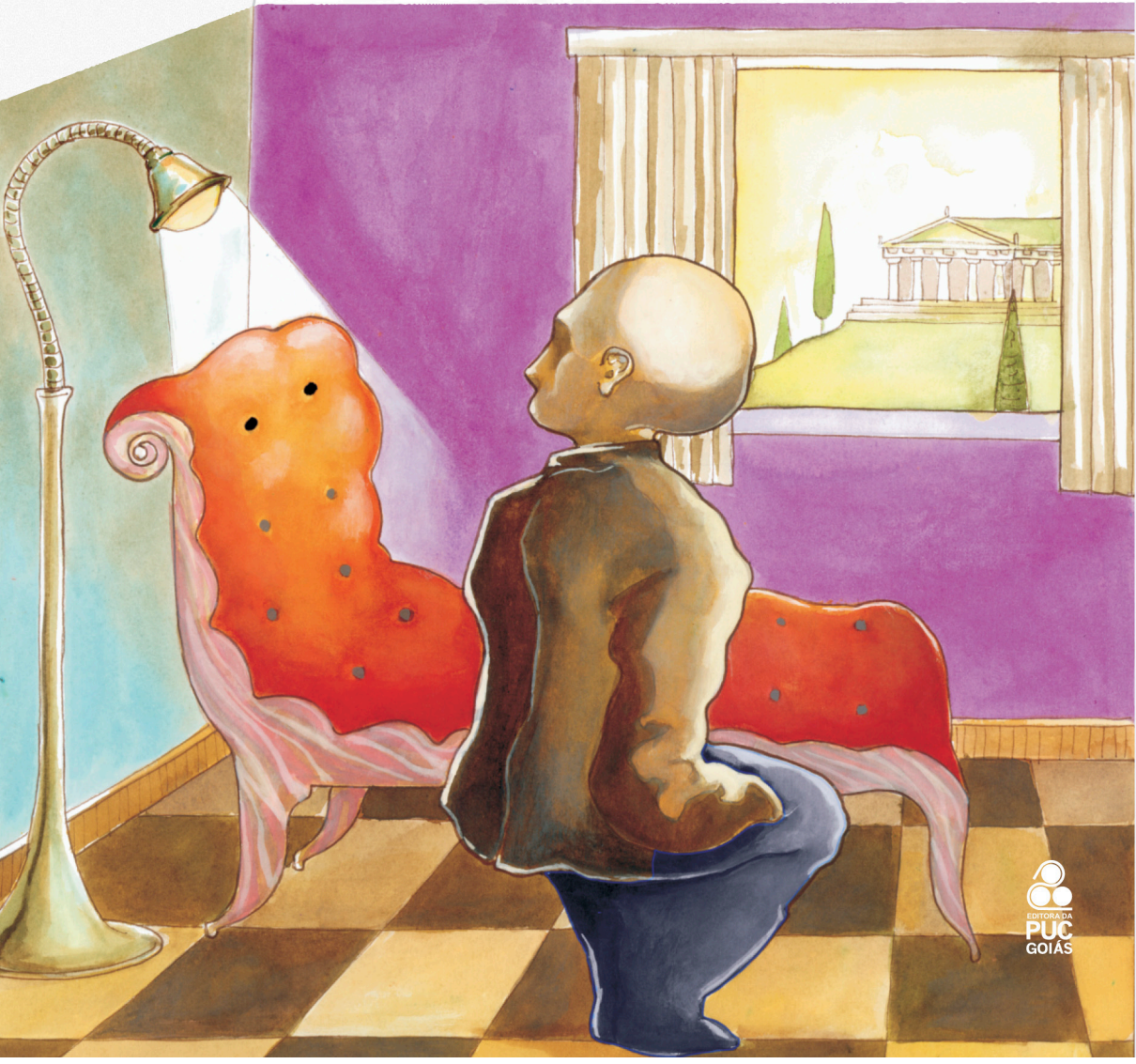
# Listening and Silence

*Will Goya*



EDITORA DA PUC GOIÁS

*Will Goya* é poeta, filósofo clínico e professor universitário. Dedica-se aos estudos de Filosofia Clínica desde 1998. Membro do Conselho de Representantes do Instituto Packter, além da prática clínica, realiza conferências em diversas empresas privadas e instituições filantrópicas. Com pesquisas e vivências nos EUA e em vários estados brasileiros, acumula larga experiência de comunicação e trabalho com indivíduos, com pequenos e grandes públicos.

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*Will Goya* *is a poet, clinical philosopher and university professor. He has devoted himself to studies in Clinical Philosophy since 1998. He's a member of the Representative Council of the Packter Institute. In addition to clinical practice, he lectures in business companies and in philanthropic institutions. With research and experiences in the United States and in various Brazilian states, he accumulates communication experience and work with individuals, with small and large audiences.*

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Alberto Tolentino

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## Lessons from Dialog in Clinical Philosophy

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Translation Clare Charirty
Revision Fernanda Moura and Thais Campos
2nd Revised Edition

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*I should like to thank my two professors in the field of psychotherapy, Pierre Weil and my dear friend Lúcio Packter, especially the latter who, with his love for life, did so much for me.*

*To my family, children, and friends – all of them brothers and sisters to my personal human benevolence. Particularly, I owe a lot to my dear sister Claudia Campos, who welcomed me into her home, in the USA, where I wrote this book.*

*My love and gratitude to my dear friends Weber Lima, for the dialog, Fernanda Moura, Thais Campos, Gabriela Santos and Mariângela Estelita, for the technical revision.*

# SUMMARY

# PREFACE

This book places the love in first place. This text written by Will Goya avoided the didacticism. The intention of Goya was to show the Clinical Philosophy in the ambit of the ethics.

The first part of the work is destined to those who don't know Clinical Philosophy. Goya invites the reader to walk. But those who already know Clinical Philosophy will be surprised with Goya's presentation: sensitive, poetic.

The opening poem seems to summarize the frst part of the book.

For Will Goya, "*Clinical Philosophy is a praxis in alterity that brought to psychotherapy all the world's visions that have been thought of in all of these 2500 years of philosophy. Because this is an authentic open reflection, critical of itself, it affords understanding of the subjectivity of any individual without coming down to one, singular existential manifestation of no one. New philosophies, yet to arise, endorsing possibilities, will only intensify the degree of listening and dialog with differences*".

I imagine that many readers will receive Laura in the heart when they arrive to the words of presentation of Will Goya: "*Laura was a sweet, sad girl when I first met her. She came to therapy brought by her mother who, for a long while, had been worried about her depressive state. In a quick conversation over the telephone, she confided she was afraid her daughter*

*would "do something silly". She told me at the time she would leave her daughter at the clinic on the appointed day and hour without coming in. And so it was for five consecutive weeks, when her daughter took it upon herself to come on her own. Our therapy lasted for approximately five months, with a few more supervisor visits at Laura's request".*

In the second part he assumes thought autonomy and introduces reflections and concepts about the practical and the ethics of the philosophical listening. The conclusion condenses his precepts, his feelings of compassion and his philosophy of clinical practice.

This book is beautiful. The reader soon will verify that this work was written by a philosopher that brings in the soul the love, the poetry, the kindness. There are touching passages. I was shaken, I was grateful, and I can only say: thank you very much, dear friend, for writing in English these pages on the Clinical Philosophy. Beautiful pages.

**Lúcio Packter**
Brazilian philosopher
Systemizer of Clinical Philosophy

# PIERRE WEIL PRESENTS *LISTENING AND SILENCE*

It is with a great pleasure that I introduce to the public the present work of Will Goya: *Listening and Silence*. First of all because it is about a person whose vocation for the psychotherapy was declared very early, as he was already in Brasilia attending the formation of our UNIPAZ at 18 years old, with a reasonable knowledge of all the great pioneers of the modern psychotherapy.

The title of the book is very suggestive of its therapeutical practice its, as he describes with a powerful force of compassion. He knows to change himself into a careful ear not only to the content of speech, but also to the many non-verbal languages in its different phenomenological expressions.

Certainly this philosophy book constitutes a great contribution to psychology and to all who currently seek to take care of the Being.

**Pierre Weil**
Former-pupil of thinkers as J. Piaget, I. Caruso and J. L. Moreno,
Pierre is rector of UNIPAZ, educator and a psychologist worldwide known,
with close to 40 books and translations in various languages.

# POEM: AN OVERTURE

## To all surrenders, and all overcomes

*By Will Goya*

It's wrong to think that love always wins and can do anything
With love, we learn to lose.
Naturally,
To control everything is to lose control
And he who is not willing to lose, loses
As pride does not destroy only guilt,
But the heart of the one who is guilty.
To love is not to wish the neighbour what you wish to yourself
It's transforming the beloved one into the first,
And youself into the neighbour.

Love is not weak, not strong, neither much nor little,
It's just whole
Even if for a fraction of seconds
In the most beautiful instants of life.
Only what's simple is completely whole.
Pure delivery, love is light.
The one who loves, walks in the clouds
For his heart reached the kingdom of heaven

Love makes the skin shine from invisible tenderness
When the body coats itself with soul.
Nobody sees the fluidity of quiet waters, the soft and scented blow of breeze
Nor has one touched the clouds with the hands
But who doesn't know where the floating blue of life comes from
That dressed it with joy for being the world's beauty?
It comes from God's dream, when men still sleep in it
An unconscious wish to love
It's called loneliness.
A secret revealed to him by God
When in him this dream made him waken better.

Fate's great melancholy is that death exists
And love cannot avoid it
But the strenght to start over is a faith
That, maybe, no other life closer to the truth will ever know
The mistery that the day lays under the sun of each new morning.
He  who likes, sleeps. He who dreams, loves.

# CONSIDERATIONS*

*We live in a world of intolerance, of political fragmentation, of religious fundamentalism, and ethnic hate. Philosophy is right on time – to remind us of other values, to dream other dreams, invent other reasons for people to be together. In its etymology (from the Greek* philo, *love, and* sophia, *wisdom) the word philosophy bears the memory of its original meaning. If philosophy is, above all, love of wisdom, we may conclude that the present day culture crisis is a crisis in the ability to love.*

*Olgária Mattos*, Revista Galileu.

This is a book about love. And the most important thing to be learnt here, is the path to beyond oneself, overcoming subtleties of vanity and listening profoundly to what the existence of another has to teach us – an immense capacity to understand another and to see oneself in his place, to the most that circumstances will allow. There is a beautiful name for this – a word built on the very heart of life, for it only exists within the conflicting pulse of an encounter. This concept may, perhaps best be translated in the science of caring, that, in my opinion, is the greatest reason for being in ethics: to love one's neighbor as oneself.

This is a book on Clinical Philosophy – always supposing it is a book – shown more as a therapeutic activity than as ethical doctrine: it is provocative and also intended to raise important ethical and epistemological discussions on the infinite personal differences in the human condition. These pages are paths of conciliation between both psychotherapists and specialists in the subject and scholars of philosophy, psychology, anthropology, psychiatry, and related human sciences in general. For such, at the end of the book, we have included a short glossary** that non-specialized readers may resort

* This edition was published on the site www.willgoya.com on May 10, 2010.

** The remissions to the glossary will be indicated by small roman exponential.

to and rely on for reading with greater independence. I have tried to write somewhere between the academic and the poetic. In this way, philosophy accomplishes its fundamental function – to help people think for themselves or, more specifically, in the case of Clinical Philosophy, to think of how to help people without ever thinking for them.

To my relief, there are other, more didactic books on how philosophical clinical practice functions, although nothing can substitute a solid therapeutic background with supervised training for guidance on the finer points of practice. In this sense, I endeavored to avoid unnecessary repetition on a theme, without foregoing the quest for new horizons. Readers with prior knowledge of the subject will be more familiar with the given depths and criticism. This is one of the greatest of tragic beauties in life: on the line of the horizon, all, strong and weak, small or large, swift or slow, will always have the same exact distance to cover. For, after all, the closest someone can get to the horizon, as far as he may progress, ends up always beginning the day once more. Those who want to go further must rise earlier...

Clinical Philosophy is a new mode of practicing therapy, based on academic philosophical theories in clinical practice from the eighties by philosopher Lúcio Packter, in Europe and in Brazil. Philosophical therapy far from outdated, mere moral counseling and that in not conceiving any diseases or behavior disorders of an exclusively psychic nature, abstract typologies, inflexible, universal structures, etc. is also farther from the psychological concept of a cure. Whether this side or the other of organic causes of neurological roots, Clinical Philosophy does not cure - it takes care.

This is philosophical praxis and may be regarded as the most radical practical exercise in alterity ever elaborated to this day. It is

a double therapeutic learning: that of the existential listening and ethical rejection of every form of silencing the alienable right of one or more people, different from each other, coexist and express themselves freely. To accept and listen to the other as he is (within a possible perception of him), however, does not always mean to agree or to support him, as the freedom of the meeting is more important than each one of us; for more important than any one of us, will always be the freedom of encounter. What there is in common between a philosopher and another are not affinities that generate trust, but the friendly certainty of the differences. There is no "us" if there are no individuals that may relate to each other. When an "us" is necessary, we must focus on individualization. To clinical philosophers, to love one's neighbor as oneself is not to love one's neighbor, but to love what is different, the one from whom one learns the world is greater than I itself. In this encounter, with the foreign unknown, a philosopher discovers the existence of opinions, of values, experiences, dreams, intimacy, suffering, joy, etc. such that no one else in the universe will ever have lived it. In this way, growing and perceiving himself as from another, he has a debt, anticipated by all, in the form of listening and acknowledgement. As a therapist, he knows the construction of his best, beyond selfishness, springs from the responsibility he has for another. Personally, what experience has taught me is that whenever I wanted to surrender to the unfathomable depths of myself, I had to go deep into someone else's immensity. In short: in clinical practice, to love is essentially to care for others.

That all of us are different is a popular axiom. However, it is not a fact understood by the majority since it's possible to realize how much each one of us tends to ourselves. All approximation is almost always a conflict, especially if it is very narrow. As the reason for this, what would the Christian saying mean? Within the scope of our personal

limits, what reflections might we extract from this? Of course, the question, for a start, justifies reading this book in its entirety and, would surely, yet, deserve serious understanding of all of a life... or more, would deserve a serious commitment, to understand all of a lifetime... or better, concerning the remarkable personality that conceived it, to the extent of marking civilizations before and after. As from now, most important it is to comprehend that my neighbor is anyone I draw close to, without violating his autonomy or his way of being. Many are close, above all, those who through the laws of affinity or interest confirm my personal world. To love one's neighbor as oneself is not, therefore, to make him similar to us, a neighbor, a mirror to our vanity, to our deficiencies and material rewards, even if this sounds pleasant for both. It is in this sense that the concept of "another" in Clinical Philosophy is better translated as "sharer" rather than "client" or "patient".

Love is something that doesn't make sense for those who don't love. By far, Clinical Philosophy will never be understood by those who don't wish to love others, even if they are right. However, before referring to love, in important chapters ahead, it is worthwhile to know that Clinical Philosophy, as a method of understanding and help, allows freedom to any therapist – full independence in terms of theoretical positions, values, and opinions in general. It's possible then, for a protestant philosopher to treat a Marxist atheist, and not having the slightest wish to convert him. Affinities exist, and this is good, but in clinical practice, it is not personal preferences that must encourage ethics and kindness. By listening completely to the diverse positions of the other, a philosopher is exempt from approval and sanctions in every sphere – scientific, religious, philosophical, and cultural. Therefore, broaching subjects only from the formal point of view, there is no defense of any rigid and universal meaning of words. A precise meaning is a contextualized meaning. Knowing

is contextualizing. In time and space, everything is perspective, everything carries a background history. The components of the words sense and the components of enunciations interpretation, when they show an opinion or a doctrinal position of the clinical philosopher must remain to the free choice of each. As for the sharer, we try to existentially locate the exact sense or the closest possible to what he expresses in order to listen to him without mistakes.

One of the fundamental purposes of this work, is to answer one philosophical question: how can we be sure that we know how to listen to someone's intention? Or, in other words, how is it possible to understand somebody, in his own way to use language, the closest we can get from the way he would like to be understood? Personally, I am sure of the huge ethical value of the answer: about all that the sharer has to say about himself, I have to make a choice. Do I want to listen to him or do I want to silence him? This is a book about listening.

In the first part of the book, with a case study, the reader is invited to become familiar with the theory and practice of clinical philosophy. It is an academic discourse. The second part examines the notion of alterity praxis in the ethics of listening, where I affirm my thoughts on the strategic differences of respect to the other. Language is rich in analogies and interpretations. Last, a short reflection on love, about which I was taught the most profound living experiences in therapy – where I try to share what to me seems fundamental to those who wish to understand and to help people, whether they have degrees or are natural therapists. For those who would rather read poetry to logic, they may anticipate their feelings reading the last chapter first. Perhaps this will make more sense.

The philosophical exercise implies on recognizing the boundaries of knowledge and, consequently, ignorance itself. If humbleness is

the philosopher's true nature, then the clinical philosopher is, by definition, an ethical being. It is not the one who knows the truth, but the one who learns from possible mistakes. As such, this author is no different. Personally, I am convinced that it is not possible to understand Clinical Philosophy without becoming a better person than one was before attaining such knowledge.

In order, as much as possible, to obviate incoherence, with grateful dedication, this book could not be but a dialog written by all of us, the exchange of which may take place *a posteriori*. It would be unforgivable, also, not to remember that the practical lessons of clinical practice, of the sharers, of so many talks and readings in diversity and in wealth, have made this author more than just one. In my opinion, there is only one author, that is no more than life itself – that many refer to as God. In addition, all of us are interpreters – the more intently we listen to others, the more each becomes plural, the more of an intense feeling of human benevolence we gather to ourselves. If there is anything on my part, of my personal faith, that can be read in these pages, it consists in the effort of these sole purposes: how to develop dialog and repay the compassion of learning with others.

# I

# WHAT CLINICAL PHILOSOPHY HAS TO SAY

*It is not enough to open the window*
*To see the fields and the river.*
*It is not enough not to be blind*
*To see the trees and the flowers.*
*It is necessary, also, to have no philosophy.*
*With philosophy, there are no trees: only ideas.*
*There is only each one of us, like a cave.*
*There is only a closed window and all of the world outside;*
*And a dream of what one might see if the window were to open,*
*That is never what is to be seen when the window is opened.*

*Fernando Pessoa* (by heteronomously Alberto Caeiro), Obra Poética.

# The Plural in Each of Us

Almost all philosophies, and with them, psychologies are, to a certain extent, correct. It is true that the physical body suffers and reveals all of the emotional conflicts the soul feels, in that it is one single bio-energetic and cosmic unit (Reich, Lowen, Pierre Weil); but also that body and soul are radically different, and often irreconcilable (Plato, Descartes).

Today, there are a great amount of cases that confirm the theory (Freud) of penis envy that women unconsciously have... and dozens more which say precisely the opposite (Horney, Simone de Beauvoir). On one hand, as is known, the unconscious is a phenomenon exclusive to each of us, made up of complexes and repressed contents. After all, who has never called a person by another's name in "faulty action"? On the other hand, there is no doubt: the unconscious is also collective (Jung), consisting fundamentally of a tendency to be sensitized by symbols and images that represent deep feelings of an universal appeal. It is very difficult to deny the present, deep-rooted in the theories of the unconscious; but materialistic existentialism (Sartre) did not hesitate to break with all the theories, because they remove the responsibility from the individual, whose consciousness in anguish

because of death is necessarily lucid unto itself and intentional in its choices. Neither can those who affirm that the economic structure (K. Marx) determines individual consciousness, be wrong. Could those who recommended self-knowledge and inner renovation (Socrates, Confucius) as the only path to an ethical and political evolution of society be fools? Could not the same be said of love? In the words of the popular saying, how can we love others if we do not first love ourselves (E. Fromm)? Although so many anonymous people who never knew how to love, themselves, made tremendous self-sacrifice to benefit those they loved...

All truth is confirmed by the method that created it and gave it substance. There are no absolute methods. Different methods for the same object of analysis come from different notions of truth. Indeed, knowledge is only valid and revalidated within its epistemological limits.[i] However, each one of these and other theories of influence made a great mistake when they generalized to beyond the fragments of reality where the principle of empirical and or logical verifiability was assured. With the advent of phenomenology[ii] in the psychological sciences or philosophical anthropologies, we can no longer attribute universal values abusively, as though they were mathematical objects, in the defense of such a "human nature" *a priori*[iii] for each subject. As a result, the instituting of psychological types, of psychopathologies and general pre-judgments applicable to the singularity of individuals is anticipated judgment in wait of confirmation, and is an ethical crime in silencing the plural in each one, especially in the form of psychotherapeutic assistance. Care must be taken as regards the dangers of reductionism that demerits and violates the unique originality of each being.

Concerning human sciences, collectivity movements demand another web of complexity to consider. Both society and the individual

are the issues of complementary but distinct studies. Efforts to build archetypes and collective structures of people are valid to capture the psychological culture of a people or of a particular group, without, however, losing sight of the strictness of knowledge – without forgetting that the greater the extent of the research, the less the depth of this knowledge. For this reason, all that is known or that can be known of the specific subjectivity of one single individual, is owing, solely, to a therapist's listening – listening that, naturally, also demands a philosophical method of its own. It would be an unhappy, disastrous mistake, as a result, to judge a person by others. To the amazement of some, we often perceive that many of the truths of mankind applied to social sciences would be lies if they were said specifically to individuals. The world that appears to all the people is not exactly the same as it appears to each one. What makes us most similar to one another is the distance of the sight – the closer the proximity, the greater the difference.

Brazilian philosopher Lúcio Packter devoted himself to the study of this subjective universe in both its aspects: on one hand, theoretical, to formulate an objective and universal understanding concerning the subjectivity of all individuals, which resulted in the "structure of thought" of the human psyche. It would be incorrect to think that in Clinical Philosophy there are different philosophical methods to different people. It's the opposite, there's only one theoretical composition, made out of five categorial exams of the sharer's existential analysis, that will be explained later on. As for the clinical practice, there are therapeutical procedures that are adequate to each person and may vary according to the case. Lúcio searched to understand the existential truths of each one, and conscious of them, guide them towards their best possibilities in life, in difficult times. Clinical Philosophy is na aboslute juxtaposition between theory and

practice. With this knowledge, he developed what he decided to call Clinical Philosophy. As from his personal clinical experience, dissatisfied with psychoanalysis and psychiatry, knowing and departing from the work of philosopher consultants in Holland, he deepened his research seeing patients in Santa Catarina in the south of Brazil, investigating ways of helping people in their existential pain with the classics in philosophy. Along his way, in the stories of different people, he observed a correspondence between concepts of life recognized in them and the various fundamental theories of the great theoretical currents of thought, in such a way that no one theory alone would be able to satisfactorily explain human diversity. With discipline, he proceeded invariably in the same direction: from people to his theories. In his didactic writings, known as *Notebooks* (undated, from A to R), that are texts as a pretext for discussion, he affirms (*Notebook* A) that, in creating this specific philosophy, it was difficult to break away and abandon several methodological, psychotherapeutical instruments he resorted to in his clinical practice experience, but that did no real service to his sharers in the clinic.

But what is Clinical Philosophy? What is philosophy is a question as ancient as the name itself – never completely defined, showing its infinite and powerful capacity of reflection. In addition, it is a question posed by philosophy itself, that may best define itself (Deleuze 1991) by its function, invariably creating new concepts, fighting against those opinions that enslave with hasty answers and solutions that are all too easy. The concepts are not formed as molds, they are not findings, as if they were products. They put themselves in themselves, by the need to affirm what something is in such a way that it may be identified and never mistaken for any other. They are created and affirmed as a knowledge of things and of beings, acknowledged through their essential attributes.

With this in mind, philosophy dwelt on several aspects of reality lived, deriving important reflections on themes such as religion, art, culture, sciences etc... Clinical philosophy, particularly, investigates the concept of psychotherapy, also searching for a new look at ethics in the relationship with others, those with whom we share therapeutic care. Lúcio Packter's efforts to lead thought once more in this respect, however, does not make of this a philosophy of psychology, even though it may discuss methods and bases. Clinical Philosophy makes it possible to re-conduct understanding and research as much as it inaugurates practical methods of working.

Clinical Philosophy is a praxis[iv] in alterity[v] that brought to psychotherapy all of the visions of the world that have been thought of in all of these 2500 years of philosophy. Because this is authentic open reflection, critical of itself, it affords understanding of the subjectivity of any individual without coming down to one, singular existential manifestation of no one. New philosophies, yet to arise, endorsing possibilities, will only intensify the degree of listening and dialog with differences. There has always been a therapeutic nature to philosophy – authentic care to be part of a human background since the Paideia of ancient Greeks when there was not yet a modern dividing line to separate theory from practice. It would be a great mistake to believe that Clinical Philosophy is not philosophy simply because it possesses psychological truths, mapping and diagnoses of psychologies, as though it were scientific. Clinical Philosophy tries, rather, to undo false existential problems derived, in a certain way, from a certain form of thinking the theories of the human psyche. That philosophical activity be efficient and have therapeutic scope does not imply any form of cure, although there may be a coincidence in some comparisons. What a clinical philosopher does is something else again: to understand the nature of existential problems of the

person who seeks him and help him in his free choice in face of the multiple, difficult choices in life. This is the epistemic, pedagogic, and ethical nature of this philosophy that afford it a therapeutic method.

There could not be a greater mistake than to believe that personal dramas are merely psychological. For sure, they are not. There are important psychological issues concerning the relationship between the mind and structures of the word that envelop it. This justifies the position and definition of concepts such as "individual-collectivity", "body-soul", "will", "illusion", "subjective truths", "death", "euthanasia" etc. Even psychological issues must be first based on philosophy in search of knowledge and transformation of what is or is called "reality". Before the psychologies or psychoanalysis, it is the mission of the philosophy to guarantee an indispensable certainty: to know the depths of somebody it must first be well known the limits of the human knowledge. The wisest has to be the most humble.

Different from psychotherapies, in philosophy, it cannot be said that one thought system is refuted, out-dated, or exchanged for another better one; except of course, if the system was poorly elaborated and is, therefore, poor philosophy. This is so because each philosophical theory possesses coherence in terms of reasoning and agreement of ideas, according to its own postulates and logical rules such as to render it undeniable. Divergence and criticism as from other principles do not take away the bases, but only open new prospects about the real. Although Clinical Philosophy, psychiatry, psychology, and psychoanalysis are based on philosophy and draw philosophical conclusions, only the first is capable of a second reading of all philosophical tradition within its own technical procedures. The force present in the consequences of this reside in the power of knowledge and of cohesion in the treatment of philosophical

conflicts of an existential nature. In solving psychological problems, it is first necessary to know whether the problem was well elaborated at the level of definition and forwarding. After all, what is the correct solution worth... of the wrong problem? And why formulate questions the answers to which can never be honestly known? How many, many times the easy relief of a psychological symptom masks the answer to research of deep causes? As can be seen ahead, at the roots of an apparently simple clinical demand, lie important epistemological, language, aesthetic, logical issues, metaphysical instances, ethical disputes etc. To disregard these would be lacking in truth, and in love.

There have been many philosophers of alterity who elaborated concepts, but did not create practical strategies for a day-to-day practice in alterity. There are some who say that this is not the mission of philosophy, but rather of science, of art, and of culture in general. Lúcio Packter accepted this task, to the benefit of those who were not able to make of books a natural extension to life. Strictly speaking, no scientific or philosophic objectivity is possible without the existence of human beings, of the subject that devises culture and constructs knowledge. To seek logical formal guarantees in structuring knowledge cannot, in practice, mean a negation to living out this reality, especially concerning ethics. To forget empirical subjectivity[vi] of real people that find sustenance in dreams, who love and suffer, sleep and waken, who must pay off debts, with children, dramas, and joys... is basically to deny life of knowledge itself. In the words of the wise of Tarso, even if we had all of the knowledge and did not have love, what would we have? In the intimacies of my faith, I have no doubts left: from all knowledges of the human soul, only love knows what's the truth.

The fact is that no theory, however brilliant and perfect, is not

worth, does not substitute, nor is it above the suffering and the smiles of a sharer. We may disagree to the very core, and even so make friendship possible. As the maxim says, humanity runs severe danger when a man makes of his truths, hammers, and of people, the nails. Nor could it be otherwise: a clinical philosopher owes his sharer the devotion and the love that we reserve for a friend. As a result, empathy is determinant in the practical foundations of philosophical therapy. The quality of intersection, of subjective involvement that affords approximation and trust between those who come to clinical practice and the one who welcomes them, is the start and, in some cases, even, the end of therapy. Although not that common, a sharer can relate only through conflicts and encounters with the therapist, by means of the challenges of excelling itself. The cares of love not always walk in positive intersections. In time, it is not difficult to recognize the great value of conviviality; others, at times, render us others also. To travel together in search of new options to problems experienced, new, subjectively better, existential addresses, implies a risk of change to other convictions and truths.

In this deep listening, day by day, a philosopher recovers the initial amazement of knowledge that gave rise to philosophy, and in face of that which is known, maintains the powerful force of hypotheses alight. Enough reason to explain that Clinical Philosophy is not and could never be simply the result of much reading. Academic philosophy is not, therefore, *applied to the clinical*,[1] as if reality were a wall that separates us from another person, and erudition, a painting of his picture. Rather, to practice clinical philosophy is walking together through the sharer's labyrinths, and, in the most difficult moments – possibly for us too – opening a window for him, as though these were eyelids to the unknown, enlightening his life.

Clinical Philosophy uses knowledge instrumentally, for sure,

but with an epistemic conscience of the practice, formalizing and shaping the links, middle, and end. The functional aspect of philosophical knowledge is dialectically[vii] linked to the therapeutic structure, without ever losing sight of same. In Clinical Philosophy, the sharer serves to bring forth knowledge and not the inverse. That is, no personal doctrine of the therapist (philosophical, political, psychological, religious... or whatever) is used to direct the subject to be listened to, or to interpret the meaning of what the sharer expresses in the consulting room. This is the reason why, many times, again and again, a philosopher may be convinced, by experience with another, to change his strongest beliefs. In clinical philosophy, the existential truths of another appear in strict relation with his person, acknowledged by the philosopher as absolutely valid in the historicity of the sharer and never regarded as wrong in their original concepts; however, the sharer may also review what he took to be certain, according to his desire or need, as an effect of therapy.

It is well known that the truth in theories will always require theories of truth, for the principle of error is in judgment and not in things judged. All of the important certainties that we inherit, if not mistaken, are insufficiently correct to decipher the mysteries of the human soul. If we compare some together with others, the great theories on man elaborated in history would annihilate themselves in contradiction or would appear incomprehensible and, at the same time, paradoxical. This being so, with what method can Clinical Philosophy gather all of the theoretical trends as therapeutic instruments at the service of an ethics in listening? And, in such a way that one single philosopher will be apt to listen and understand the infinity of visions of the world in existence, as though he belonged to them. Is such a degree of plasticity in welcoming and treating human differences possible?

Truly, if we do not consider the concepts of truth in dispute as "contents" of the real or essential substances and, in another way, take them merely as phenomena, perspectives of that which they seem to us to be or multiple categories of understanding of the same reality, this will render possible communication between theoretical differences that are so very apart one from the other. After philosophers such as Kant and Husserl, the issue of truths was no longer a problem of things in themselves and became the subject of human perception. Different perceptions of the world may co-exist and be duly understood at levels at which human thought is organized. And this was precisely what Lúcio Packter did: he located all of the main philosophical anthropologies in history, all that was thought and defined on human beings and, in this way, structured a dialog in 30 topics between the various strata of intelligence, elaborating an infinite set of possibilities. Words that silence are maximum records, pre-judged truths even before knowing the sharer's historicity. They are those interpretations that are elaborated about the other with no other cirteria than the therapist's own interest.

Differing concepts in differing topics of structure of thought are, in this way, equally valid. Thus, the disparity in antagonistic philosophical trends and concepts can be explained. In the same way as the ethical respect for all diversity and modes of being of others is broadened boundlessly. The apparent contradiction in Lucio's discourse disappears in the phenomenological architecture of thought, with its harmony and own structural unit, like a patchwork quiet very sewn well. Were this study to have the pretension of an ontology,[viii] in the search for a philosophical concept of human beings, I believe I would take it as holoplastic subjectivity,[ix] not plasticity from the outside, in which a person adapts to an outer contour, but as an attribute that is constitutively open to re-definition. Because nobody knows the essence of another and can only interpret what he/

she shows, more important than "the study of the general properties of a being" is the understanding of common good and its practice. In Clinical Philosophy, as in all, ethics comes before the theoretical functions of ontology.

I think there will never be a single theory of the knowledge (rationalisms, empirisms, and others) that is not controversial which is human. One thing is certain, article of intelligence, humility and faith: the reality will always be greater than our truths about it. It interests to Clinical Philosophy, in particular, the study of human subjectivity and thus only the reality "experienced". It is known to the Clinical Philosophy that any statements defended as "genuine", while language, it comes from the use of arbitrary rules, definitions and things like that. Without falling into pure relativism and without construct dogmatic metaphysical the philosophical method of Packter affirms itself clearly: it is given for the historicity.

In the sharer's world, history is a simple narrative of his own facts. For the clinical philosopher, historicity is way more than just that, it's the method that enables the philosopher to obtain all the knowledge about the sharer as a result of an analysis of life context, with special attention to the way he values the perspectives of his narrative. Through the hermeneutics and philosophy of language, the clinical philosopher may access a lot of the sharer's historicity even when he doesn't speak directly about himself and even when the language used for communication is not essencially verbal. For now, what matters is to highlight that any legitimate information about the sharer's way to be himself is only philosophically valid if it's a result of clinical listening. The knowledge about the subjectivity of the other must never be presupposed by similarity with another person. Historicity is the net of perspectives of the sharer's structure of thought about the world's reality as he and nobody else could and knew how to live. All

methods of Clinical Philosophy use the horizon of historicity. Theory in Clinical Philosophy is opening for the other, an ethical attitude of listening and approach ahead from that it suffers.

Unfortunately, the disciplinary knowledge over the other, in a corrective mechanism of singularity, as a set of tools to cure the sharer of presumed mental ills, is still more important than the person to be known. It is in the conformity of varied social interests, that this knowledge-power builds the political structure of madness, of neurosis, and maladjustment, generally. The impacting philosophy of thinkers as Michel Foucault and George Canguilhem, established ill-faith concerning the concept of psychopathology. Madness was transformed into a mental disease as from the Renaissance for those who did not meet the characterizations of the regime of truth accepted and divulged by Modernity. In his book *Madness and Civilization*,[x] Foucault (1965) shows that, as from the eighteenth century, sciences such as psychiatry, psychology and psychopathology condemned to silence and to isolation all of the differences that threatened the status quo. In this way, it was the power of silencing that generated the measure of normality and knowledge of the cure. In our days, all of the subtleties of classification and exclusion at last acquired a social status of culture, in discursive and non-discursive education. And what was only yet another existential manifestation of people in their specific context became a device of normality, of vigilance, and correction.

Of course there are "psychopathologies" and the Clinical Philosophy is not here to deny this knowledge, however, this judgment isn't obvious at all. The only unquestionable certainty is that they are "theories", therefore, they can never be taken as the truth in themselves. "Psychopathologies" are object of science. While the scientific method works with truth as a generalization of the phenomena that were

observed and transformed into laws accepted as the reality themselves, Clinical Philosophy investigates the phenomena that aren't objects of science: the radical phenomenon of the single subjectivity of each one, that never repeats in other person. A "psychopath" is a judgment and a "general theory of psychopath". We can't confuse a person with a "theory of the person". The difference is quite philosophical. The theories can be true or unreal, falses as a whole or in parts, but the sharer in the clinic, being sincere or not, is always deeply real. This is a kind of knowledge that can't be learned without compassion.

