

Psychiatry and Man's Quest for Meaning

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MORE AND MORE a psychiatrist today is confronted with a new type of patient, a new class of neurosis, a new sort of suffering the most remarkable characteristic of which is the fact that it does not represent a disease in the proper sense of the term. This phenomenon has brought about a change in the function—or should I say mission?—of present-day psychiatry. In such cases, the traditional techniques of treatment available to the psychiatrist prove themselves to be less and less applicable.

More specifically, I have called this phenomenon, which the psychiatrist now has to deal with so frequently, “the existential vacuum.” (1, p. 99) What I mean thereby is the experience of a total lack, or loss, of an ultimate meaning to one's existence that would make life worth while. The consequent void, the state of inner emptiness, is at present one of the major challenges to psychiatry. In the conceptual framework of logotherapeutic teaching, that phenomenon is also referred to as “existential frustration,” or the frustration of “the will to meaning.”

By the latter concept, logotherapy denotes what it regards as the most fundamental motivational force in man. Freudian psychoanalysis centers its motivational theory on the pleasure principle¹ or, as one might call it, the “will to pleasure,” whereas Adlerian individual psychology focuses on what is generally called the will to power. In contrast to both theories, logotherapy considers man to be primarily motivated by a groping for a meaning to his existence, by the striving to fulfill this meaning and thereby to actualize as many value potentialities as possible. In short, man is motivated by the will to meaning.

In former days, people frustrated in their will to meaning would probably have turned to a pastor, priest, or rabbi. Today, they crowd

¹ According to Freud's own statement, the reality principle is nothing but an extension of, and ultimately operates in the service of, the pleasure principle.

clinics and offices. The psychiatrist, then, frequently finds himself in an embarrassing situation, for he now is confronted with human problems rather than with specific clinical symptoms. Man's search for a meaning is not pathological, but rather the surest sign of being truly human. Even if this search is frustrated, it cannot be considered a sign of disease. It is spiritual distress, not mental disease.

How should the clinician respond to this challenge? Traditionally, he is not prepared to cope with this situation in any but medical terms. Thus he is forced to conceive of the problem as something pathological. Furthermore, he induces his patient to interpret his plight as a sickness to be cured rather than as a challenge to be met. By so doing, the doctor robs the patient of the potential fruits of his spiritual struggle.

The doctor should not let himself be seduced by the still prevalent reductionism into devaluating man's concern for meaning and values to "nothing but" a defense mechanism, a reaction formation, or a rationalization. The "nothing-but-ness" of human phenomena is indeed one of the foremost features in the reductionist image of man. But would it be wise to base therapy on, or even to start therapy with, Freud's assumption, for example, that philosophy is "nothing more" than a form of sublimation of repressed sexuality? (2, p. 9) A sound philosophy of life, I think, may be the most valuable asset for a psychiatrist to have when he is treating a patient in ultimate despair. Instead of stubbornly trying to reduce meaning and values to their alleged psychodynamic roots, or to deduce them from psychogenetic sources, the psychiatrist should take these phenomena at face value rather than press them into the Procrustean bed of preconceived ideas regarding their function and origin. Preserving the humanness of human phenomena is precisely what the phenomenological approach, as propounded by Husserl and Scheler, has attempted to do.

Certainly both the meaning of human existence and man's will to meaning are accessible only through an approach that goes beyond the plane of merely psychodynamic and psychogenetic data. We must enter, or better, we must follow man into the dimension of the specifically human phenomena that is the spiritual dimension of being. To avoid a confusion arising from the fact that the term "spiritual" usually has a religious connotation in English, I prefer to speak of noëtic in contrast to psychic phenomena and the noölogical in contrast to the psychological dimension. The noölogical dimension is to be defined as that dimension in which the specifically human phenomena are located.

Through a merely psychological analysis, the human phenomena are, as it were, taken out of the noölogical space and levelled down into the psychological plane. Such a procedure is called psychologism.² It entails no less than the loss of a whole dimension. Moreover, what is lost is the dimension that allows man to emerge and rise above the level of the biological and psychological foundations of his existence. This is an important issue, for transcending these foundations and thereby transcending oneself signifies the very act of existing. Self-transcendence, I would say, is the essence of existence, which in turn means the specifically human mode of being. To the extent to which this mode of being exceeds the psychological frame of reference, the appropriate and adequate approach to existence is not psychological, but existential.

