FREUD TEACHES PSYCHOTHERAPY

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RICHARD CHESSICK, M.D., Ph.D.

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Richard D. Chessick, M.D.

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Sigmund Freud was born in Freiberg, Moravia, in 1856. At four he moved to Vienna only to leave there after the Nazi occupation in February 1938. He was saved from being murdered by the Nazis through the intervention of influential friends, and left for England, where he died in London on September 23, 1939, at the age of eighty-three, three weeks after the onset of World War II.

He came from a Jewish background and retained his sense of Jewish identity throughout his life, although he did not actively practice the Jewish religion. He suffered from anti-Semitism all his life and could never forgive his father for what he felt was cowardice in the face of prejudice. When he was ten or twelve years old, his father told him how once in his youth, as he was walking in the street, a gentile passed by and threw his father's cap in the mud, saying "Jew, get off the sidewalk!" Sigmund asked his father what he did then, and Jacob Freud replied, "I went to the road and picked it up."

Much has been made of Sigmund Freud's Jewish background. The most extreme view is that of Bakan (1965), who insists that the Jewish traditional cabalistic mystical doctrine had an important influence on the development of Freud's theories. A more modest view agrees with Freud's attribution to his Jewish origin of his capacity to not let himself be influenced by the opinions of

the majority. Ellenberger (1970) adds that his readiness to believe that he was rejected was also influenced by his Jewish origin.

I think that a much better explanation of Freud's continual sense of being isolated and rejected is given by Holt (1975), who reminds us that "Freud operated always from the exposed and lonely situation of private practice." Freud's precious professorship did not carry either salary or tenure and, as Holt pointed out, "Freud might have been less of a fighter in his writing if he had worked from the protective security of an academic position." Only those who try to create from the exposed and lonely situation of private practice can understand the importance of this point.

The best brief overview of Freud's life and thought (among innumerable such publications) is the chapter "Sigmund Freud and Psychoanalysis" in Ellenberger (1970). It is interesting that, as Ellenberger points out, "The difficulty in writing about Freud stems from the profusion of the literature about him, and from the fact that a legend had grown around him, which makes the task of an objective biographer exceedingly laborious and unrewarding. Behind this mountain of factual and legendary material are wide gaps in our knowledge of his life and personality."

The first three years of Freud's life were spent in Freiberg, Moravia, a little town with a picturesque landscape. This was followed by a year in

Leipzig and then a settling of the Freud family in Vienna, in February 1860. Almost nothing is really known about Freud's early childhood except that his father, a not-very-successful businessman, changed his place of residence in Vienna several times between 1860 and 1865.

Freud began his medical studies in 1873 and received his degree in 1881, eight years later. The most important early influence on him was Ernst Brücke (1819-1892), adopted by Freud as his venerated teacher, and a rigid, authoritarian Prussian. Together with Helmholtz, Dubois-Reymond, Ludwig, and a few others, Brücke rejected any kind of vitalism or finalism in science. He insisted on striving to reduce psychological processes to physiological laws and physiological processes to physical and chemical laws.

During his work in Brücke's institute, Freud met Josef Breuer (1842-1925), a well-known and highly respected physician who became an older and rather fatherly friend, helping him in later years with substantial loans of money. In 1882 he suddenly left Brücke's laboratory, where he had worked for six years, and turned without enthusiasm to the career of a practicing physician, a shift probably related to his engagement during that year to Martha Bernays. As was the custom of the time, a long engagement entailing separation and assiduous correspondence resulted. It is clear that Freud had resolved to make a brilliant discovery so that his slow and arduous career as a practicing physician would be accelerated and he could attain financial

security and marry. In 1883 he experimented on himself and others with a supposedly harmless substance called cocaine, and in 1884 he published a paper greatly praising the drug. It was a colleague, however, who discovered the value of cocaine as a surface anesthetic, and it was the colleague who acquired the sudden fame that Freud desired. Jones (1953) mentions that Freud's pushing of cocaine already gained him a reputation of being rather rash in his judgments.