The *Diagnostic and Statistical Manual of Mental Disorders* "DSM-IV", published by the American Psychiatric Association, Washington D.C., today in its 4th edition, known as "DSM-IV" together with "CID-10" *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision, of the World Health Organization, in their structures, tales and divers inter-associated sub-classifications, list hundreds of disorders, nervous twitches and syndromes that will not allow any human being to be free for long of the stigmas and dangerous treatments to readjust. Strictly speaking, in an excess of detail, with suspected support from the pharmaceutical industry, we have all, in some way, been classified under some type of disease. Under the pretext and malice of a cure, our times have made of disease a referential of identity between people. However, we may not disregard the merits of investigation and the advance of medicine in the field of public health, especially in psychic disorders resulting from diseases, lesions, and brain dysfunction or by use of psychoactive substances, among others. Also, in dealing with psychological issues that are not purely biomedical, it is important to make no mistake: there are no mental diseases in themselves – there are theories of mental diseases.

In ethical terms, the cure of madness or the madness of a cure is, of conveniences, the worst trap, especially in discussions from the

opposition. No one is mad on his own or, as Salvador Dali (Neret, 1994) maintained: "the only difference between a madman and myself is that I am not mad". As a result, there can be no other conclusion: the belief, not naïve, anticipated in the theoretical referential that is universally superimposed, whatever, is something other than Clinical Philosophy.

Anyway, any therapy requires additional caution in being dealt with or in the use of scientific or philosophical systems when embracing one doctrine in particular – which is a professional's right. Although one should observe which methodological device would be more adequate to the circumstances of such and such an individual, unfortunately, a prevalence of models of knowledge that are more to the taste and ease of the therapist is all too common. As generic examples, naturally, a psychoanalyst is someone who truly knows how to listen... but through the ears of psychoanalysis. A Marxist, a spiritualist, a structuralist, the behaviorists and the holistic, etc., also hear and act on the principle of the same correspondence. Which can be good... ***if*** and only *if* the emphasis given in clinical practice in some way coincide with the own needs of the subject in question. With strong bonds of intersection and some authority, a professional may often be able to lead the sharer, to bring him to a world of his theoretical considerations and even to convince the sharer of this – which is truly tempting. But there are no ethical justifications for a professional who makes another a mirror to his own vanity. It is not the function of psychotherapy to use frailty and to seduce those who are lost along the way. However, happily, I see an increase in the number of psychologists who exceed in competence: they master several techniques and doctrines and resort to those most fitting to the mode of sharer. These psychologists increasingly have difficulties in defining himself theoretically, classifying their therapeutical

methods and "to label" their clients as "patients", perhaps as historical effect of the direct or indirect readings of Foucault.

But, if claims as old as humanity as to one sole path for all of us, can be overcome, with open dialog in its philosophical bases, the epistemological foundation of this therapeutic praxis can be queried. Would it consist of one method or of several methods? According to Lúcio Packter, creator of Clinical Philosophy, the correct answer is more towards the second option. There are, however, other clinical philosophers that think differently, as indicated in the important contributions of José Maurício de Carvalho (2005), to whom phenomenology is the answer. According to him, Clinical Philosophy is a psychotherapeutic technique capable of a conceptualizing of its own, that differentiates it from other forms of broaching human consciousness, with an object and a formal method obtained by applying phenomenology to the study of psychological fact. Creating a method for a relationship to help, Lúcio transformed phenomenology into clinical therapy. José Maurício's conscientious work devoted to the subject broaches the foundations, and theoretical and practical claims of this philosophy with sufficient clarity and vigor, in his own way, to the extent that it is not necessary to repeat them here. Clinical philosopher, Mônica Aiub (2005) has likewise been deriving important considerations concerning the field of education trying to understand the diverse ways in which people learn something, what they do with this learning, the existential consequences of teaching, etc. – from a study based on her practice in schools where she taught. Based upon readings of Deleuze (1991) and of Ricouer, she believes that Clinical Philosophy is situated beyond the tendency for constituting a system, whether phenomenological, analytical, structuralistic, empiricist etc. She dwells on the fact that the function of authentic philosophy is not framing, but to build a new concept – as in the case

of Clinical Philosophy, a concept as yet in a potential state.

Lúcio Packter's philosophy arose from his clinical work in hospitals and consulting rooms, only then to give rise to a theoretical framework that is not yet ready[2] Clinical Philosophy originated from philosophical clinical practice and not the other way around, directed essentially to care for another, first and foremost the loving practice of an encounter, and only later, to investigate the validity of academic theories to which it refers. According to my own intuition, research and clinical living experience, in particular, I believe that Packter's work can also be understood as an ethical perspective based on not silencing the constitutive possibilities to being another. We must later investigate whether this philosophy proposes a new ethical theory, or a reflection on the principles of morality able to determine a universal norm of conduct to be followed. Without a doubt, the exercise of clinical activity from it, possesses an ethics of alterity, whose presupposed features do not exactly coincide with the models of alterity known in our times, which leads me to believe that this ethics (or attitude) of intent listening is the base foundation of Clinical Philosophy.

In any case, there is still the need for various discussions and theoretical foundations for this new philosophy to shed light on its therapeutic procedures – which does not completely invalidate its clinical effectiveness. Adding the reading of Lúcio Packter's writings to the valuable dialog in our personal encounters over the course of the years, I know he is trying to sustain his philosophy by the joint strength of several different principles consisting of opposition concomitantly antagonistic and complementary. Within this procedural approach of the clinic, we realized the need to assume paradoxes and co-exist with the principle of uncertainty. This particular exercise of alterity acknowledges the subjective hyper-

complexity of people demanding a mode of articulation of knowledge that emphasizes problems stemming from multiple knowledge such as Schopenhauer's existentialism, in its renewed reading of Protagoras; the categorial examinations of Aristotle and Kant; the historicism of Wilhelm Dilthey; phenomenology post-Husserl and the "vital reason" of Ortega Y Gasset; Popper's logical positivism, and Gadamer's hermeneutics; adding in a constant use of formal classical logicism, of the analytical in language, from Wittgenstein to John Searle; of the aestheticidy associated to somaticity with multiple authors, starting with the empiricism of Hume and of symbolic mathematics, first with Georg Cantor.

In general, I think that this clarifies the differences between Clinical Philosophy and the traditional psychologies, besides the fact that there's a total lack of conceptions of normality against psychopathologies and universal techniques in the clinic, considering that all its fundamentation, its methods and procedures, are derived from academic Philosophy. Lúcio Packter, in his current researches on symbolic mathematics and philosophies of structuralism[xi], admits the existence of a new existential understanding of typologies of being another, which is able to cover the sociocultural phenomena of structure of thought, but with a huge condition: without ever losing or diminishing the importance of the specific and unique subjectivity of each sharer, only recognized by his unrepeatable historicity. This is a research for the soon future, as many people wish.

I believe this clarifies the differences between Clinical Philosophy and traditional psychology, also considering that all of its base, methods, and procedures, derive directly from academic philosophy and, as has been said, with the total absence of concepts of normality and of psychopathology, of typology and universal techniques in clinical practice. The focus of the existential issues, in

the therapy of Packter, may coincide in general and sometimes with the perspective and techniques of some psychologies. Depending on the specific case, the emphasis may be given to the behavior (behaviorism) or the need of experience of the "here-now" (gestalt), among others. Valuable moments for interlocution and mutual learning, reviewing concepts, practices and values.

Does clinical practice demand so much knowledge? Well... in the academic sense of the term "to know", taking concepts already completed, recombining them and inventing new theories until we arrive at a practical equivalent to the real, clinical philosophy over and above all, demands inner renovation, a kind of wisdom. This is the function of the philosophical act which is at stake, an ethical concept of life in relation to one's neighbor – not only a mode of knowledge, but a new mode of being and of union essential with other beings. The concept of "concept" in Clinical Philosophy is like life itself...For instance, the concept of pain the other talks to us about, physical or moral pain, may be profoundly bound or separate from the words he uses to express such – we may never know how far. He may suffer from language itself, with difficulties communicating or, in turn, this may go back to his inner world with so much ease and perfection that, in him, words would have more soul than body itself. This and one thousand variations... Word, gesture, the way one cannot bring oneself to say something, or a way of telling a lie, perfume, clothes etc. all of the syntax of signs is taken as a chance for proximity. In therapy, knowledge is only paths of encounter between persons.

The fact is that for clinical practice, experience will require much lucidity from a philosopher, both within and without the consulting room. With no license to prescribe medication, yet he has a background in psychiatry, in pharmacology and in neurophysiology – enough to know how to refer issues of a physical nature to a professional in an

important partnership. A therapist's knowledge and authority are restricted only to the treatment of existential issues.

When we are alarmed to see a friend behave in a manner that is very different from what we expected of him, or saying things we never expected to hear from him (especially if this is upsetting), we are led to believe we did not know him that well or that he has changed his former way of being. However, one question is due: what exactly is someone's way of being? How can we avoid the injustice of barely knowing and judge another exclusively by our own way of being? We must accept people as they are, they say. But... what are they? In fact, I do not know up to what point it is possible to know the answer, but we will always have to re-state the question. No matter whether he is a layman or an old therapist, the danger exists.

In clinical practice, a philosopher approaches fears. The fear of uncertainty, of not knowing... what to do, how to do, what to think, etc. But also the fear of certainty, of not being able to do anything about it, and of no longer having freedom of choice; in being responsible, of having to do something to be free or to break free from: of making no sense, and even so, of being profoundly real etc. I accept the challenge for the competence that made of him a clinical philosopher – a friend of the subjective truths of each – in his moral task, he is under obligation to be ever in a state of admiration in face of the infinitude of another, from the first to the last session, once and for all acknowledging his own ignorance concerning the depths hidden within the sharer. A clinical philosopher must co-exist with the limits of his knowledge, with the possibilities of error and, mainly, never cause the sharer in the consulting room to suffer fear against which he has no defense. Far from melodramatic sentimentalism, Clinical Philosophy is an exercise of love.

In a struggle, not always victorious: a clinical philosopher tries to learn how the person is structured existentially, according only to his psychic elements, by origin or consequence. Employing phenomenology in this task, a therapist can clearly distinguish subjective truths from objective truths or by convention. Maximum honesty due to a person does not permit a philosopher to know a sharer beyond the limits of judgment. When we know nothing about another, except for our own opinions and theories on human beings in general, there remains the description of phenomena such as they seem to be, with no pre-supposition as to how they must be in essence. Without purisms in judging another, it is necessary to avoid a minimum of unfounded certainties.

As a result, without metaphysical dogmas, guessing, or superficiality, the therapeutic work of this objective philosophy purports to locate the conflicts or existential "knots" in the psychic structure of an individual, to solve them or, in some way reduce suffering. Existential suffering to me, deserving treatment in Clinical Philosophy is all that which subjectively causes demands for change or existential solutions on the part of the sharer and is a motive for complaint or request for assistance to the therapist. Suffering here is not understood in the exclusive sense of physical or moral pain because various types and intensity of pain (hurt, anguish, headache, remorse, longing, self-flagellation, intense hunger etc.) may be of benefit to the sharer according to the case. Very often, it is impossible to dissociate understanding from pain without pleasure, contentment, ecstasy, and joy... and the indefinite. The help of a therapist is necessary when the action or the process of undergoing changes in life (any changes) is sufficiently difficult for the sharer. With all due respect to diversity, in the Jewish-Christian culture where guilt is religious identity to many, in the clinical practice setting, we often meet people who do

not wish to do away with the pain they feel, but to qualify it to be adequately painful, who knows joyful, as a moral incentive to God's justice and to inner reform... And why not? In May, 1933, Mohandas Gandhi fasted for 21 days as a protest against colonial oppression, repeated time and again in the course of his life, putting his own existence at risk. Each time he began fasting, he triggered a national movement in a desire for freedom. There are those who would prefer not to cure themselves from an ill and to use it in order to obtain money, favors or dignity from the family, from the government, etc. Also, there is no reason why a person who is happy, without pain without great problems in life with himself, should not seek therapy, for instance, for the purpose of knowing himself better or to help friends. In this case, suffering – that which is sufficiently difficult to the limits of the sharer, will be of another nature: to suffer the thirst for knowledge or suffer compassion and love in abundance. There are many examples that may not be judged without the context due. Because life is anticipates rules, clinical practice takes in all.

And what does the clinical philosopher do to assist the sharer in his plea for help?

Three things: first, he uses five categories of understanding (subject, circumstances, place, time, and relation) in order to research and elaborate a well-structured existential concept of the context of the person, as close as possible to reality. Once the links in the relationship between subjectivity and the surrounding atmosphere have been understood, the second stage then takes place: the philosopher moves on to an assessment of the way in which the psychological facts in consciousness are organized, mapping out the sharer's structure of thought (ST), through the person's life story. ST is the way the person is existentially in the world and describes the way in which his consciousness thinks, feels, touches, attributes value to things, etc.

There are thirty structural topics, permanently open to the advent of new ones, that explain reality according to L. Packter, from the philosophers and culture of all times in general. The sum of all the possibilities of topical elements imbricated among themselves, plus the direct relationship with the five categories, makes it possible to amass an uncountable variety of expressions for the modes of being, whether fundamental or transient, of every human being on earth. As far as I know, this is the most complete architecture of understanding and alterity on an individual's condition in human existence. In world-man links, an individual may be understood by his participation in different states of consciousness. Although divers modes of being or of the concepts that people elaborate about themselves and the world, invariably allow us to learn more about the human condition (the better we know people), diversity will never offer us a total knowledge of who is the other in front of us. The only thing we are sure about, is that singularity is in itself, a single totality in its relationship with the world. The only thing we are sure about is that singularity is an unique totality in its relationship with the world.

Once all the categorial data have been gathered and a study of the relationships between ST topics completed, it is possible to understand the complexity and the constitutive coherence of the psyche investigated, to know how to identify and contextualize information received from the sharer, often dispersed and, especially, to understand the most important reasons for the existential conflicts that motivated him to seek the help of a clinical philosopher. Only thus, and in no other way, is it possible in truth to say to someone telling us about a certain fact in his life: "...I know how that must be" or "I know exactly what you mean to say...". The depth of philosophical listening lies in this.

It is with considerable knowledge of the subject, in the maximum

that the analysis of listening and the observation allows to discover, that a philosopher is in lucid condition to take the third step – to offer strategies to help another, choosing submodes or clinical procedures adequate to untie conflict, the topical shocks contained in ST, avoiding unnecessary suffering and seeking alternatives subjectively viable to the changes that prove important.

There is much to say on clinical practice, with details, stages, and sub-stages, examples, and detailed explanations at every moment, correlating theory and practice – here, never separate. However, considering other publications from clinical philosopher colleagues who previously set themselves this task, for didactic reasons, I think it better simply to present the basic elements that make up clinical practice, re-taking and interpreting the definitions by Lúcio Packter in his *Notebooks*. For such, we added an analysis of literal passages from the case of one sharer, with due guidance. It is not possible to have good understanding of the ethics of listening dealt with here without introducing technical terms from this new perspective in therapy. On the whole, as will be seen below, they will allow broader discernment of human beings with their characteristics, building a bridge of sense between philosophy and clinical practice.

In practical terms, how does this take place? In synthesis, it functions like this... Laura, a 25 years old woman, arrives at the clinic with the following issue: a strong feeling of guilt regarding her father. She says she killed him and must now urgently relieve her pain asking him to forgive her, but considers it impossible to go back in time. She suffers from headache and chronic insomnia. What does a clinical philosopher do in a case such as this?

With no crystal ball, he does not know the reasons for the problems told to him in the first session, rarely presented clearly and often different from what might be supposed. Such complaints

brought to him are *categorial examinations*[3] theme under the gender subject. Consultations that can be made in any venue are all the more productive if more adequate to the needs and comfort of the sharer: whether in a walk along the sea front, in the country, at the table in a bar, over the telephone, by Internet, in the house of the sharer himself, or even, in the consulting room.

To be intimate in important issues, above all, not knowing anything of the life of another, beyond first impressions, a philosopher asks the sharer to provide him with a panoramic report of his history from birth down to today – respecting the data of the semiosis used by him, (speech, writing, painting, dramatization, etc.) with a minimum of interference on the part of the therapist. Registering information is to be avoided, as is directing subjects and interests by means of questions, body language or other comments... in the process of listening, so as not to render false the manner in which he shows himself existing for himself. If a person tells me his life story, and I interrupt with questions like: "Let's talk a little about your family, your dreams... about such and such an aspect etc.", I won't be listening to the story of the person by himself, according to what he wants to tell me, but only according to what I want to hear. Such a silencing would result in loss of the maximum approximation to the originality of each person, which is necessary to the knowledge of his subjective truths. Of course, dealing with children is different from adults. The clinical historicity – a special type of anamnesis – also comes from those who co-exist with the child, although their perspective is generally far from the child's subjective version. All the languages and data of semiosis are used, within a philosopher's scope and competence, when necessary for understanding. It is necessary to verify the most appropriate needs for each.

A person's story as told by himself is, in this way, obtained

by three basic criteria used by a clinical philosopher, namely: 1. as said before, using the least possible written records; 2. considering only the literal data (subjected to the hermeneutics and the analytic philosophy of language); and 3. not allowing (as far as possible) speeches in logical temporal leaps. But how is it possible to have the least possible written records with such a systematized background? Of course, there are times when a sharer in his mix-up and confusion cannot set down events in the correct order, just as there are people that will never do so. Others, wouldn't stand to talk directly about themselves. This is why the philosopher resorts to his studies in aestheticity, hermeneutics and philosophy of language (non-verbal data, impossible to rationalize, somatic aspects, expressions of art, intuition, varied games of communication etc.) in the use of clinical submodes. Special cases naturally demand alternative processes. Apart from this, the important fact is that some conditions are necessary or at least sufficient so that understanding is possible without random interpretation and without theoretical presupposition on the part of the therapist. If a sharer again and again insisted on leaving language constructions mid-sentence and changed the subject with a thousand diverging considerations... if he told his story without informing when he was referring to facts in the past or in the present, or if we were not sure he was just giving vent to his extemporary imagination concerning this... if everything were like that, there would be so many omissions, chaotic paths, gaps, etc. they would probably keep the clinical philosopher away from the methodological safety on which he finds support – and without which his efforts would have no more advantage than the therapeutic magic of common sense. Therapy is always possible to all, but each case has limits of its own.

A philosopher will very possibly resort to three or four consultations to complete the first part of his work, starting a

categorial examinations of – *circumstance*, *place*, *time*, and *relationship*. Once this is done, processes of investigation are utilized by dividing data and setting down roots in the background, deepening information by means of empiricism, of hermeneutics and the analytics of language. The sharer tells all of the physical and psychological context surrounding his life from his first memory down to present times. This is then reviewed in greater detail in various short periods, interspaced sequentially from start to finish, invariably respecting the three criteria cited above. This is the time in which new data that was formerly hidden or forgotten in the first telling can be added.

Conclusions, as yet in the realm of pure hypothesis, are many and varied: from contradictions, doubts as to factual correspondence of certain events, hesitancy about subjects avoided, complete or partial loss of memory in certain passages, creative imagination, lies, etc. Only then, alert to the complaints brought to the consulting room and with more knowledge on the way of being and living of the sharer, will a philosopher begin cautiously, minutely and punctually, to research down to the very root of the most important elements of the discourse, phenomenologically. All of this assures the conditions necessary to the study of the language of the sharer, the specific contextualized uses of each experience in his life, discovering associations made among the words he uses and the facts he lived through. Independent of me, the significance of the essence of life of the sharer is in himself. But, except for telepathy, mysticism and the metaphysical, to every human being, sense is bound to language. I can but understand and listen to it.

With problematical indications as from the *immediate* subject (or the *last*), and researching the psychic web of the person, a clinical philosopher tries to identify and assemble his *structure of thought*, considering all of the themes and perspectives existing in his discourse topic by topic. Strictly speaking, there are as many specific types of

personality as there are persons and circumstances in existence in the world. With a large structural vision of the psyche of the sharer, emphasis is given to the most important feature, namely, topic conflicts. These are of many kinds and can take place 1) in direct or indirect confrontation internally between the topics of one same ST; 2) by existential shock in the relation with structures of other people; 3) or when motivated by the physical environment etc. The philosopher observes what in them represents a pattern over the course of life which at the time is up-to-date, without the obligation of filling in all of the topics this structure is capable of. There are characteristics or existential topics that, however strong and determining they may be to some, to others, simply do not exist. For instance, it would be foolish to conclude *a priori* that sexuality is equally important to every human being. As from the culture and type of relationship involved, a sharer can be expected to experience values, emotions, eroticism, that do not exist in him, and that violate his innermost manner of being – with consequences. Without condemnations and labels of any kind, a person has the full existential right to bind himself by marriage for subjective needs other than sex and love – such as religious duty, for children, for safety in routine, purely for the satisfaction of the parents etc. Why would a sharer necessarily be judged for this reason as frustrated, neurotic, with unseemly emotions and desires...? Evaluating all there is to say about a person, these are the variations in mode and intensity to consider in five categorial examinations: "this is determinant, important, or worthless to him... and in what way specifically. Only then is it possible for the clinical philosopher to have a broad perception of how a person is himself, phenomenologically.

I believe in the search for a balance point, a equilibrium in each person, a center, a gravity axle where it is weighed the experiences of life: light ones, other difficult and many forgotten memories, but still

awaken. It is as one old scale to measure the value of the things, with a vertical shaft, a mobile dash and in each extremity two hanging plates. On one side it is met the individual measurement of what is important to someone and determinative (no psychological theory can anticipate this knowledge before a listening, knowing the specific and only circumstances of each one). On the other side, there are the limits and possibilities of somebody's history. To think a therapy demands, to begin (at first or to start), to compare masses, to determine weights or to measure existential forces, studying compensation mechanisms, when for some reason the disequilibrium between the necessities and the conditions of satisfaction is great. For example, if the psychological stability of somebody always relayed on the fact that he lives in a farm, feels the smell of weeds, hears the cattle mowing and sees the sunrise looking at the long green grass, what can be done if this person perhaps falls in depression for having been obliged to move to a city and to live in the highs of an apartment? In the existential scale of this person, when the importance of the corporal directions fed by the experiences of the nature is recognized, it becomes basic to investigate the possible alternatives of sensitivity in its new environment close to its original expectation, as to perhaps to super value the use of a patio/deck or the windows in the apartment, a little bit every day before the sunrise, being able still to hear the pleasant silence of the morning. Perhaps bringing close the sound of birds, recorded or live... the raise of a small symbolic garden in the balcony, replacing the ornamental plants for tomatoes, spices and lettuces, besides frequent jogging in parks of the city, having a pet and much more... Fact is that if in one hand I can figure out which elements and existential ways that a person carries himself and what is the importance of it in his life, on the other hand it facilitates a lot the research of alternatives and counterbalances of balance.

However, who would have ever known if disequilibrium itself would be the one thing that would make his life better? Because life is not always life didactic, some times there is nothing to compensate, moments when it is necessary to reconstruct old ways of being or learn new forms of life. Many times it is the event of a tragedy that unbalances a limited psychological structure, the only possibility of somebody to perceive all the joys and possibilities that had always been around.

As a first approach, without covering the details, it's possible to ask three questions about those that we intend to know in depth, even if finding and verifying the answer is another matter. These questions represent the three levels of categorial intensity, they are: 1. "To this unique person, what is absolutely determinant, non-negotiable, to the point of stimulating vitality and, in case it lacks, to the point of making him lose the balance of his strengths and even lose his own life?". 2. "What is important to him in such a way that it will mean personal fulfillment and be worth all of the effort to reach it; the absence of which would be painful to bear, but perfectly replaceable by another thing or experience of equal value?". In addition, 3. "What is to him so little or of such insignificant value that it makes little or no difference to him?". In the essential details, answers never repeat from person to person and, in some points yes and in others not, they differ in each period and circumstances during life. Astonishingly enough, a strict investigation of these points obliges us to recognize that things that are absolutely without importance to us are determining to people very close to us. It is more difficult when the situation is inverse. A mere word not said, a perfume, a joke or some gesture, without our knowing, may hurt, bring immense joy, recover memories from the past, be a reason for lifelong friendship... Things like this happen much more than we are used to perceiving. The greater the knowledge of the modes of being of himself

and of others, the greater the ethical capacity in this respect.

*Autogeny* is then carried out between all of the existential topics with no difficulties – a descriptive analysis, never absolute, on the way it figures in the total elements of the ST of a sharer. This is so, because each of these topics is internally continuously interlaced one with another: some with stronger bonds, others with weaker and others yet, not at all. For instance, the mere aroma of coffee (Sensation) may eventually be determinant to someone to recover the will to live (Axiology), because it will remind him (Abstraction) of a friend, of a poem, that he read once at dawn. But this experience will perhaps only cause this effect (Behavior and Function) when he is on his own (Inversion) and preferably in the twilight (time). In addition, each existential topic relates in a manner of its own with the ST of others and with the environment. Such bonds of interchange are known as *intersections* and form agreements: they combine adjustments so very subtle that, like life itself, they cannot be immobilized by the dogma of any universal theory. For instance, the belief that the human genera is in essence made up of feelings, would demand treating the emotions, for any problem in life. However, this is but one isolated topic in the psychic structure of a human being. How can one know the specific way in which each individual deals with emotions without knowing him personally and investigating the circumstances in which he, and no other, lived? I believe that when a therapist talks to a sharer without first listening to him, the therapist will only silence him.

Once the diagnosis has been elaborated, the next action relates to the *submodes* that are most adequate to the sharer. In other words, this is the set of internal resources that a person himself has to resolve his issues. While some people deal with their problems by reflecting on them, others do so through faith, by social isolation, buying junk, talking to friends, memorizing the telephone book, or going out to dance till they drop etc. Without categorial care, nobody can

understand which alternatives really benefit or are counterproductive ways out. Last of all, come the applications.

Naturally, considering the varieties, on average, in every clinical practice, all of the clinical assistance is completed in six months, with additional consultations for revision and follow-up. One of the main objectives of the clinical philosopher is working hard towards that one day in which he will become dispensable, leaving the sharer to walk with his own forces, and if possible, happier.

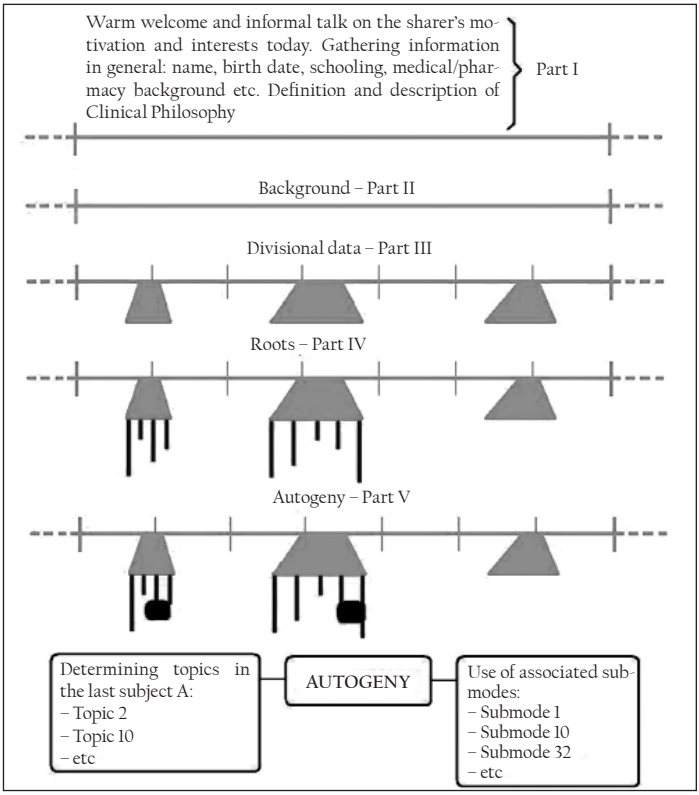



Illustration 1: Diagram of Clinical Planning in General[4]

Reference: Adapted of Packter ([s.d.]).

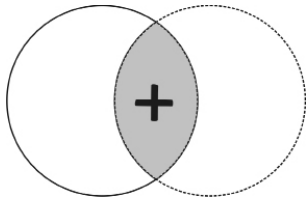
With the humility proper to an authentic philosopher, it is not always possible to cater to certain people. The sharer may be beyond capacity to comprehend... restricted by language, by an unknown culture, erudite, or more sophisticated, by mystical phenomena etc. and even for reasons of axiological struggle, out of spite, discomfort through pure antipathy, sexuality etc. In this case, the procedure most indicated is to forward the person on to a colleague who may be able to handle the case. After all, *the limits of proximity respect the distance that keeps us apart*.

In short, this is how clinical practice functions. Synthesis would be incomplete in the absence of an explanation of the basic concepts of Lúcio Packter's thought cited here repeatedly for greater familiarity with Clinical Philosophy. Within the scope of my understanding, true to the author, I will next set forth his terms and definitions. I take the opportunity to exemplify with the real case of Laura whom I once saw, for better overall understanding of the subject – with her prior permission. Obviously, there is no chance of identifying her owing to alterations made in data reported.

In a simple didactic effect, the explanation of each topic of the structure of thought and the table of submodes will be accompanied by only one reference, when possible, to Laura's literal discourse. In addition, it is important to remember that listening in Clinical Philosophy does not invent contents and interpretations for topics that do not exist or were not perceived in the language of a sharer. Fictitious examples were used in these instances. Of course, a complete written montage of her ST would take up scores of pages as can be verified in the clinical trainee work in specialized courses in therapist training by Clinical Philosophy Associations in Brazil.

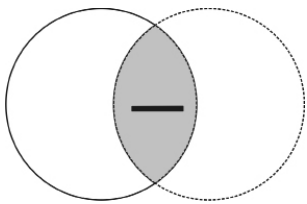
**INTERSECTION** – is the subjective quality of the relationship between beings. In clinical practice, all is directly dependent on this. There are four types of quality, namely:

- **Positive Intersection**: that which is subjectively good in the sense of well being, between the people.



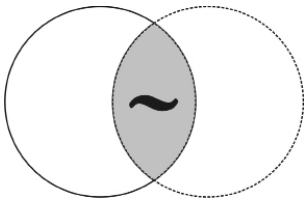
Clinical case:
Laura had two strong bonds of love in her life: for her pet dogs – she likes to sleep together with them – and for her paternal grandmother.

- **Negative Intersection:** that which is subjectively bad in the sense of uneasiness to people.



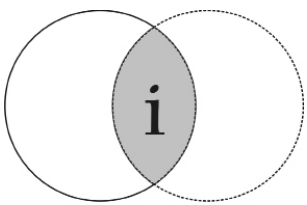
Clinical case:
Laura had an extremely poor relationship with her parents, especially her mother, ever since the age of 19. She lived in an environment at times fraught with argument, at times with monosyllabic address. She felt uncomfortable in their presence with moments of exception and longed for times past when the family were not so exacting.

- **Confused Intersection**: that which causes people to become involved without their knowing exactly what they are experiencing.




Clinical case:
Laura was once asked at a party, by a friend, whether she would be able to have a love affair or possibly a sexual adventure with a married man. She promptly answered no... but the thought lingered... if he were a handsome man, like the one walking past her at that precise moment, maybe yes, she would. However, her more conservative religious values immediately prevented her from continuing to imagine anything of the kind. Up to now, she does not know whether, in practice, she would be capable of this. She suddenly thinks that all is possible.

- **Indefinite Intersection:** that which oscillates with enough frequency, in such a way that it cannot be understood as any of the former.




Clinical case:
Laura once had an impulse to kiss Robert, a college mate, while they were talking to each other, but then she was sorry. She

thought she might ruin a very good friendship with silliness on impulse. She sometimes thinks that if she had to date anyone, he would have to be as good as Robert; hence, her conclusion that she is definitely in love with him, and she begins to miss his smile... she wants to run to his arms. She picks up the telephone, calls... hangs up at once. But other days, she is absolutely sure that between them there is only friendship, and nothing to do with love. She gets involved with other boys she thinks are more handsome... and never in fact quite knows what she should do about this. She is afraid that, at a given moment, Robert may fall in love with another woman. Laura is very fond of Robert – that is true; however, she does not know what this fondness is like. There are inner contradictions and fluctuating certainties of the opposite. Her thoughts, feelings, and hormones are completely mismatched on this point. But, Laura is lucky because although this causes her some suffering, it is essentially little relevant to her, for she always dreamed of traveling and getting to know the world and other people, or, who knows, getting a job in Germany...

**CATEGORIAL EXAMINATIONS**[5] – investigation of the five fundamental concepts a philosopher resorts to in clinical practice to express, know, and contextually situate the existence of the sharer. These are:

- **Subject** – the existential issue, whether one or many, that is the object of investigation and treatment in clinical practice. It's the philosopher's intellectual focus of attention, the center of gravity of all his analysis. It represents the existential perspective of the problem and reveals the important topics of ST in this case.

Changing subjects in therapy (like, for instance, leaving aside the unemployment issue and concentrating on the relationship matter, different situations that happen at the same time) may change completely the existential topics involved, the other categories and the sharer's examined psychological perspective. It is subdivided into **immediate issue**, in its apparent nature, symptomatic and generally presented at the beginning of the clinical session; and **last issue**, which reveals more important problems. "Last" here doesn't have the metaphysical sense, essential, unique, as if there were no possibilities of other issues beyond. It means the highest level of depth in the analysis of the problem, until then. There may be coincidences between what, at the beginning, the sharer affirms he is and the results of the philosopher's research: however, the therapist can not determine this a priori, according to his theoretical position or intuition.

Clinical case:
**Immediate S.**: Laura sought out a clinical philosopher by insistence of her mother and at the first consultation said the only "people" who understood her were her pet dogs, with which she spent the greater part of the time locked in her room. She seemed very sad, with a vague unfocused gaze on things, apparently. She complained of strong headaches and slept very little which directly affected her output at work... She could not have lasting relationships with her boyfriends without knowing why. She didn't know what she wanted of life... She wept.

**Last S.**: Laura had a strong feeling of guilt in relation to her father and had urgent need to relieve her pain by begging forgiveness directly from him, but she thought this impossible owing to his death. After years of alcohol abuse, her father had developed alcoholic cirrhosis

and, in his last crisis, was hospitalized. Death followed swiftly. In this period, as usual, father and daughter were once again at odds. Her mother was emphatic morally warning her daughter that behaving in this way, she would kill her father with pain (most probably – which was not investigated – this was merely provocative speech, not literal). Laura, in turn, was deeply hurt and decided she would not talk to her father until she received a formal apology from him, which did not happen. She felt very uncomfortable living alone with her mother. She wanted very much to leave home, but was stricken with guilt at the very idea of leaving her, also alone, remembering she had abandoned her father when he most needed her.

- **Circumstance** – this is the total sum of all the idiosyncrasy and the manifestation of the modes of being of someone in both inner and outer circumstances. It is the contextualized historicity of the sharer.

  Clinical case:
  A clinical history of Laura with literal passages from her words and conceptual definitions in each of the topics of her structure of thought follows.

- **Place** – is the psychological record of sensorial, physical experiences that the sharer elaborates for himself regarding the environment in which he is situated.

