationships were the very conditions of reliable investigation, and to claim still later that they were also the conditions of treatment.

It is easy to see how such points of difference quickly gave rise to serious, still continuing quarrels. It may not be so easy to see how these insistences of existential psychiatry grew, not only from its own discoveries but also from the discoveries of objective psychiatry, both descriptive and psychoanalytic, for both these schools were uncovering the biological and emotional roots of the symptoms. They were insisting that mental, cerebral, rational processes were only part of mental or psychic life, and certainly not the most powerful part. Mental diseases were not purely mental. Freud compared the rational ego to the rider of a great horse, the id, guiding but not always controlling its pace and direction. Thus we should have expected psychiatric efforts to deal more and more directly with emotional responses, or at least to develop increasing skepticism as to how significant any human interaction could be without them. In that respect existential psychiatry was a direct outgrowth of psychoanalytic and biological psychiatry.

Existential psychiatry was also a direct outgrowth of its own method. The attempt to get and stay where the patient was, not to allow any withdrawal into professional objectivity or neutrality, not even to allow any "getting out at all" in either a physical or a psychological sense—this holding close to the patient inevitably produced emotional explosions. The craziness of the patients was tolerable only "professionally." That was why the patients were locked away in the first place, and partly why the professional rituals were developed too. The family and society could not stand madness. The ways the doctors stood it were developed as much to protect the doctors as for any therapeutic or investigative reason. We know that the great distance between patient and others initially institutionalized, legislated, and rationalized was very slowly broken down, and that existential psychiatry, this living with the patient for long periods and then feeling what he felt, represents the almost final collapse of those institutional, legal, and rational barriers. However, the emotional difficulties of being with the patient remained. It was perhaps these difficulties that had energized the building of barriers in the first place. As a result, Minkowski was as bold and probably unwitting as any of the great explorers, although the dangers experienced did not come from an outraged community, as did Freud's, but from the existential method and its application, like the dangers the Curies and anyone who works with lethal or traumatic materials suffered.

The result of staying with the patient was an emotional explosion, in fact a series of emotional explosions. This is a better metaphor than Minkowski's "two melodies," which suggests something mild, even lyrical. If there were two melodies, they were melodies from Wagner, however much Minkowski preserved his professional veneering of the sleepless, repetitious,
irascible, quarrelsome, pitiable, altogether miserable human situation he was involved in. But the new metaphor proves as misleading as the old, because the “explosion” does not break the two people apart; in fact the result is “contact,” “a certain balance becomes established between the notes of the one and the other and lets us penetrate a little further into our patient’s psyche” [5, p. 182]. Again, what is this balance and how does it permit penetration?

Our first answer was incomplete: The balance had something to do with the discovery of features in common between the doctor and patient, and it had something to do with the patient’s desire for compassion and the doctor’s capacity to give it. However, there remained a seemingly irreducible stubbornness or stupidity on the patient’s part that required all kinds of conceptions about time, personality synthesis, disintegration, and so forth, to come to grips with at all. Like the actual period of contact, understanding was short-lived, giving way to the familiar irascibility in the personal sphere and frantic intellectual activity in the scientific. The penetration was to common elements and then to what was alien—basically understandable, as Jaspers wrote.

This first answer said nothing about the balance achieved, except to indicate that it was short-lived. But, having in the meantime underlined the place of emotions in the existential method, I think we can understand what Minkowski meant. Before the explosion, the patient overran the doctor, accusing, abusing, scattering incomprehensibilities everywhere, as busy in that direction as he was in picking up so many things. Then Minkowski’s patience gave out. He must have wanted to say “Shut up,” and perhaps he did, although we do not know whether he even managed to say “Let’s make peace.” Like students in clinical supervision, he probably said a great deal more than he reported, dressing the whole cautiously lest we decide he was “subjective” or lacked “understanding.” In any case, the patient did shut up and the doctor took his brief command of their relationship. This was the “balance” achieved. The doctor made himself felt, slowed the patient down, insisted on more acceptable behavior from the patient, so that what Minkowski reaches is the patient’s capacity to be more than the crazy, bedeviling person he had been.

