The Problems Posed by Les Havens in Psychiatry and My Reply to Them

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A teacher may be judged by the quality of his problems. Professor Havens gave me big ones. I do not think the reader would want to follow this series unless it concerned him or her personally. I think it will concern him or her personally, because the series turns out to have a unity like a mathematical proof, and that unity is the disaster of modern humanity. We are all in it, and some of us have found a way out of it.

The structure I will attempt to prove like Poincare (1908) (Gustafson, 2008, Chapter 13, Part II) did in non-linear geometry is a fractal structure: the exchange an individual gets in his or her life is self-similar on all scales of time and space, in a moment or a word, or in a lifetime.

The method of my proof is to give a series of problems posed by Professor Havens, followed by my reply, in the order they came to me over the last forty-four years. All of the problems in the series will turn out to have the same structure.

The reader, no doubt, would like to know what this structure is, before embarking on the series. Fair enough. The modern problem, and by modern I mean the last five thousand years, always turn out to be a fate set by the group he belongs to, by which the individual loses him or herself. From Homer, to Dante, to Shakespeare, to Tolstoy, to us, always the same result. The magnetic field of the group captures the individual nearly every time. Humanity is too terrified to be out of step with it.

Problem One, Auditory Hallucinations, 1964.
With Professor Havens as my advisor, and armed with his essay, “The placement and movement of hallucinations in space: phenomenology and theory” (1962), I began to see a series of chronic paranoid schizophrenics in the summer of 1964 at the Royal Edinburgh Hospital in Scotland. I asked these patients to keep a journal of what their voices said to them. The same strange loop turned up in every journal. The voices were kind at first, and then mean. If the voice was Elvis Presley inviting the patient to come sing with him in America, then Elvis would soon be terrorizing him with his gang of followers (Gustafson, 1999, Chapter 24). By the end of the summer, all of these ten patients began to back off from their inviting medical student!

My thesis (not required, but for honors) concerned the profound disorientation of these patients: they were very sheep-like (as Havens liked to say), and were cast off in group life (often too in family life), and their centers collapsed from sheer disconfirmation. Into this vacated center (as William James had argued in Varieties of Religious Experience, 1999, originally published 1901-1902) rushed up a grand claim to be of central importance to God Himself. Ordinarily, this results in even worse disconfirmation, unless the minister could help the individual shape the claim into some typical form that would sound like Christian service. Then, the patient was saved, and had his place back in the group, with, perhaps, an improved status.

My defense of my thesis lasted only five or ten minutes. One of the psychoanalysts began and ended it by asking the definition of several technical terms. I think one was “libido,” and another was “cathexis.” I really didn’t know, and that was the
end of my defence. I was disqualified, and there was no opportunity to discuss what my thesis actually claimed.

I was devastated, being only twenty-five, and didn’t write anything to submit for four or five years. I kept a journal, underground. Much later, I confirmed my findings many times, in acute psychoses, where I could turn them around like the ministers did in James’s book, because I had the dynamics exactly right. The reader can refer to The Common Dynamics of Psychiatry (Gustafson, 1999) Chapters 23 and 24. At this moment, however, I had no idea that my disqualification by the psychoanalysts was absolutely typical. Aristotle could have explained it to me in his Rhetoric (1991, originally published 336-322 B.C.). The group, which Canetti (1984, originally published, 1960, and got him the Nobel Prize for Literature) called an increase pack, is only persuaded by what it is increasing. In other words, if \( n \) is the thing being increased, only \( n + 1 \) will satisfy them. Everything else is cast aside.

**Problem Two, Reliable Findings, 1986.**

By 1986 in The Complex Secret of Brief Psychotherapy (reprinted in paperback, 1997), I understood the central problem of psychotherapy for Professor Havens, which is stated very clearly in the following chapter 10 about his work. Havens: Reliable Findings, in its core section also called

*Reliable Findings* (quoted verbatim from pp. 118-121, The Complex Secret of Brief Psychotherapy)
How then are we to get reliable findings, hour by hour? This is as crucial for brief psychotherapy as for long-term psychotherapy. Brief psychotherapy is apt to become a “convenient fiction,” a fairy tale of simplification. Long-term psychotherapy is apt to become a different “convenient fiction,” a domestic tale of settling into what is merely comfortable.