  Clinical case:
  Subsequent to the tragic impact of her father's death, Laura showed preference for her own home to anywhere else – and, more specifically, to her room. The room, in her description, revealed very comfortable subjective conditions to her existential conflicts, for there, she had the feeling she was protected from the

world outside. She preferred to stay there with the door closed, even when she was alone in the house.

Before the depressive crisis, she loved to walk out with the dogs in the road, on Sundays, in the late afternoon, wearing an old pair of weather-beaten jeans, close-fitting, that made her beautiful. She said she preferred to go alone, without a lot of talking, to see everyone gather in the sports square in her district, a place with a lot of people. She would hear flattering remarks from the boys. She liked that.

She also loved to go out evenings to chat and have a drink with friends, in places she thought were attractive, with lots of color. She had never liked dark places, even as a child.

She generally sought refuge in the house of her paternal grandmother when there were arguments at home with her parents and enjoyed the light talk and fresh baked homemade cookies.

She was born in City X but was raised in Y and had said she would like to live in another country, to travel to places she had never been to before, where no one would know even her name – all entirely new. She said it would be as though she were being born again, leaving problems behind.

Although she had gone on some pleasant outings to a farm, she said she would never be able to live in a place as quiet with no night life like in the big cities to which she had become accustomed.

She said everywhere was that much better when she was with her friend Robert.

Etc.

- **Time** – is the result of the comparison between time stipulated objectively and time lived subjectively.

Clinical case:
In her narrative she almost always used verbs in the present tense in referring to Robert, to the dogs, and to her grandmother. She said that with them, time stood still. In general, she used the past to refer to facts in her background. Also in the present, she referred to the fact she "spends hours" in the beauty parlor, having her hair done, with aesthetic massage... that she "adores" a long hot bath etc. However, for months now, she had only been to the beauty parlor for the minimum necessary, without lingering on. She said she lacked the money.
When she spoke of herself, she would keep to the past, invariably sadly. Her expression changed, however, and she smiled telling how happy she was to feel she was attractive to the boys when she went out at night, or to parties with friends. She would then go back to verbs in the present.
As from the age of 19, she had learned to get on better with her father by spending less time together. She discovered as from then that this is a basic recipe for success in any relationship: to allow time for longing, to enhance a renewed encounter and co-existence.
At times she used verbs in the past tense to refer to a dream that one day she would travel and live in Germany, saying that "she had this dream about traveling", but soon went back to speaking in the present tense, saying, with a smile on her face"...I have this dream". Etc.

- **Relation** – refers to the intimate way in which the sharer gets involved in the various connections with himself in self-definition, with things and persons interconnected with him. This is a matter of physical and psychological characteristics established

in their intersections.

Clinical case:
Among the several determining relations that Laura established over the course of all of her life, the didactic focus here emphasized only, and in short, some relevant aspects in their specific contexts – in considering her parents, the dogs, the grandmother, and friend Robert.

a) Life with her mother had always been marked by a strong Catholic influence of a conservative nature, demanding positions from her of moral rectitude, of family union, in addition to sexual repression. Laura regarded her mother as very fair and good even though she disagreed with the degree of strictness of her values. She realized that she should give back all of the kindness she had received during her lifetime. Laura learned to cope better with her mother, and with her father as from the age of 19 when she discovered it was better to lie about herself and took to living two existential lives: one, more demure, for the benefit of the family, and another, more sexually liberated for friends and boyfriends, with whom an important part of herself was more spontaneous.

b) She had few childhood recollections about her father and said she was in frequent conflict with him as from her first boyfriend, at the age of 15. He always drank a great deal, which practically eliminated the possibilities of dialog. Her efforts to spend time away from him to improve the relationship did not always work out, particularly as a result of the drinking. When her father drank, it was a matter of luck as to whether she would find him in a good or in a bad mood. There were never any guarantees. In spite of the ill-feeling, she learned to think of him as a good man

– through the strong religious influence of her mother – even because, as Laura said: "He never killed nor robbed anyone... and never let anything go lacking at home. He paid for my school and all the rest...".

c) She had always had dogs, ever since she was a girl of 9. Once one of the dogs died – there were 4 altogether – and Laura almost died of sadness, on which occasion her father said he would never take to another animal, so as not to suffer. And so it was. She thought about her father's attitude for a long while, wondering whether he was right, but her fidelity to her pet "doggies" (as she refers to the dogs) was stronger. When she moved out of town, at the age of 14, she went to live in an apartment and so, gave them all away to friends. She says she was able to part with them because of her father's phrase. As soon as she could, now at the age of 23, she again invested in a couple of puppies. She told them all she felt and thought and even "listened to" good advice from the dogs, musing to herself. She said if she did not have the dogs, she would have a personal diary of her own.

d) Her paternal grandmother "is a darling person", she guaranteed. Of the entire family, her grandmother was the one to caress her physically, to stroke her hair, with lots of kisses... Laura often spent her school holidays with her grandmother. One of the things Laura liked the most was to cook with her grandmother. She confessed that who did almost all of the work including washing the pans was her grandmother. Her grandmother always found a way to lavish acknowledgement and merit on Laura and Laura felt she was loved by her. She was even touched "for the rest of her life" when her grandmother said: "My dear, you may even be wrong, but I shall always be on your side!".

e) Robert was a very special person to Laura. They had been friends for three years, having met at college studying Languages. As she said, previously, with him, she had an indefinite intersection and saw him at times as the ideal boyfriend, and at others as no more than a friend forever. Since her depression, after her father's death, she had had several invitations from him in his efforts to help her, to go out and talk. But the constant oscillation in feelings made her opt to keep away from him for a while, and she talked to him only on the telephone. Laura knew, or thought, that Robert was in love with her, and used reason so as not to allow her own privation to act on impulse, hurt him and thus lose a great friend. She said the only reason she did not sleep with him was because she could not resist the temptation to continue being desired by other men. She thought she wouldn't be true to him, sexually. In any case, she had never felt prepared for a serious, long-lasting commitment.

**DIVISIONAL DATA** – sequential demarcations, processes of sharing over broad periods of narrative from the historicity of the sharer in which he again reports his experiences. The data result in greater understanding, lending consistency and detail to former information. The experiences clarify doubt, explain situations that were previously fragmented, sparse, etc. In the case of a historicity that is already sufficiently detailed, it is possible to effect a minimum of divisions. In the opposite case, more divisional data are made as to antecedents. A philosopher must take special care when he comes face to face with a moment that is painful to the other person: this may even impede continuity to the process.

Clinical case:
*Clinical philosopher*: "Laura, I should like you to tell me once again about everything that happened, but now, in particular, about your ages 15 through 19" (...). "Now, when you were 15 and 16, from when you had your first boyfriend... until the day your dog got sick..."

**ROOTS** – paths of epistemological depth, of specific knowledge, investigating terms and facts that, in the divisions, proved pertinent to the last subject in clinical practice. This also allows a philosopher to establish logical, syntactic, and semantic relations in the discourse. Roots are also used to overcome difficulties in narrative, when the sharer becomes laconic, shows difficulty remembering his own history or takes too long repeating. Normally roots come after divisional data, but may also be carried out parallel in cases that demand sufficient maturity and clinical experience to avoid detours far from the therapeutic process.
Expressions used include: "Talk a little more about this...", "What else happened at this time?", "How come...", "When did that happen?". It is essential that the expressions be always adjusted to a person's ST following three guidelines, basically: examples, definitions, and descriptive data.

Clinical case:
*Clinical philosopher*: "What did you mean when you spoke of wanting to leave home when you quarreled with your parents? What went through your mind at that precise moment?"

**STRUCTURE OF THOUGHT** (see page 127) – the sum total of all of the modes of being existing in a person, organized in plastic

correlations that vary to infinity. Structure of thought describes individual consciousness existentially in its divers movements during life, making it possible to come away with a safe, contextualized judgment concerning someone.
Structure of thought consists of thirty topics, because of the anthropological concepts of the history of philosophy elaborated even today and is a structure open to the inclusion of new elements. Clinical Philosophy, like any philosophy is, by definition, dialogic and anti-dogmatic.

1. **How the world appears (phenomenologically)** – is the manner in which we evaluate the world in which we live.

   Clinical case:
   *Laura*: "I was born in city X, but I moved to Y at the age of 14. It was interesting to leave up-country Brazil and move to the capital... All I know is that I got used to the busy life here, and it is no longer possible to live in a small town. I can even stay at home the entire weekend, just knowing that if I want to go out, I have options... it is worth it. If a big city is more violent, it is also more fun. We have to be careful anywhere, nowadays..."

2. **What one thinks of oneself** – the judgment a person has of himself.

   Clinical case:
   *Laura*: "I was a happy child, free of inhibition and prejudgment about my body. But this became a problem to my parents when I had my first boyfriend. To me there was nothing much to it ...

Today, as a woman, I am unhappy... I really am sorry for all I did, for having caused his death. He was my father, right? In spite of everything... I am a Christian! Perhaps if I had only swallowed my pride at the time and asked for his forgiveness, he might still be alive today... But it's no good, the past is the past! And to God, what you do, you pay for".

3. **Sensorial and Abstract** – the relationship in the sharer between experiences of the five body senses and a pure association of ideas. With no previous separation between body and soul, the perception of the sharer guides possible definitions in this regard. In principle, sensorial is the experience which is the closest to physical sensation, and abstract, which is the closest to complex ideas. What is important in this topic is not both perceptions in themselves, but the relationship between them.

   Clinical case:
   *Laura* (Sensorial): "Heavens, how good it is to talk about nothing at all with my grandmother... and to eat baked cheese biscuits... piping hot! I know they are fattening, but later, we can go on a diet".
   *Laura* (Abstract): "I remember that when I traveled and I was sad with such a lot of problems I was experiencing at the time... I had such a longing for her. I went to a bread shop nearby and asked for a cheese biscuit. It was a bit hard, no taste... But I wasn't eating a biscuit... It was my longing for her".

4. **Emotions** – the movement in which a person experiences some sort of affective state.

Clinical case:
*Laura*: "I never liked dark places. I like very colorful things. Well... now that I think about it, it's been a long time since I wore anything like this... Do you like it?" with an expression of astonishment, surprised at herself.

5. **Pre-judgments** – subjective truths that exist in a person before the knowledge or the experience to which they refer.

Clinical case:
*Laura:* "Look, I discovered what everyone one day learns: that you have to take a break every now and again, in any type of relationship... so that longing will enhance being together once more. Else no one can stand it! Even Christ, at times, left his disciples alone... then they met up again. I believe this is very right!".

6. **Terms recorded in the intellect** – terms that are most important expressed by a sharer in his communication with a clinical philosopher. They include words, pictures, touch, images, breathing, sound, gesture, smell, etc. Only those whose values are justified in the context of ST and in categorial variables are of interest here, showing they are pertinent to clinical practice. Good knowledge of the correct use of the terms utilized by the sharer makes quality in the intersection between both easier.
The terms here mean the ways each one expresses the meaning of a proper experience. If the way a person set appointments or keeps one definitive information in the ST will also be investigated (topic 20 Epistemology, as will be seen ahead), it also could be possible to discover how to remove a psychological information

eventually bad when associated to a particular Term. Stop using the old perfume that reminds the loss of a great love can empty the following suffering, without which the therapy might be useless.

Research on this topic is initially taken more with identification and importance of the terms than with the correlated subjective living experiences. It should be observed that the whole language of the sharer with its terms is the object of research in the 30 topics of ST. However, many experiences are so fragmented that they can not be fully studied in other topics beyond this. A deeper investigation of the relationship of correspondence between one term and its specific meaning is recorded under topic 16 Meaning.

Clinical case:

Laura used the term "my doggies" in referring to her dogs, in a very affectionate tone (T4 Emotions). She seemed pleased when I referred to them in the same words, with a greater degree of repercussion of T21 Expressivity towards me.

7. **Terms: Universal, Particular, Singular** – in this topic, a philosopher investigates the amounts expressed in the terms used by a sharer.

Clinical case:

*Clinical philosopher:* To be a Christian, Laura, is not to be perfect. Nobody is perfect **(Universal)**... Who hasn't done something wrong in this life? You, your father, me, your mother... The Gospel was made for people like us, Laura **(Particular)**... To be a Christian is to take a lesson of humility from a mistake... from

guilt, a debt to be paid with love, taking something that is good to the neighbor... to people, to animals... You told me you received a lot of good things from your parents... Your father **(Singular)** never let anything go lacking at home, he paid for your school... and so much else. What we do, is what we pay for, Laura!... You should pay good with good, don't you think so?"

8. **Terms: Univocal and Equivocal** – here we aim at the particularities in the efficiency of communication, trying to understand why there are one or more senses in interpretation used by the person in his speech.
   Clinical case:
   *Clinical philosopher:* Laura, if I understood correctly, the only reason you don't date Robert is because he is not handsome, right? But tell me, precisely, what does a handsome man mean to you?".
   *Laura*: "I don't know... Handsome is handsome. Something standardized that everyone can recognize".
   *Clinical philosopher*: "Just to make it clear and avoid any ambiguity... To you, beauty is what the majority would agree is attractive. Of the sort... a handsome man without a shadow of doubt would, in cinema, be Richard Gere or Brad Pitt?".
   *Laura*: "Yes! I am not talking about inner beauty..."

9. **Discourse: Complete & Incomplete** – discourse in the sense of living experience, taking the experiences of the sharer through the limits of his language. Access to his subjective world, to what he wishes to communicate, demands understanding of the combinations of language in use. On one hand through the syntactic analysis of the language that determines the formal relationships of agreement, of subordination and order; on the other hand,

by existential analysis that investigates possible psychological sensations of stages or cycles of life. The result is that the way in which the other communicates is, in itself, topical information for his ST.

– Discourse is understood as able to

a) In a syntactic analysis, carry out integral satisfactory communication between people, presenting itself as logically organized within its logistic environment (verbal or non-verbal), with a start, a middle, and an end;
b) In existential analysis, to represent an experience in the sharer that brought him an inner feeling of an end, of a stage concluded in life, or of a psychological process with nothing else owing, whether this caused him to feel good or to feel bad.

Clinical case:

a) Laura expressed herself clearly in such a way as to always complete her sentences and ideas, rarely changing the subject before bringing it to a conclusion.

Example:

b) *Fictitious speech*: "Separation was difficult for me. You know my friend... she thought it was what the photograph showed. That's why she liked herself so much. She didn't love the painting in the picture, but the frame that held it high... Better to lose it than not to find myself. We cling to a person, with psychological needs and longing... but a great deal of this is not love, I know... it is

* Translator's note: a play on the words for grape – uva, and raisin – uva-passa.

habit! Passion is substituted for vice... Habit is tranquility that hurts us... It was hard to cut loose, but I did. I was bound and didn't even feel I was bound... Now I am entering a new phase in my life... After all, there is life after marriage, right? (laughter) Everything passes... Even grapes*! (more laughter)".

– On the contrary, the incomplete is characterized by fragmentation and disorder. It is non-conclusive, vague and stimulates the need for something else. As a result,

i) In syntactic analysis, we recognize confusion in the listener on the intentions and information transmitted by the other, severely insufficient in the process of communication.
ii) In existential analysis, there are indications that a previous living experience did not cater to his existential needs, and left him with an impression of something unfinished in life. Such distinctions, of course, can only be recognized in the context of categorial examinations.

Example:

i) *Speaking of a friend*: "I was watching television, smoking a cigarette, with a bit of beer when... Did you know that the... the... (forgetting what was going to be said)? Well, as I was saying... Boy, is it true your brother is getting married? I do not believe that things are exactly so... in life everything makes sense, I may be wrong... but I don't think so. You guy, the world goes around and around while we are here talking, you guy! That's very interesting...".

Clinical case:

ii) *Laura's mother*: I am very worried about my daughter, Doctor. Ever since her father died, she seems to have lost the will to live. I never imagined she was attached to her father to such an extent... They always quarreled... She is depressed, locked up in her room all day long... her world seems to have come to a stop".

10. **Structure of reasoning** – In order to understand this topic properly, the clinical philosopher resorts to six basic criteria, using formal logicism, the empiricism, hermeneutics, and analytic philosophy of language, also associating the submodes 23 Intuition, 28 Epistemology and 32 Principles of truth (all explained ahead). Namely:
    a) The intellectual capacity to record and to respond appropriately to a stimulation;
    b) Intimate and or justifiable relationship between the antecedent term and the subsequent term;
    c) A firm relationship between cause and effect;
    d) Contiguity and similarity between terms, concepts, and propositions;
    e) Ordered, coherent, and justifiable association of ideas;
    f) Capacity of logical interpretation, literal and through good sense.

Without a vision of the ST as a whole, immense mistakes of tragic consequences to the sharer would result if hasty judgment were to be made, because in our society, people without reason structuring may have their freedom curtailed or, if not, lose the legal capacity to answer for themselves. The theme, therefore, vindicates multidisciplinary competence and discussion, just as legal sociology, neurology, psychiatry, and anti-psychiatry, psychological studies in general etc.

Example:

The film *Midnight Express*, of 1978, winner of the Oscar for best script – with Oliver Stone, directed by Alan Parker and with brilliant acting on the part of Randy Quaid. Based on real fact, an American student tries to leave Turkey carrying a small quantity of a drug known as hashish, and is sentenced to 30 years imprisonment. There, he faces terror, a nightmare, violence... until he is deemed mad. Another important Brazilian film, *Bicho de Sete Cabeças* (*Seven-Headed Monster*) of the year 2000, also awarded prizes internationally, with Rodrigo Santoro, is on the same theme. The film was based on the book "Canto dos Malditos" (The Song of the Damned) by Austregésilo Carrano Bueno, an autobiographical narration in which Carrano describes his personal tragedy after his father interned him in a psychiatric hospital when he discovered Carrano smoked grass.

Based on the six criteria above, if anyone does not take the circumstances into account (which is all too common) and bases his judgment only on the knowledge of instants of alienation in the characters, he will quickly come to the conclusion there has been a total loss in the Structure of reasoning with all of the consequences. The films, however, show to perfection that any one who is deemed sane and is interned in a lunatic asylum will be institutionally regarded as mad.

11. **Search** – is the desire or the effort to carry out a personal project – whether intense, mild, passing, specific etc. In the total ignorance of somebody's search – of the place to which a human being will go existentially – a philosopher must not invent one to a person, in fact (as in any other type of ST).

Clinical case:
*Laura*: "One day, if God allows, I want to travel around the world... to live, perhaps, in Germany. I have heard it's beautiful there! I want to travel to places where nobody knows me, not even my name... I think it will be as if I were being reborn, leaving everything behind...".

12. **Dominant passions** – the frequency that one or more specific concepts repeat in the intellective web of a person. They do not concern strength, nor the intensity of an idea.

Clinical case:
The idea of leaving home (to live with friends or travel to Germany), inner anguish, and a feeling of impotence are data that visited Laura's consciousness continuously for seven months.

13. **Behavior and Function** – both concepts have a link of reciprocity in the cause and effect relationship. Countless possibilities are associated as from the categorial examinations, and ST development, countless possibilities are associated: one behavior may have several functions (and vice-versa), one behavior may confront another with different functions, attitudes that are an exception to the rule etc. Most certainly, not all of the functions may be known by the philosopher.

Clinical case:
– *Behavior A*: Without thinking twice, Laura has a sudden appetite and goes on a visit to her grandmother's, longing for her delicious tidbits and wanting to tell her how much she loves her.

– *Function B*: To relieve her anger, sadness, anxiety suffered at home after yet another family conflict.

14. **Spatiality** – the psychological location of someone in their movements of drawing closer or keeping at a distance from her, from others and from things. This relates to the place category in four different modes:

- **Inversion** – when a person stays inside himself in solitude and self perception, or brings the other whom he has a relationship to his existential world.

  Clinical case:
  *Laura*: "...At these times, I would rather stay alone in my room and not talk to anyone – just with my doggies... until I can think of something else and feel better. I take the opportunity to tidy my things, my wardrobe. There are times when I would simply like to sleep and awaken as if life were a dream that I woke up to. But the fact is I don't sleep that well...".

- **Reciprocal inversion** – an exercise in alterity, of drawing close to another's place existentially, acknowledging differences, adding in the desire to relate to them. The capacity for positive intersections is much greater in differing degrees, with the approximation of the physical and psychological needs of the other, the capacity to make positive intersections is much greater. A clinical philosopher is aware of the impossibility of entirely occupying the exact living experiences of the sharer.
  (In research on our present studies on Clinical Philosophy, this

topic is the most determinant to the therapist for understanding and developing ethics for listening).

Example:
In The Doctor, 1991, a film directed by Randa Haines, Dr Jack MacKee (William Hurt) is a competent and respected surgeon. He is busy and never has time for his family, nor for his patients whom he treats coldly and at a distance. He suddenly finds he has throat cancer. As a patient, he experiences loneliness, fear, the uncertainty patients experience. Amid tests, medicines and bureaucratic plots, he learns the value of friendship and of kindness, and begins to view medicine, hospitals, and the doctors from the point of view of the patient.

- **Short displacement** – an exercise of the imagination or psychological effort through being in a place of things that are physically present to the senses. This implies a change in perspective over a situation, or perhaps, a broader reconsideration of the experienced problem. In this case, these are objects and not people. This is, therefore, the new understanding that is acquired when a sharer projects himself abstractly onto material things that are close and significant to him.

  Clinical case:
  Manifesting a desire to remain more in sensorial experiences, to draw apart from the complex thoughts of sadness, Laura identified with a china ornament on the chest of drawers in the room. It was a miniature dog made of glass. Talking about this, she brought the therapy important knowledge of her needs and solutions.

*Laura*: "I stay at home, in my room, looking at this little glass... And what if I were a dog? I think life would be easier, without thinking about anything... just living... with no thoughts. I can see how happy he is, transparent... there is only light inside him, nothing else. How wonderful, no? You can breathe better... Sometimes I miss sunbathing, you know?"

- **Long displacement** – follows the same procedure as the former, with one difference: Short displacement takes place only when the elements that are captured by the sensorial perception of the sharer, while in Long displacement, imagination uses spaces that are physically distant, to be inhabited existentially. The result is a new concept of reality, an existential vision of what is imagined by the one who projects.
  Clinical case:
  *Laura*, in the consulting room: "Well... my room is normal, more or less the size of this room. I have a bed, a chest of drawers and a wardrobe... Ah! and a great big red carpet (...). Heavens, if I had to change the room to fit my consumer dreams... I would start with an enormous wardrobe crammed full...". At this moment I had the distinct impression that her eyes shone with enthusiasm. She broke into a great big smile and gesticulated with joy...

15. **Semiosis** – the system of signs used by the sharer to communicate. These are the terms chosen by the person (speech, a kiss, tears, through writing, facial drawings, music, mimic, etc.) to express the concepts of her ST. It is indispensable to observe the set of messages transmitted, in that there may be contradictions or important complements between verbal and non-verbal semiosis data.

Clinical case:

*Laura*: "My doggies are my personal diary! I believe that if I didn't have them to listen to me and be kind to me... that sweet look... I would write a diary. I like to write, I'm not exactly a writer, but at college we do have to read a lot, right?".

In the phase for setting down roots, the clinical philosopher asked her: "What is this to you?".

*Laura*: "I adore novels, metaphors, Machado de Assis... reading passages from the Gospels... And I feel spiritual energy, a feeling that is at the same time giant and tiny, of being in the world (...). I like Christ's personal story – to imagine him as a man in this transient world. The highest of all, of course! I can see him walking the roads, in the hot sun, in the twisting lanes... I can even imagine the feeling of the thin leather soles he wore... there... taking the shape of the rocks on the ground, his feet alive and alert. Very different from shoes today...".

16. **Meaning** – regards the semantic content, the component of the sense of the semiosis data and the interpretation of the sharer's statement within the context of categorial examinations. It's good not to forget that the meaning of the "speeches" of the other, does not depend on the things they refer objectively in the world. Besides that, the therapist may not know "exactly" the associated set of interrelations they mean, since nobody can experience the other's reality, as organized by himself. Above all, it depends on the way these statements are used in the speech, in the communication.

The sense of the statements emerge from the context and from the articulation of language rules and conventions. Each language has its own syntax. Therefore, knowledge does not consist of

the the therapist's discovery or invention of some reality that corresponds to the sharer's speech. But consists of studying the way he works his speech. For instance, the way he tells a lie, the purposes of his intentions, why he chooses specific themes to lie about, the body language to hide the truth or simply to exceed imagination...etc; all this carries a meaning to be investigated.

Clinical case:
In one of Laura's visits to the consulting room, as soon as she arrived, she saw I was wearing a light blue shirt and said that blue is a special color. I didn't waste the opportunity and asked her: "How come?". The answer was:
*Laura*: "Look, the sea is blue, the sky is blue... Even people say: ...'Hi, true blue?' (for All Ok?). Blue gives me a good feeling about the immensity of infinity, that the world is more beautiful, is... is greater than we are, you know?. Have you ever stretched out on the grass, your arms and legs outstretched and imagined that, as opposed to China, we are the ones to be at the bottom of the planet? That your body is bound to the grass because it is under the pull of gravity, otherwise you would fall? Just imagine the effect of gravity is going to end right now... and that we are going to fall out, down into the blue waaayyy... below. As though we were jumping from a plane into an immense ocean of blue. It's kind of scary... and thrilling, isn't it?".

17. **Pattern and Conceptual trap** – Pattern is the tendency of a subject to be existentially repetitive in relation to a specific context of ST (such as biting nails, missing people, smiling, think about sex or somatizing a medical disease...recurrently almost, if not every day). The Conceptual trap through behaviors, living out

of structural topics combined etc. takes place when the sharer tries and cannot break through a given Pattern, which forms a psychological prison, which may lead to self-destruction of the sharer... or to no place at all and is often insignificant, however strange that may seem. There are people who may voluntarily prefer to keep to their suffering (or hope etc.) all of their lives as a form of motivation – romantic, religious, artistic production etc. etc. This does not necessarily mean anything bad or subjectively uncomfortable. There are other people who could not live if psychologically free and at peace, with no form of imprisonment, not knowing what to do with the much desired freedom when they do have it. Therefore, not every Pattern is necessarily a Conceptual trap and not every Conceptual trap is necessarily undue. There are no models of personality that substitute the truth for each.

Clinical case:
Laura was depressed, cut off in a room, thinking repeatedly of her own guilt ever since the death of her father seven months previously. She missed the time when she was happy and often went so far as to think of leaving home, as a form of liberation. But she just couldn't.

18. **Axiology** – the investigation of diverse values (religious, aesthetic, sensorial, moral, cultural etc.) existing in the sharer, his subjective codes and burdens. It shows what is important or relevant to him – the criteria and reasons behind the valuation that justify his choices during a lifetime. Not always valuation is related to a concrete need, and may be the result of pure abstraction etc. with no link to desire.

Clinical case:
*Laura*: "What my mother thinks is important to me. Not that I agree... Right? But I was brought up like that, you know, realizing that family is important in life for human beings. Even more so nowadays... What I do or think and she doesn't know... Why should she? I don't have to hurt her if she doesn't understand... But what she says affects me. Very often she is wrong... and I suffer".

19. **Topic of Existential singularity** – considering the infinite plasticity of the human psyche, Clinical Philosophy is exempt from pretensions of absolute knowledge, in its therapeutic function. Far from this, in the sharer, there are sometimes manifestations of topics that are incomprehensible to the intersections of a philosopher, even when he possesses a perfect Structure for reason. Such examples of paranormalities, spiritual living experiences, hallucinations caused by drugs or vascular accidents, mental organization uncommon to a time or culture etc. Experiences of this nature are described here and investigated phenomenologically, without diagnoses and precocious foundations. Although the topic of singularity may cause amazement or enthusiasm, because it is eccentric (just as doing complex mathematical calculations by instantaneous intuition) its clinical value may possibly be little relevant to the latter subject.

Example:
In the film, The Sixth Sense, 1999, directed by M. Night Shyamalan, a boy of 9, Cole Sear (Haley Joel Osment), terrified, tells child psychologist Malcolm Crowe (Bruce Willis) that every

day he sees dead people. In his search for the psychotic origins in the boy's mind, in order to cure him, Crowe is also intent on recovering from his own trauma suffered previously when one of his former patients committed suicide in front of him. The outcome of this magnificent drama and suspense, contrary to what was supposed, is that young Cole is not mad. Rather, it was the errant spirit of the psychologist that hallucinated, tormented by his own death months previously. He was one more of the many ghosts who also visited the boy in search of help.

20. **Epistemology** – the way, the limits, and the nature in which each one knows that which he knows. Invariably by reason of the pertinence that one topic may have to therapy, thousands of possibilities associate to different people. Some learn on their own, others by observing colleagues, others yet, striking the head with one hand to memorize. There are those that do it by means of reading, covering short distances, there and back, with strict religious values; other privileged people use their intuition to get to know others, but use reasoning for professional lessons; there are people that resort to mechanical experience, repetitively, under the influence of family pre-judgments or by negative intersections in dispute: there are those who only learn under pressure, at the last minute... And so forth, according to the case.

Clinical case:
*Laura*: "The day my father died was when I realized the full significance of what my mother was always repeating: "You are going to kill your father, you make him so unhappy... You are going to kill your father, you make him so unhappy! It was then

I understood what I had actually done... (Laura cries. Silence for some minutes...) I should have swallowed my pride and talked to him... because he was sick in hospital. I should have understood that!... But it was too late. Drinking made him sick... and I delivered the final blow".

21. **Expressivity** – in the quality of a subjective measure, is how much of his authenticity someone truly shows and communicates to another. Existentially, it is equivalent to saying: it is how sincere the sharer is going towards the other.
To show someone, with no hesitation, who one is, to oneself, all that is thought, and all that is felt, both in body and soul – to a few this is easy, like child's play or an adolescent impulse. Far from any perfectionism, considering our social disposition, the fact is that plain truth is almost always unwelcome, and in many places abhorred. To the majority this is very complicated and, at times, generates personal suffering and shocks at the intersections of the structure of thought.

Clinical case:
*Laura*: "Alone with my grandmother, I am entirely myself, without having to think what to say or how to behave. She accepts me as I am... and I love her a great deal. We are like twin souls, you know? I just don't talk about pure sex, really... neither do I have to. We keep some intimacies to ourselves, right?".

22. **Existential role** – what a person defines of himself, for and to himself, during the intersection. Only the moment and the circumstances in which that takes place can be considered for the record. Subjected to constant change, to additions or correction,

it is not something that can be determined or supposed by a clinical philosopher. It is different from the T2 What one thinks of oneself because, in that one, the person speaks of himself not in relation to anybody, and in the Existential role the sharer defines himself in relation to others.

Clinical case:
*Laura*: "At that time, I did the following: to my parents I was a person who was very controlled when it came to speaking... in my behavior. Imagine... they don't even know that I learned how to drink! Now, when I was out on the razzle, I was someone else, more liberal... myself, without abuse... Unto each, his own!".

23. **Action** – the way in which concepts and topics are associated to attitudes of thought. Here we can observe actions of thought and imagination descriptively: characteristics, movements, function, development, the relations between the internal psychological action and the external concrete action, etc. – without concern ahead of time for the causes of conceptual movements. Considering that people normally occupy their thoughts all of the time, the passages that are closer to the last subject are of more interest to clinical practice. Such a segment is obtained observing Patterns and singularities of communication with people, contextualizing important information in connection with ST and T17.
This is a fundamental topic to interpret dreams, together with T16 Meaning, T6 Terms recorded in the intellect and associated (T7 and T8).

Clinical case: see Topic 25.

**24. Hypothesis** – in general is the sequence of conceptual data of Action, former topic. It is, therefore, what a person is doing or what occurs in her physically and psychologically as an effect of what was thought or the way in which it was done. In search of effects, questions such as "what happens when you think of this (or do that)?" may eventually reveal the hypothesis.

In understanding the implications of specific T23 Action, nor the clinical philosopher, nor any techniques or theories, can comprehend the essence of psychism for itself, its origin and function. For this reason, the hypothetic notion invariably departs from the effects to the investigation of the causes.

Clinical case: below, at the next topic.

**25. Experimentation** – what results from Hypothesis operations.

With no causality *a priori*, with no natural order and without contextualizing the specificity of the data in the categorial examinations, it is impossible to differentiate in behavior and psychological fact precisely what Action, Hypothesis and Experimentation might be. The sense of each one of these three concepts is interdependent and, in the absence of one of them, there may be confusion in classification. Because here, it is not an exact science, it is natural that this should happen, for it is not possible to assess all of the elements necessary or recognize the apparent links between these topics at the same time. In cases such as this, it is better to accept the limits of knowledge with humility than to invent theories that are not verifiable clinically.

The trilogy appears in Topic 13 – Behavior and Function, because this is necessarily an external, behavioral manifestation.

Whereas the relationships existing between Action, Hypothesis and Experimentation are internal movements to consciousness explained exclusively as from the exercise of thought, notwithstanding the fact that, at times, consequences in behavior can be observed.

Clinical case:

a)

*1st Action*: Laura thinks in terms of leaving home to live on her own... She remembers the death of her father: that she abandoned him at the time he most needed her. She concludes that she would be repeating the same mistake with her mother.

*2nd Hypothesis*: She takes a deep breath, feels impotent and decides no longer to leave home. She is in silence, depressed...

*3rd Experimentation*: She has insomnia and ill-being.

b)

*1st Experimentation* (of a previous Hypothesis): With no more outings with her friends around town, Laura would go to bed at about 11:00 at night.

*2nd Action*: Among dispersed thoughts and feelings, she elaborated long metaphysical conclusions on the absence of sense to life and death. Night after night she repeated this T17 Conceptual trap to herself.

*3rd Hypothesis*: ...which produced insomnia;

*4th Experimentation*: consequently, she was dispirited at work the next day.

*5th Action*: tiredness as a result of a sleepless night made her believe and to think that life really did not make sense, without stimuli for joy. Hence the depressive process.

26. **Principles of truth** – the bonds of empathy that draw people together in profound intimacy. They reveal and include the positive intersections between topics of ST involved in their degrees of intensity. Without rules, it is practically impossible to find perfect affinities in the five categories and in the thirty topics of structure of thought between two persons (at least, I never heard of one single specific case). As a consequence, the Principle of truth occurs between important elements and or determinants of ST, even if distances and conflicts in various other topics persist.

Different from mere judgment and pre-judgment, truths, as possibilities, here involve the divers concepts of the intellective web, whether emotive, sensorial, axiological etc. data – subjective truths via intersection in the sense of a consensus, causing people to converge.

Without confusion, T21 Expressivity occurs when a person truly and sincerely communicates his intimacy with greater or lesser psychological defense. The Principles of truth refer to empathy, to the laws of existential affinity. People are often observed to have high, reciprocal Principles of truth with very little T21 Mutual Expressivity. These are persons with a great deal of empathy, but that avoid each other because of shyness or owing to rules of moral behavior, culture, etc.

Clinical case (as in the Relation Category):

The maternal grandmother "is a darling of a person", she assures us. Of the entire family, her grandmother was the one to caress her physically, to stroke her hair, with lots of kisses... Laura often spent her school holidays with her grandmother. One of the things Laura liked the most was to cook with her grandmother. She

confessed that who did almost all of the work including washing the pans, was her grandmother. Her grandmother always found a way to lavish acknowledgement and merit on Laura and Laura felt she was loved by her. She was even touched "for the rest of her life" when her grandmother said: "My dear, you may even be wrong, but I shall always be on your side!"

