

Thus Spake Settembrini
A Meta-Dialogue on Philosophy and Psychiatry¹

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1. What Unites Philosophy and Psychiatry?

“Analysis is good as a tool of enlightenment and civilization – to the extent that it shakes stupid preconceptions, quashes natural biases, and undermines authority. Good, in other words, to the extent that it liberates, refines and humanizes – it makes slaves ripe for freedom. It is bad, very bad, to the extent that it prevents action, damages life at its roots, and is incapable of shaping it. Analysis can be very unappetizing, as unappetizing as death, to which it may very well be linked – a relative of the grave and its foul anatomy.”

– Thomas Mann, *The Magic Mountain*

Before discussing what unites philosophy and psychiatry, I will attempt to define my terms. This is for the sake of avoiding unnecessary debates that emanate from what philosophers call “equivocations” – ambiguities of language or usage that give rise to disagreements that are semantic but not substantive. As we may find enough substantive matters to dispute, let us at least seek a degree of semantic accord at the outset.

By psychiatry, I understand a branch of medicine concerned with the diagnosis and treatment of so-called “mental” disorders. I say “so-called” because the use of the term “mental” in this context is fraught with philosophical difficulties from the outset, stemming from the unresolved “mind-brain” problem. If mental activity is considered a mere epiphenomenon (i.e. an insubstantive reflection, or ontological chimera) of brain activity, then mental illness is presumably reducible to brain dysfunction. Then again, in so far as thoughts, memories, volitions, intentions, aspirations, dreams, hallucinations and other ostensibly mental phenomena remain unreduced or incompletely reduced to neural, neurochemical, synaptic, engramic or other biological substrates, the dualistic distinction between states of mind and states of brain is bound to bear some weight. By my lights, progress in medical science (including psychiatry) is synonymous with advances in reliable knowledge of the body (including the brain); whereas progress in medical arts is synonymous with advances in reliable knowledge of the integral person, which includes approaches to understanding consciousness and its manifestations for what they are, and not merely for what they are assumed to be. Thus by its very definition, psychiatry entails both implicit philosophical assumptions and explicit philosophical challenges.

As expressed by Venezuelan psychiatrist Abraham Genis: “Philosophy has always been a preferential activity of psychiatrists ... and in many cases, in the course of our psychotherapeutic relations with our patients, we recognize that, inevitably, we are philosophizing.”²

The etymology of “philosophy” is “love of wisdom,” but academic philosophers need manifest neither passion nor sagacity in their official capacities as “trade-unionists” of formal thought. Ever since Wittgenstein, analytic philosophers of the Anglo-American tradition gradually divorced themselves from the extra-academic world and its poignantly tangible concerns; while Continental philosophers tended to immerse themselves over-deeply in surreal worlds and their intangible flights of fancy. Either way, and markedly since Wittgenstein, theoretical philosophers have largely suc-

ceeded in utilizing their considerable intelligence to make themselves irrelevant to the world at large and inaccessible to ordinary persons seeking practical philosophical guidance. Wittingly or not, they borrowed Poincaré's apocryphal toast "Here's to pure mathematics; may it never be good for anything," and transposed it wholesale to the love of wisdom.

I blame none of this neo-scholasticism on Wittgenstein. He is no more accountable for the cloistering of philosophy than is Darwin for the extrapolations of Social Darwinism, or Einstein and Heisenberg for New-Age sophistry which asserts that everything is either "relative" or "uncertain." Wittgenstein merely provides a convenient (and cult-like) focus for the endless and fruitless debates of the cloister. Since there is little consensus on what Wittgenstein meant by anything he said, his writings afford a richly unclear if ethereal basis for expedient speculation, which serves as both vocational and occupational therapy for cadres of permanently institutionalized philosophers. As such, perhaps the DSM V will identify a new dysfunction: WPD, or "Wittgensteinian Personality Disorder," characterized by aggressively defending the conjunctive proposition that Wittgenstein is the most brilliant philosopher of all time, but that nobody (including himself) knows exactly what he meant by anything he said.

Mercifully, we have other conceptions of philosophy, dating from antiquity, blossoming among the Early Moderns, and flowering during the Enlightenment, that place a greater premium on what Aristotle called "phronesis" – literally, "practical wisdom" – which lends itself to a wide variety of human concerns that unfold far beyond the narrow, stultified and mind-numbingly ecclesiastical groves of academe. It is phronesis that undergirds the re-emergence of worldly philosophy in the latter decades of the 20th century, in both its main branches: applied ethics, and philosophical practice.

All sub-branches of applied ethics – e.g. biomedical ethics, business ethics, computer ethics, engineering ethics, environmental ethics, journalism ethics, and even legal ethics – are concerned with real issues astride the Humean gap between fact and value, and with their appearances and interpretations as conceived in the Cartesian theatre of mind. The brute fact that we possess technologies to do such-and-thus – e.g. harvest and sell transplantable organs, conduct insider stock-trading, engage in data-mining, deforest the planet, manufacture news instead of reporting it, and defend any point of view (no matter how absurd) for money – does not entail any guidelines for effective reasoning on the ineluctable normative questions: *Should* we do such things? If so, why? If not, why not? Applied philosophers contribute to and help foment public debate on these and kindred issues, which in turn inform public policy, regulation and ultimately legislation, thus engendering an ethos that enhances (or at least pays lip service to) effective moral reasoning.

It is but a short step – yet also a "quantum" leap for some – from addressing a generic biomedical ethical issue (e.g. "What are the ethics of physician-assisted suicide?") to counseling a client struggling personally with that issue (e.g. "Should I myself seek physician-assisted suicide?"). This is precisely the step from applied ethics to philosophical counseling. If it is legitimate for philosophers to counsel society as a whole by addressing issues of immediate public concern, then it is

surely legitimate for philosophers to counsel individuals by helping them address the same issues in a context of immediate private concern.

Clients nowadays present a host of similar personal issues to philosophers, ranging from duties in marriage to rights in the workplace to moral dilemmas; from decision-theoretic problems concerning relationships or careers or existential crises to generalized searches for meaning, purpose and value in life at any stage. Our typical clients are neither medically ill nor emotionally disturbed. They are rational and functional beings who seek articulation and elucidation of philosophical issues, or of philosophical implications of issues, that hold some sway in their current circumstances. For self-preservative reasons, they are seeking to make sense of their situations, and to find some applicable principles for reframing their adversity, or calibrating their moral compass, or charting their course through whatever external difficulty afflicts them, or understanding the extent to which they may be afflicting themselves with external manifestations of their own internal conflicts.

If we understand practical wisdom in this way, then we can assert a (perhaps the) foundational perspective of mainstream philosophical counseling: that the human being's functionality is empirically operative in at least three interactive domains – the biological, the affective and the noetic. The Greek word “noesis” (from *noein*, to think, and *nous*, the mind) means the exercise of reason, especially in apprehending universal forms. The cognate adjective “noetic” refers to the rational and intellectual faculties of mind. Medical arts and sciences, including psychiatry, are naturally rooted in the biological domain. Psychological arts, sciences and pseudo-sciences tend to be rooted in the affective domain. Philosophical arts are rooted in the noetic domain. At the same time, there is no strict or impermeable demarcation between and among these domains. Thus one who contemplates the whole person is committed from the outset to interdisciplinary theories as well as to multidisciplinary practices.

