Rediscovering Existential Psychotherapy:
The Contribution of Ludwig Binswanger

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Ludwig Binswanger, a founder of the existential school of psychiatry, attempted to apply philosophical ideas derived from Martin Heidegger, such as Heidegger's views on the mind-body problem, to the understanding and treatment of psychiatric patients. Binswanger also interpreted Heidegger's concept of the existing individual (Dasein) as Being-in-the-World, in the sense of seeking out the existential structure of individuals' lives. I discuss concrete clinical cases from Binswanger's work, along with a contemporary example of how to use these existential methods in psychiatric practice.

The "existential" school of psychiatry has three main branches, based on different aspects of its philosophical fathers. The first, based on Husserl, emphasizes the phenomenological reduction; Karl Jaspers worked in this tradition, which formed the mainstream of Continental psychiatry for decades. The second, resting on the early Heidegger, emphasized the existential structure of each individual's world; here Binswanger made his mark. The third, building on the late Heidegger, centered itself on the importance of authenticity for the understanding of persons; Sartre belonged to this approach, along with assorted others such as Laing and Erich Fromm (1).

Existential psychiatry, much in vogue three decades ago, is largely ignored today. Identified with extreme views, such as those of Szasz and Laing (2, 3), mainstream psychiatry has distanced itself from it. Yet, there is another tradition in existential psychiatry, developed through interpretations of the work of Martin Heidegger by the Swiss psychiatrist Ludwig Binswanger that focuses on the methods of phenomenology and should be useful to contemporary psychiatrists (4). Binswanger will be the source of the ideas presented here, since he wrote extensively, as a psychiatrist grounded in clinical work, on how to relate Heidegger's existential ideas to psychiatry. Contrary to his own protestations in his main philosophical text

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Being and Time (5), Heidegger took a keen interest in pursuing the psychiatric implications of his ideas. For over 16 years, Heidegger persistently tried to teach his ideas to medical students and young doctors in Boss' Zurich clinic. His student, Medard Boss (6), has provided a painfully truthful transcript including long delays with Boss' own exclamation points ('seven minutes delay!') in between profound Heideggerian questions met with complete silence. Binswanger tried to make Heidegger's ideas clinically relevant.

In this paper, I will discuss some of Heidegger's philosophical ideas, then demonstrate three of Binswanger's cases applying those ideas, and one of my own cases illustrating how this existential work can be attempted today.

I. HEIDEGGER'S PHILOSOPHY AND ITS RELATION TO PSYCHIATRY

For Binswanger, Heidegger's ideas, mainly as described in section one of *Being and Time,* provided an understanding of normal human psychology. One could not fully understand psychopathology, he thought, unless one first understood normal psychology. Freud failed to fulfill this role for Binswanger; he was too averse to explicit philosophizing. When *Being and Time* was published in 1927, Binswanger found a theory that fit his needs better.

Binswanger identified two aspects of Heidegger's thought which were particularly important for psychiatry. First, he felt that Heidegger could lead psychiatry beyond the mind-body problem and thus provide psychiatry with a tolerant overarching theory that could allow an integration of its different approaches, ranging from the biological to the psychoanalytic. Second, he believed that Heidegger's analysis of human existence, as "Being-in-the-World," provided a lodestar in reference to which abnormalities in mental illness could be understood. Binswanger felt that abnormal existential structures, or ways of Being-in-the-World, underlay the primary pathologies of mental illness, and provided the key to understanding their origins and treatment.

A. The Mind-Body Problem

Binswanger saw the mind-body problem as an artifact of most philosophical traditions before Heidegger, and he attributed the crisis of modern psychiatry to the ill effects of this philosophical heritage. Heidegger held that one could get beyond traditional problems in philosophy by engaging in analysis of being rather than logical arguments about knowing (7). In traditional philosophy, the problems of epistemology are central: how a subject can have knowledge about an object is a core feature of traditional

philosophy. The ontology that follows from this approach leads in the direction of common metaphysical controversies in the history of philosophy, e.g., subjective vs. objective realms of existence.