27. **Analysis of structure** – a topic that changes the emphasis of the parties towards the whole – the descriptive vision of all of the sharer's ST, deriving general statements, qualities, and quantities. Considering the intersections with the philosopher and taking for granted the clinical interests that motivate such an analysis, this is a judgment of – approximation by means of trends and fluctuations. With categorial examinations sufficiently complete, a structural synthesis able to psychologically define the individuality of a person at a specific moment of his history is possible.

Far in essence from traditional typologies of personality, there is much to consider: a) perhaps some ST topics, for their importance or function, may blend with the whole; b) in what refers to the whole or to the parts, it is necessary to be alert to what may exist in common and separate; c) etc.

Only in this item can it be affirmed that, in one specific context, a sharer's ST is robust or fragile, good or bad, well or poorly structured for what he faces, happy or unhappy in relation to needs, etc. For purposes of comparison between STs we must consider the opposites, the ambiguities, proportions, and non-definitions in general.

Clinical case:

Once the Autogeny has been completed, *one* of the important

aspects to consider is undoubtedly the determining weight of the living T3 Sensorial experiences to sustain the structure of Laura's thought. A ST that fell apart with the marked insertion of T5 Pre-judgments of moral censorship (T18 Axiology) on the part of her mother. By reason of this, within that specific context and time, Laura could be defined as a person of weak psychological structure... with severe existential risks.

28. **Intersections of structure of thought** – a study of the qualities of intersection (positive, negative, confused, and indefinite), whether important or determinant, between the sharer and the persons to whom he relates.

    Clinical case:
    See, again, the examples cited under the term "Intersection" and in the category "Relation" (see page 279), for an analysis of the contacts of Laura with her father, mother, grandmother, and friend Robert.

29. **Data of symbolic mathematics** – Certainly, it's not possible to characterize all the human phenomenon under thirty topics, for this reason this topic is anomalous, open to the registration of new manifestations that can be verified in the future. Besides that, in this topic, the intersections between individuals, the set of people and the structures of the extra-human universe will be investigated. That is, we want to know what are the limits, the fusion and the transcendence between subjective, intersubjective and objective worlds. In a complex totality and using own methodology, the objective is to understand the collective structures of thought, inherent to the social and cultural phenomena, and knowing how these structures impact

the individuals and vice versa.

In a study that was not concluded, Packter also develops the theoretical foundations for symbolic mathematics – initially based on the work of George Cantor. In his Notebook A, Lúcio affirms that symbolic mathematics must be the vital end mark of all Clinical Philosophy.

Different from personal care with, for instance, depressed or violent individuals, studying their origin and the submodes of treatment case by case, the focus here would be "depression" and "violence" in societies today, among others.

30. **Autogeny** – Autogeny is topical – the understanding of the interrelations that the ST topics and submodes have among themselves, allowing a configuration of relevant conceptual data and a vision of the whole of the sharer's psychic world. In this topical it is possible better to undersatand a phenomenon that separately could not be perceived clearly in none of the current topics of the intellective web, but it may be captured in the movement of relations topical. A complex Autogeny, of course, demands a study of the bonds between topics and submodes with categories of place, time, and relation. In clinical analysis, only aspects relevant to the last subject, are the object of study.

Clinical case:

Laura believed she was responsible for her father's death (T2 What one thinks of oneself) and her objective, rational understanding of the determining cause of this death – alcoholic cirrhosis – was strongly linked and distorted by the influence of the religious values of her mother (T20 and S28 Epistemology linked to T18 and S26 Axiology at the T28 Intersection of structure of thought)

causing her severe guilt and depression. She also suffered from headache, insomnia, and resulting problems in terms of productivity at work (T2 and T4 Emotions affecting the T3 Sensorial and Abstract, generating a specific T13 Behavior and Function).

To this was added the firm belief that nobody changes the past, and that the mistake committed must be dearly paid for, according to God's laws (T5 Pre-judgments and T18). Laura actually counted the number of times she had a chance of visiting her father and asking his pardon, reinforcing the feeling of guilt (S15 Addition potentializing T4).

She kept the definition of unhappy for herself and, in the first consultations with the clinical philosopher, her facial expression was very sad. Since that terrible fact, she had been subjectively living only in the past, with negative thoughts as a souvenir. She retired to her own room as a sentence on herself (Intimate Associations between T4, T2, T3, and S4. In the direction of complex ideas, with marked use of T14 and S7 Inversion).

However, she manifested the beginnings of joy and a few smiles, desire and motivation and went back to talking in the present tense, when the subject revolved around her grandmother, the dogs, and concerned her own beauty, and body care. She spoke of flirting, of the pleasure she felt of being physically attractive and desired, wearing the right clothes... in parties, in bars, strolling through the square with the dogs etc., at which time she would say she did not like dark places, that she preferred colorful environments, as big busy cities (her strength and will to live were the result of a happy combination of T28 and T3 Sensorial together with S3 Towards sensations. This fed her T2 and T4 positively).

In relation to her grandmother, whom she did not at this stage visit as frequently, she received all of the kindness and the love she needed. She loved to cook and eat with her grandmother and repeatedly counted the number of hours she "whiled away" having a good time... (S15). This simple action, particularly, caused her an enormous feeling of well being. With no one else did Laura feel as true, as much herself (T28 established by strong bonds of T4 and T3 Sensorial which showed important T26 Principles of truth and T21 Expressivity)... with the exception of the intimacy she reserved for the monologues with her dogs, projecting her own issues on them. At times, she derived pertinent solutions to her problems in these solitary conversations (S5 Resolutive scheme in moments of T14 and S7 Inversion). Were it not for such monologues, said Laura, she would prefer to keep a personal diary, full of metaphors, for she was very fond of literature, of romance and, at times, remembered passages from the Gospels generically (T15 Semiosis and S20 Translation with applications of S22 Vice-concepts and S17 Perceive. All reinforced by S15). In moments such as these, she appeared to use S10 Arguments several times derived, but in truth, she was not long interested in continued reasoning to the end, to some logical conclusion, and soon substituted arguments for loose opinions, T4, S19 Selective aestheticity, appeals to T5, use of Semiosis (T15) such as expressing her ideas with her hands etc.

Over seven long months, Laura generated another conflict of which she could not rid herself (T17 Pattern and Conceptual trap): the self-repressed desire to leave her mother's house where she felt anguish (T11 and S12 Search connected to the T4). She vaguely mentioned the idea of living with friends or, better still, of living in Germany and getting to know places where no one would know even her name. Laura went as far as to say that this

would be as though she were being born again, leaving problems behind. But whenever she went back to thinking about this alternative, very often, (T23 Action, T3 Abstract and T14 Long displacement, T12, Dominant passions and S4) thoughts of the memory of the father and associated destructive emotions (T24 Hypothesis) stirred up her memory. Finally, she decided not to do anything about this and stay on at home (T25 Experimentation). As a final personal resource, at times for subjective comfort, she simply locked herself in her room with her dogs; in addition to passing the time tidying her wardrobe and personal belongings item by item (T14 and S7, S13 Short displacement and S1 Towards the singular).

Of course, there are yet many other important considerations that would fill pages of even more detailed analysis beyond this short summary.

**SUBMODES** (see page 127) – modes of experience of structure of thought. The way in which a person expresses behavior and action in the effort to render his will effective. There are thirty-two known procedures that, in combination with the five existential categories in multiple and recurring associations, reveal countless forms of acting, characterizing individualities also because the submodes inevitably complement each other and constantly alternate, in rotation during the applications. Just as in ST topics, Clinical Philosophy is open to the inclusion of new possibilities, of other practical procedures of therapy that may feasibly arise, by research, discovery, or creation. In this case, psychologies, psychoanalyses and popular therapeutics produce extremely rich, varied contributions. Packter avoids the term "technique" for the usual wear and tear of the word in its mechanical stereotype, and prefers "submode", the bottom to top mode, because

it is subaltern to ST.

A philosopher establishes a sharer's historicity knowing what submodes the sharer uses and their probable efficacy within each context. This demands an investigation as to which submodes could be adequate and pertinent to apply to the ST for the treatment of problems experienced being careful to observe those that might cause him revulsion or inner discomfort. In addition, use of submodes without categorial examinations is considered poor clinical practice and an ethical crime against a person; except, of course, in situations of emergency that demand special procedures. In this part of the clinical practice, the better the result, the stronger and more positive the intersection between sharer and clinical philosopher. Competence imposes on the therapist the ability to apply the submodes with verbal and corporal resources, according to the needs.

Various submodes may be present in one same moment or discourse. In the case of Laura, this is very clear. I might use other examples, resorting to fictitious creations that are possibly more didactic for understanding. However, I chose to allow some submodes to repeat in the same example, to allow us to observe how the practice of habitual clinical practice takes place more naturally.

The submodes are distinct because they are *informal*: when they are used by the person himself as a habit in life, in a desire to overcome conflict, but not always aware of their function; or because they are *formal* when applied instrumentally, through knowledge of cause and effect – in this case, by the clinical philosopher, by demanding strategic intervention. The distinction is visible in the examples that follow.

The sufferer commonly encounters difficulty in clearly perceiving the dimension of his own conflicts, with little strength remaining for the use of informal submodes, to relieve pain and pave the way

for solutions. For this reason, a clinical philosopher may also seek help from another colleague when he finds himself subject to his own drama. A therapist, better than anyone, knows the importance of therapy, in search of better possibilities.
The introductory nature of the definitions is to clarify ethical reflection. There is no intent, here, to derive practical orientation on how to use the submodes. There would be a great number of exceptions, delicate and complex considerations that would possibly demand another book.

1. **Towards the singular term** – used to bring objectivity, discernment, and precision to the ideas – in search of clear, distinct comprehension as to the concepts that are important to the sharer.

   Clinical case:
   *Clinical philosopher*: "Laura, to which jeans specifically do you refer when you say you look good, that you feel good? ... Could you wear them next week so I can see?".

2. **Towards the universal term** – has as objective to treat concepts experienced by the sharer, broadening the extent of their significance and consequently the strength of their therapeutic effects.

   Clinical case:
   *Clinical philosopher*: "Then there's something else that you told me about one day, where you are absolutely right: you have to take a break at times in a relationship... to enhance being together, otherwise nobody can stand it! Everybody needs that at one time or another, Laura".

3. **Towards sensations** – is to remove someone from intellective abstractions to sensorial experience, when this is justified by clinical needs.

   Clinical case:
   *Laura*: "Well, something else I did to get out of those arguments at home, that used to make me dizzy, uncontrolled, was to go out at night... for a stroll, for a drink, to talk with friends... But now I just can't, I don't feel like going out at night".

4. **Towards complex ideas** – takes place through a growing association of abstract terms, forming a web of thought ever more distant from that formed in sensorial experience. If the sharer is already in the mental universe of complex ideas, however, in a confused way, with dangerous, contradictory structure, etc. A philosopher may take the trouble to re-organize this universe, overcoming challenges and fitting the other into a better psychic environment.

   Clinical case:
   *Laura*: "I'd rather stay in my room you know, just me and my doggies. Then I keep thinking about things... and I even talk to them, I tell them all my problems...and they listen to it all! (laughter). Each one of them comes up with such a facial expression ...and I can just imagine what it wants to tell me, so I listen and reflect some more about this. I've had really great ideas like that... just me and my doggies".

5. **Resolutive scheme** – is the construction of hypothetical arguments to didactically exposed alternatives, the solutions to

which existential problems appear side by side in face of losses and gains, affording the sharer greater clarity in his choice. Several ST topics associated, according to the case, are: T4 Emotions, T5 Pre-Judgments, T7 Universal Terms, T18 Axiology etc. Each philosopher makes use of the way in which to know and to do, utilizing the competence of his own data T3 Sensorial, T15 Semiosis, T20 Epistemological, and others, whether simply through speech, by means of drawings, analogies with films, etc. In short, delimiting the issue to be worked, we move on to the options of the resolution. Through choice, the subjective weights of gains versus losses are recognized and compared. The following calculation is then elaborated: if the gains are greater than the losses, the option is validated; if the gains are smaller than the losses, the option is canceled. Following this, there remains an examination effecting possible valid options according to each sharer's ST characteristics.

Clinical case:
*Laura*: "I talk to them (her dogs) like this: look, on the one hand, Robert is the best friend one could ever have, but he is not that handsome... If I sleep with him, I'll eventually lose his friendship. The atmosphere between us will pall... and that's not good. Then, really, I am not prepared to have a serious relationship... I still have a lot to live. Well, if it's like that, it's better for us to be just friends. Friends are few and far between, and passing affairs are all too many... Yes... you're right!".

6. **Towards closure** – the process that leads to the conclusion of a task or to the unfolding of some ST experience to its final resolution. Characteristic of the sharers that indicate a trend,

through their historicity, existentially, towards a conclusion, to finish off non-conclusive or poorly resolved issues.

Clinical case:
*Clinical philosopher*: "...Then, go fight for your dreams, my dear!... And put everything that is good in you out...! It's only fair that people should receive this from you, isn't that so? And you are the one to benefit when you do good. For, only when you give, do you receive and only when you forgive are you forgiven...remember? The practical example, Laura... This thing that comes from the soul to the body... Do as Peter did, Laura... fill your soul with good things, and go out into the world!".

7. **Inversion** – is the therapeutic movement of leading the sharer to physical and/or mental introspection.

Clinical case:
*Clinical philosopher*: "Laura, then I want you to do the following: I want you to go back home, lock yourself in your room, tidy things the way you like them to be... and then, when you are thoroughly comfortable with yourself, call your doggies, and talk to them about everything we talked about today. Exchange some ideas, listen to some advice... listen to them attentively like you always do. And, next week, tell me all about it, OK?" (In other words, she is being asked to talk to herself, to interiorize and listen to her own consciousness).

8. **Reciprocal of inversion** – is the effort to get the sharer to become interested, to get to know and be intimately affected by the existence of another person. We must admit our subjectivities

are infinite by definition; therefore, however close we draw to another's world, we will never have the exact concept that he experiences.

Clinical case:
Inversion reciprocals were made in relation to the persons of Christ, Peter, and Laura's father.

*Clinical philosopher*: "Laura, you are Christian, don't forget that! You know what Jesus thought of guilt? Well he said, forgiveness should be given not only seven times over, but seventy times seven. He was uncommon, of immense wisdom... You know that... He deserves to be listened to! Don't you think you also deserve to be forgiven? After all, what is it to be a Christian? Read Matthew, 18:21 and 22. Remember Peter, the disciple Jesus lived with? Jesus slept and ate in his house so many times... Well he, and no one less, denied Christ... Not one, nor two, but three times over, and precisely when he was in greatest need: at the hour of his death. And then, what did he do? Did he go back home and sit in a corner, waiting for the time to pass, waiting until his body grew old... or did he go out to fight, paying back all the goodness he had received from Christ in double? ...working to the last minute for the needy? Do you believe Peter was not really a Christian? To be a Christian, Laura is not to be perfect. Nobody is perfect. Who does not make mistakes in life? You, your father, myself, your mother... The Gospel was written for people like us, Laura... To be a Christian is to make of a mistake a lesson in humility... of guilt, a debt paid with love, taking something good to one's neighbor... to people, to animals... You told me you received a great many good things from your parents... Your father never

let anything go lacking at home, he paid for your school... and so much else. What is done, is what is paid for, Laura!... You must pay good with good, don't you think so?".

9. **Division** – is the process of detailed investigation into serious problems that show up in a person's background: trauma, phobia, paranoia, etc. Without opting for pain the sharer is careful to avoid, a philosopher starts his search with events that are known to the person always as from before and after important issues, carefully drawing closer. It is thus possible to augment the degree of intersection – a great help to those who are shy or who speak little. This is a specific use, located and possible, distinct from former divisionary ST data. Division certifies information, affords understanding of the way in which such difficulties function or happened in life, and helps the sharer to remember things he had forgotten, with a view both to undoing the psychological shock, and enhancing positive experiences. A submode, as any other, it is only utilized after the categorial and T30 Autogeny Examinations.

   Clinical case:
   Several successive divisions were made for the purpose of collecting more information on her father's death with the resulting psychological implications to a point that seemed to the clinical philosopher productive, without greater suffering.
   *Clinical philosopher*: "Tell me now, about all you experienced between '97 and '99".
   She told me, telling about the tragic moment and going ahead, concluding the period. Her eyes showed she was fighting back tears. She was silent, and I respected this. Then I asked her: "Do

you want to go on?" She answered yes, and shook her head.
*Clinical philosopher*: "So, what was that month of July like for you?" (The month her father died).
Laura commented. She added details about her feelings, judgment and perception in general about this... Finally, in a last question, I asked her, as soon as she finished the sentence...
*Clinical philosopher*: "What exactly happened in those three days?".

10. **Derived argumentation** – continuous act, the philosopher argues with the person looking for her reasons, initially considering the subject broached without taking the last issue out of sight.
The relationships of cause and effect do not commonly draw away from the subjects that are closer to the sharer, associated to behavior experienced. Only with Autogeny T30 is it possible to adapt this submode to the needs of each, with well managed knowledge and application.

Clinical case:
*Laura*: "I wanted to understand why my relationships never last. I believe that if I understood the reason for things, everything would be easier! Tell me, what makes a relationship work?".
*Clinical philosopher*: "Affinities my dear...".
*Laura*: " But how can we know what out real affinities are? When we fall in love, everything seems so perfect? ... Until the day the dream is over".
*Clinical philosopher*: "Two things are necessary to understand a human being: good knowledge of his personal characteristics, person by person. However alike we may seem at first sight, each is very different from the other. In second place, it is necessary

to know the external circumstances that involve and limit each one's way of being. The ideal is a maximum of affinities in both aspects. With some people, you are only involved with their body: with others, you have to marry the entire family... For instance, tell me three things that for you are absolutely essential in a boyfriend so that the relationship will work".

*Laura*: "Hmmm Good, handsome, and sexy (laughter)".

*Clinical philosopher*: "Very well! Without going too deeply into what this specifically means to you... Out of context, it may not mean anything. Let's say you have met someone like that, with a great number of qualities, better than you imagined... but to live in a little town up-country, living in someone else's house and with little money to spend... Would that do for you?".

*Laura*: "Of course not!".

*Clinical philosopher*: "There you are! There's more... if it is like this for you, we would still have to know what it is like for the other, in addition to the circumstances that will affect both of you. It is necessary to know all of this... You told me the other day you were in conflict in your feelings for Robert, isn't that right? And if I understood correctly, he is all that's good except he's not handsome... and that at times you think of forgetting about the handsome bit and having an affair with him, even though you're not sure you are going to manage, isn't that right?".

*Laura*: "Precisely! Absolutely right".

*Clinical philosopher*: "And you just told me that, at first, everything seems perfect and then, the problems start to appear... It is true, when the affinities were not sufficient. Just imagine, then, if you embark on a relationship with Robert, a splendid person, with one of the aspects that are essential to you lacking: beauty? What can happen?".

*Laura*: "I am beginning to understand...".
*Clinical philosopher*: "But our needs may also change in time, with the body wishes, with important, even unexpected alterations in the contexts of our lives... Let's talk about your personal needs – the needs deep in your heart. Be sincere with yourself: are you ready to have a serious relationship now, to lose a chance in life of meeting other men?".
*Laura*: "You know it's not so, because I told you this already".
*Clinical philosopher*: "Talking a little about circumstances... would you really like to go and live in Germany one day?". *Laura*: "God willing!".
*Clinical philosopher*: "And what can you conclude from this?".
*Laura*: "That you are right. The question is not Robert. I believe my relationships are not lasting because I am not ready yet. I think that it is I who do not want any lasting relationship for the time being. That's it".

11. **Short cut** – a question or attitude used to obtain any new datum, a mere opinion, an approximate answer, when another, more complete (type: "What do you think of this?") is impossible. When in clinical practice we need some answer that will render the continuation of the work viable; then the philosopher induces the sharer to synthesize, to provide some inkling about what is taking place within, as well as he can. It is incredible what can be observed: an unlimited capacity to mix, join up, separate, divide ideas in other modalities.
When possible, this is a submode used to overcome possible blocks that would demand unnecessary time and effort. Often, this submode is used and reused several times over, to a satisfactory continuation...

Clinical case:
*Clinical philosopher*: "Laura, then I want you to do the following: I want you to go back home, lock yourself in your room, tidy things the way you like them to be... and then, when you are thoroughly comfortable with yourself, call your doggies and talk to them about everything we talked about today. Exchange some ideas, listen to some advice... listen to them attentively like you always do. And, next week tell me all about it, OK?" In other words, she is being asked to talk to herself, to interiorize and listen to her own consciousness).

12. **Search** – as submode, is every clinical undertaking in which a philosopher takes it upon himself to support a personal project, the needs and the objectives of the sharer bound for the future in an existential journey. Pertinent to the context of ST, search is plastic, and changes, evolves, disappears... but may also be inflexible, dogmatic, according to the person.

Clinical case:
Laura had two main Search objectives: to live away from home, and to travel to Germany. The first, indicated clearly, would be a relief to her personal suffering. In the second, in addition to motivation, there was also the desire to discover new experiences in life. With practical possibilities through her mother's support, Laura was advised to live with her grandmother. This resulted in a considerable improvement in her depressive state. As to Germany, there was an important psychological reinforcement to this old wish, towards a subjective displacement of her sadness, linked to the past, to hopes for the journey, focusing her attention on the present time, towards the future.

13. **Short displacement** – intellective projection of subjectivity itself in objects present physically (not people) within reach of the body senses, in order to learn something – the objective being that, according to clinical indications, the sharer will modify or develop concepts in his ST. Knowledge is only acquired if experienced as regards things that are beyond the body, but bound to it through the five senses.

    Clinical case:
    Short displacement was emphasized in therapy because Laura's self-esteem was at a low ebb in respect to her body and because topics 2 and 3 (What one thinks of oneself and Sensorial) proved important to her.
    *Clinical philosopher*: "Laura, stop and think... Put yourself in the place of these blue jeans that you are wearing at the moment. They are the same as you were wearing months ago, is that not so? ...and tell me if the jeans did not fit you perfectly. How could you be overweight...? You are beautiful, girl". She agrees and laughs.

14. **Long displacement** – a movement in which a person emerges from himself and moves conceptually to things that are beyond reach of his physical sensations, whether logical, fantastic, extemporaneous realities, etc. This is a submode much used when the sharer can not stand his present day experiences in the space in which he finds himself and requires conceptual distance to re-structure himself internally: when, in short, distance is existentially more recommendable than closeness. Distance does not necessarily mean alienation. In Lúcio's own words, one's own body is not always the best existential address.

Clinical case:
*Clinical philosopher*: "Tell me what your room is like, describe it to me... all of it. Whether it is large or small, colors, everything".
Laura describes her room in compliance with his request. She is then asked to do something else.
*Clinical philosopher*: "Tell me: what would you change in the room to make it tops... Don't be afraid of exaggerating, use all of your imagination. Imagine you can do anything and that you have all the money in the world to re-decorate, to enlarge, and to fill it with whatever you fancy...

15. **Addition** – a process of mathematizing quantitative compositions that considers things by measurements, weights, and exact perspectives. It implies a total of variable concepts, good or bad, motivating behaviors or experiences in ST as an effect of a conclusion. Addition may also be utilized simply, in an exercise of subjective accommodation, improving the quality of the intersection, of communication between philosopher and sharer.

Clinical case:
*Laura*: "...The first time I didn't even want to hear the end of the sentence. I let my mother go on talking to herself, after I had said some things as well. I was too angry to apologize at the time... Was he (the father) to call me a good-for-nothing with no reaction on my part? No way! The second time he told my mother I was the one that was wrong... that's when I really refused to apologize! But I should have understood things the fourth time round, when I could...".

16. **Scripting** – the elaboration of a script adapted to the life of the sharer, developing a step-by-step direction for him of what to do, to think, to feel, etc. – as from his psychological reality, with the data supplied by his ST, using his words, his personal experiences etc. in such a way that he become involved in the plot of his own story. In this submode, a philosopher intends to unravel conflict, suffering, and confusion that the sharer experiences, when he finds he is lost and in difficulties to find his existential way out.

    Clinical case:
    *Clinical philosopher*: "Laura, then I want you to do the following: I want you to go back home, lock yourself in your room, tidy things the way you like them to be... and then, when you are thoroughly comfortable with yourself, call your doggies and talk to them about everything we talked about today. Exchange some ideas, listen to some advice... listen to them attentively like you always do. And, next week, tell me all about it, OK?" (In other words, she is being asked to talk to herself, and listen to herself).

17. **Perceive** – the exercise of leading the sharer on, through her imagination, to experience sensorial perception. Memories of things such as smell, taste, gentle breezes, and colors, etc. are recovered psychosomatically. Other mental elaborations are associated to this, repeating, renovating, or creating new sensations that are more adequate to the needs of the person. The intensity depends, above all, on the force of the intersection established, for it is an experience lived together with the therapist. Because it causes a deep awareness of the body, particularly, this is a submode that must be applied uninterruptedly during the procedure.

Clinical case:
*Laura*: "Look, the sea is blue, the sky is blue... People even say: 'Hi, how are things doing? Blue, blue...? Everything fine? Blue gives me a good feeling of the immensity of the infinite, that the world is more beautiful, that it's bigger than we are, you know? Have you ever stretched out on the grass, arms and legs outstretched, and imagined to yourself that it is not China, but we who are on the underside of the planet? That your body is stuck to the grass because you are being pulled by gravity? Imagine the effect of gravity is over and now you, who were stuck to the grass on the ceiling, begin to fall into the blue waaaay... down below, as if you were falling into an immense blue ocean. Kind of scary/thrilling, no?"

18. **Aestheticity (rough)** – every initiative or provocation that leads the sharer to express himself, to put out all that bothers him existentially, brimming over spontaneously and without any effort of control, order, or significance.

Clinical case:
In the third session, when she spoke of her father, Laura could not hold back her tears, broke down, and cried a great deal. At another time, she said that to cry was one way of relieving herself of everything that weighed her down.

19. **Selective aestheticity** – equivalent to the former procedure, however, with direction and some control over the exteriorization process. In this case, a philosopher is able to conduct the sharer's procedure, perhaps of relief, creativity etc., specifically within the clinical issues.

Clinical case:
One certainty: whenever Laura expressed herself with growing joy and enthusiasm, spontaneous movement with her hands increased, and supplemented reasoning with gestures. The consistent impression in therapy was precisely this: she felt existentially better, the greater the non-thought, sensorial, impulsive language, the less the physical control over herself, by means of abstract thought.

20. **Translation** – a transposition of semiosis data used by a person of one term to another. Can be used to clarify a confused signal or to alter the degree of intensity of some significance, to increase or diminish intensity, according to the case.
Clinical case:
*Laura*: "My doggies are my personal diary. I believe that if I didn't have them to listen to me and give me some kindness... that sweet look... I would write a diary".

21. **Directed information** – when the sharer is supplied directly with information, adequate to his mode of being, with intent to help him to solve a problem. Example: books, films, medical directions, personal opinions (if pertinent to the case) etc.

Clinical case:
*Clinical philosopher*: "You know what Jesus thought of guilt? Well he said, forgiveness should be given not only seven times over, but seventy times seven. He was uncommon, of immense wisdom... You know that... He deserves to be listened to! Don't you think you also deserve to be forgiven? After all, what is it to be a Christian? Read Matthew, 18:21 and 22. The Gospel was

written for people like us, Laura. To be a Christian is to make of a mistake a lesson in humility... of guilt, a debt paid with love, taking something good to the neighbor... to people, to animals... You told me you received many good things from your parents... Your father never let anything go lacking at home, he paid for your school... and so much else. What is done, is what is paid for, Laura!... You must pay good with good, don't you think so?"

22. **Vice-concept** – the substitution of known terms for others of approximate significance in one same datum of semiosis, allowing one to be chosen or exchanged for another in specific contexts, without altering the general sense of the sentence as a whole (use of metaphors, analogies with films or situations, synonymies, etc.). The form is different, preserving the significance. At times, this makes it easier for the sharer to talk of his pain without direct use of the words that cause him most suffering, reducing his discomfort. However, the efficacy of the words is proportionate to the knowledge of linguistic elements of the intellective web of the sharer.

Clinical case:
*Laura*: "Look, I discovered what everyone one day learns: that you have to take a break every now and again in any type of relationship so that longing will enhance being together once more, Else no one can stand it! Even Christ, at times, let his disciples alone... perhaps so they could learn on their own... then they met up again. I believe this is very right!".
*Clinical philosopher*, in a moment of submode, of devolution: "Then there is something else you told me about one day, and you are absolutely right: you have to take a break every now and again in relationships, to

enhance being together once more, else no one can stand it! Everyone needs this one time or another, Laura. Think about it... you can spend one week with your grandmother and the weekends with your mother, in addition to going out whenever you please with friends, of course. If even Christ, at times, left his disciples alone every now and again, this can not be wrong, don't you agree?".

23. **Intuition** – the use of immediate perception of things or of oneself, prior to reasoning and independent of bodily senses. Takes place through an association of data and other submodes of the sharer's ST, in such a way as to produce "insight" that is: a sudden, deep understanding of reality. When intellect supersedes the habit of applying conceptual categories to real life, it is possible for him to capture the supposedly real essence of life itself.
It is not the only form, nor the best form of access to knowledge of things, but is available when necessary, especially at times of emergency when a situation demands instant solution. The mechanism of validation always takes place *a posteriori*, by confirmation. Use of a submode is authorized when a person (either philosopher or sharer) in his historicity shows repeated use of events of this nature with positive effect – otherwise, not.

Example:
There are people who guide their decisions in life through special dreams, ardent prayer, deep meditation etc. Once the reality and the benefits of this submode in the sharer's background have been ascertained, investigation through categorial examinations must show what the best physical and psychological conditions are so that intuition will manifest itself who knows if, through certain rituals, or by the combination of food and drink at specific times or,

yet, by means of smell, sexual abstinence, reading, yoga exercises, fasting, early morning walks, stimulating conversation etc.
Other people have an intuition without absolute control, and it is important for them to know how to distinguish true intuition from their many T5 Pre-judgments. Discernment is possible at times through T30 Autogeny, with special attention to the trilogy – T23 Action, T24 Hypothesis, and T25 Experimentation.

24. **Retroaction** – a return from a specific problem to its hypothetical origin or to where it is useful, recovering the memory of moments experienced, detail, thought, emotions, sensations etc. in regressive order. It can, at times, be mistaken for the S9 Division, with the difference that Retroaction takes place necessarily in a backward sequence in each of the facts recollected.

Example:
I once lost my wallet riding a motorcycle. I was shaken for the money and the documents that were in the wallet. I pulled myself together, sat down, closed my eyes, and tried to visualize all of the path I had traveled in the reverse direction, as from the chair I was at that moment sitting in. Using S17 Perceive, I tried to enrich my imagination with the greatest number of details possible and, at last, was able to recollect the exact feeling of my wallet falling out of my jeans back trouser pocket when I stopped at a traffic light. I went back and was lucky enough to find it on the curb.

25. **Directed intentionality** – a filtering of consciousness, of discourse by a philosopher, calling attention to something that is very

specific. Of the themes in general, we draw only on those which are of interest to clinical practice, towards essential issues.
Based as strictly as possible on categorial examinations, we now permit counseling, programming various concepts, lovingly comforting pain and conflicts, or offering guidance to various philosophies of life.
Together with S10 Derived argumentation and S21 Directed information, this submode is widely used in the so-called "counseling philosophy" (Achenbach 1984, Sautet 1995, Marinoff 2001) first developed in Europe and later in the U.S. This type of philosophy without categorial examinations, divisional data and T30 Autogeny for the combined use of submodes, is in no way similar to Clinical Philosophy originated in Brazil.

Clinical case:
In referring to notions of sin and guilt linked to the idea of family, Laura was a Christian under the heavy influence of religious conservative behavior on the part of her mother. The death of her father and religious self-punishment, which resulted in chronic, lasting depression. Opportunely, as a result of the clinical analysis of her ST, it was necessary and most important to insert a religious theme in the role of counselor. With ethical listening, such guidance was drawn from its own values, filtering only the evangelical theme of pardon from these values in order to provide her with a renewed, more adequate stimulus and outlook. At no time was there any attempt towards religious indoctrination, and no values were presented to her that were of a different nature from those which previously proved essential to her vision of the world. The use of this submode in particular was indispensable to the case, for the root of the last subject for Laura was precisely

the values of modern Christianity directed with awful prejudice and conceptual mistakes on the part of her mother.

26. **Axiology** – in the submodal quality, a philosopher reinforces, develops, or weakens sharer values, on indication from T30 Autogeny and the equivalent Topic 18 of structure of thought.

    Clinical case:
    *Clinical philosopher*: "To be a Christian, Laura, is not to be perfect. Nobody is perfect. Who hasn't done something wrong in life? You, your father, me, your mother... The Gospel was made for people like us, Laura... To be a Christian is to make of a mistake a lesson in humility... of guilt, a debt paid with love, taking something that is good to one's neighbor... to people, to animals... You told me you received a lot of good things from your parents... Your father never let anything go lacking at home, he paid for your school... and so much else. What we do, is what we pay for, Laura!... You should pay good with good, don't you think so?".

27. **Autogeny** – with the due dimensions of existential conflict and its rightful location within the intellective web (Autogeny, while Topic 30 of the ST), a philosopher tries to reorganize topical associations in their entirety, by means of several submodes. An attempt is made to generate new compositions in the structure of thought, in such a way that the sharer will find existential ways out that are more adequate to the problems that afflict her. It is worthwhile to identify theoretical differences that are not always possible in practice, between this submode and S29 Reconstruction. S29 Reconstruction does not necessarily concern a reorganization of the ST, and may be only the effort to recover

that psychological state formerly lost or destroyed, without alterations or additions. On the other hand, an S27 Autogeny may simply reorganize the ST with only its present elements, without necessarily having to rebuild it as from a cellular datum.
While topic it presents the *structural* aspect of the ST; while submodo treats its possibilities of adjustment and restructuring in its *organizational* aspect.

Clinical case:
Going back over ST Topic 30, ever since she was a child, Laura had suffered from a heavy, difficult influence of her mother's religious authority against her manner of being and defining herself, laden with pre-judgment of punishment, above all regarding sexual restraint (T28 Intersections of structure of thought, T5 Pre-Judgments, and T18 Axiology confronting the T3 Sensorial and T2 What one thinks of oneself). But Laura eventually developed informal submodes that allowed her to deal with this very well, such as: prophylactic lies to her parents, appearing to them in a way she did not to her friends (T26 Principles of truth, T22 Existential role, and T21 Expressivity); experiences with eroticism that reinforced her self-image positively, emotions, and personal vanity (S3 Towards sensations strengthening T4 Emotions and T2 What one thinks of oneself); and pleasant visits to her grandmother where she was given a great deal of affection and sensorial experience (T28 Intersections of structures of thought to enrich the T4 Emotions and T3 Sensorial).
With special emphasis, her happier life was full of important sensorial experiences for her strong autonomous psychological structure (T3 Sensorial and T27 Analysis of structure). However, it all came apart with the condemnatory insertion of values

and pre-judgments of guilt (T18 and T5) from her mother, that Laura took to heart which debilitated other fundamental topics: T2 What one thinks of oneself and T4 Emotions. Because of these heavy maternal values, her understanding (T18 Axiology subjugating T20 Epistemology) of the physical reasons for the death of her father – the sole begetter of his own alcoholic cirrhosis – lost in lucidity and she developed a T17 Conceptual Pattern and trap for herself. Direct consequence: loss of the capacity to use these, her informal submodes of relief, chronic depression and a structure of thought rendered fragile (T27 Analysis of structure).

