lost in dialogue
anthropology, psychopathology, and care

GIOVANNI STANGHELLINI
Lost in Dialogue
International Perspectives in Philosophy and Psychiatry
Series editors: Bill (K.W.M.) Fulford, Lisa Bortolotti, Matthew Broome, Katherine Morris, John Z. Sadler, and Giovanni Stanghellini

VOLUMES IN THE SERIES:

Mind, Meaning, and Mental Disorder 2e
Bolton and Hill

What is Mental Disorder?
Bolton

Delusions and Other Irrational Beliefs
Bortolotti

Postpsychiatry
Bracken and Thomas

Philosophy, Psychoanalysis, and the A-Rational Mind
Brakel

Unconscious Knowing and Other Essays in Psycho-Philosophical Analysis
Brakel

Psychiatry as Cognitive Neuroscience
Broome and Bortolotti (eds.)

Free Will and Responsibility: A Guide for Practitioners
Callender

Reconceiving Schizophrenia
Chung, Fulford, and Graham (eds.)

Darwin and Psychiatry
De Block and Adriaens (eds.)

Oxford Handbook of Philosophy and Psychiatry
Fulford, Davies, Gipps, Graham, Sadler, Stanghellini, and Thornton

Nature and Narrative: An Introduction to the New Philosophy of Psychiatry
Fulford, Morris, Sadler, and Stanghellini (eds.)

Oxford Textbook of Philosophy and Psychiatry
Fulford, Thornton, and Graham

The Mind and its Discontents
Gillett

The Abraham Dilemma
Graham

Is evidence-based psychiatry ethical?
Gupta

Thinking Through Dementia
Hughes

Dementia: Mind, Meaning, and the Person
Hughes, Louw, and Sabat (eds.)

Talking Cures and Placebo Effects
Jopling

Vagueness in Psychiatry
Kell, Keuck, and Hauswald

Philosophical Issues in Psychiatry II: Nosology
Kendler and Parnas (eds.)

Philosophical Issues in Psychiatry III: The Nature and Sources of Historical Change
Kendler and Parnas (eds.)

Philosophical Issues in Psychiatry IV: Psychiatric Nosology
Kendler and Parnas (eds.)

Discursive Perspectives in Therapeutic Practice
Lock and Strong (ed.)

Schizophrenia and the Fate of the Self
Lysaker and Lysaker

Embodied Selves and Divided Minds
Maiese

Responsibility and Psychopathy
Malatesti and McMillan

Body, Subjects and Disordered Minds
Matthews

Rationality and Compulsion: Applying action theory to psychiatry
Nordentoft

Diagnostic Dilemmas in Child and Adolescent Psychiatry
Perring and Wells (eds.)

Philosophical Perspectives on Technology and Psychiatry
Phillips (ed.)

The Metaphor of Mental Illness
Pickering

Mapping the Edges and the In-between
Potter

Trauma, Truth, and Reconciliation: Healing Damaged Relationships
Potter (ed.)

The Philosophy of Psychiatry: A Companion
Radden

The Virtuous Psychiatrist
Radden and Sadler

Addiction and Weakness of Will
Radoilska

Autonomy and Mental Disorder
Radoilska (ed.)

Feelings of Being
Ratcliffe

Experiences of Depression: A study in phenomenology
Ratcliffe

Recovery of People with Mental Illness: Philosophical and Related Perspectives
Rudnick (ed.)

Values and Psychiatric Diagnosis
Sadler

The Oxford Handbook of Psychiatric Ethics
Sadler, Van Staden, and Fulford

Disembodied Spirits and Deanimated Bodies: The Psychopathology of Common Sense
Stanghellini

Lost in Dialogue: Anthropology, Psychopathology, and Care
Stanghellini

One Century of Karl Jaspers Psychopathology
Stanghellini and Fuchs

Emotions and Personhood
Stanghellini and Rosfort

Essential Philosophy of Psychiatry
Thornton

Naturalism, Hermeneutics, and Mental Disorder
Varga

The Healing Virtues: Character Ethics in Psychotherapy
Waring

Empirical Ethics in Psychiatry
Widdershoven, McMillan, Hope and Van der Scheer (eds.)

The Sublime Object of Psychiatry: Schizophrenia in Clinical and Cultural Theory
Woods

Alternate Perspectives on Psychiatric Validation: DSM, ICD, RDoC, and Beyond
Zachar, St. Stoyanov, Aragona, and Jablensky (eds.)
Lost in Dialogue
Anthropology, Psychopathology, and Care

Giovanni Stanghellini
Contents

Prologue  1

Part One  Anthropology: What is a human being?
1 We are dialogue  9
2 The primacy of relation  12
3 The life-world of the I–You relation  15
4 The innate ‘You’: the basic package  19
5 The dialogue with alterity: narratives and the dialectic of identity  22
6 A closer look into alterity: eccentricity  28
7 The Uncanny and the secretly familiar double  30
8 Epiphanies of alterity: drive  33
9 Habitus: the emergence of alterity in social situations  36
10 Emotions: the person in between moods and affects  39
11 A closer look at moods and affects: intentionality and temporality  42
12 Emotions and the dialectic of narrative identity  45
13 Alterity and the recoil of one’s actions  48
14 Alterity and the other person: the anatomy of recognition  50
15 The basic need for recognition  53
16 A logic for recognition: heterology  55
17 An anthropology of non-recognition  57

Part Two  Psychopathology: What is a mental disorder?
1 First steps towards the person-centred, dialectical model of mental disorders  65
2 What is a symptom?  68
3 The truth about symptoms  71
4 Symptom as cypher  75
5 Conflicting values: the case with post partum depression 80
6 The body as alterity: the case with gender dysphoria 84
7 The trauma of non-recognition 89
8 Erotomania and idolatrous desire 92
9 Depression and the idealization of common-sense desire 95
10 Borderline existence and the glorification of a thrilled flesh 98
11 Schizophrenia and the disembodiment of desire 101

Part Three  Therapy: What is care?
1 The portrait of the clinician as a globally minded citizen 109
2 The chiasm 114
3 The P.H.D. method 117
4 Empathy and beyond 123
5 Second-order empathy 131
6 Unfolding 139
7 Position-taking 147
8 Responsibility 155
9 Perspective-taking 165
10 What is a story? 168
11 Personal life-history 174
12 Intimacy 179

Epilogue: Dialectic Method and Dialogue 189
References 197
Index 209
The question ‘What is it to be human?’ is at the core of philosophical anthropology. Rationality, language, self-awareness, self-knowledge, and moral sense have been indicated as the distinctive features of being human. In this book, I will build on and develop the assumption that to be human means to be in dialogue. Dialogue is a unitary concept that will guide me in attempting to address in a coherent way three essential issues for clinical practice: ‘What is a human being?’, ‘What is mental pathology?’, and ‘What is care?’. I will argue that to be human means to be in dialogue with alterity, that mental pathology is the outcome of a crisis of one's dialogue with alterity, and that care is a method wherein dialogues take place whose aim is to re-enact interrupted dialogue with alterity within oneself and with the external world.

We are a dialogue—of the person with herself, and with other persons. In brief: we are a dialogue with alterity. We encounter alterity in two main domains of our life: in ourselves, and in the external world. In the first case alterity is in the involuntary dimension of ourselves, our un-chosen 'character', including needs, desires, emotions, and habits. In the external world, alterity is encountered in the challenging otherness of the events and in the meetings with other persons that constellate our life.

Alterity manifests itself when I am at odds with my needs and my desires, or when a discrepancy between my habits and a concrete situation becomes manifest, or finally, when my feeling-states surprisingly disclose my situatedness. Alterity also manifests itself in the course of my action, as every action involves a recoil of unintended meanings and intentions back upon the actor. The consequences of my actions inevitably express something beyond what was intended by me. This throws me, or my self, into question. The question is about the entanglement between selfhood and alterity, the voluntary and the involuntary. And the answer is the story I can tell about myself when confronted with this entanglement. Only after I recognize alterity as an incoercible datum of the involuntary dimension of my existence can I begin to use it in my service.

The encounter with alterity may offer the vantage from which a person can see herself from another, often radically different and new, perspective. Thus, alterity kindles the progressive dialectics of personal identity. Narratives are the
principal means to integrate alterity into autobiographical memory, combining personal experiences into a coherent story related to the self.

Yet, the encounter with alterity is also the origin of mental symptoms. Mental disorder is the interruption of this dialogue through which we strive to build and maintain our personal identity and our position in the world. It is the crisis of the dialogue of the person with the alterity that inhabits her, and with the alterity incarnated in the other persons. Human existence is a yearning for unity and identity. Yet, this attempt is unfulfilled with the encounter with alterity, that is, with all the powers of the involuntary: unwitting drives, uncontrolled passions, and automatic habits leading to unintended actions, as well as needs, desires, impulses, and dreams. And finally, a further source of dissatisfaction is the awareness that the other person can only be approximated, not appropriated, and that our need for reciprocal recognition is an unlimited struggle and a spring of frustration.

The encounter with alterity is also a form of collision between opposite values: private conscience and social customs, desire and reality, one’s values and the others’ values, nature and culture. All this generates feelings of estrangement. Mental pathologies may be read as miscarried attempts to struggle for a sense of reconciliation, to heal the wounds of disunion.

The production of a symptom is the \textit{extrema ratio for} alterity to become discernible. The symptom is the last chance for the person to recognize alterity in herself. Mental symptoms are not simply the direct outcome of some kind of dysfunction or of a ‘broken brain’. A person’s symptom is not generated as such—as it was in the case of Minerva, who sprang fully armed from Jupiter’s head. Rather, it is the outcome of the need for self-interpretation that each person has with respect to her encounter with alterity, that is, with challenging, unusual, or abnormal experiences. The psychopathological configurations which human existence takes on in the clinic are the outcome of a disproportion between the person and her encounter with alterity, and with the disturbing experiences that stem from it. The person is engaged in trying to cope with, solve, and make sense of the basic disturbing experiences stemming from her clash with alterity. Alterity is made manifest as a kind of estrangement from oneself and alienation from one’s social environment. Faced with new, puzzling experiences the person tries to make sense of them. The attempt to achieve a self-interpretation of her perplexing experiences characterizes the person’s attitude, alongside a comprehending appropriation, that is, the constant search for personal meaning.

We live out a traumatic existence, stained by the tragic experience of our failed encounter with the Other. Trauma is not merely an accident that took place in a remote past, an episode in our life that cannot be appropriated in
our narrative identity and remains without a semantic inscription, relegated in our dynamic unconscious. Trauma is part and piece of everyday existence, an experience we live by that is one with our need and desire to establish relationships. The kind of teleology at play in human relationships is the desire for reciprocal recognition. Our existence is inescapably You-oriented and as such is conditioned by the spiritual value of recognition, alongside the organic values of my biological life (hunger, sex, etc.). Yet the need for recognition can even be stronger than other needs rooted in our organic values. Recognition is a task, rather than an automatism. It is a kind of emotional and intellectual readiness to acknowledge the reasons of the other person. Recognition is set within an experience of relatedness or ‘We-experience’ in which I am aware of the Other’s emotional distress and I try to attune with it. We desire to be recognized by the Other to such a degree that our being-so is acknowledged by the Other as a value in itself. Our deepest need and desire is to be loved as we are, notwithstanding our limitations, weaknesses, faults, and culpabilities.

This book is an attempt to re-establish such a fragile dialogue of the soul with herself and with others. Such an attempt is based on two pillars: a dialectic, person-centred understanding of mental disorders, and values-based practice. Building on and extending these two approaches, it aims to improve therapeutic practice in mental health care.

The dialectic understanding of mental disorders acknowledges the vulnerability constitutive of human personhood. It assumes that the person is engaged in trying to cope with, solve, and make sense of new, disturbing, puzzling experiences stemming from her encounter with alterity. Each patient, urged by the drive for the intelligible unity of her life-construction, with her unique strengths and resources, plays an active role in interacting with these experiences and thus in shaping her symptoms, as well as the course and outcomes of her illness.

Conflicts of values go with being human, in society as well as in the soul. The forms of human life are inherently plural. In values-based practice, value-pluralism and recognition are the basis for clinical practice. This statement reflects the ideal of modus vivendi that aims to find terms in which different forms of life can coexist, and learn how to live with irreconcilable value conflicts, rather than striving for consensus or agreement.

Therapy is a dialogue with a method—or better a method wherein dialogues take place whose aim is to re-enact interrupted dialogue with alterity within oneself and with the external world. The method at issue includes devices and practices that belong both to logos—e.g. the method for unfolding the Other’s life-world and to rescue its fundamental structure—and pathos—e.g. the readiness to offer oneself as a dialoguing person, and the capacity to resonate with the Other’s experience and attune/regulate the emotional field. These
two complementary sides of therapeutic dialogue are called ‘logocentric’ and ‘anthropocentric’, respectively. Whereas the first is the search for the precise description of a given phenomenon of experience and a mutual understanding about it, the second consists in a shared commitment to transcend the space between each other. This dimension of the therapeutic dialogue is an act: the sharing of an intention whose transcendental referent is not a fact, but the relationship itself.

As citizens who are trained to confront human vulnerability, the evidence of our animality and fragile rationality, the anxieties for our mortality, the dilemmas of autonomy and authority, and the conflicts of inclusion and exclusion, and in general with the encounter with Otherness that characterizes human life, we as clinicians need to develop special virtues. As ‘ideal citizens’ we should have the capacity to conceive of what it might be like to be in the shoes of a person different from oneself, to be an intelligent reader of that person’s story, and to understand the emotions, wishes, and desires that someone so placed might have. Also, we should possess the ability to have concern for the lives of others, to imagine a variety of complex issues affecting the story of a human life as it unfolds, and to understand human stories not just as aggregate data. This epitome of the human being should be able to see other persons, especially marginalized people, as fellows with equal rights and look at them with respect.

This is an overly optimistic portrait of ‘real’ clinicians, who are obviously not so virtuous as reported above. Yet, this is an ideal educational goal, and as such it is suggested that it should be taken as a challenge to current educational curricula. On one side, there are those who radicalize the view that mental health professionals must be(come) members of the biomedical community, and thus should refine their scientific knowledge (chiefly in the field of the neurosciences) and technical skills. On the opposite side, there are those who reject the former view and embrace the party of psychiatry as a ‘human discipline’. This controversy, as it is clear, is abstract and sterile. All clinicians know very well that both kinds of knowledge are needed to practise (and sometimes to survive) in mental health care. Taking for granted that practitioners need a thorough scientific education, the question is what kind of humanistic learning is needed, and why. The concept of Bildung makes a good starting point. Bildung approximately means cultivation or formation—rather than education restrictively understood as skill training—that cannot be achieved by any merely technical means. It is a process of ‘forming’ one’s self in accordance with an ideal image of what it is to be human. Cultivating one’s self is a complement—a necessary balance—to acquiring skills, as Bildung provides the indispensable ground for technical skills to be developed and put to use in a proper way. Bildung implies participation rather than indoctrination, and questions rather than assertions.
It is a process of appropriation through which what is formed becomes completely one's own because through it, rather than acquiring a capacity, one gains a self-understanding, a sense of where one stands in relation to the world.

There are two general characteristics of Bildung. The first is keeping oneself open to what is other. This embraces a sense of proportion and distance in relation to oneself. The second is that it contributes to developing a sense, rather than acquiring an explicit, cognitive knowledge. An example of this is tact—not a piece of knowledge, but rather a kind of sensitivity, namely the sensitivity to what is appropriate in dealing with others, for which knowledge from general principles does not suffice. Tact touches upon the very origin of the moral law, as it is a form of connection released from an instrumental relationship. It expresses a kind of contact that is not that of possession—physical (e.g. to take hold of the Other in order to force him to do something) or intellectual (e.g. to grasp the significance of the Other’s behaviour). Rather, it is a kind of grace, an implicit promise, and the capacity to wait until the moment is ripe for making explicit what I sensed. Without tact, the other person is stripped of his possibility to signify his uniqueness. Lack of tact is at the basis of any politics of exclusion. Tact as the capacity to feel the atmospheric, to attune with it, not to intrude into the Other’s sphere, to avoid instrumental relationships, and to let the Other manifest his uniqueness is an essential quality of the clinician.

Campolungo, in front of Fiesole
August 2016
Part One

Anthropology: what is a human being?

Man has experienced much,
Many Heavenly he has named,
Since we are a dialogue
and we can listen to one another

(Friedrich Hölderlin, Conciliator, you who never believed..., 1984)
To Hölderlin we are human because we can dialogue. Hölderlin’s ditto condenses five essential aspects of being in dialogue: experience, the Heavenly, naming, history, and listening.

Dialogue is a kind of ‘experience’: it is not merely a verbal exchange, an exchange of information; rather, dialogue *lets something happen*. What emerges in dialogue is neither mine nor yours and hence transcends the interlocutors’ subjective opinions. Dialogue moves in unpredictable directions to experience something that is new for both interlocutors. Something unexpected comes about in dialogue.

This is the case with what Hölderlin calls ‘the Heavenly’. If we engage in dialogue, we stand in the presence of alterity, including other persons, things in the world, and even the radical alterity personified by gods. The Heavenly here is the hyperbolic personification of what is other from oneself. Alterity claims us. We can ignore it, refuse to listen to its challenges, insist on a limited set of habits, and remain identical to ourselves. Or we can engage in confronting ourselves with alterity and take the route of becoming.

In dialogue we ‘name’ alterity, we use words to address it. Yet, this is not mere designation. Dialogue is the very opposite of monadic language, as it takes place in a public space and is a confrontation with alterity rather than its labelling. In dialogue, we inhabit alterity. We as human beings are grounded in language. Yet, there are two ways that we use language. Whereas when we use language to designate something we take distance from it, in dialogue we *let ourselves be touched by alterity*.

Dialogue implies ‘listening’. As suggested by Heidegger (1971), in dialogue the Heavenly call us and we respond. Dialogue is based on the possibility to listen to each other. Being able to listen is the presupposition of speaking. Listening is the original phenomenon, answering comes after; it is a consequence of attending to the other’s speech. Language is the means through which we exist. Yet, here with ‘language’ we do not mean merely a set of words or rules to be used appropriately by an isolated individual. Between language and dialogue there is the same relation that occurs between knowledge and practice. Practice (as Gadamer reminded the assembled psychiatrists of the United States in their
annual convention in 1989) is more than merely the application of knowledge. Language happens authentically only in dialogue. Dialogue is the essential happening of language, since through dialogue we use language to encounter alterity and to let the unexpected happen.

