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This chapter is from anthropologist Tanya Luhrmann's recent book *Of Two Minds* (Knopf, 2000). Dr. Luhrmann spent an extended period at the Austen Riggs Center studying the way we work clinically. She uses a substitute name (the Norton Inn) in this piece, and describes in brilliant detail the process of working with patients at Riggs.

A Psychodynamic Hospital

From a psychodynamic perspective, a patient is ill because he has learned to interpret and respond to other people in maladaptive ways. (At least, that is part of his problem. These days, most psychodynamically oriented psychiatrists acknowledge that there is also a biological vulnerability.) One helps him by helping him to be aware of those unconscious patterns. But because all people, including psychoanalytically trained staff, are limited by their own unconscious, no one person can be an authority on what is going on with any other. No one can state definitively what is a mental illness and what is not. That is the problem. You need to identify what is maladaptive in the patient's unconscious to help the patient cope, but you cannot know clearly whether you are seeing the patient's craziness or whether you are looking at the patient through your own craziness. To understand patients, the staff on a psychodynamic unit talk about how they perceive the patients, how they perceive one another, and how they perceive one another perceiving the patients far more openly and exhaustively than in any other setting I have ever seen. But because none of these comments about the people one works with intimately are objective and most are personal, the emotional temperature of such a community can run rather high. Most psychoanalytic encounters take place behind closed doors, within confidentiality, with a person the patient will never see outside the session. Once the psychoanalytic context broadens to include the office, the cafeteria, and the assembly hall, a certain kind of public cul-ture emerges to keep the potential chaos in check.

The Norton Inn is a small psychodynamic hospital in western Virginia, widely thought to be among the best of its kind and certainly among the last, a determined tortoise in a world of eager hares. It has the feel of something that belonged to a different generation but has not outlived its usefulness, like an old and beloved desk. When I arrived for two weeks in 1995, there were somewhat more than forty patients. They stayed in a large white colonial building called the "Inn," or in smaller, porch-wrapped clapboard houses within easy walking distance. Next to the Inn there was another elegant building, which housed the staff offices and the conference rooms. This twin building used to be called the Medical Office Building, but after the new director arrived to help the hospital face the changing health care world, he added the phrase "and Administration" to the small green sign on the front lawn. He felt that this was only fair. That year, for the first time in many years, the hospital settled its accounts in the black.

This was an open hospital. It is harder now than it would have been twenty years ago to convey the sense of what this means. Twenty years ago, there were many open units. Now almost all psychiatric inpatient settings are locked. Patients are escorted onto psychiatric units, the doors are locked behind them, and over their stay privileges are doled out to them that hinge on the locked door: going out to smoke, going to the cafeteria to eat, and so forth.

In an open hospital, there are no privileges, no seclusion rooms, no security guards to wrestle an out-of-control patient to the ground and place him in restraints. In an open hospital, patients come and go as they please. In the grand hallway of the old colonial Inn, the door swung free. Patients went out for walks, to work out at the local gym, to see their therapist, to see friends. Occasionally, they went out into the woods to hang themselves. That is the danger of an open hospital, and one reason that more hospital units are locked these days than in earlier decades is to deflect insurance companies' argument that if the patient isn't sick enough to need a locked door, he isn't sick enough to need a psychiatric admission. This hospital, however, argued that the locked door was infantilizing, demeaning, and ultimately counterproductive to the psychiatric treatment, because the ultimate goal was to enable people to feel responsible for their lives. It is hard, one staff member remarked to me, to feel in charge of yourself in prison. Most of the patients in the hospital had been admitted first onto a locked psychiatric unit somewhere else, and most had found the experience humiliating. Nevertheless, the admitting physician at this hospital had to explain to a potential patient (and, often, the family) before admission that he or she had to take responsibility for staying alive and would be admitted only if he or she took that responsibility, despite the fact that many patients are suicidal when admitted. Suicide threats are only occasionally theatrical. Fifteen percent of depressed patients eventually kill themselves. The day I left, the hospital admitted a woman with a bright pink scar on her throat that ran from ear to chin: she had sliced into her carotid artery because she had had thoughts, she said, of shooting her children.