There are several fruits of this “encounter.” We see immediately that the crazy people are not so inaccessible, so removed from personal influence as some biological and psychoanalytic opinions would suggest. (Later the interpersonalists would extend still further this attack on the inaccessibility of crazy people.) We also see the doctor being most effective when he is least professional, which observation must unsettle our comfort in traditional practice, until this unprofessional behavior can be carried up into fresh modes of practice. Most important of all, we see that the “balance” in human relationships—our not taking refuge in professional authority, on the one hand, or the patient’s not commanding the doctor by his accusations or pitiableness, on the other—permits closeness, shared feelings, a contact that attracts everyone by seeming peculiarly human, desirable, and perhaps even the goal of human life. Or is it an intoxicating vision only for people removed from others either by their oddities or by their professions and little accustomed to everyday closeness? In any case, this ideal of human contact or closeness not only becomes a central part of modern young people’s ideals but teaches the psychiatric profession too, so that there is a great concern with improving human relationships, a comprehension of the limitations of many people’s capacity for closeness, a dawning realization of how restricted most people are where we would expect them to be strongest. Affection, warmth, and closeness do not seem difficult to achieve, nor do they seem the bugaboo sexuality once was. Gradually both the traditional symptoms of objective psychiatry and the concern with sexuality of psychoanalysis lose their
central place to this existential concern both with contact and with the closely related personal integrity or togetherness.

We have seen how the subject matter of existential psychiatry developed from individual phenomena discussed by willing informants with objective physicians into whole inner states now experienced in explosive contact between people not always recognizably physician and patient. The objective, aloof, and analytic was giving way to a respect for subjectivity, a concern with closeness, and a growing suspicion of everything partial, reductionistic, in contrast to grasping experience whole. At first phenomenology was analytic and reductionistic too. There was a search for the particular experience which explained all others—for example, Herr Klug's pathoplastic hallucinations—just as Kraepelin searched for the critical external features. Then a broader view was taken of inner experience; such categories of experience as space, color, time were seen as primarily affected (as the facultative movement named diseases mood, behavioral, or thinking disorders). However, this search for a categorical defect also proved narrow, and larger and larger elements of experience were taken up into the explanations. At this point we see the two movements inward, psychoanalysis and existential psychiatry, rapidly diverging, psychoanalysis turning toward fewer and fewer psychic elements more and more sharply defined. The Oedipus complex, castration fear, and penis envy take on growing psychopathological responsibilities, while existential psychiatrists reach for larger and larger conceptions, until they seem as abstract and general as psychoanalysts seem narrow and reductionistic.

The strengths of the schools increase, too. Psychoanalysis gains in precision and explanatory power over broader and broader reaches of historical experience. It finds parallels in primitive society, religion, and humor for what it understands of neurosis. It radically reshapes man's view of himself. Existential psychiatry, all the while growing more abstract, uses its evolving method to get at feelings and marshals a great power over feelings which its being-where-the-patient-is brings to light. So, paradoxically, the one, psychoanalysis, at the moment of its seeming almost trivial, finds its data everywhere and gains command of the modern mind. Existential psychiatry, at the moment of its seeming almost abstract and woolly minded, enters the felt world of the patient and gains there power to evoke and change feelings. We observe again and again this paradox, this play of opposites, both in developmental processes and in psychosis, and are forced to ask its meaning: it is as if life threw outriggers always to either side to balance movement during change.

**Binswanger**

What follows is a case of Binswanger's, the foremost spokesman for existential psychiatry. See how he goes right to love and to what the patient suffers and attempts now.

Our patient is a thirty-nine-year-old intelligent woman. She was happily married; but not fully satisfied in her marriage, Protestant, religious, mother of three children, daughter of an extremely egotistical, hard, and tyrannical father and an "angelic," self-effacing, touchingly kind mother who allowed herself to be treated by her husband like a slave and only lived for him.

From the time she was a child Ilse suffered greatly under these conditions, feeling powerless to change them. For three years she had shown symptoms of overstrain and "nervousness." Following a performance of Hamlet, the idea came to her mind to persuade her father through some decisive act to treat her mother more considerately. During her boarding school period, the precocious girl had developed a somewhat ecstatic love for her father, and she believed she had great influence upon him. Ilse's resolution to carry out her plan was reinforced through that scene in which Hamlet plans to murder the king at his prayer but shrinks back from doing it. If at that particular time Hamlet had not missed his chance, he could
have been saved, Ilse felt. She confessed to her husband that she planned something unusual and was only waiting for the right moment. Four months after the Hamlet performance, when asked for help against her father by her mother, she told her husband that she wanted to “demonstrate to her father what love can do.” If he forbade her to do it, he would make her unhappy for the rest of her life; she had to “get rid of that.”

One day, when her father had once again reproached her, she told him she knew of a way of saving him, and in front of her father she put her right hand up to her forearm into the burning stove, then held out her hands toward him with these words: “Look, this is to show you how much I love you!” [6, pp. 214-215].