All this can occur ‘since,’ that is, from the time we became a dialogue. To be in dialogue is to have lost a sense of self-unity—that sense that only belongs to gods. Since the time we realized that we are human, we realized that we are inhabited by alterity. Dialogue is what situates us in a world inhabited by alterity. To be in dialogue overcomes a-historical time, that is, a time without becoming. To be a dialogue and to be historically belong to each other. Being in dialogue with alterity is the root of becoming. It is to have lost the sense of self-sameness—another feature that only belongs to gods. Also, to be in dialogue with alterity overcomes being immersed in mere now-moments or in “torrential time” (Heidegger, 1971). Dialogue paves the way to a third-time, the time of narration, the time of being human.

Are Hölderlin’s lines enough to persuade us that the ground of human existence is dialogue and that from this, human existence receives its significance and foundation? I do not think so. In the following I intend to offer something more substantial. I will attempt to substantiate this claim with the help of more prosaic arguments taken from philosophy as well as evidence from developmental psychology and the neurosciences. But let me first try, for the sake of clarity, to preliminarily address one basic question that will be fully answered in the course of this book: ‘What is a dialogue?’

Dialogue is so ubiquitous in philosophy that perhaps the highest philosophical principle consists in holding oneself open to the dialogue. Gadamer (1996) is obviously one of the philosophers who made the greatest contribution to establishing a philosophy of dialogue through his understanding of hermeneutics as a kind of dialogue between the reader and the text. The theory of dialogue, according to Gadamer, informs phenomenology—“in the exchange of words, the thing meant becomes more and more present” (Hahn, 1997, p. 22); philosophy of mind—“thinking is the dialogue of the soul with itself” (Gadamer, 1996, p. 167); philosophy of language—“language has its true reality in dialogue” (Hahn, 1997, p. 274); philosophical anthropology—(quoting Hölderlin) “dialogue is what we are” (Gadamer, 1996, p. 166); history of philosophy—the “hermeneutical reorientation of dialectic (which had been developed by German Idealism as the speculative method) toward the art of living dialogue . . . represented a correction of the ideal of method” (Gadamer, 1980, p. 23); and, naturally, the philosophy of interpretation—“tradition is a genuine partner in dialogue, and we belong to it, as does the I with the Thou” (Gadamer, 1989, p. 358).
Some preliminary remarks are needed to delimitate the concept of ‘dialogue’.

Dialogue is not conversation, as what happens in everyday informal exchanges, or mere idle chat. Whereas idle chat confirms and strengthens common sense assumptions, dialogue provides the conditions for the emergence of a new understanding from a manifold of voices. Whatever understanding really is, many things can be said of dialogue that are equally appropriate to understanding. One of them is incompleteness, and genuine dialogue—as it is the case with Socratic dialogues—is often aporetic, that is, characterized by lack of completeness and structure.

Dialogue is not merely an exchange of pre- given information about something. Rather, something unexpected comes about in dialogue. Dialogue is driven by the subject matter to reveal something new about the subject matter itself to the interlocutors. It functions like Husserl’s phenomenological reduction: in the genuine dialogue, the participants’ initial assumptions are challenged and become evident and thus they can be scrutinized, challenged, and modified. Thus, dialogue is the means by which it becomes possible for the person to become aware of her own prejudices and for things to show themselves. It is likewise in the experience of art that in dialogue subjectivity is displaced (Gadamer, 1989). One enters into dialogue, but one does not control the progression of the dialogue. Dialogue forces the participants at a certain point to be taken by surprise and finally to see things in a new light.

Also, genuine dialogue is not simply a discussion about a subject matter that is external to the interlocutors. Rather, it is a genuinely social act. At a given moment the interlocutors themselves become the subject matter. In dialogue not only is something new about the subject matter of the dialogue revealed, but also something about the interlocutors themselves.
Chapter 2

The primacy of relation

Buber is perhaps the one who most impacted recent philosophy of dialogue in the sphere of the ‘I–You’ relation. In the *I and Thou* (1958), Buber’s main thesis may be summed up as follows: There is no ‘I’ taken in itself. The ‘I’ of the ‘I–You’ combination is different from the ‘I’ of the ‘I–It’ combination. When a person says ‘I’ he refers to one or other of these.

There is a radical difference between a person’s attitude to another person and her attitude to things. In the personal relation an ‘I’ confronts a ‘You’. In the connexion with things an ‘I’ connects with an ‘It’. These two attitudes constitute respectively the world of the ‘You’ and the world of ‘It’. The ‘You’ cannot be appropriated. So long as the ‘I’ remains in the relationship with the ‘You’ it cannot be reduced to an experienced object—an ‘It’.

In more recent times, we speak of ‘third-person’ (I–It) and ‘second-person’ (I–You) relations. What distinguishes these two modes is not the object per se. We can relate to an object (say, the Moon) as to a ‘You’ (as for instance children and poets do), or to a person as to a thing. What changes is our attitude, not the object. This change of attitude may occur across time, as in one moment we may address a person as a ‘You’ (for instance, in the ‘openness’ of the therapeutic interview) or as an ‘It’ (for instance, in the course of an assessment interview).

Buber’s *I and Thou* (1958) paves the way to a radical philosophy of dialogue imbued with mysticism. His opinions are not immune from criticism. I will not engage in evaluating and censoring Buber’s views, although some points are divergent from my own. Rather, I will focus on two main issues that contribute to the development of my argument.

First, Buber’s understanding of the ‘I’ as originally and ontologically relational is the precursor of the ‘second-person’ approach to intersubjectivity. As such, it paves the way to a deeper understanding of the phylogenetic and ontogenetic history of human subjectivity that will be developed in the next chapters.

Second, Buber’s description of the ‘I–You world’ can be expanded in such a way as to capture the ontological implications of establishing an ‘I–You’ relation in the therapeutic setting. Treating the Other as a ‘You’ is not simply instrumental to establishing a better kind of relation in ethical or epistemological terms. Rather, it may generate a profound transformation of the basic structures of the life-world in which both the ‘I’ (the therapist) and the ‘You’ (the patient) live.
“In the beginning is relation” (Buber, 1958, p. 18). Buber supports his thesis of the relational character of the ‘I’ by arguing that this character of human existence was even more pronounced in the primitive life. The ‘I–You’ relation, he argues, precedes the ‘I–It’ relation in the primitive human and the child. “In the actual development of the human person, entering into relation precedes the thickening of distance that obstructs relation” (Friedman, 2002, pp. 82–3). Buber suggests that we consider the speech of primitive people, “whose life is built up within a narrow circle of acts highly charged with presentness. The nuclei of this speech, words in the form of sentences and original pre-grammatical structures (which later, splitting asunder, give rise to the many various kinds of words)—he argues—mostly indicate the wholeness of a relation” (Buber, 1958). The spirit of what he calls the “natural man” is awakened by impressions and emotions that arise from incidents and in situations that are relational. The elementary impressions and emotional stirrings that awaken the spirit of the natural man proceed from incidents—experience of being confronted with—and from situations—life with a being confronting him—that are relational in character (ibid.). Buber mentions Mana, Orenda, and the whole Pantheon of momentary gods as characteristic of the most primitive stage of mythical thinking. Gods do not arise out of inherited tradition, writes Buber, but out of the fusion of a number of “moment Gods” that are the personifications of those decisive, surprising, or threatening situations in which the primitive human encounters Otherness. Language grew out of mythical thinking. Usener (1896) explains that the spiritual excitement and impression that arose from the meeting with a significant event is experienced as a momentary god (Augenblicksgott) and originates a name. Events of special importance were divinized. All the names of gods were initially names for special actions or momentary events. At a later stage, special gods (Sondergotter) were created and nominated for situations or activities that were deemed particularly important (Cassirer, 1946, p. 75).

These momentary deities are something purely instantaneous, a fleeting, emerging and vanishing mental content. Every impression that man receives, every wish that stirs in him, every hope that lures him, every danger that threatens him can affect him thus religiously (Buber, 1958). Momentary gods stand in stark uniqueness and singleness; they exist only here and now, in one indivisible moment of experience. In Buber’s terms, they only exist within the I–You relation. Only at a later stage, and on a somewhat higher plane than these momentary daemons, which come and go, appearing and dissolving like the subjective emotions from which they arise, we find a new series of divinities. These new divinities are called by Usener “special gods” (Sondergotter). Within their respective spheres these divinities have attained a permanent and definite character, and therewith a certain generality. The relation toward the outer
world changes proportionately from a passive to an active attitude. Man ceases to be a mere shuttlecock at the mercy of outward impressions and influences (Buber, 1958). These gods become permanent, as they get a name that does not evaporate with them.

Agamben (2010) highlights the sacred character of language in this context. In it, the distance and inadequacy that separate the signifier (word) from the signified (thing or event) tend to vanish. A word is generated by an event. A name is an emergent phenomenon, as words emerge from worldly situations. Here a word that names an event is directly connected to it and fully corresponds to it. Agamben may speak of the ‘sacrament of language,’ since pronouncing a name here has the value of an oath that bonds the speaking person with the event itself and with other persons. Names acquire a performative character. Extending Agamben’s argument, we say that the I–You relation connects the two partners through names in a kind of promise, a sacred bond. In the I–You relation, names may acquire a sacred and bonding character.
Chapter 3

The life-world of the I–You relation

Does this suffice as an evolutionary foundation of the dialogic principle? “In the beginning is relation—as category of being, readiness, grasping form, mould for the soul; it is the a priori of relation, the inborn Thou” (Buber, 1958, p. 27). Events, namely significant events, are encountered as I–You meetings, rather than as Its that one observes from without. This relation has the temporal character of presentness. Some of these ‘present moments’ are so charged with meaning that they emerge as momentary, living gods. These meetings with ‘momentary gods’ generate names. These names are not simply attributes for the god that are imposed to it from without, but are one with the god itself.

Only at a later stage, language breaks up the ‘I–You’ relation and creates an ‘I–It’ experience: “There is a tree.” “The primary word I–It, the word of separation, has been spoken” (ibid., p. 23). Language grows out of a more primitive stage of human development in which words are used to indicate phenomena that are relational in nature. In this stage, the primitive ‘You’ precedes the consciousness of individual separateness. We will come back to this in the chapter entitled ‘The innate You’.

To sum up: establishing an I–You relation in the context of care may generate a profound transformation of the basic structures of the life-world shared by the therapist and the patient, since the ‘I–You’ relation radically affects the structures of subjectivity of the two partners. A transformation of selfhood (directedness), agency (reciprocity), spatiality (in-betweenness), temporality (presentness), and language (sacredness/bonding) is involved.

Yet, Buber’s reconstruction of the origins of the ‘I–You’ relation must not be confused with a naïf nostalgia of Paradise Lost in which the ‘I’ and the ‘You’ are fused together by the primordial force of Nature. The ‘inborn Thou’ in primitives and children is not an ideal condition to be regained through an inane categorical imperative or moral ideal to adhere to a symbiotic, pre-linguistic stage considered as the origin and the fulfilment of human existence. The primitive ‘We’ precedes true individuality. The structure of ‘modern’ selfhood would make of the effort to re-join this type of we-ness a catastrophic route to mental
pathology. Buber’s dialogic principle indicates the route to an ideal we-ness that proceeds from the awareness of individual separateness and tries to reconcile it with the basic reality and value of the ‘I–You’ relation, given the vital necessity for a restructuring of the broken ‘We’. This can only be done by establishing relations between men, who are separate and live in a society that encourages isolation, of a more genuinely dialogical nature. Through this ‘We’ can man escape from the “impersonal one of the nameless, faceless crowd. A man is truly saved from the ‘one’ not by separation but only by being bound up in genuine communion” (Friedman, 2002, pp. 208–9).

The ‘I–You’ relation is not simply a special kind of epistemological status of the ‘I’ when it is confronted with an ‘object’, or merely a way to cognitively relate to it. The ‘I–You’ relation radically affects the ontological status of both the ‘I’ and the ‘You’, deeply modifying the structures of subjectivity of the two partners. The ‘I–You’ relation originates a special kind of life-world, different from the one originated by the ‘I–It’ relation. Buber speaks of the ‘primary World’ of the ‘I–You’ relation and by this he means that the way one is related to the Other creates the World they are both going to live by. The life-world in which the ‘I–You’ relation takes place has specific ontological features that need to be analysed.

First of all, the relation to the ‘You’ is direct. Buber claims that no system of ideas, no foreknowledge, no fancy, no aim, no lust, and no anticipation must be involved. A radical epoché must be performed for the ‘I–You’ relation to happen. It is a kind of mystical encounter during which memory and desire are transformed. Desire “plunges out of its dream into the appearance” (Buber, 1958, pp. 11–12). A profound transformation of selfhood is thus involved, as no screens or filters are allowed. “Only when all these means have collapsed does the meeting come about” (ibid., p. 12). The very development of the Self is dependent on the ‘I–You’ relation as “I become through my relation to the Thou; as I become I, I say Thou” (ibid., p. 11).

A transformation of agency is also involved. The ‘I–You’ relation is mutual. Both parts are at the same time affected and affecting, passive and active. “The [‘I–You’] relation means to be chosen and choosing, suffering and action in one” (ibid., p. 11). “Concentration and fusion into the whole being can never take place through my agency, nor can it ever take place without me” (ibid., p. 11). In the ‘I–You’ relation subjectivity is displaced: one cannot control the development of the dialogue. What happens when one engages in the ‘I–You’ relation is irreducible to one person’s activity.

experiences has no part in the world. For it is ‘in him’ and not between him and the world that the experience arises” (ibid., p. 4). The ‘I–You’ meeting involves a metamorphosis of spatiality, as it takes place in-between the ‘I’ and the ‘You’. The ‘I’ does not incorporate the ‘You’, but meets the ‘You’ in an intermediate, public, and common space. Between—writes Buber—is not an auxiliary construction, but the real place and bearer of what happens between men; it has received no specific attention because, in distinction from the individual soul and its context, it does not exhibit a smooth continuity, but is ever and again re-constituted in accordance with men’s meetings with one another (Buber, 1947).

Temporality is also deeply affected. In the ‘I–You’ relation, Buber writes, situations do not always follow one another in clear succession, but often there is a happening profoundly twofold, confusedly entangled (Buber, 1958). The merging of the ‘I’ and the ‘You’ takes place in a special kind of temporality, as the ‘I–You’ relation is immediate. The temporality of the primary ‘I–You’ world is the present moment, the time of actual presentness, meeting, and relation (ibid.). In the ‘I–You’ relation, depths and intensity give breadth and extension to the relation itself. This present here is not fugitive and transient, but a real, filled present (ibid.). True beings—writes Buber—are lived in the present, the life of objects is in the past (ibid.). Quite a different temporality as compared to instantaneousness, in which the ‘I’ experiences and ‘uses’ the other as an ‘It’. In the ‘I–You’ relation what counts is not duration itself, but cessation and suspension (ibid.) that creates the wholeness of a relation charged with the quasi-eternal character of presentness. The concept of ‘present moment’ was fully developed some 50 years later by Daniel Stern (2004). These fleeting and intensive momentary experiences not formatted in language are intrinsically shareable with others since they relate to an innate primary system of motivation.

To sum up: the way I relate to the Other affects my way of being a Self. Buber quite convincingly shows that the relation affects the ontological status of the ‘I’. But what about the ontological status of the Other? It is reasonable to think that this may happen, at least, when both partners agree to engage in an ‘I–You’ relation. Obviously, the fact that I talk to the moon does not make the moon change its ontological status and turn into an ‘I’. The moon turns into a person for me, not in itself. Can relating to a person (say, a patient) as a ‘You’ affect her ontological status, that is, the structures of her subjectivity? Can this happen if the patient is reluctant, or incapable, of engaging in an ‘I–You’ relation? In short, does my attitude towards the ‘You’ affect the ‘You’? Buber writes that “[m]y Thou affects me, as I affect it” (Buber, 1958, p. 15). The mode I relate—he argues—includes an effect on what confronts me (ibid.). Do we have evidence for that? What happens, then, if this occurs? How does my relation to the Other affect the way she experiences herself?
These are obviously crucial questions for psychotherapy. Remember that, in order to achieve a sound foundation for psychotherapy we need three basic elements: a theory about how the human person is constituted; a theory about the way the person breaks down in mental pathology; and finally, a theory about the way care may positively affect the destiny of a broken person. Buber’s philosophy is clearly a contribution to the third issue: let’s call this the *primacy of relation*.
Chapter 4

The innate ‘You’: the basic package

There is strikingly copious and converging evidence that attests to the intrinsic relational nature of human beings—the news is that such relational nature also transpires at the neural, subpersonal level (Ammaniti and Gallese, 2014). Nature has designed our brain to directly recognize that other people are special kinds of ‘objects’, that is, persons like ourselves capable of sharing mental states, of directly intuiting the others’ intentions by watching their goal-directed actions, and of seeking out the others’ experiences so that we can resonate with them (Stern, 2004). There is evidence for such an intersubjective matrix coming from the neurosciences, developmental psychology, and psychopathology.

The ‘You’ could be initially viewed as the crystallization of the outcome of the appetitive motivational (or seeking) system (Panksepp, 1998a, 1998b; Solms and Panksepp, 2012) coupled with a relational programmed motor system (Gallese, 2000; Rizzolatti and Gallese, 1997; Rizzolatti and Sinigaglia, 2007, 2010). This basic package (Ammaniti and Gallese, 2014) is effective in the development of the primary matrix of intersubjectivity, that is, in establishing attachment bonds, in the constitution of the Other as an alter-Ego (i.e. in experiencing him as another person like myself), and in the feeling of growing up in a shared world of emotions and sensations. All these are necessary prerequisites for survival and for mental health.

