If I believe certain problems are malignant, I do not believe we are useless to help our patients with them, no more than oncologists are useless with malignant cancer. We will be worse than useless, however, if we underestimate their severity, for we will set up hopefulness that is dashed. This is a grave disservice, for these patients have only little hope when they begin these devastating careers of illness.

I have had my share of such failures. I never learned anything critical without getting it wrong first and losing a patient. In my defense, I can say that I have learned, and I can also say that I have had few teachers who warned me adequately. Few writers map this territory. (A short, but decisive list, in historical order: Freud on negative therapeutic reaction [Asch 1976], Jacobson on mania [1953], Sullivan on paranoia [1956], Main on the ailment [1957], Balint on malignant basic fault [1968], Winnicott on antisocial problems [1971b], and Kernberg and colleagues [1988] on borderline personality.) I will show a number of these failures here, to illustrate underestimation. What is finally crucial is to see what they have in common, so that we are ready for the entire series. Then we will have eyes for the next variant that comes along in our practices.
The Entire Series as Variations of the Malignant Basic Fault

Perhaps there is no substitute for the experience of failing with these grave disorders a certain number of times, thus correcting one’s youthful therapeutic zeal. At some point one has had enough pain to want to bend one’s mind around the way in which severe problems persist. Fortunately, they all work in pretty much the same way. This similarity of structure in all severe cases is not well marked out in the literature. It can be inferred from the data of the Menninger Psychotherapy Research Project described in Wallenstein’s book, *Forty-Two Lives* (1986). Even there it remains a list of difficult topics (I will return to this data fully in Chapter 16).

The reason for this lack of description of a common structure to grave disorders, I think, is that you need a dilemma concept (Gustafson 1995) to grasp the double jeopardy of these disorders, and dilemma has never been more than a word used in passing, without a grasp of its general theoretical significance. These severe disorders are not only based on dilemmas, but tragic dilemmas, which have no easy way out. As in tragedy it is too late for turning back and for rescue; yet something can often be accomplished when the dire situation is fully grasped.

A tragic dilemma is one in which the patient is sliding into ruin, but the alternatives are worse. The patient always complains of this drift to disaster, but is never prepared to do anything else. The first reason for the disaster is that the patient cannot manage by himself, and the reason for refusing help is that it brings him too close to the helpers as persecutors. Thus, it is what I call a far/near dilemma, as in my first diagram.

The reader may want to turn to Chapter 11 for a full exposition of my representations of the topology of the mind, and to Chapter 16 for a theoretical comparison with the mathematics of catastrophe theory and chaos theory. Here I will outline a few key points about my mapping, so that the reader may get a better glimpse of what these figures are designed to show.

First of all, the reader may think of the two horns in the diagram as the horns of a dilemma. In Figure 1–1 the far horn slopes into perishing alone, while the near horn falls rapidly or even precipitously into the perfidious hands of the so-called “helpers.” The heavy and dotted
line between the two horns indicates the hiatus or disjunction between the two halves of the map: it signifies that you are either in the conscious mind to the right, which is conscious of terrible loneliness, or you are in the unconscious mind to the left, which is unconsciously terrified of “help,” which is actually betrayal. The unconscious dread of the left half of the map is so terrible that the patient is likely to flee to the right where the other peril gets him.

Thus, the mapping generally has coordinates of the external world and conscious mind to the right, which is smaller in energy, and thus drier, and earthbound in its metaphors, like Dr. Jekyll, discussed in Chapter 11. Conversely, the unconscious mind is mapped to the left, which is far larger in energy, and thus wetter, and oceanic in its metaphors, like Mr. Hyde, also discussed in Chapter 11. In other words, the vertical dimension of these diagrams is a coordinate of the size of the energy involved.

These diagrams allow me to picture for myself and for my patients and students the force field in which the patient exists, which is highly non-linear or abrupt in its sudden changes from gradual to steep rates of change. Without such a pictoral assistance, it is hard for us all to reckon the difference between standing on the banks of a huge river,
Brief versus Long Psychotherapy

where one can move freely without falling over, and being up to one's waist in the river, where a single step can subject oneself to overwhelming torrents. Thus, we are inattentive to the differences in territory, between the dry and relatively linear conscious mind, and the wet and overwhelming forces of the unconscious mind. This is why I often picture clouds over this force field, which obscure the situation, in which the patient is imperiled for lack of reckoning about what is coming next.

