A Discussion of Philosophy and Psychotherapy: Part 1—Metaphysics

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A Discussion of Philosophy and Psychotherapy:
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George E. Atwood, Ph.D.

This article presents a discussion with an anonymous psychiatrist, Dr. E., of the importance of philosophy for the psychotherapist. The focus of the interview is on the question of the nature of the ultimately real, the concern of metaphysics. This question is approached in an interchange about three psychiatric patients whose worlds departed dramatically from all that is conventionally held to be real and true. Dr. E. argues that applying an understanding of the phenomenology of annihilation states allows such discrepant realities to be interpreted in terms of the subjective truths they contain.

G.A.) recently listened to a lecture in which the speaker said that every psychotherapist must be a philosopher. My colleague, Dr. E., the most experienced therapist I have ever known, has expressed contempt for philosophical arguments in a number of talks I have had with him. I wondered what could be the basis of this attitude, and what his overall thinking might be on the significance of philosophy to our work as clinicians. So, I decided to see if I could engage him in a series of conversations on the matter, recognizing I was once again placing myself at risk of getting beaten up by a very difficult old man. This first interview focuses on the nature of the ultimately real.

1This is the first in a series of four parts presented in the Personal Reflections section.
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Part 1—Metaphysics:
The Question of the Ultimately Real

G.A.: Good morning Dr. E. Today I want to see if I can get you to talk to me on a topic you usually try to avoid: the philosophical ideas that lie behind our work as psychotherapists. Why do you shy away from this sort of discussion?

Dr. E.: I am violently allergic to discussions that get lost in clouds of abstraction. If you try to draw me into such a thing, you may pay a heavy price, old friend.

Philosophy itself, understood as a love of thinking, there is no problem with. We all need to think about what we are doing, and what our assumptions are. It is a challenge, however, for psychotherapists to find a productive way of discussing such matters. I will not embark upon a voyage into this realm with you, G.A., unless I have as my companion the story of a specific human being in trouble. If the philosophy cannot be directly related to a clinical case, I find it to be a total waste of time.

G.A.: Let me begin then with a series of clinical stories, ones that I think raise questions that are about the concern of metaphysics: the nature of the ultimately real.

1. My first story concerns a 30 year-old man with whom I sat down last week, a man who had been given a diagnosis of schizophrenia. He was silent, for a number of minutes. I asked him finally: "What are you thinking about, brother?" The answer that came back was:

"I don’t think. It thinks."

When I asked him what “it” was, he answered:

"The machine. It is. I am not."

No matter what I said after this initial interchange, he kept repeating the statement that he did not think, was not there, and there was only a machine. What do you make of such statements? Most people would regard his words as in plain contradiction to all that is real.

Dr. E.: I might relate what this young man says to the way you addressed him. Your question asking him what he was thinking about might imply to him that there is a “he” or a “you” within him capable of being spoken to. If there is no such being, the posing of the question opens up a gulf of misunderstanding and invalidation that might well have ended your communication even before it had begun. People carrying the diagnosis of schizophrenia often do not experience themselves as existing. As a result
the customary ways of being addressed in our society cast them into a no-
where zone: unseen, unacknowledged. They then react to this banishment,
and their reactions to the misunderstanding, in turn, are viewed as symp-
toms of the illness from which they are said to suffer. This is the situation of
madness in America.

When you ask him about himself, and then persist even when he has
told you he is not there, you commit an act of infinite abandonment and in-
validation, G.A. It would have been far better if you had simply sat by his
side, quietly, knowing that he feels your presence. At least then your emo-
tional stupidity would not have walled him out.

Furthermore, when you addressed him as “brother,” you made an at-
tribution he cannot possibly have been able to make sense of. You are not
his brother. He is no one’s brother, in that he is no one at all. To be con-
strued as such is to be swept into a controlling agenda that is unrelated to
the nonbeing that is his authentic state. So the machine arrives: something
that speaks, that thinks, that attributes, that perceives. You, G.A., may well
be that machine, annihilating what little remains of his personhood by your
misguided friendliness. As the man told you, he is not—there is only the
machine. I like this man, because he speaks the truth as he sees it. There is
hope for such a gentleman. But you have certainly been of no help.

G.A.: How in the world is one to establish communication with some-
one like this?