She seemed “oblivious to pain,” energetic, and elated despite terrible burns. Her father responded, ameliorated his behavior toward the mother for a few weeks, but fell back again. Then Ilse’s fourth child died and she “firmly believed that the loss was the atonement for her love for the doctor who had treated the child” [6, p. 215]. “Eight months after the act she was busier and moodier than before” [6, p. 215]. She went away for health cures, grew increasingly grandiose, and with it was convinced that everyone was sneering at her. Then she came to Binswanger’s sanatorium.

When asked about the burning, she explained: “I wanted to demonstrate to my father that love is something that overcomes itself, not by words but by deeds. This should have had an effect on him like a lightning bolt, like a revelation, and should have made him stop living as an egotist. When the idea first came to me, it was for my mother’s sake, but then I thought if I were to do it for his own sake it would be the right thing. I pitied him, and since then had felt even more love and understanding for him. I guess I must love all men so much because I loved my father so much” [6, p. 216].

The theme of the patient’s life, Binswanger argues, is father. Her “almost idolizing veneration of the father” is matched by “energetic rebellion against his tyranny.”

. . . The dissonance in this theme signifies an open, never-healing life sore; it could only be resolved by a change in the mind and behavior of the father, by a divorce of the parents, or by eliminating the father. All these roads were blocked by insurmountable external and internal obstacles. Thus, living turns into suffering from the dissonance of its main theme, into grievous floating in the pangs of hopelessness. What from the angle of the world appears as hopelessness is, in terms of the “ego,” irresolution, indecision, and shrinking away from decisions. This is the situation Hamlet is in. In his fate Ilse sees her own as in a mirror. The decision which she cannot make for herself she can, at least, make for Hamlet. She believes he should have killed the praying king without consideration of the situation and thus would have saved himself. Only such resolution to act would have saved him “from insanity!” Now the stone starts rolling. In her own situation, the possibility of eliminating the tyrant is excluded. The idea of patricide cannot develop, and, if it did, her love for the father would interfere with the act. Both parents are dead set against divorce. What is left to her is an attempt to persuade the father to change in attitude and behavior toward the mother. The theme that now offers itself is named sacrifice. For a sacrifice will offer Ilse the opportunity to prove her love to her father as well as to make the desired “impression.” The “sacrifice of love” is designed to overcome the father’s brutal tyranny. Through the sacrifice of love Ilse takes the brutality upon herself. It is she who submits to suffering from some brutal pain so that mother does not have to suffer any more. The father himself is “spared” throughout [6, p. 217].

Perhaps the existential language is unfamiliar, but the ideas are not. In psychoanalytic terms she is resolving a conflict between love and hate of the father, a conflict that includes the
mother. Her solution, the "sacrifice," is the presenting symptom and expresses both sides of the conflict, indeed several sides of what are many conflicts. She indicates to father the pain that his behavior causes her, also how much she will sacrifice for him, and to mother that Ilse is still more servile than the mother, more loving than her mother, but at the same time more effective; she can make father a good husband. The sacrificial act serves as the final common pathway of many currents, for a moment joining and expressing them all, as if the central nervous system were a symphony orchestra that must let out its complicated, often dissonant music through one occasional voice.

Whether we emphasize her fantasies, her attachment to the mother and father or, on the other hand, the difficulties of the family situation, we will speak of conflict, on the one hand, or adaptation, on the other, favorite terms respectively of the psychoanalytic and interpersonal schools. The one emphasizes problems that patients bring to families; the other, problems families bring to patients. Neither alone can resolve the empirical problem as to where the problems begin or how much weight to give either side. Each presents only the data that its method collects, whether fantasies or family facts. Existential psychiatry, for its part, accepts both the individual and family contributions to Ilse's tragic situation and then sings its own song, about the patient's felt relationship to herself and the world.

Ilse's sacrifice, her solution or adaptation to the conflict, fails. "The life-sore opens again, deeper and more painful than ever" [6, p. 217]. So a fresh solution is called for. The original solution, her sacrifices, had been self-chosen, a decision of the self to reconcile the discordant forces. Now "the self succumbs under the heavy task of pursuing further the leitmotif of its history" [6, p. 217]. The new solution is forced on her and is "self-effacing."