This holds true even for therapy. Logotherapy is that psychotherapy centering on life's meaning as well as man's search for this meaning. In fact, *logos* means "meaning." However, it also means "spirit." And logotherapy takes the spiritual or noölogical dimension fully into account. In this way, logotherapy is also enabled to realize—and to utilize—the intrinsic difference between the noëtic and psychic aspects of man. Despite this ontological difference between the noëtic and psychic, between spirit and mind, the anthropological wholeness and unity is not only maintained by our multi-dimensional concept of man, but even supported. Speaking of man in terms of his spiritual, mental, and bodily levels, or layers, may well prompt one to assume that each of these aspects can be separated from the others. Nobody, however, can claim that viewing a human being in his manifold dimensions would destroy the wholeness and unity inherent in man.

There is a practical implication involved in our "dimensional ontology." I refer to the specific capacity of man to detach himself from himself. Through the emergence into the noölogical dimension, man becomes able to detach himself from his psychological condition. This specifically human capacity for self-detachment is mobilized by logotherapy particularly against pathological events within the psychological dimension, such as neurotic and psychotic symptoms. In spite of the emphasis that it places upon responsibility as an essential quality of being human, logotherapy is far from holding man responsible for psychotic, or even neurotic, symptoms. However, it does hold him account-

² Insofar as psychoanalysis is more or less linked to abnormal phenomena such as neuroses and psychoses, the spiritual aspirations of man are likely to be dealt with not only in psychological but also in pathological terms. Thus the pitfall of psychologism is increased by the fallacy that I have termed "pathologism."

able for his *attitude* toward these symptoms. For it regards man as *free and* responsible and considers this freedom not to be freedom from conditions, but rather freedom to take a stand, to choose a stand toward conditions. What is called paradoxical intention (3) is a logotherapeutic technique designed to make use of the human capacity for noö-psychic detachment.

A multi-dimensional view enables us to avoid not only psychologism, but also noölogism. Spiritualism is no less a one-sided world view than materialism. Monism, be it spiritual or material, does not so much disclose the alleged oneness of the world as it betrays the one-sidedness of its own view.

An example of flagrant noölogism would be the contention by some psychiatrists that a patient suffering from endogenous depression not only feels guilty, but really is guilty, "existentially guilty," and hence depressed. I regard endogenous depression as somatogenic rather than noögenic—not even psychogenic—in origin. This somatogenic psychosis in turn engenders an abnormal awareness of the guilt that is normally linked to the "human condition." One could compare this to a reef that emerges during low tide. Yet no one could claim that the reef causes the low tide. Likewise, the guilt has not caused the psychotic depression but, on the contrary, the depression—an emotional low tide, as it were—has caused the guilt to be felt so acutely. But imagine the potential effect of confronting the psychotic patient with such a spiritualistic, even moralistic, interpretation of his illness in terms of "existential guilt." It just would offer additional content to the patient's pathological tendency toward self-accusations, and suicide might well be his response.

In itself, the existential vacuum is not anything pathological. Nonetheless, it may eventuate in a neurotic illness for which logotherapy has coined the term "noögenic neurosis." This neurosis is not the result of instinctual conflicts or clashes between the claims of ego, id, and superego, but rather the effect of spiritual problems and existential frustration. What is required in such cases is a psychotherapy that focuses on both spirit and meaning—i.e., logotherapy. However, logotherapy, as a psychotherapeutic approach and procedure, is also applicable in psychogenic, and even somatogenic, neuroses. As an example of the latter, hyperthyroidism brings about an inclination to anxiety states (4, p. 205) to which the patient often responds in terms of what is called "anticipatory anxiety." That is to say, he is afraid of the recurrence of anxiety, and the very expectation of such an attack precipitates it again and again.

Increasingly, the patient is thus caught in a feedback mechanism that becomes established between the primary somatic condition and the secondary psychic reaction. This vicious circle must be attacked on its somatic as well as its psychic side. In order to achieve the latter, one must use logotherapy, more specifically paradoxical intention (3), which "takes the wind out of the sails" of anticipatory anxiety, while tranquilizing drugs accomplish the other requirement: namely, to remove the somatic foundation and basis of the whole disorder. According to the observation of the author, mild hyperthyroidism frequently results in agoraphobias just as masked tetany does in claustrophobias. And it happens that the first tranquilizer ever brought out on the European continent (it was developed by the author as early as 1952, even before the "march to Miltown" had begun) has proved itself to be the most effective drug treatment of choice in cases of somatogenic phobias.