In short, clinical planning in this case intended a reconfiguration of Laura's ST and a S29 Reconstruction of her informal submodes through the associated use of various submodes (cited ahead), minimizing the conflicts brought on by the excesses of T14 Inversion and T3 Abstraction in her negative bonds of T5 Pre-Judgments. The objective was through renewed bonds with her grandmother (T28 Intersections of structure of thought), to strengthen the complex of her determinant topics, namely: T2 What one thinks of oneself, T3 Sensorial and T4 Emotions. This was greatly facilitated by the direct intervention of the clinical philosopher with her mother, which enabled Laura to alter her capacity of making new choices in life (T18 Axiology) positively, including fostering her T11 Search.

For better understanding on the part of the reader, some literal passages of therapeutic guidance and submodes utilized by Laura have been included under the next item of this chapter entitled "Words that Listen".

28. **Epistemology** – once topic 20 of someone's structure of thought is known (Epistemology), that is, the nuances of one particular way

in which he understands reality, a philosopher makes use of this knowledge to help the person overcome difficult circumstances in his life. This is an indispensable submode if it is necessary for a sharer to have any important guidance or learning.

Clinical case:
Laura saw the world, by and large, through Christian values, but not in any perspective. Laura assimilated/absorbed knowledge and directed her behavior through her family's religious values and particularly through the impacting force of her mother. In addition, she also understood and elaborated personal opinions by a demystified reading of the Gospel and of Jesus as man. Such reading, however, was not sufficient to overcome the obstacle she faced.
Through her mother's accusations, reinforcing the moral of guilt, Laura understood she herself was the determining cause of the death of her father. This enormous mistake had to be dispelled for Laura's own benefit. But it could not be done by mere physiological analysis of alcoholic cirrhosis. Philosophically, the psychological root of her personal suffering was not owing to any lack of medical knowledge or to the absence of well-structured reasoning (T10), but rather, to the unique nature of her T20 Epistemology.
Her particular way of knowing and signifying family issues was respected because of this – through the religious element as she herself specifically understood it. In this sense, as clinical philosopher, I understood it would be unwarranted to convince her of an absence of guilt, for she clung too hard to this concept for it to be uprooted in an effort to convince rationally. Clinical data showed with certainty that the best path for her T20 Epistemology was to insert the concept of forgiveness, forgotten, back in the origins of Christian morality, both by her mother and by Laura.

This new gentler, equally strong Axiology (T18 and S26) lent new understanding (S28 Epistemology) to Laura's existence, and brought her peace of mind. As she herself was to say "Thank God!".

29. **Reconstruction** – When a person is internally destroyed, complaining about the lost years studying for a course that he didn't want, that the marriage is over and his heart is broken, etc; but now he wants to start a new life... as painful as the past may have been, with the strength that is left, it's possible a submode of reconstruction of his structure of though.
By joining various other submodes, a philosopher will reach at least one positive, solid concept in the intellective web of the sharer and as from this datum, search for others that are adjacent, in the vicinity. The more subjectively good experiences can be used in the process, the better the Reconstruction will be – similar to assembling a jig-saw, with mistakes and correct choices natural to the process. It is fundamental to take care never to rebuild the structures of thought as from T17 Conceptual traps and from extemporaneous situations that no longer make sense within present experiences significant to the sharer.

Clinical case:
Knowing that Laura lost her existential balance because of complex thoughts beset with sadness, as bonds attached to the past, therapy included various efforts of Reconstruction as from former sensorial experiences that were a source to her of strength, joy, and enthusiasm. In one of the applications of this submode, I endeavored to recover in her the use of clothes that did her self-esteem a world of good, as from one specific ancient pair of jeans... from the time she was happy. I asked her to wear

the jeans on some of the days she had therapy and, at this time, to describe how she felt wearing the jeans – to tell me of the pleasant fun times she had had with that pair of jeans: flirting, on walks with the dogs on Sundays etc. And so, I began with her good past experiences enriched with her T3 Sensorial experiences at the present time, optimizing mainly T4 Emotions, T2 What one thinks of oneself, and re-enforcing T18 Axiologies of incentive.

30. **Indirect analysis** – refers to the strategy and management of topics of conflict of a ST by the clinical philosopher, studying the functions of thought phenomenologically during the process of thought, movements, and relations existing therein, of cause and effect. Possible changes in the way of thinking and of acting on the part of the sharer are made objective here. This, of course demands former knowledge of T23 Action, T24 Hypothesis, and T25 Experimentation, because there are concepts interdependent.
With an understanding of the process and functioning of a particular concept in the intellective web of some sharer, it is intended to find out how to reorganize the movements and directions of thought (T23). A better thinking here does not mean a more accurate argument, but a better way to follow in mind the factors that have been thought, that is, to articulate the psychological experiences. This leads directly to the search for how the sharer, within the limits of his own TS, under the orientation of a clinical philosopher, may hypothetically solve his problems (T24), and which can work in the practical application (T25) of this hypothesis.
While the S27 Autogeny develops operations involving all of the submodes important to the last ST subject, Indirect analysis is conducted exclusively with outlines of thought and consequent movements.

Clinical case:
Investigating the phenomenon of Laura's insomnia (T24 Hypothesis), by the use of S9 Division, it was observed that her T17 Conceptual trap of thoughts without end concerning the metaphysics of a lack of sense in life and death (T23 Action) invariably began whenever she lay down to sleep (T25 Experimentation) excepting, however, when she fell asleep watching TV in her living room some weekends.
Studying and understanding this dynamics, it was very clear that when she lay down on the sofa to watch action films (T25), for some reason unknown to me or not investigated by me (T23), she quickly fell asleep and seldom remembered her dreams (T24). Results were not so positive with drama films.
Sleepless nights spent in her bedroom generally left her with the impression that she had had bad dreams (T23) and, although she did not remember them, she experienced an uncomfortable feeling in the chest, of anguish and, at times, felt slightly off-color during the day (T24).
By the Indirect analysis submode, I first suggested that Laura install TV in her room and that she rent action films she would like to watch before falling asleep (T25). This did not work out (T24). To obviate complex ideas (T23), she was asked to begin whenever possible sleeping on the living room sofa whenever possible or, at least, on the days she had greater insomnia and that she not lie down in bed if she were not sleepy (T25). Efforts resulted in a good reduction in frequency of insomnia (T24) and consequences...
Together with therapeutic care, Laura was also seen by a specialist, a well-known psychiatrist, an expert in sleep disorders.

31. **Expressivity** – good T30 Autogeny and sufficient depth to the divisional data guarantee a comfortable response as to how much

and in what circumstances anyone should be spontaneous and true to those with whom he co-exists – a criterion previously defined more by structure of thought than by ethical norms of social accommodation. We look for balance in this submode – an adjustment in the degrees and modes of authenticity (T21 Expressivity), where the sharer is himself in his relationships with others.

Clinical case:
Without greater consideration and new features, informal uses of this submode that Laura adopted as from the age of 19 were simply reinforced. She availed herself of an attitude that was erotically more demure with the family and more spontaneous with friends. In addition, there had always been in her a deep mode of Expressibility with her grandmother. In particular, Laura would say she felt a lot lighter after she talked to her grandmother.

32. **Principles of truth** – with clarity in the categorial and ST homonymous topical exams (T26), considering the future value of relationships with persons who are existentially similar, in this submode, a clinical philosopher encourages positive experiences at the T28 Intersections of the structure of thought s relevant to the sharer.

Clinical case:
As a result of the former submode, Laura was advised to move temporarily to her paternal grandmother's house, for her relationship with her mother did not bring her comfort and, in fact, very often, quite to the contrary. The beneficial effects of her Principles of truth in her relationship with her grandmother – amongst which an end to solitude – were encouraged.

## THOUGHT STRUCTURE

1. How the world appears (phenomenologically)
2. What one thinks of oneself
3. Sensorial and Abstract
4. Emotions
5. Pre-judgements
6. Terms recorded in the intellect
7. Terms: Universal, Particular, Singular
8. Terms: Univocal and Equivocal
9. Discourse: Complete & Incomplete
10. Structure of reasoning
11. Search
12. Dominant passions
13. Behavior and Function
14. Spatiality: Inversion
    Reciprocal inversion
    Short displacement
    Long displacement
15. Semiosis
16. Meaning
17. Pattern and Conceptual trap
18. Axiology
19. Topic of Existential singularity
20. Epistemology
21. Expressivity
22. Existential role
23. Action
24. Hypothesis
25. Experimentation
26. Principles of truth
27. Analysis of structure
28. Interactions of structure of thought
29. Data of symbolic mathematics
30. Autogeny

## SUBMODES TABLE

1. Towards the singular term
2. Towards the universal term
3. Towards sensations
4. Towards complex ideas
5. Resolutive scheme
6. Towards closure
7. Inversion
8. Reciprocal of inversion
9. Division
10. Derived argumentation
11. Short cut
12. Search
13. Short displacement
14. Long displacement
15. Addiction
16. Scripting
17. Perceive
18. Aestheticity (rough)
19. Selective aestheticity
20. Translation
21. Directed information
22. Vice-concept
23. Intuition
24. Retroaction
25. Directed intentionality
26. Axiology
27. Autogeny
28. Epistemology
29. Reconstruction
30. Indirect analysis: Action
    Hypothesis
    Experimentation
31. Expressivity
32. Principles of truth

# Words that Listen

*The professor holds forth*
*On a difficult point in the program.*
*A student falls asleep*
*Tired of the Weariness of this life.*
*Will the teacher shake him up?*
*Will he reprimand him?*
*No.*
*The teacher lowers his voice*
*Afraid he might awaken him.*

Carlos Drummond de Andrade, *Poesia Completa.*

Laura was a sweet, sad girl when I first met her. She came to therapy brought by her mother who, for a long while, had been worried about her depressive state. In a quick conversation over the telephone, she confided she was afraid her daughter would "do something silly". She told me at the time she would leave her daughter at the clinic on the appointed day and hour without coming in. And so it was for five consecutive weeks, when her daughter took it upon herself to come on her own. Our therapy lasted for approximately five months, with a few more supervisor visits at Laura's request.

After listening to her, sure that I had understood her well, within my possibility... both through words and mute gestures, the way she dressed and the desire to hide details from me... all, in fact, it was time for me also to speak. This is an extremely important issue in Clinical Philosophy: to know how to talk to a person in such a way that she listen to the best in herself and, if one day it prove necessary, the best in the therapist. Whatever, the pedagogic nature of this activity is no more than a lesson in philosophy, well intentioned advice on what the books say. On rare occasions, a sharer will simply wish to enrich himself with new information through clinical practice

(S21 Directed information). There are those who consult a clinical philosopher to philosophize, to exchange ideas, opinions, correct rationale etc. rather than watch a film, for instance and apart from psychological problems. And, why not? But, certainly, this was not the case for Laura. She lacked words... different from those in her innermost that would seem to have been said by her though they came from somebody else. It is almost certain that nothing of what I told her would be repeated. But if it were, it would have another meaning. After all, what are words that have never been said?

Words that listen are those that tell another how deeply he was heard – language that approximates and cares. That is, they are responsive languages that approach and care. A clinical philosopher speaks to one who listens by the method that supports him. This explains why, in work well done, sharers will commonly believe that a philosopher "guesses" their thoughts. This is calculated precise clinical tautology that does not naïvely repeat another's discourse (which would not be philosophical listening), but rather, reorganizes internal possibilities of existence so that it will be the best of himself and no more. Personally, as a clinical philosopher, I believe that this best in the sharer never runs dry, although the limits of my assistance, unfortunately may.

For sure, I must mobilize those experiences to which the sharer refers in myself, coming indirectly to the experiences to which he refers. In the measure in which I am successful, he can feel I am talking not only about his experience, but about something we shared together. He may feel I am some kind of sage of great worth. However, these would be mistakes relevant only to himself. What binds us is not similarity, but a profound respect for differences. We understand each other and, of course... bring the limits that define us closer, but each of us is infinite within. In therapy, what is most

commonplace to another is infinite to me. If in philosophy nothing is obvious, why should the significance of the words of another be so?

Talking to Laura, whenever possible, I used her own words laden with the significance she lent them. Her words are her outer existence. For me, there are other languages and nothing beyond; for her there is still all that was not said... These are the limits of honesty in philosophical therapy. There is no interpretation without language, and it would not be fair to judge her with the language of my world. Only true listening to another person can make known his truths. If there is something to be said, may these be words that she will listen to, words the significance of which talks to her from the inside. Learning does not always consist in learning new things to move ahead, although this may also be the case. Rather, it lies in the useful use of personal resources. Undoubtedly, in all of us, there is an optimum point of that which we can become. I feel that a great number of our crises are a mere waste of possibilities within reach.

In therapy, the word isn't a substitute for listening, but its own voice. We, who practice, and are made through practice must, in the absence of words, with a great deal of humility and consideration, rely on gestures and signs in general; to understand at least enough to be aware of that which we do not understand. If a sharer does not express himself or does not wish to communicate, there is nothing to be judged about him. It is a great adventure to inquire into the mystery of others, but it is necessary to have courage so as not to betray the miracle that is not revealed. There are two choices of what is not known: silence intact, or words that silence dialog. In Clinical Philosophy, what listening cannot do, neither can words.

Using gestures together with words, I began to use the same submodes that she used during all of her life to solve her problems, avoiding those that proved counterproductive. All in all, whenever

possible, I tried to minimize in her the bad impact of abstract thoughts to which, for a long time, she had condemned herself in her moments of Inversion (S7). And, when strictly necessary, this submode was used to introduce new values and more productive pre-judgments without violating the compatibilities of her personal universe. I tried to re-create former inner sensory links with life (S3 Towards sensations) that had previously led her favorably to ST as a whole. Then the submodes were progressively reinforced and perfected within the context of small new items she brought during the course of weeks. Of course there were submodes applied by me, that sometimes proved useless or very weak. Fortunately, however, in the case of Laura, there was no experience of negative intersection between us. Therapy proved successful because we became friends.

In perfecting, there would be much to reproduce of my talks with Laura. However, the essential to understanding the last part of the clinical practice will be restricted to the three segments or summaries chosen here. My wording does not follow any specific order, whether chronological or of value in therapy. Words only provide a theoretical, very general notion of the forwarding done, considering the psychological force of its most important elements. One ideal explanation would demand a complete reference to the specific ways in which ST topics associate to categorial examinations, together with each submode. One book would be too little. An informal conversation, with a good cup of coffee would be best for me. Coffee and philosophy make for details.

With a passion for clinical philosophy, with the affection Lúcio Packter taught me, I only know that consulting room practice is and must be a precious exercise in generosity and compassion. Laura did not increase my vocabulary, nor did she teach me new psychological theories. She helped me to be more of a philosopher...

to understand not only the significance of listening, but also the inverse.

* * *

1. Eventually, with categorial examinations completed, I waited for the time she would once again broach the subject of her own fault. When this occurred, I tried to introduce new values to her self-image such as it was (S26 Axiology and S7 Inversion). Because she resorted strongly to abstraction in the depressive process of guilt, I resorted to this same condition to help her also understand the subject of pardon (S4 Towards complex ideas and S28 Epistemology) – a subject carefully filtered and "mathematized" to her taste, as from the stories and lessons in the Gospels (S25 Directed intentionality, S15 Addition, and S22 Vice-concept). Within other concepts, I worked directly with the force of sensorial elements – so very important to her. The feeling of self-punishment to which she had condemned herself for so long did not allow any other path.

*Clinical philosopher*: "Laura, you are Christian, don't forget that (S7)! You know what Jesus thought of guilt (S26)? Well he said to all, to all who would listen... that forgiveness should be given not only seven times over, but seventy times seven (S15). He was uncommon, of immense wisdom... You know that... He deserves to be listened to (S6 Towards closure)! Don't you think you also deserve to be forgiven (S7 and S26)? After all, what is it to be a Christian? Read Matthew, 18:21 and 22 (S4 and S21 Directed information). Remember Peter, the disciple Jesus lived with? Jesus slept and ate in his house so many times... Well he, and no one less, denied Christ... Not one, nor two, but three times over (S15) Laura, and precisely when he was in greatest need: at the hour of his death. And then, what did he do? Did he go back home and

sit in a corner, waiting for the time to pass, waiting until his body grew old... or did he go out to fight, paying back all the goodness he had received from Christ in double?... working to the last minute for the needy (S26 and S15)? Put yourself in his place (S8 Reciprocal of inversion). Do you believe Peter was not really a Christian? To be a Christian, Laura, is not to be perfect. Nobody is perfect (S2 Towards the universal term)... Who does not make mistakes in life? Your father, your mother, myself... you (S1 Towards the singular term)! The Gospel was written for people like us, Laura... To be a Christian is to make of a mistake a lesson in humility... of guilt, a debt paid with love, taking something good to one's neighbor... to people, to animals... You told me you received many good things from your parents (S32 Principle of truth)... Your father never let anything go lacking at home, he paid for your school... and so much else. What is done, is what is paid for, Laura!... You must pay good with good, don't you think so (S7, S26 and S6)?".

*Laura* answers yes, moved and alert.

*Clinical philosopher*: "Any good you do is one debt less to God (S26). We start with something that is very practical, if possible made with our own hands. These here! (As I spoke, I took hold of her two hands and pressed them firmly – S3 Towards sensations). Like picking up the telephone and saying good things to someone you are fond of and miss (S32)... Who knows how to help those you feel are in need... The soul is like a vase: when it is full of guilt, like dirty water, we gradually fill it with clean water, with small daily actions and the dirt gradually subsides... exchanging evil for good, dirt for clean, guilt for forgiveness (S22). Are you a Christian, Laura (S7)?".

*Laura* nods to the effect that yes, she is.
After some time of therapy together, with strong intersection, I was convinced of the truth of her feelings (T21 Expressivity). Above all, because we realized our intersection and my comments encouraged experiences of self-confidence (S32 Principles of truth) in her.

*Clinical philosopher*: "...Then, go fight for your dreams, my dear!... And put everything that is good in you out... (S6 and S12 Search)...! It's only fair that people should receive this from you, isn't that so (S31)? And you are the one to benefit when you do good. For, only when you give, do you receive and only when you forgive are you forgiven... remember (S26 and S7)? The practical example, Laura... This thing that comes from the soul to the body (S3)... Do as Peter did, Laura... fill your soul with good things, and go out into the world!" (S8 and S6).

Laura takes a deep breath... and says: "Thank you. Will. I hadn't thought of it like that... I believe you are right..."(S4).

The session continues for a few minutes more, with responses from Laura. Before concluding, I give her some final guidance. This day I invested in the results of this reflection, within the habitual state of inversion progressively directed towards sensorial experience (S30 Indirect analysis and S3), aware that this could generate solutions created by herself (S11 Short cut).

*Clinical philosopher*: "I want you to do something else... (S6). Go home, with peace of mind... Have a long soak in a hot bath... I know you like that. Be beautiful... for yourself! Then go to your closet and choose clothes that will make you feel comfortable. Something colorful, that

suits you... and take a good look in the mirror... from top to bottom (S3 and S16 Scripting). Tell me specifically what clothes match this description for you?" (S1 Towards the singular term).
*Laura* looks up, to the sides, searching in her memory... and is happy to describe an item of clothing (S14 Long displacement).

*Clinical philosopher*: "...Well, call your doggies, close the door of your room and talk to them about everything we talked about today. Tell them everything...Listen to what they have to say and... then you can tell me how it went, OK?" And I said goodbye to her as she liked to say goodby herself: "...Go with God!" (S26).

The next week she was back with the following observation right from the start:

*Laura*: "Look, they told me that I am a bit overweight... that I must lose some weight – some 3 kgs. I think that's really what I am going to do!..." (S3) and she laughed away showing her trousers with one hand (S1). She seemed happier...".

* * *

2. One day, we arranged for a session in the late afternoon on a Sunday, in time to watch the sunset, on the edge of a small lake where there were usually a good lot of people. I asked her to take one of the dogs (S29 Reconstruction). She brought them both. It was most amusing, mainly because she talked the whole time about different, varied issues: frivolity, fashion, television etc. (S3 Towards sensations). I listened without interruption. At the end of the session, she said she felt fine and asked if we could go back there again. I agreed,

emphasizing a request: that next time, she not bring the dogs, that she wear her favorite pair of jeans and a blue shirt, because I wanted to conduct an experiment. I knew the effects of good planning as regards the jeans and the word blue (S29). She was curious until the following week... she wanted to know what it was about and look forward happily to the next session (S28).

*Clinical philosopher*: After compliments on her clothes and hair, I asked her how she felt physically in those clothes (S3 and S1 Towards the word singular), I said: "Let's make an experiment: touch the blue of the sky with your tongue... And you make a horrible, funny face (S3). Have you ever done that before?".

*Laura*: "No!?" ...and she laughed.

*Clinical philosopher*: "Do as I do... lie on your back and find yourself a comfortable position. Come on there, lie down with me... Stretch out your arms and legs wide, close to the ground and look fixedly at the sky. As deep as you can... Now try and touch the sky with your tongue... There's probably a Little Prince up there looking at us (laughter)! Let's make a face and put out your tongue to the sky? ...Prepare, we are taking off... We are starting to enter the atmosphere that involves all of the Earth... Did you know that in the heavens there are no barriers between countries? Now we are going to dive into the vast blue of the sky... Prepare! (...)".
I continued with S17 Perceive for some twenty minutes. We concluded the experiment and, before we went home, she told me that at that moment she felt as if she were being born again... a bit cold in the stomach (S3).

* * *

3. One of the most important questions and perhaps the greatest in therapy, was the long-suffering relationship of Laura and her mother in the same house, reinforcing a fixation on the sadness of the past and great isolation in her room (S4 Towards Complex Ideas and S7 (Inversion). So, I also had to dialog with the mother. Because she was the one to personally bring her daughter to me, the opportunity and the invitation for a talk in the office were well accepted. I informed her of the gravity of Laura's depression. I argued without pointing to details (S21 Directed information and S10 Derived argumentation). I also told her that if she wanted her daughter to be happy, avoiding more severe consequences, it would be best to allow her to live for a while with her paternal grandmother; who knows, returning home at weekends (S32 Principles of truth). I explained to her the urgent need to exit from a psychological state of isolation and generically affirmed that the physical environment where they lived would not allow her to get over her father's death, with no mention on my part of the true and delicate reasons (S25 Directed intentionality). I took the opportunity to ask her if she would, especially, paint her daughter's room pale blue, justifying its therapeutic effects (S4). Finally, she agreed with the initiative and said she was ready to help, which allowed me to talk to Laura about this, using the submodes that I knew were most suited.

*Clinical philosopher*: "Laura, do you remember when you took a break from fights at home and went to your grandmother's house? Well, perhaps it would be a good idea for you to do that right now (S6 Towards closure), but in a different way... I know you are reluctant to leave your mother alone without support but, if you were sure in your heart that your mother would be fine, would you also feel good?".

*Laura*: "... Yes, but I know that it's not like that!".
*Clinical philosopher*: "Yes, but if by chance your mother were to give you this assurance, that she would be fine, that she would be happy simply because you are happy... would you go your way with a lighter heart, or not?" (S5 Resolutive scheme).

*Laura*: "In that case, of course I would!".

*Clinical philosopher*: "I think you would too. I thought a lot about this, and I believe that really, it would be a good idea. I talked to your mother the other day, as you know: I talked to her about this. She agreed saying she only wants what is to your good and that you must not worry about her. Then, there is something else that you mentioned one day and you are quite right: you have to give every relationship a break... to enhance living together, otherwise nobody can stand it! Don't you agree?".

*Laura*: "Yes, I do".

*Clinical Philosopher*: "...Everyone needs this sooner or later, Laura (S26 Axiology and S2 Towards a Universal Term)... Just think... you can spend the week with your grandmother and weekends with your mother, and you will able to go out whenever you please, with your friends, of course (S32). If even Christ used to let his disciples on their own once in a while, this can hardly be wrong, don't you think so?" (S22 Vice-concept and $26).

*Laura*: "That's true!", stated with conviction.

We talked some more about the subject... and she told me that really, it would be wonderful to live for a while with her grandmother, but

that she had heartache at the thought that one day she might look back and hear her mother accusing her of having abandoned her (S4). I emphasized it would not be abandonment because she would be there at the weekends... and, most important: it was according to her mother's own will (S10 Derived argumentation). Remembering this, Laura perceived (S28 Epistemology associated to S32 Principles of truth) that, more than mere hypothesis, this was a real possibility to her immediate choice. She was interested and lively in continuing the conversation.

*Clinical Philosopher*: "Listen Laura, this business of leaving people alone every now and again is even deeper than you might think. It is not to do only with your mother, but with your father, too. We know that life here on earth is but a passage... In spite of your father's faults, he was also a good man, just as you yourself are too... I believe that one day, when all of us meet again up above, this period of separation between those who went first and those who stayed will enhance the re-encounter, don't you think? (S4, S22 Vice-concept and S26).

Laura stayed there in silence, without an answer, her gaze firm:

*Clinical Philosopher*: "Do you remember when you were 14 and you had to leave the doggies, because you had to move? You told me that you could only part with them because of a sentence from your father, that it was important not to cling to them so as not to suffer... Do you remember? You even bought some more later on... That's it, Laura not to cling is the art of letting things go when it is time for them to go. On the clock of life, everything has its hour... (S26, S32, and S22)".
"You're right about one thing: past is past. I once heard that if we cannot go back and make a new start, we can now begin another

end. You told me you pray to him... I am sure he hears your prayers, and also wants what is to your good, just as your mother does... It's all going to work out just fine, you'll see! No one on this earth is abandoned by God. Here we are... living, making mistakes, learning... improving, evolving. Again, all we could wish for is to find a sackful of gold in the street (laughter...) (S4 and S26). Especially you, who besides everything else are young and attractive (S3 Towards sensations)... There's so much to get to know in this world... You never know, you might still do your graduate studies in that marvelous country – Germany, and send me a postcard later? Can you imagine?" (laughter) (S12 Search and S14 Long displacement).

Laura cried, apparently in a mix of sadness and laughter... laughing and crying. She said she was touched, said she was sorry about the tears... and then thanked me: "Thank you, Will. Heavens...! So many beautiful things... we are overwhelmed, isn't that so? I believe you're right... I'm going to talk to my mother".

* * *

The last week she came to the clinic, she showed me the more recent pages of her diary that I had suggested she keep (S20 Translation). Laura made a point of reading out a passage about the dogs that had stayed on at her mother's. In one of the passages she said she did not know why (S10 Derived argumentation), but she didn't suffer as much to tell them her secrets, as she had before – in spite of the fact she was still very fond of them.

For a long time, she would only talk, cry, confide, maintain physical contact of affection etc. (S19 Selective aestheticity, S3 and S31 Expressivity) with her pet doggies. But Laura re-learned her old

ways... with new possibilities.
*Clinical Philosopher*: "... Now you have other friends to talk to. People who talk non-stop, to the dogs, as we say in Brazil!", I kidded her (laughter).
This time she laughed... she was so happy.

# Words that Silence

*...To please the visitors, all that is ugly, old, or dirty is thrown into Gregor's room that gradually becomes a real garbage deposit. One night three guests hear his sister play the violin in the kitchen and invite her to play to them in the room next to Gregor's. They soon grow weary and behave with disdain towards the girl. Gregor is attracted by the music and goes to the room with no thought of hiding, in full view of the three gentlemen who are alarmed to see him and threaten the family over the outrageous presence of an animal as revolting. That night, Gregor hears the rejection from his family. 'I would rather he were dead', says his sister. Next morning the maid opens Gregor's room and finds him dead. The death of Gregor is viewed with relief by the family.*

*Franz Kafka*, Metamorphosis.

How much is truth worth that silences our desire to hear it? An ancient story has it that, even today, in hell lies the man who only told the truth. Long ago, he was walking through a forest when he heard someone drawing close and stopped at a fork precisely in the middle of two roads: one to the left and the other to the right. A poor wretch was running away – a slave to the wickedness of a cruel master and chose one of those paths for freedom. His pursuers arrived on the scene shortly after and asked the man who only told the truth what direction the slave had taken. Well, you know the end of the story...

Everyone knows that the path that leads us to the inferno of consciousness is paved with good intentions. A person is not better, nor any more real because he is more sincere; nor does a personal opinion become truth to others through mere desire to convince. This means to say what is not rare: in practice, theory is something else again. Then, on any point, there are many different truths, similarities, and opposites... really brilliant philosophies, psychologies and personal guidance, perhaps more so than the effects may confirm their bases. If only we could, all of us, affirm in

our hearts what biographer Evelyn Beatrice Hall (Tallentyre, 2004) says about Voltaire: "I disapprove of what you say, but I will defend to the death your right to say it", we would have inscribed in us one of the greatest claims of every great therapist. However, one question to Voltaire might be: Of what value is the right to contradict without compassion? The right simply to disagree? No, a clinical philosopher must have another quality: he should ask himself about the caring dimension of all knowledge. Similar to what Krishnamurti asked Einstein when they met (Boff, 2004), when he asked him to what extent his Theory of Relativity helped to diminish human suffering. Perplexed, Einstein did not know what to answer at the time, but as from this day strove for world peace and fought against nuclear armament.

Imagine all of the culture produced by humanity as though it were an immense wardrobe where each item served one specific purpose, to the contextualized size of its needs... It would be an affront to want to fit ties to teenagers on the edge of a swimming pool, to strip Eskimos or to tidy the hair for those who prefer an unkempt look. This seems obvious, above all to more experienced therapists. However, what can be observed in therapy in general is the old fondness for themes of behavior or family drama, for sexuality, social influence of harboring trauma, in the past, or to the last senses of existence etc. according to the theory of choice. Those who are in search of a basic, universal psychological cause for the sum total of all of the intimacies of each, even with the best of intentions, do not seem capable of true dialog. To reduce specific questions to one sole general answer (it's this or that) silences differences, but without a doubt, facilitates judgment and even justifies the years of study to those who specialized. However, every human being has the right to be unique and to speak for himself – the reason for the choice: silence or listening.

Each great philosophical and psychological theory on man centered on only one aspect of the immense human complexity. I, particularly, am a faithful scholar with a passion over the years for the exceptional contribution of Socrates, Sartre, Carl Gustav Jung, Nietzsche, J. L. Moreno, Karl Jaspers, Ortega Y Gasset, Victor Frankl, and Erich Fromm... who greatly opened my own eyes to what they saw. I always return to them in my doubt as an eternal apprentice. The problem of these truths lies not in their being wrong on the limits of what they showed; but in the fallacies of generalization against singularities and differences. In academic discourse today, one readily sees how much theory has lost of investigatory personal contact with the "living world" and the empirical subjectivity of the other... he, over there, specifically: Sr. João, Brazilian, age 73, with appealing brown eyes; neighbor to an enigmatic character who insists he talks to extraterrestrials; young Liu Chong, on the other side of the world, a student of arts, newly widowed; my dear reader... etc. In Clinical Philosophy, the desire to convince cannot be greater than the humble ambition to learn more and more from another, any other. From an illiterate to doctors in philosophy, we are all of us profound – living miracles in each.

From philosophers such as Immanuel Kant and Husserl, it is known that it is not possible to know reality such as it is in itself through physical and human sciences, but only to interpret it within the range of our small capacity of understanding. It would be absurd to conclude that the rocks, plants, all of the animals, God, people, the infinite, and the rest can be *totally* explained by logical rules of rational thought. Since all philosophical knowledge is no more than objective interpretation, the basis of any therapy demands at least something of the philosophy of language and hermeneutics. Since philosophy is a universal and necessary knowledge, it is not

possible for a therapist to know another for himself. It is necessary objectivity to interpret in the sharer the relation between word and thing, between semantics and syntax, for this is what listening consists of.

Things do not talk and people use words or other signals of thought. In addition to my own intuition, if anything exists to be thought about and said, it is language. If a rock exists in the bottom of the sea and is verified, to in fact exist, my thought concerning this is a fact. In this sense, a fact is more than a convinced thought: it is a cognitive system and a logic of convincing. What, therefore, exists, is what has been understood to exist. This makes a good deal of sense to philosophers of language such as Wittgenstein (1981): strictly speaking, life is not made up of things, but of facts.

Of course, sciences are not foolish, all is verified by one method or another. Of course, there are discussions as to what method is more adequate, and while they do not agree, the discussion remains scientifically valid. In other words, these are the words of Karl Popper (1977), the great philosopher of science, resolving ancient debates between trains of thought – described as materialistic and idealistic. Taking conflicts apart and preventing dispute, he explains there is not one, but three worlds or realities: 1. *the objective*, by universal agreement; 2. *the subjective* – exclusively one to each one; and 3. the *inter-subjective*, that is proper to the culture, to similarities and differences construed by the laws of affinity.

Things exist without people. People exist without the words ... What joins the words and things are intentionalities. Where and when there will have language will have "conscience of" because nobody communicates without will and minimal understanding of a language, the mechanisms and dynamics of interaction with others (verbal and non-verbal terms, anything that affirms meanings,

including smells, touches, looks, the style of the clothes etc.). However, not every state of consciousness is lucid or clear, and it's not always focused on objective, clear and distinct intentions. Therefore, it must be understood as an unconscious message, an intentionality out of focus that communicates all associated intentions as for the conscience is, at some point, concentrated elsewhere. The tram of the language is extremely complex since no state of mind works alone, and is always in relation to a holistic net of organizations and psychological and brain processes (Searle, 1983). This way, unconscious is not a substance, "content" or internal representation of the psyche, it is not a hidden region where the symbols, values or desires are hidden. If there is language, there are intentionalities, even though the listed are elaborated by a dissimulation system. What can be affirmed about the unconscious of someone – only and so only – it is what can be understood of the specific analysis of syntax, the signs and intentions of its speech. In my conversations with Lúcio Packter, he used to say: "the unconscious is an invention, not a discovery". In another way, if the conscientious question *versus* unconscious will be replaced as rational *versus* irrational language, the issue will be a problem of the theory of the knowledge. The subject, wide developed by psychology, is resubmitted by Lúcio as previous a philosophical question. Strictly, to a therapist that seeks to understand what the other means, the most perfect state of the unconscious psyche is the one that has not been or can not be said, that did not use no game of language. By definition, what's more real and profound, more beautiful or despicable of the human soul, will remain in mysterious silence. Not everything is said, some things are only shown.

Assuming an agreement of the uses of the common language (such as Portuguese or English language), if a sharer says something

to a clinical philosopher which could suggest some meaning beyond or different from what he decided, knew or could reveal, how could the therapist know objectively in his speech what it is unconscious? How could the therapist know the intentionality of the reasons implied? At this point, we need to be acknowledged: it is not possible any psychology of the unconscious mind without the foundations and inquiries of a hermeneutics and a philosophy of language on the individual speech. Truely, no one can know the wishes and beliefs of another person without the interpretation of his statement according to the logic and categories of his understanding. That is, the way that he, in his culture builds and articulates subjectively the meanings of his language. All learning is a close re-signification – that is an attitude that attributes new meaning to the information received from the world, so that will keep a sense itself and adequate to the singular way as each individual is able to understand. Inhabited by the language and thought, the human being carries the power of re-signify knowledge, considering the different knowledge, cultures, and over all the individualities. Knowing this, it is essential and increasingly urgent the requirement of an ethics of listening the diversity and alterity as Clinical Philosophy proposes.

Therefore it is against-sense speak in psychological universal contents. There would be honesty in clinical listening if the rules of interpretation valued more the opinions of the interpreter than the interpreted? Those who wish to use words that call real, and thus to judge the others and all the reality, knows: it has to speak only of what and how interprets, but never of things perceived by themselves. Since the words promote the common understanding, they inhibit the singularities of the feeling. As well knew the philosopher Nietzsche (1979),[6] what feels differs of saying what is felt.