... You must love all men so much because you love your father so much (viz., delusions of love). This may be complemented by: You must attract the attention and interest of all people to yourself, because you have attracted the attention and the interest of your father to yourself; you must know what impression you are making upon all people because you wanted to make an impression upon your father; you must react to everything the others do because you wanted to know how your father reacted to you; in short, you must be "in the center of attention" of all people (viz., delusions of reference). The lack of insight into the must of this loving and attracting-of-attention we call insanity. The cure for such insanity consists in the shaking off of the must and in the restoration of the rule of the self [6, p. 217].

The restoration was effected! "Ilse stayed perfectly healthy up to her death at the age of 73. She was able to direct the theme 'salvation' and 'purification' into healthy channels, that is, to confirm it through social work. Advised and counseled by experts over a period of time, she successfully practised as a psychological counselor and at times was also the leader of a psychological workshop group" [6, p. 218]. So Anna O., too, carried forward her life.

However, for a while Ilse's self was effaced in the second, psychotic solution. She gave up her local, particular loved and hated one for the whole world of men. It was a psychotic solution, Binswanger says, because it was not chosen by an integrated self but was forced on her by a dissociated part of mental life, indifferent to the claims of reality. Such are the signs of the "unconscious," psychoanalysis would add, this element of "must" or compulsion, the demand to be met from within, rather than an integrated life-force meeting the world. Further, the unconscious translates father into all men, perhaps expressing a childhood time when father was the only man; and so she loves all men, but also is tyrannized over by all men, as she was by the father.
Just as the father's harshness and coldness, inaccessibility to love and sacrifice, turned into a tortuous riddle for Ilse, so the entire environment now becomes an enigmatic power; at one time it is a loving You, one to which she would like to surrender not just her hand but herself altogether; at another time it is a harsh, loveless, inaccessible world which scoffs at her love, derides and humiliates her, wounds her honor. Her entire existence is now limited to the motions and unrest of being attracted and being rejected. But with the pluralization of the You, with the theme extended all over her existence without limit, and with the loss of the original thematic goal, the father, no solution of the problem is possible any more. The theme spends itself on an inappropriate object, it rotates in eternal repetition around itself. The only remaining question is ... whether the existence will find a way out of this form of self-discussion, return to itself, and so clear the road for new possibilities for a solution or whether it will be blunted in the process by endlessly repeating and stereotyping the discussion as such through acts, behavior, or phrases [6, p. 224].

Note how polarized Ilse's world had become. The elements were loving attention and sneering attention, fight and surrender, all men or none. The treatment was to bring this dissociated, compulsive, polarizing power out into the open, challenge its "must," and restore "the rule of the self."

We do not hear much from Binswanger as to how he helped Ilse "shake off the must"; it is characteristic of existential writings that technical matters get short shrift beside abstruse, philosophical discussions, despite the great technical problems the existential method generates. However, Minkowski has already prepared us to expect certain elements: a direct, feeling relationship to the patient and an active seeking of the dissociated, unconscious father theme. Binswanger now advances a little farther. It is not enough intellectually to grasp which psychic parts have been dissociated, not even enough to bring them to the patient's attention, he implies. All this is too readily cast aside by fresh "explanation," now on the patient's part, or evaded outright. Nor is it enough to confront the psychotic behavior, as Minkowski did. The "moment of contact" is only a moment; the psychotic material soon flows back over the relationship. A lasting contact must be made, what is called empathy. However, this empathy of Binswanger's proves quite different from the traditional rapport, therapeutic alliance, and contracts so much talked about and advocated between the doctor and the "normal" parts of the patient. The effectiveness of Binswanger's empathy depends upon rapport with what is "sick"! There can be no standing aside from any part of the patient. Only with this deepened empathy can the therapist bring back into the self the lost parts.

First the empathic experience is approached phenomenologically.

... We would have to examine to what degree [empathy] is a phenomenon of warmth, a phenomenon of the possibility or impossibility of fusing the chaleur intime (as in our instance); or a vocal or sound phenomenon, as when the poet Hölderlin writes to his mother that there could not be a sound alive in her soul with which his soul would not chime in; or a phenomenon of sharing, as expressed by Diotima in Hölderlin's Hyperion—"He who understands you must share your greatness and your desperation"; or a phenomenon of participation, as in the saying, "I partake in your grief" or, lastly, a phenomenon of identification, as when we say, "I would have done the same in your place" (in contrast to, "I don't understand how you could act that way"). All these modes of expression refer to certain phenomenal, intentional, and preintentional modes of being-together (Mitseinandersein) and co-being (Mitsein) which would have first to be analyzed before the total phenomenon of empathy could be made comprehensive and clarifiable. For this reason alone, the differentiation of psychic life with which we can empathize from psychic life with which we cannot empathize (schizophrenics) loses a great deal of its scientific value, apart from the fact that the limits of empathic possibilities are purely subjective and vary according to the empathic ability and "imagination" of the investigator [6, p. 226].
Then he asks from what base we call the dissociated elements sick.