Again and again, however, it turns out that the feedback mechanism called anticipatory anxiety thrives in the existential vacuum. Filling this vacuum prevents the patient from having a relapse. Re-focusing him on meaning and purpose and de-centering him away from obsession and compulsion cause these symptoms to atrophy. In such cases, the source of pathology is psychological or even biological; but the resource of therapy, the therapeutic agent, is noölogical. As Edith Joelson puts it, "Logotherapy can also be used as non-specific therapy, i.e., neuroses which are caused by psychosexual disturbances during childhood can be relieved by spiritual therapy during adulthood." (5)

We do not regard logotherapy as a specific therapy in every case. That is why in psychogenic neuroses logotherapy serves as a supplement to, rather than a substitute for, psychotherapy in the usual sense of the word. The question arises whether or not therapies that are considered specific really are so. As for psychoanalysis, Joseph Wolpe recently presented "a survey of follow-up studies comprising 249 patients whose neurotic symptoms have either ceased or improved markedly after psychotherapy of various kinds other than psychoanalysis [which] shows only 4 relapses (1.6%)." Wolpe concluded that "this evidence contradicts the psychoanalytic expectation of inferior durability of recoveries obtained without psychoanalysis and does away with the chief reason for regarding analysis as the treatment of choice for neurotic suffering." "In other words," he adds, "what psychoanalytic theory holds to be necessary for enduring recovery is in fact not necessary. Does this imply that what the theory proposes as the basis of neurosis is in fact not

the basis?" (6) At least, I should say, it has been demonstrated that psychoanalysis is not as specific as the psychoanalysts think it is. It has been pointed out for some time by many writers in the field that one and the same case allows a variety of theoretical interpretations. Different techniques based upon these interpretations, however, obtain the same therapeutic results. What is important, apparently, is the human relationship between the doctor and the patient. The personal encounter or, in Jaspers' term, the "existential communication" seems to matter. "The warm, subjective, human encounter of two persons," Carl R. Rogers says, "is more effective in facilitating change than is the most precise set of techniques growing out of learning theory or operant conditioning." (7, p. 93) In another place, Rogers states: "Personality change is initiated by attitudes which exist in the therapist, rather than primarily by his knowledge, his theories, or his techniques. . . . It may be a new way of experiencing, experiencing in a more immediate, more fluid way, with more acceptance which is the essential characteristic of therapeutic change, rather than, for example, the gaining of insight or the working through of the transference relationship, or the change in the self-concept." (8)

The degree to which the encounter between the doctor and the patient may be working, even without the slightest investment of any technique, may be illustrated by the following experience. Once, an American girl, a student of music, came to see me in Vienna to be analyzed. As she spoke a terrible slang of which I could not understand a word, I tried to turn her over to an American physician in order to have him find out for me what had motivated her to seek my advice. She did not consult him, however, and when we happened to meet each other on the street, she explained: "See, Doctor, as soon as I had spoken to you of my problem, I felt such a relief that I didn't need help any longer." So I do not know even now for what reason she had come to me.

This was an instance of an extremely nontechnological approach. The story should be complemented, however, by another one that is an example of an extremely technological procedure. In 1941, I was called one morning by the Gestapo and ordered to come to headquarters. I went there in the expectation of being immediately taken to a concentration camp. A Gestapo man was waiting for me in one of the offices; he started involving me in a cross-examination. But soon he changed the subject and began to question me on topics such as: What is psychotherapy? What is a neurosis? How would one have to treat a case of

phobia? Then he began to elaborate on a specific case—the case of “his friend.” Meanwhile, I had guessed that it was his own case that he wished to discuss with me. I started short-term therapy in an extremely nonpersonal way, namely, by advising him to tell “his friend” that he should do thus and so in case anxiety cropped up. This therapeutic session was not based on an I-thou relation, but rather on one of I-he. At any rate, the Gestapo man kept me for hours, and I continued treating him in this indirect manner. The effect of the short-term therapy can hardly be evaluated. As for my family and myself, it was life-saving for the time being, for we were permitted to stay in Vienna for a year before being sent to a concentration camp.

Apart from such exceptional situations, the two extremes, encounter and technique, seem to be a matter of theoretical importance only. Live practice hovers *between* the extreme poles. Neither should be looked upon contemptuously or disparagingly.