Dr. E.: You connect with what the man is saying! If he says he is not
there, you certainly do not keep asking him what he is thinking or calling
him brother! Sometimes, Atwood, I wonder what is the matter with you.
What are you thinking?

There are lots of things you might do with this patient. You could focus
on the purely physical and direct the conversation to the way he is dressed, or
to the heat or humidity. You could address him in the third person—people in
annihilation states cannot experience “I am,” and often cannot tolerate be-
ing addressed as “you.” Bring him a cup of coffee and a doughnut and talk to
him about how good or bad they taste. You could rest there quietly by his side,
or you could take him for a walk or go swimming. He lives in a personal catas-
trophe, and opportunities are there to be with him without making his situa-
tion worse. If your gestures ascribe to him something he cannot experience,
you catapult him into the grip of the machine. Just think about it my friend—
benign pathways of approaching him will open up to you.

G.A.: Here is what the world will say, Dr. E.: This is a man who lives in
an alternate reality, and there is no way to make contact with him.
Dr. E.: The world that says such a thing knows nothing, G.A. This man lives in the same reality as the rest of us—the problem is that he is in a state he experiences as nonbeing. It is possible to exist within a state of felt nonexistence. You can ask what this means, where this comes from, what to do with it—but avoid any approach that undercuts what he is telling you.

G.A.: Talking to someone like this gentleman poses serious problems though. How can one do it? Conversation requires a shared basis of understanding about things, and here we have a rift separating his world from ours. What is one supposed to do with such a discrepancy? Do we suspend our own reality and try to enter his? Do we tell him he is wrong and try to draw him into ours?

Dr. E.: Why don't we start with the unremarkable idea that this patient, and you, and I, and everyone, all live in a common world, G.A.? I suppose that could be considered a philosophical assumption, but I don't see how one could speak to anyone about anything on any other basis.

Don’t overstress his talk about the machine and about his own absence. He is experiencing these things, but they do not mean he lives in an alternate universe. These are just particular points at which his subjective life does not correspond to yours. There are plenty of other points at which there is no significant disparity.

If you want to relate to him, a space has to be created in which he can begin to feel himself in your presence and you in his. A firm handshake and a squeeze on the shoulder might begin to establish this, and then could be followed up by a comment or two directed to your physical situation with him. Perhaps he will say nothing in response, but he will be listening.

You could bring out the coffee and doughnuts and offer them to him. Warn him that the coffee is very hot and ask if he wants any milk or sugar in it. If he still does not respond, pour coffee for yourself and bite into a doughnut. Tell him how good or how bad it tastes. Maybe you will just have to sit there drinking your coffee and eating your doughnuts until they are gone. Hang out a little longer, and then tell him you will be back tomorrow, and you’ll be bringing more coffee and doughnuts. Tell him to take it easy and say goodbye. Perhaps the next time you come he’ll talk a bit and have something to eat. Who knows? A foundation might have been laid for a healing relationship with him.

G.A.: What is it that might have happened though in this man’s life that would help me understand him better? How do people come to an experience of not being there, and of there only being a machine? Maybe if I
could grasp something of his overall situation, it would make it easier to experience him as living in the same world that I do.

Dr. E.: People who feel they are not present, and who affirm the existence of a machine that controls their minds and bodies, are usually the products of profound enmeshment with their caregivers in childhood. An accommodation has taken place at a very young age in which the agenda of the caregiver—it can be the mother, the father, or both—becomes the supreme principle defining the child’s developing sense of personal identity. The experience of the child as an independent person in his or her own right is nullified, so that the child the parents wish for can be brought into being. Very often there are no outward signs of anything amiss, as family life unfolds in a seeming harmony. Somewhere along the way, however, the false self begins to crumble, and a sense of the degree to which the child has been absent from life arises. This emerging feeling of having never been there, of having been controlled and regulated by outside forces, is so unstable and fragmentary that it is given concrete form. What is seen from the viewpoint of others as a delusion then begins to crystallize, for example in the image of an influencing machine. Within the world of the child, now perhaps chronologically an adult, the so-called delusion is a carrier of a truth that has up until then been entirely hidden and erased. What looks like a breakdown into psychosis and delusion thus may represent an attempted breakthrough, but the inchoate ‘I’ does require an understanding and responsive Thou in order to have a chance to consolidate itself. This could well be the situation of the patient described in your little story, and the challenge you face if you choose to continue with him. Prepare yourself for a very long journey.