For instance, it is clear that problems with affect can themselves be signs of medical illness. Then again, affective disorders can also arise because of inconsistent beliefs (as in cognitive or existential dissonance). By the same token, the kind of medical advice that a patient hypothetically seeks and ultimately follows (e.g. allopathic versus homeopathic) is partly dependent upon that person's web of beliefs about medicine, influenced by reason and experience alike; in other words, is influenced by a patient's informal philosophy and conditioned psychology of medicine itself. Moreover, the availability and quality of medical, psychological and philosophical services themselves, in a given sovereign state or region thereof, depend upon the broader philosophies of politics and economics that undergird, shape and ultimately govern the prevailing ethos.

A person who is medically ill is bound to have reduced functionality in all three domains. Disease in the biological domain almost always entails some distress in the affective domain, which in turn tends to interfere with the higher cognitive functions, such as rational choice. It is the physician's and psychiatrist's tasks to diagnose disease, prescribe treatment, indirectly restore health – and thereby re-instate the patient's overall functionality. At the same time, a person who is philosophically confused or conflicted also has potentially reduced functionality in all three domains. An

unresolved moral dilemma, for example, can cause loss of sleep and appetite (in the biological domain), along with anxiety and irritability (in the affective domain). But in such a case, symptomatic treatment by medicine, psychiatry or psychology (e.g. medications or psychotherapies) will not resolve the core problem, which is axiological and subsists in the noetic domain. A philosophical resolution of the moral dilemma is required to re-instate the overall functionality of such a client.³

Thus philosophy and psychiatry are united in the first instance by a common mission, albeit grounded in different domains: to restore the functionality of the beneficiaries of their respective services. For most human beings, optimal functionality requires persistent maintenance of an unstable equilibrium of physical health, emotional balance and conceptual order. What divides philosophy and psychiatry, as we shall see more pointedly, is that typical clients of philosophers tend to be affectively well-balanced, whether they are confronting a marital break-up, a career crisis, or even a fatal prognosis. By contrast and almost by definition, typical patients of psychiatry tend to be affectively ill-balanced, for a constellation of possible reasons. As a service provider, the psychiatrist therefore faces a more difficult daily mission than does the philosopher. However, the meta-mission of determining *whose* mission it should be in a given case – i.e. of demarcating more fully between psychiatric and philosophical criteria of functionality – is a collaborative challenge for psychiatrists and philosophers together.

Idiosyncratically, philosophy and psychiatry are united by reciprocal professional relations. Some philosophers do seek (while others should seek) psychiatric help; and some psychiatrists do seek (while others should seek) philosophical help. It is therefore mutually incumbent on philosophers and psychiatrists to participate in meta-dialogues concerning the theory and substance of their reciprocating professional dialogues. I will characterize two such meta-dialogues for you. The first was an indirect exchange, refracted through the distorting medium of a prominent American newspaper. The second was a direct exchange, through an invited course given to European psychiatrists.

Philosophical counseling was introduced to mainstream American culture in the late 1990s, partly through a series of newspaper articles. A formulaic norm by which journalists often feign balanced reporting is to represent (or possibly misrepresent) the position of a story's protagonist, then to provoke precipitous objections (nominally, rebuttals) from the protagonist's competitors or detractors. Thus the Associated Press represented philosophical counseling as help for the "ethically-challenged" in a 1998 article published on the front page of the *Los Angeles Times*.⁴ The journalist had elicited her perfunctory precipitous objection from no less a figure than the (then) President of the American Psychiatric Association, Herbert Sacks, who rashly accused philosophical counselors of "practicing medicine without a license."

This draws two brief retorts from me. First, I assert that any psychiatrist who reflexively equates a moral dilemma with a mental illness might benefit from philosophical counseling himself – in this case an initial consultation on Plato's distinction between appearance and reality, then Hume's distinction between fact and value. This would be followed up by Hume's argument illustrating the impossibility of deriving "ought" from "is," which applies straightforwardly to most clients

facing moral dilemmas. The brute facts of circumstance do not permit the derivation of normative conclusions, unless normative premises are smuggled into the argument. The philosophical counselor's role in such cases is to conduct a dialogue that helps the client to articulate his or her implicit normative premises, to elucidate their normative prescriptions, and to evaluate moral alternatives and their probable consequences.

Moreover, as I have explained, if moral dis-ease is "diagnosed" and treated as though it were medical or psychiatric disease, the symptoms might be temporarily alleviated, but the moral dilemma would persist until addressed and resolved in its proper domain. That domain is ethical, not medical. This leads to my second retort; namely, that any psychiatrist who diagnoses and treats moral dilemmas (or other philosophical problems) as "mental illnesses" is *practicing non-medicine with a license*.

The power of licensure is such that any physician (or licensed psychologist) can not only misdiagnose ethical problems as medical ones, but also can legally dispense ethics counseling to patients without necessarily knowing anything at all about ethics. Whereas a philosophical counselor who so dispenses can attract accusations of practicing medicine (or indeed psychology) without a license. Viewed in one way, such accusations are hubris arising from poor professional formation, from lack of appropriate continuing education, and from perennial corruptions of power itself. In America, an admixture of hubris with profit-motive exacerbates turf-wars between and among professional caregivers, which nonetheless can have the salutary aftereffect of obliging consumers to think more carefully about what might be wrong with them, and therefore also about what kind of help to seek. *Caveat emptor*.

On the whole, Europeans are far better-educated than Americans, whose system is in free-fall, although I gather that one of globalization's unfortunate side-effects is a marked decline in European educational standards as well. Many Americans regard philosophy as a pointless elective study to be avoided at all costs, mostly because it requires intellectual exertions incompatible with hedonism and consumerism, generally because it cannot be done while watching television, playing video games or surfing the world wide web, and specifically because deconstructed "education" in America is no longer predicated on reading, writing or reasoning skills – rather on vacuous pretensions to self-esteem, puerile denigrations of rigor, and sophomoric ideologies celebrating "diversity" as the primary goal and overarching virtue of institutions of erstwhile higher education. Thus even willing students can nowadays barely parse a sentence of any Enlightenment thinker. Unslaked conceptual thirsts, combined with untutored palates, make mainstream Americans so vulnerable to slogans, cults and circuses. Europeans, by contrast, tend respectfully to regard philosophy as a mandatory component of a decent formal education, but not as something especially useful in subsequent personal or professional life. Thus Europeans study philosophy early on, but eschew it as a luxury later. So they too, for manifestly different reasons, miss out on its quotidian benefits.