First of all, one should not make one extreme the battlefield of the other, i.e., make encounter a battlefield of technique. Technique, by its very nature, tends to reify whatever it touches. As far as the partners of a therapeutic relationship are concerned, man is seen as one thing among other things, as a *res*. To be sure, it is fashionable to blame Descartes for the dichotomy between *res extensa* and *res cogitans*. But I think he should have gone further than he did. He should have denied to man not only the attribute *extensa*, but also that of *res*.

Worshipping technique at the expense of encounter involves making man not only a mere thing, but also a mere means to an end. According to the second version of Kant’s categorical imperative, no man should ever be taken as a mere means to an end. I doubt whether there is any realm in which the difference between indulging in, or refraining from, rendering man a mere means to an end is more crucial than it is in the case of politics. I dare say that the most important distinction in politics is the one between the sort of politician who believes that the end justifies the means and the kind who understands that there are means that would desecrate even the most sacred end.

Seeing in man a mere means to an end is the same as manipulating him. Referring to the issue at hand, i.e., encounter falling prey to technique, we should listen to the warning voice of Rudolf Dreikurs when he says that “the assumption of transference as the basic therapeutic agent puts the therapist in a superior position, manipulating the patient according to his training and therapeutic schemes.” (9)

It is true that at the McGill Conference on Depression and Allied States, which took place in Montreal, "a number of speakers pointed out the great danger, inherent in shock treatment and drug treatment, that the medical management may become mechanized and the patient cease to be regarded as a person." I think the danger is not so much inherent in shock treatment or drug treatment in themselves as it is in the extremely technological attitude by which so many therapists are dominated. I think the danger is even greater in the field of psychotherapy than in that of shock treatment or drug treatment.

Second, even if the personal character of encounter is preserved, the I-thou relation should not be regarded as a closed system. Karl Buhler, in his theory of language, distinguishes among three aspects. From the viewpoint of the one who speaks, language is expression; from that of the person to whom the speaker addresses himself, language is appeal; and from the viewpoint of the subject matter of which one speaks, language is presentation. It is the third aspect, I should say, that is overlooked whenever one forgets that the therapeutic relationship is not yet exhaustively characterized by the concept of encounter between two subjects, but rather hinges on the object with which one subject is confronting the other. This object is usually a fact of which the patient is to become aware. What in particular he should be made conscious of is the fact that there is a meaning waiting to be fulfilled by him. Thus the therapeutic relationship is opened, as it were, to a world. The world, however, is to be considered assignment and challenge.

It is a tenet of logotherapy that transcendence is the essence of existence. What is meant by this tenet is that existence is authentic only to the extent to which it points to something that is *not* itself. Being human cannot be its own meaning. It has been said that man must never be taken as a means to an end. Is this to imply that he is an end in itself, that he is intended and destined to realize and actualize himself? Man, I should say, realizes and actualizes values. He finds himself only to the extent to which he loses himself in the first place, be it for the sake of something or somebody, for the sake of a cause or a fellow-man, or "for God's sake." Man's struggle for his self and identity is doomed to failure unless it is enacted as dedication and devotion to something beyond his self, to something above his self. As Jaspers puts it, "What man is, he becomes through that cause which he has made his own."

Human being fades away unless it commits itself to some freely chosen meaning. The emphasis lies on free choice. An outstanding Amer-

ican psychoanalyst reported after his trip to Moscow that behind the Iron Curtain people were less neurotic because they had more tasks to fulfill. When I was invited to read a paper before the psychiatrists of Krakow, I referred to this report, but remarked that even though the West might well confront man with fewer tasks than does the East, it leaves to him the freedom to choose among the tasks. If this freedom is denied to him, he becomes a cogwheel that has a function to carry out, but no opportunity to choose it.

A psychotherapy that confronts man with meaning and purpose is likely to be criticized as demanding too much of the patient. Actually, however, man of today is less endangered and threatened by being over-demanded than by being underdemanded. There is not only a pathology of stress, but also a pathology of the *absence* of tension. And what we have to fear in an age of existential frustration is not so much tension per se as it is the *lack* of tension that is created by the loss of meaning. I deem it a dangerous misconception of mental health that what man needs in the first place is homeostasis *à tout prix*. What man really needs is a sound amount of tension aroused by the challenge of a meaning he has to fulfill. This tension is inherent in being human and hence indispensable for mental well-being. What I call noödyamics is the dynamics in a field of tension whose poles are represented by man and the meaning that beckons him. By noödyamics man's life is put in order and structure like iron filings in a magnetic field of force. In contrast to psychodynamics, noödyamics leaves to man the freedom to choose between fulfilling or declining the meaning that awaits him.