Some patients had been at the hospital for years. Many of the staff looked back nostalgically to the times when all patients were expected to stay at least a year. When I was there, the average length of treatment was about eight months, although usually that figure included many months when patients would stay near the hospital for partial care but would not receive "hospital-level" care, in which all needs are provided for and nursing care is always available. The hospital had developed a variety of less expensive "step-down" residential and outpatient programs, in which patients took more or less responsibility for their food, housing, and self-care but could still participate in most of the hospital activities, such as community meetings and other group meetings. Insurance would invariably pay for some of this, and the hospital was, compared to others, cheaper both for full care and for step-down care. Once, the director said, an insurance company had sent the hospital a letter of thanks for the (relatively) low cost of its treatment of a patient who had bounced from inpatient unit to inpa-

tient unit in the years previous to her Norton admission and afterward had not needed readmission. Her year at Norton had cost significantly less than her previous year of revolving-door hospitalizations. Most patients at the Norton Inn had "failed" treatment elsewhere, by which is meant that multiple hospitalizations, medications, and psychiatrists hadn't really helped. Some of the insurance companies would pay for a longer-than-average stay for these patients out of desperation, in the hope that one long stay would "stabilize" the patient and enable him to function as an outpatient. (A five-day inpatient admission can cost \$ 5,000. Multiple short admissions become extremely costly.) But many of the patients and their families would pay directly out of their own pocket bills that were more than \$ 20,000 for the first month of hospitalization and evaluation, then sank as low as \$ 9,000 per month for residential care, and \$ 2,700 for after care, but not lower.

These costs, the open-door policy, and the reputation the place had for tertiary care meant that the patients were mostly upper middle class, very smart, and young, often under thirty. They were (for example) Yale students and Columbia medical residents who had arrived at school, done well, then fallen apart. Most of them—roughly 70 percent—were women. Why there were so many women no one seemed to know, although it is a psychiatric cliché that disturbed men tend to act out their aggression on others and end up in jail, whereas disturbed women tend to act out on themselves—slash their wrists, take overdoses—and end up hospitalized. Most of the patients were depressed or bipolar (or had some kind of mood disorder) and also had personality disorders. A few were psychologically minded patients with schizophrenia. That the patients also had personality disorders is not surprising. An uncomplicated, "easy" depression or manic state can be treated well in a short admission that "brings down" the mania or "relieves" the depressive suicidality with medication. This is not the case if the patient also has a personality disorder, which a course of antidepressants will barely impact. Those were the patients who ended up in this hospital. Mostly, their personality disorder was of the type called "borderline": as before, women with a history of intense but unstable relationships, deep identity confusion, and anger. Such patients wind up in the hospital because they can be astonishingly destructive to themselves and others.

Tracy, for example, was a beautiful, blond, twenty-eight-year-old Southern belle with high cheekbones, a body conditioned by long winters on the ski slopes, and a taut, forlorn stillness. (To protect patient confidentiality, "Tracy" is a composite of several different patients.) She had ostensibly arrived in the hospital because, she said, her relationship with her mother had become too difficult for her to live at home. Her chart told a more dramatic story of violence, alcohol, sexual abuse, and suicide attempts. In her first interview with her treatment team, she announced that her mother had given her free access to her bank account. She needed to use the money wisely, she said, to make it last as long as possible.

Within a few days Tracy had slept with one of the few male patients. Sex between patients was actively discouraged. Officially this was because it was supposed to create dyads that pulled against the cohesive quality of the group. It was also, no doubt, because psychiatric patients can be stunningly nonchalant about their sexual practices—in these times, unprotected sex can be a form of passive suicidality, and in this population it not uncommonly is. In any event, the patients held a meeting to talk about the divisiveness of sexual dyads (the sex had not been particularly secretive) and the need for commitment to the community. Tracy essentially shrugged and remarked that it hadn't been a big deal for her, that sex was sex, and that she had slept with the man only because she had been horny. Two days later she saw him sitting on a sofa next to a newly admitted female patient. To show her displeasure, Tracy picked up a large bowl on the coffee table and hurled it through the closed glass window. She was angry.

As the staff understood it, Tracy's treatment rested on a tripod of psychosocial interventions: intensive psychodynamic psychotherapy, the therapeutic community program, and the "interpretation-free" zone of the art studio. Psychopharmacology was also important, and in keeping with standard hospital practice, most patients were medicated. Tracy was placed on Paxil for her depressive symptoms. She was assigned a therapist, whom she saw four times a week. At Norton, all patients saw their therapist four times a week. This therapy was insight-oriented psychotherapy, psychoanalytic therapy, the kind of therapy in which (as the more orthodox analysts conceive of it) therapists do not reassure, console, or soothe. I sat in the corner one afternoon as Tracy's therapist was supervised on her sessions by a senior staff member. The young therapist, reading from notes written after the sessions, reported that Tracy had said, "I've got to get rid of this stuff with my mother." The supervisor interrupted, "That's great, she's in the language." The therapist continued, reading what she had said to Tracy: "I think that this is a core issue for you, that in your relationship with your mother you were never sure of what other people felt, you felt teased and criticized." The supervisor murmured in approval, "You've joined her." The therapist continued reading: soon thereafter, Tracy had said, "I begged you for something for sleep, and you never gave it to me." The young therapist looked up from her notes sheepishly and told the supervisor that she had responded by explaining to Tracy that she had tried to help but Tracy had refused her help at the time. Now the supervisor said, "Look at the process. You say, get into the transference, and she says, 'You don't give me what I need.' "That's what you want. It's great; and then you panicked. Give with the one hand and take with the other, that's what my teacher said. Keep backing up, and she'll lay it all out."