Heidegger sought to supersede this philosophical path by asking a different primary question (7). Instead of asking "How do we know?", he asked "What is the nature of Being?" or more precisely "What is the nature of our Being?" He wished to proceed by "concrete demonstrations" of the character of Being, rather than logical argument about the nature of knowledge. Thus, instead of emphasizing logical analysis, his philosophical method emphasized finding new words or definitions to describe the character of Being as "*Dasein.*" This term in Heidegger referred loosely to the being of humans, or, more precisely, anything which exists and "takes a stand" on its existence. In other words, *Dasein* asserts something about itself when it exists, such as the fact that it has this or that capability or engages in this or that activity. It is "being there," something which is present outside of itself ("there") in a way which allows it to recognize itself.

Heidegger's aim was to delineate the "pretheoretical" nature of the being of *Dasein*—what its characteristics are, what it depends on, before any cognitive appraisals it makes about itself or other things. This method was his attempt to start at a different beginhing point than traditional philosophy.

In his description of the being of *Dasein,* Heidegger discussed what *Dasein* finds in the world around it (7). *Dasein* does things; it acts in relationship to other things in the world. This is a primary characteristic of *Dasein.* Intentionality represents this characteristic of the "comportment" of *Dasein.* It is involved with other things and beings aronnd it. These other objects are either "available" for *Dasein* or they are "unavailable." They are available if *Dasein* makes use of them, "manipulates" them, in its activity; and when it does so, *Dasein* is not aware of its use of the objects; it is "absorbed" in the world. When, for some reason, the objects fail to perform the use *Dasein* makes of them, due to some "obstacle," they become unavailable, and then *Dasein* becomes aware of their independent existence outside of *Dasein.* Then *Dasein* faces them in the traditional subject-object relationship. *Dasein* "decontextualizes" them in order to understand what went wrong in its use of them. If *Dasein,* engaged in science, "recontextualizes" them in some model or theory, then the objects are "occurrent." If *Dasein* does not recontextualize them, and merely "stares" at them in curiosity, then the objects are "purely occurrent" and *Dasein* faces them in the extreme stand of "traditional philosophy of mind:" the isolated subject beholding the isolated object.

Heidegger holds that the primary relationship between *Dasein* and other objects is an "ontic transparency" where *Dasein* manipulates objects as "equipment" instead of thinking about them as independent objects. Thus, this primary relationship is ontological and not one consisting of mental states. In other words, the primary problem in epistemology and philosophy of mind, the relationship between subject and object, is pre-empted by an even more primary condition of existence, in which there is no distinction between *Dasein* and the world in which it is absorbed.

Binswanger felt that this approach, by bypassing the subject-object distinction altogether, also bypasses the mind-body problem (4). For psychiatry, this means that Heidegger provides a theoretical scope which can reveal why differing schools of thought only understand a part of the patient's experience and only partake of partial, rather than absolute, knowledge.

B. The Existential Structure of the Individual

Heidegger's second major contribution to psychiatry, as interpreted by Binswanger, was the concept of Being-in-the-World as a means of understanding the existential structure of each individual (4). For persons with mental illness, Binswanger argued, these existential structures differ from persons without mental illness (and even among persons without mental illness, all sorts of variation exists). It is these differences in existential structure which underlie the most primary differences of mental illness; everything else (symptoms and signs, biological changes, psychosocial aspects) follows from and is secondary to the changes in existential structure.

Binswanger interpreted Heidegger's conception of *Dasein* as Being-in-the-World as an "existential a priori," in a way, whose job it was to ground an individual in the characteristics of his life and his world of relationships and roles (4). If this structure of one's existence was in some way altered, due to biological or psychological reasons, then it could lay the basis for varied manifestations of mental illnesses. While Heidegger nowhere makes such explicitly clinical use of the concept of Being-in-the-World, this aspect of his thought is central to his contribution to Binswanger's theory and practice, as Needleman stresses in his introduction to Binswanger's writings (4). This core concept is most clearly described by Binswanger in his classic case studies.

It is interesting that Binswanger's adaptation of Heidegger avoids certain of Heidegger's ideas that would seem to have a direct relationship to psychology. For instance, Heidegger describes three attitudes that *Dasein*

can take towards its own being. 1. It can "fail to take a stand" on its being, so that it allows itself to be formed by "public interpretation." 2. It can "disown" its being, "actively identifying" with public social roles as a way of "fleeing its unsettledness." 3. It can "own up" to its own being, where social roles never become one's identity but merely ways of expressing *Dasein*'s "understanding of the groundlessness of its existence." Binswanger nowhere takes up these notions directly in his description of the theoretical contribution of Heidegger to psychiatry.