Pace the peripatetic Golden Mean, it appears that the European extreme of underutilizing philosophy out of misplaced reverence for its antiquity and theoretical complexity is more virtuous

than the American extreme of underutilizing philosophy out of received anti-elitism and entrenched mass-marketing of junk food and junk thought alike. This hypothesis would account for the best-selling status of my popular book, *Plato Not Prozac*, throughout Europe but not in America. And perhaps for this reason, I was invited by the Swedish Psychiatric Association to direct an accredited course in philosophical counseling, team-taught along with two outstanding European colleagues (Anders Lindseth and Antti Matilla), at the 2002 EAP conference in Stockholm. Dr. Henrik Nyback, a member of the SPA Board, subsequently commented “Your presentations of various aspects of philosophical counseling were very inspiring to me and to the international audience ... I’m convinced that in the future the interaction between our disciplines, philosophy and psychiatry, will grow and deepen into further collaboration.” Needless to say, this open-minded European view of philosophical counseling is a far cry from the unvarnished buffoonery of the American charge of “practicing medicine without a license.”

The nuanced picture, of course, is never so black-and-white. In fact, many rank-and-file American psychiatrists also support the idea of philosophical counseling, and some are even using *Plato Not Prozac* as a philosophical field manual in their own practices. I myself collaborate with a psychiatrist, Dr. Mahin Hassibi, on my *pro bono* philosophical counseling research protocol at City College. Psychiatrist members of the Association for the Advancement of Philosophy and Psychiatry have acknowledged that perhaps 10% of their patients present philosophical, and not exclusively psychiatric, problems. Our potential for collaboration is indeed considerable, and probably universal.

2. What Divides Philosophy and Psychiatry?

“Order and classification are the beginning of mastery, whereas the truly dreadful enemy is the unknown. The human race must be led out of the primitive stage of fear and long-suffering vacuity and into a phase of purposeful activity. Humankind must be informed that certain effects can be diminished only when one first recognizes their causes and negates them, and that almost all sufferings of the individual are illnesses of the social organism.” – Thomas Mann, *The Magic Mountain*

Western medicine, of which psychiatry is a special branch, is based on an allopathic (rather than a homeopathic) model whose roots are essentially Newtonian. The body is viewed as a kind of machine, replete with parts and systems. Defective parts can be repaired or replaced; malfunctioning systems can be restored to acceptable levels of functionality. All bodily parts and systems are ultimately subject to biochemical and biophysical laws, greater understanding of which conduces to greater power, in a straightforwardly Baconian sense, over maintenance of health and management of sickness. The role of the mind and its faculties – such as volition, intention, imagination, and the like – are quite marginalized in this materialistic paradigm, which views thought (or ideation) as an epiphenomenal by-product of neural and synaptic activity. Notwithstanding the shortcomings of this view, its successes are undeniable: Life expectancies in the developed world, whose citizens have fair to excellent access to leading-edge medical technologies, have almost doubled in the past century or so.

Psychiatry is in the exciting and also unenviable position of treating the most interesting and least-understood organ in the body: the brain. Notwithstanding Freud's postulated reduction of thought to deterministic cerebral activity, carried on philosophically by eliminative materialists among other physicalists, the issue of substance dualism is far from settled. Even untrammelled idealism of Buddha's, Plato's or Berkeley's kinds, although disparaged by current Western philosophical fashion, is not thereby refuted. Given the organ it treats, psychiatry is *de facto* the most philosophical of the medical arts. However, consistent with the successes of the allopathic model, the received philosophy of current mainstream psychiatry is also inherently mechanistic. In so far as the brain is viewed as a volatile soup of neurochemical transmitters, whose unstable homeostasis is normally auto-regulating but susceptible to uncontrollable perturbations as well as congenital imbalances, the first line of defense against so-called "mental illness" is the restoration of neurochemical balance, effected by the latest generation of serotonin re-uptake inhibitors and other "mood-enhancing" formulations. The default medical treatment is therefore molecular psychiatry, ideally but not necessarily followed by some kind of dialogue.

Given the enormous demands placed upon physicians and psychiatrists, who typically have large case-loads and correspondingly little time to devote to each case, and who are increasingly afflicted (at least in the USA) with mountainous paperwork plus the daily struggle of justifying proposed treatments via telephone to bureaucratic third-party insurers, medical professionals have increasingly little time to talk to their patients. This potentiates a fruitful alliance between psychiatrists, physicians, and philosophical counselors, provided that the medical profession is willing to admit that faculties of mind also play an active and vital role in maintaining overall well-being. This in turn requires at least two related modifications to the Newtonian model of medicine: first and generally, adopting a more holistic view of the human being; second and particularly, abandoning the notion that psychiatry guarantees an objective perspective from which to study the human being.

The integration of more holistic theories and practices into the extant mechanistic model is ongoing, and its elaboration lies beyond the scope of this essay. It is the second modification that I wish to address: the rejection of the premise that one human being, through the lens of any paradigm, can study another human being with scientific impunity. Just as there are no uniquely "privileged frames" from which one can observe absolute properties of physical objects, there are no uniquely "privileged frames" from which one can make absolute diagnoses of human beings. For example, while "paranoia" entails a set of attitudes and behaviors that are dysfunctional in open and free societies – hence "diagnosable" as a "mental illness" – the same set of attitudes and behaviors might be highly functional – and might therefore become a norm, not an "illness" – in a totalitarian regime. And even if one rebuts such panoramic sociological relativism, one does not thereby avert or remedy the value-ladenness of diagnostic criteria.

In the former Soviet Union, dissidents were routinely confined to psychiatric hospitals instead of political prisons. The rationale was purely dialectical (*qua* Orwellian), and not at all medical. The Soviet Union had been declared, by the Communist Party, to be a "worker's paradise."

Anyone who objects to living in paradise is obviously crazy. QED.

Lest we who inhabit less paradisiacal but nonetheless freer polities fall prey to smugness, consider the Rosenhan experiments, in which researchers posed as “mentally ill” patients in order to gain admission to psychiatric wards, where they clandestinely studied the psychiatrists and other staff. Unable to observe ongoing signs of “mental illnesses” in these patients, the staff made pejorative notes on their normal activities – such as, “patient engages in writing behavior.” Surprisingly, only the psychiatric patients were able to penetrate the deception: “You’re not crazy. You’re checking up on the hospital” said one.⁵

The Rosenhan experiments raise a serious philosophical problem, which has nothing to do with professional ethics. Let me illustrate the problem with parallel scenarios involving auto mechanics, and surgeons. Some unscrupulous mechanics defraud their clientele, by making unnecessary repairs to cars, or by replacing perfectly functional parts, or by charging for work not done. Similarly, some unscrupulous surgeons malpractice medicine by performing unnecessary surgeries. In both kinds of cases, the dishonest mechanics and the dishonest doctors are obviously aware of their fraudulence. Thus they stand in knowing and willful violation of their respective professional ethics. In the Rosenhan experiments, by contrast, the psychiatrists and staff did not knowingly or willfully malpractice medicine. They simply assumed *ab initio* that anyone who came under their care was “mentally ill,” and thus they sought observational data that confirmed their hypothesis. Failure to observe such data in specific cases should have suggested disconfirmation, but instead they re-interpreted the data to salvage their unsound hypothesis. Blinded by their pre-conceived notions, they were unable to make objective assessments of their putative “patients.”