Intersubjectivity is an innate, primary system of motivation that organizes human behaviour towards valued goals felt as need and desire by human beings. There are two such valued goals for the intersubjectivity motivational system: the first is the need to read the feelings and intentions of another; the second is the need to establish or re-establish self-cohesion and self-identity (Stern, 2004, p. 105). We need orientation in the intersubjective field, that is, we need to know where we are situated and what the others are going to do. When we are intersubjectively dis-orientated a special kind of basic anxiety arises, namely “intersubjective anxiety” (ibid., p. 106). The second felt need is that for the Other’s regard: the other’s look is constitutive of our selfhood and personhood. We need a ‘You’ who looks at us to form and maintain our basic self and personal identity. We need the recognition of a ‘You’ to become and remain an ‘I’.
Perhaps it is not possible to conceive oneself as a human Self without rooting such appraisal in an early developmental stage in which sharing prevails over isolation. Mother and infant create a pre-verbal communication context that forges a dynamic system based on an affective lexicon. In this context, Self and Other appear to be intertwined because of the intercorporeality linking them.

“We live our life from the beginning with the other (...) we literally inhabit the body of the other, our mother” (ibid., p. 1). Evolutionary psychology shows how human mothers learnt to care for immature and helpless infants by becoming attuned to their affective expressions, and that infants who are more attuned to caregivers have a better chance of surviving. Mother and infant are intrinsically motivated to be attracted to and seek contact with one another, and human beings are born as social persons who “constantly seek other persons in order to engage in reciprocal imitation and in mutual emotional regulation” (Ammaniti and Gallese, 2014, p. 141; see Trevarthen, 2009). At birth, humans already engage in interpersonal mimetic relations, by means of neonatal imitation. Neonates are innately prepared to link to their caregivers through imitation and affective attunement. This is the intersubjective matrix from which human life arises. This matrix is non-symbolic, non-verbal, procedural, non-propositional and not reflectively conscious (Ammaniti and Gallese, 2014; see Stern, 2004). It has a “protoconversational turn-taking structure” (Stern, 2004, p. 21).

Selection processes favour individuals with a particular competence in grasping others’ intentions. Mother–infant interaction research has shown that mother and infant create a pre-verbal communication context based on affective attunement. This implicit code—that develops hand in hand with a basic sense of self—is affective and pre-reflective. Embodied simulation, challenging purely mentalistic views on intersubjectivity, provides a neurobiological account based on intercorporeality and affective communication. The capacity to understand the others’ actions relies on mechanisms that exploit the intrinsic organization of our motor system. Humans reuse their own non-propositional engrams encoded in bodily format in their brain to functionally attribute intentions to others while observing their intentional behaviours as if one were performing a similar behaviour or experiencing a similar emotion.

Recent investigation on the neural bases of the human capacity to be attuned to others is ecologically plausible, as it includes real persons’ narratives and not merely lab experiments. Mainstream approaches to social cognition (e.g. Theory of Mind) are framed within a ‘detached observer’ paradigm that presupposes the role of an inner representation of the other’s behaviour in order to make sense of it. The ‘attunement’ paradigm presupposes interaction. The requisite for understanding others, and for intersubjectivity in general, is an experience of concern—engagement and interest, rather than a merely spectatorial
attitude—and of *reciprocity*—the mutual regulation of affects, that is, the mutuality between being moved by others and moving others. Attunement between my own body and the other’s body (and especially my own emotions and the emotions of other people) provides the basis for intersubjectivity. Attunement is a pre-reflective, pre-verbal, and tacit bridge linking the emotional lives of other persons with my own. My understanding of the actions of other people is rooted in my capacity to resonate with another person’s emotions. We don’t need to furnish others’ behaviours with meanings; rather they are intrinsically meaningful. No introspection or explicit simulation is needed. Rather, interaffectivity and intercorporeality are playing a role here. What is implied is a circular process of resonance and mutual influence that is at the basis of participatory sense-making (De Jaegher and Di Paolo, 2007).

To understand others is to know how to deal and interact with them. Attunement creates dyadic emotional states that bring about implicit relational knowing (Lyons-Ruth, 1999; Stern et al., 1998) or body-with-body micropractices.

This paradigm explicitly builds on Buber’s ideas. A very stimulating aspect of Buber’s book lays in the suggestion that the I–You relation is primal to the I–It, since the latter presupposes the existence of an I. According to Buber, the full-blown I only emerges once one perceives oneself as a You, when interpersonal dialogue turns into self-centered inner dialogue. They suggest that we should abandon the Cartesian view of the primacy of the Ego and adopt a perspective emphasizing that the Other is co-originally given as the Self.

What is really new about this research is that it studies the developmental and neurobiological underpinnings of intersubjectivity without eliminating the experiential dimension of social behaviours. It looks at intersubjectivity from a phenomenological angle. It delves into ‘what it is like’ to be with another person. It strives not to describe intersubjectivity from a declarative, metarepresentational, third-person perspective, as is the case with mainstream approaches to social cognition. In this perspective, the other person appears in a quite different light than that of a ‘mentalizing monad’ or a disembodied representational system; the Other ‘becomes a bodily self, like us.’
Chapter 5

The dialogue with alterity: narratives and the dialectic of identity

The connection with the ‘You’, the openness to it, and the capacity to dialogue with it are necessary for establishing and maintaining selfhood and personhood. A preliminary clarification of the meanings of ‘selfhood’ and ‘personhood’ is needed.

The phenomenological notion of selfhood serves to explore the fact that we live our conscious life in the first-person perspective, as an embodied, self-present, single, temporally persistent, and demarcated being, who is the subject of his perceptions, feelings, thoughts, volitions, and actions. This basic form of self-experience is implicitly, pre-reflexively, and non-observationally manifest.

The notion of personhood is markedly more comprehensive than the notion of selfhood. ‘Personhood’ helps to clarify the ways pre-reflective self-awareness is structured as an embodied and situated experience inextricably entangled with an experience of a basic otherness. Hermeneutical phenomenology explores how the person reflectively relates herself to, and tries to make sense of, this basic experiential fact that she is a self whose self-awareness is constantly challenged by that which is not herself. I experience myself as more than my sense of being a self. The feelings of otherness at the core of my self-awareness make my sense of identity fragile, prompting questions about who and what (ontologically) I actually am, and how I should cope with this intimate sense of otherness (normatively).

The ‘You’ may take several forms in human life that are essential for personal identity and becoming. Let’s for the moment collectively call alterity these forms of the ‘You’. Our identity as a human person is a narrative identity that stems from the dialectics between what we are and the alterity that we encounter in our life. In this chapter, I will try to introduce the concept of ‘narrative identity’ as one basic form of dialogue with alterity. In the next chapters I will try to elucidate the concept of ‘alterity’. Ricoeur (1992) calls the dialogical process through which human existence develops the dialectic of sedimentation and innovation. Mental health is the equilibrate dialectic and proportion between
sedimentation and innovation, that is, between the alterity that comes manifest through the encounter with one’s un-chosen, ‘involuntary’ disposition or with an event, and the capacity of the person to cope with, modulate, appropriate and make sense of them. First and foremost, this dialectic progresses silently and implicitly. Some other times, it becomes explicit and progresses in a reflexive form. Narrative identity can contribute to the unfolding of this dialectic. Its task is to balance, on one side, the immutable traits which this identity owes to the anchoring of the history of a life in a character [l’ancrage de l’histoire d’une vie dans un caractère] and, on the other, those traits which tend to separate the identity of the self from the sameness of character. (ibid., p. 123)

Narratives help unfold the dynamics of our identity in that they are able to articulate the reasons for our character and dispositions, as well as the meanings of the events that we encounter in our life. The narrative defies, so to speak, the immutability of the character and the traumatic potential of the event, because it makes the otherwise inalterable part of our personhood (the same or Idem) and the alterity contained in the event a dynamic (thus ‘healthy’) part of our personal history.

The concept of narrative identity is first introduced in relation to the temporal character of human existence. Temporality is critical for the question about personal identity. We cannot ask about the identity of the person without dealing with the temporal dimension of human existence (ibid., pp. 113–14). Unlike what it is the case for an object—say, this book—whose identity relies on remaining the same over time (idem identity), the identity of a person is a dynamic process that both implies sameness and change. For instance, your identity as the reader of this book will (hopefully) slightly change while confronting with it. It would not make sense to read this book if not for gaining some new ideas that may affect your professional or personal identity. A person changes over time, gains new insights about herself, transforms and loses old ones, and yet she may also be said to remain the same person. Still, it is problematic simply to assert that the person remains the same person over time, since personhood is not something static or certain, but a conflict approached in terms of an intrinsic process of appropriation and affirmation (or restoration) of the self (Stanghellini and Rosfort, 2013a).

Experiencing oneself as a person involves more than a sense of self-sameness. Ricoeur introduces the notion of narrative identity in order to cope with the problematic temporal character of human identity in the sense that the notion integrates the apparent polarity in the identity of the person, between persistence and diversity over time. The concept of narrative identity is part of the hermeneutic approach to this conflict inherent in human subjectivity. The
A hermeneutic answer to the question ‘Who am I?’ understands human existence as the dialogue between a person and alterity—that is, of a Self and what is Other-from-Self. The person engages with alterity by means of symbolic mediations: the person continuously tries to come to an understanding of what affects it (alterity).

The identity of a person cannot be reduced to what happens to the person over time, to the way events in time work on the self (cosmological time), but must necessarily include how the person herself acts on her being affected by these events that happen in time (lived time). The problem of persistence and diversity, i.e. whether the person remains identical to itself through the diversity of different temporal states or simply disintegrates into a mere flow of different ‘nows’ with nothing but a contingent connection, is mitigated when we approach the identity of a person as “refigured by the reflective application of narrative configurations” (Ricoeur, 1988, p. 246 [Translation slightly modified]).

Personhood makes evident the problem of identity over time. We are the same person throughout our life, but the sameness of our identity as a person is continuously challenged by the changes that all persons undergo over time. To be a person may be a fact, but it is also a task. We experience ourselves not merely as selves, but as persons who are both a unique person and an anonymous organism. Human beings constantly question their being the peculiar beings that they are. To be human has an unavoidable interpretive character. A person is what we are (e.g. our past), but also how we make sense of what we are through the stories we tell about ourselves, and who we want to become (our project). To be a person is to strive for an identity that is constantly challenged by biological and historical factors. How can we talk about being the same person when, more often than not, we change drastically over the span of a lifetime? The notion of personhood emphasizes the alterity which is at the heart of being a person, that is, those aspects of my existence that are constitutive of the person that I am, but over which I have no immediate control (e.g. my body, other people). This feature somehow brings together the previous ones in the question of how to cope with the tension, and sometimes conflict, between alterity and selfhood in being a person over time. I am a person in the eyes of other people, yet my particular way of being a person is continuously challenged by other people. Again, I am who I am, but I might feel that I am not myself, or that the person that others take me to be is not the person that I really am.

My choices and actions when done leave my control and may result in unexpected, happy, or unfortunate results that in some way or other influence the person that I am. The responsibility for my words and deeds does not end when they are out of my mouth or hands, so to speak. My body changes, becomes
different as the years go by, and I may become alienated by these transformations. I can accept such changes, despair because of them, or fight them, but every one of those attitudes affects the person that I am. In short, to be a person involves the inescapable struggle with the otherness that constitutes the person that I am (Stanghellini and Rosfort, 2013a).

I feel that I am not myself, and at times I say and do things that I do not consider as expressive of who I am. Those feelings and actions are nonetheless mine. It is I who feel and act, although my feelings and actions may be disturbing to my understanding of who I am. The notion of narrative identity is introduced to make sense of these intimate feelings of otherness at work in my sense of being a self, and to articulate the normative implications of selfhood. The focus is on the tension, and potential conflict, between self and otherness in our experience of being a person. This tension is experienced in who and what we care about, and is inescapably connected to the ontology of the peculiar beings that we are, namely, human beings who are influenced and shaped both by a-rational factors (we are organisms) and rational factors (we are persons). In other words, to make sense of and deal with what we care about, we need to take into account both the anonymous biological factors and the personal factors that constitute our identity as persons over time.

This inescapable struggle with alterity is the reason why I both am and must become a person. In other words, to experience myself as a person is to experience the fragility of my autonomy. Being a person is characterized by the indefinable and restless autonomy that makes each person the individual person that he or she is; that is, I am the person I am, but I am also faced with the constant task of becoming who I am through the alterity that constitutes my life as a person. Alterity challenges my life not only from without, for instance, as an unexpected event, but also from within in the form of the sedimented, obscure texture of my identity (my brain, my past, my parents, my nationality, my character). Being a human person is trying to exist as myself in and through the challenges of innumerable features that make up what I am, but which cannot entirely define who I am. Two major factors of the alterity that constitute the person that I am are my body and other people. My body is an ambiguous thing. It represents an intimate aspect of the challenge of alterity: “To the extent that the body as my own body constitutes one of the components of mineness, the most radical confrontation must place face-to-face two perspectives on the body—the body as mine, and the body as one body among others” (Ricoeur, 1992, p. 132). My body is the most intimate part of my identity as a person, and yet it is also an integrated part of an anonymous nature that does not care about what I want and who I feel I am. Because I am embodied, I live with feelings, sensations, and needs that produce values that are not of my making and
with which I have to live my life. Values are anything positively or negatively weighted as a guide to action (for example, needs, wishes, and preferences) (Fulford et al., 2012, valuesbasedpractice.org). As Ricoeur explains:

Need is the primordial spontaneity of the body; as such it originally and initially reveals values which set it apart from all other sources of motives. Through need, values emerge without my having posited them in my act-generating role […] Before I will it, a value already appeals to me solely because I exist in flesh. (Ricoeur, 1966, p. 94)

My body is the organ of my autonomy, and as such it is permeated and shaped by my intentional engagement with the world, but it also challenges this autonomy through the a-rational factors at work in the physical organism that I call my body. My body ages, becomes sick, and eventually dies in spite of everything I do. The incomprehensible character of my feelings and emotions, my urges and desires, reveals the challenge of the a-rational, anonymous character of the What constitutive of who I am. My body expresses the pathic character of my autonomy by making me aware that my relation to the world, other people, and myself is felt before it is understood (Ricoeur, 1987, p. 81). The fact that I sometimes say and do things that I do not want to say or do makes this biological aspect of who I am an inescapable problem in my life as a person. My dreams and hopes are realized through my body, but they also shatter against this impermeable alterity with which I live my life. In this sense, my body is one major expression of what is seemingly the most stable, thing-like aspect of personhood involving the physical characteristics and long-standing dispositions shaped by genetics, upbringing, education, and convictions.

My dispositions to act are shaped by how I am brought up and by our social, geographical, and cultural context. The formation of habits and seemingly implicit or automatic dispositions to act is our most obvious and docile tool to cope with alterity, since these internalize otherness and make it a part of our person. But even our own choices may become habits and long-term dispositions, which turn into something that we no longer choose. Through narratives, I may become aware of how I came to have such a nervous character or such violent dispositions, instead of accepting that, in the end, this is just how we are. Through narratives I can work through the meaning of an event that involves my body, the world, or other people, as for instance an event of loss, and meaningfully integrate it in my personal identity.

The encounter with alterity is a necessary precondition for mental health, yet we know that this encounter may become pathogenic. We call ‘vulnerability’ the alterity that we find in ourselves (in our involuntary disposition) when I as a person cannot dialogue with it (that is, when I fail to appropriate it, to cope with, modulate, and make sense of it). We call ‘trauma’ the alterity that I encounter in
my dealings with the external world when I as a person cannot dialogue with it (that is, when I cannot appropriate it, cope with, modulate, and make sense of it). Thus, vulnerability is the underside of an involuntary disposition, and trauma is the underside of an event. A vulnerable trait and a trauma are the effect of a disproportion between a given disposition and a given event, respectively—as well as the effect of the incapacity of the person to dialogue with them.

Narrative identity is a practical category, which means that it deals with the aporetics of identity (selfhood and otherness, sameness and change, organism and person) in relation to the concrete existence of the person, that is, with how the person acts and suffers in the actual coexistence with alterity. Ricoeur would in no way deny that narrative identity has its limits with regard to the explanation of both time and identity. Also, he would in no way subscribe to the thesis that the identity of a person is nothing but the story he tells about himself, as radical constructivists hold. In fact, he explicitly points to the limits of narrativity in relation to the unrepresentability, inscrutability, or inappropriability of certain aspects of alterity, and further emphasizes that “[n]arrative identity thus becomes the name of a problem at least as much as it is that of a solution” (Ricoeur, 1988, p. 249).
A closer look into alterity: eccentricity

At the heart of alterity lies a double paradox.

First, alterity speaks of eccentricity, of the non-coincidence of the Self with itself. Most of the philosophical anthropologies of the last hundred years emphasize that the phenomenon of eccentricity is indigenous to human existence, and characterize Man as an eccentric being; he is never entirely what he ‘is’ (Plessner, 1964). As a person the human being is a *homo duplex*. The term ‘homo duplex’ was originally elaborated by Maine de Biran (1852). We are passive in our nature as sentient beings because we are shaped by our physiological nature, by our environment, and by our past history. Yet, we are active in virtue of being persons. On the one hand, we are a part of nature, and therefore nature sets a pre-reflective agenda for our behaviour in the form of instincts and emotions (a core sense of self, sexual and survival instincts, fear of danger, etc.); in short, we are an extremely complex machine set to solve the problems encountered during our lifetime in the ongoing interaction with the environment. On the other hand, Man is a being who poses problems and raises questions (Ricoeur, 1966, 1987; Stanghellini and Rosfort, 2013a).

Fundamental to the understanding of human subjectivity is clarifying the ways self-awareness is structured as an experience inextricably entangled with an experience of a *basic otherness*. I relate myself to, and try to make sense of, this basic experiential fact that I am a self whose self-awareness is constantly challenged by that which is not myself. In other words, I experience myself as more than my sense of being a self. The feelings of otherness at the core of my self-awareness make my sense of identity fragile, prompting questions about who and what I actually am, and how I should cope with this intimate sense of otherness. Hermeneutical phenomenology introduces the notion of personhood to explore this fragile sense of identity involved in our troubled selfhood, making use of the notion to systematically examine and make sense of the ontological and normative implications of this entanglement of selfhood and otherness.

A human person is both a rationally governed self and a biological organism subjected to the a-rational biophysical laws of nature. Thus, human thinking,
feeling, and actions are shaped and formed by two kinds of causality: an a-rational biological causality and a rational causality. This peculiar ontological character of human personhood becomes manifest primarily in the strangely ambiguous character of bodily experience. This ambiguity produces a dialectics between myself as an anonymous organism conditioned by the a-rational, impersonal laws of a nature that involuntarily and a-rationally generates bodily phenomena, and the voluntary, rational elaboration of those phenomena on the part of the person who lives in and through her body (Ricoeur, 1992).