... Let us look at our case and specifically at Ilse’s sacrifice, and let us see how a layman would react to such an act. He would probably ask himself: Would I have done this, or could I have done this in Ilse’s place? And his answer would be: No, no normal person would do a thing like this in our day and time. And in view of the pluralization of the “Thou,” he would have felt even more emphatically: “Now this woman has gone completely crazy!” So we see that the judgment on the sickness or health is subject to the norm of the social attitude. If an act, behavior, or verbalization deviates from that norm, it is judged even by the layman as morbid, as a symptom of an illness. However, there may be people who see in the sacrifice the expression of a genuinely religious or ethical self-effacement, of a genuinely ethical readiness for sacrifice and love for one’s fellow man; such persons would strongly reject the idea that the sacrifice be considered a symptom of disease. We realize that the norm of behavior is by no means fixed once for all, but that it varies according to an individual’s education and culture or to a cultural area. What appears abnormal—or a deviation from the norm—to one person may look to another quite normal, or even like the supreme expression of a norm; the judgment “sick” or “sound” is accordingly formed within a cultural frame of reference. Naturally, the same is true for insanity. What we of the twentieth century consider a symptom of disease was seen by the Greeks as a blow from Apollo or as the work of the Furies, and by the people of the Christian Middle Ages as possession by the Devil. What at the peak of Pietism could pass for an expression of supreme piety would today be considered a phenomenon of morbid self-reflection and morbid guilt feelings, and so forth. But all this cannot alter the fact that a person is judged “sick” wherever his social behavior deviates from the respective norm of social behavior and thus appears conspicuous or strange [6, p. 227].

Carrying this analysis into the relationship between two people, Binswanger asserts that someone is strange or sick because something has come between the doctor and the patient which is experienced as a barrier to communication; the doctor has formed an idea of the patient: she is so-and-so; the patient is at least momentarily objectified.

Now Ilse is no longer “someone else” like any other, let alone a Thou, but another strange person and a You which is excluded from the possibility of a purely loving encounter. The barrier to communicatio (social intercourse) and communio (love), the obstacle, turns into an object (of conspicuousness, avoidance, pity, judgment, etc.). Thereby I separate or remove myself from my fellow men, and the closeness of sympathy and intercourse changes into the distance of objective regard, observation, and judgment [6, p. 228].

If we ask, Why does this objectification interfere with communication? we are immediately confronted with the secret nature of the doctor’s thought. He cannot tell the patient that she is schizophrenic without the gravest damage to her self-respect and more withdrawal from him. Yet if he keeps his secret, she must suspect something, as he is all the time judging her, even if he is only determining “to what extent” she is schizophrenic. Furthermore, this judgment, “she is schizophrenic,” imposes a predetermined structure on the world experience that the doctor may attempt to share. He cannot really build up his understanding of it bit by bit as he gets to know his patient, because he has read Minkowski or Binswanger and already “understands” the world experience of the schizophrenic.

No more is there a single essence to the existential method than there is one factor, rule, or attitude of mind that says everything about free association, the psychological examination, or even participant observation, which is the least complex of all the great psychiatric methods. Each is a medley of acts and attitudes requiring description from many angles. However, this freedom from prejudice or fixed expectation, this attempt to come naked into the clinical encounter, what Binswanger called “putting the world between brackets,”
approaches as closely as anything the essence of the existential method, its "fundamental rule." It is certainly the essence of the phenomenological method, the "psychological-phenomenological reduction" of the philosopher Husserl: "In the presence of a phenomenon (whether it be an external object or a state of mind) the phenomenologist uses an absolutely unbiased approach; he observes phenomena as they manifest themselves and only as they manifest themselves" [6, p. 76].

**ROLE OF EMOTION IN TREATMENT**

We have seen that the result of phenomenological reduction, and of our staying not only with the ideas but with the experiences of the patient, is that our feelings are engaged. Subject to the same world as the patient (insofar as we can develop empathy), we react much as he does. Or we refuse to accept the patient and, like Minkowski, tell him that something must change, for in practice I can never enter anyone's experience without his adjusting that experience at least a little to fit mine; the empathic movement is never all in one direction. It is, however, mainly in one direction, because by a professional encounter, as opposed to friendship or falling in love, we mean this reaching out for the patient. The doctor must make the initial, strenuous efforts precisely because the patient cannot, or else he would not need to see the doctor.