*There are two prevailing, overwhelming tendencies that are apt to get us to accept fiction, which is our defeat. Can we make measurements without distorting the findings? Our problem is very much like that of modern physics (Havens, 1982). There is both a particle phenomenon and a wave phenomenon. The particle phenomenon is that the patient is like a hidden particle. She is self-absorbed, but she has little faith in being found out there. How to go looking for her? There is also the wave phenomenon. The patient plays to the social field, giving what is expected. Everything she says is shaped by these social waves. How to find the patient in these distorting waves?*

Attempts at precision are apt to fail. Objective-descriptive psychiatry will place the patient on its coordinates of “illness” – every case is defined by the “syndrome,” its cluster of expected symptoms, its natural history, epidemiology, prognosis, and standard treatment. One might get a rough idea about the patient, by a protocol which can be repeated with precision, but what patient wants to be caught in this matrix? The brain may be subjected to precise measurement, because it can be found in the cranium, but the mind need not be in the room. Of course, some patients *appear* to be willing to be subjected to this kind of precise study, but this is likely to mean they see some advantage in presenting themselves as “ill.”
Psychoanalysis may be an improvement. It too sets up “standard conditions” for observation, namely, its strict “standard technique” of free association and keeping only to the analysis of resistance and transference. This is to allow the past to come into the present. But the same kind of distortion is possible with psychoanalysis as with objective-descriptive psychiatry. The past will come into the present as the patient finds this advantageous. What kind of past does the analyst want to hear about? What kind of past is advantageous to the patient to construct? Whose past are we getting? It is very difficult to know.

If precision cannot force us into reliable observations, what is more promising? Havens believes that “loose holding” is more likely. This is possible with the methods of both the interpersonal and existential traditions. They are the corrections for the wave and the particle phenomena (Havens, 1982). If the patient is continually playing to the social field, adjusting to the powerful waves she feels coming toward her, then it is necessary to see what these expectations require of the patient. This helps to clear the field of the wave distortions, allowing us to see what else might be there as well. But since waves keep coming, forcing and obliging responses from the patient, this activity of counter-projection is always necessary to renew.

If the patient is self-absorbed, like a hidden particle, then the search for her, the methods of active empathy, of putting oneself in the patient’s place, are the only ways one is likely to get a view of how the world and her position actually look and feel to her. Therefore, given the priority of reliable observations, the methods of interpersonal and existential psychiatry, in some kind of alternation, become the principal tools for Havens. They serve the purpose of moving the “narrative flow” in directions more likely to be
believable and reliable. This gives “successive approximation” as to where the patient lives. This is our principal job.

We not only find the patient this way, but also set her free. For the projected expectations force her responses, in a closed circuit, while her hidden self-absorption remains disconnected from the world. For instance, Havens discovered of the young woman writer of the first conversation that he had to uncouple her from the force of three different projected expectations: that he too would expect her to be perfect; that he too felt sorry for her (was “touched”); that he too could alter the world for her. All three expectations would have kept her very passive. Her poor responses would have been forced. These massive forces uncoupled, she could begin to allow her feelings to flow. But they were so painful. They needed to be shared to be tolerable at all. She was so lost in this torment, how could she give back in writing to the world? The interpersonal methods help break the closed circuit, while the existential methods help carry the person in the transition back to the world.

