What's to Become of Psychotherapy? Medard Boss, R. D. Laing, and Dasein-therapy

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São Paulo, November 2018

Psychotherapy must remain *an obstinate attempt of two people to recover the wholeness of being human through the relationship between them.* – R.D. Laing (1965)

The highest aim of psychotherapy is and remains to enable our patients to a being-able-to-love-and-trust, which can overcome all oppressive anxiety and guilt, as mere misunderstandings cleared away. Such trust can and may be regarded as the most mature kind of human love. – Gion Condrau and Medard Boss (1968)

"Why in the world *not*?" – Medard Boss, *Existential Foundations of Medicine and Psychology* (1971)

"The treatment that we give someone is the way that we treat that person. It should not be a noun; it should be an active affair. The way we treat one another is the therapy." – R.D. Laing, in Shandel & Tougas (1989)

"You know, I never knew where we were heading." – M (2017)

I.

The theme of our congress is "Daseinsanalyse e a Prática"—"Daseinsanalysis and Practice" or "Daseinsanalysis in Practice." That means we should expect to hear about how sessions go between a daseinsanalyst and his or her patient or client. We want to see how daseinsanalysis differs from other modalities of psychotherapy. We are eager to hear about specifically daseinsanalytic techniques and examples of how such techniques are applied. We look forward to hearing case reports in which a trained, licensed, professional daseinsanalyst helps someone who pays for a service to alleviate, even cure his or her suffering.
In a few minutes I will present an account of my work over a period of more than two years with a young man in his late 20s—"M". I call my work dasein-therapy— therapy of dasein in which both the subjective genitive and objective genitive senses of the preposition are at play. Note that in characterizing my account, I did not use the word psychotherapy. Nor did I speak of a case, a client or patient, or a psychological disorder for which treatment was indicated.

Before recalling "M", I wish to make some observations. We daseinsanalysts make a number of assumptions:

1) Daseinsanalysis is a form of psychotherapy for which institute training is available which an individual must complete in order to prepare and authorize the individual to represent himself or herself as a daseinsanalyst and carry out the form of treatment termed daseinsanalysis.

2) The practice of psychotherapy of any modality (like the practice of medicine, dentistry, massage, and haircutting) is authorized under certain civil laws to be practiced legally, no matter how well or how poorly. Practitioners certified by a school or training institute are licensed by an agency at some level of government which has oversight over the profession.

3) Psychotherapists charge a fee for their service. Since psychotherapy is expensive, for decades individuals now rarely pay "out of pocket" for 100% of the fee charged them, which in the USA may range from as little as a co- pay of $50.00 to an out-of-pocket charge by a famous psychoanalyst that can exceed $350.00 for a 45-minute "hour." Governments and public healthcare systems therefore coordinate with the offices and institutions where such services may be purchased by consumers. Much like the first superintendents of asylums for the insane, men and women who work in such places are in business and, thanks to money collected from taxpayers, payments are distributed by way of Byzantine channels to psychotherapists. Privately purchased healthcare policies are also available to some consumers who acquire

such insurance as an individual or at a reduced rate as the member of a group of fellow employees where they work (a school, factory, union and the like).

In all cases, a third party pays entirely or in part for the services provided. This is the *purchaser-provider-payer* model of obtaining psychotherapy and it is now standard in the West. It has a long, though relatively recent history in Western medicine. In 1960, my parents paid a doctor out of pocket for a visit. Even in 1970, a session with my daseinsanalyst, who was both a psychiatrist and psychoanalyst by education and preparation, cost only about $40.00.

4) The patient (or client) must have been assigned a *diagnosis* in order to qualify for treatment for which the insurance carrier will reimburse the practitioner. In medicine and surgery, it will be the diagnosis of a disease for which there are tests that confirm the presence of changes in tissue or systemic functioning that will determine eligibility for treatment. In psychotherapy, there are no such tests. Instead, functioning is assessed by identifying diagnostic features.