G.A.: Thank you Dr. E.—I will bear everything you have said in mind, and I will start by buying some coffee and doughnuts.

Let me tell a different story, but one that again relates to the question of what is real.

2. A well-established psychiatrist of my acquaintance was recently murdered by a young man who came to his office late at night. The patient was in a panic because he believed he was being poisoned in a vast conspiracy. He begged the doctor to help him find a way to rid his body of the toxins that had accumulated, crying out that this was his last chance to survive. The persecutors, as the man described them, were led by a number of psychiatrists and other mental health professionals, in league with various relatives who had turned against him. There was also some talk about there being a machine that was involved with his suffering.
The doctor, himself a respected but very conventional person working in Manhattan, made a diagnosis of paranoid schizophrenia, and gently but firmly advised the patient to begin on a course of antipsychotic medications he would prescribe. The patient listened to this advice, and pulled out a knife and plunged it into the doctor’s heart. I know what happened because I was able to look at interview material collected from the patient by the police shortly after the murder.

So here we have someone again living in a different reality, and in this case the effort to connect with him precipitated lethal violence. What about this, Dr. E.? How should this doctor have understood what the young man was saying, and what different response might he then have given? A clash of worlds occurred here, ending in homicide.

Dr. E.: I can see that the psychiatrist in this awful story “knew” his patient was delusional, and he “knew” the so-called delusion was a symptom of a mental illness that could only be treated with medications. I have two or three thoughts about this running through my mind, and I am not sure which to go into first.

I suppose we can start with the antipsychotic medications the patient had probably been on in his previous treatment. These medications are actually poisonous, and I am wondering about the patient’s complaints being the result of negative physiological reactions to their presence in his body. He claims toxins have accumulated within him, and the chemicals likely to be involved here are known to be toxic. But the doctor responds not by addressing the possible validity of the patient’s complaints, but instead by prescribing more of what the young man is saying is poisoning him. This was not a swift move on the psychiatrist’s part, and it got him killed.

As in your first example, there are points at which the patient’s experience here departed substantially from all that your doctor friend believed to be real. The physician viewed his patient as engaging in paranoid distortions of what were efforts to help him on the part of other clinicians, for example, and it is likely he also saw the patient’s relatives as equally to have been drawn into a paranoid delusional system. The patient, by contrast, was in the midst of an experience of being plotted against and attacked by a whole range of individuals, some of whom probably are the people to whom he originally turned for help. It strikes me as something of a miracle that there is still a particle of hope left inside this young man, as evidenced by his coming to your colleague in the middle of the night. What a sad and tragic thing it is that this court of last resort, as its first action, joined the conspiracy that was destroying the patient. A physician lies dead, and the young
man is destined to spend the rest of his life incarcerated in mental institutions. It probably did not have to end this way.

G.A.: What other way could have been found, and what other ending might have taken place?

Dr. E.: That leads to my second thought, concerning how the doctor might otherwise have responded, and what experience then the patient might have had in consequence. What if the first thing the doctor did was to ask about the specific poisons that had been introduced into his system by those that had hurt him so terribly? Let me imagine that the patient did know the names of the drugs that he had been given, and that they were the standard medications given by professionals in our field for psychosis.

I picture the possibility, not embraced obviously by the doomed psychiatrist, of giving the patient a specific, point-by-point summary of the destructive effects of his various medications. One could speak of the dangers of tardive dyskinesia, of diabetes, of various cardiac effects, of lasting alterations of the neurochemical environment within the brain, of excessive weight gain and its complications, of temporary and permanent interferences with cognitive functioning, of generalized emotional numbing that many patients describe as being made into a zombie.

I also imagine one could have instructed the patient about exactly what he needed to do in order to stop such effects and reduce any reliance there might have been on the tranquilizing action of the medications he had been taking. I would have told him that if he wanted to detoxify his body and get away from these substances, he had come to the right place. I would promise him I would provide the help he needed and he would accomplish what he was trying to do. I seriously doubt a murder would have occurred, because what reason would there have been for it?

G.A.: But how can you promise such things to someone you scarcely know? You can’t possibly be sure that you will be able to help in the way you are guaranteeing.