I do not raise the Rosenhan spectre to attack psychiatry or defend anti-psychiatry; rather, to remind psychiatrists of Plato’s salient distinction between appearance and reality.⁶ The moral is: Not everyone who appears as a patient is necessarily a patient.

The history of science is riddled with examples of theory-laden obfuscation of observed data – from Penzias’s and Wilson’s inadvertent discovery of the Big Bang’s cosmic echo to Margaret Mead’s ironic coming of age in Samoa. These examples among many others, writ large across the entire spectrum of the sciences, are all indicative of the main point: namely, that there is no uniquely privileged paradigm from which to make value-neutral observations. All empirical observations are theory-laden; that is, are made through the lens of imperfect knowledge, and are therefore susceptible to distortion or aberration by received false premises mistakenly held to be true. Moreover, since nothing is more value-laden than states of mind themselves, then states of mind attempting to evaluate other states of mind, and attempting to evaluate responses to those evaluations, are bound to potentiate the drawing of irremediably subjective – and at times ineluctably arbitrary – inferences.

One way to restore a measure of implied objectivity to such an imprecise science, especially in the absence of specifiable causal reductions of many so-called “mental illnesses” to actual brain-states, is via statistical correlation. That is, patients who present with certain symptoms, and who exhibit particular signs, are statistically likely to be suffering from such-and-thus syndrome. On this

view, the DSM affords a sensible – perhaps the sole sensible – approach to “diagnosing” dysfunctions of the brain. At the same time, however, such a manual is conspicuously vulnerable to two kinds of defects, which some philosophers and psychiatrists have identified. The two are: reification (an ontological and epistemological problem), and science by democracy (a political and economic problem).

Reification occurs primarily through neglect of the Duhem-Quine thesis, namely the unavoidable underdetermination of theory by data. Simply stated, it means that there are in principle any number of theories that could account for a given observation; and that there is no way, *a priori*, to ascertain which of these theories is in fact the sound one. Consider the empirical proposition “Disorder A produces behavior B.” Suppose this is demonstrable, whether causally or correlatively. Now consider the diagnostic inference: “Behavior B evidences disorder A.” This is not necessarily true at all on causal grounds, and may or may not be significant on probabilistic ones. For example, the empirical proposition that attention deficit disorder (ADD) produces misbehaviors in the schoolroom is statistically if not causally verifiable. However, the diagnostic inference that misbehavior in the schoolroom evidences ADD is clearly dubious. Any number of factors could induce students to misbehave. But it is precisely on such dubious converse inductions that the so-called “epidemic” of ADD has been “diagnosed” (that is, reified), resulting in the coerced drugging of millions of American schoolchildren with Ritalin. While obstreperous children should certainly be tranquillized on airplanes, the reification of an ADD “epidemic” in the schools is ontologically suspect, commercially motivated and educationally scandalous.

An underlying cause of reification itself, not just of one “disorder,” but of many, is indubitably the ballot-box method by which disorders are elected to the DSM. No significant discovery in the history of science, including medicine, has ever been made by such democratic means. On the theoretical side, the Newtons, Darwins and Einsteins all worked alone, had their theories subjected to the most withering skepticism, and their hypotheses rigorously tested, before winning gradual (if not grudging) acceptance by communities of their peers. On the empirical side of medicine, important breakthroughs by the likes of Pasteur, Lister and Semmelweiss met with uniformly vituperative opposition from peers, until finally accepted and adopted. The way of scientific progress is verisimilitudinous but combative; that is, unfolds via asymptotic approaches to truth made by clear-sighted individuals initially opposed by bias-blinded herds.

By contrast, the politicization of science – by any political system – is bound to have the opposite effect, and lead to antiverisimilitudinous scientific regress. Naturally, both fine- and coarse-grained distinctions between various political systems are reflected in their respective politicizations of science, which makes regress a matter of degree, but not of kind. From a copious and lamentable historical catalogue of such cases, one could cite the Roman Church’s prohibition of Galilean astronomy, the Anglican censorship of Hobbesian political theory, the Creationist denial of Darwinian evolutionism, the Nazi proscription of “Jewish physics,” the Soviet endorsement of Lamarckian agronomy, the Maoist annihilation of its intelligentsia, the African denial of AIDS’s etiology, or the

American radical feminist repudiation of science itself. Whether the political interference has been motivated by theocracy, misogyny, totalitarianism, despotism, or hysterical anti-realism, the result is always the same: retreat from truth, obstruction of progress, increase in suffering, and – in the worst cases – needless death on extravagant scales.

Churchill's stinging aphorism about democracy being the worst form of government – except for all the others – translates into the comparatively benign face of the democratization of science. Nonetheless, one decisive factor in democratic politics is lobbying, and the pharmaceutical industry's ability to lobby the medical profession is undeniable. Thus, when the American Psychiatric Association elects a "mental illness" like Social Anxiety Disorder to the DSM, and when we witness prime-time television advertisement campaigns for prescription drugs like Paxil, billed as a panacea for life's concerns, we are bound to conclude that the pharmaceutical industry and the medical profession have struck a nefarious albeit democratic bargain to perpetrate fraud on gullible consumers. While this will not result in mass-death, as did the corrupt lobbying of politicians and others by the tobacco industry during many decades, it does represent the undesirable colonization of medicine by *laissez-faire* capitalism.

As long as the DSM remains vulnerable to charges of reification of disease and democratization of science, philosophical aspersions will justifiably be cast on it, and by extension on those who take it and its paradigmatic peculiarities too literally.

So what – if anything – divides philosophy and psychiatry, besides the standard objections raised by medical and professional ethicists, and beyond the paradigmatic critiques that philosophers of science level across the spectrum of such endeavors? Given the plurality of philosophical approaches to psychiatry by psychiatrists themselves, from Karl Jaspers' existentialism to Raymond Prince's transculturalism; from R.D. Laing's unorthodoxy to Thomas Szasz's apostasy – it appears that psychiatrists have recapitulated many of the differences that divide philosophers themselves. The starkly contrasting views of human nature held by Rousseau contra Hobbes, or by Buber contra Foucault, are typical divisions in a discipline defined de facto by diversity of opinion on everything. The operative divide in either profession is between those who view man as a fundamentally sick animal (a position espoused theologically by Augustine, psychoanalytically by Freud, and commercially by the pharmaceutical industry) and those who view man as a circumstantially afflicted but ultimately transcendent being (a position espoused pragmatically by Buddha, idealistically by Emerson, and allegorically by Huxley). So perhaps philosophy and psychiatry are actually united by their respective divisions.