Part of this complex dialectic can be traced back to the fact that Man is a “still undefined animal” (Nietzsche, 1992): Man is lacking instincts—where an instinct is a rigid coupling between a given stimulus and a given behaviour—and has too many drives. I am tethered to “an invincible obscurity” (Ricoeur, 1977, p. 458), but I do not coincide with it. This obscure and involuntary side remains “an ineluctable partiality” (ibid., p. 458), not the totality of my Self.

To paraphrase Pierre Bourdieu, to be a human being is to be in juxtaposition, and sometimes to feel in opposition, to a set of given involuntary dispositions in front of which we need to voluntarily take a position. The complexity of my identity as a person consists in the fact that besides the impersonal changes that I undergo as the consequence of the sheer fact of being a developing biological organism, I also autonomously relate myself to these changes, and these personal attitudes, in turn, affect the person that I am. Or, as Arnold Gehlen would say, Man is that being that makes something of himself (Gehlen, 1988). I, as a person, am not simply situated in the world in a given way; I also have the privilege and responsibility to take a position with respect to my being-situated. Position-taking (Plessner, 1928/1975) is the metaphor that most precisely and vividly expresses the essence of a person as a homo duplex and questioning being. Man is that being that among his most important tasks has to take a position with respect to himself (Gehlen, 1988), that is, with respect to his instincts, emotions, past history, social constraints, and so on. He also has the task to (metaphysically) define his nature and position in the Cosmos (Scheler, 2009).
Duplicity is just one of the paradoxes of being a person. The second, and perhaps most striking paradox is that alterity is not felt as totally extraneous to the Self.

Alterity is extraneous and familiar at the same time. It comes as a surprise from the most intimate and proper region of the Self. Indeed, what is experienced as most extraneous is also what is most proper to the Self. Extraneous and essential are the two sides of a *fold*, that is, a zone of continuity—even of correspondence—rather than of discontinuity. This is the literary as well as philosophical and psychological *topos* of the Double (*Doppelganger*) and the Uncanny (*Unheimlich*), since only what is so extraneously familiar can touch me in such a deep way. Only what is so genuinely mine can impose on myself, can make me wonder as to shake my innermost certainties, can produce such a vertigo bringing my Self to the very edge of itself. Lacan (1992) coined the term *extimacy* (*extimité*) to represent this paradox. This neologism was created by Lacan from the term ‘intimacy’ (*intimité*) to designate the exterior that is present in the interior. The most interior has a quality of exteriority, since the most intimate is at the same time the most hidden. Paradoxically, the most intimate is not a point of transparency but rather a point of opacity. The intimate is other-like, a foreign body in the context of the person. The experience of extimacy is tied to the vacillation of the subject’s identity to himself (Miller, 1994).

It is worth listening to Freud’s (The ‘Uncanny’, 1919) discussion of the Uncanny. The German word *Unheimlich* is clearly the opposite of *Heimlich*, which means ‘homely’, that is, what is ‘familiar’. One would be tempted to conclude that the Uncanny is frightening precisely because it is not familiar. Obviously, not everything that is unfamiliar and novel is frightening. Thus, something has to be added to novelty and unfamiliarity in order to make it uncanny. After an in-depth analysis of the several shades of meaning of *Heimlich*, Freud points out that this word is not unambiguous, but contains two sets of ideas that, without being contradictory, are very different. *Heimlich* means what is familiar and
agreeable, but also what is concealed and out of sight (ibid., pp. 224–5). Quoting Schelling, he suggests that

everything is unheimlich that ought to have remained secret and hidden but has come to light (…) Thus heimlich is a word the meaning of which develops in the direction of ambivalence, until it finally coincides with its opposite, unheimlich. Unheimlich is in some way or other a sub-species of heimlich. (ibid., pp. 225–6)

The Uncanny is what is “secretly familiar” (ibid., p. 245).

The experience of the Uncanny may be the appearance of some element of the ego, harking back to particular phases in its development in which “the ego had not yet marked itself off sharply from the external world and from other people” (ibid., p. 236).

On one side, we may understand the impression of uncannyness as the effect of the temporary suspension of repression, that is, as the re-appearance of repressed memories. But on the other, it also seems that what emerges from uncanny feelings must not necessarily be a repressed memory. It could be better addressed as the experience of my Double. The secretly familiar double that I experience in the Uncanny is not necessarily a part of the Unconscious that was previously repressed.

It is important to note from the start that alterity does not coincide with the Freudian Unconscious as the product of repression and other defence mechanisms. An example of non-repressed alterity is my experience of myself as a biological organism. I live by an impersonal and pre-individual element that is at the same time the closest to and the remotest from myself. It is my very life in as much as it does not belong to me. I obscurely feel it in the intimacy of my physiological life; it is at the same time the most intimate and proper to myself and the most extraneous. My thinking, feeling, and action are shaped by two kinds of causality: an a-rational biological causality and a rational causality. This peculiar ontological character of human personhood becomes manifest primarily in the strangely ambiguous character of bodily experience. This ambiguity produces a dialectics between myself as an anonymous organism conditioned by the a-rational, impersonal laws of a nature that involuntarily and a-rationally generates bodily phenomena, and the voluntary, rational elaboration of those phenomena on the part of the person who lives in and through her body.

Alterity and the person belong to each other. The good life is first and foremost based on the dialogue with alterity, and this dialogue presupposes the awareness of the fact that the individuated Self is not entirely individuated. In ancient Rome this pre-individuated alterity was named the genius. Genium
suum defraudare meant to cheat oneself, to deceive oneself (Agamben, 2004, p. 9). This part is “the most intimate and proper”, “the closest and remotest” (ibid., p. 11). This very intimate and personal part is what in myself is the most impersonal. ‘Genius’ is my very life, in so far as it was not originated by myself, but gave origin to myself. It is my own life in as much as it does not belong to me. I obscurely feel it in the intimacy of my physiological life as “the force that drives blood in our veins . . . and loosens or contracts our muscles” (ibid.). Emotions are also part of “the impersonal in ourselves . . . through which we get in touch with the pre-individual” (ibid., p. 14).

This impersonal and not individuated part is not a chronologic past that I left behind myself. It is not repressed. It is the obscure side of my own existence as it manifests itself in front of myself. From this stems a further paradox, ethical in nature: “If Genius is our own life in as much as it does not belong to us, then we must respond for something for which we are not responsible” (ibid., p. 16). I must listen to and honour this part as “one honours one’s debts” (ibid., p. 10).

The complexity of my identity as a person consists in the fact that besides the impersonal changes that I undergo as the consequence of the sheer fact of being a developing biological organism, I also autonomously relate myself to these changes, and these personal attitudes, in turn, affect the person that I am. Thus I must learn how to establish a dialogue with this extraneous being, to live in the intimacy of it, and to keep myself in relation with this non-knowledge zone (ibid.).

Freud, in his own terms, spoke of the need for a recognition of alterity that becomes manifest in symptoms as my own alterity, that is, as an integral part of the person that I am. The recognition of alterity as an indiscernible part of the person that I am paves the way to the reconciliation between the person and its own alterity:

He [the patient] must find the courage to direct his attention to the phenomena of his illness. His illness itself must no longer seem for him contemptible, but must become an enemy worthy of his mettle, a piece of his personality, which has solid ground for its existence and out of which things of value for his future life have to be derived. The way is thus paved from the beginning for a reconciliation with the repressed material which is coming to expression in his symptoms, while at the same time a place is found for a certain tolerance for the state of being ill. If this new attitude towards the illness intensifies the conflicts and brings to the fore the symptoms which till then had been indistinct, one can easily console the patient by pointing out that these are only necessary and temporary aggravations and that one cannot overcome an enemy who is absent or not within range. (Freud, 1914, p. 152)
Chapter 8

Epiphanies of alterity: drive

We encounter alterity in two main domains of our life: in ourselves, and in the external world. In the first case alterity is in the involuntary dimension of ourselves, as (for instance) our un-chosen ‘character’, including needs, desires, emotions, and habits. In the external world, alterity is encountered in the challenging otherness of the events and in the meetings with other persons that constellate our life.

A good way to further approximate the meaning of the alterity we encounter in ourselves is to see it from the angle of Ricoeur’s notion of the ‘involuntary’ side of human existence (1966). The involuntary is the a priori determined Whatness of Who we are. Ricoeur defines the involuntary as ‘experienced necessity’, that is, the experience of necessity, of what we did not and cannot choose. This notion comes close to that of sheer biological life (Ricoeur, 1966), but also to what Heidegger calls ‘thrownness’ (Geworfenheit), in the sense of being stuck with the particularity of my being-so. Thrownness expresses our being cast into a set of unwilled conditions and circumstances that we did choose, the limiting characteristics of my existence. Yet this does not imply any kind of strict determinism, since I have other counter-characteristics that tend to resist the influence of thrownness. Notions like ‘drive’, ‘emotions’, ‘habitus’, ‘character’, the ‘unconscious’, ‘sheer life’, etc., belong to the circle of the involuntary.

The involuntary dimension of my being the person that I am includes what is a priori given in my existence, the raw material that constitutes the sedimento-dispositions of my being and sets the boundaries of my freedom. The involuntary is the un-chosen, implicit possibilities limiting my actions and reactions, the dark side of the person, and its obscure and dissociated spontaneity. The roots of the involuntary are my history, my body, and the world into which I am thrown. These three roots determine respectively three sets of values that are operative and almost implicit in my life: historical values (e.g. my family’s values), organic values (e.g. my sexual preferences), and social values (e.g. societal rules and roles). Just as I have not chosen my historical situation, I have not chosen my body and the world in which I am embedded. History, body, and world situate and ‘incline’ me in an un-chosen way. The receptivity to these values stands in a reciprocal and sometimes conflicting relation with my sovereign
decision to consent to or dissent from them. For instance, I cannot choose my emotions, desires, or habits. I am simply thrown into them, though I am not at their mercy. I am responsible for them—I can approve, or disapprove and refuse, them. Who I am stems from the fragile, complex, and obscure dynamics of the voluntary and the involuntary what inherent in human personhood.

The involuntary must be clearly differentiated from the Freudian ‘dynamic’ unconscious, that is, the unconscious that is generated by repression (Verdrängnung)—as we have done already with Genius and our biological life. Drive, emotion, and habitus—the three emblematic components of the obscure and dissociated spontaneity that make up the involuntary dimension in human existence—are forgotten not forbidden, implicit not rejected, automatic not censored. This impersonal part of ourselves is not a repressed chronologic past that we left behind ourselves.

A relevant part of the involuntary is drive. Drive is the principle of all obscurity in my will. Its two basic profiles, need and desire, affect me coming from the deepest regions of my being. Especially need seems to leave no other escape but its satisfaction. Need is the primordial spontaneity of the body; as such it originally and initially reveals values which set it apart from all other sources of motives. Through need, values emerge without my having posited them in my act-generating role. “[B]read is good, wine is good. Before I will it, a value already appeals to me solely because I exist in flesh” (ibid., p. 94).

It’s not easy to trace a sharp line dividing needs from desires. Need embodies my organic values, like hunger, thirst, and sex. Need is something that “we would gladly dissolve into mechanism and attribute it to the body” (ibid., p. 378). Desires, as the very word seems to suggest, are felt as coming from above, rather than from the subsoil where we posit the roots of need. Perhaps, the paradigmatic manifestation of desire is the desire for recognition—the craving for being recognized by the Other. Need seems to be always need for something definite and specific, as if there were a beeline between need and its object. Yet, there is also another experience of need: a kind of need unsaturated with a precise object that makes me ask myself ‘What is it that I really want?’ The teleology of need implies the possibility of deviation from its targeted object. “Man is able to choose between his hunger and something else” (ibid., p. 93). Sublimation is an intrinsic possibility when experiencing need. This is also the case with desire. This is a structural possibility inherent in need and desire, embedded in their very nature. They are not like a reflex, a reaction following a stimulus in a rigid pattern. They are not like an instinct that “leaves no organic problems unresolved and renders invention unnecessary, making the animal a constantly resolved problem” (ibid., p. 95). I can reject my drive as a reason for action, and in this I show my humanity. Also, and even more important, at different
times I can forge different representations of the object of my drive: now it is food, later it will be crude sex, earlier it was the tenderness of a smile. In need I discover myself needful (and in desire desiring), not merely lacking something specific or aspiring to it. Need and desire have an inherent plasticity; they can change their target, and they can be saturated with different objects.

Even in its most organic and biological dimension as is the case with need, the involuntary is matter, whereas the voluntary is its form. The involuntary has no specific form; the voluntary has no substance in itself. The voluntary is an *adverb* rather than a substantive, as it is the mode, the way the person gives form to the involuntary.
Chapter 9

Habitus: the emergence of alterity in social situations

My habits seem to be what is most distant from alterity as they pertain to order and regularity. Yet, habits exonerate me from reflecting each time about the proper way to act under given circumstances. Thus, acting on the basis of habit means to act unreflectively and involuntarily. The ‘habitual self’ is opposed to the ‘reflecting self’. Habit is indeed the power of forgetting. It is not unconscious in a psychodynamic sense. It is not repressed: rather it is a form of unreflecting, practical Cogito. As such, it is another form of dissociated spontaneity, next to drive and emotion, that may surprise me, especially when it prescribes me a given action that is inappropriate to the circumstances. Habit is what lets me discover alterity as repetition in the course of my intersubjective life.

Habits are parts of procedural memory, distinct from semantic memory, and as such they become manifest while performing some kind of action. They are incorporated schemes of action acquired in the course of individual life trajectories. Simply put, habits focus on my way of acting, feeling, thinking, and being. The concept of ‘habit’ captures how I carry within me my personal history, how I bring this history into my present circumstances, and how I then make choices to act in certain ways and not others. Family upbringing and social and educational circumstances are the principle roots of habits. Pierre Bourdieu (1990a, 1990b) defines *habitus* as an embodied property of social agents (whether individuals, groups, or institutions). Our arms and legs, our entire body, are full of mute imperatives. These imperatives include ‘Sit up straight!’ and ‘Don’t put your knife in the mouth’. They select the range of affordable perceptions and actions. These corporeal orientations that people acquire through their rearing in a given culture constitute the track of our action and perception. In particular, they orientate my social relations. They are non-conceptual in nature: embodied schemas that are out of one’s voluntary control and are difficult to make explicit.

The habitus is a disposition, that is, a tendency, a propensity, or an inclination that generates practices, beliefs, perceptions, feelings, and so forth in accordance with its own structure. This disposition is durable in that it lasts over time, and transposable in being capable of becoming active within a wide variety of
social theatres of action. Bourdieu’s habitus comprises a “structured and structuring structure” (Bourdieu, 1994, p. 170). It is ‘structured’ by one’s past and present circumstances, such as family upbringing and educational experiences. It is ‘structuring’ in that one’s habitus helps to shape one’s present and future practices. It is a ‘structure’ in that it is systematically ordered rather than random or unpatterned. This ‘structure’ comprises a system of dispositions that generate perceptions, appreciations, and practices.

Experientially, I often feel I am a free agent, yet reflectively I may become aware that I base everyday decisions on implicit assumptions about the predictable features of social interactions based on my pre-reflective understanding of the character, behaviour, and attitudes of others. The phenomenon of ‘habit’ transports the involuntary into the social dimension of human existence. My habit is what prescribes me with a limited set of expectations of self-with-other schemes of interaction.

The mode by which I experience and represent others, and accordingly the way I experience and represent myself in the context of social situations, are an essential part of my own life-world. The repeated experience of being with another person, especially a significant Other, contributes to gradually shaping a prototype of a self-with-other relation. Once this prototype is formed, it becomes a generalized and encoded habitus (Stern, 2000, p. 111). The habitus is an experience of being-with that is retrieved and activated whenever one of the attributes of the relation that gave origin to it is present. This may occur out of awareness, that is, the person is neither aware that what is going on is the recall of an actual past happening, nor that she is exploiting a pattern of interaction stored in her implicit procedural memory.

These schemes of being-with form a coherent and persistent structure that consists in a form of practical, implicit Cogito that drives my body to behave in a given way under given circumstances. It is an endless invitation to repeat the same schemes of actions, perceptions, and interactions. The victim–perpetrator, or the guilty–accusatory schemes of interaction are examples of that. These schemes are reproduced automatically and may surprise me, since their origin remains in the shadow. Sometimes my habitus is helpful to make me behave appropriately with little or no reflection. It exonerates me from thinking and reflecting each time about the suitable behaviour under similar circumstances. Habitus is not based on a kind of reasoning by analogy mechanism, but on embodied schemas that orientates me in the ongoing social state of affairs and situates me accordingly. First and foremost, there is good relation and balance between my dispositions, my position in a given situation, and my position-taking with respect to both of them. Good practices are not simply the result of my habitus, but rather of relations between my habitus and the current circumstances.
In some occasions the spontaneity of habitus is pointless and inappropriate. It surprises me, as it makes me act mechanically, disrupting my voluntary actions and leading me to mis-recognition. The actual Other is not recognized in its individuality. My self-with-other habitus distracts me from understanding the specificity of the present situation, as it overwrites it with the bias of preconceptions. It forces me to behave inadequately, as it reiterates a standard scheme of interaction inappropriate to the actual circumstances. This is typically the case when the present situation is felt as analogous to a traumatic interaction that I experienced in the past. My past literally materializes ‘right now’ in front of me, becoming an obstacle to experience the present situation differently from a mere repetition of the past.
This dialectics between person and alterity is paradigmatically manifest in my emotional experience. I cannot choose my emotions. Yet my emotions are an essential part of my own Self. Acknowledging this ontological complexity, and in particular the challenge that the interplay between involuntary and voluntary factors poses to our sense of identity, allows us to explore and make sense of the normative problems involved in being a person.

This is experienced as the challenge that to be a person is not a fact, but a continuous task. We are the same person throughout our life, but the sameness of our identity as a person is continuously challenged by the alterity that all persons experience through time. Emotions are part of this emerging alterity. Being a person is trying to exist as myself in and through the challenges of all those features that make up What I am (e.g. my anonymous biology, my past, my present uncanny experiences, the way I feel defined by people while they look at me), but which cannot describe Who I am.