Overall, on the medical model, impaired functioning may range from the restricted movement of one's arm to the inability to ask someone for a kiss. Diagnoses of psychological disorders are coded using the American *DSM-5* or World Health Organization's *ICD-10-CM*, encyclopedic classificatory systems based on lists of behavioral features or reports of symptoms that must be ticked off in a certain number and have been present for a designated period of time (six months is a magic number) in order for the diagnosis to be made. From time to time, diagnostic categories are voted into and out of existence by psychiatrists themselves as new iterations of the manuals appear. Some psychological disorders that were invented in the 1950s have disappeared and others, newly minted, have been named.

5) *Treatments* suitable for a given disease or disorder are said to be indicated for a given disorder. Over time, indicated treatments are differentiated from ineffective treatments. We may compare resetting a bone and providing rehabilitative physical therapy for a broken arm to the administration of an antidepressant drug and participation in psychotherapy for a broken heart. Psychotherapy of the cognitive-behavioral variety is currently the most popular modality of psychotherapy. It is indicated for many disorders ranging from specific phobias to posttraumatic stress disorder and even so- called personality disorders.

6) Treatments are *manualized*. That means there are, for example, consensually agreed upon ways for an orthopedic surgeon to reduce a compound complex fracture and a physical therapist to restore full range of motion to a dislocated shoulder. This is important since one can expect the treatment to be more or less the same for a given ailment whether you are in São Paulo or New York, Venice or London. Likewise,

a psychotherapist intervenes in the life of his or her client or patient by attempting to reach the patient's mind by speaking to the client. What happens here is not entirely clear, although many scenarios have been offered through the years since Freud instituted the modern practice of psychotherapy with his psychoanalysis. The psychotherapist's speech is uttered in the presence of a living body with a name—for example, "M", whom you will hear about soon.

The addressed mind responds to the psychotherapist's speech with its affiliated body by merely acknowledging the attempt at communication or responding with a verbal utterance of her own. Increasingly, for a variety of reasons—ranging from reduced cost to reaching individuals in outlying locations—psychotherapy is now offered online. It is therefore becoming common for a psychotherapist to speak in the direction of a tiny camera above the electronic image of her client glowing on an LED display. The physical presence of the patient or client is virtual, not actual. What now can be said about his existential presence or the presence of his mind? The presence of the psychotherapist, whose own digitized image and voice are seen and heard by the patient or client, is also physically virtual.

We must therefore wonder about her existential presence and the presence of her mind. It is well known that the colors produced electronically by an LED display are nowhere to be found in nature and the audible output of a laptop's speaker does not correspond to what can be picked up by a pair of human ears near enough to another person's mouth to be able to collect the vibrating air surrounding both human beings and conduct evidence of it to the middle ears of each body. A body does, of course, pick up on the vibrations produced by a laptop speaker, but as acousticians tell us, these will be very different in quality from those produced by a speaking living body seated nearby. It is as different as attending a live vocal recital or chamber music concert and listening to an mp3 through ear buds or earphone speakers.

7) Finally, among psychotherapists, groups of *professionals* ranging from behavior modifiers to daseinsanalysts, have formed associations somewhat like guilds. Such a group convenes conferences from time to time where its members meet to discuss their theory and practice, much as we are doing this weekend.

What could be more obvious and self-evident than all this, and why have I taken precious time repeating it? A half-century ago, in October 1967, at the Dialectics of Liberation conference held in London, R.D. Laing eloquently warned that nothing could be less unproblematic than the obvious. The obvious is what we take to be the case without reflection, unexamined and taken for granted without further ado, on the basis of which we move bravely forward.

Briefly, my presentation today is about the obvious fact—the first of the underlying assumptions just adduced—that daseinsanalysis is a modality of psychotherapy with its own armamentarium of techniques that can be mastered while completing a program of training, certification and licensure, and can be used to treat (for a fee) a diagnosed psychological disorder. I believe this is fundamentally mistaken. Note the language: treat a psychological disorder. Where is the human being? Do we not treat human beings?