There was a sense at the Norton Inn that patient and therapist were locked in mortal combat. "You couldn't engage with her," a young therapist said about one of his patients, proud that the patient had improved under his care, "unless you could accept that she thought that there would be death, and that it would be either yours or hers." Indeed many of the patients—witness Tracy—were angry, at everyone. The therapeutic

focus on aggression was understood to be appropriate to these patients; there was a sense that patients who "failed" at other hospitals and were sent to Norton were likely to be the kind of patients whose anger made them hard to handle. Some of the clinicians drew from a theoretical perspective often attributed to Melanie Klein and Otto Kernberg, analysts whose work teaches that hostility—not loneliness, not love—is a driving emotion behind human experience, that idealization can be a mask for persecutory anger and affection a subterfuge for sadomasochism.

"What's missed in the field's dominant model of the therapeutic interaction is Klein's perspective," one of the senior clinicians said. "The more the patient sees you as a good parent, the more it leads to envy, malice, and a desire to kill." A patient is perceived to be using the therapist to advance her own pathological goals of selfhood: to defend against connection, to induce guilt, to punish herself and others. The only hope for therapeutic success is for a therapist to confront a patient's need to bend the world to serve her needs by helping her to see the awesome destructiveness of her own rage. This is not comfortable for young therapists. One of the young fellows had grown up in a religious background that directed her to look for the good in human nature. When she had chosen psychiatry, she had seen it as one way out of a world that covered over the unpleasantness of human life. She told me that when she had been sixteen, the truck carrying her horse had jackknifed and crashed. She had sat by the horse's body, waiting for the police and ambulance, asking God how he could allow such unfairness and pain. Norton pushed her to the edge of her ability to tolerate the contradiction she lived within. "It is very disillusioning," she said, "to think that I have to believe that all of these good people have murderers inside them. You would think that it would be reassuring to discover that we are all alike, but it's not. They teach me," she continued, "that for the patients I am a coat rack to hang coats on."

If therapy is the naked encounter of two souls, these souls are imagined as wrestling in a mud pit. A case report about a patient who was being discharged described her as having entered with a "black, despairing and fragmented psychic state." In therapy, "she has easily, repeatedly and ragefully experienced empathic breaks." Her previous therapist had said that "the metaphor of a hurricane was appropriate in describing Ms. Deever's emotional struggle. He states that, like Ms. Deever, in a hurricane there is a hole in the center which is a vacuum and the hurricane swirls around it, trying to fill that hole." She had been hospitalized at Norton for three years. Her most recent therapist—she had run through a number; a senior clinician said that this patient was more difficult to work with than any other he had seen—presented her case to the staff. He was a laconic, low-key man, once an English major, who said that he had not understood racism until he had worked with this child of racial intermarriage and seen her rage and guilt. He spoke about her for more than an hour, without notes. He talked about the way she had told him how pathetic he was, how little he, an ambitious Jewish Long Islander, knew about the world. It was clear that she had made him feel small. He said that she had gone for his defenses, the ways he hid to protect himself

against a patient's rage. He frequently said, when he was reporting such an attack, that she was right. When he finished speaking, he had tears in his eyes. "The patient has made him honest," a senior clinician said with respect.