Theodore A. Kotchen explored the relation of the concept of meaning to mental health by constructing a questionnaire and administering it to mental patients and to nonpsychiatric control groups. The results gave empirical validity to a conception of mental health as offered by "logotherapy, or any other variety" of existential analysis: a mind is healthy when it has achieved a sufficient store of "meaning." (10)

In 1899, James Jackson Putnam lectured to the Massachusetts Medical Society on "Not the Disease Only, But Also the Man." What is meant by this title is, in my opinion, that the doctor should treat the disease plus the patient's *attitude* toward it. Through the right attitude, unavoidable suffering is transmuted into a heroic and victorious achievement. That is why life does not lack a meaning until the last breath, until a man's death. Even through death, however, life does not lose its meaning; for this meaning does not consist in preserving anything for

the future, but rather storing it in the past. Therein it is saved forever.

By giving unavoidable suffering the status of a positive value, Edith Joelson states, logotherapy may help counteract unhealthy trends in the present-day culture of the United States, where the incurable sufferer is given very little opportunity to be proud of his suffering and to consider it ennobling rather than degrading. "Thus," she writes, "the burden of the unhappy is increased, since he is not only unhappy, but also ashamed of being unhappy." (5)

"Another aspect of logotherapeutic philosophy pertains to the conception of time," Edith Joelson concludes. "The past of an individual is seen, as it were, as a store-house of everything he has brought into existence, of safely and immutably materialized possibilities, while the future consists of opportunities yet to be materialized. Thus, the past of an individual is the part of his life in which he has overcome transiency and achieved eternity. Such a positive evaluation of the past may counteract the fear of aging and death to a certain extent and it may counterbalance the discomfort of middle-aged or old people in cultures, such as that of the United States, which stress the value of youth. Especially in the treatment of climacteric disturbances such philosophic considerations might be helpful." (5)

However, the ultimate meaning of man's life is no more a matter of his intellectual cognition, but rather the matter of his existential commitment. It exceeds and surpasses the intellectual capacity of a finite being such as man. Through his personal religion, man takes a stand and makes a choice. When a patient stands on the firm ground of religious belief, it is legitimate to draw upon his religious convictions, and there can be no objection to making use of the therapeutic effect of these spiritual resources.

So I did, for instance, when once a rabbi turned to me and told me his story. He had lost his first wife and their six children in the concentration camp of Auschwitz, where they were gassed, and now, it turned out that his second wife was sterile. I observed that procreation is not the only meaning in life, for if it were, life in itself would become meaningless, and something that in itself is meaningless cannot be rendered meaningful merely by its perpetuation. However, the rabbi evaluated his plight as an orthodox Jew. He despaired because there was no son of his own who would ever say Kaddish for him after his death. But I would not give up. I made a last attempt to help him by inquiring whether he did not hope to see his children again in Heaven. My question pro-

duced an outburst of tears, and now the true reason for his despair came to the fore: he explained that his children, since they died as innocent martyrs,³ were thus found worthy of the highest place in Heaven; but he, an old, sinful man, could not expect to be assigned the same place. Once more I did not give up, but retorted, "Is it not conceivable, Rabbi, that precisely this was the meaning of your surviving your children; that you may be purified through these years of suffering, so that finally you, too, though not innocent like your children, may *become* worthy of joining them in Heaven? Is it not written in the Psalms that God preserves all your tears?"⁴ So perhaps your sufferings were not in vain." For the first time in many years, he found relief by seeing his suffering in the new light I had cast upon it through having him re-evaluate it in his own terms.

An appropriate and adequate theory of man must follow him into the dimension of the specifically human phenomena that is the noölogical dimension of being. But it would be fragmentary if it did not recognize the essential openness of human existence to the next higher dimension. A human being, it is true, is a finite being. However, to the extent to which he understands his finiteness, he also overcomes it.

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³ L'kiddush hashem, i.e., for the sanctification of God's name.

⁴ "Thou hast kept count of my tossings; put thou my tears in thy bottle! Are they not in thy book?" (Psalm 56:8)