The verbal and mostly conscious means we have are too weak to grasp these typical situations. This is why the unconscious, which can correct the conscious, utilizes pictures in dreams. As Jung (1963) argued, the #1 self of the conscious mind is in grave difficulty if it cannot heed the #2 self of the unconscious mind. The #1 self mostly is familiar with words, while the #2 self mostly is strange with its night-portraits of how things stand, or fall. This is why these drawings are of grave importance to my patients. Winnicott (1971b) found the same thing with children.

The reverse or near/far dilemma is equally tragic: the patient clings to the doctor, and cannot bear separations. I will divide what can be done with such situations into three broad categories. The first is to decline psychotherapy, but remain available for emergencies. The second is to manage the situation, by facing with the patient that it is very bad either way. The third is to get the patient to make a huge change that transcends the terms of the dilemma.

Declining Psychotherapy, While Remaining Available for Emergencies

One common presentation is the patient with the ailment (Main 1957), who can't work, can't study, or can't relate to other people. This can be complained about bitterly, because it leaves the patient without money, qualifications, or friends; yet he throws the entire burden on the doctor to fix it, while he is prepared to do almost nothing but make efforts that are certain to fail. Almost always, he is angling for a disability income from the government, or a sinecure from the family.

A Case of Making Messes

A middle-aged man lived with his aging parents, and complained that he had been fired several times from jobs. He was very nice and made such a good first impression that he was easily hired, but it
The Malignant Basic Fault

was getting harder with his record. He just made endless mistakes. Somehow he lost his concentration, and forgot things important to the boss. For example, he was supposed to watch over some children one day, became bored, turned on the radio, and one child wandered away and was lost for many hours, causing a tremendous panic. Needless to say, he was fired, but his attitude was that the boss had made too much of a little thing that had turned out all right! Always, it was someone else's fault.

I spent five years with this man going from one fiasco to another and never learning anything, despite my best efforts. He lived in a kind of cloud, which he could actually describe as surrounding him. He had learned as a child to tune out his baleful parents, by becoming absent or simply absent-minded. They could scream all they wanted; he hardly heard them. The trouble was that he could not come out of the cloud to engage fully with anyone or any task or anything. To come out would be like blowing in the wind. So he never did. He sank perpetually in one job after another, and never got near anything. Finally, no one would hire him, and he started receiving disability.

A Case of Unbearable Flashbacks to Incest

This patient, like so many others, complained of unbearable body memories like abdominal pain and genital pain and vomiting, which she believed were due to incest with her father. She was extremely suicidal, and had no ties to anyone but the mother who had always overlooked her troubles and told her to shape up. She had no work and no interests that anyone had been able to find. (I suspected they were wrong about this, since she was not yet dead.)

Whenever she began to tell her resident doctor about any of these memories, she would become overwhelmed, more suicidal, and come to a dead stop; yet she insisted that the resident relieve her of her terrible distress. She would take no responsibility for her safety between sessions, saying that was for the resident to figure out. All of this was presented to me for consultation.

I saw her with the resident and found exactly the same situation reported to me, except for one difference. I saw the dilemma was impossible. She could not go on like this, yet probing her trouble made her worse. So I told them that the treatment was even worse than the disease. (See Malan [1979, Chaps. 21 and 22] for some har-
Managing Tragic Dilemmas

Sometimes it is possible to manage in malignant situations, and sometimes one has little choice. For example, our second year residents in the emergency room are forever having to manage dilemmas with borderline patients of the following sort.

The Case of Yet Another Borderline Patient in the Emergency Room, or The Malignant Helping Profession Syndrome

A young female is brought in by police, after she alarmed her roommates by cutting on her wrist. She is stubbornly quiet, and resentful that she has to answer annoying questions. The resident locates her chart and finds this is the twentieth episode of this kind in the last year, and that three hospitalizations have accomplished nothing, except to anger the staff who do not want her back.
The resident calls me on the telephone, and is in the usual dilemma. If he takes her into the hospital, he feels used. If he sends her out, he is apt to be woken up later when she comes back in the middle of the night. I reply that this is the usual dilemma, and that he is going to suffer one way or the other, so which suffering is he going to prefer? He decides to put her in the hospital.

Since I am also covering the inpatient service, I get to see her for a staffing the next day. She is a little more communicative, having gotten her way, but emits the usual air of resentful tolerance of inquiry about her affairs. I find that she used to be a social worker herself, but this broke down when she could not set any limits on the funds she was giving out. She had been terribly nice, and complete advantage was taken by her clients.