One of the patient's problems, as her therapist saw it, was that she failed to perceive herself as having a psychodynamic problem. She needed to be persuaded of her responsibility for her experience. "This work is difficult," a senior clinician said, "because analytic work is about responsibility, taking responsibility. There's a fine line that separates responsibility from guilt, and this patient has a huge amount of guilt." The case report said, "Over the course of the meetings with me over the months, Ms. Deever has demonstrated an increased capacity to experience her symptoms as a result of psychological stressors rather than biochemical imbalances." Patients at the Norton Inn learned to see problems that seemed to be uncontroversially biological in psychodynamic terms. A bipolar woman told me that privately, she thought her illness had something to do with the brain but that a person like her needed to understand it as dynamic. One of the patients told me that his psychosis was a defense against his angry feelings, which had something to do with his family's lack of boundaries (in other words, he had become psychotic because he couldn't emotionally handle his family). The patient of the case presentation could not make this shift to psychodynamic thinking, and this was seen as a problem for her. She had a dream about hummingbirds, which she interpreted as her GABA receptors crying out for Ativan [a Valium-like tranquilizer]. "Actually," her therapist murmured, "I thought it was about separation anxiety."

The second leg of the psychosocial treatment tripod is the psychotherapeutic community. In this "therapeutic community," the patients, with the help of some staff, essentially manage the social and some of the administrative life of the patient group. The large community meeting was held four times a week for fifty minutes and included everyone who was willing to come; at the largest ones, it seemed that most of the people in the patients' building (patients, nurses, and psychiatric workers) and some of the therapy staff and social workers were there. There might be thirty or more people in the room. The agenda (reports from community groups, for example, and reviews of people's difficulties and relationships to staff) was just a mechanism to generate discussion. There was a sense that the group should meet, that someone would speak about something that had been bothering him, and that as other people began to contribute to the discussion, everyone present would learn what "the issues" were. Staff assumed that this public airing would help people learn to handle those issues. The goal here was to give patients another mirror in which to see how they came across to other people and to give them a sense of being responsible members of the group. Much about these meetings reminded me of a small boarding school.

There were also smaller groups. There was an activities group, which controlled a significant annual budget (more than \$10,000 per year) and a task group, which dealt with social problems in the community. If a patient kicked in a plate-glass window, he or she

was "referred" to the task group, and roughly eight patients and three staff members discussed with the patient the community's perspective on his or her behavior and its impact on the group. There were groups for each house outside the main hospital, as well as a women's group, a men's group, an eating disorders group, a substance abuse group, and a relationships group. Patients were elected to major positions in these groups and through their election acquired certain responsibilities, such as chairing meetings, running discussions, and, in the case of the activities group, allocating money. One patient who left the hospital and subsequently prospered in business said that her experience of being community chairperson and its associated responsibilities had been the single most important preparation for running her business.

Emotions could run high. I attended one smaller meeting where the discussion turned to the larger meeting, where a patient who hadn't been present had been criticized. She was, however, now sitting in the smaller meeting. People began to use convoluted sentences to explain how distressed they had been that someone had been criticized in her absence without telling the victim who it had been. She sat knitting obliviously until one of the patients said, "Oh, hang it, Kate, you're the one they're talking about. They think that you're a little uptight." This was, of course, an understatement. Kate was one of the most anxious people I have met, a tense sparrow with a drawn, well-bred face. "Well," she said, "you're just annoyed at me because I'm more competent than any of you are." The sympathy for her evaporated at once, and various people explained crisply just how uptight, defensive, and pretentious she was: "I mean, the other day you told me you were writing the most amazing novel, and finally you showed it to me. All you had was a page, and that page stinks." For the next few days, Kate drooped like a withered balloon. She would come up to me and say plaintively, "But it was an accident, really. You must know that. I really didn't mean it. Really."

"Eighty to ninety percent of behavior is a function of expectation," a senior clinician told me. "If you make it clear to people that they have the capacity to engage in the community process and that their treatment is their responsibility, they will respond. The culture must give them responsibility." The counterbalance to the stress of public unveiling is supposed to be responsibility. You are supposed to learn, through such interactions, how to be responsible for your feelings and their impact on others.

In general, these meetings were remarkable for their tone. Discussions were usually straightforward, calm, and inquiring. They were often psychologically astute. People often took responsibility for something that had bothered others: unwashed coffee cups, a monopolized phone. The content of the discussion tended to circle around an individual and his or her role: as a member of a community, as a member of a meeting, as a group leader, and so forth, with a kind of insistent focus on the expectations of the group. ("Why do you feel the need to use the phone in that room, where we can all hear you? How do you conceive of your role here as a patient, and where do the rest of us fit in?") They called this "examined living": all behaviors were up for discussion.