3. What Transcends Philosophy and Psychiatry?

"In general, our pharmacologists would do well not to be too overweening about their knowledge, for they had the same problem with a great many things: they knew this and that about the dynamics and effects of a substance, but any questions as to precise causes all too frequently proved an embarrassment." – Thomas Mann, *The Magic Mountain*

Thomas Mann's *Death in Venice* is not simply an elegant novella, charting the demise of the neo-classical literatus Achenbach; it is an allegory on the demise of classicism itself, which heralds the death of Western civilization. While generally taken to be Mann's last word on the subject, there does remain a plausible alternative view, put forward by Mann himself in his windier classic, *The Magic Mountain*.

Set in the Swiss Alpine village of Davos, whose elegant hotels during the latter 19th and early 20th centuries were sanatoria for the respiratorily-challenged, *The Magic Mountain* hypothesizes that Western civilization is merely ill – perhaps even gravely ill – but has some unascertained prospect of recovery. A central question of the novel is whether that which is yet-to-be-ascertained is in fact ascertainable at all. Interestingly enough, this later became a central question for 20th century epistemology of science.

Much of Mann's characters' colloquy about the diagnosis and treatment of potentially fatal respiratory ailments is straightforwardly transposable from the medical metaphor to the geopolitical, dialectical, eschatological and teleological axes of Mann's (and man's) perspective on the West. In order to explore the intricacies and interstices of this debate more deeply, Mann provides an erudite mouthpiece: a scholar and belletrist by the name of Lodovico Settembrini, who plays metaphysician to our ailing but possibly convalescing civilization.

I have embarked this far on literary interpretation only to introduce to you the character of Settembrini. To those readers already acquainted with him, as well as to those newly-introduced in virtue of the foregoing, I should now like to re-acquaint you, via an unusual missive. Since the letter in question was penned by a psychiatrist, it may prove a more reliable source of re-introduction than the idle speculations of a philosopher. The letter was published in *Psychiatric News*, newsletter of the American Psychiatric Association, and was written in response to an article on philosophical counseling.⁷ The article itself had emerged from that seminal piece in the *L.A. Times*, and was penned by the newsletter's editor Richard Karel – not a psychiatrist himself, but an in-house journalist employed by the American Psychiatric Association.

Psychiatric News, Letter to the Editor, May 15, 1998⁸

Philosopher Therapists

Richard Karel's piece in the April 17 issue on "philosopher practitioners" (philosophers who claim to practice a form of psychotherapy) brought back memories of Thomas Mann's novel, *The Magic Mountain*. There we meet the humanist scholar, Settembrini, who embodies the enlightened classicism of the Renaissance.

"There is one power, one principle, which commands my deepest assent. . .," Settembrini says, and this "is the intellect." When spring comes to the Alpine sanitarium, Settembrini is ecstatic: "All the disquieting, provocative elements of spring in the valley were here lacking: here were no seething depths, no steaming air, no oppressive humidity! Only dryness, clarity, a serene and piercing charm."

Reading the words of the “philosopher practitioner” Dr. Lou Marinoff, one feels that he and Settembrini are kindred spirits. In a recent article in the *New York Times*, Professor Marinoff holds forth hope to troubled souls, who would “explore and address their dilemma through the long history of thought, rather than through Prozac, for example.”

Let us leave aside Professor Marinoff’s admission that “the history of thought” might not suffice for those with “severe personality disorders” – or, presumably, psychotic disorders or suicidal depressions. Let us leave aside the matter of how philosopher practitioners will be trained to recognize when their “clients” are too sick to benefit from Sartre or Nietzsche. Let us defer the critical issue of unrecognized medical and neurological illness in many patients with so-called existential problems. Let us even put aside the huge medicolegal question of whether unvalidated “treatment” by philosophers may delay lifesaving care by mental health professionals.

We must still return to Settembrini, with his love for dryness and clarity and his distaste for seething depths and steaming air. It is in precisely such a tropical clime that the psychotherapist must often work. The sexually abused individual who experiences traumatic flashbacks, the narcissistic character who bristles with anger at the world’s indifference, the substance abuser who explodes after a single drink: these individuals do not live in Settembrini’s (or Marinoff’s) sunlit world of philosophical humanism. Many are struggling in that darker land of the shattered self, and there – with courage, care, and passion – must be joined by the therapist. This is no place for well-intentioned scholars, armed with the serenity of the Western philosophical canon. Sometimes the text must come close to the flame before its words take wing.

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I must offer a well-tempered response to Dr. Pies, whose comments certainly merit one. But before doing so, let me thank him for his flattering – and, as it turns out, prescient – comparison to Settembrini. I will instantiate his prescience in due course; but first, here is my reply to the good Doctor.

First, we need not leave aside my admission, shared by most philosophical practitioners, that great ideas alone will not suffice to remedy severe personality disorders, psychoses, or suicidal depressions. To quote from my IRB-approved research protocol at The City College of New York: “Philosophical counseling is intended for clients who are rational, functional, and not mentally ill, but who can benefit from philosophical assistance in resolving or managing problems associated with normal life experience.”⁹ The assertion that some people can benefit from philosophical counseling does not entail the assertion that all people can. Thus this objection by Dr. Pies (if it is one) is a straw man.

Second and more important, let us not leave aside the matter “of how philosopher practitioners will be trained to recognize when their ‘clients’ are too sick to benefit from Sartre or Nietzsche.” My reply is straightforward. Like every other profession, philosophical counseling has a scope of practice. City College’s IRB approved this one:

“The most suitable candidates for philosophical counseling are clients whose problems are centered in:

- 1) issues of private morality or professional ethics;
- 2) issues of meaning, value, or purpose;
- 3) issues of personal or professional fulfillment;
- 4) issues of underdetermined or inconsistent belief systems;
- 5) issues requiring any philosophical interpretation of changing circumstances.”

Note that the IRB’s approval of this scope of practice entails its recognition that all the foregoing issues are intrinsically or primarily philosophical, and that none of them is intrinsically or primarily psychological, medical or psychiatric. The APPA’s training and certification of philosophical counselors is consistent with this scope of practice. We are not trained to diagnose or treat “sicknesses” or other conditions lying outside this scope. We are trained to dialogue with rational and functional clients whose issues lie within it. If during an initial consultation or a subsequent dialogue it emerges that a client’s primary problem appears not to lie within this scope, the client is referred for psychological, medical or psychiatric evaluation.

Philosophical counseling is defined by the APPA as an educational activity. It is not radically different than teaching philosophy in a classroom, save that it applies philosophical analysis and insight to issues pre-selected by the client, instead of to texts or topics pre-selected by the professor. One might as well ask “How are university professors trained to know when their students are too ‘sick’ to study Sartre or Nietzsche”? The answer is that they aren’t, and needn’t be. Students who lack sufficient rationality or functionality to cope with philosophy courses either drop them or fail them or find other subjects to study, or else seek tutoring to help exercise reason or improve academic performance. Similarly, persons who lack sufficient rationality or functionality to dialogue with philosophical counselors either don’t come to us in the first place, or are referred by us for more appropriate help. In general, clients too “sick” to benefit from Sartre or Nietzsche are usually too “sick” to make and keep appointments with philosophical counselors, or too “sick” to engage in lucid or coherent dialogue with them – hence merit referrals for psychiatric or psychological evaluation. Thus the good Doctor should be reassured on this score.