In 1885, as a result of the intervention of Brücke and Meynert—a famous brain anatomist with whom Freud also studied for a short time—Freud received a traveling grant to study in Paris at the Salpêtrière with Charcot. What can the practicing psychotherapist learn from this? Freud regarded his experience at the Salpêtrière under the influence of Charcot as a turning point in his intellectual development. When he arrived in Paris, Freud's chosen concern was the anatomy of the nervous system; when he left, his mind was filled with the problems of hysteria and hypnotism. From October 1885 to March 1886, at around the age of 30, Freud turned his back on organic neurology — primarily because of the discovery in Charcot's clinic that the symptoms of emotional disorders could be removed, altered, and substituted by psychological methods alone. This of course is the *fundamental hypothesis* of the practice of intensive psychotherapy. It was Freud's lifelong task to develop to the best of his ability the clinical practice of altering the symptoms of mental disorders by purely psychological techniques and to establish the

principles of this clinical discipline, a basic science that he named psychoanalysis.

Volume 1 of what is known as the first *Standard Edition, (The Complete Psychological Works of Sigmund Freud;* all Freud references in this book are to this edition) contains prepsychoanalytic publications and unpublished drafts from this period. The first thing that can be learned from this early material is the remarkable influence that a fine teacher can have on the development of a serious student. The description of his experience with Charcot has great literary beauty and the depiction of Charcot as a teacher is worthy of emulation today by those who would attempt to train others. It is no wonder that Ellenberger describes Freud's meeting with Charcot as "an existential encounter," even though it lasted for less than four months.

Freud in 1886 describes Charcot at work, openly surrounded by his assistants as well as by foreign physicians, of which Freud was just one. "He seemed, as it were, to be working with us, to be thinking aloud and expecting to have objections raised by his pupils" (1956A;1:10). Anyone who wished to ask a question or contribute to the discussion was welcome and no comment was left unnoticed by Charcot. Freud was impressed by the informality of the discussion and the way in which everyone was treated on an equal and polite footing; he remarks that this informality came as a surprise to foreign visitors and made it easy for even the most timid to take part in Charcot's work. Freud

observed his method: Charcot would first be undecided in the face of some new and difficult manifestation of illness and then apparently work and think out loud in order to demonstrate how he arrived at an understanding. He was especially impressed that Charcot never grew tired of looking at the same phenomenon until his repeated and unbiased efforts allowed him to reach a correct view of its meaning. Years later, in his autobiography, Freud (1925D;20:3ff) mentions this as the most important methodological rule that he learned from Charcot. Freud was also impressed with the "complete sincerity" of Charcot. It might be added that Charcot was a rather theatrical individual who, in the way of many great teachers, was able to maintain a high level of interest and excitement in his seminars.

Freud returned to Vienna and in 1886 presented a paper on male hysteria before the distinguished medical society, The Imperial Society of Physicians. The paper, received with incredulity and hostility, was the starting point of Freud's lifelong, open feud with the Viennese medical world and the world of physicians in general. Ellenberger makes a convincing case that the hostile reception was in substantial part caused by Freud's over- enthusiastic attributions to Charcot of what were the views and discoveries of other authors and of his narcissistic need to make a famous discovery and come into the Viennese limelight, especially after the narrow miss with his work on cocaine.

In the ten years that followed, Freud struggled to raise his family and build up his private practice, first in neurological work and then in the new psychology that he created. Not only did he start out in 1886 with the usual handicap of a young doctor with debts and few private patients, but from the very beginning there seems to have been an atmosphere of isolation and distrust fostered by his unsuccessful presentation to the society of physicians and by their scorn of his uncritical enthusiasm for cocaine, which of course was soon discovered to have addicting properties. He also broke with his supporter Meynert and became involved in an acrimonious quarrel with him in 1889. During this period he remained friendly with Breuer, who sent him patients.

Freud allegedly enjoyed a happy marriage; he was able to work very hard and gradually develop his reputation as a neurologist. He had six children and moved in 1891 into the now famous apartment at Bergasse 19 (Engelman 1976), where he stayed until 1938. In these unpretentious quarters [which I visited and found to be surprisingly small in contrast to the greatness of Freud's psychological vision (Chessick 1977a)] Freud worked from early morning to late at night six days a week, but took three months of summer vacation spent traveling, sometimes without his wife and sometimes with colleagues or his sister-in-law.

The important point is that in the ten years from 1886 to 1896 he made

an overwhelming transition from neurology based on the work of Charcot, to his own system of psychotherapy. The two major events in this transition are Freud's relationship with Fliess, involving first Freud's neurotic disturbances and self-analysis, and Freud's work at first with Breuer and then alone in discovering and elaborating the basic concepts of psychoanalysis.