Neither does Binswanger make use of certain aspects of Heidegger's thought in Section II of *Being and Time,* which seem more readily applicable to psychology, such as *Dread of Death* and *Authenticity.* Instead, Binswanger sticks to a more limited reading of Heidegger's description in Section I of the ontic realities that *Dasein* faces and of the ontological underpinnings of *Dasein*'s experiences in the world.

2. PRACTICE: FOUR CASES OF EXISTENTIAL ANALYSIS

"Clearly, in the case of an applied phenomenologist, it is much more relevant to pay attention to what he does than what he says about phenomenology" (8).

Binswanger's best work is in his published clinical cases (9), where his allusions to theory are forced to face the concrete demands of patients.

Case 1: Freud's Patient

The first case (10) involves Binswanger's discussion of a patient treated by Bleuler and Freud for a "hysterical phobia." She was a 21-year-old woman "who at the age of five experienced a puzzling attack of anxiety and fainting when her heel got stuck in her skate and separated from her shoe." She continued to suffer such anxiety attacks afterwards "whenever a heel of one of her shoes appeared to loosen or when someone touched the heel." While accepting the "clear and convincing" psychoanalytic explanations of "birth fantasies" that led to her attacks, Binswanger asserts that her "predisposition" to such anxiety could be due to an abnormality of her existential structure, or "world-design," whereby she was overcommitted to "the category of continuity, of continuous connection and containment." He implies that whereas psychoanalysis analyzes the self's development, the real pathology is one layer behind at the level of the "world-design" or structure of existence.

> Where the world-design is narrowed and constricted to such a degree, the self, too, is constricted and prevented from maturing. Everything is supposed to stay as it was before. If, however, something new does happen and continuity is disrupted, it can only result in catastrophe, panic, anxiety attack. For then

> the world actually collapses, and nothing is left to hold it up. . . . The world must stop here, nothing must happen, nothing must change. The context must be preserved as it has always been. It is this type of temporal orientation that permits the element of *suddenness* to assume such enormous significance; because *suddenness* is the time quality that explodes continuity, hacks it and chops it to pieces, throws the earlier existence out of its course, and exposes it to the Dreadful, to the naked horror. This is what in psychopathology we term, in a most simplifying and summarizing manner, anxiety attack. (p. 204)

This is Binswanger at his most eloquent. His passion underlines the breadth of content left out of any abstract biological approach to what we would call today panic disorder. What makes the psychological symptoms possible, again in a Kantian transcendental a priori sense, is a certain existential structure that emphasizes continuity of space and time. It is this existential a priori, Binswanger explicitly argues, which transforms a minimally traumatic ice-skating incident into a pathological effect.

What are the clinical strategies implied by this analysis? Binswanger does not elaborate, but I would suggest that his perspective would impel the therapist to focus on the patient's need for continuous connection with others. In particular, a goal of psychotherapy would be to determine if indeed, as predicted by Binswanger, this patient's life was full of excessive reliance on interpersonal connections. If so, the patient would benefit from improved self-reliance, learning to be alone, and to accept a measure of interpersonal distance. Change would also be a subject of psychotherapeutic exploration. If indeed the patient's life appeared routinized excessively, the sources of this attitude could be explored, and a gradual shift toward spontaneity encouraged.

Case 2: Ilse

Ilse (11) was a thirty-nine-year-old woman who, after watching *Hamlet,* decided to force her father to treat her mother more kindly. She one day hit upon her method: as her father reproved her mother, she placed her arm into a hot oven and then exclaimed: "Look, this is to show you how much I love you!" Over the next few months, she was "vigorous, agile, energetic," and began to experience delusions of reference and, upon hospitalization, erotomania with the belief that her doctors were in love with her. In the course of her 13-month institutionalization, Ilse "passed through severe states of excitation with suicidal tendencies," and ultimately was discharged "completely cured of her acute psychosis." Today, we might have reason to doubt whether it was her doctors who "cured" her or nature, in what seems to be the duration of a rather typical manic-depressive episode. To analyze this case of what might today be called bipolar disorder, Binswanger

appears to rely on the notion of the existential a priori. His first comment is: "Much as war is described as a continuation of politics by different means, so in our case we could interpret Ilse's delusions as a continuation of her sacrifice, but by different means." His method again seems to be a Heideggerian take on Kant's transcendental method: given Ilse's delusions, what existential structure must exist in her that would allow such delusions to exist?