Emotions are the most embodied of mental phenomena. Emotional experience is permeated with feelings and sensations that constantly elicit and challenge my attempts to make sense of and cope with it. Although human emotions are sometimes characterized by intentional and cognitive contents, in the sense that I assess and comprehend my emotional experiences by means of intentional and conceptual analysis, there is more to my emotional experience than is disclosed and explained by intentional and conceptual analysis. Moreover, there is more to the person that one is than the emotions that one feels. To be a person means to articulate and interpret one’s emotional experience. In short, to be a person involves a permanent confrontation with the alterity that becomes manifest in emotional experience, that is an inescapable part of the person that I am.

Emotions are kinetic, dynamic forces that drive us in our ongoing interactions with the environment. This understanding of ‘emotion’ focuses on the embodied nature of emotions, but rejects its reduction of the body to the object-body or physiological mechanism (like visceral changes mediated by the autonomic nervous system). It obviously also rejects the conceptualization of emotions as
pure ‘mental’ phenomena because an emotion is not a purely and primarily cognitive phenomenon affecting the mind, but a phenomenon rooted in one’s lived body. Emotions are characterized by their connection to motivation and movement. Emotions are functional states, which motivate and may produce movements. This view is held by contemporary evolutionary psychologists (Plutchik, 1980), as well as by phenomenological analyses (Sheets-Johnstone, 1999a, 1999b). As functional states that motivate movement, emotions are protentional states in the sense that they project the person into the future, providing a felt readiness for action (Gallagher, 2005).

Essential for the understanding of the dialectics between emotions and the person is the distinction between the two forms that emotional experience may take: affects and moods (Smith, 1986). This distinction is merely incipient in Husserl’s writings and is made explicitly by Scheler (1966, 1970), Heidegger (2010), Sartre (1971), and Ricoeur (1966, 1987). Whereas affects are responses to a phenomenon that is grasped as their motivation, moods do not possess such directedness to a motivating object. Although their terminology differs, and often confusingly (Scheler: Affekten/Gefühlen; Heidegger: Affekten/Stimmungen; Sartre: affects/emotions; Ricoeur: sentiments schematisés/sentiments informes), their analyses of the phenomena concur in the general characteristics.

Affects are focused and intentional, and possess directedness. Affects are felt as motivated; they are more determinate than moods and more articulated. Affects do not open up a horizontal awareness, but occupy all my attentional space (e.g. in fear I am completely absorbed by the phenomenon that terrifies me). When I am affected, a relevant feature of the world captivates me, irrupts into my field of awareness without me having decided to turn my attention to it. I become spellbound by it and all my attention is captured by it. Typical examples of captivating affects are grief (when the death of a beloved person occupies all my attentional space) or phobias.

Moods, on the contrary, are unfocused and non-intentional. They do not possess directedness and aboutness. They are felt as unmotivated, and there are no ‘felt causes’ for them. They are more indefinite and indeterminate than affects and are often inarticulate. Moods have a horizontal absorption in the sense that they attend to the world as a whole, not focusing on any particular object or situation. Moods often manifest themselves as prolonged feeling-states as opposed to the more instantaneous nature of affect. Whereas most affects fill up the whole field of awareness for a brief period (e.g. in fear or anger), moods convey a constellation of vague feelings that permeate my whole field of awareness, and they often last for a longer period than affects. Moods are global feeling-states that do not focus on any specific object in my field of awareness. When we
are in a certain mood we relate ourselves to the world and to ourselves through that mood.

In euphoria, the perception of my body is diminished and may even vanish. I feel absorbed in my concerns; my self-awareness, my body, and the world fuse together in perfect harmony. In sadness, the perception of my body comes to the foreground; I may feel my body as an obstacle, a hindrance separating me from the world and perhaps even from myself. Thus, moods are atmospheric and often corporeal in that they permeate my perception of the environment. They can bring me closer to or distance me from the world in that they elicit a certain atmosphere that becomes the tonality through which I perceive the world and myself. When I am feeling happy, the world and other persons appear in a soft light of possibility and openness. I feel differently from when I am jealous. In this case, things appear as prowling perils; even the most sincere smile might be perceived as false and dangerous to my person.
Chapter 11
A closer look at moods and affects: intentionality and temporality

Intentionality is the aspect of a psychic state being ‘of’ or ‘about’ something. The standard phenomenological view on moods and affects is more or less clear on one fundamental difference: moods are experienced as unintentional and affects intentional. However, this view may be modified by relating the two feeling-states to the person. It is correct to say that an affect such as fear is about the particular object of fear (e.g. the bear), and that an anxious mood does not point to any specific intentional object, but manifests itself as an unarticulated background tonality or atmosphere that contaminates my whole field of awareness. Nevertheless, my mood seems to contaminate the way I relate to the world in the sense that it is accompanied by a certain atmosphere in my perceptions. A situation that beforehand would not intimidate me at all now fills me with an irresistible desire to run away and look for protection. The feelings involved in the intentional attitude of my affects are indeed changed by my current mood. My mood is expressed by how perceptions or thoughts affect me. Moods materialize in affects in that I am affected through my mood. This may suggest a covert intentionality in moods. Whereas affects have a direct and clear intentional object (an object of perception or a thought), moods are characterized by multiple objects (Siemer, 2005). Whereas affects point to an explicit experience such as a dangerous situation, a happy smile, a beautiful landscape, a difficult task, and so on, moods, on the contrary, point to my being the person I am in a given situation.

Moods can be compared with what Ricoeur calls ‘ontological sentiments’ in that “[t]hey denote the fundamental feeling . . . namely, man’s very openness to being” (1987, p. 105). We can say that whereas affects point forward towards a specific object, moods point inward towards my being the person I am. More precisely, moods contain a bipolar intentionality in the sense that they often materialize in a certain affect owing to an explicit object. But at the same time they point to my being the person I am, and thereby in moods alterity manifests
itself and awakens questions, doubts, considerations, evaluations, and finally deliberations about my-being-this-person.

One way to ascertain a mood from an affect and, perhaps even more important, to understand the dialectic between them in relation to the person is to consider temporality. Temporality is understood as how the person experiences time and how the existence of the person is inevitably formed and developed in time. The person changes through time and experiences how the world, other people, and herself change in time. Temporality is not time as an exclusively private (solipsistic) or pure cosmological (objective) phenomenon, but both time as experienced and lived by the person and time as working on and with the person.

Moods and affects display different temporal patterns. Affects are often briefer than moods. They captivate me, occupy my whole field of awareness, and thereby move me to a determinate action within a restricted period of time. Moods, on the contrary, may last for days, weeks, or even years in that they paralyse my thoughts and retain me from acting (sadness) or throw me into weird actions without any thoughts of the past or the future (euphoria). The intensity of the feelings involved in affects demands a concrete action regarding our present situation, such as to express our anger, escape the bear, return the happy smile, work on the difficult task, and so on. Obviously, we often do not act out of the affect but retain ourselves from acting out of it. We can dominate the affect by cognition. For example, the irresistible desire to insult or thump a malicious boss may be suppressed by the fear of losing my job. The intensity of the affect then gradually subsides, and I turn my attention on other matters. This, however, does not imply that the affect vanishes altogether. It may remain as a bitter memory that brings forth unpleasant feelings every time it pops up in my mind (Goldie, 2000/2002, pp. 149–51).

The dialectic of moods and affects is complex. Affects may transform themselves into moods and finally become a permanent part of our ‘character’; moods may determine affects because they alter the way we are affected by objects and thoughts. Last, but not least, a given mood may become an affect when in reflection I can articulate it and find its motivations and ‘felt causes’, that is, the way it roots me in a given situation. An affect may transform itself into a mood that imposes itself on me for days or longer (grief can transform into a general sadness, anger into dysphoria, boredom into tedium). Thus, a mood may develop out of an affect as the affect itself loses its instantaneous, focused, and motivated character. Also, a mood might not be the product of a single affect and the following action or suppression of action, but a constellation of feelings elicited in several episodes. Moods (e.g. irritability, sadness, tedium, euphoria)
change the way I am affected by the world (and my own thoughts) in that they predispose my field of attention (thus my conscious experience) in a certain way. And in the course of time, moods may—in virtue of being dispositional—transform themselves into an inherent and permanent part of my self. An affect can develop into a mood, and a mood can develop into a basic emotional tonality. For instance, a dysphoric state can gain such a hold on my person that it turns into a certain trait, for example an irritable, hostile, mean, polemic, misanthropic, or adverse character. This basic emotional tonality is a permanent, implicit protention, or readiness to (re)act and be affected in a given way, and probably also to develop certain moods more than others. In this way, emotions become an essential part of a person, of one’s sense of personal identity. This feeling of sameness comes close to what Ricoeur (1992) calls ‘character’. This basic emotional tonality is usually tacit and I notice it only when it is not there. It is important to notice that all these transformations from affects to moods to character occur pre-reflectively and without a deliberate and thematic involvement of the person in the process, whereas the transformation of a mood into an affect involves reflection.
Chapter 12

Emotions and the dialectic of narrative identity

The theory of narrativity comes in endless variations and influences a vast array of disciplines (e.g. philosophy, psychology, sociology, theology, economy). Narrativity, here, indicates that a significant part of a person's self-experience and self-understanding is based on self-narratives—an ongoing process of establishing coherent formulations about who I am, who I was, and where I am going. Through self-narratives I seek to understand my actions and experiences as a semantically coherent pattern of chronologically ordered elements, and to grasp the way I relate myself to that understanding and to the world. In the present context, I restrict myself to a narrow concept of narrativity to clarify how the emotional experiences of moods and affects play a crucial role in the life and self-experience of the person.

In virtue of being linguistic animals characterized by ontological ambiguity as well as position- and perspective-taking we tend to constitute our experiences and our identity through self-narratives. The temporal aspect of our being becomes emphasized in the narrative approach to personhood. I am changing every second of my life, and yet I remain the same person. Identity— in the sense of personal identity—is not mere sameness. Personal identity is formed through a dialectic of two forms of identity: Being-the-Same (idem/sameness) and Being-Oneself (ipseity/selfhood). The fundamental trait of Being-the-Same is permanence. Character is the set of distinctive marks which permit the reidentification of a human individual (1992). My character is that in which my feeling of remaining the same in time and through change is rooted, and that by which other people identify and describe me.

A person, however, does not coincide with her character traits; being who she is involves another kind of identity. Whereas my character is formed involuntarily in the sense that it is determined by my past actions, random events, and contingent factors that are now out of my control (Ricoeur, 1966), my identity, on the contrary, depends on how I voluntarily relate my self to this particular character, constituted by a certain past, and situated in a world of other persons. My identity is constituted by the active relation of the Who I am with the What I am (including my character). It is I who have the responsibility for my being
this person, that is, for deciphering my moods and for evaluating my character, and then take a position of front of them. Here enters the question of responsibility involved in being a person. As Teichert (2004, pp. 177–8) eloquently puts it, “[i]dentity as selfhood is linked to a realm where actions are ascribed to agents in the light of ethical norms”. It is still me who did that terrible thing in the past, even though it would not cross my mind to do anything like that today. Personhood entails a kind of self-continuity that implies responsibility not as a contingent, but as an essential component of personhood. This dimension of self-continuity is mainly shaped through self-narratives.

How, then, do moods and affects figure in the dialectic of character and personhood developed in the narrative structure of self-experience? A given mood can develop itself into a character trait, that is, a permanent part of one’s sense of personal identity; this transformation occurs pre-reflectively and without a deliberate and thematic involvement of the person.

Through narratives, moods can also be incorporated actively, reflectively, and thematically into a person’s identity. Moods are connected to self-understanding. I understand who I am in the context of my practical engagement, as embedded in a certain world (private or social), and this engagement is primordially enveloped in a certain feeling-state. My questioning about myself is often elicited by my mood before my identity becomes an explicit problem. Moods may disclose to me what word and deeds do not. Feeling-states are no hindrance to ‘cognitive’ knowledge, but the via regia to understand myself as embedded in the world. When confronted with a given mood, I ask myself what has generated that feeling-state. A human person is that being that spends much of his time in trying to make an (intentional) affect out of a (non-intentional) mood. Focusing on the intentional object of my mood and understanding its origin, I can incorporate that feeling-state into my existential situation, and thus into my personal life-history. The possibility of self-disclosure, which belongs to moods and affects, is fundamental for cognition in that a given mood can point to a breach in the way I, reflectively, understand myself. I can be locked up in my own way of thinking, chained to my thoughts in such a way that my formulations about myself reflect a wrong or at least problematic understanding of my personhood.

In summary: emotions are an essential feature of alterity. The human experience of emotions is drastically different from that of other animals. Human emotional experience cannot be understood without considering the nature of the entities that have this particular experience—namely, persons. A person is a contextualized self with intentional attitudes capable of position-taking, i.e. evaluation and deliberation, with respect to alterity. The feeling that an emotion elicits is an essential component of the emotion itself because we, as persons,
need to acknowledge this feeling to fully access the emotion. To differentiate among various emotional experiences we need to pay attention to the diffuse and vague constellation of feelings involved in our interaction with the world. Feelings fundamentally contribute towards uncovering a person’s situatedness in the world. I, as a person, can understand myself and the world in which I am situated through the awareness of my practical engagement, and this engagement is primordially enveloped in a certain feeling-state. Personhood is anchored in a continuity that entails a demand for taking responsibility for one’s choices. This normative feature becomes emphasized in a narrative structure wherein we seek to connect past, present, and future. Emotions are fundamental in this process since they may disclose problems in the stories I formulate about myself. They disclose the fact that my formulations can be right or wrong according to my being this specific person.
Chapter 13

Alterity and the recoil of one’s actions

Alterity manifests itself when I am at odds with my needs and my desires, or when a discrepancy between my habitus and a concrete situation becomes manifest, or finally when my feeling-state surprisingly discloses my situated-ness. Only as I recognize alterity as an incoercible datum of the involuntary dimension of my existence can I begin to use it in my service.

Alterity may also manifest itself in the course of my action. This is not merely the case with tics, slips of the tongue, or forgotten acts. All human experiences can be produced or reproduced as a text. The text—be it oral or written—is a work of discourse that is produced by an act of intentional exteriorization. One of the main characteristics of a text is that once it is produced, it is no more a private affair, but is of public domain. It still belongs to the author, but it also stays there “independent with respect to the intention of the author” (Ricoeur, 1981, p. 165). The externalization of one’s experiences via the production of a text implies their objectification; the objectification of a person’s experiences entails a distanciation from the person herself and an autonomization of the meaning of the text from the intentions of the author of the text. Once produced, the text becomes a matter for public interpretation. Now, the author’s meanings and intentions do not exist simply for-himself, but also for-another.

This process of objectification and of autonomization is nicely described in Hegel’s theory of action (1975). Indeed, there is a parallel between a text and an action since, as explained by Ricoeur (1981, p. 206), “in the same way as a text is detached from its author, an action is detached from its agent and develops consequences of its own”. In the same way that every action involves a recoil (Rückschlag) of unintended implications back upon the actor, every text implies a recoil of unintended meanings back to its author. In a paragraph entitled “The Anatomy of Un-Intentionality”, Berthold-Bond (1995) elucidates Hegel’s basic theory of the structure of action as involving a recoil of consequences back upon the intentions of the actor. “All action”, he explains, “is a circle wherein our conscious purposes are projected outwards, in a deed whose consequences inevitably express something beyond what was intended; the deed therefore recoils back upon the purpose, throwing it into question, exposing the disparity
between its intended meaning and its actual outcome” (Berthold-Bond, 1995, p. 123). This happens because the deed immediately establishes a train of circumstances not directly connected to it and not contained in the design of the person who committed it. All conscious intentions—Berthold-Bond concludes—are “incomplete, unable to anticipate and encompass the full train of consequences, unable through any sheer exertion of will to force the world to become a simple mirror of our purposes” (ibid.).

The upshot of this is that whenever I act, via the externalization of my unwilled intentions, I experience a kind of alienation from myself. I experience “estrangement, division, self-doubt” (Berthold-Bond, 1995, p. 124) and “consciousness, therefore, . . . has really become a riddle to itself” (Hegel, 1975, pp. 220–1). The text exposes its author to this very tragic destiny (see Ricoeur, 2004; in particular, the second study on self-recognition). Once produced, an action shows the disparity between the author’s conscious intentions and unintended consequences. The action recoils back upon its author exposing the discrepancy between the private intended meaning and its public tangible result. The action as a text, as the tangible result of a linguistic act, with its unintended consequences, reflects the ‘mind’ of the author much more faithfully than a simple act of self-reflection. To paraphrase Hegel, a person cannot recognize herself until she produces a text objectifying herself in a social act. This objectification includes the externalization of alterity. Since all conscious intentions are incomplete, self-reflection is just an incomplete form of self-knowledge. A person cannot know what he really is until he has made of himself an external reality by producing a text, and then reflecting upon it. With Jaspers (1919/1960) we could say that a person can only understand herself in a situation. Self-knowledge is not to be achieved through abstract self-reflection, but in the act of self-recognition in the mirror of one’s action.

Recognition, in the case of the recoil of the unintended consequences of my actions, implies both self-knowledge—knowing myself as reflected in my actions—and responsibility—acknowledging that I avow all the consequences of my actions, although they are unintended, and I am ready to respond for them. There is a close semantic kinship between these two dimensions of recognition, the epistemic and the ethic. In recognizing that I have done something, I implicitly attest that I was capable of doing it. This implies that that action, including both its intended and unintended consequences, reflects the person that I am, including both my selfhood and alterity. Recognizing myself as the agent of that given action, including its unintended consequences, implies attesting that those unintended consequences come from myself, or better, from a part of myself that can only become manifest in action.
There is another kind of teleology at play in human emotional experience that we could call the *desire for recognition*. I desire that my being-so is acknowledged by the Other as a value in itself. I long for the Other to appreciate me as I am rather than how I should be. My deepest need is to be loved *as I am*, notwithstanding my limitations, weaknesses, faults, or culpabilities.