Perhaps I can describe this kind of help best by describing my own experience. I am as sensitive as anyone to not fitting in. The animal out of step with his local environment does not feel well. That’s what his nervous system is for, to let him know when he is out of step. This is to keep him from being killed, wounded, or humiliated. Therefore, when I am out of step, when I do not like what is happening in my faculty meeting or at a social gathering, I feel down or nervous. I often know only one more thing, which is how I am supposed to be reacting – like my smiling neighbor, or course, or my nodding colleagues. If I could get no farther than this, I would be in neurotic misery. Given my own nervous or discouraged feeling and the weight of social
expectations, I would have nowhere to stand. But I have learned to talk to myself with the interpersonal or existential methods of inquiry described by Havens. I step back out of the force of the social field, giving myself the benefit of the doubt. Perhaps my colleagues and neighbors are forcing a response upon themselves that I do not want to force upon myself? In their light, my response is wrong, but what do I think of their light, anyway? Not so much. I begin to get some room to see what I do feel about the situation. I have uncoupled myself from the extreme force of social expectations. But now that I have some room, I must listen and accept and look after myself, or get someone to help me, for it is painful to feel situations all by yourself. We human beings are not well equipped for this. If I can carry myself along, with some help, I can begin to accept my own feeling about the situation. I can begin to find other people who could accept my feeling as well. I am making a transition, in my mind, to a niche where my response fits. Then, I feel fine.

In this perspective, neurotic misery is a *forme fruste*. You might have a response, which is not seen in your family, your neighbors, or your colleagues. But until they are pulled off your back, you will not be able to know the possibility. It cannot become a story. It is merely negative, an absence. The circuit is closed. The interpersonal methods of inquiry are necessary to allow the response its own room. Then the existential methods of inquiry nurse the response along, which is difficult to bear alone, until the response can discover its positive domain. This is what the “loose holding” methods can do.

But notice that the “loose holding” inquiry about myself would not have been possible unless I had some faith in myself as a worthwhile person who is often right. I would never know there was something to look into. I just would have felt badly. Many
of our patients do not feel worthwhile or admirable, and so they just feel badly. This is why Havens could get nowhere with his third conversation, why he was reduced to smiling at the young woman, since any comment by him was taken up as a new self-criticism. Why give her fresh ammunition? Finally, he saw a place which could not be taken away from her, a place to live from, as Winnicott would say, where Havens could begin a stand. She was not as garrulous as her mother the editor told her. She was brisk and to the point. He admired this in her. “Loose holding” now can make its discoveries, when he has fastened to what is admirable in the patient.

And one more thing. Some patients act foolishly when they are appreciated and understood. “Loose holding” could discover them, only to have them charge off and do something stupid. The megalomanic patient of the second conversation was this sort of person. “So much for hope!” Havens had to say to him, driving a wedge sharply between himself and any notion the patient might have that Havens approved of his great expectations. If one is going to use these “loose holding” methods to find the responses of the patient, one has also got to keep in mind that patients act on what they find. As Sullivan would say, the psychiatrist better find out what the “routinely futile operations” of the patient are likely to be and discourage them! Then it might be all right to get to know the patient better (Gustafson, 1986/1997, pp. 118-121, newly italicized for emphasis by myself) (end of quote from The Complex of Brief Psychotherapy).

Now, twenty-two years later, I completely agree that this is the principle technical problem of psychotherapy, and psychiatry, that Professor Havens has posed correctly. To
put it in a single sentence, having italicized it in the four key paragraphs in four pages, I would simply say:

The patient will not be found, without the interviewer setting up a transitional field, or equipoise (Gustafson, Brief Versus Long Psychotherapy, 1995), where the two strange attractors of the group and of the body are of equal strength, (The Great Instrument of Orientation,, Gustafson, 2008).

Otherwise, the patient will disappear into the group, or increase pack, as described in Problem One, Auditory Hallucinations, or, vice versa, the individual in excitement will make the group disappear, also described in Problem One, Auditory Hallucinations, being full of God Himself. In other words (Gustafson, 2008, Chapter 2, Numinous Jung), the general tendency of the force field is twofold: psychic deflation or inflation!