Dr. E.: That is a bad question, G.A.—Someone like this is in a state of terror and despair. My goal would be to relieve him of the fear and provide a reason for hope on which he and I could build. The literal content of what I was suggesting is less important than the message of reassurance I am trying to give to him. I would be speaking to him in a language that is the only one he was in a position to understand at this desperate moment of his destroyed life. Don’t get literal on me about this, or I will become angry with you again.

Maybe I should also say that if I had seen he had a knife, and suspected he might use it on me, I would have done everything in my power to
physically escape the situation. I would have run out of the building and called the police. It is a cardinal principle of my practice never to allow myself to be killed, and there have actually been some close calls.

My third thought about this story, however, concerns what it means in terms of the patient's probable life history. Here he is, feeling poisoned by persecutors, running to a man who is his last hope. The situation lends itself to an interpretation along the lines of the persecutors being symbols of maternal malevolence and the doctor being a rescuing paternal authority. This is a memory of a little boy who runs to his father after being massively threatened by something happening with his mother. He seems not to have received much help from his father though, because how otherwise would he have ended up in this condition? Still and all, the presence of hope remains in the picture, however tenuously; that is, it remains until it is destroyed by the psychiatrist's response. I would expect the patient to want to kill himself after murdering the doctor—the violence is a sign of his despair having become absolute and everlasting.

G.A.: Give a more detailed picture of the possible course of events in this case if a better response to the patient had been given. What would be the next steps to be taken?

Dr. E.: Who can know what might have occurred? I will tell you what comes to mind as I let your question flow over my mind.

I will try to answer by drawing on clinical experiences I have had in a situation not dissimilar to this one. I would imagine seeing this young man on a very frequent basis, probably every day in the initial weeks. I treated such a person many years ago, and we met every morning in a local diner for breakfast. I had no openings in my regular schedule, so this was the only basis on which we could have time together.

My patient was initially very fearful of meeting me in public, saying his enemies were everywhere and intended to kill him. I answered these fears with a simple declaration: "As long as you and I are meeting, your enemies will not hurt you. I guarantee it."

This helped him begin to relax, but it was many days before he calmed down enough to join me in actually having breakfast. I did not wait, however, and so for the first week and a half he had to watch me consume cheese omelettes, french toast, pancakes, hash browns, and fruit, even as he sat there eating and drinking nothing. It was kind of pathetic to look at this poor, hungry, frightened man, while I was feasting. Eventually though he ordered some bacon and coffee, and things improved. A foundation was thereby created for a very long and productive relationship. This patient
eventually recovered essentially completely from a paranoia that had been present for many years.

So I would try to repeat this good experience by inviting the young man to breakfast over the ensuing period. I would certainly expect him to be suspicious, but I would disarm him by unrelenting friendliness and I would order food for him in the hope that he might accept it. In the mean time, he could be tapering off the medications he thought were poisoning him, and, who knows, maybe he could get off them entirely over the course of a few weeks or months. In pursuing this strategy I would be building on the spark of hope I saw at work in his first contacting me.

G.A.: Would you speak to him directly about your hypotheses regarding his early traumas with his mother and father?

Dr. E.: I would know we were speaking of that at every stage. Sometimes it is a fine and perfect thing to proceed in an indirect fashion, and a pathway can then be found to bring the therapeutic relationship right into the heart of things. Psychoanalysts often think you have to talk explicitly about history or it is not psychoanalytic. This shows that a lot of them are stupid.

G.A.: But how is having breakfast with someone to heal that person's wounded soul? You make it sound like all you need to do is eat pancakes, and then the patient is cured. Moreover, a theme is starting to emerge: you seem to respond to all these crazy people by eating breakfast or doughnuts! Do you really think this is the key to psychotherapy in such cases? Give me a break Dr. E.—this is starting to sound ridiculous.

Dr. E.: Do you know what it might mean to break bread with someone to whom one has turned as the last hope on earth? You can make fun of the idea of having pancakes if you want. So would you suggest talking to the patient about his paranoid schizophrenia? If you follow that pathway, as our story indicates, you get yourself killed. Wake up, G.A., and smell the coffee!

G.A.: Okay, Dr. E., but I don't think people will believe in your breakfast therapy. They will make fun of you. Let's move on to still another clinical episode. This one concerns the CIA, and once again throws us into a conflict over what is real.

3. I was walking with a young woman, a 24-year-old, on the grounds of a psychiatric hospital where she had been for a number of months. Like the other two cases, she had been diagnosed as schizophrenic.