In this spirit, once a month there was an all-hospital meeting of patients, clinicians, nurses, even the cook. It lasted about an hour. As in many meetings, technically there was no agenda, but there was often a sense of what "needed" to be discussed. When I was there, the issue was confidentiality. A patient in the hospital had thrown a glass of water at another patient, and there had been a great deal of communal distress about why and whether it might happen again, and so forth. The water throwing had been a major discussion point for the community meeting on more than one occasion. In a therapy session, the water thrower told her therapist that it had been only a joke. This was not something she mentioned to anyone else. Afterward, a social worker (who was not her therapist) came to the community meeting and when the water-throwing incident was raised again, the social worker pointed out that it had been meant as a joke. She had intended to calm the patients down. Instead, when the patients talked to the water thrower, they became very distressed. They saw the social worker's remark as a violation of patient-therapist privilege. They assumed that what they told their therapists was confidential. Yet here was clear evidence that their sessions could be discussed in meetings in which they were not present and with people they had never meant to hear them. They wanted what they said in therapy to stay behind closed doors.

So in the meeting, once the sixty or so people had gathered in the conference room, a patient raised the point with the director of the hospital. Several patients spoke; some staff spoke; the discussion occupied most of the allotted time. "We don't know the truth of what happened," the director said. "There may be many truths. In this case there seems to have been a boundary violation. But we must recognize that therapists must talk to other staff members and that they try to be thoughtful about issues of confidentiality." The hospital discussion didn't set any new rules about what was sacred to therapy and what not, but it did point out that there were inherent awkwardnesses in the combination of therapy and communal life. "It's hard to get hold of the ethic of examined living simply by making rules," the director said. I was sitting in back with some of the patients. The discussion seemed to resolve the tension.

The goal of this community structure, as staff conceived of it, was to provide what the analyst Donald Winnicott called a "holding environment": a place where people could act out their feelings without retaliation or withdrawal by others. Within the resilience of a good psychotherapeutic community, staff members argued, a patient should be able to play out the developing parts of his or her personality, see how people reacted to them, and learn from the reaction without actually risking anything in the real world—a job, a partner—in the process. I was impressed by how well it seemed to work. That is, I was impressed by the effectiveness with which patients could define their roles as members of the community to one another and to new patients, who entered the hospital irrational and deeply disturbed. There was a kind of insistence on maintaining the limits of acceptable behavior that seemed as if it might be comforting if your world

were falling apart. But it is a strange society, in which the unconscious intentions of all its members are the focus of its intellectual and social life. "The issue is," a patient said in community meeting, "what is the meaning of these unwashed cups? What do we want to say when we leave our coffee cups on the table?"

Tracy told me that before she had been referred to the task group, it had never occurred to her that her actions had an impact on people. She had felt voiceless, as many psychiatric patients do, inadequate and without self. The community, however, was clear that her voice was strong. They had noticed the broken plate-glass window. However, it was not until the incident with Stoddard that she heard them tell her how powerful she was. Stoddard was a tall, round man about Tracy's age, with intellectual pretensions and a scraggly beard. He announced one evening, in one of the smaller community meetings, that he would never sleep with a slut like Tracy. Few people in the room seemed to believe this, but some hours later, when news of the comment got back to Tracy, it did not occur to her to chuckle. She called Stoddard, cursed him, and declared her intention of coming over to see him in person. Stoddard then promptly called the town police, who were there to greet her when she arrived. (He was a citizen of the town. He could call the police.) Tracy was profoundly humiliated (this probably was what Stoddard had intended). She ran out of the building into the woods, pulled out a razor, and made twenty parallel cuts up the side of her arms and in her cheeks. She returned to the building dripping blood. By then the police had gone, and the nurses patched her up.

Over the next two days, I saw Tracy in various group meetings. I have never been as viscerally aware of someone's anger. Tracy sat in the meetings quite silent, pulsing with rage. I think she was on the cliff edge of control. I know that I was seriously worried, for the first time in a psychiatric setting, about where I sat in the room lest she should suddenly decide to leave and kick her way out. Patient after patient said, "You scare me; use words instead of razors." She said only, "Stoddard is an asshole. If he says one more thing about this, I won't be responsible for what happens." I had not realized until those meetings that the members understood themselves to be involved with keeping Tracy safe in the community and keeping the community safe with her, and how much senior patients saw themselves as coaching patients who had not yet learned to manage.