Now, she is in a hopeless fix. Without her helping profession, she feels worthless. She can’t really go back to it, because she can’t stand up to anybody about anything. So, she makes suicide attempts, and gets worse with each fiasco. For example, her roommates are fed up with her, and she with them.

In this particular interview, I neglected the most important question, which is what did she want to do about all this? This is most important, because such cases go nowhere without the patient wanting to do something herself. (Malan’s [1976] chief finding with long-term therapy is that motivation is the greatest limiting factor.) Without self-motivation, patients get us to take the initiatives, and subsequently prove they will not work. (The helping profession syndrome is Malan’s coinage [1979], and the malignant version is my adjective.)

I fell for this one. In my cleverness, I pointed out that she could only take back her profession if she could refrain from being so nice. This annoyed her, because she felt being nice was her best point. It was just that the clients had misused her; so it was their fault.

I did have the sense to warn her of the hazard of changing her nice, helping stance. I told her she’d be apt to swing the other way, and let loose of her aggression. It would be difficult to find a middle way, and take a long time. Well, she soon showed the futility of my ideas, by storming violently at her visiting roommates, and leaving against medical advice!

Her proof was complete, and fits the tragic dilemma. She goes on and is betrayed by being nice. She engages help, becomes violent, and breaks off treatment. Next time I see her I will not make a move until
I find out what she prefers to do, and then I will, as Sullivan (1954, 1956) would say, make the unpleasant implications perfectly clear, that is, the two ways that she is very likely to fail: by being taken advantage of, or by blasting people.

A Generic Paranoid Patient in Psychotherapy

I have had somewhere near ten paranoid patients in psychotherapy in the last several years. Of course, I do not want to describe any one of them, because I will be obliged to seek their consent, and I do not want any legal arrangements with any of them. In any event, the same unpleasant sequence of events occurs in every single case, and that is what I have finally grasped, and will relate.

These cases are not grossly and obviously paranoid at the start, or I never would have been tempted to begin. The patients are actually appealing, because they suffer terribly. As Reider (1953) suggested, they come into psychotherapy in a state of "positive paranoia," or the delusion that the world is out to help them. Often, they have had dreadful childhoods of torture and abandonment. A little kindness got in there just enough that they believe in it with a vengeance.

I go through an early phase, in which my understanding eases their terrible isolation with their unbearable pain. Often, there is a great letting go of tears. This brings me closer, and this is too dangerous. I am now regularly attacked over the smallest misstatements, failures of empathy, or insinuations that I had never intended. The positive paranoia has shifted to its shadow side of negative paranoia. If I have my wits about me, I do not allow myself to be provoked into an outburst, which will discredit me completely and allow them to get their distance back by walking out on the spot. I do allow them to regain some distance, by being somewhat unpleasant in return. "Thus, while the therapist ordinarily should try to make things run rather smoothly, with the paranoid person he should go to some trouble to make all implications, especially the unpleasant ones, very clear" (Sullivan 1954, p. 232).

Since they all have a genius for discovering things that are slightly wrong, I always grant them their point. I follow with disagreeing with the conclusion drawn, and I tell them they are determined to put me in a bad light because they were getting very anxious about seeing me in a good light. For example, one such patient hounded me about being too distant when she cried, another for how my department handled
her crazy mother, and another because she felt worse after draining sessions. Some of them get enough distance from my being accurate about their dilemma, and some have to quit to get far enough away from my help. For a fantastic account of a brief psychotherapy with an extremely paranoid, but capable, patient of this kind, see Balint’s “Stationery Manufacturer” (Balint et al. 1972). The first half of the therapy concludes with the patient’s dream of curling up with Balint as a big snake, and the second half ends in an unrelenting attack on Balint in an attempt to extrude him altogether. Balint barely survives it, while being absolutely clear about what is going on.

The dilemma of paranoids is yet another variation on the tragic dilemma. Alone, they are unbearably isolated. Connected, they are defenseless. Reider (1953) was one of the first to grasp the double nature of paranoia, when he wrote that there is both positive and negative paranoia. Positive paranoia is the belief that someone is out to help you, and negative paranoia is the belief that someone is out to harm you. When we play into the first, we get too close and bring on the second.