The dynamics of recognition are represented in the way Sonia responds to Raskolnikov’s confession of his murder in *Crime and Punishment* (Dostoevsky, 2011, p. 729):

> ‘What have you done—what have you done to yourself?’ she said in despair, and, jumping up, she flung herself on his neck, threw her arms round him, and held him tightly. Raskolnikov drew back and looked at her with a mournful smile.
> ‘You are a strange girl, Sonia—you kiss me and hug me when I tell you about that . . . . You don’t think what you are doing.’
> ‘There is no one—no one in the whole world now so unhappy as you!’ she cried in a frenzy, not hearing what he said, and she suddenly broke into violent hysterical weeping.
> A feeling long unfamiliar to him flooded his heart and softened it at once. He did not struggle against it. Two tears started into his eyes and hung on his eyelashes.
> ‘Then you won’t leave me, Sonia?’ he said, looking at her almost with hope.
> ‘No, no, never, nowhere!’ cried Sonia. ‘I will follow you, I will follow you everywhere. Oh, my God! Oh, how miserable I am! . . . Why, why didn’t I know you before! Why didn’t you come before? Oh, dear!’

What animates Raskolnikov’s action, the desire to confess, is the desire for the Other’s recognition. Sonia fully senses, acknowledges, and corresponds to Raskolnikov’s desire for recognition. Her compassion encompasses his ambivalence. Recognition is neither mere understanding, nor simple approval of the Other’s actions. It is not understanding since it is not mere identification of the mental state that causes his actions. It is not merely approval or consent, since it is not a kind of judgement or ethical stance with respect to the Other. It is a much more complex emotional and intellectual readiness to acknowledge the reasons of the other person. Recognition is set within an experience of relatedness or ‘We-experience’ in which I am aware of the Other’s emotional distress and try to attune myself to it.
Recognition is not an easy task—as Sonia’s spontaneity seems to suggest. It is not a default mode of a generic empathic attitude. Recognition can be split into two complementary phenomena, the first chiefly emotional in nature, and the second of a more intellectual kind.

Recognition first and foremost presupposes attunement with the Other. It is a mode of being with the Other, a kind of intimacy with the Other, a modulation of the emotional field in-between myself and the Other. In an essay significantly entitled *Making music together*, Alfred Schütz (1976) explains that the experience of the ‘We’ that is at the foundation of all possible communication is a mutual tuning-in relationship, a sharing of the Other’s flux of experiences similar to that of two co-performers (let us say a soloist accompanied by a keyboard instrument) who have to execute a piece of music. Each co-performer’s action is oriented not only by the music sheet, but also by the experiences in inner and outer time of his fellow performer. Each of them has not only to interpret his own part, which as such remains necessarily fragmentary, but he has also to anticipate the other player’s interpretation of his—the Other’s—part and, even more, the Other’s anticipations of his own execution. Either has to foresee by listening to the Other, by protentions and anticipations, any turn the Other’s interpretation may take. This is possible because making music together occurs in a true face-to-face relationship. The Other’s facial expressions, his gestures in handling his instrument, in short all the activities of performing, gear into the outer world and have to be grasped by the partner in immediacy. Even if performed without communicative intent, these activities are interpreted by him as indications of what the Other is going to do and therefore as suggestions for his own behaviour. The face-to-face relationship is this dimension that unifies the fluxes of inner time and warrants their synchronization into a vivid present. This togetherness is experienced as a ‘We’. And only within this We-experience do the Other’s body and his movements become meaningful to the partner tuned in to him.

The We-relationship presupposes in the first place a You-orientation, that is, the mode in which I am aware of another human being as a person, the recognition of the Other as a fellow man to whom I immediately and without reflection attribute life and consciousness. The You-orientation, that is, the default mode in human existence (as we are all born and raised within a social world), makes it possible to coordinate temporally the series of my own experiences with a series of yours. While I am living in the We-relationship, I am living in our stream of consciousness. It is like an undivided stream, and every experience is coloured by this involvement. It is an experience of intimacy, an “interlocking of glances”, a “thousand-faceted mirroring of each other” (Schütz, 1967, p. 170). This intimacy is not observed, but lived through. The greater my awareness of
the We-relationship, the less my involvement in it, and the less I am genuinely related to my partner.

This experience of simultaneity and of temporal coordination that I share with you is, in its own turn, the necessary precondition for apprehending your subjective experiential contents and meanings. Understanding another person presupposes this experience of intimacy and simultaneity that Schütz, poetically, names “growing older together”. Given this emotional experience, the following step, the noetic act of recognition, its intellectual side, is a fairly complex mode of relatedness that requires a training entailing five basic steps.

First, I must acknowledge that the life-world of the other person is not like my own. Second, I need to grant the meaningfulness of the other person’s actions as embedded in the other person’s life-world. Third, I must learn to neutralize my natural attitude that would make me evaluate and judge the other’s experience as if it took place in a world like my own. Fourth, I must try to reconstruct the existential structures of the world the other lives in. Fifth, I can finally attempt to understand the other’s experience as meaningfully situated in a world that is indeed similar to my own, but also constantly and indelibly marked by the other person’s particular existence.
Chapter 15

The basic need for recognition

Recognition, thus, requires a preliminary emotional attunement in which, in my You-oriented attitude, I experience my stream of consciousness as coordinated temporally with yours—exactly as it is in the case of making music together (but we could also say dancing together, or making love). The following step, intellectual in nature, in recognizing the other person is to acknowledge the existential difference, the particular autonomy, which separates me from the way of being in the world that characterizes him. Any forgetting of this difference will be an obstacle to recognition since the Other may live in a life-world whose structure is (at least in part) different from my own. I need to set aside my own pre-reflexive, natural attitude, and to approach the Other’s world as I would do while exploring an unknown and alien country. I need to be interested in the invisible semantic ordering of the world the Other lives in. I also must acknowledge that it belongs to my ownmost possibilities as a vulnerable human being. Finally, I need to concede that the way of being in the world of that individual person transcends the concrete situation of that person herself and can thus be envisioned as a universal phenomenon since it belongs to human existence as such.

The constitution of the person as a ‘healthy’ person can only be realized within an intersubjective framework: the Other is needed to achieve basic trust, respect, and integrity. These realizations can only be achieved through the experience of the Other’s recognition. Self-recognition, that is, the recognition of oneself as capable of certain realizations, requires at any step the recognition of the Other (Ricoeur, 2004).

The need and the desire to be recognized as an individual person, and as part of a human society, to be accepted, respected, forgiven, and loved is a fundamental disposition in human existence—as well as eating and staying alive. My existence is conditioned and articulated by the value of social recognition alongside the organic values of my biological life. Yet, the need for recognition can even be stronger than other needs rooted in my organic values:

No doubt the passion to achieve recognition goes beyond the animal struggle for self-preservation or domination; the concept of recognition is not a struggle for life; it is a struggle to tear from the other an avowal, an attestation, a proof that I am an
autonomous self-consciousness. But this struggle for recognition is a struggle in life against life—by life [...] This is the sense in which desire is both surpassed and unsurpassable. The positing of desire is mediated, not eradicated; it is not a sphere that we could lay aside, annul, annihilate. (Ricoeur, 1977, pp. 471–2)

Axel Honneth (2008) shows that we as human persons can choose to renounce, at least in part, our material gains (e.g. a part of one’s salary) in order to achieve social recognition (e.g. respect, dignity, and the acknowledgement of one’s capacities). His analyses of recognition, from a sociological and political standpoint, show that the experience of recognition is indispensable to achieve basic trust, a sense of autonomy, the confidence that is necessary to articulate one’s needs and desires, and to put into use one’s own skills and capacities.

Honneth indicates three paradigmatic forms of recognition.

The first is Love, whereby the person experiences the recognition of his particular needful nature in order to attain that affective security that allows him to articulate his needs. The prototype of this is the experience of parental care. This form of recognition is necessary to achieve ‘basic trust’, that is, to trust oneself.

The second is Law: the subject experiences that juridical institutions guarantee the recognition of his autonomy. This form of recognition is necessary to achieve ‘respect’, that is, to respect oneself.

The third is Solidarity: the subject experiences the recognition of the value of his own capacities. This form of recognition is necessary to achieve ‘integrity’, that is, to feel a meaningful part of society and to contribute with his capacities to sustain other subjects and, reciprocally, to be sustained by them.

These three forms of recognition are basic requirements for the good life. They cannot be achieved by the subject as an individual separated from the others. They can be only achieved through interaction, that is, through the experience of recognition.
Chapter 16

A logic for recognition: heterology

What is the intellectual condition for the possibility of recognition? On which kind of logic is recognition based?

We discussed the role of position-taking in the dialectic between the person and the alterity that inhabits her. The alterity that inhabits me is at the same time extraneous to my person and part of it. It is an indomitable fold of my being, which, as such, encloses a space that is at the same time external and internal (Deleuze, 1988). It is external since it belongs to the involuntary dimension of my being the person that I am, the raw material that constitutes the sedimented part of my being, and sets the boundaries of my freedom: my past, my body, and worldly rules and values that I have introjected. At the same time, this involuntary alterity that dwells in me is part of my self and I am responsible for it, since only as I recognize my involuntary aspect as an incoercible datum can I begin to use it in my service. The logic of alterity, in fact, contradicts the principle of the excluded third. It is ‘me’ and ‘not-me’ at the same time.

A similar logic affects my relation with the alterity embodied by the other person. The other person is alien to me but she is also like me. The other is not like me (empirical dissymmetry) and at the same time is like me (transcendental symmetry), as he is aware of the space that separates him from the Other as he is about to cross it.

The fight for recognition exposes me to defeat. I would like to bring together the thesis affirming that the need/desire for recognition is a basic motivational system in human existence with a second thesis that can be summed up as follows: the essence of human existence is the tragic awareness of the fragility of the reciprocal recognition.

This thesis builds on and extends a distinctly Jaspersian statement: the essence of man is the tragic awareness of the inaccessibility of the Other. Jaspers has addressed this problem several times and has made it the anthropological foundation of his epistemology and ethics (Stanghellini and Fuchs, 2013). The foundation of all knowledge is the unknowable. The foundation of all practice—especially, social practice—is the awareness of such horizons of unknowability. “All practice on the basis of knowledge must rely on the unseen encompassing”, Jaspers writes in *Existenzphilosophie* (1938/1971, p. 24). Shortly after, in a consequential but no less paradoxical way, he adds: “medical treatment must rely on un-understood life” (ibid., p. 24). Jaspers is referring to medical treatment and to the practice of
psychotherapy, but it is obvious that his perspective is that of care in general, the care of oneself, as well as the care of the Other. Once purified from any spiritual, religious, or theological overtone, Jaspers’ sentence can be rephrased as follows:

The essence of man is the tragic awareness of the inaccessibility of the Other—the other toward which he tends.

The theme of the inaccessibility of the Other becomes intelligible only when the Other is seen not only as unreachable, but also as the destination of a movement that attempts to reach the Other and invariably unfolds within a horizon of unattainability.

We may call heterology the logic that posits the Other as radically other, in contrast to a conception of the relationship with the Other based on the category of analogy. Heterology maintains that the Other is not knowable to me as analogous to me. The Other’s experiences, its world, are not grasped if I rely on my own experiences under similar circumstances as the way to understand what happens to her. Rather, as radically different from me, the Other remains unknowable to me. The Other’s logos—that is, the ordering principle behind the meaningfulness of the Other’s world—is not reducible to mine. The Other is ‘hetero-logos’. Of course, the following question remains open: what is the logos and what kind of discourse can be made about the Other?

This experience of the otherness of the Other can be described in different ways: as a failure in the encounter with the Other, as the unknowability of the Other in its entirety, as the irreducibility of the Other to the same, as the radical alterity of the Other, as the infinity of its face, or as the incompatibility between the Other and my desire—and these are only a few of the possible descriptions. All of these descriptions imply a kind of aporetics of recognition.

In this sense, the inaccessibility of the Other is the mark of being human, not a flaw or a subjective inability. Mental pathology from this angle is seen as an awkward attempt to deal with the suffering that results from this tragic experience. In the next section, I will argue that what we call ‘mental pathology’ can be seen as the effect of the intolerability of the awareness of the Other’s radical alterity—that is, as the effect of the reciprocal non-recognition between myself and the Other. In my tending towards the Other I experience the Other as unattainable. I become mentally ill when I cannot bear the irreducibility of the Other to my own categories, when the Other is not compatible with the forms of relationship imposed on me by my own prejudices and desires.

I do not mean that mental pathology develops every time the Other is not encountered. Rather, mental pathology manifests itself when this failure in encountering the Other leads to a state of suffering such as to generate defensive existential movements, alternatives, compensations, escape routes, or shelters that later develop into fixed forms of miscarried existence and become part of the spectrum of what we regard as mental pathology.
Chapter 17

An anthropology of non-recognition

To become (and remain) a ‘healthy’ person, I need to be recognized by the others. I need the others to recognize me in my being-so, that is, in my otherness with respect to them, and at the same time I need their acknowledgement of the value of the otherness that I am. Also, to establish ‘healthy’ relationships, within which I can feel recognized by the Other, I need to be able to recognize the otherness of the Other—and this, we have seen, is not an easy task. Thus, recognition is at the same time a necessary precondition for mental health, as well as for the ‘good life’, and an extremely difficult achievement. Non-recognition, in milder or more severe forms, is the norm and not the exception in human life.

What kind of reaction can generate in me my awareness of non-recognition, be it a kind of emotional dis-attunement, or misunderstanding; or, in general, what could be the outcome of my failed dialogue with the Other?

In order to adequately answer this question it is necessary to make a further premise: first and foremost, we are with the Other. Imagine that at this very moment we are in a meeting or in a symposium. We all probably share a similar feeling (regardless of how mistaken this feeling might be): we are gathered in one place, and we feel that we are engaged in the same activity, we are working on the same theme, and we are all paying attention to each other. We feel that our focus is converging on a particular task, on a shared goal. Implicitly and pre-reflexively, we experience that—first and foremost—we are sharing a situation, and this leads us to feel that we understand each other.

However, the slightest incident is enough to turn such a feeling of mutual understanding into the realization that something is eluding us. Sooner or later, whether because of a misunderstanding, a linguistic inaccuracy, a mismatch between my theoretical premises and yours, or a disjunctive emotion, this initial feeling of mutual closeness inevitably turns into the painful awareness of the illusory character of such closeness. Suddenly, we have the feeling of losing ourselves: you have the impression of losing me, and I have the impression of losing you.

Several philosophers have regarded the failed encounter with the Other as typical of human existence. Some believed it to lie at the basis of our social
life: think of the notion of “idle chatter” in Heidegger (Heidegger, 2010, p. 273)—the foundation of our being with the others is nothing more than the mere illusion of a mutual understanding, of a common discourse.

Encountering the Other on the ground of mutual understanding is nothing but a misconception. However, it is a welcome one, since it appeases one’s anxiety caused by the failure to understand the Other. Even without going that far, I should say that if initially we have the impression of being with each other, in the sense of a mutual understanding (which is a form of pre-understanding, of pre-reflexive understanding), sooner or later everyone experiences this annoying, disturbing, and painful misalignment between oneself and the Other. In what follows I will describe the various ways in which each of us reacts to such painful misalignment.

But before describing the existential movements generated by this painful experience it is important to note that this no longer naïf consciousness can still realign with its previous status and return to being unaware of its experience of misalignment. The desire and the need for recognizing the Other and being recognized by him can serve as a kind of elastic strap that brings one back to the initial state. This distressing experience can simply be repressed. Thereby one can regain the reassuring path of common sense, that is, a “judgment without any reflection” (Vico, 1998, p. 57), which is nothing but a strategy for the domestication of alterity. For the most part, common sense relies on implicit and uncritically accepted categories, a set of beliefs that people assume to be shared by everyone, representing the rock of knowledge and truth. Common sense is essential to experience mutual understanding and to achieve social adaptation (Schütz, 1962, 1970). A good mother should take care of her children; from kids, it is expected that they respect their parents; etc.—such are the abiding certainties of common sense. Common sense relies on two basic dispositives. First, it equates the Other to an impersonal (Das Man, in Heidegger’s terms) entity and to a general role (that is, an external and stereotyped representative of personal identity). Common sense is what one thinks that all the others think. Alternatively, it subjectifies the Other’s behaviour by connecting it to one’s own personal experience: I understand the Other because I would have done the same thing in such circumstances. Each case is subsumed under an impersonal or a personal rule. And when this is not possible, any anomaly is normalized as, in fact, an exception—which means that it is classified as an anomaly. Such anomaly is attributed to another general category—that of the abnormality.

Common sense is just one way to recover from the failed encounter with the Other. Different to common sense, but homogeneous to it with respect to strategies and outcomes, is the domain of scientific knowledge (and especially of its commonly accepted beliefs) as another strategy for the domestication of
the alterity. Scientific knowledge reduces the Other to a particular instance of a general category. Scientific knowledge, in the area of psychology and psychopathology, builds on and formalizes naïf knowledge about the Other: the other acts in a certain way because he is shy, outgoing, impulsive, paranoid, or hallucinating. Scientific psychological and psychopathological knowledge has laid the foundations of our knowledge of abnormality, thereby complementing common sense in its task of domesticating our experience of the Other. Common sense knowledge may also appropriate scientific knowledge. An example of this is the concept of ‘unconscious motivation’ that common sense has drawn from depth psychologies in order to make sense of the Other’s irrational behaviour. Obviously, since it works through generalizations, this kind of knowledge can do so only at the price of ignoring the individuality of the Other and the uniqueness of the relationship that one has with the Other.

Common sense and the vulgate of scientific psychology usually coexist and cooperate in the process of domestication of the experience of the Other that takes place in our everyday existence. However, in case these strategies prove not sufficiently effective, alternative defensive strategies may emerge, which transform the naïveté of the experience in a kind of practical philosophy devised for more sophisticated—because supported by speculative and quasi-philosophical arguments—strategies for the domestication of the alterity of the Other. People assume a ‘philosophical’ stance to find their way in relating to the others and in coping with the frustrating experience of the missed encounter with the Other.