This is not the place to defend my view by examining the literature, beginning with Ludwig Binswanger's papers and on the most up-to-date presentations on our topic, including Alice Holzhey-Kunz's systematic, well-organized book *Daseinsanalysis* (2014). A review of daseinsanalysis as theory and practice would include giving special attention to the discussions of psychotherapy by Jan van den Berg, R.D. Laing and, of course, Medard Boss.

Forgive me for not providing a complete list, but there are reasons for limiting myself in what follows to the last three individuals named. In fact, I will have nothing to say here about van den Berg, who did not identify himself as a daseinsanalyst. Nor, of course, did Laing make this self-attribution. I mention van den Berg because he was my teacher and mentor, and as one can infer from reading his monograph on psychotherapy, he was at heart if not by name a dasein-therapist. On the other hand, Boss (somewhat reluctantly, I understand) was recognized as the founder of daseinsanalysis, in the generally accepted sense of the term today, based on a correct and adequate understanding of the philosophy of Martin Heidegger, in particular his fundamental ontology, and analytics of Dasein (existence).

The attribution of daseinsanalyst to Boss is problematic, however, given the fact that while being profoundly critical of Freud's metapsychology, in his office practice Boss retained the formalities of classic psychoanalysis, including the use of the couch. Like Freud, however, without a second thought he evidently broke the rules of practice that had been set down for psychoanalytic practice on the Eitingon model of psychoanalytic training. It is also clear in all of his publications that, first and foremost, Boss thought of himself as a physician—a doctor—albeit one whose preferred method of treatment was psychotherapy (daseinsanalysis), what Pedro Laín Entralgo called "la curación por la palabra"—"the therapy of the word" (Láin Entralgo 1970 [1958])—in preference to pharmacotherapy and the other, more vicious somatic treatments he was legally authorized to employ such as electroshock. I do not know the extent to which he prescribed medications especially in his later years, although early on (1951) he published a paper on the use of the hypnotic scopolamine (Plexonal). In 1941, he had reviewed the uses of electroshock.

No, instead of a review of the literature or a critical analysis of theory, I simply want to propose the idea that the project of psychotherapy, which began with Freud and now finds itself in forms as varied as existential psychotherapy and cognitive- behavioral therapy, must in principle exclude daseinsanalysis (or what I prefer to term dasein-therapy) from its purview. Daseinsanalysis is not a form of psychotherapy. I will explain why by examining the first underlying assumption I named and then presenting a very brief account of my work with "M".

The meaning and purpose of daseinsanalysis, I suggest, is inconsistent with those of psychotherapy of whatever modality. Just what is unique about it as I practice dasein-therapy will become clear in the account of my encontro with M.

By way of manifesto, I want to suggest that if it is to survive as a meaningful practice, therapeutic encounter must return to its origins with practitioners who understood it as a calling and abandon it as a profession, like medicine or haircutting. The therapist—I prefer the term therapeut and will use it from now on instead of psychotherapist—the therapeut attends to the other who has sought her out, she leans in, lists toward (zum) the other, list-ening in order to make way for him. This gesture indicates, but does not direct. She raises a finger but does not point.

Much as spirituality has often gotten lost in the trappings of organized religion, rituals and ceremonies that may occur only in certain designated places, therapeutic encounter was co-opted by medicine (psychiatry) and the illnesscare network. There is, of course, a place for ritual in culture and religions provide relief and reassurance to many, but neither may have anything to do with spirituality. Therapy has been notoriously absent in psychiatric hospitals and even in private consulting rooms, although it did from time to time happen there. We know this from the examples of Freud, Sandor Ferenczi, Harry Stack Sullivan, Masud R. Khan, Wilfred Bion, Laing and Boss—and an individual with whom I worked when young.