**A Case of Manic Sport**

Like borderline and paranoid patients, those who suffer from mania have interludes which are deceptively pleasant. This is where we get hitched, unwittingly, to what will turn out to be a shooting star. One such patient was very appealing in a boyish way, but had a terrible track record of false starts. At the time I began his treatment, five years ago, I was interested in what Michael White (White and Eptstein 1990) called unique outcomes, especially in the dreary lives of chronic careers of mental illness.

This young man might have been seen, alternately, as a chronic paranoid schizophrenic, or a schizo-affective disorder, or a paranoid personality. These diagnoses tend to overlap to a great extent. He was excitable, and that was the big thing. He was driving a girl crazy with his enthusiasms, which she could not get him to stop. Finally, her parents went to the police, who sobered him up a little. Then he came to me.

He spent most of his days thinking about this young woman, and her puzzling refusal of his great love. I ought to have left him in this great quandary. Instead, I proposed he might do something more useful. He began yet another job. This got his parents’ hopes up that he finally had found a competent psychiatrist. Soon, he became mad again,
16 Brief versus Long Psychotherapy

convinced that the boss was gay and out to seduce him. He quit. After this, the parents gave me a good deal of grief.

Again, we were in a tragic dilemma. In his high states, the patient was untouchable; he was in a cloud like Jehovah (Jones 1923). But he would bother the young woman and this brought on the police. If he wasn’t solipsistic like this, and actually got engaged in work, he felt too deficient and vulnerable, and could not bear the pain.

A Case of Manic Rage

As every experienced psychiatrist will testify, the really frightening thing about mania is the booming rage. Whenever I am in charge of the inpatient service, I hope I do not have too many of them sounding down the halls and putting everybody on edge. Even in our back room, we hear their ominous ranting.

One patient came to me on a good dose of lithium, pleasantly enough, wanting help to get through medical school. The picture was very simple. She had very high ideas about correct behavior. When these ideas were refuted, she had a fit. For instance, she believed in fairness. Three times a day something unfair could be counted on to come along and set her off, and set her friends’, professors’, and parents’ teeth on edge.

I saw her about once a month for two years in a long brief psychotherapy. The therapy was long in lasting two years, but brief in its number of sessions (Gustafson 1986). I confined myself to countering her amazement at these impingements of unfairness. For a long time, I saw little effect. She kept reporting more of the same, with more of the same outrage. She did quiet down in each session, and so her response to understanding was benign. (See the final case of this chapter, “The Case of Danny Boy,” for a discussion of mixed malignant and benign basic fault.) Finally, after a year, she began to anticipate at least what I was going to say about her incredulous reports. “Oh, yes, you’re going to say it is really amazing!”

What finally got to her was that two close friends sat her down after one of her rampages and told her they had almost given up on her. This shook her. The following session, she had faced about ten different situations that were unfair, and kept her composure through all of them. I had told her in the previous session that even
if she could not help feeling frantic when these things happened, she would feel less so if she were not surprised, and she might need to take a hike to keep from bursting out, until her adrenal cortex calmed down in an hour. In the next session, she said I was right about everything, except it took her three or four days and not an hour to settle!

**Gustafson’s Thesis**

When I was a medical student, I went to the Royal Edinburgh Hospital to study chronic hallucinating schizophrenics for my thesis (Gustafson 1967). I had about ten such patients, who were willing to keep journals about what the voices told them. One even took dictation from the voices on a typewriter. I found that all of them listened to the voices when their lives had broken down, and the voices comforted them. Later, as they came to rely on the voices, the voices got extremely mean and punishing. Here was the tragic dilemma played out in a hallucinatory world!

For example, one woman had felt terribly alone in the world, and began to hear voices of helpful doctors watching over her. As soon as she trusted them, they began to experiment on her, give her orders, and tamper with her body.

At the beginning of the summer, she was relieved that someone was interested in her world, but by the end of the summer she pulled back from me as if I might become like one of those doctors. All ten of the patients did the same thing. They were dreadfully alone with their hallucinatory worlds, and really quite eager for my company, but they then began to fear my company as if it too would become persecutory.

This becomes the cycle of paranoid schizophrenia. Beset by their voices, they come toward the staff. This is a brief relief, before they fear depending on staff, and pull away to depend on their voices. This solitude becomes harrowing, and they go back toward staff, and so on, in a perpetual circle.