There was silence as we began our walk, but then she turned to me and said the following:
“You know, there is a cavern beneath this hospital, and there are assassins that hide in it. At night they come out and murder the patients. I think they work for the CIA. Every hospital in America has a cavern.”

Dr. E.: I am curious as to how you responded to the patient, G.A.

G.A.: I did not know how to respond. I think I just said, “Wow!”

Dr. E.: Well, we can call that “Wow-therapy.” They are going to be laughing at you as well as at me. What was your patient’s response to your exclamation?

G.A.: She stared into my eyes for five or ten seconds, and then posed a series of questions and demanded answers:

“What do you believe I just told you? Tell me if you think it is true. Is there a cavern, or is it just that I am mentally ill? Am I right about this, or am I sick? Which is it? Tell me right now! Do you believe? I want to know: True, or Sick? Yes, or No?”

I knew better than to tell this patient she was mentally ill, but I could not bring myself to say that I believed her. We struggled for a few minutes with this and finally I just left, with her shouting at me. It seemed to me that I was damned if I did and damned if I didn’t. If I told her she was mentally ill, she would feel condemned and invalidated. If I said I believed her, she would see I was lying. That might be worse than saying she was crazy. Also, believing the delusion could be seen as encouraging psychotic thinking.

Dr. E.: What would you say, G.A., if I told you there actually was a cavern of assassins under your hospital, and under every psychiatric institution in our country? What would you do if you came to know that patients were indeed being murdered, by the thousands, every single day?

G.A.: You have to say more about this. What are you talking about, old man?

Dr. E.: I am letting the vision of caverns and assassins wash over my mind like a waterfall. You know I like to do that, G.A. Sometimes then a thought appears, as if from a cloud, and very occasionally that thought turns out to be a good one.

In this instance I am reading her words symbolically and metaphorically, and I am searching for their truth. We have to listen softly to what is said sometimes, at different levels of meaning, and if we do an inspiration might come to us as to how to respond. Listening with a hard, literalizing attitude, on the other hand, can be a death trap for the patient, and also for the therapist as in that last case we discussed.

Have you ever thought about what it feels like to be seen as a “schizophrenic,” G.A.? To have anything and everything one does viewed as a
You have someone for whom the bottom has fallen out, who struggles to maintain the most basic sense of integrity, perhaps even of existence itself. Then subject that person to an unrelenting experience of being personally discredited and pathologized. Psychiatric hospitals, which should be healing asylums, by and large are annihilation factories instead. The murders that are committed there are soul murders, and the medical model itself is one of the primary instrumentalities of this infernal work. If you tell the patient she is ill, you complete the killing.

There is one other thing, my friend. Many psychiatric hospitals do have tunnels beneath the floors in which the patients are housed. These tunnels are often used for unobtrusively removing the bodies of those who have died or committed suicide.

G.A.: Dr. E., in this case you would be proud of me. I was able to catch on to something along the lines of the metaphorical meanings you are emphasizing, and I found a way to respond to this young woman that did not make the situation worse. My response was also consistent with the death tunnels of which you speak.

Dr. E.: Tell me about that.

G.A. I was struggling with how to deal with her in the days after the difficult encounter, I happened to pick up a paper written by one of my own former students, a clinician who was employed at a large public mental health center. She had worked for years as an outpatient psychotherapist, often with young men and women who were very seriously emotionally disturbed. The overall philosophy of this psychiatric institution was based on the medical model, and its primary mode of treatment was the provision of psychiatric drugs. My student had grown more and more appalled over the period of her employment by what she thought was damaging mistreatment and unforgivable neglect. I looked at the title of her paper, and it seemed to cry out to me:

“Contemporary treatment of young adults in community mental health centers: Are we murdering a generation of geniuses?”

Dr. E.: That is beautiful.

G.A.: My patient had been claiming murders were taking place in her hospital, and at all the psychiatric hospitals in our country. It occurred to me that she and my student were talking about the same thing. I asked myself also why my patient was describing the assassins in the cavern as com-
ing out only at night. She was saying they do their deadly work secretly, out
of anyone’s sight. The medically oriented treatment of her institution pres-
ents itself as a constructive, healing procedure. In the daylight world, it
therefore manifests in a form that one would hope would be of help to those
receiving it. But its invalidating, discrediting impact is hidden, and takes its
toll on the souls of the so-called mentally ill out of public view. In other
words, it occurs in the dark.