In fact, it was this individual who, like Boss and Laing, had been educated as a psychiatrist and psychoanalyst—but had shed the medical model and introduced me to genuine therapeutic encounter.

It should be clear by now that, for me, Boss is the critical figure in all this, but as such is a paradox. While maintaining formal ties with the International Psychoanalytic Association throughout his life, he was a trenchant critic of Freud's theory, including especially the idea of transference. He was also the only psychiatrist who worked directly and over a long period of time with Martin Heidegger, who gave his stamp of approval to Boss's account of a therapy of *Dasein*, in particular in Boss's *Grundriß der Medizin und Psychologie*, parts of which Heidegger himself wrote and the entirety of which he edited. Laing seems not to have used the term daseinsanalysis anywhere

in his lectures and publications, yet in my view he was perhaps the exemplary daseinsanalyst. From the start, in *The Divided Self* (1960), he referred to his approach as existential.

To summarize: There is something seriously amiss and self-contradictory about the idea of daseinsanalysis as a modality of psychotherapy, employed by professionals who have been trained at certain institutes in the treatment of diagnosed disorders and are legally authorized by governments to offer a form of treatment of such disorders in exchange for a fee paid to them to help someone who desires to be helped, whether the source of the payment be the patient or client himself or some third party.

I am suggesting that the continuing affiliation of daseinsanalysis with the profession known as psychotherapy (which is without fail based on the medical model) will lead to its disappearance, much as psychoanalysis has all but vanished in the USA. There, efforts on the part of "humanistic" psychologists (Division 32 of the American Psychological Association was founded in 1972 to devise a more "humane" psychology), sad to say, have come to little during the last fifty years. A chapter on "Existential Therapy" is still included in the current edition of the most widely used graduate school textbook of *Contemporary Psychotherapies* (Wedding and Corsini 2014), but it can be expected to go the way of the chapter on Jung's analytical psychology, which last appeared as a recognized modality of psychotherapy in the 11th edition (2011) of the textbook. I seriously wonder whether there will be a 12th edition' of Contemporary Psychotherapies in the years to come.

Government healthcare service industries such as social work, technologies such as behavior modification, and the prescription of psychoactive, psychotropic medications by a variety of illnesscare professionals have proliferated. The few remaining non-medical candidates for psychoanalytic training are now drawn mostly from the ranks of social workers and only a handful of psychiatrists go on to train in one of the institutes of the American Psychoanalytic Association.

It is alarming to note (Shedler 2015) that the results of all modalities of psychotherapeutic intervention now available in the States are estimated to be at an effectiveness rate of about *5%--five percent*! I do not know what comparable studies in Australia, Austria, Brazil, and Germany would find.

The self-contradiction of understanding daseinsanalysis as a form of psychotherapy is implicit in the work of R.D. Laing and Medard Boss. About a generation apart and although as different as one can imagine in background, appearance, and personal style, both studied medicine and specialized in psychiatry. Their first experiences with "mental illness" were in the hospital setting. Both observed electroshock and

the results of leucotomy. Both saw the advent of psychotropic medications in the treatment of mild and serious "mental illnesses." Both were also radicalized by their encounter with Eastern spiritual traditions (Boss in the late 1950s, Laing about 20 years later) and by the philosophy of Martin Heidegger, indirectly with Laing who rarely explicitly acknowledged Heidegger in his lectures or in print. On the other hand, Boss experienced Heidegger as mentor, friend and perhaps even patient.

Both experienced a training analysis—Boss with Hans Behn-Eschenburg, Laing with Charles Rycroft and Donald Winnicott. Both reported they thought little of the experience. Boss never ceased to comport himself with the patrician formality of the early 20th-century medical doctor and psychoanalyst, while Laing was capable of taking off his shoes and sitting cross-legged with a patient. At the height of his notoriety, having returned from India, he allowed himself to be photographed hanging upside down from the branch of a tree.