Either of these loses half of reality in a split second. The weighting of exterior reality, in terror of the group, loses interior reality altogether. The weighting of interior reality, usually in compensation for its sacrifice to the group, (Gustafson, 1999, The Common Dynamics of Psychiatry) loses the capacity to take in exterior reality. In other words, Robert Louis Stevenson was right in The Strange Case of Dr. Jekyll and Mr. Hyde (1985, originally published 1886) that this strange case is after all the typical result of these dynamics between the modern group and the individual body. Dr. Jekyll is depleted and/or deflated by his subordination of himself to the increase pack of daily life,
and, at some point, Mr. Hyde bursts forth out his back gate at midnight with total
disregard for the laws of the group (Gustafson, Very Brief Psychotherapy, 2005).

**Problem Three, The Art of Looseholding, and its Domain, 1988.**

The Looseholding Technique, so clear by 1988, had a painful problem in it that
Professor Havens and I discussed many times in his kitchen between 1986 and 1991, on
my once a year visits. The painful problem was the domain of who was capable to do it,
and, thus, even more painfully, what would its place be in psychiatry, and
psychotherapy?

Previously, when I had watched him interview a poor, depressed woman before
our medical school class in the fall of 1964, I had known something very unusual was
afoot. The woman just opened right up, at the bottom of the ampitheatre, in front of a
hundred fifty of us. Later I was reminded of the famous painting of a surgery by Thomas
Eakins, The Gross Clinic, 1875. Later, also, I remember Professor Havens comparing
psychotherapy to a surgery, where the essential ability was to cut between what is well
and what is pathological.

By 1973, Professor Havens had written Approaches to the Mind and made it clear
that the art of surgery in psychotherapy depended upon seeing differently. He borrowed
from Wolfflin’s Principles of Art History (1932) the analogy of the transition from
classical to baroque perspective to convey the transition from objective-descriptive
psychiatry to psychoanalysis:
In taking the step from objective-descriptive psychiatry to psychoanalysis, we can use a distinction Wolfflin made in his account of the development of artistic perception. There is a movement, he argued, from “linear” to “painterly” perception, away from the edge or line of objects and toward what is within the edge. In the classic period, “the eye is led along the boundaries and induced to feel along the edges,” while with the baroque (Rembrant is the most extraordinary example), “seeing in masses takes place where the attention withdraws from the edges, where the outline has become more or less indifferent to the eye as the path of vision, and the primary element of the impression is things seen as patches.”

…Through much of nineteenth century psychiatry, a distinct outline of conditions was sought; emphasis was on whatever distinguished a group of patients, the external features separating one group from another, like an edge. These prominent phenomena, particularly signs (objective events such as catatonic movements that all can observe at once), lend a distinctiveness, a sense of precise outline to the descriptions. They are the farthest thing from later preoccupations with internal states, ideas, subjective reports, and understanding the whole person; these fill up the outlines provided by what we call objective-descriptive psychiatry (Havens, 1973, pp. 80-81).
Of course, the analogy to art history would also allow Professor Havens, to bring in the existential perspective and the inter-personal perspective, between the objective-descriptive and the psychoanalytic. Each perspective had its own way of sitting with the patient, its own language, even. I thought he was exactly right, but it was also clear to me that he was worried about his place in the field. The field was getting more trivial, as he was getting more sophisticated. Each school had its game (n), and seemed to be only interested in enlarging its territory (n + 1), as Aristotle and Canetti argued (see Problem One).