These quasi-philosophies are shelters, defensive housings with respect to my failure in dealing with the aporias of recognition. I may enter into such housings when I am exasperated by my incapacity to understand the Other, as well as when I am frustrated by my experience of not being recognized by the Other. In general, I enter into one of these shelters when commonsensical assumptions are jeopardized. When I enter into one of these shelters, a given kind of pathway to non-recognition becomes a structured and structuring organization for me. My shelter protects me from the moral pain produced by the experience of non-recognition, but endlessly produces other experiences of non-recognition. It cannot be overseen—I cannot see beyond my shelter. It is extremely difficult to become aware of the housing I live in, of its precariousness, and of the way it structures my relationships. My shelter is a habitus, a disposition that generates practices, beliefs, perceptions, feelings, and so forth about social encounters. From the vantage of my shelter, the Other is no more an event that impresses me, stirs my emotions, and awakens my spirit—as Buber would say. Rather, it is an anomaly to be normalized.
For example, there is one of these shelters that could be defined as sceptic. A sceptic is someone who believes that the words of the Other may well hold some sense, but that such sense is not accessible, and the meaning of the Other’s discourse is incomprehensible. By adhering to a philosophy that proclaims the Other’s incomprehensibility, and without attempting any further approach towards the Other—in other words, by taking for granted the emptiness and futility of any real dialogue with the Other—the sceptic finds relief from the anguish caused by his incapacity to recognize the Other.

The irreducibility of the discourse of the Other to one’s own can also originate a second kind of movement, which consists in a withdrawal from this uncanny feeling of misalignment. We could define such a disdainful estrangement from the Other as cynical: the discourse of the Other, according to this view, is senseless, and therefore it is pointless to look for its meaning. It is not even a discourse. Actually, it is regarded as situated outside the realm of meaning and meaningfulness. Therefore, any effort to understand such discourse, to dialogue with it, is in vain. Recognition cannot even be contemplated when the discourse of the Other is deemed senseless. Therefore, other modes of interaction should be taken into consideration (incidentally, the cynical mode of interaction with the Other is that of technology, which represents an objectifying knowledge slightly more sophisticated and presumptuous than the one described earlier).

There is also a third mode of distancing oneself from this painful and uncanny failure in understanding the Other, which we might call the mystical way of the failed encounter. According to this view, when I move towards the Other I am still wrapped and trapped in my own vestments and prejudices: these encrusted layers of theory do not allow me to understand and encounter the Other. Such encounter becomes possible only once all these layers are shaken off: a mystical encounter with the Other, one that allows me to meet him authentically, is possible only through this process of purification.

However, the mystical way does not belong to the dimension of an authentic encounter with the Other, but is to be placed next to the domains that I have defined as sceptical and cynical. Even assuming that the mystical option could really lead to an encounter with the Other, its results would be uncontrollable— especially as regards its effects on the Other, whose autonomy is only partially preserved. This makes the very shiny expectations of this approach appear under a different light. Besides, the presumption of authenticity typical of this approach makes it a very dangerous practice from an ethical point of view, and also a spurious one epistemically (in fact, it is assumed here that the most authentic experience is that of the encounter with the Other rather than the awareness of the failure, contrary to what we assumed).
Other approaches could of course be added to the list. Everyone can give his personal contribution: for example, someone may propose an agnostic way (whose motto is I don’t care about the problem of recognition), and so on. I shall simply add another one: the way of contemplation. According to this view, while it is impossible to recognize the Other, it is possible to contemplate it. The Other cannot be recognized through the process that we earlier described: one’s attitude towards the Other must be and remain a purely contemplative one. Here there is no real encounter, because this is impossible, but the authenticity of the experience is preserved as long as I stay here and the Other stays there. The Other is there, exerting a strong and enchanting pull on the one who contemplates; however, any pragmatic move from both sides is excluded. The Other and I stand face-to-face as the antithesis to the thesis.
Part Two

Psychopathology: what is a mental disorder?

What has turned us around like this, so that,
Whatever we do, we always have the aspect
Of someone who leaves?

This is what Fate means: to be opposite,
And to be that nothing else, opposite forever

Lovers are close to it, in wonder, if
The Other were not always there closing off the View

(R. M. Rilke, *Eighth Elegy*, 1968)
Chapter 1

First steps towards the person-centred, dialectical model of mental disorders

We are dialogue: of the person with herself, and with other persons.

Mental disorder is the crisis of the dialogue of the person with the alterity that inhabits her, and with the alterity incarnated in the other persons. Human existence is a yearning for unity and identity. Yet, this attempt is unfulfilled in the encounter with alterity, that is, with all the powers of the involuntary. A further source of dissatisfaction is the awareness that the other person can only be approximated, not appropriated, and that our need for reciprocal recognition is an unlimited struggle and a spring of frustration.

The encounter with alterity is also a form of collision between opposite values. All this generates feelings of estrangement. Mental pathologies may be read as miscarried attempts to struggle for a sense of reconciliation, to heal the wounds of disunion.

Care is an effort to reconstruct such a vulnerable dialogue of the soul with herself and with others based on two pillars: a dialectic, person-centred comprehension of mental pathology, and values-based practice.

The dialectic understanding of mental disorders assumes that the person is engaged in trying to cope with and make sense of puzzling experiences stemming from her encounter with alterity. Each patient, urged by the drive for the intelligible unity of her life-construction, plays an active role in interacting with these experiences and thus in shaping her symptoms and the course and outcome of her illness.

In values-based practice, value-pluralism and recognition are the basis for clinical practice. This statement reflects the ideal of *modus vivendi* that aims to find terms in which different forms of life can coexist, and learn how to live with irreconcilable value conflicts, rather than striving for consensus or agreement.

Mental symptoms are not the direct effects of a psychological or biological dysfunction. A person’s symptom is the outcome of her need for self-interpretation with respect to her encounter with alterity, that is, with puzzling experiences.
Psychopathological symptoms are the outcome of a disproportion between the person and the disturbing experiences that stem from her encounter with alterity. Alterity is made manifest as a kind of estrangement from oneself and alienation from one’s social environment. The person’s attitude is characterized by her attempt to achieve a self-interpretation of her disturbing and perplexing experiences, alongside a constant search for personal meaning.

The encounter with alterity may offer the vantage from which a person can see herself from another, often radically new, perspective. Thus, otherness kindles the progressive dialectics of personal identity. Narratives are the principal means to integrate alterity into autobiographical memory, providing temporal and goal structure, combining personal experiences into a coherent story related to the self. Yet, the encounter with alterity is also the origin of mental symptoms. The production of a symptom is the *extrema ratio* for alterity to become discernible. Psychopathological symptoms are the outcome of miscarried attempts to give a meaning to distressing experiences, to explain and cope with them.

The main difference between this person-centred understanding of mental disorders and an exclusively neurobiological model is that in the latter the patient is conceived as a passive victim of her symptoms, whereas the former attributes to the patient an active role in shaping her symptoms, course, and outcome. Urged by the painful tension that derives from the drive for the intelligible unity of life-construction (Mayer-Gross, 1920), each patient, as a ‘goal-directed being,’ plays an active role and stamps her autograph onto the raw material of her basic abnormal experiences. When a clinical syndrome emerges, the line of the pathogenic trajectory is the following: (1) a disproportion of alterity and the person’s resources for understanding, of emotions and rationality, of *pathos* and *logos*, of otherness and selfhood bringing about a disturbing metamorphosis of self and world experience; (2) a miscarried autohermeneutics or self-interpretation of one’s abnormal experiences and of the transformations of the life-world that they bring about; (3) the fixation in a psychopathological structure in which the dialectics between the person and alterity gets lost.

This person-centred, dialectic approach helps us to see the patient as meaning-making entity rather than passive individual. The patient “can see himself, judge himself, and mould himself” (Jaspers, 1997, p. 424). His attempts at self-understanding are not necessarily pathological and are potentially adaptive.

This approach contains a theoretical framework and practical resources for understanding the diversity of psychopathological structures, including symptom presentation, course, and outcome as a consequence of the different ways
patients seek to make sense of and value the basic changes in self and world experiences. It also contains a framework for engaging with human fragility by means of a person-centred, dialectic therapy.

The person-centred, dialectic approach involves two fundamental attitudes to mental illness:

- It is a therapeutic approach that acknowledges the subjective fragility constitutive of human personhood.
- It also insists, however, on our responsibility to care for this fragility for becoming the person that we are.

To become the person that we are, we must become aware of what we care about because being a person is to take upon oneself the responsibility involved in what one cares about. This approach is sensitive to the constitutional fragility of ‘who’ and ‘what’ we are and thus conceives psychopathological structures as the result of a normative vulnerability intrinsic to being a human person. It insists that to help a suffering person is to help that person to responsibly deal with the obscure entanglement of freedom and necessity, the voluntary and involuntary, and with her sufferings as the result of the collapse of the dialectic of selfhood and otherness.
Chapter 2

What is a symptom?

Handbooks of psychiatry and clinical psychology usually present a list of phenomena that should be assessed and treated. By doing so, they establish a system of relevance concerning what should attract the clinician’s attention. These relevant phenomena are called ‘symptoms’.

Of course, there are different psychopathological paradigms (among which the biomedical, the psychodynamic, the phenomenological, etc.) and each paradigm has its own hierarchy of priorities (what should be the clinician’s focus of attention) as well as its own concept of symptom. As a consequence of that, the concept of symptom covers a vast array of indexicalities. In biological medicine, a symptom is the epiphenomenon of an underlying pathology.

Red, itchy and watery eyes, congestion, runny nose and sneezing, sometimes accompanied by itchy ears and buzzing sound, itchy and sore throat, cough and post-nasal dripping are known to be the manifestation of an inflammation of the respiratory apparatus.

But long before we found out what was the cause of these disturbing phenomena (namely, rhinovirus infection), we all knew that they were the symptoms of a mild, although distressing and untreatable, disorder called the common ‘cold’. Within the biomedical paradigm, a symptom is first of all an index for diagnosis, i.e. it is used by clinicians to establish that the person who shows that symptom is sick (rather than healthy), and that he or she is affected by a particular illness or disease.

The principal utility of any system of medical taxonomy relies on “its capacity to identify specific entities to allow prediction of natural history and response to therapeutic intervention” (Bell, 2010, p. 1). The biomedical understanding of ‘symptom’ is clearly coherent with this. Biomedical research aims to sharpen its tools to establish increasingly more reliable and valid diagnostic criteria. Its real ambition is not simply to establish a diagnosis through the assessment of clinical manifestations (i.e. symptoms), but to discover the causes of these symptoms (aetiology) and the pathway that leads from aetiology to symptoms (pathogenesis). “Ultimately, disease specification should be related to events related to causality rather than simply clinical phenotype” (ibid., p. 1). It is assumed that progress in medicine is dependent on defining pathological entities as disease
WHAT IS A SYMPTOM?

based on aetiology and pathogenetic mechanism—rather than as clinical syndromes based on symptom recognition. In the biomedical paradigm the truth about a symptom is its cause. The main, more or less explicit, assumptions in the biomedical paradigm are the following: (i) each symptom must have at least one cause; (ii) this cause lies in some (endogenous or exogenous) noxa affecting the living organism; (iii) the presence of a symptom causes some kind of dysfunction (cause → symptom → dysfunction). Also, (iv) if we want to eliminate a symptom, we should eliminate its cause or interrupt the pathogenetic chain that connects its putative aetiology with the symptom itself.

Thus, the biomedical paradigm is a knowledge device based on the concept of ‘causality’. In general, causality (in the biomedical paradigm) goes from aetiology (in our example, the presence of a virus), to symptom(s) (breathing difficulties), to dysfunction (poor physical performance due to blood hypo-oxygenation, and thus reduced adaptation of the person to his or her environment).

An important, implicit assumption is also that symptoms are considered accidental, i.e. non-essential (synbebekos, as in the sense stipulated in Aristotle’s (1991) Metaphysics) to the living organism, whereas the absence of symptoms is considered essential—i.e. normal to living organisms. In other terms, health is considered normal, whereas disease is considered abnormal.

Many of these assumptions—if we apply this paradigm to the field of psychic pathology—are at least controversial, or even counterfactual. What is of utmost interest here is the fact that in the biomedical paradigm, symptoms have causes, not meanings. This assumption has been challenged by the psychodynamic paradigm. But before we analyse the shift from the biomedical to the psychodynamic concept of ‘symptom’, let us focus for a while on the relationship between symptom and dysfunction with the help of the criticism of the biomedical paradigm that arises from evolutionary (Darwinian) medicine. Diagnosis, in the biomedical paradigm, puts emphasis on symptom profiles, as symptoms are considered the most proximal indicators of a disorder. From an evolutionary viewpoint, a clinical assessment that focuses exclusively on signs and symptoms limits itself to explaining only partial features of disorders. According to Darwinian psychiatry, clinical assessment should focus primarily on functional capacities and person–environment interactions (Troisi and McGuire, 1998). It is argued that the capacity to achieve biological goals is a better measure of health than the absence of symptoms because it is an indication that the individual possesses those optimal functional capacities that promote biological adaptation.

From an evolutionary perspective, not only do symptoms cause dysfunction, but also dysfunction or maladaptation may generate symptoms. When classified from an evolutionary perspective, symptoms can be divided into two broad
categories: symptoms as defects in the body’s mechanisms, and symptoms as useful defences. For example, seizures, jaundice, coma, and paralysis have apparently no adaptive function and arise from defects in the organism. But many other manifestations of disease are defences. Vomiting eliminates toxins from the stomach. The low iron levels associated with chronic infection limit the growth of pathogens. Coughing clears foreign matter from the respiratory tract (Troisi, 2011). In the field of mental pathology, it is argued by evolutionary psychiatrists that some depressive symptoms may have adaptive functions serving in the regulation of behaviour and psychological processes. For instance, crying elicits comforting behaviours and strengthens social bonds, whilst pessimism withdraws the individual from current and potential goals. Also, absence of positive emotions discourages approach behaviour and risk-taking. More generally we could explain depressive behaviour by saying that someone withdraws depressively in order to protect himself socially. Thus, the Darwinian concept of disorder—including mental disorder—encourages clinicians to consider re-prioritizing their selection of diagnostic criteria to ensure that the focus shifts away from mere symptom profiles and towards a comprehensive data collection that includes functional capacities.
Chapter 3

The truth about symptoms

Early psychodynamic conceptualizations of ‘symptom’ address both the cause of a symptom and its meaning. Before Freud, no one asked about the meaning of a symptom. Or better: no one posed this question systematically and rigorously. However, since the main aim of early psychoanalytic thinking is to answer the question ‘What is the origin or cause of this psychical symptom?’, it still represents a mechanistic view in touch with the biomedical model. But at the same time early psychoanalysis paved the way for the quest for the meaning of the symptom: ‘What does that symptom mean?’.

Psychodynamic thinking develops its genealogy of symptoms around two main pathogenetic devices: trauma and conflict. The psychodynamic question of trauma was first posed by a French neurologist—Jean-Martin Charcot. We are in the year 1885.

Charcot examines a group of patients who underwent a physical shock and developed a series of motor or sensory symptoms—typically some sort of paralysis or anaesthesia. Charcot’s careful medical assessment established that: (i) the physical shock was very mild and left no traces in the patient’s organism, whereas symptoms still persist—these symptoms are (so to say) sine materia; (ii) the motor and/or sensory symptoms, their localization, the way they are correlated with each other, do not correspond to an organic lesion of the nervous system; that is these symptoms do not correspond to the symptoms one could expect as a consequence of any given lesion of an area of the nervous system. The localization of these symptoms—namely hysterical symptoms—in the patient’s body does not reflect the rules of anatomy; rather, these symptoms mirror a kind of imaginary anatomy that imitates true anatomy.

From these observations Charcot concludes that these symptoms are the outcome not of a physical, but of a psychic, trauma. Hysterical symptoms are not the epiphenomena of a neurological lesion, but rather the manifestation of a psychopathological syndrome. Hysterical symptoms force Charcot (and later Freud) to see behind the neurological body another kind of body—the “sexual body” (Foucault, 2003). Medicine in general, and psychopathology in particular, from Charcot and Freud onward, must consider the existence of another kind of body next to the neurological one: this new body is the psychological representation of the body or “representational body” (Leoni, 2008, p. 18), whose imaginary anatomy does not correspond to the anatomy prescribed by the cortical homunculus discovered by neurology.
The representational body, according to Charcot (as explained by Foucault), enters into the mind of a person during a traumatic event and will be inscribed in his cortex “as a kind of permanent injunction” (Foucault, 2003, p. 274).

Some neurotic symptoms are the outcome of a conflict—usually a conflict between an unconscious drive (typically: a sexual desire) and a proscription or prohibition by the Ego.

According to classic psychodynamic theory (Freud, 1905), this conflict generates anxiety, and anxiety “alerts” the Ego that a defence is necessary. Defences lead to a compromise between the Ego and the Id. This compromise is the symptom: a symptom is therefore a compromise that at the same time defends the patient from the desire that emerges from the Id, and satisfies this desire in a masked form. Freud (1926, p. 91) wrote:

> The main characteristic of the formation of symptoms have long since been studied and, I hope, established beyond dispute. A symptom is a sign of, and substitute for, an instinctual satisfaction which has remained in abeyance; it is a consequence of the process of repression. Repression proceeds from the ego when the latter—it may be at the behest of the super-ego—refuses to associate itself with an instinctual cathexis which has been aroused in the Id. The ego is able by means of repression to keep the idea which is the vehicle of the reprehensible impulse from becoming conscious. Analysis shows that the idea often persists as an unconscious formation.

It is clear that psychodynamically oriented clinicians cannot avoid delving into this profound dimension of abnormal behaviours entailing the reconstruction of traumatic events and the unearthing of conflicts.

Psychodynamic thinking has a number of basic assumptions or postulates. Brackel nicely sums up these underlying assumptions (2009). First, all psychological events have, at least as one of their causes, a psychological cause, and can thereby be at least in part explained on a psychological basis. Second, all psychological events can be understood as psychologically meaningful to the person who displays them. Third, there exists a dynamic unconscious that must be posited because without such a postulate many psychological events are neither psychologically explicable nor psychologically meaningful.