Appreciate how completely existential psychiatry is thus protected from the charge so often made against it: that the existential doctor feels and expresses whatever he wants; he is a clinical wild man imposing his views on the patient. Quite the contrary. He is to feel what the patient feels. This is the discipline of the existential method. Only when the doctor is deep enough into the patient's feelings, only when he is securely emphatic, does he gain freedom for his own personal responses, just as meaningful transference interpretations in psychoanalysis can spring only out of a slowly, strongly developed transference. The doctor knows that he has gained this freedom because the patient changes his feelings when the doctor presents his. This is the existential meaning of a relationship: Insofar as a relationship exists, both parties to it change. Thus, rather than permitting a free or wild exchange of feelings, existential psychiatry insists on a careful, slow, even methodical development of our understanding the patient, the extent of which is judged by the extent of our empathy, of our being able to feel what the patient feels. At the same time, the doctor cannot bring a disembodied spirit to this meeting. If he understands, he will feel what the patient feels and will therefore be affectively present. When he cannot feel what the patient feels, but remains with the patient, there is by definition a clash of feelings which either destroys the relationship or moves it forward on the basis of a fresh understanding. In these encounters both parties must change or they will fly apart.

Such are the elements of the existential method: a focusing on the inner experience of the patient; the shedding of all expectations, all efforts to reach behind appearances, in order to reach that inner experience as fully as possible; the development of feelings as one penetrates the other's world; then the periodic collapse of empathy as one cannot "understand," with resulting clashes that may or may not usher in a fresh understanding; all the while a feeling experience during which objective understanding is postponed—in short, so great an emphasis on subjectivity and feeling that we must pause again to make the necessity of this clear.

How is the patient to know (or how is anyone to know) that I am in his world if I stand there silently, unmoved? Even my giving a carefully articulated, reasonable account of that world may mean only that I have caught the idea of the pa-
tient's world without in any way implying I am experiencing it. Or, to use psychological language, I may isolate my feelings about the patient's experience and express only my intellectual awareness, and such a limited involvement must carry that much less conviction of "being-together" to the patient. Further, emotional clashes are necessary because, except in the rarest and perhaps nonexistent cases of perfect compatibility, we cannot come to understand one another without exposing those places where we are each dumb to the other's world. (Happy couples must fight.) Finally, only in the occurrence of the emotional clash is there provided the firepower to change each side, and change must happen if there is to be new "understanding." This is a genuinely new understanding in that it springs from both parties' having been changed by the encounter; the understanding is possible because they have changed.

I hope the discipline and difficulty of this complex technology are clear. I hope, too, that grasping the existential technique carries with it a beginning understanding of what the technique is meant to achieve. Of course, at the start all that was aimed at was data, reports on the inner experience. Later, as we have glimpsed briefly, there were hopes, largely forlorn, that the method would contribute to the understanding of causes. It does not seem to have done so because the psychotic lesion found, as in Minkowski's case, was the dissociative one familiar to every school. However, what can be more justifiably claimed was an opening up of "therapeutic" power resulting from the engagement of feelings. If the doctors could remain within the patient's worlds, "contact" them, challenge and clash with them, and with all the dissociated elements, too, there was at least the possibility that the dissociated elements might be changed, at least led back into the newly integrated personality. The doctor's being where the illness was seemed to make the illness more vulnerable. And being there might make it possible to leave something behind in the patient that the patient could use in times of trouble. Such is the therapeutic rationale of the existential method.

Binswanger occupies a much larger place in psychiatric development than he is usually given. Indeed, it would be difficult to name many greater students of psychiatry. He had profound knowledge of nineteenth-century ideas and, what is perhaps unique, assimilated this knowledge into the discoveries of the twentieth century. He was a moving force in existential psychiatry while to a surprising extent he understood psychoanalysis. He did not have the systematic gifts Kraepelin and Freud and Janet had; nor did he have the gift of discovery Charcot had, or Jaspers' encyclopedic mind. Jaspers seemed to know what was missing because he knew everything else. What Binswanger did was to carry the existential and phenomenological ideas more deeply into clinical material than anyone else except perhaps Minkowski. The clash of these ideas and the clinical material gives us fragments of a great psychiatric advance. It cannot be credited to Binswanger as a settled, full achievement, as is the work of Darwin and Freud. We must piece the fragments together, like broken pottery, but this is something we also had to do for Charcot. In regard to clinical techniques especially, the existential literature is very bare when contrasted with the objective and psychoanalytic literature, so that any reconstruction of what the existential doctors actually did must be an imaginative one. However, let us take the fragments once more in hand.