By 1988, when Professor Havens visited me for a week, to conduct a series of videotaped consultations to our different services, he concluded with a Grand Rounds, on March 2, called “Talking with Difficult Patients,” which is my favorite of anything I ever heard from him. Its summation of the different ways of seeing, sitting, and moving with the patients, in looseholding, was absolutely beautiful. I can draw a picture of it, like the one he drew for the audience, to depict the geometry in the four different schools, and the radically different consequences that follow from the geometry (Professor Havens has a copy of the videotape of the lecture, which he loans out copies of, if you want to see and hear it):

![Figure 1. The Arrow](image)
In words: Psychoanalysis sits behind the patient, and follows his free association; objective-descriptive descriptive sits in front of him, and brings his trajectory or flow to a dead halt to question him; existential psychiatry rides the arrow itself, to strengthen its force; and interpersonality psychiatry sits alongside the arrow to look out ahead into the social field to where it is going. Loose-holding, then, is the great capacity to move from one position to the other three positions as necessary.

I thought it was stunningly beautiful, and elegant in its condensation of everything you needed to know about psychiatry and psychotherapy. Not quite. The audience reacted as if nothing remarkable was being shown at all, and had only desultory questions at the time for Professor Havens, and virtually none afterwards for me.

Something else you did need to know, evidently. Loose-holding is a great art, and a surgical one in its precision, and here was Havens’s painting of the whole procedure. But the increase packs cannot see any virtue in it at all. They are only interested in their single technique (n), and extending its territory (n + 1, i.e., the technique applies to further kinds of patients). Look in any journal of any of the schools of psychiatry or psychotherapy, and you will find this trivial extension of n, whatever n is. Kuhn (1962) called it the procedure of normal science.

It took me another twenty years to come to terms with this problem, enacted by Professor Havens, namely, that a highly sophisticated, and highly dimensional technique is necessary to find and free the patient, but that the geometry of this space is not accessible to colleagues in the normal science of increase. They are in a different space and time, and will disqualify anything that is not in their space of increase. Indeed, they
will not see anything else, like the *grandes personnes*, counting things in St. Exupery’s *Little Prince* (1943).

So, this left me with a twenty-year journey to figure out where this high-dimensional art could practice its beautiful work, and protect itself from disqualification, and undergo further beautiful developments. The results of this search, 9 books later, culminate in my book to be published this year, *The Great Instrument of Orientation*, (Gustafson, 2008).

The simplest way to pose the reply to Professor Havens’s dilemma is to draw a picture of it, as what is called a phase-space in physics or in biology: a map of non-linear changes of state, as from water as ice, liquid, or cloud. Here is my map of the non-linear geometry of a sophisticated art in psychiatry or psychotherapy. It is a variant of a phase-space map drawn by Mathews and Strogatz (1990), of a plot of points resulting from the coupling of limit-cycle oscillators, varying, first, the tightness of coupling of them (strong or tight coupling results in synchrony) (loose coupling results in incoherence), and secondly, varying the frequency range of the oscillators (great frequency range results in incoherence, and less frequency range results in synchrony). But the astounding and great result is the transitional field between these regions of synchrony and incoherence, namely, large-ordered oscillations or large-chaotic oscillations, depending on a subtle shift in the density of interactions within the system (Gustafson, pp. 233-234, 2008).
The result is elegant, like Havens’s Arrow diagram, Figure 1. The difference is that the region of loose-holding (in relation to the arrow) is now placed in its phase space of group life in our field. It is the region mid-way between synchrony with the group (which only yields n + 1, or normal science), and incoherence, which is so high-dimensional that it is totally inarticulate. At a glance, the phase-space shows the tiny domain of loose-holding as an art, as a surgical art.
The following four problems will now ask the correlate question: **how is this beautiful slice of transitional field to be found in our daily work, if it is not possible to prove it to the schools of psychotherapy or psychiatry?** I will give four examples. They are all examples of what I call **fractal conditions. When the outer or exterior world (group life) and the inner or interior world (the body) are in equal balance, details of exchange between the inner and outer fields will turn out to be self-similar on all scales of space and time: in other words, huge ordered and chaotic oscillations will occur up and down the entire range of the great instrument of orientation.**

**Problem Four, My Crypt for Teaching Medical Students, 2008.**

Our medical students are introduced to interviewing in their second year in groups of four for four weeks in the spring. The teaching is supposed to get across, i.e., instruct them, in how to gather information to put into the medical chart, as they will be expected to do in their third year rotations on our inpatient services. The teaching, thus, comes down to filling out two worksheets for each patient two of them interview, which are checked by the faculty teacher. One list is for the findings of present illness, past illness, and family history. The second list is for the findings of the mental status.
Instructions: After the interview, fill out this homework form on the patient interviewed. It may be incomplete, but do what you can. Note: do not write the patient's name on this form (to help ensure confidentiality) and treat this report with respect in terms of confidentiality. Turn it in at the next interview session.