Binswanger's specific interpretation of Ilse's case is, to me, not particularly convincing: he discusses different stages in her life and interprets her actions and beliefs from her perspective of what was going on in these life-stages. What is most interesting to me is Binswanger's *method* rather than the content of his interpretations. His method, it seems to me, is an altogether original version of an "empathic" approach to psychosis. Binswanger is explicit about this. He emphasizes the need to live in the world of "*Mitsein,*" ("being-with"), where one becomes an equal, so to speak, of the person one is analyzing. Standing shoulder to shoulder in the *mitsein,* the person's world becomes intelligible as a series of "modes of being-together" (*Miteinandersein*); one would be tempted to call these modes of being-together the world of interpersonal relationships, but it may mean more; Binswanger is not overly clear about what he means here. What he says next, though, implies that he wishes to contrast this "being-together" approach to traditional types of empathy, such as in Karl Jaspers's work. Jaspers famously identified psychosis, in his *General Psychopathology* (12), as where empathy with the patient breaks down. That point, where the patient's world becomes unintelligible to the doctor, is the phenomenological boundary of psychosis, he asserts. Binswanger challenges this idea, without directly referring to Jaspers, and implies that it is an overly intellectualized approach to empathy. Empathy is not a matter of understanding ideas, it involves "being-together," i.e., understanding the existential structures that function in the *Mitsein* world of the psychotic person. Binswanger seems to proceed from this point in his discussion of the case to a direct extension of his criticism of Jaspers' approach, an approach which is similar to what is considered to be the mainstream "medical model" of "biological psychiatry" today. The psychiatrist, Binswanger says, is not too different in his approach than the "layman:" "He *judges* Ilse's sacrifice." The italics are Binswanger's, not mine, and he goes on to emphasize the evaluative, as opposed to the avowed descriptive, nature of the approach in traditional psychiatry:

> He (the psychiatrist) sees the complex and dramatic life-historical *phenomenon* of the sacrifice as an individual *event* 'in time' and 'in' a human being, he

> places it in the category of bizarre, absurd, or 'eccentric' acts . . . and lists the latter as a symptom of schizophrenia . . . But now we have to ask ourselves: what has happened here? . . . If we judge abnormal social behavior—a cultural fact—psychiatrically as a pathological phenomenon, we have left the area of purely biological judgment and entered the area of judgment of biological *purpose*. . . . Health and illness are value concepts . . . based on biological purpose. (Binswanger's italics) (p. 228–229)

The modern reader may hear echoes of Thomas Szasz in Binswanger's emphasis on the origin of psychiatric diagnosis in abnormal social behavior, and his implication that the movement from there to biological etiology may not be warranted. Further, he betrays a philosophy of medicine that is at odds with today's mainstream approach in psychiatry; instead of basing medicine on science, i.e., the empirical facts of normal and abnormal functioning, he bases medicine on ethics, on the value-judgments we make about our biological purpose. He may not be far off the track on this point, as K. W. M. Fulford recently has made a well-thought-out case that such a value-based approach to conceptions of health and illness may be the most philosophically sound approach (13). Binswanger goes on to assert that when a biological basis for a psychiatric symptom is asserted, nothing more is done than to "name" the "hidden," but "its being (*Sein*) or essence" is not revealed. So, it is worth noting, Binswanger advances an essentialism obviously at odds with the type of rigorous empiricism with which mainstream psychiatry identifies itself. But Binswanger seeks to build a bridge to the mainstream approach. While he denies that Ilse's specific delusions can, one by one, be identified with brain-phenomena, he does allow the following:

> The total form in which the life-historical theme is treated, the form of solution to the task which is posed by the theme, can be pathological and thus dependent on disturbances in the central organ . . . for it is not the 'brain' that thinks and treats a life-historical theme, but the 'man' (*der Mensch*). (pp. 230–231)