Freud explained that like every other foreigner in a similar position, he left the Salpêtrière as Charcot's unqualified admirer. In the presence of such a fine teacher it is easy to see how Freud became fascinated by the clinical phenomena of hysteria and hypnotism that added so much drama to Charcot's demonstrations and lectures. Since that time many others, after discovering Freud's writings or under an inspiring teacher, have had a similar experience in moving from the field of organic neurology to the field of psychodynamic psychiatry. This also happened to me.[i]

Freud's first book, *On Aphasia* (discussed in detail in a later chapter), was published in 1891 and dedicated to Breuer. It is not included in the *Standard Edition* of Freud's works, but it does show him at the age of thirty-five as an experienced neurologist with an outstanding literary style. As one might expect of Freud, in place of minute localizing schemas to explain aphasia, he introduced a quite different *functional* explanation based on the Hughlings Jackson doctrine of "disinvolution," according to which more recently acquired or less important capacities suffered earlier than more

fundamental ones. Jones (1953) sees this functional explanation as a stage in Freud's emancipation from the more mechanical aspects of the Helmholtz School in which he had been brought up in the laboratory of Brücke. The explanation includes severe criticism of Meynert's theory that ideas and memories are to be pictured as attached to various brain cells. The book sold 257 copies after nine years and was obviously not a success. The book that brought Freud his reputation as a neurologist was published in 1891 with his friend Dr. Oscar Rie, and dealt with unilateral paralysis of children. This and other work on cerebral palsy and his neuroanatomical research established Freud's neurological reputation. It should be remembered that by 1893 he had established this reputation as a competent neurologist on the basis of about twenty years of work.

As we go through the many pages of the first volume of the *Standard Edition,* we witness Freud's intensive intellectual struggle with a series of theoretical concepts in trying to explain the various clinical phenomena of hysteria, neurasthenia, depression, obsessive-compulsive neurosis, anxiety, and even paranoia. Over and over he grapples with complex theoretical problems, adopting one explanation and then discarding it for another. Even a cursory reading of this material demonstrates the extreme difficulty of attaching diagnostic labels to patients in the field of psychotherapy, a confusion in psychiatric nosology which very much continues to this day.

What emerges with compelling clarity in his famous letters to Fliess (Freud 1950A;1:175ff) is the paramount importance of Freud's self-analysis. Thus in the teaching and learning of psychotherapy, the *first* principle for success lies in the importance of the opportunity to identify with outstanding teachers and clinicians, and the *second* principle rests on the intensive psychotherapy of the psychotherapist. It was only after his own thorough self-analysis, and in spite of the obvious defects that such a procedure entailed, that Freud was able to arrive at a deeper understanding of the phenomena of mental disorders and to devise a more profound technique than hypnotism and suggestion for their treatment.

It has become my increasingly firm conviction that no one should practice intensive psychotherapy without first undergoing *a thorough intensive psychotherapy* of his or her own. The question often arises: How much psychotherapy? As a rule-of-thumb, I advise students to limit their treatment of patients to a frequency of one time per week *less* than that of their own intensive psychotherapy. Thus a psychotherapist who has successfully completed a twice-a-week personal treatment will protect himself or herself and tend to stay out of trouble with destructive countertransference and clinical confusion if he or she sees patients once weekly; patients who need greater frequency of treatment should be sent to others.

For example, a young doctoral candidate who had just finished his dis-

sertation came to me, because his supervisor had become ill, for a few supervisory sessions near the end of his schooling. The candidate was personable, successful, and well thought of. He had been approved for graduation and was about to take a post as a psychotherapist in an important clinic.

He presented himself with tact and dignity and showed no evidence of psychopathology. He reported on two female patients whom he had been seeing and casually mentioned that the second of the two constantly complained because he started her sessions late. The admitted reason for this was that he had a tendency to keep the first of the two female patients for extra time; he attributed the second patient's complaining to her personal psychopathology and was attempting to interpret it to her. The doctoral candidate had received about a year of once-a-week psychotherapy but had terminated treatment at the end of the year because both therapist and patient agreed that there was "little further to talk about." After a cursory description of each patient, he launched into a complex metapsychological description of what he regarded to be their psychodynamics and psychopathology. I had to stop him because I could not fix in my mind any superficial physical description of either; they seemed fused together in my head and were only intellectual abstractions as he presented them.