Patient ID:

<table>
<thead>
<tr>
<th>Date of Interview</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Interviewer</td>
<td>Number of Children</td>
</tr>
<tr>
<td>Patient Age</td>
<td>Occupation</td>
</tr>
<tr>
<td>Patient Gender</td>
<td>No. of Hospitalizations</td>
</tr>
</tbody>
</table>

Briefly summarize the patient's psychiatric history

Chief Complaint

History of Present Problem

Onset and Possible Precipitants

Psychological Signs and Symptoms

Somatic Signs and Symptoms

Duration & Course

Effects on personal, social and interpersonal functioning

Past History

Psychiatric

Medical (including substance use and abuse)

Family History

Psychiatric

Medical

Figure 3. The History
Psychosocial/Developmental History

Mental Status Examination

Appearance and behavior

Speech

Mood and Affect

Perceptions

Thought
  Form
  Content

Cognitions (Sensorium and intellectual functions)

Consciousness
Orientation
Concentration/attention
Memory
Calculation
Abstraction
Judgment
Insight

Attitude toward interviewer

Case Formulation

Diagnostic Impression (DSM-IV-TR Axis I, II & III)

Figure 4. The Mental Status
In other words, **the general tendency is to ask the patients two lists of questions.** The arrow is brought to a dead halt, as in Figure 2, The Arrow, by standing in front of it.

I happen to teach four students at a time in a crypt-like room in the basement of one of our hospitals. I do not train them to ask lists of questions. I simply ask them to get out the two lists, and try to listen to the words of the history and watch the body at the same time. They are to record the words of the history on the first worksheet, and, simultaneously, the movements of the body on the second worksheet. The body will be found to comment, profoundly, on the words.

I also give them a couple of hints as we go along. Namely, that certain words, under these fractal conditions balancing words equally with body movements, will have the entire set of exchanges of the patient’s lifetime condensed into them. In other words, the key word, or the key sentence, or phrase, of the present illness will be the same one as for the past illness and the same one as for the family history. Also the body will confirm or disconfirm the words, augment or criticize them, as we go along.

For example, in the case of a man of great talent as a professor, the entire history turned around the single word, **mean.** When he did not or could not defend the seven year old boy in him (his phrase), the pain was so great that he came very close to suicide many times. When he was able to muster the strength to get away from the mean assailants, i.e., father, high school pals, boss, wife, he recovered dramatically. After the interview by two of them (I always follow up for five or ten minutes, if the patient wants to discuss it with me further), the five of us discussed the findings of the body. As always, they saw everything of importance: the hand over his heart, to protect it, talking about his father;
the trembling hand when he spoke of his present wife; the pointing of two fingers when he got to her meanness.

**Problem Five, Rounds on the Inpatient Service on Sunday Morning, 2008.**

Here is another out-of-the-way place, on a very small scale, where fractal conditions can be evoked. Each of the inpatients is brought to me by the nurse. I ask the nurse if she has any questions, and I ask the patient the same. Last Sunday, the last patient surprised herself, and the nurse and me, by a huge set of discoveries (a cascade up and down all scales), as follows.

First, she replied to my question by asking if she could have a pass. I said yes. Second, she asked if her diet could be changed. I said yes, again, in company with the nurse’s opinion. Then, I said, “Do you have any bigger questions?” She stopped a minute, contemplated, and said, “Yes. Why am I always hopeless every day, and dangerously suicidal, between four and five in the late afternoon?”