So, he seems to be saying that the altered existential structure, in a way, may be linked with brain pathology; Ilse's interpretation of the world as a place of sacrifices and love, as an existential theme, may be driven by some brain phenomena; but the details of her beliefs about this world are the product of her thinking self, not of stereotypic or static brain abnormalities. Binswanger concludes that Ilse's illness needs to be understood both as a disease and as a life-historical phenomenon. He refuses to take sides on this conflict between Wilhelm Dilthey's famously conflicting approaches of the natural sciences and the humanities (*Geisteswissenschaften*), because, he

thinks, the unity of mind and body preclude such divisions. This is where he uses Heidegger's approach to the mind-body problem clinically. Since the separation of mind and body is an artifact of science, the philosophical approach need not accept it, and existential analysis is based on this "philosophical insight." So Binswanger, in his characteristically eclectic fashion, uses the case of Ilse to describe how a traditional biological approach to "schizophrenia" could be combined with an existential approach which perceives the "life-historical phenomenon" at work in the patient's life. Allowing for the diagnostic inaccuracy of what was probably a case of bipolar disorder, one would have to say that Binswanger's claim in this case is not as radical as those of many later existential writers, like Szasz and R. D. Laing (2, 3).

Case 3: Ellen West

Except for the fact that the unfortunate Ellen West committed suicide, her story might be called the most compelling case history in the history of psychiatry (14). Ellen West was a walking test case of different psychiatric theories. She underwent two periods of psychoanalysis, was treated as an inpatient in a psychiatric hospital by Binswanger, and was consulted upon by the doyens of biological psychiatry, Emil Kraepelin and Eugen Bleuler. Perhaps so much expertise expended upon one person was bound to be dangerous.

Briefly, she was born of Jewish parents, with a strong family history of completed suicide, probable depression, and manic-depressive psychosis, according to Binswanger. From her childhood, she often seemed unhappy, "with days when everything seemed empty to her." At age 18, based on diary notes, Binswanger noted that she wanted "to gain fame, great, undying fame; after hundreds of years her name should still ring out on the lips of mankind." At age 20, she was extremely happy; "from her poems stream radiant joy of life, indeed wild ecstasy of life." She then falls into a deep depression, from which she will never completely recover until her death at age 33. Around age 21, she developed the other main pathology that never left her, "a dread of getting fat," coinciding with the end of a romantic relationship. Over the years, she alternated between bingeing on food and starving herself; she took long walks to burn her weight off; she abused thyroid pills and laxatives to control her weight. She fell in love with her cousin and married him at age 25. He remained supportive of her throughout her life. But she was obsessed with being thin, and, at the same time, distressed by this obsessive idea and wished that she could eat food normally.

Today, she would be diagnosed with bulimia nervosa, with possibly a brief period of anorexia as well, and her psychopathology would be discussed mainly in terms of the obsessive-compulsive phenomenology of those eating disorders. In Binswanger's day, "obsessive neurosis" indeed was her initial diagnosis, apparently provided by her first psychoanalyst, who saw her for six months at age 32. She stopped this analysis because she felt it was "useless," but resumed another one with a more "orthodox" Freudian, according to Binswanger, who apparently saw her for about a year. He seemed to be an imperious man, ignoring a period of one month when she made at least four serious suicide attempts by overdosing twice, trying to throw herself in front of a car, and ever attempting to jump out of her analyst's office. She then began to see an internist with common sense who felt she should be treated in a hospital. Her analyst disagreed. A consultation was arranged with the most famed clinician of the day, Emil Kraepelin, who diagnosed "melancholia" and recommended rest and treatment in a hospital. The analyst "considered this diagnosis incorrect" and continued outpatient psychoanalysis. Ellen's diary described her frustrations in the analysis despite an apparently sincere motivation to engage in it: "I wanted to get to know the unknown urges which were stronger than my reason and which forced me to shape my entire life in accordance with a guiding point of view . . . to be thin. The analysis was a disappointment. I analyzed with my mind, and everything remained theory. The wish to be thin remained unchanged in the center of my thinking." At one point, she apparently developed an erotic transference to the analyst, jumping on his lap and kissing him. She remained very ill with her (probable) bulimic and depressive symptoms. Ultimately, her internist prevailed upon her to be hospitalized and she ended the analysis after about one year. Binswanger treated her during her two-month long hospitalization at age 33, but essentially got nowhere. Attempts to reform Ellen's eating habits produced few results, and she became more and more suicidal. Surprisingly, however, Binswanger tellingly observed that she did not seem deeply despondent as in typical severe depression. "One has less the impression that she suffers under a genuine depressive affect than that she feels herself physically empty and dead, completely hollow, and suffers precisely from the fact that she cannot achieve affect." This perceptive comment is typical of what would today be called a characteristic dysphoric affect of borderline personality disorder or other personality disorders. Since she was held on an unlocked unit, but was becoming more and more suicidal, Binswanger recommended transfer to a locked unit. Ellen and her husband insisted on evidence that she would improve before agreeing to the transfer. Binswanger,