The third leg of the tripod was an "interpretation-free zone"—the studio, where patients painted, worked in clay, and did other crafts. "These creative activities," a history of Norton recounts, "aimed to uncover, explore, preserve and enlarge those areas of activity which were relatively free of conflict for each patient." Intensive psychotherapy is said to be "regressive" for patients, to throw them back into a more infantile, more emotionally overwhelming experience of the world. Some psychiatrists argue against long, psycho-dynamically oriented hospital admissions precisely because, they say, such intensive therapy encourages already shaky people to fall apart, not to cope. That

was the point of arguing, back in the sixties, that only people who were actually pretty healthy could tolerate the strains of psychoanalysis: the intense emotions that helped neurotics to see themselves more clearly would throw the seriously ill into psychosis. Norton argued that the regressive pull of intensive psychotherapy was counterbalanced by the progressive demands of the therapeutic community and the art. Patients in therapy were supposed to fall apart. Then they could put themselves together in healthier ways by using the art studio and the therapeutic community to bolster their creativity and personal authority. In 1994, artwork was sold in a crafts store for summer vacationers; the annual play auditioned both townspeople and patients. Over the course of her stay, Tracy became a weaver. She would bend over the angled loom, open like a mechanical butterfly, and concentrate on threading and then passing the shuttles through to create her pattern. Her blue-and-purple chenille scarves sold easily in the crafts store, even for extraordinary prices. She began to feel like a craftswoman.

The goals at Norton are very high: not simply to keep a patient safe until he can survive outside but to come as close as possible to curing him, to restructuring a self-destructive personality. "Psychiatric units these days do good work," one of the most respected (non-Norton) senior administrators in psychiatry told me. "They do good medicine. But if my daughter were ill, I'd send her to Norton. At Norton they adopt their patients and keep them until they get better." If the biomedical world takes responsibility for a patient's body, the psychodynamic one takes responsibility for a patient's soul and for teaching that person how to take responsibility for himself. That is a more taxing role in a person's life. It is much harder on therapists, who become, as it were, surrogate parents for these bright, promising, and profoundly destructive patients.

Therapy is hard on therapists. It is harder the more they identify with their patients, and it is harder the more they feel attacked by patients or the more patients attack themselves. At Norton it is easy to feel involved with the patients because it seems that if you could only change them a little, they could do so very much. When one treats the cynical ne'er-do-well derelicts who haunt many of the places where psychiatrists train, it is hard to convince oneself that they will change, let alone make a difference to the world. At Norton, the patients come from families that are often wealthier and more distinguished than the psychiatrists' own. It is easy to fantasize that they could be powerful and effective doctors, lawyers, professors, philanthropists. Because they are young, bright, and rich their prognosis, if the illness can be dented, is far better than that of people who are old, dull, and poor. Patients like Tracy seem to have everything but happiness. They desperately need and want help; then, when a therapist reaches out to them, they bite the hand—hard. Most analysts do not take extremely disturbed patients into intensive psychotherapy, not only because their theory suggests that the therapy will be too powerful but because they fear that as therapists they will get too involved, that these patients need help so badly that they will want to help equally badly, and then, because the patients are so disturbed, the patients will hurt them more than the therapist can bear.

Norton took these very ill patients and gave them intensive psychoanalytic psychotherapy, and the psychiatry and psychology fellows—fresh from residency and its equivalent—felt beaten up and hollowed out by them. When I was there, the hospital had five full-time senior clinicians and seven fellows, a mixture of psychiatrists and psychologists. Fellows work there for two to four years. If they are psychiatrists, they are likely to spend their last year of residency there. Each fellow sees a maximum of four patients, and each full-time therapeutic staff member sees usually one and occasionally more patients.

The fellows dreamed about their patients. They said that the patients got under their skin and into their lives in ways that were nearly intolerable. "I live with them in me, and it makes me crazy," a new fellow said. "But then I really see how the theory works, because I see it, the way I'm projecting, the way I get angry and then paranoid. You're forced into really grasping that you construct your own world, that your language is drenched in your history." These are not the obedient conflicted patients of Upper West Side New York who worry about their unconscious aggression in paying their bill three weeks late. These patients walk into sessions furious that their therapist (they say) is sadistically torturing them with his or her sexual feelings for them. They try to make the therapist confess those feelings. (Psychiatric patients can be unnervingly insightful.) They talk about their hatred for their therapist and their therapists' hatred for them. They threaten to commit suicide. One fellow, confident and poised, with five years of psychotherapeutic experience behind her, found herself so shaken after the sessions with one patient that she vomited after the therapy hour, session after session. "I feel things first in my body," she said, "all this anger and rage. It was too much." Feelings about patients, particularly for new fellows, seemed barely under control, or what the staff would call "contained." Sometimes they spilled out from the therapy session to the therapist's dealings with the nurse, social worker, or check-in person at the local gym. And these are patients who talk about suicide and go back to a hospital building without locks, who talk about their therapy to nurses who may question the therapist's wisdom. There is always a hovering question in a nurse's mind about the doctors anyway, particularly new doctors, because doctors conduct their work behind closed doors.