Finally, it is worth highlighting that both came into their own and into prominence in the fabled "Sixties." I had the pleasure of meeting with Boss for an hour at his home and office in Zurich in 1976, a few weeks after Heidegger's death. I observed Laing only at a distance for several hours during one of his last appearances in New York in the 1980s at a very crowded venue but formed a powerful impression of his presence. I mention these experiences because they reflect the way these men had of interacting with others. To be able to describe their way would go a long a way to characterize the existence of the genuine therapeut.

Laing once wrote that the two necessary features of an effective psychotherapist are a good memory and a sense of humor. I can vouch, first-hand, for the presence of the latter in both, especially with Boss. We are fortunate to have video records of Laing at work and can observe his gentle ease and light touch with those who sat across from him. So far as I know, sadly, there are no such recordings of Boss at work. On the other hand, in his extensive account of working with "Regula Zürcher" we can imagine his style of therapeutic encontro.

II.

But now to the sharp edge of the point I want to make here today. I have said that daseinsanalysis is not a form of psychotherapy. That is the claim I wish to defend. It is reflected in the title of my presentation. You may gain a more detailed exposition of dasein-therapy in my book *After Psychotherapy* (2017), especially Part VIII, but here I am concerned with elaborating on what I have said about the future of psychotherapy, using daseinsanalysis as the critical example.

Boss has not been surpassed in his ability to make Heidegger's language and thought accessible to the general reader, especially physicians and psychiatrists—and psychotherapists. His *Outline of Medicine and Psychology* was written under Heidegger's watchful eye and was published after the last of the Zollikon seminars for psychiatrists had been led by Heidegger. In spite of significant problems of translation, it is the best primer of daseinsanalysis. Yet I think that in Laing we see the daseinsanalyst in its most evolved form. We hear it in his comments that serve as two of the epigraphs to my presentation. Note especially the absence of any mention of patient or client. He speaks of "someone," of another human being, of a person. He deconstructs the term treatment (*Kur, terapia*), replacing the idea of technical intervention (making a transference interpretation, advising or exhorting, giving homework) with that of stepping aside, way-making. I believe this is what the therapeut does and I see it as the non-technique of a fully realized daseinsanalysis.

But the paradox remains. Boss continued to use the terminology of medicine and psychiatry. Indeed, his *Grundriß* contains chapters on psychopathology and social psychiatry (preventative medicine) as well as *Therapie*. The title of its revised version even duplicates the term *Psychologie* in the main title. It also appears in the subtitle. But there is a problem and with it we are at the heart of my critique. If Boss is correct—and I believe he is—there is no such thing as a psyche and terms such as psychology, psychiatry and psychotherapy need to be replaced just as psycho- analysis was replaced by dasein-analysis.

On the other hand, for Boss treatment was not imposed, but offered. "Why in the world *not*?" Interpretations, which form the core of psychoanalytic practice, are replaced by opportunities for liberation. Laing takes this one step further, suggesting that the *terapia* is our manner of comportment toward the other as another human being *simpliciter*, not as a patient, friend, client or lover.

I see Boss exhibiting such a way-making looking after the other in contrast to the interventional looking after of the doctor, who would be charged with (and exact a charge for) providing a causal explanation of a symptom or report of an experience such as a headache or a fear of mice. Doctors give "orders" and expect them to be followed. They prescribe regiments. Cognitive-behavioral psychotherapists give homework. Doctors take over our illness for us as we hand over to them the temporary management of and responsibility for our bodies.

This provides us with relief, much as a frightened child is comforted by the comforting oversight of a parent who says: "Don't worry. I'll take care of you. Everything will be OK." Boss is not a doctor when he says "Warum denn eigentlich nicht?"—" Porque não?" At the same time, however, he always writes about the "doctor's" relationship with his patient. Yes, there is a paradox of practice in Boss.