In the second supervisory session, the candidate attempted to go into greater depth regarding the psychodynamics of the patients. Finally, I insisted

that he give me a detailed superficial, empirical, clinical description of each patient. It immediately became apparent that the first patient was beautiful and seductive whereas the second patient was dumpy and unattractive. In spite of his repeated efforts to return to psychodynamic descriptions, I insisted that the candidate dwell on his emotional reactions to each patient. He finally blurted out that he had many fantasies of sexual intercourse with the first patient. It was most difficult for him to let the first patient go at the end of her session and only with reluctance did he face the unattractive patient.

Although I attempted to explain in every possible fashion how this preoccupation with sexual fantasies about the first patient might profoundly affect his treatment of both patients, the candidate really did not grasp what I was trying to say and tended to slide over the subject. At my suggestion that perhaps some further psychotherapy would be indicated for him, he agreed that perhaps "some day" he might consider it. He finished his schooling and to my knowledge is now operating as a clinician.

Over years of supervising residents and various students, many episodes of this nature could be reported. Even experienced supervisors are sometimes amazed when an advanced student brings tense countertransference reactions into the very first evaluation interview — reactions of such a transparent nature that it is incomprehensible how they

could be overlooked by the candidate. The only protection for the patient against such countertransference is to insist that the candidate see patients on an infrequent basis, if his or her own treatment has been infrequent, in order to minimize intense development of emotional misalliances with patients (Langs 1975). And this is only a very weak protection.

In case the reader feels that only beginning students can experience such problems, Greenson (1967) describes a painful example of a candidate at a psychoanalytic institute who was unable to empathize with a patient's concern over her seriously ill infant. Treatment ended abruptly with the patient telling the candidate that he was sicker than she was. Although Greenson quotes the candidate as agreeing to his need for further treatment, he does not inform us whether the candidate *actually went for it:* my experience has been that it is very difficult to get students to re-enter treatment once they have found a way to "finish" what they consider to be their "training psychotherapy."

Wilhelm Fliess, an ear and nose specialist in Berlin, was the author of a number of theories involving the correspondence between the nasal mucosa and the genitals, bisexuality, and the existence in each individual of a double periodicity with a feminine and masculine cycle of twenty-eight to twenty-three days, respectively. A friendship developed by 1892, during which Freud in his isolation used Fliess as a touchstone to correspond about his new ideas

and theories. In one way the famous letters to Fliess are a kind of diary; but there is no question that the friendship and the emotional interaction with Fliess were supportive and therapeutic for Freud also, which is something one does *not* obtain from a diary. As with Charcot, Freud tended to enthusiastically over exaggerate his friend's abilities and theories, calling him "the healer into whose hands one confidently entrusts one's life.'' In fact, Fliess, in contrast to Charcot, was mediocre in every way.

At the beginning of 1894, Freud suffered from heart symptoms, and on Fliess's advice stopped smoking for fourteen months until he could stand it no longer. From July 1895 up to the death of his father on October 23, 1896, he published with Breuer *Studies On Hysteria,* broke off his relationship with Breuer, and worked on the unfinished "Project For a Scientific Psychology," which is the last item in the first volume of the *Standard Edition* (1950A;1:283-387).

Freud's cardiac problem was marked by an arrhythmia and some chest discomfort, but Fliess's diagnosis of nicotine poisoning was wrong, since abstention and then smoking a few cigars seemed to make no difference. There is no evidence that Freud's twenty cigars a day had any effect on his heart although common sense suggests that it could have, but the arrhythmia seems to have been at least partly psychogenic in origin. The subsequent break with Fliess is attributed to a number of circumstances involving, first,

Freud's partly successful self-analysis (Kohut 1977), and second, their basic disagreement on scientific matters, in which Freud could not accept Fliess's numerology and Fliess could not accept Freud's dynamic etiological findings in the psychoneuroses.

One must keep in mind that Freud and Fliess had much in common in their life situation. Both were young medical specialists, both were from the Jewish middle class, both were concerned with establishing a practice, and both were preoccupied with maintaining and raising a family — although Fliess had an easier time of it because he married a wealthy woman and was more successful than Freud in his Berlin practice. Both men were educated in the humanities and so could understand each other's allusions to classical and modern literature. Fliess was also influenced by the Helmholtz School; his Christmas present to Freud in 1898 consisted of two volumes of Helmholtz's lectures.