The heart of this culture, confronted by its terrible uncertainties and risks of emotional chaos, lies in a paradox: that feelings are its insistent focus, yet its public culture repeatedly and consistently defuses strong feelings. That is the way this culture manages the greatest threat its intellectual commitments pose to its existence. Emotions are to be spoken about, not expressed. "The whole damn place is affect-avoidant," a social worker grumbled. Tears were utterly unsanctioned. In any meeting of more than four people the correct tone of voice was deadpan. When people mentioned that a first-year fellow had cried in a team meeting, they lowered their voices and raised their eyebrows. A therapist's inability to manage his feelings in public would lead the general staff to question his ability to manage the intense emotions of the therapy relationship

in private. In the staff's culture, the psychotherapeutic culture of examined living—in the clinical case conference, when all staff meet for two hours twice a week to discuss one patient; in the thrice-weekly clinical meetings, when all staff meet for an hour to discuss all the patients; even in the smaller twice-weekly team meetings, when ten staff members meet to discuss perhaps a third of the patients—there was a style that took the wind out of overwrought passion as effectively as a damp English afternoon.

These meetings set a premium on formal, crafted, eloquent speech. The senior staff spoke in sentences rounded out with caveats and considerations, with deliberate, complex rhythms. They spoke well and fluidly in psychoanalytic prose "For this patient, connecting to her feelings and communicating them to the other is fraught with peril." My notes on one patient presented in a team meeting read, "Youngest of five, can't leave home for fear of what will happen to parents or to her—possible history of sexual abuse—that may in turn contribute to her difficulties in being sexual, may be afraid of being father's wife, as re morning seminar—fears of oedipal victory over father's wife, who doubles as her mother—rage at mother for unavailability—may have contributed to eating disorder at time of puberty—fearful, insecure attachment style." Presentations were done with an implicit bow, not a sense of brisk efficiency.

Defensiveness was bad. In this public culture, when staff or patients were confronted with criticism in public, they were expected not to deflect the criticism but to address it. At one staff meeting, a senior staff member announced that the executive committee had decided to hire a senior staff member's wife to serve as a therapist from time to time, and did anyone have any feelings about that? One of the fellows—the one who vomited after difficult sessions—stuck her hand up aggressively and said, "You've made the decision; we won't influence it, so why are you bothering to ask for our response, which will just leave us vulnerable and won't have any impact?" I was watching the senior clinician at the time. He did not, as I thought he would, stiffen up. After a moment, his shoulders relaxed. "You're right," he said. "We have made the decision, and unless you feel very strongly about it we won't change it. But if you do feel strongly that it is inappropriate, we will consider changing our minds."

There were jokes here as well. "The patient," said the therapist for the interracial woman, "had a dream that she would die in a plane accident and on the weekend she was scheduled to fly to Canada, she learned that the East Coast would experience its worst winter storm of the season. She was superstitious and became quite agitated in the session. Now, as it happens, I am a little superstitious, too. I told her that she might consider the train." But the humor was not about madness. It stabbed at the high seriousness of the therapeutic endeavor, and it was self-deprecating for the therapist. Staff laughed comfortably at themselves. When they laughed at the patients, they immediately became apologetic and nervous. In this case conference, the therapist remarked that the patient, who kept saying that she was desperate to leave, had developed striking neurological symptoms before discharge. Everyone listening laughed, because to

them this meant that despite her many protests, she liked her therapist and wanted to stay in the hospital. But they quickly became contrite. A senior clinician immediately said that the laughter might be a way of "breaking out of the confining frame that the patient has set." A fellow pointed out that the patient's symptoms were real for her. The director remarked that laughter was a healthy response to the countertransference. Clearly, at Norton you are not supposed to laugh at madness. But staff members laughed at doing therapy. They laughed at therapeutic blunders, at the ambitions of the therapist, at the difficulty of being what they would call "in role." That is because the contradiction in this culture, its impossible model, is about the therapist, not the patient's madness. These therapists did not think that patients are rational people with a physical illness. They did not put much stock in anyone's rationality, or at least in his ability to think clearly and independently of his unconscious desires. What was funny, then, was not the patient's madness but the very attempt to do therapy, to comment objectively on a patient's superstitious comment when you yourself are a little superstitious and think she ought to take the train. The stories they told were often about the doing of therapy: how a patient worried that her boyfriend would kill her and the therapist made a psychodynamic interpretation of that fear and the patient then brightened with visible relief and said that she was so relieved that there was a psychological explanation, because her boyfriend's brother had gone after his ex-girlfriend with a gun. They laugh at the way a patient turned an interpretation around and suddenly the therapist was the one receiving therapy. They traded stories about the way senior clinicians had been narcissistically preoccupied and failed to attend to something they thought was obvious about a patient, and how that had backfired. They laughed at the attempt to step outside one's own dynamic frame to understand another person, which is what a therapist is supposed to do.