who had diagnosed "a progressive schizophrenic psychosis," could only offer a poor prognosis. One final consultation was made, with Eugen Bleuler and "a foreign psychiatrist" (perhaps an American?) "whose views were not too close to the Kraepelin-Bleuler theory of schizophrenia." Not surprisingly, Bleuler felt that "the presence of schizophrenia (was) indubitable." The other psychiatrist opined (probably rightly) that her overconcern with her weight did not represent a delusion (and thus did not represent a symptom of schizophrenia) but rather an "overvalent idea" or what today we would call an overvalued idea (one step short of an obsession); her symptoms were part of a "psychopathic constitution" (i.e., a personality disorder), he surmised. Neither held out any hope for a good prognosis. With that final word, she was discharged, and three days later, after one day of "a positively festive mood" and an uncharacteristically healthy appetite, she killed herself with poison.

Binswanger made a great effort to understand Ellen West's being-in-the-world using his new existential techniques. He began a discussion of her "*Eigenwelt,*" the "own world" of her subjective purely personal experience, compared with her "*Mitwelt,*" the "with world" of interpersonal relationships, and her "*Umwelt,*" the "surrounding world" of natural objects, including our bodies, existing independently of us (14). He held that Ellen West's mode of existence was marked by a withdrawal during childhood into her *Eigenwelt* from her *Umwelt* and her *Mitwelt.* "The *Eigenwelt* does not go trustingly over into the *Umwelt* and *Mitwelt,* to let itself be carried, nourished, and fulfilled by it, but separates itself sharply from it." She met a few failures in love and work as a young adult; Binswanger appears to mention these in passing, leaving the impression that they were common and unavoidable, part of Shakespeare's ubiquitous "slings and arrows of outrageous fortune." Yet, as a result of these expected setbacks, her interest in others in the *Mitwelt* began to shrink more and more. Soon her interest in her existence in terms of her future fell away, and her existence became more and more identified by her past, an unchanging remembrance of failures and unfulfilled wishes. "Her failure to realize 'the old plans and hopes' transforms the world into boundless desolation, soundless stillness, and icy cold, in which the *Eigenwelt* shrivels to an infinitely tiny point. Her soul is weary, the bells of death in her heart cannot be silenced." Thus her existence, spatially conceived, moved from being a line pointing toward the future to a circle imprisoned in the past. By her early twenties, her existence was held up in this "vicious circle" which she would never break until the end of her life. Thus, at the age of 21, her existential development had ended, just as her psychopathological symptoms would begin.

> The dread of becoming fat . . . with which the true illness in the psychiatric sense manifests itself, has thus to be seen anthropologically not as a beginning but as an end. It is the end of the encirclement process of the entire existence, so that it is no longer open for its existential possibilities . . . Existence now gets hemmed in more and more, confined to a steadily diminishing circle of narrowly defined possibilities, for which the wish to be thin and the dread of getting fat represent merely the definitive (psychophysical) garb. The way of the life-history is now unmistakably prescribed: it no longer runs into the expanse of the future but moves in a circle. The preponderance of the future is now replaced by supremacy of the past. All that remains are the fruitless attempts at escaping from this circle. (p. 281)

The fundamental existential structure of her life was set, and her future was preordained by it. The onset of her bulimic symptoms were merely an expression of her constricted circular mode of existence. The irrelevance of the *Mitwelt* and *Umwelt* was symbolized by her fixation on her "bodily *Eigenwelt,*" of her eating habits. Her particular symptoms were an expression of her existential pathology.