Psychotherapists will recognize Ilse's psychotic experience not only because it has a familiar grandiose-persecutory content but also because of its similarity to a common transference phenomenon. Let us pretend that a patient's hostile feelings toward her father are becoming more manifest in therapy; she finds herself searching what is apparent of the doctor's life for some point of criticism. Perhaps the father did not have the
present generation's identification with minority groups, and perhaps the psychotherapist is openly prosperous. The patient then complains of her father's bias and, in alternating breaths, of the therapist's excessive concern with his status at the expense of everyone else's. The patient is identified with poor minorities, feels herself put upon, and grows angry with those practicing the discriminations. She has generalized her individual, childhood plight onto the larger, social scene (putting aside whether the generalization fits), just as Ilse psychotically generalized her ambivalent relationship with the father.

We categorize Ilse's generalization as psychotic and the other patient's as neurotic, but in both cases we want to make some change in the generalized material, above all in the conflicting feelings that have not been able to reach a resolution outside psychosis, or in the case of the neurotic patient outside the distortion of a contemporary relationship.

Note that both the existential and the analytic understandings include a heavy debt to the concept "adaptation." Ilse's first solution, her arm burning, had failed. The next solution, her psychosis, does not seem an adaptation aimed at changing the father, except by inference, yet it does seem an attempt to adapt to the conflicting currents within her. However, because the psychotic adaptation is by definition only tenuously related to reality, there falls on it the charge of "sick." But the tenuousness of the relationship to reality is not a product of the generalization. Ilse's "healthy" solution, her social and group work, shares that. When she is well, she not only transfers her attention from father to humanity, as in the psychosis, but also does something for humanity. Her healthy solution is thus successfully adaptive to both her inner needs and outer reality.

In order to arrive at that final point, however, she had to complete a real transfer of feelings from father to humanity, which in the psychosis did not seem a transfer at all but was only an equivalence. Father was the humanity of her childhood. A realistic "transference" to humanity from father depends upon giving up her father as the dominant love object for the love of humanity—or, better, what Binswanger would call "caring." Insofar as that is a real caring and not an equivalence or translation into childhood language, she does indeed act in humanity and for humanity; we no longer speak of transference but of sublimation. How is this healthy shift of feelings achieved?

Binswanger starts from Charcot and Janet: A critical part of the illness process is dissociation of mental elements away from integrated function. Further, he understands, thanks to Freud's teaching, that this dissociative process is not a passive one—that is, not a falling apart without pressure—but an active pushing apart of mental elements due to conflict, strain, tension among them. Therefore, and now we come to what is innovative about existential technique, the therapist must place himself within the split world of the patient and gain the allegiance of the dissociated elements (not just an alliance with the "normal personality") for the purpose of reuniting the patient. Nothing short of this entering the patient's world, feeling with all elements of the patient's personality, will make such a reunion possible; how can intellectual insight march against the dynamic forces of conflict? As Laing particularly has emphasized [7], this reuniting may require more change in the "normal personality," and in the family structure around that personality, than it does in the supposedly sick, dissociated parts of the patient! These last two existential steps need still more explication.

I have already discussed "entering the patient's world." I hope that this entering or meeting is sharply enough contrasted with psychoanalytic "drawing out" of the patient's world so that no confusion between the two exists. Granted that Freud recommended for the analytic third ear a "free-
floating,” unstructured, receptive listening to match the patient’s free associating. This was something like Minkowski’s “two melodies.” However, the analytic attention was a listening, an experiencing of verbal content in the search for infantile themes. The patient was to bring this verbal content to the doctor, place it within the doctor’s world; Freud did not move his place of business to the patient’s living room (at first Freud’s patients visited his living room). More importantly, there was not the active seeking out of the experienced, felt life of the patient, no great empathic twisting and turning into the patient’s world. Freud wanted to understand, to penetrate the most hidden reaches of the patient’s motivation, but he did not want to experience those motivations, himself feeling them, the two, doctor and patient, living in the patient’s world. No, psychoanalysis sought and seeks to dissect free from the personality the neurotic formations, throw onto them the most pitiless possible light, and then, hand in hand with the patient’s mature ego, wear away their power. Everywhere the goal is to bring the emotional under the rule of the rational; where the id is, there shall the ego be.