I replied, as I always do, “Well, would you like to find out right now?” She nodded yes. So I asked her to consider what she already knew about that detail, so precise, of four to five in the late afternoon. I took it like I would a dream element, to ask how she knew of it (i.e., where in her life and when in her life that time of day meant something to her?) She considered the question, and rather quickly said, “That’s when my father used to come home from work drunk and beat me up.” Now, that shocked her. I said, “When else?” “When I was married, and my mean husband was about to come home.” I
said, “When else?” “Now! When I feel so alone without my grown-up children.” And she began to cry.

After she cried a bit, I asked her how it was that, having connected to her children, she was now left unconnected? She said it was because she was unwilling to invest (her word). If you invest, you get hurt worse. If you do not invest, you end up alone, and will eventually kill yourself. I said to her, “You do not know how to invest, and keep the exchange going, in a way that is good for both parties.” I asked her if she’d like to learn about this, and have a therapist, and she gladly did.

Of course, it is just at turn by a borderline patient towards a possible and different trajectory (Gustafson, Very Brief Psychotherapy, 2005), but it is also a very striking reading of herself on every scale of her life. The diagnosis and the treatment in a few words, like four to five in the later afternoon, and invest.


Finally, a third small place, that is out of the way, where fractal conditions can also be evoked:

As attending in the outpatient clinic, every hour, I have four or five cases to look in on for five to ten minutes, and sometimes fifteen or twenty if it is a new evaluation, or if the patient has a dream.

The residents know I will ask but one question, usually, and ask the patient if I may? The most common one is, “What is your biggest concern, even as we sit here
now?” If the patient is in serious danger, I will ask, knowing with Havens (1967) that the presentation in the room may be far from the reality in the middle of the night, “When you are at the very lowest point of this depression, what is it like?” or, when the patient is always suicidal or chronically so, I will ask, also following Havens (1965), “Yes, but here you are – what is keeping you going?” There are seven or eight less common ones, but these three will give the feeling and the sense, that I am coming straight to the point, if they would like to reply to it. Most of the time they do, and most of the time the words are interesting, and so is the body’s resonance.

For example, one woman in her mid-twenties, divorced a year, asked of her biggest concern, said she would graduate from law school in May, and go off to New York City, and never come back again. “How am I going to feel that day in May, when I get in my car to go, and it hits me I will never see my ex-husband again?”

The resident and I had seen her a number of times in the last year, and discussed by ourselves that we might offer her a full hour in my weekly Brief Psychotherapy Clinic. Here, as Winnicott (1971) would say, the patient was quite ready to drop into her grief. The hour had the same fractal conditions as the ten minutes I attended to her. The word exit loomed everywhere in the hour, but, yes, everywhere in her life. The exit from Madison, anticipated as overwhelmingly painful, gave rise to the hour. The past history gave rise to an exit, at age fourteen, out the back door of her mother’s house where her mother humiliated her. The end of the hour of consultation gave rise to a joke from her, light-heartedly, when the resident was concerned that the front door of the clinic might already by locked. She just laughed and said, “I’ll go out the back door!” (exit).
The sticking point was this. She left her mother’s house to stay with an older brother who looked after her, and a year later met her husband-to-be from a very sweet family that took her in. She felt totally indebted to him and to them, and then the two of them came here to law school. Here, he, very social, gave big parties, while she, retiring, cooked. As time dragged on, he became more and more dissatisfied with being alone in the drawing room, and began to pair with another female student.

The course was downhill, and finally unbearable when he and this other female law student repainted the kitchen, her only spot in the house, while she was away. This was more than she could bear, and so she took her exit, once more, out the back door.