Freud's extreme dependency on Fliess, up to the age of forty-five, is described by Jones (1953) as having the appearance of delayed adolescence and is marked by Freud's inordinate overestimation of Fliess. The basis of this attachment seems related to Freud's separation from Breuer. Fliess, in contrast to Breuer, was quite preoccupied with sexual problems, although in a curiously mysterious and numerological way. He was much more willing to speculate and explore forbidden territory than the older and conservative

Breuer, and he was faithfully willing to listen to Freud's accounts of his various findings and theoretical explanations and to pass judgment on them. Freud often wrote to Fliess more than once a week, and they had frequent personal meetings lasting a day or two. I agree with Jones that Fliess served essentially as psychological encouragement (mirroring) at a time when Freud was suffering personally and wrestling with his discoveries.

The letters to Fliess show that for about a year after his father's death, Freud brooded day and night in a psychoneurosis which seems to have had depressive, obsessive, and hysterical components. Interpretation of this malady seems to depend essentially on a critic's general feeling about Freud and his work, with his adversaries contending that it shows he was severely ill and his writing simply the expression of neurosis, and his rather uncritical followers (such as Jones) claiming that his self-analysis was a heroic feat without precedence, never to be performed again.

I agree with Ellenberger (1970) that this self-analysis was part of a creative illness reaching its resolution with the publication of *The Interpretation of Dreams* in 1900:

> A creative illness succeeds a period of intense preoccupation with an idea and a search for a certain truth. It is a polymorphous condition that can take the shape of depression, neurosis, psychosomatic ailments, or even psychosis. ...Throughout the illness the subject never loses the thread of his dominating preoccupation. It is often compatible with normal professional activity and family life. But even if he keeps to his social

> activities, he is almost entirely absorbed with himself. He suffers from feelings of utter isolation, even when he has a mentor who guides him through the ordeal. ...The termination is often rapid and marked by a phase of exhilaration. The subject emerges from his ordeal with a permanent transformation in his personality and the conviction that he has discovered a great truth or a new spiritual world (Ellenberger 1970, pp. 447-448).

Freud made a point of spending two or three months in the country every summer, even during the years when he was not doing well financially. For climatic reasons long summer holidays were the custom in Vienna, but Freud recognized this as a necessity rather than a luxury. As Jones (1953) points out, "Freud found early that the strain of the work of intensive psychotherapy was such that without an ample period for recuperation its quality would surely deteriorate."

In addition to his sensible precaution of taking ample vacation time in spite of the financial losses incurred, Freud also had at least one passionate hobby—antiquities. This seems to have gratified both his aesthetic needs (he was uninterested in music) and his abiding interest in the sources of civilization. Like his vacations, the hobby also represented a financial extravagance; he was able to make himself only occasional presents of various archeological objects. Clearly, Freud's attitude toward money was a mature one, and in fact he insisted that wealth brings little happiness, since money is not primarily involved in childhood wishes.

We have gone a long way from this attitude in our present civilization. In previous publications (1969) I have discussed vanity and greed in the life of the psychotherapist and later (2007) the effect of the collapse of civilized behavior in a barbaric society on countertransference. Generally speaking Freud had more insight into the greed problem of psychotherapists than he did into vanity; it remained for later pioneers to investigate the nature of narcissism in greater depth.

Perhaps the most dramatic description of the problem of life in private practice with respect to money is presented by Saul (1958), who deplores the current emphasis on the equation stating that the more hours that the analyst works, the more money that he makes. The average therapist is in middle life with wife and children and perhaps even in debt because of his training. He is insecure about filling his time and not sure when a patient finishes treatment whether the next available hour will be filled promptly by another patient: "Therefore he works all the hours he can and risks slipping into the mire of equating hours and income. Of course, this equation is true, but if not properly balanced and separated, the result is entrapment and slavery." Thus the therapist cannot take time for lunch because the time represents a lost fee, and he cannot take a day off or vacation for similar reasons. Saul calls this "the dance of the hours" in which the therapy hour becomes too intimately associated with the therapist's receptive needs. Thus "Time off is no longer a legitimate, wholesome respite from work, the satisfaction of his proper

receptive needs; it has become a frustration of his receptive needs because he is not receiving, in the form of money, when he is not working. ...He is pushed in the same direction by the pressures of a money-civilization in which money is a means to security, pleasure, prestige, romance—well-nigh everything" (p. 22).