Existential analysis, too, sought a kind of free-floating attention—at least the freedom from rigid ideas, expectations, diagnoses that defined the “psychological-phenomenological reduction.” The existential doctor was to listen, understand, like the psychoanalyst, but then, some freedom to listen having been achieved, fresh technical elements appeared. Minkowski, having stayed with the patient and endured his abrasive demands, did not reduce them to an interpretation or postpone their discussion until a later hour. He grasped the patient’s world, shook it, moved closer rather than farther away; every effort was being made to retain “contact.” This was painful; it was emotionally explosive; there was constantly the danger of the patient’s extruding the doctor (as there had been of the doctor’s extruding the patient). From the beginning it might have been that Minkowski was not “sincere,” that he did not want to stay with the patient but would use only whatever closeness he had to the patient to categorize him, call him sick, express any hatred he had of what he saw in him, the whole justified by a sensible dislike of mental illness. Existential technique could become an excuse for emotional license in the patient’s presence, just as analytic technique could fall into the excessively neutral, aloof, passive hands of some therapists. However, the ideals of both schools were as clear as they were different. Psychoanalysis was to keep on asking of its students: Are you really listening? The comparable question in existential analysis was, Do you really want to be where the patient is?

Minkowski discovered that abandoning the objective, neutral position of descriptive and psychoanalytic psychiatry sometimes resulted not in clinical disaster but in the patient’s improvement. The delusions fell away and contact occurred, if only for a moment. Later existential case reports extended this beachhead. We catch glimpses of a technique aimed at retaining contact. Because the existential therapist tries to stay with the patient, he must be willing to “encounter” or confront aspects of the patient not so comfortably assimilated. This “encounter” produces feelings in the therapist, who must then decide whether to “be himself” or preserve his professional objectivity. Plainly, Minkowski attempted to preserve his objectivity, but he also wanted to remain with the patient and understand; so the explosion was only postponed. By then, however, the therapist had earned the right to express his own, personal responses, or, more accurately, these responses were no longer personal. Then the patient felt, “This man has tried to understand me; his anger is not personal; I must look to myself for its cause.” At the point of intersection of the therapist’s getting where the patient is and of staying there must occur these explosions, each of which signals a
meeting of feelings. The resolution of these conflictual meetings means continued contact, therefore a later explosion, and, through the series of explosions, change. AsBinswanger wrote, a relationship is defined as a human contact in which two people change, and psychotherapy is a professional relationship.

It is not easy to exaggerate the amount of discipline required by this technique. More is being asked of the therapists than perhaps even by the laborious technique of psychoanalysis or by the demand for quickness and dexterity made by Sullivanian methods. Minkowski was in the farthest position from being a "wild analyst." Quite the contrary, he was obviously embarrassed by the emotional tumult caused in him by this staying with the patient. One can wonder whether he did not, like Freud, at this point contemplate abandoning "the line" of his scientific development, as in fact Joseph Breuer had. Minkowski seems barely willing to tell us what he said and did, probably because he was trying to retain the familiar, traditional medical objectivity even while he was, largely inadvertently, starting down a fresh path. Perhaps it was this very conflict of styles that made possible the new development in the first place, for the objective, disciplined, patient-centered approach of the great medical tradition is also a necessary part of existential technique, which permits the abandonment of that objectivity only, as it were, at the last minute, after the therapist is strained to be objective but cannot.

Some contemporary psychoanalysts and many existential psychiatrists, like Laing and Szasz [8], emphasize that the series of explosions should result not so much in maturation of the dissociated libidinal elements (as psychoanalysis had originally emphasized) as in change in the ego which had dissociated those elements. Further, if that ego is to gain more tolerance and flexibility, the patient's social context must change. Laing and Szasz met everywhere families and society making mature development impossible and therefore extended their therapeutic net outward. Once securely within the patient's world, therapists discover that the world of surrounding others takes on an unsettling morbidity; the others too must change. Of course, the existential analysis of the relatives must result in understanding their worlds as well, after a fresh series of explosions; there can be in the end no one person to blame. What we seek, as Binswanger wrote, is a loving and caring world which is in constant process of creation out of all those attempts to understand, all those encounters and explosions. In the best of possible worlds these processes will go on spontaneously. However, we mean by sickness that world or those parts of the world for which professional assistance is required; then in place of spontaneity we find psychoanalysis, the phenomenological reduction, "being and staying with the patient," and the new willingness to accept a place for emotion in the treatment [9].