Through a well done philosophical research, considering all

the examinations categories (subject, circumstance, place, time and relation) presented in the Clinical Philosophy, it is possible to recognize in people several and unusual modes of intentionalities, conscious or unconscious. Surpassing poverty and the dangers of the stigmata personality without ever disregard the neurobiological studies of mental psychosis, there is everything. There are thousands of floating information apparently de-configured: sensations, feelings, logical, axiology, pre-judgments etc., in momentary disuse, dispersed of the current interest focus. Such as a neglected breath, no one (or almost) is lucid all the time. If we are able to feel our feet while walking smoothly in the morning, why do we lack feeling them during all day? The fingers of my feet are now unconscious because I have no interest in them or in my totality. Moreover, there are lucid consciences with parallel and simultaneous thoughts; understanding and bipolar desires; spiritual influences, altered states of consciousness, metaphysical, paradoxical languages, symbolic, through gesture, intuitive etc., for sure difficult or uninteresting to those (many) that basically resort to common perception, socially conditioned in each period. And, last, there is the pure unconscious that, beyond my physical and spiritual reach, is a lack of knowledge of the entire world.

In the same way in which each human being's conscience is characterized by individually directed intentionality, with a structure of thought without equal, each society avails itself of its own system of categories of understanding that determine or reveal its cultural forms of perception. With no difficulty, social sociologies and psychologies in general[7] handle a kind of psychic mechanism of social standardization in order to shape values and behaviors under restrictive pressure, in such a way that each society in a specific historic context will eventually interfere in the capacity of its members, in

general (not all, of course), with greater or lesser influence, in order to keep stable in the particular form in which it developed and is characterized.

What can honestly be said about that which is unconscious to us by definition? More than the knowledge of things and the invention of ideas, philosophy shapes the certainty of life in thought. If there are more things between heaven and earth that philosophy and science in vain can not, art and religion can. Should a clinical philosopher need to investigate and experiment the intentionality of transpersonal knowledge[xii] for himself, of the countless spiritual and aesthetic experiences, to familiarize himself with metaphors and literature, etc. in order to understand another, he will. But it is as well not to forget that a philosopher, like any human being, has a right to his own values and refusals, without dogmatism. Re-defining limits – topic 19 of the ST – Existential singularity – is a window open to the windows of the mind. In Clinical Philosophy, through the love of knowledge, what cannot be proven is neither true nor false: it is listening.

The infinite and the unutterable in man and of what could be referred to as "beyond man", as legitimate manifestations of the sharer, have their own means of communication and understanding, other than logic. The rules that define what a tree must have to be a tree, make of trees concepts, not trees. Both trees and human consciousness deserve intact, metaphysical silence and not the authoritative silencing by those, who in the name of their truths, prefer to silence and destroy what they do not understand. The intact silence of metaphysics is not the mere absence of words, but the intuitive language of all that does not communicate by argument. Perplexity exists and lies in understanding the significance of that which is not explained, the intuition that precedes word and

thought. To paraphrase the famous saying from Galiza, northwest of the Iberian Peninsula: "*Las brujas y las metafísicas [my addition] no existen, pero que las hay, las hay*".[8]

Suddenly breaking through, uncovering transcendence, a forerunner to why, intuition is perplexed consciousness itself of unconscious latency, humble and wise. This is a non-rational concept of truths and, as such, intuition exists and is proof of its strength to those that manifest it. It may refer to a psychological synthesis, a marvelous and inaccessible internal organization, or be evidence of parapsychological realities, external to experiences that have been lived. To perceive or foster intuition demands suspending the motivation that habitually, routinely, directs the attention of the person to listen as freely as possible to the topics of structure of thought itself. I watched a film in the early hours, the name of which I do not remember, where an artist only reached ecstasy and brilliant intuition when he isolated himself from other people and experienced intense hunger, to the extent he became delirious... In other people, the unconscious only "speaks" through demands of religious faith, by praying aloud, with a strong intonation, if and only when there are other people with him, doing the same. Some decide to get drunk to find the necessary intuition. There are musicians who hear wonderful compositions in their dreams, while they are asleep; some incite intuition listening to special recordings, reading certain types of books, or watching films of the kind... But there are those who cannot stand to read, who do not like television, etc. Someone could still say that God or the psyche of the universe, talks to us through the unconscious, personal or collective, and communicates with people all of the time, revealing signs, happenings and synchronism...

All very well, no problem. Philosophy apart, when one consciousness interprets another, how can one become aware of what

is, in fact, unconscious? It may be possible to know past existences or access all that we have repressed therein. But what is the past, if not language? We must leave the occult to the occult sciences while dialog is possible. There is much knowledge, where that philosophy declares it is better. Clinical philosophy is only of interest to human beings as a phenomenon, a manifestation. It is not what we guess, but what proves important to the sharer's mode of being. It does not confer magical authority to the therapist, manipulating the secret thoughts and desires of another, as though he were invariably impotent to himself. Abuse nowadays has reached the point of eliminating even the fundamental right to disagree with opinions, leaving a person with no defense. As if this were not enough, the right to refuse this abuse has even been made into a mechanism of confirmation: "... proof of what I told you lies precisely in your not accepting my words because truth is awkward – an unconscious reaction to aggressivity!". In theory, we agree or otherwise: we discuss. As longs as it's possible and through the same language used, regarding the dialog problems, as longs as it's possible and through the same language used, more dialog. As to the other, in clinical practice, just two things: to listen and take care. The unconscious is ours for listening, not for accusation.

But, of course! The unconscious is a psychic phenomenon like any other. We must be content with the existence of only two things in the subjective world: eternity of what we shall never know, such as faith; and all that is perceived and signified by codes of deciphering, right or wrong – if possible, with science and philosophy in judgment. Critic sense does no bad. The human unconscious is not a guarded secret, nor the gold that comes to view when a missing chest is unearthed and you look for the bottom, but all of life and nature concealed on one's back below the heavens. The unconscious

is an eyelid: for sure, it exists, but the interior is never visible when the eyes are shut.

Just as there is a blind spot, far from the physical gaze, where alternatives beyond the surface lie hidden, there is also a soundless direction in which I silence all those that do not complete an extension of myself with words. I can remember a sad, but at the same time amusing, incident that happened to me, many years ago, when I was twenty some years old. My cousin, like a brother to me and close to my heart, one day came over to my house with a sad, lost gaze. He was walking aimlessly about. Obviously, I couldn't wish to leave him in that state. I invited him for a long conversation and plied him with all of the philosophy I had learned at college. I said beautiful things about the sense in life, universal love, beauty of everything etc. After patiently listening to me, he went away. And I felt good at having charitably helped someone out in a difficult moment. Years later, recollecting the occasion and laughing together, he told me he had come to pay me a simple visit, and that he felt well, at ease, with no drama. But when he went away, having listened to what I had to say, he felt very bad, melancholic, and incomplete... He was so pensive, disembodied, he could hardly find his way home... That day he harbored for himself a silence full of all that had been said.

Thought is repeated as a dogma within the grammar of silence. At times, it is a game of seduction in which truth is a feeling confined to the words of the seducer, lying to himself, with gallant compliments. When what is not understood is repeated, however beautiful, in its few instants of reality, thought is encapsulated in words – pills that, if little used, reduce the faith in one's own convictions. An incommunicable gap between words and gesture is not rare among those who like to win and convince. Language is a game in which the rules are or should be no other than those rules in

which players understand each other. New contexts, other linguistic circumstances, and the rules of significance are modified. Then, the same words, gestures, looks etc. are completely transformed.

If a person, for instance, tells me that, in the field of emotion he defines himself as "self-sufficient", what does he want to say by that? That he doesn't want or doesn't need anyone else...? That he is angry at someone and says this specifically in the aftermath of a frustrated love affair five years previously? That he finally achieved financial independence some weeks ago, without which he would never have a balance of feeling within himself? That he is religiously arrogant... or humble? That this speech only makes sense in relation to the desire to free himself from fondness for his elder son who uses drugs and makes him unhappy? Or that he simply finds the phrase beautiful and wants to cause a good impression about himself to others, for he had once seen someone who seemed mature say the same words in a film? As a clinical philosopher, if I resorted to Wittgenstein's analytic philosophy of language (1999), Gadamer's hermeneutics (1980) and John Searle's research (1893) about intentionality of mind, investigating deeply the speech of those that I know best, the closest friends, I would surprisingly find answers to a simple sentence such as this. Those who know must never forget: out of context, all is nothing.

So, a six-month-old cries for food... Crying is simply crying and food is simply food, until the day when someone stops to think about it. Thence doubts, interpretations and a great deal of confusion. The child may even be given no food, in wait of an answer: is it hunger or a stomach ache?. The child knows nothing and has nothing to do with this, apparently, and continues to cry. But what does he really want to say when he expresses himself? Listening to a question such as this, someone might say that this is pure (and useless) philosophy

and that one must take practical measures. All very well, he might well be right in this specific case... but he might also be wrong. If we take the child to a pediatrician and he investigates facts with rapid exams, the doctor may well think that this a spoiled child wanting candy. There may also be different medical interpretations... But being optimistic and simpler, we must conclude there was nothing much to it. The discussion being over, there is a basic understanding: spoiling is a fact, a psychological and cultural fact. Would other children act precisely like this and for the same reasons? What would different nations in different ages, say about spoiling? For sure this concept did not always exist, in spite of the fact children always cry... for some reason.

What can be concluded from this? That life is too complicated to live without philosophy? No, for sure. We do not need philosophy to love, to eat bread, to go to the cinema, say bad things about others, laugh, change clothes, go shopping etc. However, even though unconscious of the consequences, people judge one another and themselves... And, in general, knowing as much, they do not know each other deeply. I am pleased if one single conclusion remains here: yet again, that no psychological theory without the five associated categorial examinations (subject, circumstance, place, time, and relationship), describing a structure of thought is able to grasp a simple fact or human phenomenon in its totality – nor the proper clinical philosophy, valley to add –, for all that is simple in man is prior to thought. For those who are philosophers, to think is to commit oneself to the world. In Clinical Philosophy, to know is to assume responsibility for another. Recollecting the "vital reason" concept of Ortega Y Gasset (1961), that I resort to for greater depth to Lúcio Packter's therapy: "I am myself and my circumstance and if this is not safe, neither am I safe".

Secrets only exist when they are not revealed. To listen to secrets is not to discover what is hidden. It is to respectfully keep intact what cannot be violated: the awareness of one's own ignorance about the sharer. After all that is heard and interpreted, to listen to secrets is to continue to listen to the mystery of another. Those who only listen to what they understand, ordering, correcting and prescribing other people's thoughts, prefer the silence of another, less of a size for oneself, and the voice of solitude. When words silence another so that the claims of our judgment can be heard, all that matters most in therapy loses its value. Love for truth cannot be greater than love for one's neighbor. At some stage of maturity, it will be necessary that the therapist no longer convince, but rather, be convinced of the real inaccessible existence of the deep unconscious, his own and that of others – a moment of humility in which there will be peace of mind in judgment and in dialog in the relationship. This is the price of truth in philosophical listening: with perfection, one only gets to know someone well when all of their secrets are known. At the door of a consulting room, we must always admire one who is about to enter. Only the mystery reaches the end intact.

# Therapy is a Tragedy

*"When you are confronted with comments of the type: 'how can a therapist of the soul lose his bearing to the extent he may shout and fight, lie, make mistakes, with more doubt than certainty, be insecure, cry, and, so often, be weak? Don't leave it at that! Add to the list: the pain of a hangover after a drinking spree, tell them you only passed in Ontology in college because you cheated on the final exam, tell them about the time you wanted to impress a girl and it all went wrong, tell them also that you would be embarrassed if they were to find out that you exchanged that bar with live, classical, boring jazz for a disco with ordinary music; tell them you masturbate, that you sometimes tell lies and try to look like what you are not, that you pretended you understood the lecture about ethicizing, through which you slept having verified your own ignorance, tell them that someone got up in the middle of an interview and sent it to hell; do not forget, also to say you are contradictory, human, perfect and imperfect, good and bad, right and wrong; show them you can love and that you can hate with the same intensity; manifest rage when you are hurt on purpose, say you think of vengeance, on mediocre things such as revenge. Please be sure to be completely human".*

*Lúcio Packter*, Caderno de Submodos.

If we cease to focus on the real or ideal type of human being, things such as the female archetype, a child's psyche, and its need for a father figure, psychological behavior in senility etc.,– or typology, the absence of which deserves to be remedied, we will also be able to relieve the consequences: the heavy toll of mental disease, maladjustment, dysfunction and of the categories of existential imperfection that weigh down almost all humanity, beginning with the rationale, unhappily all too common, of what is commonly described as our inevitable neurosis. Poet Drummond was indeed right... "Thy shoulders bear the world and it weighs no more than the hand of a child". To overcome the desire for superiority and domination demands a new axis of gravity in the concept of life, substituting norm for art – the order that classifies and labels by comparison raised to the infinite, that denies absolute nature and awards equal importance to beings compared by their beauty. Therapy can only take care of the internal limits of the sharer and,

who knows, alter the outer contour that envelops it a little, for the whole world is not constructed in clinical practice and the fullness of life is beyond any control.

If we consider the extraordinary impact of personal differences, of what makes us unmatchable to any being in the universe, how can it still be possible to judge the nature of what is perfect or imperfect in face of the concept of unique unto itself? If perfection is defined by maximum elevation of the qualities of which something consists, what power would increase the characteristic of exclusivity to render it more unique? Then, in understanding there is no cure, but simply assistance: in what does clinical philosophy intend to help the sharer, to attain what kind of subjective welfare? Well... together with tragedy and perfection, the concept of happiness will also need re-signifying. The beauty of Clinical Philosophy has its complexities... and rewards.

In clinical practice, the search for happiness or any form of well being whether passing or lasting, spiritual and/or physical, pleasurable or otherwise etc., may be totally insignificant depending on the T11 Search and other needs of the sharer in question. There are people (I consider) marvelous that feel guilty when they are happy and may possibly dispend the last energies of the body to attain goals they will never achieve in this lifetime. It might be said, this is their happiness. It's possible, but not always. If anyone, for instance, harbors a T5 Pre-judgment that happiness is not of this world and with difficulty exchanges every pleasurable moment for a heavenly reward, I must, as a clinical philosopher understand the Function of his Behavior (T13) and respect him, if this really is an important subjective truth to him. My personal convictions do not ensure competence to absolutely judge and decide whether he is right or not. In addition, there are those who would never be directly interested in

the subject, who desire paths that are exclusively punctilious such as how to find an answer for behaviors of inhibition speaking in public, for sexual impotence, the wish to optimize memory etc.

Our times have, in particular, produced a culture of anxiety and a certain easy, illusionary desire for happiness by consumption – with a consequent reality that is impracticable to many people. In any case, if happiness is not to be for a sharer, a philosopher would never have to abandon therapy or grow frustrated with the benefits of clinical practice. Happiness is not the ultimate end of therapy except when the case demands it. By and large, well being may 1. not be a pressing need at the time of the therapy; and, if it is, 2. with specific relevance, namely; 3. may be the result of rare personal wisdom in any condition of existence, even the most adverse; or 4. may be absolutely impossible for the tragic contexts of life. What can be done in face of death refused, unwanted old age, betrayal on the part of a friend, rebellion without control, love that comes to an end, unemployment that humiliates and all of that which is impossible to put off, that strikes us without so much as a by your leave? Whatever, the answer is the same: a maximum. In tragedy, maximum is all.

The bourgeois revolutions at the end of the 18th century re-positioned the statute of relationships established in the west between society and the individual, and made of this the supreme value in modern culture: a being of reason and the normative subject of institutions, the indivisible element and synthesis incarnate of entire humanity. It was an end to the gregarious, holistic concept of the Middle Ages in which the collective was the basic reference of the identity of its members. With paradigms inverted, society became the "means" and the individual an "end" in himself. Subordinate to individual yearnings, society gave priority to the elements to the detriment of relationships. Among the advantages and disadvantages

of emphasis to the kingdom of subjectivity – already discussed by so many authors (Arendt, 1998; Dumont, 1986; Foucault, 1984a and 1984b; Perrot, 1990; etc.) – modernity gave rise to law, a desire for personal happiness, but also, a phenomenon without precedent, namely, boredom. In the mechanics of the capitalist world, tedium, routine and normatization were necessary for success in professional work. In this sense, the banner of positivism "Order and Progress" (on the Brazilian flag) would be more honest if it were to read "Tedium and Progress" or in the light of feelings: "Tedium and Personal Happiness".

This contradiction was intensely felt and studied, in its own way, and within its limits in the brilliance of Sigmund Freud (1989). What he believed was a universal demand for inner happiness was also for generalized unhappiness, but for other reasons. To him, we were all of us born with an inaccessible fate: the compulsion to cater to instincts that culture will not allow. Investigating human suffering and the ways of dealing with it, Freud cites love as one of the least impotent means of fulfilling our desires, and happiness as the greatest instinctive fulfillment of needs that, although intense, never last. Hence the world condition of human neurosis. Freud described as "human nature" what has never been other than individuals and societies historically situated within their own dramas and consequences. There are so many significant differences between a bourgeois man of the 19th century and the "street boys" who grow up in Bahia in Northeast Brazil... so many differences and similarities between one single person and his closest neighbor... that, to not consider them, is to destroy the spirit of research and respect for diversity. It was thus for Freud. The revolution of his criticism taught us to re-think all that was until then accepted without question. It is necessary to follow his example. Shifting the focus of unbalance

and suffering in the capitalist way of life to a supposed *a priori* notion of the human psyche, many of Freud's heirs spread throughout the world by culture, preferred to call neurosis – among so many aspects to consider – the existential effects of politics, of the economy and impotence in doing anything about it. But the human being does not have nature it has history.

The fact is that T5 Pre-Judgments and T17 Conceptual traps as strong as this in our times, believing ahead of time that personal happiness is less important than tedium and professional fulfillment, may definitely exclude real concern with well being from therapy. I say, it may or may not. In day-to-day practice, while there is money or the hope of money, very few would leave happiness for later whether I like it or not. In truth, dozens of other arguments and examples distant from historical and economic foundation could be used here without difficulty, to reach the same conclusion: *a priori*, not even the thrilling and classical idea of a search for happiness may be upheld as a universal human value in Clinical Philosophy. Love that listens to all does not charge in happiness from those who do not have it, and may, perhaps, have very little to donate.

At least in counterpoint, I believe a person in therapy can be helped far more by substituting the goal of tragedy for happiness. The word "tragedy" in modern times acquired a catastrophic, painful, ungrateful sense, where someone has been struck by some ill fortune. It denotes passivity of being, the condition of victim that we may become at any moment, through a whim of existence. However, in the classic Greek concept of *tragikós*, an individual is invested with heroism by grandeur in facing his destiny, and rise once more existentially from the inevitable downfalls of life. The experience of tragedy has values that are still important to rescue in clinical effort.

Above all, because today we experience the unbalance of the influence of two extremes (that the Clinical Philosophy equally of them moves away): the inheritance from illuminist rationalism that gave rise to modern scientism that judged it could explain everything by the exclusive force of logic and of matter and its opposite, the so-called "post-modernity" reaction[xiii] that shook the reliability of reason, also generated a generation of irrational appeals and the deep belief in the supremacy of emotions. Both left a long-lasting mark on psychotherapies. The first directed clinical practice by means of practically the only criterion of S10 Derived argumentation, convincing another of their own issues. In the second, the most popular consequences were a refusal of economic and structural powers and the propagation of the culture of self-esteem, of self-help, by facilitating the magical formulas of will based on mere emotional stimulus of self-image (T2 What one thinks of oneself and T4 Emotions). Within this perspective, willing is power.

Although the majority of the western notions of happiness have been formulated by moral rationale and by the charismatic doctrines of persuasion, in Greek tragedy, on the contrary, life is an aesthetic phenomenon whose experience of art is not experienced by the individual while he is a mere spectator.

The concept of tragedy is dramatic, intense, cathartic, and transforming. Above all, because those who live it never know their own fate. Tragedy is the courage that is not afraid of the scandal of life. In other words, the tragic sense of existence cannot be defined or anticipated by any universal theory to the taste of those who uphold it, tranquilizing the certainty of death *a priori*. Whatever the sense of life, it can only be understood in the light of one's own inner struggle with oneself. As each carries the existence of his own drama, so, also, there is a sense of life that is unique to each sharer in Clinical Philosophy.

The tragedy in therapy is the development of the art of not previously using psychological theories to anticipate explanation of significance to the sharer, setting aside thoughts on life. It is the substitution of the thought of representation, that is, of theories that are not experienced instantly in conscience (where mind and world correspond separately) through direct experience of phenomenological listening, that is the living certainty that the soul has of itself when it perceives the world enveloping it and inviting him to know it. All that which is perceived objectively in one sole sharer, as material, cultural, ideal realities... what is heard and remembered of him... in fact, all, are not exclusively things of his, they are also phenomena of my perception. In clinical practice, significance that appears to consciousness and that is made up of one's own consciousness, is the result of an encounter between me and the other. Nothing that is true can be said before this encounter. Without my consciousness, there would be no other for me. Without the existence of the sharer that communicates with me, I would have no means of knowing him, nor how to act in the clinic. Conscious and believing that I am in the world and that the world is older than I am, that another person existed even before I knew him (the dialog with many ensures me this certainty in common), I know that the reality of therapy exists only concomitantly in our encounter. Therefore, nobody listens truly to another if he has with him some theory based on universal truth pre-formulated in him. Before the encounter and listening, all that speaks silences.

In the ancient Hellenic amphitheater, a person did not watch a theater play performed by others. He became the collectivity of the audience, he was one with all and with the universe in the spirit of the myth staged. A therapist assuming philosophy as art is in clinical practice listening to persons through themselves, through their own

categories of understanding, as if both were but one reality. If a sharer, tells all of her story since birth, with an impressive wealth of detail and says that is all, but forgets to mention husband and three children, the art of clinical listening is in believing this is absolutely natural. Only at a later time, does the philosopher begin categorial examinations, through analysis and reflection. Just as in musical criticism, there can be no judgment before appreciation.

In the initial moments of listening, a clinical philosopher intervenes as little as possible in the original manifestation of speech or of the many languages with which the other communicates, and later, only does so for two reasons: to capture everything that has been said better and in greater detail, or to welcome the news that the other would still like to reveal himself. While a psychotherapeutic practice, Clinical Philosophy is ostensibly an art, an experience of the synthesis of the real. Above all, responsibility, and later, the thought of responsibility. A philosophy that is not art could not be clinical. Meaning, theory is important, logical structuring is fundamental... but at the time the therapist is before the sharer, the person is important. A philosopher cannot do only what he theoretically imagines should be done, for sometimes it is practice which guides the way and teaches new directions which is very natural, for truth in philosophy is an invitation and an ever open door.

Besides, everything in life is perfect. This is the tragedy of therapy: there is nothing to be cured, everything is perfectly what it is in the context that it's located. In the appearances, the idea of "perfection", when it's applied to the human being, it's no more than a purely metaphysical and ontological matter, as if we were talking about the concept of "God-Man", of a complete and absolute being. However, we are dealing here with a new clinical perception of the philosopher, about the other as a sharer. Naturally, it all starts with

a redefinition in language of what is "perfect" and "imperfect" in the other, and what can be done about it. This is what we will talk about next, in a quick genealogy of the concept.

In the tradition of Aristotle, metaphysics is the theory of being while being, universal science devoted to investigating and defining the nature and structure of all that exists. For this purpose, he created ten categories of definition or classification based on the Greek language. Almost two thousand and thirty years later, Kant's philosophy reformulated the doctrine of Aristotle's categories to twelve, removing these from classical metaphysics. In this sense, the categories of modes of being became modes of functions of thought; they no longer referred to content, but to forms of perception with which the human mind would synthesize the logical understanding of the world. For traditional, pre-Kantian metaphysics, our conceptual schemes are the path to access things in themselves thereby affirming that the attributes used in sentences of judgement are true or false truths ("Laura is truly Christian") and serve to qualify and describe things and people. But in the line of Clinical Philosophy, far from all of the realistic metaphysics, language that allows another to be judged had perceptual attributes, that is, a therapist does not dare think that his interpretation of the sharer is a truth in itself. For he knows that language is a live game of relative re-significance, and it is not always possible to define a predicate. As a result, the impossibilities of a final, absolute definition about a sharer lead us to conclude that the other is not essentially true or false when he communicates with the therapist. In whatever form, it is a being who expresses himself, transforms himself, and is sometimes understood. Therefore, the other – just as I am another to someone else – is not an imperfect being for not possessing the qualities of what is not even understandable, definable: the absolute essence of perfection. There

is no means of comparing him to any other static perfection beyond interpretation. Therefore, there is nothing, nor any reason to fix it. In the words of Portuguese poet Fernando Pessoa (2005): "to be great, be whole: nothing that is thine exaggerates or excludes".

From a certain point of view, our arbitrary moral anxiety of perfection is the requirement of a concept's plenitude. The perfection concept tends to be the architecture that we guess proposal as alternative to the real, a species of utopia or unsatisfied power. This is absolutely natural considering that life is movement and transformations between the I and its surroundings. But what it is the future if not language and meaning ethically the value of a choice for the form as the problem is elaborated? The ones that had acquired social and historical conscience communicating itself with the others have faith that the world is bigger than the individual perception reaches. They know that they do not know. Since there is no knowledge that exists outside of the living (creature), right or wrong, all the concepts are limited by the experiences of who perceives them. Thus saying to each new thought, each new term that express an idea of perfection, the individual brings up to date its necessities and molds of life completeness. As long as there are judgements about perfection, there will be also the exposure of what are the criteria of importance for those who judge it this way. So to argue on human perfection is talking about perspectives and individualities. For thus saying there is a perfection for each person, as there are no accurate two angles of view for two singularly unique people. Indeed for me on this subject, especially when it comes to the arrogance to decide on the imperfection of the other nothing could be more perfect than the absence of judgment.

Perfection here, in my reading, is never understood as a hyperinflation of the selfishness or of the individual in the Greek sense

of atom, that is, that one which does not divide itself and excludes the other while another unit, and is considered separately distinct from the group to which it belongs . In the alterity ethic of the Clinical Philosophy the awareness of the limits of "itself" only accomplish itself, discover itself and develop itself in the meeting to the neighbor and with the surrounding world. It is a "relational I" by definition. Define itself is positioning itself, it is to take responsibility in relation to. In the human condition as well as the listening supposes a speech, each perfect individuality is only in fact understood and respected ahead to another. Using another term, it's the same as saying that an "individuality" is a "co-individuality". The individual perfection is at least double.

Judging that somebody is perfect causes a moral scandal. The sense of "perfection" that I try to develop in Clinical Philosophy is another one, radically. The only way that I have to explain what qualifies someone to be "perfect" is by comparison. Any concept is defined by its limits, making a difference between what it is and what it is not. In this case, perfection of an individual requires a comparison with other individuals – starting by the one who is judging – about who he is and who he is not. If we compared and classified an individual only by general differences from the others, like gender, age, ethnic, physical and psychological types, we wouldn't be able to recognize him in his uniqueness. If it was as easy as assembling a puzzle, in order to know somebody it would be enough to put together all infinite subjective details that compose the body and soul formula in each ones's way, the world's social circumstances in the limits of time and space that influence him, plus the terrible free-choice to redefine himself as a person. Finding out that the other person has the power to be infinite in his intimal composition is knowing that the same greatness that separates us by the differences also brings us closer

by admiration. Isn't it "perfect" the one who can be judged unique and infinite at the same time? This way, the concept of individual perfection is an idea that was built by the wish to meet the other, that is, by the ethical effort of approach that never excludes differences. Summing up, without love, nobody is perfect.

To me, what defines the individuality to be exclusive – because it is unique – and such as it is perfect, in nothing it means exclusion of the other in the self-definition process, since the predication of the "I" (such as tall or short, beautiful or ugly, can be intelligent, just, calm or irritated, etc.) only can be understood when inserted and contextualized in different situations in the world. The individuality is exclusive only in the sense that no one ever will feel what I feel exactly as I feel. Therefore, "exclusivity" must mean "privation" of an individual conscience of the intimate experiences of another one person. This is because the concept of "life" takes place necessarily from "my life", of the life of each one. How could it be different? For Clinical Philosophy, the great epistemological problem of reality is the sharer's life, the existence of the other.

With no means of repair and no cure... what is there to be done in therapy? In his perfection, a sharer is not sufficient to prevent suffering, which is natural. Even because, to be perfect is not to be isolated from the world, from the bonds, the excesses and the needs that render us so human in this powerful encounter of forces between birth and death. The greater the sensitivity towards joy, the greater the capacity of recognizing the effects of sadness and of what love leaves us in its absence. He who would like to moderate his feelings and sensations, controling sensitivity, so as not to suffer a great deal... if he does manage to do so, will reduce pain, and with it reduce the depths and subtleties of pleasure. And for the same reason, those who prefer to economize thoughts and still wish to be understood,

in their own doubts, will understand only very little of themselves. But who can prove that self-knowledge and sensitivity will always be more desirable than the comforts of one's own ignorance? Such is the aestheticity of clinical practice in which life is made patent and protects itself.

In the terms of the ethics of listening, all that is different and that does not repeat itself is perfect in comparison. Perfection is that which it is impossible to better, to the full degree of its relativity. A person "X" is perfect as compared with "Y". So much so that all of the similarities that both possess do not change the fact that the individuality of each one merits dignity to be deemed non-replaceable either for more, or for less. Some say we should not compare people in order to understand them, because they differ one from the other. Are they trying to say that we should not try and make them equal? For, in what better way could differences be observed? When people identify themselves by the laws of affinity, they are equal at a distance, similar in common life, and very different in their innermost. Any doubt may be verified in those living together under the same roof.

When people resemble each other in the laws of affinity, they are equal at a distance, similar in understanding, and different in their innermost. Any doubt may be verified in co-existence in one same house of those who live therein.

In the measure in which the needs for physical or moral changes alter an individual, movement does not constitute re-adjusted perfection to him, as if it were the adjustment of the essence aged, and all were unreal because it is not raised to the power of what it should be. Understanding the movements of life is removing the focus of what's observed in the context of comparisons and in the comparisons of contexts. Clinical Philosophy seeks the appropriate proportion between the existential needs of the sharer

and what circumstance offers him, with its limits and possibilities. At times when life's tragedies take happiness from us and charge us a maximum, it would be as well not to forget the scope of our dimensions; beyond resistance, there is space in abundance. If all is relative and dependent, individuality is the perfect difference. A clinical philosopher is there to remind us.

Notes

1 "... no philosophy [and I might say, much less Clinical Philosophy] is pure technology [...]. The mistake of these [some neophyte students] in wanting merely to learn clinical practice procedures for assembly of the Structure of Thought [the subjective psychic structure of the sharer – ST] and resulting use of the Submodes [all of the processes and practical actions applied in compliance with clinical interest] makes them forget that methodology is not use of techniques. This gross mistake, would make it possible for any relatively intelligent person, with a certain good will – even a non-philosopher – without philosophical reflection – irresponsibly to practice clinical philosophy mechanically, reducing CF mechanically to its technical procedures. They forget, that to think philosophically is to think reality through a concept or by means of concepts. Yes, there are techniques in CF, in that it is clinical; however, as with any philosophy, CF is reflexive thought with analyses, criticism, and syntheses of the real permanently refused in its appearance and re-presented as justified understanding. For initiates and laymen in general, practicing philosophy commonly implies this mistake in thinking as though there were a natural order of first understanding theory and then putting it into practice, without querying whether the problems or theories presented are fundamental, correct, or even whether the questions are well elaborated, before the bold interest in answering them. Other examples beyond CP are to be found in courses that are presented and carried out under headings such as "Philosophy Applied to Management" etc. [...], confusing praxis with practice." (Goya, 2005).

2 Today, discussed and developed by hundreds of philosophers all over Brazil – experts, masters, and doctors, with a wealth of multidisciplinary space with other knowledge and important discussions on human relationship and conflicts. Doctors, law-makers, psychologists, students in general etc. are today completing graduate studies in Clinical Philosophy. These discussions are under the guidance of the Council of Representatives of the Packter Institute, supported by the National Association of Clinical Philosophers.

3 The terms in italics will be defined ahead.

4 For details on clinical practice and planning referring to the diagram, please see *Cadernos J and N* by Lúcio Packter.

5 A previous reading of the *thought of the complexity*, of Edgar Morin (1990), will hinder the belief of that the clinical philosopher can to know the subjectivity, the ST, of a sharer without knowing **at the same time** the categorial examinations that gives him meaning and context. Sincerely, I do not believe that a fragmented vision on the other comes alone of innocent gestures. The ethics of Morin know well of that. To break up an alive being is to kill it.

6 "What is a word? It is the copy in sound of a nerve stimulus.
(...) we believe that we know something about the things themselves when we speak of trees, colors, snow, and flowers; and yet we possess nothing but metaphors for things--metaphors which correspond in no way to the original entities. (...) and all the material within and with which the man of truth, the scientist, and the philosopher later work and build, if not derived from never-never land, is a least not derived from the essence of things.
In particular, let us further consider the formation of concepts. Every word instantly becomes a concept precisely insofar as it is not supposed to serve as a reminder of the unique and entirely individual original experience to which it owes its origin; but rather, a word becomes a concept insofar as it simultaneously has to fit countless more or less similar cases--which means, purely and simply, cases which are never equal and thus altogether unequal. Every concept arises from the equation of unequal things. Just as it is certain that one leaf is never totally the same as another, so it is certain that the concept "leaf" is formed by arbitrarily discarding these individual differences and by forgetting the distinguishing aspects. This awakens the idea that, in addition

to the leaves, there exists in nature the "leaf": the original model according to which all the leaves were perhaps woven, sketched, measured, colored, curled, and painted–but by incompetent hands, so that no specimen has turned out to be a correct, trustworthy, and faithful likeness of the original model.
(...) What then is truth? A movable host of metaphors, metonymies, and; anthropomorphisms: in short, a sum of human relations which have been poetically and rhetorically intensified, transferred, and embellished, and which, after long usage, seem to a people to be fixed, canonical, and binding. Truths are illusions which we have forgotten are illusions – they are metaphors that have become worn out and have been drained of sensuous force, coins which have lost their embossing and are now considered as metal and no longer as coins". (Nietzsche, 1979).

7 Among various contributions such as Pierre Bourdieu (1991), Louis Dumont (1986), Peter Berger (1967), and others. For better understanding, it is worthwhile to read Erich Fromm (1960), concerning what he defines as "social filter". These are psychological, intentional devices, that lead a person to absorb reality selectively, with parcial perception, in such a way as to limit the full lucidity of which a human being is capable. To him, this filter operates in three ways: 1. through language, that in its entirety includes with it an attitude to life, whose words, syntax, grammar etc. do not always permit a foreign translation of the affective experiences to which they refer; 2. by means of the logic of culture, never assuming that what is illogical in one tradition is not universally illogical in another (Fromm exemplifies this common mistake comparing Aristotelic logic to paradoxical logic in Chinese and Hindu thought); and also 3. by the context of taboos and orders demanded and intended to maintenance of culture of a social nature, the violation of which implies terrible isolation. To him, in effect, the main factor that prevents a person from full awareness of his own experiences lived, is the fear of isolation in society, in the measure in which it contradicts the demands of the group to which it belongs. However, a society does not have the power to determine and repress a person in an absolute way, in that man is not only a member of one particular society, but also a member of humanity.
As a psychoanalyst, he directed important criticism to traditional theories of the unconscious (Evans, 1981). The fact is, in classic psychoanalytic

terminology, it became habitual to refer to "the unconscious" as though it were a place – a region within a person, referring to certain psychic locations and certain contents associated to these same locations. Thus, "consciousness" has been viewed as a part of the personality with specific contents, and the unconscious as another part of the same, with other differentiated contents. This topographical use of the unconscious is, to Erich Fromm, the result of a bourgeois project of modern times that stimulates the values of "to have" as an omission to the importance of exercising "to be". This is the general trend of thought, driven by the consumer need to "possess" things. In the same way as we own an item of clothing, a thought, a problem... equally one would have within oneself an unconscious. For this reason, the author concludes: the unconscious is no more than a mystification or metaphor (used didactically by him, himself).