We dropped halfway through, like Winnicott (1971), and like I always do when it is possible (Gustafson, Chapter I, Winnicott, 1986/1997) into her two recurrent dreams: one is that she is with her horse, and the horse is not recognizing her, and the second is that her ex-husband is safe at her big brother’s, and she is not. Of course, these two words are fractal and have everything of importance in her life. She had thought, she told me, that the Golden Rule would apply to her and him: Do unto others, as they would do unto you. She did. But he didn’t return what was given: recognition, and safety.

Northrup Frye (1983) would have said that this is a variant of the great code of the Bible, which is of deliverance. She was delivered out of her mother’s house (as out of slavery in Egypt, to the Promised Land). The great code sustained her, but made it hard for her to see the actual reality: her husband only recognized himself, and only made the house safe for himself. Now, it is up to her to deliver herself, in the next turn, watching for the recognition and safety that must be there for her, as well as for her next husband.
If the fractal conditions of the transitional field (the slice) are only likely to be set up on a tiny scale by oneself, how is one doctor to live with this truth? The larger scales are ruinous, and merely devoted to increases of numbers. My wife and I have been reading the great new translation of *War and Peace* (2007, Pevear and Volokhonsky), one chapter a night. Usually, it slays us, or makes us laugh, with its absolute clarity about the increase pack, in the field of war or in the field of so-called peace which is just war by other means. One might truly say that Tolstoy’s findings are the best test of any general theory of psychiatry and psychotherapy (see Gustafson, 1995, Chapter 15, Tolstoy’s Fate). The trouble for Tolstoy is that he never could quite draw the necessary conclusion for himself, as did Thoreau (1947) and Emily Dickinson (1960): bogs are much better company than people. Here are three dreams, which brought home to me, like Poincare (1908) the non-linear geometry and its turbulent forces.

*The Dream of Bald Hills*

I had been thinking a lot of Poirier’s book, *A World Elsewhere* (1985), and its invocation of the great rhythm which leads into Faulkner’s (1942) “Bear” or Twain’s *Huckleberry Finn* (1962, originally published 1885). It is style, as Poirier says, but it is also a great calm, as in my theoretical dreams in *Very Brief Psychotherapy*, 2005, Chapter 17, Dreaming the Theory. The first scene of my dream that night was this:
I am a young surgeon moving into a very small, barren town like Mitchell, South Dakota. I am carrying a ten foot lance, but I cannot find a place to put it down, while I go to a lecture of the senior surgeon to the townspeople. I will scare people, if I leave it in the town Laundromat! So I go out to where the senior surgeon is lecturing, just over the hill. I see the white crowns of old ladies just above the crown of the hill, and can imagine their gazes, on the other side of the hill, directed totally at this senior surgeon.

![Figure 5. Mitchell, South Dakota](image)

*The Dream of Protestant Furniture*

I am very pleased with the $180^\circ$ arc (see Vincent Scully, *The Earth, The Temple and the Gods* pp. 4-8, 1979) of the previous dream, in contrast to the $1^\circ$ arc of the white haired old ladies. I dream as follows:
There is a doctor-illness, neuromuscular, for which we all must be examined, in a huge crowd, in a kind of medical inferno. One of my students, so agreeable, to be accepted, looks at me, but the other faces are unrecognizable. I flex my biceps to show I don’t have it, nor do I have the pink blotches. One of my other old students rejoins, “Yes, but … you do have something wrong with your tower which is Puritan (or Protestant) Furniture.” I look where he is pointing and see black walnut chests, very flattened, lightless, ugly, like the awful ranch style houses on the way to my department.

Figure 6. Protestant Furniture

_The Dream of My Cor(e) Body, or Room_

I am thinking that I do not care anymore what anyone says about me or my work.

I know what I can do with fractal conditions, in one word or one sentence, and watching for the body’s reply. I dream
Of a red, pulsing magma, from the earth’s core. I am building a room in the center of my house to receive it, or is it also in the center of my body?, yes. Its floor is like a tympanic membrane which arises with every pulse from below.

Figure 7. My Cor(e)

References


(Original work published, 1901-1902).