And I have never seen an institution so focused on the roles, hierarchical and otherwise, of its members: discussion of how a patient had not improved until her therapist had assumed his appropriate role with respect to her; the role of the hospital in interaction with the insurance company and the patient's parents; the role of the community with respect to the behavior of two patients. The reason for this is, no doubt, that people were not, in fact, defined by their roles. In a biomedical unit, the hierarchy of power can reflect what was assumed to be the hierarchy of knowledge in an unproblematic way because the possessing of knowledge is not problematic. In a psychodynamic setting, knowledge is complex, ambiguous, and uncertain. A patient can see things about her therapist, about a nurse, about the director of the hospital that these people do not recognize, and the structure of the hospital life is set up to allow the patient to point out to these people what she perceives about them. It becomes easy to doubt that someone has accumulated knowledge, no matter what his credentials. In any event, this institution was profoundly conscious of its social structure. What the social workers did was clear, and it was not what therapists did (much to the distress of the social workers, who wanted to do individual therapy and were not allowed). Even the small lunchroom was informally segregated, so that senior clinicians ate at one table, fellows at

another, administrative staff in a separate room, and patients, nurses, and mental health workers in another building. Patients would have long discussions about whether the eating disorders group would still be the eating disorders group if its members met without their leader, whom they had decided they didn't like; they concluded that without a leader, however irritating she was, it would not be a group. "You have to stay in the role," the supervisor earnestly told his supervisee, a fellow. "Educating the patient, doing reality testing for him, telling him whether his responses are appropriate—that is not staying in role. Staying in the transference is your role as a therapist, allowing yourself to be trapped, to be stuck in an enactment, and then taking a step back to ask what this has to do with the patient's inner life." The explicit emphasis on role definition—far more explicit and formal than in the biomedical setting—becomes a way of clarifying the realistic differences in training and stature despite the interest in unconscious fantasy that dominates the intellectual life.

In the end, it seemed to me that one could summarize the complex culture of this place around four paradoxes. First, emotion was the content, focus, and most important issue of most clinical discussions, yet feeling was not to be displayed; it was to be discussed formally and calmly. Second, psychotherapy took place in private and was confidential, yet the environment of examined living demanded that everything be open to discussion. Third, this hospital hierarchy was as clear and as solid as I have ever seen, yet it was consistently flattened in the service of an egalitarian democracy of open discussion. Fourth, there was a great deal of discussion about limits and boundaries—whether patients should have sex, whether throwing a glass of water was an effective means of communication—yet the hospital had no real constraints, no doors, no security guards, no watchdogs. Thus, to live in the culture successfully as a doctor (or another staff person) meant that you had to talk about your own emotions in public and in depth, but not express them; you had to keep secrets but know when to share them; you had to behave democratically but with a deep respect for hierarchy; you had to substitute talk about responsible living with your patient for taking responsibility for that patient's life by keeping her under lock and key. It was a hard transition for the new clinicians, who felt the deep strain of living rubbed raw in open view of other people. "They are used to controlling people, to managing them," a senior clinician said severely. "They have to get used to doing therapy."

Norton is a very special hospital. The psychiatrists at San Juan would probably love to do this kind of work, but they can't. Even if they could, their patients would not have the success that Norton's seem to have. They do not have the money. They do not have the time. They must handle thousands of patients each year. Norton handles perhaps several hundred, with more staff. Norton's patients are young, bright, often wealthy, and usually struggling with disorders that, when managed, can leave the patient highly functional and effective. The upper reaches of our society hold many depressed and bipolar high achievers, not to mention mild borderline personality disorders. San Juan's patients are often uneducated, unemployed and unemployable, and

older. Their prognosis is poor. It would be poor no matter where they were treated. They struggle with substance abuse, and are treated and then discharged into a community where crack and heroin are rampant. They struggle with depression, and are treated and then discharged into the realistically depressing world of the underclass. They struggle with schizophrenia, and though medication will stabilize them it will not make them self-sufficient. Psychiatric illness, like all medical problems but more so, is mired in the ugly realities of the American class structure. This is one reason psychiatric illness presents our society with moral choices.