**Beels’s Dilemma**

Twenty-five years later, I read an interview with Chris Beels (1991) that explained the implications of the schizophrenia cycle I had noted, and the tragic dilemma of these patients between being far away or near.
Beels said that schizophrenia was a housing problem. By this he meant that schizophrenics did best in small boardinghouses where they could keep their distance, such as from dinner table conversation, yet there was always somebody up to have some slight company. In short, the patients had a space in which to traverse between far and near as they needed to, every day, as illustrated in Figure 1–2.

**A Case of High Expectations in Schizophrenia**

One patient was brought to me with her husband and little son, because she was getting worse and worse for several years after a psychotic break. The husband was a severe man, who outlined for me her countless household blunders. Some were actually quite dangerous, such as leaving things burning on the stove. The patient was barely audible, and hung her head.

In striking contrast, the boy was full of life, and looked like he was well taken care of. I made much of this, and suggested she

![Figure 1-2. Beels's Housing Dilemma With Schizophrenia.](image-url)
must be a pretty good mother. She replied that she was hardly her old self, and her husband nodded in agreement.

I replied that this was a very dangerous idea she had about full recovery of her old self. She was thinking much too big. That was always very dangerous, and she would have to fail. Nobody ever got anywhere with this unless they did little things. That was the consultation.

About a year later, a woman grasped my hand in the hall and thanked me profoundly. It was she, looking so great that I had not recognized her. This too passed in the subsequent year, because she let her church think she could run the place, which she could not. Then she felt guilty, hung her head, and got back to where I first saw her.

Finally, she had another child, and got so paranoid she would not come out. Her husband asked the resident to come see her, and she did. The resident had learned something from me about the far and near dilemma of these patients. She came only for a half hour. There she found the patient very fearful that she would have her child taken away from her as a bad mother.

The other supervisors of the resident advised her to prescribe more antipsychotics, but the resident was fearful of what was already coming out in the breast milk. I had different advice. I thought she was having the usual postpartum disaster of mothers who lack mothers themselves or the equivalent, and who only get criticism instead. She was unduly isolated, yet feared intrusion, in the tragic dilemma we have discussed in all of these cases. "Oh," said the resident. "Let's have the church grandmother come, she will be welcome."

Of course, any company is dangerous. The trick is to allow some room, yet not too much; always with the understanding that both near and far turn sour. That is the gist of Beels's Dilemma.

Transcending the Terms of the Tragic Dilemma

I have had a few patients transcend the terms of the tragic dilemma in long-term work. All of them had a malignant exterior, which hid a very benign response to understanding. In the language of psychoanalysis (Kohut 1971, Ornstein 1974), there is a vertical or horizontal splitting of the psyche, and the two halves operate very differently. In these cases,
the malignant demands for literal gratification hide the quiet, comforting, trusting, and benign response to understanding that is felt to be too hazardous. The patient appears and acts much worse than he is at the core. He has a kind of antisocial crust, to keep him out of the jaws of trust (Winnicott 1971b).

Tragic Antisocial Cases

The antisocial trend can become so much of a rut that the patient cannot give it up. It has simply gone on too long, and gotten too much of a set of connections in the world, and the possibility of trust just fades into marginal improbability. Trust is not for this world. (See Winnicott’s [1971b] case of Mrs. X, and my discussion of Winnicott with Mrs. X [1986, Chapter 7]. Winnicott barely finds her behind her barrier of a ruined life.) So there are countless antisocial cases—criminal, drug-abusing, alcoholic, prostitutinal—that are tragic in this very same dilemma, because it is too late to get near them. They are all variants on Winnicott’s formula. The child is hurt, trusting. He attempts revenge, to take his own back. Nobody stops him. He keeps on going in his cynical distance. Finally, he becomes unreachable.

The variations that look malignant, but turn out to be benign, go like this: the authorities stop the child; the doctor then can reach behind the crust, to the hurt child. The trusting connection is re-established. I will return to this subject in Chapter 6, because it is one of the chief activities of garden variety family therapy.

False Positives

Before I show how the tragic dilemma is sometimes transcended, I would like to discuss falsely positive situations. Often, the patient wishes to be delivered from a tragic dilemma, but it is impossible. As I say, often, it is contrary to physics.

The Case of the Wizard of Oz, and Semrad’s Comfort

One of my male patients had a wild business career until the age of 35, which ended because he was in several drunken car crashes. Because of his near-death experiences, he was persuaded to go into
the hospital for long-term treatment of his alcoholism. In other words, he hit bottom. He admitted that he was powerless on his own with alcohol, and accepted the Alcoholics Anonymous helping community with God, in the hospital. If far was tragic, near seemed possible.