The distinction between two sorts of *Fürsorge*, concern, solicitude or (as I prefer) looking after or attending (to) someone else (and, as Laing reminds us, this is the root meaning of the verb from which we get the word therapy: to attend to)—this fundamental distinction made by Heidegger in § 26 of *Sein und Zeit* constitutes the basis for the insight that led to Boss's daseinsanalysis and Laing's practice. It is missing in Binswanger, for whom loving the other is the treatment. It is also missing when treating the suffering of the other is the principal goal of therapy.

Surely, loving someone amounts to intervening in the life of the other since it must be demonstrated. *Vorausspringende Fürsorge* is also missing in Gestalt psychology, the goal of which is to create a shared existence with the other. But being-with (*Mitsein*) is ontologically assumed in dasein-therapy. As Boss often says, being with others is the precondition of any *encontro* with another human being.

The medical model is based on doing something that breaks into the existence of the other. What then does it mean to say that the sole goal of the dasein- therapist—the therapeut—is to make way for another human being? For Boss, it is to restore to the other his or her freedom. But here I must question Boss, and at this point the problem of Boss's straddling psychoanalysis and daseinsanalysis becomes evident. He was fond of pointing out that the λύσις of both psychoanalysis and daseinsanalysis has the sense: freeing up, releasing. But this, too, is a form of intervention. Its model is the work of analytical chemistry, the task of which is to take apart a compound to discover its elementary constituents.

By contrast, the goal of dasein-therapy is nothing other than making way for the other to recover his present [*Gegenwart*]—not his presence (*presença*), but his present (*presente*). A genuinely therapeutic stance does not consider the nationality, language spoken, class, level of education, sex, or gender of the other. The stance can be taken here in Brazil as well as in the UK, Germany, or the States since it is a stance with respect to the other's existence. For this reason, the phenomenological existential stance and approach of which dasein-therapy is the paradigm will be as effective in "non-Western" cultures as well.

III.

It is often said that people come to therapy because they want to change or to be changed. I take a different view about what motivates a person to consult a therapeut and this has a bearing on the therapeut's stance. It seems to me that if, acting on one's own, a person seeks what the genuine therapeut can provide, it is because his or her existence (Dasein) has changed. A world has changed. In everyday terms, we

say one's whole "life" or "way of life" (in the Adlerian sense) has changed. One's *Existenz (existência)* has changed. Every aspect of being-in-the- world has changed, even though the other may not have conscious knowledge (*Bewußtsein*) of what at some level she does in fact know, namely, that something has changed and perhaps what that is. It matters little if we term this not- consciously-known the unconscious (*das Unbewußt*).

In English, we say; "Things have changed. Everything's different." Sometimes there is only a sense that something has changed, and the mood is one of uncanniness *[Unheimlichkeit, estranheza]*. Or one may know that something has changed but not be able to say just what the "that" is. "Something feels different," we say, but just what that "something" is remains inexplicit, unthematized, unclear. The frequent appearance in our "offices" of people who say "Something's up. I just don't know . . ." attests to this kind of change. Yet the person is there. Why? She may have seen on television that one goes to see a psychotherapist to change a bad habit to a better habit, to be rid of a fear, to stop smoking tobacco, to be able to sleep at night or stay awake during work. For these concerns, a visit to a doctor, a social worker, a guru, or a priest may be in order, but for that vague uneasiness, the therapeut is appropriate. That is why we will need more therapeuts.

The therapeut does not set out to "fix" or alter or change the other. He responds to what has motivated the other to seek her out—that something (which means everything) has changed, no matter what the initial complaint or (again borrowed from medicine) the presenting symptoms are. A comparison with the body is even apt here. If I have stubbed my toe, my whole body has been changed. I never just injure my toe; I injure myself. I walk differently, I even handle things differently in my new off-balance standing and walking.