8 "Witches *and metaphysics* [my addition] do not exist, but that there are, there are."

# II

# THE ETHICS OF LISTENING

*The Philosophy of Meeting or How to Find the Perfect Person?*
*In place of imperative steps, an emperor.*
*In place of creative steps, a creator.*
*An encounter of two: eye to eye, face to face.*
*And when you are near, I will retrieve your eyes*
*And place them in place of mine;*
*And I will retrieve my eyes*
*To place them in place of yours;*
*Then I shall see you with your eyes*
*And you will see me with mine.*

*J. L. Moreno,* Divisa.

# The Philosophy of Encountering: about how to find the perfect person

In a true encounter, nobody can have a relationship with another person that is equal to equal. He is my neighbor at an ethical distance. The therapist cannot go to another person to be in his place, experiencing his inner world just as the person himself perceives and experiences it. A therapist cannot even prevent the effect of his own presence in it, for anyone remaining precisely the same, unaltered and face to face with another, has, in truth, never found the other. A therapist may, however, become another, for the better, after this encounter. To be authentic, sufficient in his will, one who calls himself a therapist must first reach himself, be lucid in his attitudes, before going out to the other person's world. Because only by recognizing his own experiences as legitimately his own, will he not mistake them for those of his neighbor. As a result, the force of therapy brings to both an addition in the power to live drama and tragedy. In a special way, a philosopher appreciates the certainty that caring for another is an expression of love, of recognition and gratitude, for each new sharer augments the possibilities for him of being. A therapist is privileged to gain in maturity through the experiences of others.

In Clinical Philosophy, what is authentic in the sharer is not always autonomy. Philosopher Martin Heidegger (1996) does not

think so. He once stated that to be alone is the natural condition of all human beings from birth, whether we like it or not, and that it is the way in which we deal with solitude that distinguishes us from others. A man becomes authentic when he accepts solitude as the price for his freedom and unauthentic when he interprets solitude as being abandoned by God or by life in relation to himself. To Heidegger, a non-authentic person does not feel responsible for his existence, becomes a stranger unto himself and will not run risks to attain his objectives: he will look for dependence and security in others and disguise himself in the impersonal. Because he cannot live his life intensely as his own, he will only find strength and enchantment in things and in others and not in himself. Authenticity turns to anguish, ill-ease when an individual discovers the fatality of death... both physical and as to each one of the possibilities of existence, as if he were dying a little more at each frustrated desire and project in his life. According to Heidegger, a condition of anguish does not necessarily mean a negative experience, as if human beings would have to do away with solitude or were to suppress this natural feeling, for instance, pursuing supposed love simply to fill an existential vacuum. Anguish brings, as its reward, a true capacity to know oneself and respect the limits of one's own self; to express and try to achieve desires under the full power of will, elevated to a maximum, as a being unique and special unto himself. In doing so, life becomes filled with meaning. What is to be said? This is logic to Martin Heidegger. Beyond the perspective of him, there are other readings...

If a person is alienated, dissimulating himself in every day banality, fleeing from the anguish of a mortal life, clinging in despair and pleasure to an abundance of things... things to have and to see, not things to be..., why should I, in clinical practice, judge alienation,

always, and necessarily, as a defect? Anyone who needs rings to see his fingers, will be this way until the needs of life – without and within – invite him to change. Anyone who has not understood the dictum, must reflect: when one has all the answers, it is only natural that life will change the questions. Can a therapist help him to overcome alienation in search of autonomy? Of course! If this is a demand of clinical practice, it is, as much as possible, even desirable. But to me, the ethical concept of perfect individual is an alive trial of relationship, only intellectually understood when it is able to love and respect (respect is not always agree) the *power of authenticity*[1] of the other – be it good or bad –, even if he can not or do not want to have the extraordinary vigor of autonomy perfectly human, less authentic than any other, because he prefers peace of mind to clinging on to freedom from anguish? And what ethical judgments would allow judging a depressive as a person who is existentially wrong or any inferior if compared to a glad and independent person? Was Sartre, by any chance, irresponsible, in bad faith because he was a heavy smoker, or Modigliani a painter any less authentic because he drank too much? Their vices were companions to their virtues, perhaps without separation. What right does a therapist have to remove a support from those who would otherwise not stand it? If death separates a couple whose individualities have blended, who loved each other for over forty years, together, and on leaving one behind wishing he too could die, would it be absolute truth to come to the conclusion that this person, in his love is a non-authentic coward? Issues of physical and public health are other subjects equally open to discussion. During the encounter, what is most important to the sharer during therapy is to know and to feel all of the availability for listening that a clinical philosopher will offer him and, that even on revealing all of his most difficult and cruel truths, will

even so, continue to be his friend. It is as well to understand: it is indispensable to respect the autonomy of one who has autonomy and fundamental not to demand it from one who cannot give it. Clinical Philosophy, more than general care with a human being, is caring for each one's way of being.

There is another way to explain this, searching for relationships of similarity and disparity between alienated people said to be normal in our vicinity, and those others, acknowledged as saints and scholars. Imagine a rare type of perfection – not the perfect difference that can be affirmed in a T27 Analysis of structure, comparing values with values, people with people. Think of someone who is perfect to himself in self-definition, complete in his own humanity and without debts towards his own consciousness – so conscious and honest in the totality of his limits, that with any other demands for perfecting, he defines himself by frontiers unknown to the remaining beings of his kind. Beyond fools, vain individuals and those mistaken about their own importance, if we imagine anyone as exceptional, the proximity of whom will make him a stranger to his peers in his unmatchable autonomy, we will lose the capacity to judge him morally for two reasons: 1. because values of judgment only exist in a comparison, and any judgment about him would be no more than a confirmation of our parameters. 2. because notions of good and evil do not refer to beings as they are (if perfect), but as they should be. Good and evil are not nouns, essences, but adjectives, modes of being to the differing needs of each person, individual, or group – in such a way, that he who has attained totality in himself, in the absolute reason of his demands, no longer needs guidance in his existence. It is his own path, truth, and the life of his choice.

Interpretations apart, the history of civilizations elected individuals in this condition. References to behavior, the direction

they were bound for, was taken as an address of good. In their differing historical and cultural contexts, Jesus, the carpenter, Prince Siddharta, the prophet Moses, legendary Lao-tzu and others less known but notable in their sublime anonymity – were giants in their own grandeur. But the cult, idolatry, and the process of institutionalizing over the course of time made their lessons of ethics almost always a universal demand for absolute perfection, without rest, as if everyone had the same intensity, characteristics and levels of consciousness, in being desirous of the same purpose. In the measure to which divers religions preferred to create disciples instead of personal autonomy, inspired on examples of their dear masters ascended, humanity developed a difficult morale, that brought more condemnation and suffering than enlightenment to paths of fulfillment. In a study of the origin of moral principles that have governed the western world since Socrates, bitter criticism to Christianity is well known, though not of Christ, made by Nietzsche (1967a), according to which we live in cruelty towards ourselves and others, because we are not as perfect as we should be or are expected to be. This is a substitution of debt to one's own consciousness through defects of imperfection. He (1995) proposed extinction to this specific, overly human and authoritarian modern notion of God and placed the individuals in submission to the churches in the name of a false, metaphysical legislator. In this way, he tried to remove the bet on external alienated salvation to replace responsibility for action in the hands of man himself, breaking with the culture of absolute values and unattainable essence. Of so many religions, it was man himself that killed the true spirituality of life. Different from atheists, Nietzsche does not wish to prove that God does not exist, but to show the deep absence of humanity in which we live, that brought death in our times to the principle on which Christian

man based his existence. Without a doubt, he was one of the most misunderstood philosophers in history, for he was a thinker of great depth and erudition and can be regarded as no less.

This rapid mention of Nietzsche is included for simple effect of pertinence of philosophical knowledge in clinical treatment, as in the case of Laura. My poetic re-reading of Christianity, inspired on ethical studies of this philosopher proved opportune at the time. The academic culture philosophy and literature in general are indispensable as theoretical support for better understanding of the themes brought to clinical practice. This is far from a Nietzsche approach or a theoretical option made by me in this case, for Clinical Philosophy does not elect preferences for "content" as has been said. It is critical and meta-critical. Some universal postulates of this philosopher are indefensible in clinical practice if directed to all of the sharers, such as the non-divisibility of power and will in the belief of man originally as a pulsing of instincts: autonomy as absolute demand for all etc. But Nietzsche made me a valuable contribution to Clinical Philosophy and to the understanding of an ethics to listening, because he inspired me to a new reading of the concept of perfection. The manner and consequences in which someone may define himself as perfect must not result in his being described as comical, mad, or idiotic. This is a being to be cared for, and, most important – not above nor beneath those who are perfect in themselves: the other will always be perfect to a clinical philosopher. Anyone who has not yet met a perfect person should perhaps re-think what he understands by perfection. In order to find the perfect person, it's necessary to think over about what is understood by perfection.

As a result, ethics in Clinical Philosophy must be understood as distant from a universal hierarchy of fixed values of good/evil or of

love/hate and shift the problem of identity to alterity. The paradigm of modern philosophy of the subject and of consciousness whose focus is I in first place, is transferred to the category of "relation", as a dimension necessary to understanding human reality, in such a way, that the knowledge of the other, no longer be without the live participation of the therapist, co-existing. Together with kindness and care, it is alterity that allows us to establish and demarcate the outlines of some theoretical universe, of knowledge that differentiates and relates. The thought of alterity is well set forth by philosophers such as Levinas, Sartre, Buber, Ortega, Habermas, Ricouer, Derrida, and others more... However, to think the correct measure in which Clinical Philosophy is separate from these philosophies one by one, by creating new concepts is a giant task for many, and beyond the unassuming claims here but suggested. Lúcio has lent due praxis to the grandeur of the thought of alterity. A better even if introductory outline to the issue that is subjected to rectifications and criticism by the author himself, and may be possible in my *Philosophical drafts* (2005).[xiv]

It is important to explain that Packter's philosophy acknowledges Kant's fundamental ethical principle (1996), and is a norm that commands the western world in all relations, namely, *it acts in such a way that its action is a universal norm of conduct, respecting humanity in me and in the other, invariably, as an end and never as a means.* Packter's philosophy also applies this principle to concrete situations in life, conveying a sense of immediate responsibility with the other. He thus refuses his purely rational and abstract nature in the principle. Up to this point, Clinical Philosophy coincides in kind with existential phenomenology; however, it is distinct in number and degree from various concepts and theoretical bases that explain moral experience and function in ways different from intellectual, religious experiences etc.

For instance, it is useful, at a glance, to highlight ethical reflection

imposed by practice in Clinical Philosophy on the important theory of Max Scheler (1973), to whom moral values are cognitive perceptions associated to affectivity, more specifically to basic feelings of human condition: love and hate. According to him, these two feelings allow the construction of values present in choice. On investigating what occurs in the act of moral judgment phenomenologically, inseparable but distinct from the psychological experience of emotion, he perceives an *a priori* order and a non-temporal hierarchy of invariable principles. The discovery and perception of these values would take place by intuition that resembles intentional feeling. Scheler proposed broadening Husserl's original project that remained in a process of eminently rational nature, giving rise to a phenomenology of feelings. Thus, to him, the reason that someone would prefer one specific option over another would not be the choice of pure reason, but the result of emotion combining values with experience lived.

In general, the fundamental characteristics of a value are 1. *preferability* (non-indifference); 2) *bipolarity* (each value has an anti-value counterpart; good x evil; pleasurable vs. non-pleasurable; beautiful vs. ugly; etc.; 3) and the *hierarchy* (superior and inferior values in life, the scale of which varies according to the background of the subject, customs, culture of each society etc.). Indicating expectations, aspirations that characterize man in his efforts to transcend himself and his historic situation, there will be as many values as there are human needs. As such, they mark that which *should be* as opposed to that which *is*.

Clinical experience demonstrates, in human diversity, cases in which people perfectly identified as moral agents make important ethical choices in their lives using emotions, and also other categories to determine the value of action. Up to this point, this is not counter to Scheler's thought. However, based on this same experience, it is

also not possible to conclude that feelings are the determining or the only causes to motivate moral choice. However strange it may seem to certain philosophers that do not work in clinical practice or who have not discovered how to build bridges between theory and the world of experiences, there are people whose wish to do what they like for the good, have been motivated by other determining interests: T5 Pre-judgments (in the sense given by Gadamer), purely logical reasons (T10 Structure of reasoning), T3 Sensations, and S23 Mystical Intuition etc. where emotion, associated to a desire for good, were almost, if not insignificant in the motivation to act. This through clinical anamnesis, through a phenomenogical investigation of the historicity of the sharer. To cease to consider the results of this verifying of intentional data collected in clinical activity would be a mistake in method and direct silencing of the other who speaks for himself and directly or indirectly affirms what the values signify to him.

In addition, I cannot now say without demonstrating whether Clinical Philosophy creates new values or not. But the insertion by Lúcio Packter of new categories of understanding of phenomenology, I suspect, favor thinking a new ethical model of relations. Many ethical presuppositions found in the most important thinkers of alterity are absolutely questionable: not all the choices responsible are the result of anguish, as Sartre believed (1989); not always must the path to ethical understanding presuppose mutual rationality in the opposite relations of conflict to build a strategy for dialog, as Habermas would have (1993), etc. In the context, the history of thought offers a clinical philosopher a great variety of ethical models, different concepts and authors to consider. Therefore, it would be impossible, from among various authors, to choose one moral philosophy in particular – with all of the consequences – as

basic and immovable reference of Lúcio Packter's moral thought. This is so because no ethical doctrine intending practical guidance for life has, up to now, devoted itself to the infinite task of delving down into the subjective depths of individuals to see whether their theoretical postulates are confirmed. Obviously, all philosophy that is coherent with its own postulates and logical rules is for itself, valid and authentic. With no intents of absolute truths, Clinical Philosophy suggests to be only one among many possible ways for those who may need it.

The demand to develop a long argument explaining the moments of rupture and the advance in divers philosophical concepts of alterity persists.[2] However, the shifting of this problem to another, may not only mediate and reveal alterity dimensions subjacent to the practice of therapy, but also elucidate the possibilities of construction of an ethical concept of subjectivity proper to Clinical Philosophy. What is now proposed is a change in the question "What theory of alterity is subjacent to Clinical Philosophy? to this other: "What clinical praxis ensures a real condition of listening and effectivating of alterity?". This is so because, in philosophical therapy, there are at least two important figures of alterity to highlight: 1. *the transcendent-other*, abstract, of semantic derivations that might also be called the "other-universal" of study and reflections, while a pure form of structure of thought. 2. And *the other-person*[3], empirical, that is a sharer that presents himself as a concrete being under the therapist's care. From this, it may be affirmed that the other, whilst another, cannot be phenomenologically reduced to a being from the therapist's consciousness. Rather, he exists in himself, even if the philosopher's gaze never sees the sharer through interiority and through his viewpoint.

Distinctions having been established, there is nothing to favor

in the separation, as if the ethics of listening in Clinical Philosophy were a dispute between theory and practice, between knowledge and sensitivity. There are spaces and choices: there are experts who do not like clinical practice and are devoted to pure research. Fine. One even comes across excellent natural therapists, with no academic background whatsoever. Equally laudable. But a clinical philosopher consists precisely of both terms that define him. Then, it's always advisable not to forget the original meaning of the word "philosophy", created by Pythagoras, which is "love of wisdom". The philosopher who is willing to help another knows that in order to love wisdom it's necessary to have a loving knowledge. For me, the clinical philosopher is a philosopher of love.

With emphasis, the basic thought in Packter's philosophy was the search for another's help at a clinic. His research and practical results that generated the concept of categorial examinations at the service of submodes of treatment of a sharer, position him as a philosopher beyond the modern project of rationality, of representation, and of the full theoretical subject. In his way of thinking, as I understand it, ethics plays a central role anterior to epistemology. Thus, knowledge is defined as responsibility and the logic of therapy as a moral of clinical thought. Therefore, Clinical Philosophy is constitutive and essentially an ethical praxis and cannot be thought beyond actions. If this praxis is sustained, who knows, by new contemporary moral philosophy, is another formidable question, however, less important than the loving care owed to one's neighbor when he is loved.

# The Language of Approximation: about the art of saying it all in no more than two words

*Why do I always swim against the current?*
*Because only in this way, does one reach the source.*

*José Lutzemberger*, Sinfonia Inacabada.

The art of caring is concerned with the pain and joy of another, with his thoughts, feelings, desires and all of that in which loss of love makes us feel like half. To love is to welcome a stranger as a guest in our home. Above all, it is the gift and happiness to welcome another as a neighbor. But it is also a visit to the world of those who call us, returning an invitation with tokens of friendship. An approximation may happen in some place between one oneself and another, between there and here, where affinities show us a path in this universe that is greater than we are. This is the profound significance of clinical practice, of the development of the capacity to bring about an encounter and manage its inadequacy.

However, would there be enough beauty in the Christian commandment to "love thy neighbor as thyself" remembering enemies, with retribution of evil, with good? In clinical practice, how is it possible to stand the sight and, more so, to care for a Nazi partisan, a pedophile of our friends' children, a terrorist, a murderer, an agent in human organ traffic, a women trader, a drugs dealer and so many others? In all honesty, the question the goes against the poetry of those who do not have compassion. Clinical practice,

however, is made of people and purports to assist those who need help: the need for ethics in listening arises precisely because of its lack. If listening were mere moral competence, it would leave the problem to the limits of each. But adding good will to intelligence, experience to reflection, it is only fair to seek a strategy for clinical praxis of caring, understanding principles and demarcations. In the many possibilities stemming from the construction under way of this Clinical Philosophy, I see an ethical path made up of two lateral extremities, within the scope of my eye. Merleau-Ponty (1993) said the world the eye can see will always be within the perspective of an eye that sees the world. From my point of view, the universe of moral behavior in philosophical therapy cannot be reached beyond this path, without the risk that this praxis will not be sufficiently theoretical, nor practical.

On one hand and in principle, at the end of each sentence, of each analysis of one's neighbor, a philosopher must always come to the same conclusion in his last words in judgment: *et cetera* (Latin: and *other things*) – a term that does not come from reasoning because it comes before any thought of explaining the significance of life. No matter what is said or thought about claims of truth, no sentence would be profound and living without a statement to complete it: "It is this *and other things*". There are no words for the definitive, the immutable, the absolute. These are not human qualities. In clinical practice, a philosopher deals with thought as an art, and makes of knowledge an ability to visualize the space of the infinitude of another, the dimensions of the creation in which he re-invents himself, and the hiding places from which he sometimes reveals himself. In the measure in which this therapeutic vision is made up of a partnership between knowing and caring, the art of clinical practice is inspired by careful listening to the *et cetera* through the

language of the incomplete. Beyond my concepts that are already formulated, the other can always manifest himself as another in a new word. The proximity which is established, therefore, demands a disposition for service, because the innermost of every human being is open to countless possibilities of achievement.

On the other hand, there is only one moral restriction, a logical and practical impossibility in Clinical Philosophy: It's impossible a relationship in the clinical approach with those who stop any kind of dialogue and end up silencing the therapist with violence. Psychotherapeutic help to another presuppose the wish to be helped – confused, incomplete, indefinite, fluctuating will, with total or partial loss of autonomy of thought, hesitant... as strange as it may seem; however, never, definitely, against lucid, peaceful free-choice, under the pretext that this is "for the sharer's well being".. Of course, in situations of emergency, cases arise of rapid sessions, inevitably precarious and ill-matched because, without the categorial examinations, the sessions are not guided by reflection, but rather by experience and sensitivity of the clinical philosopher, such as unrestrained despair over the death of a loved one, psychotic outbursts of hallucination apparently triggered by the use of psychotropics etc. These are the exceptions that justify the rule.

Apart from this, there will always be other important issues, permeating the subjective data in practice (as per the conflicts of values between therapist and sharer, which is natural) and objective aspects of theory (such as the juridical dimensions of professional action in a democratic state). In both cases, a clinical philosopher relies on the *Clinical Philosophers' Ethical Code (2004)* to uphold human dignity, discussing fundamental points and guiding duties in society to himself and in the relationship with the sharer.

The art of judging another morally is to think of approximation

where the elements of language are removed by the practice of listening. The sharer is not a clear, distant object of analysis to the philosopher. Judging demands a continual re-start of understanding, for these are situations in which the sharer establishes relationships that attribute sense to appearance. The answer to the question "Who is he?" is invariably an indication of localization, a constant search for reference and anchoring on the circumstances in which he lives or lived, even if on prior situational definitions. Making up significances does not take place, therefore, through answers, but by rewording the question in each journey the philosopher makes into a sharer's background. It is a judging of indexation, adding the countless day-to-day interactions to the concept of "person". In Clinical Philosophy, thinking the other is to go to him. A philosopher thinks in the same way as one he walks with.

If a man rapes his son, and comes to therapy in search of some way to preserve the same desires, is it not more than correct to regard him as a man who is eminently bad, sick morally? No doubt, there are many ethics and, therefore, delicate differences. In general, the west has defined every form of reducing a human being to the condition of a thing, merely a means to inhuman ends, object (crime, vice, etc.) as evil.

Three ethical criteria have been acknowledged generically in modern times to assess persons as moral beings: 1. *to be aware of oneself and of others*. That is, through self-knowledge, to have with oneself, an obligation to use reason to understand and act on the possible, on that which may be and may not be; for there is nothing can be done with what is independent of the will. As a complement,[4] first to have an attitude that is primarily of indifference; then, of acceptance and love towards his difference, learning and becoming a better person after this encounter. 2. *To possess one's own, free, autonomous will –*

which means saying that wills are not often contradictory between themselves, demanding control of passion. By reason of this, to respect one's own wishes is not to cater to any one, but only to those whose choices do not entail loss of freedom to continue choosing. For instance, a person who by free choice chooses to resort to cocaine, would lose his freedom, totally or partially through having become dependent on something other than his own will. A lot more than the mere choice among the options offered, true freedom ponders, selects, and even reformulates its alternatives. 3. *To be responsible*, the capacity to provide an answer to problems arising from choices made. This differs from being guilty. Guilt is a voluntary lack of a conscious moral principle, with fixation and lingering in the past. In a case of self-guilt, rancor towards oneself persists with a desire for vengeance at another's accusation, in a responsible individual there is an effort to understand the problem of making a mistake and the courage necessary to resolve it or to apologize. When there is nothing that can be done, an ethical person is left with humility and a lesson in growth.

If this father did not experience any temporary or permanent mental disorder to block his capacity to perceive himself and, equally, the existence of a son, of his own free will, aware of the consequences of his gestures, for himself, the father, and for him, the son, no doubt and fairly so, the father is a bad man. But what does it matter? Regarding the one who comes to therapy asking for help with his sufferings, difficulties or demands, the therapist's ethical reason ought to be loving his neighbor, good or bad, similar or not. Just as a doctor or a fireman must always first save the life of those who need him, prior to any judgment, a clinical philosopher, also, offers himself, with the difference that in his own case, moral implications are essentially binding. This is so because the center of gravity of

listening is the quality of the intersection. In the measure in which a philosopher devotes himself to treating another person, the best or the worst in him, his own identity, no longer belongs to him with exemption. He knows that it is also a consequence of therapy with the other and what he does with this. He is and re-defines himself at each new sharer. What is reciprocal depends a great deal on the type of intersection established but, in principle, the ethics of listening starts with the responsibilities of the philosopher, not of the sharer and develops during the process in the measure of the encounter for care with another and the possible conflicts of the relationship. Given this, if there's no direct violence to the philosopher, when the sharer happens to be bad, it remains to figure out whether the affinities between them both will be enough for therapy.

Certain that a sharer is not exempt from moral judgment on the part of a clinical philosopher, however, sexuality, politics, opposite ideologies, quirks, action and reaction etc. of those who come to clinical practice are not judged morally by specific ideology, although a philosopher may have his own convictions. In Clinical Philosophy, the ethics of listening is guided by another space and definitions. It does not deal directly with the issue of co-existence as a group seeking social order and cohesion. It does not establish the foundations nor the validity of norms and of judgments of value according to the historical and geographical interests of each society, in order to preserve the integrity of the individuals. This specific ethic has claims that are exclusively clinical which is no small matter. Even if the sharer is evil – psychotic or not – the ethical matter in Clinical Philosophy is to know whether, or how much, the therapist can give him a subjective well being, without ever losing the bonds with world's responsibility.

In general terms, the many contemporary doctrines conclude

similar practices with beneficial systems and procedures of exclusion. Divergence is in general, metaethical[xv], and refers to issues of a purely theoretical basis. But what is behavior other than the subject of intentions? It is in the research of intentionality of the nexus that constitutes will, of free choice, and the external pressures of the world, that the truth of another lies hidden. *A priori*, without clinical procedures in categorial examinations, all of the deep certainty of a therapist about the sharer is immoral. This means that the professional ethics of a clinical philosopher does not consist merely of good will. A good therapist does not do what is right, naïvely, by chance. His kindness possesses philosophy and a knowledge of cause. Not every clown is happy. After all, a smile is something more than just showing one's teeth.

Unless a therapist gives evidence of some mystical, sublime wisdom, and even so... the first conviction is always an appearance: signs of language and behavior that indicate the path of infinitude of another. Even if in a dream, all of the truth about someone were known, he could still change his mode of being, either imperceptibly so, a little or a great deal. This means to say that the classical principle of philosophy, namely, not to judge by appearances, is altogether impossible, although necessary. This is so because the task of philosophy is never-ending. In the measure that all therapeutic knowledge (as any other) travels invariably from appearance to essence without human reason ever attaining an absolute "one-self" of things, all will always be appearance of. Thus, a fact judged as true, will never be anything else other than a phenomenon of logical perception, of intuition that it would seem to me to be. Either that or we would have to accept that things that are known by reason would themselves be rational, which is absurd, for the nature of the world (of plants, of the mind of the sharer, of God, of animals,

of far-off galaxies...) is not made up of logic with which I produce theories: my understanding is rational. Only that which is anterior to judgment can be the essence of what it is, for every deep truth is a non-superficial appearance.

That is why a clinical philosopher also avails himself of literature, of music, religion, of all of the arts and *of other things*: to know how to listen in the sharer, to what philosophy alone cannot explain or translate. Reason imposes limits that the world cannot bear, but it is of these that our small knowledge of life is made up. For certain, the first impressions that are perceived by reason are makeshift, simple, fragmented, and very possibly, false. However, the ultimate understanding will never be greater than the most recent. Furthermore, true it is: any point of view, whether simple or complex, shallow or deep, is but a view from one point. In therapy, what is known is conclusion, and what is true is repercussion.

What can be derived from this? That the knowledge concerning the sharer is never essential and definitive, because he is alive. It will always be a degree of greater or lesser intensity, by trained listening of the language of another. In the departments of moral judgment, the other is the size of my interest in understanding him. The dimensions of the depths of human existence are more richly possible beyond what is known to exist and what is probable. The deepest that can be known of a human being is in listening to the hitherto unheard of, to the *et cetera*, to the stranger there is in oneself, in the other, and in each one. To truly get to know a person is to say to oneself in thought after some time of co-existence: "Do I know him? If he is important to me should I take an interest in what is interesting to him, for even his name has a new significance that today I no longer know about. I can no longer call him without some astonishment in face of the novelty that I am not aware of".

It is at this stage that theory must transform itself into art, and thought into gesture. When philosophy becomes clinical practice, the desire for knowledge concerning the other becomes knowledge of love for one's neighbor. If a philosopher continues interested in an infinite extension of the et cetera when in exercising judgment without condemning and its consequences of living a permanently alert relationship, without ever having one single absolute truth on which to rest judgment, he will understand the depths of the moral concept of perfection mentioned here. To perceive the infinitude of what is not known of the other by the eternal revision of one's own certainties, renders intelligence a practice in humility. Moreover: from therapeutic listening, lucid indulgence, for he who can judge his neighbor in face of the infinity or his own ignorance, listens with greater love to what seems to him to be evil. For the evil of the sharer even if true, is not all, "*it is this and other things*". I believe that this justifies the French dictum: "to know all is to forgive all".

In addition, in the clinical depths of compassion, ethically, all is always perfect. I am good to such a level of goodness that if I were to compare myself infinitely – on an inferior scale to extreme imaginary evil, I would be extremely good. I, who by common social parameters (I believe) am not evil, because I fight for the dignity of people, without distinction, and try to be ever better as compared to Hitler, would be what?... However, on a superior scale – to infinity, I am bad to such a level of evil that, if I were to be side by side with Jesus, comparatively, I would not deserve the title of good. In fact, what would good and evil be seen in the light of the history of civilizations of all times? Ethicity such as intelligence is relative: to an idiot, I am a genius and to a genius, I am the inverse. To the one who is superior in relation to the inferior (and vice-versa) it is perfect on comparison. So, how can I judge a sharer in an adequate form morally: in relation

to my particular values, to his own, or who knows, before the rules of society today? In Clinical Philosophy, where all of the universe is limited to the infinity of the singular, of the subject in contact with others and in the direct reason of their circumstances, it would be unwarranted to affirm full moral *relativism* through inconsequence of actions, as if any thing or value were indifferent to its consequences. On the contrary, what the ethics of listening affirms is *subjectivism* that does not annul the demands of co-existence with the therapist with others, nor disregards social rules. It only looks for a solution of conflict and a direction to the problems faced by the individual in the world in which he is inserted, invariably as from his inner perspective, in an effort to conciliate external demands. At no time, through absent-mindedness, must a philosopher forget that the understanding of the other does not take place in his pure interiority. For, I only see the other in an encounter with me, when I am lucid and present.

In the logic of this ethical compassion, exercised by the precise competence of a clinical philosopher, the greater the contextualization of the circumstances that involve, delimit, explain the structure of thought of a sharer, and also offer him the opportunities for growth, the less will be the impetus of accusation in moral criticism. In the impossibility of permanent knowledge, a philosopher can have but one attitude, the living source of true listening: to contemplate the other's infinitude in admiration, and with such greatness in understanding, not to judge superficially by what is not known in depth and completely. This humility in treating a sharer is synonymous with love and makes the other a neighbor. Anyone, in face of the limits of reason and seeing the infinite in a human being, will understand the extent of his perfection.

Within the real possibilities of Lúcio Packter's therapy, when

the other seems lost, with no way out – bitter, sad, distressed or morally condemnable, the fundamental practical question in ethics for the clinical philosopher in relation to the sharer will always be the same: "What else can I do to help him?". This means that many, many times, on approaching the evil element in certain sharers, a philosopher will also draw close to the guilt that is his, which may not be easy for both. It is common to prefer not to know, nor to reveal the obscure side of oneself, dormant in the soul, and those who have renounced the lessons to be learned from tragedy, will not know how to perfect the maximum value of life. Nor must the clinical philosopher be the finger of God pointing out the sins of the world, forcing others unnecessarily to examine that to which they have built up a resistance, even among those people that apparently swear they want to know all about themselves. For the sake of love, one should not wish to know the intimacies of anyone without being called upon to do so. Conscious of this, a philosopher re-doubles his responsibility and care for those who have had the courage to lay bare their shame and expose a difficult moment from the hidden immensity of their being.

It is important to make clear that if, through some fear in his personal sensitivity, a therapist is not able to bear the somber truths filed away in the drama of another, it is better to spare himself from listening, with the same ethics with which he devotes himself to less severe cases of equal worth. It is not, therefore, a matter of not lending ears to evil, but of listening with kindness. The curiosity concerning another's evils without kindness is deceitful desire; for no one remains neuter in choice in the absence of good.

If there is an encounter, there will be art – alterity art of loving. Some, for others, in the uncertain measure of our co-existence will each learn the beauty of exiting from oneself to show concern for

another, sharing common good with him. The purpose of this ethics of auto-creation and sharing that exists in practice in Clinical Philosophy, awakens in the soul a powerful state of compassion, which is the effort of helping another to grow and find the strength to live.

Notas

1 See details in my *Philosophical drafts* (2005) – (see partial reproducing in glossary, note xiii).

2 In Clinical Philosophy, the concept of alterity is open to every form of communication and understanding between beings, not only between humans, in the measure that someone's "I" is defined constitutively by the presence of the other, whether a mystical entity, a plant, an animal etc. One classical example is St Francis of Assisi's vision of the world and of himself. See also Peter Singer (2002).

3 For better detailing of the distinction between the "other-abstract" and the "other-person", please see under "Empirical Subjectivity" in the Technical Vocabulary.

4 See the relation between Jesus and alterity, in Signates (2007).

# III

# WHEN LOVE TALKS, EVERYONE IS LISTENED...

*On a day when He and I were alone walking in a field, we were hungry, and we came to a wild apple tree. There were only two apples hanging on the bough. And he held the trunk of the tree with His arm and shook it, and the two apples fell down. He picked them both up and gave one to me. The other He held in His Hand. In my hunger I ate the apple, and I ate it fast. Then I looked at Him and I saw that He still held the other apple in His Hand. And He gave it to me saying. "Eat this also". And I took the apple and in my shameless hunger I ate it. And as He walked on I looked upon His face. But how shall I tell you of what I saw? A night where candles burn in space, A dream beyond our reaching. A noon where all shepherds are at peace and happy that their flock are grazing; An eventide, and a stillness, and a homecoming; Then a sleep and a dream. All these things I saw in His face. He had given me the two apples. And I knew He was hungry even as I was hungry. But I now know that in giving them to me He had been satisfied. He Himself ate of other fruit from another tree. I would tell you more of Him, but how shall I? When love becomes vast, love becomes wordless. And when memory is overladen, it seeks the silent deep.*

*Kahlil Gibran,* Jesus, Son of Man.

# The Last Words Will Be Only the Most Recent

Before we know each other, in our windows we are all neighbors in heaven. It does not seem fair that the encounter occur in a space beyond freedom, especially when we elaborate our own thoughts. Thought is nowhere: it is in itself like the blue in the invisible air we breathe, but this is a color that only exists in the heights to anyone raising their eyes to the clouds. Just as the Earth is blue, the entire planet is enveloped in thoughts. Anyone wishing to listen to the thoughts of another, must know how to think about them and reflect on the listening. I have learned that *Cl*inical Philosophy is not an answer to all of the questions, but it is an intelligent way of drawing close without invading, to disagree without dis-union or agree without mixing one's own ideas with those of another. This intelligence of conciliation that never reaches me in a definitive form, that does not pretend to be complete, is what I understand as love.