Third, let us not defer “the critical issue of unrecognized medical and neurological illness in many patients with so-called existential problems.” On the contrary, let us meet it head-on. During the APPA’s training of philosophical counselors, we do indeed make this very point: that a good many illnesses can manifest symptoms that appear as philosophical, psychological or even psychiatric problems, but which in fact require a medical or neurological diagnosis to reveal the underlying disease.¹⁰ About 10% of self-referred psychiatric patients have symptoms provoked by medical illness, and that is no small number.¹¹

The most rational conclusion to draw is that, in the best of possible worlds, any person wishing to see a counselor of any kind – whether psychiatric, psychological, philosophical, pastoral, legal, etc. – should receive a full medical work-up first, to ensure as far as possible that the actual

problem is not corporeal. However, in the real world, there are hundreds of thousands of psychiatrists and psychologists seeing millions of patients annually, a substantial proportion of whom apparently have undiagnosed medical problems. In the same world, there are several dozen philosophical counselors seeing several hundred self-selecting clients annually, many of whom have previously received treatment from psychiatrists or psychotherapy from psychologists, and some of whom are simultaneously under the care of physicians for diagnosed ailments, but still need to make philosophical sense of their lives (and ends-of-lives, when prognoses are fatal). A small fraction of these clients claim to be suffering from *angst*. Where, then, does the crisis of undiagnosed illness manifest most severely? Clearly it does so in the camps of psychiatry and psychology themselves. Thus the medical profession, including psychiatry, ought to be concerned first and foremost with its own epidemic of undiagnosed disease.

As the profession of philosophical practice develops and grows, philosophical counselors will begin to see enough clients to make statistically-significant studies feasible. Then we'll be able to test this question empirically: What proportion of clients of philosophical counseling have undiagnosed diseases? I predict that this fraction will be significantly smaller than that for patients of both psychiatrists and psychologists. Furthermore, I predict that it will be as small as, or smaller than, that of the general populace. Statistically, this would mean that seeing a philosophical counselor poses no risk greater than that of going about one's normal business in everyday life – e.g. of crossing the street, or driving to work.

That said, I now shift from a defensive to an offensive posture, to raise a crucial point implied but ignored by Dr. Pies's concern about undiagnosed illness. There are two gross ways in which nosology can err: by failing to diagnose existing disease, or by succeeding to diagnose non-existing disease. Let us re-address the latter possibility. As previously mentioned herein, and as elaborated for lay readers in two popular books,¹² the DSM IV contains a number of ontologically-suspect "diseases" – either transparently subjective on their face (e.g. "non-compliance with treatment disorder"), commercially contentious in their application (e.g. "attention deficit disorder"), or pretentiously pseudo-scientific in their jargon (e.g. "post-traumatic stress disorder").

The DSM has steadily increased the number of its democratically-elected "mental illnesses;" has encouraged widespread "paint-by-numbers" diagnoses of every conceivable complaint, often as not without any demonstration of causal reductions to putative brain dysfunctions; and has become the definitive instrument of unprecedented and growing pharmaceutical avarice, through which a gargantuan industry of legalized drug-dealing is imposed on consumers by an alliance of big business interests, complicit medical (and pseudo-medical) professionals, and states which license them. They are capitalizing on a myth foisted initially upon gullible and uncritical American consumers, and increasingly propagated throughout the global village, to the effect that every experience of disease (*qua* noetic or emotional discomfort) is a "symptom" of some sickness (*qua* "mental illness" or – as the popular catechism goes – "chemical imbalance in the brain"). It is almost effortless for an intellectually shoddy, technocratically dependent, abjectly ill-educated and consumer oriented popu-

lace to ingest this myth wholesale, then to ingest the medications advertised as panaceas for the conspirators' catalogue of reified "diseases." On this issue, Dr. Pies remains regrettably silent.

Fourth, let us not put aside "the huge medicolegal question of whether unvalidated 'treatment' by philosophers may delay lifesaving care by mental health professionals." Rather, let us confront this sublime assertion head-on. How many patients, world-wide, die annually in the so-called "lifesaving care" of so-called "mental health" professionals – whether of suicide, or of undiagnosed diseases, or of related causes? There were 30,575 suicides in the USA alone in 1998.¹³ How many thousands of these committed suicide while in the "lifesaving care" of "mental health" professionals? In New York State, such patients have a suicide rate well above the general population – 115.9 per 100,000 versus 9 per 100,000 respectively, in 1985 – and growing.¹⁴ At the same time, to my knowledge *not one single client of any philosophical counselor has ever committed suicide*, or died of an undiagnosed disease, or died because a philosophical counselor somehow "delayed" the provision of "lifesaving care." Nor has any philosophical counselor ever been sued for malpractice. Those who make the most outrageous accusations against our profession cannot present one shred of supporting evidence, while all the evidence extant suggests that they are most vulnerable to the very charges they levy against us! Are critical thinking and scientific reasoning no longer taught to medical students in general, and to psychiatric residents in particular?

And let me re-proportion Dr. Pies's "huge medicolegal question" of so-called "unvalidated 'treatment'." I reiterate that philosophical counseling is defined by the APPA as an educational activity, not a medical one. The APPA trains and certifies philosophical counselors with the explicit authorities of the New York State Department of State, and the New York State Department of Education. Furthermore, philosophical counseling is legislatively unregulated in every state of the union, and thus is not legally proscribed anywhere in the USA. So what becomes of Dr. Pies's "huge medicolegal question"? It is neither medical, nor legal, nor huge, nor even a question at all. As to "unvalidated 'treatment'," philosophical counselors neither *diagnose* nor *treat* our clients. Rather, we *dialogue* with them, as providers of an educational service. The provision of this service is indeed validated, by a professional association (the APPA) of those best-qualified to validate it. The APPA's Certification Standards and Code of Ethics bind our Certified Practitioners.¹⁵ I trust that the good Doctor is not implying that *all* professional services must be validated by psychiatrists in order to be reputable.

Fifth and finally, "We must still return to Settembrini, with his love for dryness and clarity and his distaste for seething depths and steaming air. It is in precisely such a tropical clime that the psychotherapist must often work ... Many are struggling in that darker land of the shattered self, and there – with courage, care, and passion – must be joined by the therapist. This is no place for well-intentioned scholars, armed with the serenity of the Western philosophical canon."

I couldn't agree more, save that many of us philosophical practitioners bear two arms; the other being the serendipitous Eastern philosophical canon. Nevertheless, it is clear that psychiatrists must contend daily with the darkest aspects of dysfunctionality, derangement and dementia. So many

of the “shattered” selves in their custody suffer metaphorically from “Humpty-Dumpty disorder,” in that all the King’s horses and all the King’s men – not to mention all the King’s psychiatrists – cannot put them back together again. By contrast, it is equally clear that philosophers’ clients are neither dysfunctional nor deranged nor demented. They inhabit a land not doomed by darkness, though not always flooded with light. They seek, and more often than not find, illumination via bright sparks of philosophical inquiry.