From a therapeutic perspective, a who [*a Wer, a quem*] has changed, and the change is disorienting. I no longer know my place in my world. As I see it, what distinguishes genuine therapy—dasein-therapy—from all of the modalities of psychotherapy is that it is non-interventional. At least it should be. One may imagine intervening with an ego, a what [*a Was, o que*], but not with a who, unless one has reified the who. And this is precisely, Boss claims, what psychoanalysis and the other forms of applied medical psychology (clinical psychology) have done. The most egregious example is cognitive-behavioral psychotherapy.

If this formulation sounds odd to you and you are saying to yourself, "But we must do something, we must step in!"—I reply:

a) As physicians and other illnesscare providers, we are obligated to intervene when someone is agitated, confused or intoxicated. We may elect to chemically quiet

his nervous system until and so that he can reflect on his existence. This is best done under close supervision, on an inpatient basis, and for a brief period of time.

b) As a culture we must authorize certain people to step in and interrupt patterns of interpersonal aggression between men and women, parents and children when they are occurring. For this purpose, we have police.

c) We must attempt to educate or re-educate adults who are unfamiliar with customs new to them or those who are entangled in double binds. We must help children become accustomed to new family or new social and cultural settings. For this we have teachers, counselors of various kinds, special schools and rehabilitation centers.

d) As social workers, we inform and assist relatively helpless, uninformed or incapable (developmentally delayed or senile, demented elders) negotiate the bewilderingly complex system of our legal and illnesscare institutions.

e) Finally, as parents we must embody certain values of civility and model rationality—and hope for the best. However, as a therapeut our only goal is to acknowledge to ourselves that change has taken place in the world of the fellow human being sitting there next to us and make way for the other to recover his or her present. Whether they wish to take advantage of professionals of one kind or another to make practical changes in their lives is up to them. It cannot be the *Fürsorge* of the therapeut. You may ask about so-called malingerers and those diagnosed with factitious disorders who "feign helplessness," and these will be very interesting questions!

Now to be clear (since this often comes up in discussions of therapy): to attempt to *be nothing to the other existence* does not mean doing nothing. The effort to make way for the existence of the other requires continually monitoring when he entreats us to help him, to solve a problem, to reconstruct a past, or to plan a future. To abstain from complying with the other's everyday tendency and desire for someone to step in (*einspringen, ficar na or substituir por*) and modulate his temporal orientation for him is hard work.

At this point, it is worth briefly recalling that the two principal problems of everyday life we see as therapeuts are "feeling stuck" (known to clinicians as depression) and wishing to control the future (known as anxiety). Both are disturbances of temporality. As we know from Heidegger and as Boss often repeats in exceptionally clear language, however, the past makes sense only as the now-having-been and the future is what is now-to-become. The therapeut can only make way for the other to

recover, recuperate, restore this infolding present that philosophy since Plato and Aristotle have separated from the past and the future.

Minkowski's important notion of *temps vécu* (lived time, *tempo vivido*) is useful here. All changes of existence (being-in-the-world) are forms of disorientation of *tempo vivido.* The work of the therapeut is to provide a situation in which another human being is permitted the opportunity (perhaps for only an hour a week) to recover his or her present and experience it.

Of course, we will not always be consistently successful in staying out of the other's way. We remain aware that there are clocks and the other must leave us and return to "the real world" where his or her existence does not matter—just as I must bring this presentation to its 30-minute time limit—but only what they are. For the therapeut, this requires ending the meeting. Is this a form of intervention, after all?

I leave that open as yet another important question for discussion.

Finally, at last, I come to a few words about "M". It turned out that what had changed for this young man, then in his late 20s, that prompted him to seek me out, was that he desired parenthood. He had met a young woman of about his age where they worked. Up to that time, thoughts of marrying and fathering and parenting were the stuff of television programs and movies.

That this is what had changed for him was not realized, acknowledged and verbalized during our meetings. Nor did it become evident for months after our last hour together. Our therapeutic *encontro* consisted of twice-weekly meetings for more than two years. During that time, having read Freud he often asked for an understanding of how his parents' way of treating him had made him the person he was. He also wanted a label assigned to him.