I saw him ten years later. He was dry, but very depressed. He was barely dragging himself, with low energy, through days working in a bureaucracy. At home, he was so exhausted that he was of almost no help to his wife or his teenage children.

He had flashes of his old expansive genius, which had propelled him in business. Mostly, these took the form of telling war stories from the good old days, of his big investments, which had mostly crashed. He could make this very funny. He would gather energy entertaining this way, which brought light into his face, and force into his gestures. Then, ending a story, he could be seen to fizzle, like the Wizard of Oz shrinking into a little man.

For about three years, I saw him once a month. Every session was the same. He would come in dead, rise to life about two-thirds of the way into the hour, go grey and small, and then go out like ashes once more. I told him he was a miracle, like an Egyptian religion of one, a Phoenix who rose from the ashes, which I witnessed once a month. This went on and on. Eventually, it became clear that he imagined I would get him further. As my old teacher, Semrad, used to say, I was, unwittingly, in collusion with delusion.

In our discussions of his Egyptian religion, he told me that his resurrections were all too fleeting. He was but a Friday Phoenix. Mostly, he was exhausted, frightened by having to race work, and a complete failure at home. He cried. I replied as gently as I could that he had hoped to be much more than this. He said he was absolutely nothing.

I disagreed, pointing out some good reports on him at work. He said it wasn’t really him. I disagreed and told him he had done these things. He said that nobody knew what rotten feelings he had inside. I agreed. The worst was, I submitted, that I was not magic. Now, he wept. Yes, he had hoped I would deliver him. Perhaps, I said, there is a little comfort in bringing out this pain. I was thinking of Semrad, who did precisely this, and this is what relief I can give this man.
False Selves

The trouble with these people is that they have been abandoned and intruded upon unmercifully as children. This man had been sexually and violently abused, and had no defenders. He had gotten a very high idea of himself as an entrepreneur Wizard, like Citizen Kane. It was so extravagant an image (Binswanger 1963) he could not live up to it: hence, the alcohol, and finally the crash. He is little better being dry. He requires extravagant images of himself to counter his meager self-respect, yet he cannot measure up to these claims at all. He is either dispirited, or having a comeback that lasts like a ten-minute flight up into the air. His modest accomplishments feel like a false self to him, while his true self is rotten (Winnicott 1971a, Chap. 2). It is extremely painful, and it is too late, as in tragedy. He is far away, because near is terrible to bear. He let me go there a little with him, like Semrad would do, and Winnicott.

A Case of Danny Boy

I have had a handful of patients who have transcended the tragic dilemma, like a patient I have described at length (Gustafson 1976b). I will just summarize it here, as a striking contrast to the case of the Wizard of Oz, and the reader can refer to the original report for full technical detail of how to conduct a long-term psychotherapy of that very difficult kind. The reader may also refer to Goldberg (1975) for two clear examples of split off well-being behind an external crust of sexual perversion that appears malignant. The eating disorders, anorexia, bulimia, and obesity, and the obsessive-compulsive disorders, need also to be distinguished between malignant and secretly benign. The decisive thing is whether you can reach the pain behind the crust so the patient is comforted (Winnicott 1971a), but it also helps a great deal if the patient has a competence to show his or her abilities in a non-pathological way (Masterson 1988).

On the surface, he was similar to the Wizard in having been terribly let down as a child, in being extravagant in his claims, and in requiring alcohol to keep him up in the air. He too had had a terrible, nearly tragic car crash. His demeanor was very antisocial. He lied,
cheated, sang, and even danced drunk on rooftops. He was also very cynical.

Behind this was a capacity to connect and bloom that had been split off. I reached it most movingly, after he had told me about smashing a leprechaun when drunk:

When I asked him in the next hour about the leprechaun and what it had meant to him, he told me it reminded him of a song he had always loved and which he had listened to before he had gone to the bar that day. The song was "Danny Boy," which he went on to explain was a song about a father saying goodbye to his son, sending him to war. When I asked the patient what the father says to the son, he replied that the father says, "I love you so much," and then the patient began to sob and shake. [Gustafson 1976b, p. 79]

We reached back to his well-being here, long lost. It was a well-being in which he could be simply loved for himself. It was sound, and did not have to make claims, like the Wizard's, that would inevitably collapse.