But what is love over and above all that has been said? It is common to hear people pass judgment on love, on what it is and what it is not... as if there were pure, logical categories and all were no more than a simple question – truth by exclusion: either this or that... This shared mistake in which some see others imposes

inflexible choice and absolute condemnation. What right allows me to judge, to eliminate truth, to resume all of the values, desire, and imagination to silence in the sole condition of being all or naught; completely true or completely false? If anyone tells me he loves, or that he does not love, there is always yet a third possibility, at the same time and in the same relation. In the infinite complexity of life, feelings and sensations etc. may be contrary, contradictory, subaltern to all of the changes to which we are subject, independent of any theories about love. I may love little, but truly, and only in very specific contexts of my history; my emotions may be weak, but may last all of a lifetime; powerfully strong, if lived only in passing moments; intense in a profession and poor in marriage... There are those who are true when they express their ideas and feelings by means of actions, but who lie in their words; one who is a model of a mother, and an ungrateful daughter; one who hates the love she feels; those who only learned how to love by suffering; those who do not like sentimentality and make of love a moral duty, simply because it is logical; those who insist they only know love through segments of time, and those who disagree with all this, with reason. This and so much more. Who can decide on all these realities, on how the other should or can be himself in his own way?

Clinical practice taught me that more important than theories about truth, is the dialog of understanding that shelters the other, it's the sincere humility of the mistake that can be fixed and the spontaneous wish to serve. Thus, as wished, one may define love, whether wisdom expressed by a diversity of thoughts or by emotion, by intuition of the body, soul, and by conjunction, by which cultures they understand in different ways, or by a form ever unmatchable in each person. To me, love is the absolute expression of what in Clinical Philosophy I have termed the ethics of listening. It is an ethics of

compassion, of approximation of the sharer in his plea for help in order to care for his existence, in favor of his needs. Should there be pre-judgment in this ethics of love towards those who suffer, I believe that it is this: any suffering may always be relieved in some way, at least a little, even if we do not know how. And if there is joy in love, whether pleasurable or otherwise, that it may be food shared with those with the same hunger for living it. For love and its call speak by listening in all of the languages of welcome.

Particularly whenever I thought about establishing rules to make me a good therapist or define what would be my maximum principles as clinical philosopher I rediscovered the ancient truths of the man of Assisi and everything was similar to this: where there was despair and hatred, sadness or loneliness, that I would bring relief and love, joy and friendship. I know that there are times when the distress teaches more lessons of tenderness than the moments of peace. In moments like that a good therapist is specially accompanying. Isn't it interesting that the philosopher wants to give to the other the same compassion that he would like to receive from life? The true love to the next one as itself is not transfering the personal needs keeping alive the lacks of the desire. It is powerfully more lucid: it is possible to donate yourself to the other only who developed before in itself the charity to receive it exactly as it is. The charity to receive can be as or more important than to give. Who far received, must repay. Therefore, it makes a lot of sense to call the other sharer.

I learned clinical practice with Lúcio and, with my sharers, something that was even more powerful about the art of loving. They taught me important things to be shared here in this last chapter. These are some of the items to take care of in the presence of another. They are no more than reflections of my experiences. Were they advice, I myself should have liked to be given them. Life gave

me them as a present from the hands of those whom I was first ready to serve. These are only ideas, words in some other way, already recorded in this small book. To a writer, words are not that which antecede action, not a promise of that which exists beyond, but the gesture itself of making known the names of life, framing truth of thought. From so many lessons on ethics, I learned that

...many a time an expected encounter may begin even before someone's arrival. There are those that, in terms of expectation, bear with them intensities so powerful that, whether wise or foolish, they can overcome all of the obstacles and prejudice of separation at a glance. However, this is rare. It is only natural to expect self-defense, suspicion and accusation from those who hurt themselves or were hurt. Any encounter is subject to this. If a woman believes in her innermost that every man betrays and lies, denying possibilities of knowing another reality, clinging to judgment with strong desire, I must take my task to be approximation, because on this point I am free, while she remains immovable in a trap of ideas. Whatever the opinion, each can be what he wants, but any one who, for a long while has been closed to dialog, shall hear, from silence what solitude has to say. In the presence of such a woman, I must anticipate the meeting, and wait for her on the outside of her thoughts. The time of each is the right time for him. Probably, in her pain she may still be asleep in her sleep of pain. If I can listen to her complaints, why should I not also listen to her dreams? If I had sufficient patience, I would wait for all those who in the name of truth cut themselves off from love. The strength I gathered to me came from the gratitude of friends who waited for my time of maturity, so we could walk together. With intelligence, it was not difficult to understand that my good qualities came from the care of others and in them, from others also, for it is life

that gives life while we simply retain the gift of giving back. Love is strange and contrary to itself, only accumulates in one who does not keep it for himself.

...if I wish to change someone's way of being, to have this legitimate right, I must in the same proportion allow myself to be changed by that person with the same criteria of fairness. Not easy. This reflects on that which is the key point of every discussion: how to know whether I have the right or not to interfere deliberately and radically in the life of a person? For if I were to do this exclusively on my own values, it would be hypocrisy to deny that I consider myself better than she is, otherwise I would try to approach him to learn and not to change him. No matter if, in some point, I regard myself as more correct or more lucid than someone that is natural to all. What matters is that in exacting charges, I must always lay hold of a rule: to travel from the limits of the real to the ideal, and never the inverse. Each time I begin to think what the other "should be" like, which he is not (and perhaps never will be) like a complaint demanding change, even if I do feel absolutely fair, this would only prove the comfortable capacity of my objecting and saying bad things about people. Dishonestly, I would be wishing that, first, the other change, and only then, would I declare myself the author of the transformation. Anyone in fact interested in knowing and respecting people such as they are never says "If he were different... it would be better". As innermost change, hypotheses are mere strategies of action. One position adequate to anyone genuinely wishing to help is this: if to me someone should be what he is not yet, better think of another perspective, who knows if in these words: "Considering that someone is precisely this way and not any other way, *what*, *how*, *how quickly*, and *how much* can be done in his/her present situation? I understood that in co-existence, it is very important to reflect whether my indignation concerning this

hides my dominating side. Very often, freedom is only defined by disobedience, precisely when it is the other who is dubbed wrong, ignorant, unhappy, or impossible to advise. Anyone requiring inner renovation, when we least deserve love, more than ever, we will need to be loved.

...in each of us, there is a book in which life is described in every detail: when we read as rare a book, we feel as though the heart itself, whatever heart it may be, were responsible for the secrets revealed – deep confiding between the reader and the author of the words. What difference does it make if it is an open book, if wisdom is necessary to read it? But few get beyond the cover that protects it. To read the intentions, interpret the spirit of each phrase said, one must pay attention to what comes before the text and know from the words, what "pre-text" they are charged with. Every human being lives in one region in the world, in one particular time, is from a culture and a language the rules of which already existed... and, above all, has a personal history that is unequaled anterior to the "text". To forget this would be a mistake as gross as believing that the Old Testament spoke of the sins of watching television. Then, at the precise moment in which thoughts communicate through one thousand signs combined (a deep breath, a swift glance at the clock...and the sentence: "It's hot today, isn't it?"), it is absolutely fundamental to understand that each unique person is situated in his adequate "con-text". Each has specific relations with others, a way of expressing himself differently according to the concrete circumstances that he experiences. Only thus, can the other's discourse reveal itself in intimacy, like an open diary entrusted to a best friend.

...that very often it is easier to be a therapist hiding one's weaknesses, avoiding encounters away from clinical practice, avoiding friendship in the relationship. It would be necessary to be neither very far, nor too inserted in the world of the person that one wishes to get to know. They say: "The other has to be safeguarded from the privations of the therapist". I agree. In truth, few sharers realize that strength is not made up of an absence of fear, but of courage to rise once more, happily, in face of life, once the battles are won. It is usual for the sharer to prefer help from one he believes so powerful that he does not suffer from the same problems. After all, it is strange to him to think that a therapist in difficulties with his family may help someone else on this same score. Stranger still would be to believe that anyone is exempt from life. In spite of all the true friendship and all the kindness a therapist may show, a disturbed sharer is the enemy of peace of mind. I myself chose the most difficult path, accepting as a sharer only one I became friends with. Friendship is one of these things given by addition – neither sought for nor found: but practiced in an encounter. Not for me a mask of theatrical virtue, searching for a means to make clinical practice seductive, pleasing those whose esteem avoids sincerity as to my true size. Human universality is so various that I may satisfy some entirely and others never, however hard I try.

In concluding, of all I know and that I have lived... of all they taught me... I cannot accept any other ethics other than true listening. And if my experiences bear some value beyond myself, I shall be happy to share the reward. Sincerely, I can sum up everything in one question: with all your heart, do you really wish to serve your neighbor, listening to his deepest needs in life? How can I explain this truth that to listen is not enough, if one is absent-minded? We do

not communicate directly with the individuality in people, but with the bonds that unite us. If the spirit is distant and consciousness asleep, there is nothing to say. If souls lived alone, there would be no words. A word is a gesture of intent, a desire to communicate, a play of interests. As can be observed, words disguise thought, but also reveal thought through the way in which it hides thought. If anyone refuses to talk about a given subject, and changes the subject, this tells a lot... In any one, every lie, hallucination, or mere day-dream has a style of its own. A word is a gesture of intent, a desire to communicate, a play on interests. A good therapist, a good friend, a philosopher knows that the act of talking implies listening and no one can forget this. Ears hear, the soul listens. If there is something to be said between two persons, may it be an encounter.

Said thus, it is necessary to take care with intention, so that it will not cause words to die in the throat, the spirit in the eyes, the body in life. It is not a matter, therefore, of avoiding saying certain things when they are necessary, but to know how to say them in a certain way, with love. Style makes for beauty, love for understanding. In a dialog made up of listening, a therapist must use the words of others with care. They explain the ideas of the person who speaks better and may strike a chord of association in the mind of the listener. This is the ethical mission of dialog: to talk like the one who is listening and talk as though small good things will seem great and be deemed as such. And, above all, in face of the counter-sense, of the unheard of, of the incomprehensible in another, never say: "this is absurd, it makes no sense!". Contrary to an answer anticipated, it is necessary to ask: "What sense does this make to him?".

That is why I wrote the book. Those familiar with my answers to life and to Lúcio Packter's dreams will trigger hundreds of other questions. The dreams must materialize, for after all, what there is

that is most solid in the world is the subject of somebody's dreams. In the words of one of the greatest orators in the Portuguese language, Priest Antonio Vieira (1959), "A book is a mute speaking, a deaf person answering, a blind person who guides, a dead person who lives and, not containing action in itself, a book stirs up emotion and is of great effect". Absent body, my consciousness is not afraid of existing. May words be said... may a book become dialog, time and again! In an encounter, I would never allow my words to be the last, as if truth were to conclude silence. Truth can give rise to two opposite feelings: if scant and poor, it makes us think that all knowledge is insufficient in face of life, with no defense against the unknown; or if too much and erudite, to believe in the illusion of pride casting one's own ignorance in the face of another. To awaken from this type of dream would be no more than a nightmare. In this ethical praxis of listening, if there are conclusive truths, may they stem only from the most recent words, especially those that are as yet readying themselves to exist. For human beings, about many sciences of the other, there is no greater knowledge than dialog.

# GLOSSARY

[i] **EPISTEMOLOGY**: also known as THEORY OF KNOWLEDGE. Is the branch of philosophy that deals with nature and the validity of knowledge ("What is knowledge?", "What is its origin?", "What can we know?", "How do we justify our beliefs?", "Confirmation", among others. The name derives from '*episteme*': a term from the ancient Greek meaning knowledge. The opposite of this word was '*doxa*', meaning opinion. Over the course of the history of thought, there are different and opposing epistemological currents such as empiricism, rationalism, phenomenology, historicism, structuralism, etc.

[ii] **PHENOMENOLOGY**: is the philosophical understanding of reality, understood as a phenomenon of perception and not as a belief that things exist outside consciousness, that is, independent from it. Phenomenologically, the world is not only the result of my thoughts, and the possibility that exist trees in the amazonic rainforest is clear, even if I am not there to see them. The world is prior and bigger than my perception. However, the "simple" fact of imagining a tree is a phenomenon that depends on my notions of time and space. The world needs my perspectives so that I can perceive it. In other words, the knower and

the known thing exist simultaneously. This is an opposite perspective to the positivist thought of the nineteenth century.
The phenomenological method begins as from the analyses of Franz Brentano on the intentionality of the mind. To him, all consciousness is the consciousness of something; therefore, consciousness is not a substance, but an activity made up of acts (imagination, perception, speculation, will, etc.). In this way, essences are significances, objects that are only captured by intentional acts and not otherwise. The process of phenomenological reduction or *Epoché* takes place by gaining distance progressively from appearances or phenomena of the outer world towards investigating operations carried out by consciousness, in search of the essence of the phenomenon. In the words of Edmund Husserl (1976), a student of Brentano, knowledge of the world is characterized by the fact it cannot be finished, for we will always be able to review things from a new perspective, enriching this knowledge.

[iii] **A PRIORI**: an expression in Latin much utilized in philosophy to designate knowledge acquired before or independent of experience. Mathematics, logic, pure abstract intellectual intuitive abstractions, universal postulates etc. Knowledge *a priori* is a contrast to *a posteriori* knowledge that is, that which requires perception via the five bodily senses. *A posteriori* is a basic concept of epistemology by means of empiricism in social and natural sciences.

[iv] **PRAXIS**: reflected action, thought with a transforming potential of reality. Thought and action become dynamic, one modifying the other, while they make each other mutually in the dialectic process of existence itself.

[v] **ALTERITY**: is the deep and existential meaning of "being another" that goes unnoticed, it's the perception of intimacy, of exclusive and unique personal experiences of each human being. It's the effort to put ourselves in the other's shoes - his way of thinking, feeling and acting – in such a way that their personal experiences are preserved, respected, without the slightest wish to overlap or destroy them. For thinkers such as Peter Singer (2002), the alterity is an ethics of respect, not only among humans but also extended to other animals.

[vi] **EMPIRICAL SUBJECTIVITY**: refers to people who exist concretely, individualities at the level of day-to-day relations and therefore distinct from abstract subjectivity, the sense of which is purely theoretical, of a universal "I". Philosophy traditionally utilizes the concept of "I" in a transcending abstract, *a priori* form, to refer to all people, not considering the ephemeral and accidental in them; whereas sciences, psychology and anthropology refer to them and to cultures directly through experience.

Clinical Philosophy has a peculiar way of availing itself concomitantly of these two concepts of subjectivity. The concepts of "categorial examinations" and "structure of thought" can only be understood with deep theoretical abstraction, in their phenomenological and existential instances. It is this knowledge *a priori* that lends a philosopher unmistakable understanding of the sharer, obviating two common errors of judgment: naïve belief in appearances and the imposition of universal prejudice (that includes other abstractions).

Lúcio Packter raises an interesting question concerning this. In creating Clinical Philosophy, he affirms that it was as from his experience as a therapist that he elaborated the abstracts of the

thirty ST topics. By this logic, Clinical Philosophy originated in clinical practice, which would lead us to the apparent conclusion that it is originally empiricist philosophy. So much so, at various stages of his work, he affirms that it will be through experience in clinical practice that the changes necessary to the theory will arise and, who knows, with the inclusion of new topics. However, only as from the five categories of *a priori* understanding utilized in clinical practice (subject, circumstance, place, time, and relation), will that practice becomes philosophically possible. Would Packter's philosophy be *a priori* or *a posteriori*? The answer is reassuring: there are no competitions in methods. Clinical Philosophy is, above all, a combination of benefits to the sharer. This is what he says in Notebook A:

"... I must admit that the basis of my work led me to these methods and never the contrary, until I came across certain difficulties engendered by stubbornness. In spite of some opposition between foundation and method, at the start of my work, I shall cite those that outlived confrontation. As I stated to my students, I have discarded – not without some pain – all that did not have a practical application" (§12).
(...).
"Please note that a person is anterior to structure of thought, for it is only through a person that such a Structure can exist.
"When a clinical philosopher considers another being who seeks him out, will he have before him a person or a structure of thought?
"If you want to know what I believe, just read the lines above.
"I have now perceived that here, just as in almost all else, there is no consensual data: some philosophers will certainly consider a person as mere structure of thought; others will know how to keep one apart from the other; not to mention those who will understand all, Person & ST, as a whole. In short, take this as you will" (§16).

[vii] **DIALECTIC** – the term is one of the most ambiguous in the history of philosophy, with different concepts. *By and large*, it is opposed to the causal method where understanding takes place through linear relationships of cause and effect. In the dialectic method, understanding is the result of a process of conflicts and opposition between different perspectives to explain a new situation resulting from this conflict. In this sense, it possesses three basic elements: thesis, the statement given initially, antithesis, its opposite, and synthesis, the result of this conflict. Synthesis is not merely the victory of one over the other two, but a new situation that bears within itself the elements of both, with no waste of knowledge or of experience. In a cyclic continuous movement, synthesis becomes a new thesis, contrasting with a new antithesis, generating a new synthesis.
In the present text, the non-divisibility between theory and practice is affirmed, in search of a synthetic vision of the therapeutic process.

[viii] **ONTOLOGY**: is the part of philosophy devoted to the study of concepts, characteristics, identity, significance, composition and essential relations of the different beings in this world, allowing a definition of what something is. To affirm that something is real ontologically, implies first defining reality. For such, various elements are called on for elucidation, according to the nature of what it concerns: if values, *quality* for instance, is researched (whether positive or negative), *opposition* (whether good or bad), etc. whether material things of the natural physical world such as a rock, a tree... or whether of the artificial physical world such as clothing, cars... *causality* (cause-effect) is investigated, as is *temporality* (its transformation and durability in time), etc. Ethics, reli-

gion, consciousness, politics ... and all there is, are studied in this form. When anyone, for instance, says he is concerned, that he is responsible, or that he does not know the time... ontologically one would ask: What is it, What is the essence of his "concern"? How is "responsibility" defined, in order to verify whether this person is really responsible or not? And, what is "time"?

[ix] ***HÓLOS:*** greek prefix meaning "total, complete, whole". By holoplasty, we must understand the unpredictable capacity of a human being to shape his psychological way of being in face of the world. Human existence is understood, in this sense, as singularity, plus the contours of external circumstances in which it redefines itself permanently, a surprise and expectation to all of the theories developed in this respect. By definition, holoplasty would be an unfinished concept of man.

[x] ***MADNESS AND CIVILIZATION*** / **THE HISTORY OF MADNESS IN THE CLASSICAL AGE**: Foucault upholds the idea that the way man deals with madness has changed significantly since the 18th century. Until the previous century, madness and reason were not separate. Rather, reason and "non-reason" were confusedly implicated. With scientific re-birth associated to religious philanthropy, within the absolutist order of government, the medieval experience of madness, as yet poetic, amusing and, at times, metaphysical acquired the status of mental disease. Since then, contemporary man no longer communicated with a madman, and made of him a pathological accident. This broken dialog condemned to silence all imperfect, hesitant words with no fixed syntax and enough knowledge and, at this, the language of psychiatry revealed an abstract monolog of reason over madness.

Renouncing confirmed truths, Foucault purported to make an archeology of this silence, combating and stripping the organizing role of the concepts of psychopathology, psychiatry, and psychology, that played a decisive function in the change. In his studies, he intended to suspend the figures of conclusion and absolute certainty established concerning this. In his analysis, he developed a history of language implemented by silencing scientific reason, revealing the structure of refusal and its mechanisms. His method includes a historical complex that involves several notions, legal and police measures, therapeutic institutions, lunatic asylums, schools, etc.
The "disciplinary power" was created once the normality/abnormality constitution had been established by medical-scientific knowledge, legitimated by the advent of statistics. These are social devices of rehabilitation and re-education, in order to humanize and correct persons then considered dangerous to themselves and to the population. With strategy, pedagogy and morality for the control of bodies and souls, subjects were arbitrarily measured and ordered. Those subjected to psychology and classified as dysfunctional (ranging from restless, non-docile children, the deaf, mutes, unstable people, weak-minded and "handicapped" etc.) were isolated in observation laboratories to obtain therapeutic techniques for treatment. Finally, modernity built up a new form of domination, a more subtle policy of coercion, useful and powerful for slavery rebellion: the identity of obedience.

[xi] **STRUCTURALISM**: method of thinking that analyses things such as languages, religious practices, family relationship and others, investigating the system of interrelations, the deep "structures" of culture, through which the meaning is produced and reproduced in a society. It was one of the most widely used methods

by the sciences in the second half of the twentieth century, especially in the humanities areas. Among the greatest representants of structuralism are F. Saussure, in the linguistic field, and Lévi-Strauss, in Anthropology. According to Lévi-Strauss, there must be universal elements in the spirit activity – the modus operandi – understood as irreducible and suspended parts in relation to the time that all the human being's way of thinking would pervade. The structuralism has been frequently criticized by the post structuralism and by the desconstrutivism, for being non-historical and for supporting deterministic structural forces instead of the ability of individual people to act. Particularly, Clinical Philosophy uses the structuralism as a non-deterministic understanding of the structures of thought, that is, through "open structures" of human condition.

[xii] **TRANSPERSONAL KNOWLEDGE**: the word transpersonal means "beyond the personal" or "beyond the personality" and is a level close to mystical experience focusing on the sense of the spiritual dimensions of the psyche. Different definitions have been given over the course of history, with the idea of dissolution between "I" and the "outer world" as utilized by C. G. Jung, remaining generically. Together with Vitor Frankl, Stanislav Grof, James Fadiman, and Antony Sutich, Abraham Maslow (1968) officially created the term "transpersonal psychology" in the U.S. to announce the advent of the "fourth force" in psychology, behaviorism being the first followed by psychoanalysis and humanism. Transpersonal psychology investigates non-ordinary states of consciousness to which we may surrender in a new non-materialistic sense in life – ranging from hallucinogenic experiences, religious states of trance, and similar states.

[xiii] **MODERNITY AND POST-MODERNITY**: illuminism was a movement that arose with greater strength in France in the second half of the 18th century (the so-called "century of lights"), subsequent to the traditions of the Renaissance and of Humanism, to uphold the worth of Man and of Reason. Philosophers of modernity, impelled by capitalism, insisted that belief be rationalized. However, together with the powerful ascent of science, revolutionizing the industrial economy, the next century was to see stiff opposition as regards the foundations of reason. Criticism such as that by Marx of liberalism, by Nietzsche of Christian morale, and by Freud of rationalism made them porticos of a new contemporary era, that is difficult to name.

So-called "post-modernity" possesses different philosophical concepts as to the term (Lyotard, 1984; Jameson, 1991; Habermas, 1983; Santos, 1993; etc.) generically demarcated as from post-industrial capitalism, around 1900. Once the belief in absolute truths, in historical linearity of progress understood as accumulative evolution had been shaken, the world was characterized basically by services and the exchange of symbolic goods such as information. Added to the deception of rationalistic pre-suppositions that did not prevent two world wars, in addition to subsequent losses of long term references, owing to the alarming acceleration of communication technology, to multiplicity, fragmentation and instantaneity in consumption, there was a wave of maudlin romanticism and a crisis in language. Excess of information, especially audio-visual, globalized economy, a poly-cultural and virtual nature of reality "online", an end to prohibition, transforming all into products, into goods with complete freedom of choice for consumers... and so many correlated phenomena, brought to psychotherapy an

impact difficult to assess, with brave therapists overcoming reason in their search for new perceptions and treatments: there were those who, through insufficient reasoning, were limited to marketing, to a charisma and to pseudo-mysticism of fashion.
Whereas modern sciences were regarded by illuminists in their possibilities of irrationality, to post-modernists these same sciences did not ensure the de-mystification of the world nor the incalculable increase in techniques of violence.

[xiv] **PHILOSOPHICAL DRAFTS ON A (NEW) CONCEPT OF SUBJECTIVITY IN CLINICAL PRACTICE**: Below, a partial reproducing of Will Goya's article (2005).

"... In CF, respect for the mode of being of others, not only to their axiological data, but to their holoplastic subjectivity, affirms, according to the reach or the addition of my own reflections affirms a notion of worth: the *power of authenticity*, or the capacity to promote an existence (or an existential function), to assume the greatest value that its grandeur can be. In a word, arouse a maximum of efficacy to the subjective achievements of each, according to the autogeny of the Structure of Thought considered. This value possesses an unrestricted validity in the measure in which it would ensure total respect to the existential freedom of the subject, guiding him therapeutically in the use of Submodes – that is, generating over his customs and existence in general, if possible and or necessary, a new mode of being, in search of solutions for his inner conflicts, many times independently of the plural or hegemonic axiological cultural interests in effect outside him.
"Beyond the limits of the sphere of pure rationality, my reading of Packter comprehends a distinct ethics both of logical *a priori* and

of axiological *a priori*, in the sphere of feelings. In CF the axiological *a priori*, acknowledges its specific legitimacy only when inserted in the Categorial Examinations, in an autogeny of ST – a fact that allows us to verify clinically that, also, in some subjects, there is no emotional manifestation or even the need for the existence or predominance of axiological data. Once any "contents", psychological or metaphysical typologies of universal human nature were absent, there would be no reason for a person to undergo healthful or moral re-conveyance. In this reading, no transcendental form of having to be, or of good/love in holoplastic subjectivity subsists. This is mostly a clinical conclusion. In this way, CF does not prolong the continuity of readings of phenomenological data of the analyses of an intellectual nature (Husserl) or of emotional experiences distant from intellectual and religious experiences (Scheler) as mere improvement. To think of ethics, in CF, is to think of a moral value beyond the imperatives of emotion, although there may be some overlapping. This is an *ethics of power* beyond Good and Evil, but in no way favoring a wish for power, as natural instinct (Nietzsche) – beyond the philosophical postulates of any concepts defined of a certain nature or human condition, according to the listing of the history of thought. All are circumscribed or relatively true, by coincidence or otherwise, if they are adjusted to subjective singularities. It is inexcusable to hope that an ethical paradigm even if by far assume the infinitude of each one within the history of himself or in that of societies. If these drafts indicate a valid path for research – as intuition originating both from my clinical praxis and from renewed reading – I dare say that Clinical Philosophy adds, possibly in the same direction, to what existential phenomenology has revealed in this respect. Consequently, I can foresee that CF does indeed create a new value, beyond Kant

and Scheler's ethics of responsibility, precisely because it removes the concept of morality from good/evil values and from love/hate hierarchies. Divergence does not affect Kant's principles that govern the western world in all its relationships, or, it acts in such a way that its action is a universal norm of conduct, invariably as an end and never as a means. In CF statutes, what is questioned is compliance to the norm as duty pure and simple. They also disagree with Scheler when he sought to ensure the universality of ethics by emotional experience of values, making of affectivity a fundamental topic of choice. The result of the criticism pursues a genealogy of judgments of value, not of psychological introspection, but repositioning the issue of subjectivity and of the relationships of autogeny that act on will in debate.

"The fact that new categories of understanding are added to phenomenology requires ethics because it reflects on two fields, namely: 1. from the theoretical point of view, is a basis for an *ethics of power* within the parameters outlined here feasible? 2. Formerly, what was to the field of observation and clinical analysis, it is inevitable that CF praxis have ethical presuppositions, which would justify investigating as to which they would be. This would allow us to base ethics on CF so that the judgments of value be attributed significance of false or true, and that they guide human activity in conformity with clinical-philosophical understanding, without relying on support from any metaphysical, religious, or cultural realism.

Therefore, in CF they are above the influence of absolutism of individual ethics, nor do they advocate emphasis of an essentially public ethics (that is universal, whether in community, relativistic versions). They supersede the debate between individualism/universalism/rationalism versus holism and anthropological read-

ings (social, historic, hermeneutic, or contextual). In the measure in which this still remains as existential phenomenological reading, more transcendental or formal conditions whose materiality of objective values also result through pure emotional perception also do not subsist because they are irreducible axiological phenomena. In a different way, in CF, the phenomenal manifestation of ethical values while an intentional act in effecting any values, seems to me, to certify a new basis: access to objectivity will occur by phenomenological observation of the experience lived by the psychological subject, but through the investigation of conditions and circumstances of the phenomenal manifestation of value of a *subjective vital force*.

"Within this ethical concept, *good is any value that is manifest in an intentional act that will allow the existential practice of a person, potentializing what he is phenomenologically in intersection with the world, that is, all that will maximize the unique and possibly fluctuating mode of being of each one. And by ethical attitude of a clinical philosopher all that, through necessary effort and competence can do to a sharer for the purpose of ensuring him a strong autogeny in his intersection with the environment – the total of important and complex persons and things – in which he is inserted*"

Should ethics not necessarily coincide with a quest for "well being" or "happiness", given the subjective holoplastic configurations, there may be a choice for suffering, without the moral connotation of a bad value. Of course, this is only validated through philosophical-clinical methodology according to the inner elements or categories of Structure of Thought and application of Submodes compatible with each. An ambivalent therapeutic criterion because this *subjective vital force* or *power of authenticity* may present in two ways. In principle, it is desirable, at least possible to obtain the much desired autonomy of the clinical sharer about his regrets,

while an inner question, located in the restricted universe of his subjectivity. This type of autonomy is seen on the intra-organizational clinical limit to the Structure of Thought. In other words, the concept of psychic autonomy generally presupposes independence of outer factors under the control of one's own will, having as opposite, degrees of anti-ethical alienation. With emphasis, this establishes a truth if and only subsequent to the completion of a clinical autogeny, showing an important obstacle in existence or loss of that *vital force* owing to bonds of subjugation or reification etc. In this case, CF would care for the sharer in the sense of guiding him to the productive reorganization of elements constituting his Structure of Thought, for his own good. However, on the other hand, because it cites Freud-Marxist trends of thought far from paradigmatic stigma, through the demands of clinical praxis, CF identifies another manifestation of autonomy, able to reveal the existence of individual structures of thought that join together in an indivisible form, that is at times confusing, in one sole ST with other people or even with inanimate objects. In this case, the *power of authenticity* is optimized in the sense of autonomy as belonging to an analysis and treatment of a structural scope. Therefore, ethically, it would be condemnable to guide or even to lead a person to separate from his closest attachments – whether people or things – because of suffering or through ideological incompatibility between clinical philosopher and sharer. *A priori* and without the Categorial Examinations due and, above all, classifying it as "pathological" it would be an ethical crime to CF. No charismatic answer is worth more than the infinite queries that the mystery of another arouses in us.

"It could hardly be otherwise, I understand ethics originating from clinical practice and not for the clinic; a therapist philosopher and

not a therapist that studied philosophy. This is what CF brought to light. In the sense I present it, Clinical Philosophy is ethical therapy – an ethics of tautology that does not intend moral development supported by any doctrine of scope, precept, value for another human being. When need requires clinical care, a sharer seeks some change within the context of his personal experiences, not necessarily what he thinks or feels about himself, but in the condition of his Structure of Thought that does not satisfy him – possibly topical shocks, conflicts in existential categories in his psychic totality, insufficiency or excess, absence of submodes, etc. things that can not be known without due analysis. It is important that, with immediate subjects (in general) symptomatically, he find himself in an extreme situation of which he feels a prisoner or short of his full existential freedom. *This condition of being, that according to Category Exams done previously, vindicates to be different from what it is or where it finds itself, may be described as condition of non-authenticity.*

"This new philosophical concept of subject (Structure of Thought) and of the method that reveals it, (Categorial Examinations), are bound to the notion of clinical practice (Submodes) by an inseparable equilateral triangular configuration, consisting not only of sides, but of an existential area and angles. To view CF fragmenting this configuration would necessarily result in an instrumental reason, in which mere technique of knowledge that is more or less utilizable, by any interests, is to be preferred above the ends to which they are intended, or be it, psychotherapeutic efficiency would be preferred. To think subjectivity in a Categorial Examinations without the concomitant elaboration/reading of a compatible Structure of Thought would be sheer, useless *academicism* whose only worth would be in the vain glory of reflection that draws away from the world in order to better know it theoretical-

ly, but neglects to return to it. After all, what is the sense of knowing a method if one cannot resort to it for the purpose for which it was intended? A Structure of Thought, in face of the Submodes, without Categorial Examinations, is anti-ethical, for making of the other what I want him to be, as from pre-judgments. And, to transform into an object of study and practice, as can be observed so flagrantly in psychological and philosophical theses that have, each in dispute, immobilized what they condemn as being "his true" universal human nature.

Submodes without Categorial Examinations or Structure of Thought, appreciated in the multiple psychotherapeutic techniques in existence – and almost all of them effective for the purposes for which they are intended – incur in the well-known mistake of attributing value to the technique rather than its intent. To do before knowing how is somewhat like insisting with the right key and the wrong lock. More than simply not opening the door is to imprison oneself.

"I know that, for a draft, there are many words here, above all with a daring, if interesting idea. From the phenomenological point of view, CF purports (if I have understood philosopher Packter's thought), among other things, an anthropological-ethics, a spectrum of understanding open by category which is *above all a responsibility and only then a thought of responsibility,* in search of the infinite paths of truth and thought. In this particular, I believe, there is agreement with Emmanuel Levinas, according to whom sense first arises as morality. The ethical-gnoseological issue of Clinical Philosophy, in face of the intentionality of the ego is this: who can I be or not be in intersection with the world, according to my autonomy? That instead of totalizing theoretical idealism: who am I, according to which perspective besides myself or in my pure representations? With the ontologizing of a human being, we always

run the risk of alienating this same being through ideology, often authoritarian travestied through a discourse "on" reality. At least in intention, this draft fulfills its role: to invite mistakes for learning and truth for revision."

[xv] **METAETHICS**: is the theoretical investigation concerning the significance of the propositions, of the foundations and of the methodology of the conceptual universe of ethics. Essentially speculative, it draws away from moral reflections that involve empirical problems and practical aspects.

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"... I can sum up everything in one question: with all your heart, do you really wish to serve your neighbor, listening to his deepest needs in life? How can I explain this truth that to listen is not enough, if one is absent-minded? We do not communicate directly with the individuality in people, but with the bonds that unite us. If the spirit is distant and consciousness asleep, there is nothing to say. If souls lived alone, there would be no words. A word is a gesture of intent, a desire to communicate, a play of interests. As can be observed, words disguise thought, but also reveal thought through the way in which it hides thought. If anyone refuses to talk about a given subject, and changes the subject, this tells a lot... In any one, every lie, hallucination, or mere day-dream has a style of its own. A word is a gesture of intent, a desire to communicate, a play on interests. A good therapist, a good friend, a philosopher knows that the act of talking implies listening and no one can forget this. Ears hear, the soul listens. If there is something to be said between two persons, may it be an encounter".

***

"*... resumo tudo numa única pergunta: de toda a sua alma, quer verdadeiramente servir ao próximo, ouvindo-lhe as mais fundas necessidades da vida? Como lhe haveria eu de explicar essa verdade que ouvi-la não basta, se estiver distraído? É que não nos entendemos diretamente com a individualidade das pessoas, mas com os laços que nos unem. Se o espírito é distante e a consciência dorme, não há o que dizer. Se as almas vivessem sozinhas, não haveria palavras. Como se sabe, a palavra disfarça o pensamento tanto quanto o revela pela maneira como o esconde. Se alguém se recusa a falar sobre determinado tema, mudando de assunto, isso diz muito... Em qualquer um, toda mentira, alucinação ou simples devaneio tem seu próprio estilo. A palavra é um gesto de intenções, um desejo de comunicação, um jogo de interesses. Sabe o bom terapeuta, o bom amigo, o filósofo, que a operação de falar implica a de escutar, e que ninguém pode esquecer-se disso. Os ouvidos ouvem, a alma escuta. Se houver algo a ser dito entre dois, que seja um encontro*".

ASSOCIAÇÃO BRASILEIRA
DAS EDITORAS UNIVERSITÁRIAS