"What's wrong with me," he would ask. Is "it" a bi-polar mood disorder, a generalized anxiety disorder, a gender dysphoric disorder. Well, no one, we know, ever is something. No one ever has a mental illness. All we can say is that a human being (and only the human being) exists, and to exist is precisely not to be something or someone. This, I believe, is the gist of Prince Hamlet's famous question—"To be or not to be?"—which we might "translate" as "To be or to exist, that is the question."

Again, I was not always successful in avoiding becoming ensnared with "M" in his re-imagining his existence during an earlier era of his *Existenz*, what we mistakenly refer to as remembering or recollecting one's past, in this case, one's childhood. So also for dealing with answering his repeated requests for advice and counsel about what decisions he should take or moves he should make.

At a certain point, he decided he would prefer to spend the hours we had set aside to meet each week to do other things. He dated more frequently and was married last June. Once before we parted, he said: "You know, I never knew where we were heading." He seemed to want to express a kind of disappointment, but when he said that I knew our therapeutic work had been as effective as my calling as a therapeut allows. In any case, nothing had ended, since nothing had ever begun.

Postscript: The practical question about whether to charge a fee for what is provided in response to a calling is a sensitive topic. As I have said in *After Psychotherapy*, the solution to this is perhaps best found in restoring the requirement of a MD degree as a requirement for practice as a therapeut. In that case, the physician could earn a living practicing medicine while not charging a fee for dasein-therapy. The arrangement afforded ministers and priests, who are paid by a parish in order to support the individual cleric and sometimes his or her family, seems feasible, but there is no community of others to be served who tithe weekly in order to support their daseinsanalytic fellow human beings. This leaves only the option of "having a job"—a profession such as medicine or teaching—in order to support oneself while offering therapy as required.

A second, related problem is that of "training" requirements, institutes, certification and licensure of the therapeut. The calling of the cleric leads to seminary education and ordination, but there is no church of therapy and no ritual laying on of hands that is part of "becoming" a therapeut. The situation is very much as it was at the beginning of psychoanalysis before the Eitingon model or training was set up in Berlin. The becoming of a therapeut occurs during a process of mentorship, from one to the next. Something like Renaissance schole for painters comes to mind. There the master would kindly ask a would-be apprentice to move on. Or, like the original Therapeutae, for all but one day of the week they lived apart from each other. On the remaining day, they met, ate and talked. The title "clinical psychologist" is legally guarded. To date, "therapeut" is not.

WORKS CITED

1. APA. DSM-5 [2013]. (Washington: American Psychiatric Association, 2013).
2. Boss, M. [1971]. Existential Foundations of Medicine and Psychology (New York: Aronson, 1979).
3. Condrau, G. and M. Boss [1967]. "Existential Analysis," in B. Wolman (ed.),
4. Psychoanalytic Techniques (New York: Basic Books, 1967), pp. 443-467.
5. Groth, M. [2017]. After Psychotherapy (New York: ENI Press, 2017).
6. Laín Entralgo, P. [1958]. The Therapy of the Word in Classical Antiquity (New Haven: Yale University Press, 1970).
7. Laing, R.D. [1964]. "The Psychotherapeutic Experience," in The Politics of Experience (New York: Penguin), pp. 39-49.
8. Shandel, T. and K. Tougas [1989]. Did You Used to Be R.D. Laing? (Santa Monica: Direct Cinema, 2007 (DVD)
9. Shedler, J. [2018]. "Where Is the Evidence for 'Evidence-Based' Therapy?", in Psychiatric Clinics of North America 41, 2018, pp. 319–329.
10. Van den Berg, J. H. [1970]. "What Is Psychotherapy?," in Humanitas 7, 1971, pp. 321- 370.
11. Wedding, D. and R. [2019]. Current Psychotherapies [11th ed.] (Belmont: Cenage, 2019).
12. WHO. [2019]. ICD-10-CM (New York: Elsevier, 2019)

New York July 2018