Saul makes the solution sound easy, but it is not. Basically it requires maturity in the therapist's wife as well as in himself. An income less than that of most physicians must be expected for the intensive psychotherapist. Still, working with no more than six or seven patients a day to avoid fatigue, and allowing for breaks for meetings, illnesses, and vacations, the psychotherapist can make a reasonable income and have a nice life "if he and his wife are not greedy."

The wholesomeness of the therapist is a very important subject. Sociability among friends, where there is normal, nonstructured interaction and physical exercise on a daily basis, are absolutely essential to the mental and physical hygiene of the psychotherapist.

Many authors have discussed an epidemic of depression, depressive equivalents, and suicide in physicians, especially psychiatrists, in the age group of 45 to 55. In the case of psychiatrists attempts have been made to connect this to the unusually great professional identity problem of psychia-

trists in their residencies and later in their mid-career crises. The gnawing sense of dissatisfaction and impatience, the feeling of being boxed in, doubts about our choice of profession, and doubts about our very life style were termed "destination sickness" at the 1976 meeting of the American Psychiatric Association (Rosen 1973, 1976). The problem of destination sickness is related rather to our sense of self, which forms as the consequence of transformations of narcissism—and which therefore, may be disturbed either by initial developmental deficiencies or eroded by the vicissitudes of living.

Every human being is forced by the ambiguity of existence to make two fundamental choices—choices that Kierkegaard called "criterionless choices" or "leaps." We cannot avoid these choices; their very nature will have a profound effect on the way each individual lives his life, and on the healthy or pathological state of the spiritual aspect of the human mind. These choices are: (1) either we declare the human situation to be utterly absurd and hopeless and just try to make the best of it on a day-to-day basis, or we look for a further dimension, or depth, or ground, to human existence that makes more sense out of it, supports it, and brings order and fulfillment to it; (2) either there is a force in the human mind that drives man, in spite of his limitations, to bump up repeatedly against the limits of pure reason, as Kant put it, and to constantly strive to transcend the self and make contact with something outside of and greater than the self—a force which makes man

unique among the animals—or there is no such force and we are strictly physico-chemical entities with inherent and conditioned behavior patterns exactly like all other animal species.

These choices have special meaning to every psychotherapist because not only do they affect, as in the case of all humans, the personal life of the therapist; they also seriously affect his approach to his patients and the psychic field (Chessick 1971) that he has to offer them. Furthermore, because these problems and choices cannot be avoided in the dialectic of long-term psychotherapy, the therapist is forced to think about them.

There is general agreement that the rate of suicide among physicians is significantly higher than that of the general population. Steppacher and Mausner (1974) indicate that below age 45, women physicians are at the highest risk; whereas over 45, male physicians show a higher suicide rate than women. Most authors agree that the rate increases with age and that married physicians are the least prone to suicide, as compared with bachelors, widowers, and especially divorced physicians. Ross (1975) presents preliminary data from the American Psychiatric Association Task Force on Suicide Prevention and reminds us that in the United States suicide causes more physician deaths than do automobile accidents, plane crashes, drownings, and homicides combined. He reviews the literature extensively and reports a high incidence of psychopathology, alcoholism, drug addiction,

and most of all, depression, in physicians who commit suicide.

Green et al. (1976) describe the problem of drug addiction among physicians and point out that the median age of onset of addiction in their series was 43 years. Many authors have reported and discussed the tragic problem of the middle-aged physician as alcoholic or drug addict. Furthermore, Ross (1975) explains, "Among physicians who committed suicide, colleagues have noticed a change in behavior, an increasing indecisiveness, disorganization, and depression for two to four months preceding suicide."

The question of whether psychiatrists have a significantly higher rate of suicide than other physicians is not settled. Several contradictory studies have been published and methodological problems have left the question unanswered. Physicians hostile to psychiatrists have jumped at the chance to use some published reports to attack the psychiatric profession; Rosen (1973) from the Langley Porter Clinic has eloquently and maturely addressed such critics.