There is a notoriously but understandably permeable demarcation (that is, a “fine line”) between cops and criminals. In the small minority of worst cases, only a badge distinguishes one from the other. In all cases, law enforcement officers deal daily with criminals and crimes of every description – not to mention their victims – and so are continuously exposed to the worst of what nominally accountable citizens do to themselves and others. Thus one can understand the cop’s conditioned (and probably self-preservative) inclination to view all suspects as guilty until “proven” innocent, even in a criminal justice system that upholds the presumption of innocence and lays the burden of proof of guilt upon the prosecution.

A similar demarcation obtains between psychiatrists and their patients. In the small minority of worst cases, only a license distinguishes one from the other. In all cases, psychiatrists deal daily with human dysfunctions and dysfunctional deeds of every description, and so are continuously exposed to the worst of what citizens nominally unaccountable (by reason of diminished autonomy) do to themselves and others. Thus one can understand the shrink’s conditioned (and probably self-preservative) inclination to view all patients as dysfunctional until proven functional, in other words as “mentally ill” until proven mentally well, even in a Republic whose civil and criminal justice systems jointly if implicitly uphold the presumption of sanity, and lay the burden of proof of insanity upon the State.

Even so, the vast majority of human beings are neither criminally inclined nor mentally ill, and yet require care or guidance from myriad helpers at different stages of their lives – whether from parents, teachers, friends, spouses, lawyers, doctors, coaches – and sometimes even from philosophers. The very best of these helpers, like the very best law enforcement officers and the very best psychiatrists, all join courage, care and passion to their helpful services. Here endeth my reply to the good Doctor, a reflective and conscientious professional, who perhaps sustains understandable regret that so little light from the blazing suns of human mentation at its best can ever penetrate the murky depths of human dysfunction at its worst. At the same time, I am sure he would encourage (rather than obstruct) the delivery of philosophical services, properly construed, to those who can benefit from them.

4. Thus Spake Settembrini

“Letting oneself go, in fact, was doubtless a definition of madness in many cases, inasmuch as it was a way of fleeing from great affliction and served weak natures as a defense against the overpowering blows of fate, which such people felt they could not withstand in their right mind. But then anyone could use that excuse, so to speak; and he, Settembrini, had brought many a madman back to reality, at least temporarily, by confronting his fiddle-faddle with a pose of unrelenting reason.”

– Thomas Mann, *The Magic Mountain*

Dr. Pies may not realize that he is also somewhat prophetic. Unbeknownst to us both, his flattering but fanciful comparison of me to Settembrini would, within three years of its publication, become more actual than either of us could have imagined.

Since the early 1970s, the sleepy ski resort of Davos has become home to the Annual Meeting of the World Economic Forum. Each year in late January, the world’s business, political and cultural leaders gather to deliberate and shape the planetary agenda for the evolution of the global village and the amelioration of the human estate. Owing to my pioneering labors in philosophical practice, and its positive reception in many countries and cultures around the world – and notwithstanding assorted critiques by psychiatrists, psychologists and philosophers as well – I was invited to participate in the 2001 and subsequent WEF Programmes. Thus, in January 2001, I found myself in Davos. More to the point, the closing luncheon traditionally takes place on the parapets of the majestic Schatzalp, in the very hotel in which Thomas Mann wrote *The Magic Mountain* and invented the character of Lodovico Settembrini.

There on the Schatzalp, surveying the vista Mann surveyed when he deliberated the fate of Western civilization in the mouths of Settembrini and his interlocutors, I have been implicated in a sequel to that scene, in a latter act of our long-running play. What could we say about the West and its undeniable decline, that had not already been said more eloquently by Mann, more dramatically by Nietzsche, more apocalyptically by Wagner, more historiographically by Spengler?

Lodovico Settembrini had been involved in a multidisciplinary project to catalogue the world’s sufferings, with the positivistic aspiration that an accurate taxonomy would abet their alleviation. In retrospect, the myriad historical sufferings that Settembrini contemplated classifying pale in comparison to the unprecedented horrors of the 20th century, during which the very scale of human conflict and its needlessly imposed miseries was recalibrated several times over, to accommodate the escalating excesses, before being consigned to that special obsolescence reserved for instruments that measure too much too well. Just as the obese have little use for bathroom scales and mirrors, so moralists have little use for Sivard indices and daily newspapers.

It is Job’s comfort to tens of millions of victims – butchered in but one of many wings of the 20th century’s sprawling slaughterhouse – that Erich Fromm “diagnosed” Joseph Stalin posthumously as “a clinical case of non-sexual sadism.”¹⁶ Shall we consult a political DSM, to discover what “disorders” motivated not only Stalin, but also Hitler, Hirohito, Mao, Pol Pot, Amin and Milosevic,

among other noteworthies in the pantheon of mass-murderers of that agonized century? Shall we consult the fatalist Tolstoy, who believed that kings are History's slaves? Shall we consult Henri Bergson, Aldous Huxley, and Karl Popper, who understood all too well the etiology and pathology of 20th-century mass-slaughter, but whose ideas were powerless to prevent it?

And in the wake of September 11, 2001, shall we consult Thomas Carlyle, who claimed that no false man could found a religion? The great proselytizing faiths, Christianity and Islam, also have their hallowed places in the fulsome annals of wanton carnage. The havoc wrought by men in the names of their Gods rivals that wrought by Gods in the names of their men. If the monumental arrogance and rabid intolerance of fanatical Christianity at its worst attracted diagnoses of infantilism from Freud and epithets of enslavement from Nietzsche, while Christianity at its best helped sustain the high culture that nurtured them both (two stars twinkling in a veritable galaxy of luminaries), what dare we say about Islam, whose worst is possibly yet to come – on both the giving and receiving ends? I travel across America and around the world these days, heightening the philosophical awareness of individuals, groups and organizations, and everywhere I am asked searching questions about Islamic terrorism. People in America and the world over remain profoundly perturbed by the events of 9/11 and what they portend, and are dissatisfied with pseudo-explanations they have received – from expedient half-truths told by politicians, to half-baked analyses by television's talking heads, to half-witted pronouncements by celebrity ignoramuses. And what can pharmacology and psychotherapy offer to survivors and relatives of victims of 9/11, save temporary symptomatic diminution of their grief and "validation" of their emotions? What can pharmacology and psychotherapy offer to millions who live in fear of terrorism, or who cannot possibly begin to make sense of it in our prevailing ethos of the slogan and the sound-byte, and in the absence of coherent historical exegesis, realistic political analysis, and cogent philosophical insight?