> The dread of becoming fat has revealed itself as a concretization of a severe existential dread, the dread of the 'degenerating life,' of withering, drying up, moldering, rotting, becoming a husk, eroding, being buried alive, whereby the world of the self becomes a tomb, a mere hole. (p. 349)

As she focused more and more on food, the existential structure of her life developed into a process of being-in-a-hole, the hole of her unfulfilled need for food, rather than a process of being-for-others in the *Mitwelt* and being-for-herself in an authentic *Eigenwelt.* "In this world design the multiplicity and multiformity of the world are reduced to the forms of the hole. The form of being in such a world is that of being confined or oppressed; the self which designs such a world is an 'empty' self, concerned only with the filling of the emptiness."

Ultimately, she showed her one moment of authentic existence when, paradoxically, she ended her physical existence. For when she died of her own volition, she broke the circle of existence that imprisoned her for the first (and last) time. Binswanger seemed to approve rather explicitly of her suicide in this way. She was already dead, he asserted, existentially dead, since her early twenties when her being-in-the-world was distorted into that vicious circle. The rest of her life was a mere waiting for her physical death. Like a chronologically old person, who looks upon death as a welcome deliverance after becoming gradually more and more detached from "the needs of life," the "young . . . Ellen West had already become old." She had aged existentially very rapidly, and was "ripe for death," and finally she

hastened herself what nature would not speed up. "The suicide is the necessary voluntary consequence of this existential state of things." In that moment, she reconciled herself with her mode of existence; since it took death for her to reach such harmony of life, her story was a tragedy. "The festival of death was the festival of the birth of her existence. But where the existence can exist only by relinquishing life, there the existence is a tragic existence." Binswanger refused to pass judgment on her, or to assume that continued life would have been better or more right for her (although he speculated that she possibly might have recovered somewhat had electroconvulsive therapy been available at that time). He wished to understand her way of Being-in-the-World, and he did so by recognizing her death as in some way necessary. "Life and death are not opposites . . . death too must be lived . . . life is 'encompassed' by death."

Case 4: Jenny

I will present a fourth and final case from my own clinical experience. Jenny was a 29-year-old woman, clinically depressed in a modern sense, with chronic depressed mood, difficulty with sleep, decreased energy and interest, and increased appetite. She had chronic suicidal thoughts which waxed and waned. She also had brief periods of euphoria, with decreased need for sleep, racing thoughts, and increased talkativeness. She had been diagnosed with severe depression and later bipolar disorder, but medications failed to help. Life was bleak, miserable, endless. She lived alone; her mother moved away after many years of trying to help her. Despite living in her hometown, she had no friends left. I asked Binswanger's question: What was the existential structure in her make-up that allowed her depression to persist and worsen? We might allow a biological etiology (in her *Umwelt*), but the existential question is separate: What was it like *being* her? And how did that influence her depression? I sat with her, trying to be with her in her *Mitwelt,* and attempting to see the world from her view. I felt the extreme loneliness and the unending sameness of her life. Any change, even death, seemed preferable. I focused on maintaining the therapy relationship at least, and I saw that she needed to break through the solitude of her *Mitwelt.* Anything would be welcome, including living in a halfway house, volunteering, seeking out new friends in part-time attendance at school. All these ideas came to me with urgency, but not to her, and when suggested, were rebuffed. With time, I realized that she, paradoxically, felt safe in her aloneness; at least it was familiar. She seemed trapped, and so did I. This existential wish to be alone, though perhaps initiated by her depression, had taken on an apparent life of its own. She

believed that nothing else was possible for her. Our therapy was difficult and continued along the lines of trying to break the grip of this existential structure on her life.

CONCLUSIONS

Binswanger deserves a number of distinctions for his contributions. He was the first to systematically apply Heidegger's ideas to clinical psychopathology. He was original and independent-minded, not allowing himself to be bound by niceties of orthodox interpretation of the philosopher. He was adept at psychoanalysis and more descriptive clinical approaches to his cases as well. In his cases, he was at his most brilliant, providing rich material in which he tried to concretize the application of existentialist ideas to human psychology. His biggest weakness, it seems to me, was a certain intellectual sloppiness, marked by his overly eclectic use of different ideas that, in retrospect, seem little related.

There are crimes of passion and crimes of logic, Camus once wrote, and the border between the two is not always clear. While Binswanger may have committed misdemeanors of logic, he committed no crimes. If anything, he was too wary of commitments of any kind to expose himself to such criticism. Binswanger was passionate about understanding something more about persons with psychiatric symptoms than most orthodoxies would admit. Contemporary psychiatry would likely benefit from reexamining some of his ideas.

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