Kelly (1973), and Pasnau and Russell (1975, also Russell et al. 1975) surveyed suicide in psychiatric residents. They found no higher incidence than for residents in other specialties, and no difference among males, females, minorities, or foreigners. Detailed analysis of five cases of suicide demonstrates that all the residents were intelligent, motivated, sensitive, and

ranked high in their class. This fits the description by Ross (1975) of the suicide-prone physician: "graduated at or near the top of high prestige medical school class, and now he practices a peripheral specialty associated with chronic problems where satisfactions are difficult and laggard."

We can help the psychiatrist to reintroduce quality, as I have described it elsewhere (1969), into the physician's life. We must urge him or her to find the leisure for keeping up with and contributing to medicine, for expanding his or her soul (Chessick 1978) through the transcendent beauty of art and music, and for contemplation of human life in terms of first principles; that is, for what is true, what is good, and what is valuable. Gilbert Highet (1976), one of the inspiring teachers of our time, puts it this way:

> Wholeness of the mind and spirit is not a quality conferred on us by nature or by God. It is like health, virtue, and knowledge. Man has the capacity to attain it; but to achieve it depends on his own efforts. . . . That is the lesson that the great books above almost all other possessions of the human spirit, are designed to teach. It is not possible to study them—beginning with Homer and the Bible and coming down to the magnificent novels of yesterday (*War and Peace*) and of today (*Doctor Faustus*)—without realizing, first, the existence of permanent moral and intellectual standards; second, the difficulty of maintaining them in one's own life; and, third, the necessity of preserving them against their chief enemies, folly and barbarism (pp. 16, 33-34).

Clearly, a firm sense of self and the mature capacity for love and intimacy with others are indispensable foundations for protecting us against the chronic drain of our psychiatric work. In a previous book (1976) I have

described the death of a middle-aged psychiatrist, from coronary artery disease, as a result of neglect of these factors, and later I (2011) have unfolded all this in clinical detail. Intensive psychotherapy is mandatory to enhance these capacities within us, and common sense ought to force us to seek such therapy both as a protection in training and later on in life.

Not enough has been done to reduce the isolation of the practicing psychiatrist and to provide an atmosphere where self-esteem is not reduced but rather enhanced by the decision to seek further personal psychotherapy. Channels for consultation with colleagues are not sufficiently open and little has been provided to educate the family of the psychiatrist to the fact that psychiatrists also are human and at times must be strongly urged by those around them to get help. Exactly contrary to the popular misconception, it is the psychiatrist who seeks help for himself by consultation and further psychotherapy that shows best the capacity to help his or her patients; psychiatrists who deny their needs and pretend to be self-sufficient may temporarily impress those around them but actually are showing weakness rather than strength. Support from colleagues and loved ones is vital in helping psychiatrists deal with the narcissistic problems involved in seeking help and consultation.

We have a special obligation to residents in training; we clearly already know how to reduce the number of breakdowns and suicides by residents.

Kelly (1973) suggests such measures as psychological testing and psychiatric interviewing at the time of selection; sensitive individual supervision; early explicit discussion of the stress residents will experience and of suicidal thoughts as well as innumerable other reactions, thoughts, and fantasies that may plague the resident under stress; periodic evaluation of emotional development during training; and prompt recognition of crisis situations and referral for treatment—preferably without financial burden to the resident.

In addition Kelly poses the question, "What can be done during the years of residency to prepare the psychiatrist to cope more readily with personal depletion and distress throughout the years following formal training, when he will be fully engrossed in his practice, carrying the burden of his patients' fears, angers, and self-loathings and separated from close personal contact with understanding colleagues?" Up to the present we have failed to address ourselves sufficiently to this question and to recognize its great importance.

[i] I began as a medical student doing research during elective and vacation periods on the histochemistry of the nervous system. In this field I published a number of papers; but, due to the influence of Dr. N. S. Apter, an outstanding teacher of psychodynamic psychiatry (and my earlier personal discovery of the writings of Freud under the famous "Hutchins plan" at the University of Chicago), I shifted my interest to the field of psychodynamic psychotherapy and psychoanalysis. Such teachers are becoming rare in medical schools today; from time to time I receive moving letters from medical students in various countries, including ours, who have read my books and approached the department of psychiatry in their medical school only to be told that the era of biological psychiatry is at hand and to forget about psychoanalytic psychotherapy and

psychodynamics.

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