And what does psychiatry say about the perpetrators themselves? Will the APA elect "Islamic terrorist disorder" to the DSM V? Probably not, and with good reason. In America, the "temporary insanity" defense has deservedly lost popularity and currency, along with other juridical vestiges of radical liberalism's illiberal campaign to eradicate individual responsibility for thought, speech and deed. Since the domestic terrorist-bomber Timothy McVeigh was tried and convicted of multiple premeditated murders, one can hardly expect suspected foreign terrorists to find a safe psychiatric haven in the USA, except perhaps among those extreme liberals whose militancy has immunized them against reason, suggesting that they themselves need psychiatric care. For example, the American Civil Liberties Union recently defended the alleged "right" of a fundamentalist Muslim woman to remain completely veiled for her driver's license photo. Prudently, the Court ruled that official identification photos really ought to identify someone's face, as opposed to their costume. Only on the campuses of America's politically correct universities, which have for thirty years engendered toxic hatred for Western civilization and fatuous contempt for its hard-defended liberties, do Islamic terrorists continue to be accorded the heroic status of "freedom fighters" – but soberingly sane ones withal.

At the same time, no enlightened political philosophy hitherto conceived, nor any psychopathology yet elected, can begin to circumscribe the farrago of convoluted fatalism, revisionist historicism, exquisite anti-realism, venomous hatred, enduring enmity, fulminating prevarication, hyperbolic Schadenfreude, tortuous casuistry, and disregard for chivalry that characterizes Islamic among other fanaticisms, excludes its adherents *en masse* from the realm of eudaimonic possibility, and represents a greater threat to Western civilization than even Western civilization itself.

Viewed from the Schatzalp, the world-at-large is neither a charnel house, nor a prison yard, nor a psychiatric ward, nor a café-philosophie. From the dry, clear, serene and piercing charm of the Schatzalp's perspective, civilization is but a thin, transparent and fragile veneer over humanity's perennial barbarism and congenital savagery, applied and maintained by the few for the many, by dint of profound vision, prodigious effort, unstinting optimism, courageous leadership and consummate civility. The masses – now billions – of civilization's beneficiaries are fed, clothed, sheltered, networked, acculturated, employed, amused and retired by processes they barely understand, but upon which their very lives, limbs and longevities, along with their scant knowledge of the past and abundant hope for the future, are utterly reliant. They do not know where their food comes from, nor their clothing, nor their shelter, nor their electricity, nor their fuel, nor their entertainment, nor their scant knowledge, nor their abundant hope.

Those who view the world from the Schatzalp do know these things, and more, for they are charged with providing them. For the most part, they tirelessly sustain, defend, implement and improve the blueprint for our global civilization. Those who err on the side of avarice, and indulge in excess for its own sake, are justly sent to prison like common criminals. But the majority of the business and political leaders whom I have met safeguard the manual of best practices for a decent life, a commodious society, and a prosperous humanity. Without them, anarchy would prevail, evil triumph, and suffering proliferate even more than it does despite their best efforts. Yet the masses are given to protest this civilized state of affairs, egged on by radical agitators or naïve reformers; preyed on by murderous revolutionaries or maniacal gangsters; harried by hustlers, swindlers, parasites and bureaucrats – the endless baggage-train of camp-followers that civilization is condemned to pull.

Viewed from the Schatzalp in these early years of the 21st century, the world today is a more ample study in contradiction than a sanatorium brimming with cloned Settembrinis could fathom. It is at once a more hopeful place than Lodovico could have imagined, and yet a place of greater despair than he could have feared. Human progress remains both credible and measurable, yet has developed even greater resistance to metaphysical analyses. Human regress too remains, incredible at times yet no less irreversible, compassed partly by the scope of meta-dialogue between philosophers and psychiatrists, but lying well beyond their joint and several capacities to redress. Here even Bacon may have erred – not all knowledge is power, if by power we mean more than understanding – while Ecclesiastes hit nearer the mark: “For in much wisdom is much vexation; and he that increaseth knowledge increaseth sorrow.” And Lord Acton too was quite mistaken: Not all power corrupts. In actuality, power can even purify, as long as its wielder judiciously tempers a Nietzschean

Weltanschauung with a Kantian good will, and exercises contemplation in quintessential quietude, avoiding Promethean flames and eschewing Daedalian wings alike.

“Human reason needs only to *will* more strongly than fate, and it *is* fate.”

– Thomas Mann, *The Magic Mountain*

Notes

¹ I would like to thank Profs. Drs. Thomas Schramme and Jonannes Thome, MD, for inviting this contribution, and for making helpful editorial suggestions. I would also like to thank Prof. Keith MacLellan, MD, for his help with research.

² Abraham Genis, “Maieutics and Philosophy,” 4th Virtual Congress of Psychiatry, 10/02/03 <http://www.psiquiatra.com/interpsiquis2003/9661>

³ This is not to assert that philosophical resolutions, where attainable, eschew or obviate affective dimensions of distress. The authoritative sanction that accompanies the invocation and implementation of a given moral principle, e.g. Aristotle’s golden mean or Kant’s categorical imperative, has indubitable psychological undertones. Yet here the sanctioning authority itself is clearly philosophical; and the medium of deliberation, primarily noetic. E.g., see L. Marinoff “On the Emergence of Ethical Counseling: Considerations and Two Case Studies,” in *Essays on Philosophical Counseling*, eds. Ran Lahav & Maria Tillmanns, University Press of America, Lanham, MD, 1995, 171-91.

⁴ *Los Angeles Times*, Sunday, April 5, 1998, A1.

⁵ Rosenhan, D. L., On being sane in insane places. *Science* 179 (Jan. 1973): 250-7

⁶ See Plato’s “Allegory of the Cave” in his *Republic*, *Book VII*.

⁷ <http://www.psych.org/pnews/98-04-17/philos.html>

⁸ <http://www.psych.org/pnews/98-05-15/pies.html>

⁹ The IRB is the Institutional Review Board, which must approve all research conducted on or with human beings, even if non-iatrogenic. IRBs are governed by Federal Regulatory Law, and NIH guidelines.

¹⁰ See e.g. Talbot-Stern JK, Psychiatric manifestations of systemic illness. *Emerg Med Clin North Am*, 01-May-2000; 18(2): 199-209, vii-viii; Reeves, RR, Unrecognized medical emergencies admitted to psychiatric units. *Am J Emerg Med*, 01-Jul-2000; 18(4): 390-3.

¹¹ Hall RCW, Popkin MK, Devaul R, et al: Physical illness presenting as psychiatric disease. *Arch Gen Psychiatry*, 1978, 35:1315-20.

¹² L. Marinoff, *Plato Not Prozac*, HarperCollins, NY, 1999; and idem. *The Big Questions*, Bloomsbury, NY & London, 2003.

¹³ <http://www.menstuff.org/issues/byissue/seniorssuicide.html>

¹⁴ <http://www.cqc.state.ny.us/publications/puboutsu.htm>

¹⁵ <http://www.appa.edu>

¹⁶ E. Fromm, *The Anatomy of Human Destructiveness*, Holt, Rinehart & Winston, NY, 1973.