Dr. E.: That is interesting, G.A.—You are learning to let the images
wash over your mind like a waterfall.

G.A.: I have been instructed by a phenomenal teacher, Dr. E.—Any-
way, I decided, based on these reflections, that my patient was right, that
there was indeed a cavern of assassins beneath the hospital, and that mur-
ders were indeed taking place each and every night. So I decided to tell her
just that.

The next time we met, she was waiting for me with those same urgent
questions, repeated over and over. I asked her to listen to my response:

“My dear, listen to me. I have to apologize for running out on you the last
time I was here and not answering your questions. The problem was that I did not
understand what you were asking me, although you were being very clear. Now I
do understand and I am going to tell you what I think. You are speaking the truth.
Death is everywhere at this hospital, and you are also right that it is present at ev-
ery hospital in our country. This is not illness; this is you speaking the plain, un-
varnished truth. My answer to you is Yes, Yes, Yes, Yes!”

Dr. E.: And let me guess how she responded to this simple declaration,
G.A.—She was satisfied and the imagery of the cavern and the assassins re-
ceded.

G.A.: Exactly, and I never heard another word about it in the long
and continuing course of my relationship with her. The incident I have
been describing occurred very early in our work together, only a few months
after I first met her. But there were signs that something very good had hap-
pened in the subsequent days and weeks.

Dr. E.: Tell me something about those good signs.

G.A.: Perhaps a week after the discussions about caverns and murders
had come to an end. I was walking with her again over the hospital grounds.
I never knew what to say to this patient, so I would just say anything that
came to my mind. On this day, I asked her:

“Tell me. What is the most beautiful thing you have seen today, on this
lovely morning we are sharing?”

She answered with the following words:
“I saw a beautiful flower growing at the center of a cold, gray rock.”

Dr. E.: And how did you respond to this interesting little communication, G.A.?

G.A.: I had understood already that the patient had been subject to feelings of inner deadness for a number of years. She had cut herself really seriously a couple of months earlier—deep slashes across her chest and on her arms performed with a coffee can lid. I had originally thought she was trying to commit suicide; but she informed me that she had wanted to feel the intensity of the pain and see her bright red blood flow. She had been in an experience of numbness and deadness and, rather than intending to die, was desperately seeking signs and sensations of life.

So I thought the rock might be a symbol of that deadness, an enclosing prison in which there were no feelings and there was no life. But she was telling me now that life had appeared in the midst of death, and that it was a beautiful flower. This had to be a good sign for her and for our connection. I did not put my thoughts into any direct words, but chose instead to suggest that she and I compose a poem about that lovely flower. We sat on the edge of a pond in the morning sunlight and wrote one out, entitled “The Midnight Blue Rose.”

Dr. E.: That is a good story. There might be hope for you, Atwood.

G.A.: That means everything to me, Dr. E., coming from you. This is the first time you have said anything nice to me.

Dr. E.: Don’t press your luck, my little turkey.

G.A.: I am not sure where this discussion has left us with respect to the topic I began with: the role of philosophy in psychotherapy.

Dr. E.: We have gotten nowhere on that—the discussion has just been about some people’s experiences. I say let the philosophers do the philosophizing. We should just concern ourselves with the human situations that confront us. Everyone should mind their own business and the world will be a better place.

G.A.: But wouldn’t there be a value to explicating our deepest premises, if only to articulate the ways our thinking differs from that of others? I think students would like to see a spelling out of such things, and it might even help in disseminating your ideas.

Dr. E.: Here are three assumptions, and if you want, you can call them philosophical: first, we live in a common world; second, people are experiencing beings; and third, not everyone sees things in the same way. How is that for my philosophy? This is implicit and obvious in everything I have ever said to you, G.A., and spelling the premises out is a pointless exercise.
So go find something better to do with your time. Go write more poetry with your patients, and discuss it over pancakes.

G.A.: I will do that, my friend. Can I come back tomorrow for some further talk about philosophy and psychotherapy? I know you think we are getting nowhere, but the stories we are going over are interesting and may serve a useful purpose for people.

Dr. E.: Okay, but I hope you can stay on the level of specific human situations. I have become unable, in my old age, to tolerate empty abstraction.

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