As a consequence of these postulates, psychodynamically oriented clinicians will not merely focus on conscious phenomena like overt symptoms, but will try to elicit unconscious or pre-conscious mental phenomena (e.g. repressed thoughts, representations, fantasies, desires, etc.) by means of free associations (as well as by asking open questions, leaving certain kinds of pauses, not always trying to reduce the patient’s anxiety, etc.). Also, they
will focus on unconscious defence mechanisms (e.g. displacement, idealization, projective identification, etc.), or other subpersonal devices (e.g. attachment styles, self- and other-representations, etc.), as well as on the patient’s personal life-history (not merely the medical anamnesis) and interpersonal patterns that will complete the psycho(patho)logical picture. The Psychodynamic Diagnostic Manual (PDM Task Force, 2006) clearly states that symptom patterns can only be understood in the context of the personality of the patient and of his mental functioning, since symptom patterns are the explicit expressions of the ways patients face and cope with their life experiences. The reason for this extended assessment beyond mere symptoms or isolated behaviours is exquisitely practical: treatments that focus only on symptoms are deemed ineffective in producing changes and recovery (Westen et al., 2004).

In a symptom, as we saw earlier, an unconscious desire seeks to make itself manifest. What is at stake within a symptom is a repressed desire repugnant to the consciously accepted self-conception and values of the person. This desire, if it is to gain satisfaction, needs to be expressed indirectly. Whilst some symptoms function to express repressed desire (or are a product of defence mechanisms other than repression, such as projection, projective identification, splitting, etc.), others seem to be “unmentalized” (Fonagy and Target, 1997) fragments of emotions or of self-experience (McDougall, 1996). For instance, one way of understanding a patient who somatizes is conceiving of her symptom as a product of anxiety that cannot be understood by the patient and instead is experienced merely bodily. It is as if the meaningful affective component is not simply repressed, but never had the chance to develop—because of an inadequate early environment, for example.

In contrast to the biomedical paradigm, in the psychodynamic approach the symptom asks to be heard and deciphered—rather than to be explained and removed. Lacan’s conceptualization of ‘symptom’ is a good example of the turn from searching for the causes of a symptom to searching for its meaning in psychoanalytic thinking. According to Lacan (2005), a symptom (that he spells *sinthome*) is a special kind of speech act through which the unconscious is made manifest. The unconscious itself is structured as a language, and a symptom is a meaningful event. A symptom is a signifier that takes the place of a signified that has been repressed. It is a kind of embodied metaphor (Miller, 1990). The Lacanian understanding of ‘symptom’ completely reverses the biomedical concept. A person’s symptom is not accidental (*synbebekos*) to that person; rather it is the manifestation of his or her true identity. Lacan
even held that someone’s symptom could be the most authentic thing he possesses. A symptom has a similar structure to Heidegger’s *aletheia* (literally: unhiddenness). Although obviously Heidegger’s concept is much broader than the notion of symptom I am discussing here, both play a kind of revelatory role. The symptom as *aletheia* is the place where truth about oneself manifests while hiding itself.
Chapter 4

Symptom as cypher

The symptom is not an accident to that person; rather it displays his true essence. As such, it is the contingent opportunity of a possible encounter between the person and alterity. Symptoms are the via regia to recognition, as they express the person’s vulnerability. Someone’s vulnus displays what is most personal and intimate to him.

“Come inside— says Eumeus to Ulysses when he arrives at his hut—and when you have had your fill of bread and wine, tell me where you come from, and all about your misfortunes” (Homer, 2005, XIV, p. 47). Only after Odysseus has had a hearty meal of pork does Eumeus ask about his story:

And now, old man, tell me your own story; tell me also, for I want to know, who you are and where you come from. Tell me of your town and parents, what manner of ship you came in, how crew brought you to Ithaca, and from what country they professed to come—for you cannot have come by land.

The recognition of Ulysses in the episode of Euryclea— Ulysses’ wet-nurse— comes with the recognition of his scar. As Euryclea is putting Ulysses’ feet in a basin of water, she notices a scar on one of his feet. She immediately recognizes it as the scar that he received when he went boar hunting with his grandfather Autolycus:

As soon as Euryclea had got the scarred limb in her hands and had well hold of it, she recognized it and dropped the foot at once. The leg fell into the bath, which rang out and was overturned, so that all the water was spilt on the ground; Euryclea’s eyes between her joy and her grief filled with tears, and she could not speak, but she caught Ulysses by the beard and said, ‘My dear child, I am sure you must be Ulysses himself, only I did not know you till I had actually touched and handled you.’ (ibid., XIX, p. 392)

This has a clear correspondence in Karl Jaspers’ concept of ‘cypher’ (2003). What stays beyond the limit of our knowledge, which in Jaspers’ parlance is named the Encompassing (das Ungreifende), manifests itself through cyphers. “Cypher-reading is the primary requisite of manhood” (ibid., p. 50). Cypher-reading is an essential character of being a man. Cyphers show what without them would remain implicit for us. Symptoms are a special category of cyphers: through them alterity, that is, the hidden yet operative (and perplexing, or disturbing) dimension of our existence, is made manifest. Like a patient’s symptom, which is not accidental to that patient but is rather the manifestation
of his or her true identity, cyphers are the contingent opportunity of recognition, that is, of a possible encounter between the person and the encompassing dimension of her existence.

The cypher must keep on an inexhaustible signification with which no definite interpretation is commensurate (ibid., p. 42). If the cypher “becomes fixed and definite and turns into an object, then it loses its essential force. It collapses into a sign” (ibid., p. 49). Cyphers must not be crystallized into a kind of definite, categorical concept. The meaning(s) of the cypher must be kept “in suspension” (ibid., p. 38)—remain unsaturated. The defection from the cypher to the pure concept (as occurs when the cypher grows a single meaning), as well as the interpretation of a cypher as if it were a symbol (such as when the cypher is interpreted through an ‘other’), destroys the force of the cypher.

Phenomenology is essentially concerned with laying bare the structure of the life-world inhabited by a person. A symptom is a feature of a person’s life-world whose meaning will be deciphered by grasping the deep architecture of the life-world itself and the person’s invisible transcendental structure that projects it. Life-world, in Edmund Husserl’s sense (1970), is the original domain, the obvious and unquestioned foundation of our everyday acting and thinking. In its concrete manifestations it exists as the realm of immediate evidence. Although the majority of people are situated within a shared life-world, there are several other frameworks of experience—for example, fantasy worlds, dream worlds, and “psychopathological worlds” (Schütz and Luckmann, 1989). Abnormal mental phenomena are the expression of a modification of the ontological framework within which experience is generated. The overall change in the ontological framework of experience transpires through the single symptoms, but the specificity of the core is only graspable at a more comprehensive structural level (Parnas, 2004; Stanghellini and Rosfort, 2013a; Stanghellini and Rossi, 2014). The experience of time, space, body, self, and others, and their modifications, are indexes of the patient’s basic structures of subjectivity within which each single abnormal experience is situated.

Before we proceed in this direction, I need to clear the ground of a possible misunderstanding. To consider phenomenology as a purely descriptive science of the way the world appears to the experiencing subject is a serious mistake, although it is true that phenomenology sponsors a kind of seeing that relates to something already there, rather than to what stands before, beyond, or behind what is existent. “Making the invisible visible” can instead be taken as the motto of phenomenology, just as it was the passion that possessed many of the artists of the twentieth century and the intellectual motor of the major scientists of the “invisible century”, including Einstein and Freud, in their search for hidden universes (Panek, 2005).
Phenomenology shares with Modernism, and with the *Zeitgeist* of the twentieth century, a passion for the invisible, and a sceptical stance towards the way things are seen in the natural attitude, that is, in straightforward cognition. It sponsors a sui generis kind of seeing—enlightening the enigmatic poetry of familiar things. But, especially in its hermeneutic coté, it is also resolutely tied to hearing and the spoken word since—as Gadamer (2004, p. 458) has acknowledged—“the primacy of hearing is the basis for the hermeneutical phenomenon”.

The symptom is conceived as a part of a discourse, to be deciphered and analysed as a text. The issue, then, is how to rescue its invisible and unintended meaning. All human deeds can be produced or reproduced as a text. As discussed in Part One, Chapter 11, the text is produced by an act of exteriorization. Once it is produced, it is no more a private affair, but stays in a public space independent with respect to the voluntary and conscious intention of its author. An example of this is the following:

A patient is overcome by a feeling of estrangement from himself when he recounts an event of his life during a therapy session: ‘Doctor, I have repeated to myself this story so many times, but now that I tell it to you it sounds to me completely different. I got so bored with this way of telling my story over and over again that now it appears totally extraneous to me. Now I see it from a completely different angle!’

Another, even more explicit, example is the parapraxis, that is, the emergence of an unintended meaning while putting a fact into words.

Consider a solitary and rather ascetic person who, coming back from a trip during which he had the chance to meet a lot of people including several girls, tells the therapist: ‘You know, one evening I even took a photo with the sex of them’ (of course, what he meant to say was ‘with the six of them’).

The externalization and objectification of oneself via the production of a text implies a distanciation from oneself. The meaning of the text becomes autonomous with respect to the intentions of his author. Now, the author’s meanings and intentions do not exist only for-himself, but also for-another.

This process of autonomization of the text was explored in Part One, Chapter 14. Indeed, there is a parallel between a text and an action because in the same way as a text is detached from its author, an action is detached from its agent and develops consequences of its own. Just as every action involves a recoil of unintended implications back upon the actor, every text—including symptoms—implies a recoil of unintended meanings back upon its author.

Whenever we act, via the externalization of our intentions, we experience a kind of alienation and estrangement from ourselves. We discover alterity within ourselves. The symptom deployed as a text exposes its author to this very destiny (see Ricoeur, 2004; Stanghellini, 2011). A text is the product of an action—a
linguistic action. Like all actions, once produced the text shows the disparity between the author's conscious intentions and unintended consequences. The symptom exposed like a text recoils back upon its author, displaying the discrepancy between the private intended sense and its public tangible result. The text, as the tangible result of a linguistic act, with its unintended consequences, reflects—makes visible—the 'mind' of the author much more faithfully than a simple act of self-reflection. To paraphrase Hegel, the 'mind' cannot see itself until it produces a text objectifying itself in a social act. Because all conscious intentions are incomplete, self-reflection is just an incomplete form of self-knowledge. A person cannot discern alterity within himself until he has made of himself an external reality by producing a text, and after reflecting upon it.

The production of a symptom is simply a particular case of this general rule. As a text, in the symptom alterity becomes manifest. A symptom is the outcome of an interrupted dialogue between the person and alterity. The symptom is nothing but a text by which an unrecognized alterity is made manifest. When alterity is no more integrated into the narrative the person fabricates about herself, a symptom is produced as an *extrema ratio* for alterity to become discernible. The symptom is the last chance for the person to recognize herself.

To note, the essential question is not to recover, behind the text, the lost intention of the author (as it is often the case with the psychodynamic paradigm) but rather, to unfold “in front of the text, the world which it opens up and discloses” (Ricoeur, 1981, p. 111). Alterity comes into sight, materializing in the pleats of the text I have produced. By unfolding the pleats of the text in front of me, I get a panoramic view of how the parts of the text are articulated. To paraphrase Merleau-Ponty (1964), the mystery is exposed in the exteriority of things perceived in their reciprocal intertwining.

A patient in his fifties is going through a rather difficult period in his life. He says that he feels 'anxious, unstable, precarious, and I don't know why.' His mood is almost inscrutable and unintelligible to him, and this makes him more and more insecure, tense and nervous. During a session he tells the following story: 'You know, this may sound irrelevant to you; none the less I will tell you what happened to me this week. I have been travelling a lot, and every morning I woke up in a different place. One day very early in the morning I took the elevator to the breakfast room, my eyes still half shut. All of a sudden I see a shadow in the elevator and I think: 'What's my father doing here?' Of course, it was my image in the mirror of the elevator.' During the following sessions he remembers that when he was about 10, and his father about 50, his parents had a horrible conjugal crisis apparently caused by their infidelities. His father, who was a businessman, was often away from home and—he says—'he could not take care of his marriage in a proper way.' His bad mood was an allusion to the resemblance between his situation and that of his father when he was about his age, and a warning to take care of his family better than his father did. What could disclose the enigma of his bad mood was grasping the relation between his bad mood, being often away from home,
and the analogies between his present situation and his father’s when he was about his age, through the resemblance between his own and his father’s image in the elevator. He could get a panoramic view over all these phenomena, see their connections—the bonds that tie each element of the story with the others.

This patient could now see himself, his own present situation, from the vantage point of his father’s story. He could also discover in himself his father as the alterity that was haunting him—his father as a destiny to be avoided. ‘Only after making these connections’—he once said—’I realized that my bad mood was the way through which all this was revealed. My feeling shaky, wobbly, unsteady was indeed an admonition: ‘Give yourself a form, a form different from that of your father!’

This is a kind of understanding that “seeks to find the logos of the phenomena in themselves, not in underlying subpersonal mechanisms” (Fuchs, 2008, p. 280). The symptom, then, in the phenomenological–hermeneutic paradigm is an anomaly, but not an abnormal, aberrant, or insane phenomenon in a strict sense. Rather, it is a salience, a knot in the texture of a person’s life-world, like a tear in the matrix. It is a place that attracts someone’s attention, catches one’s eyes, and awakens one’s care for oneself in a double sense. The symptom reflects and reveals alterity in oneself—in it alterity becomes conspicuous. From the vantage offered by the symptom one can see oneself from another, often radically different and new, perspective.
Chapter 5

Conflicting values: the case with post partum depression

What we can learn from a psychodynamic understanding of the concept of ‘symptom’ can be summed up as follows: (1) symptoms are not accidental to a person, rather they express a fundamental trait of her vulnerability; (2) symptoms are the outcome of a mediation between some kind of disturbing experience and the person; (3) these disturbing experiences arise out of a conflict or a trauma; (4) symptoms have meanings to be deciphered next to causes. In the previous chapter I focused on the first point and on the last one. In this chapter I will concentrate on point (3) and set the concept of ‘conflict’ within the theoretical framework developed in the first section of this book.

A young woman develops a kind of palsy that mimics paraplegia a few days before she is going to get married. Careful medical assessment excludes any sort of neurological deficit. Imagine that through careful interviewing we can ascertain that she suffers from the unconscious desire not to marry her promised husband (or not to get married at all), and that she cannot manifest this desire, not even to herself. Her symptom, which impedes her walking to the altar, satisfies her desire in a masked form, and at the same time it speaks on behalf of her desire.

This can be taken as a paradigmatic example of the understanding of the relationship between conflict and symptom formation from the psychodynamic angle. The patient’s symptom (‘paraplegia’) has a psychological cause (conflict) that kindles a pathogenetic cascade. This cascade involves a disturbing affect (anxiety) that alerts defence mechanisms (repression and conversion) that, in turn, lead to the formation of a symptom as a compromise between two clashing desires (getting married and not getting married) and two corresponding clashing values. These conflicting values can be spelled out as ‘do not get married if you do not want it’ and ‘keep your word if you promised to get married’.

In this case, one of the desires is unconscious—it belongs to the dynamic unconscious as the outcome of repression. Yet, it is not always necessarily so. Conflicts do not inevitably involve an unconscious desire—they involve plurality. Conflicts go with being human, in society as well as in the soul. We are intrinsically plural, as we are inhabited by alterity, and the forms of human life are inherently plural too. There is an inner cleavage in man’s innermost nature:
whatever he thinks of himself, he must think against himself and against what is not-himself. He sees everything in conflict or in contradiction [...] The decisive point is that he must always be setting himself in opposition to himself. There is no human existence without cleavage. Yet he cannot rest content in this cleavage. The way in which he overcomes it, the way in which he transcends it, reveals the conception he has of himself. (Jaspers, 2010, p. 146)

Jaspers (along with many others philosophers of the twentieth century) subscribes to an *anthropology of disunion*. Disunion does not amount merely to internal conflicts in a strict psychoanalytical sense; rather, it is the ubiquitous presence of non-coincidence and eccentricity. Human existence constantly escapes any coinciding with an essence. This is the signature of the human condition: its perennial duality, otherness-haunting selfhood, complexity-challenging one-sided concepts, antithesis-troubling, so that we are condemned to perpetual self-becoming. This anthropology of disunion is also a theme that Jaspers takes up in his studies on tragedy (Jaspers, 1952), epitomized in Iago’s lament “I am not what I am” (Shakespeare, *Othello*, I). Disunion also means that the human condition is one of radical homelessness, of diaspora, and of nostalgia. I am away from myself. But I cannot rest content in my condition of separateness. I cannot find peace by simply defining myself an outcast, someone decentred, away from home. I constantly set myself the task of overcoming my condition of disunion. Domesticating disunion, dialoguing with alterity, and reaching a condition of intimacy with it is a task in human existence. The way man faces this task reveals the conception he has of himself.

Disunion, finally, means that I am called to take a position in front of myself, and more specifically in front of the otherness I experience in my existence. I do not coincide with my experience. There is a cleavage between myself and my suffering. I am a self-interpreting animal and thus I am compelled to make a logos out of my pathos. To be human is to deal with this reflective duplicity by taking upon myself the responsibility for articulating, making sense of, coping with, and appropriating experiences—well aware that the logos is always restless and fragile (Stanghellini and Rosfort, 2013).

'I thought it was right to have a baby in this moment of my life. My husband had had a promotion and I had my job. We had a beautiful house ... only a child was missing! So we decided to have a baby. The baby arrived soon afterwards and I felt euphoric. I focused on all the things that needed to be done: the medical checks; the dietary restrictions; the training course for pregnant women; the proper arrangements for the arrival of the baby ... everything that needs to be done during the pregnancy. When the baby arrived nothing was like I had planned and imagined. I was terribly afraid I had to give up my job, or that they could fire me because I had to look after my baby. I did not know what to do. I could not make a decision. I felt guilty for that. My mother gave up her job to raise me, but if I had decided to stay home I thought I might go crazy! My husband helped me a lot, but after a while I started thinking he had a story
with another woman as I did not feel like making love with him at all and he did not complain. I knew that when you are milking sexual stimuli disappear. Yet I felt totally inadequate for that too! I ended up having no interest in sex, but also in my husband as a person. I realized I did not love him. And the bond to my baby seemed to lessen too. It was horrible! I felt cold and detached from everything. The most painful sensation I ever had in my life. My mother too was very helpful. But that made me realize that I was totally unable to be a “really good mother” as she used to be with me. I can’t manage everything, I am not able to be a mother!”

This is an example of conflicting values that led to a severe form of depression, namely post partum depression (Ambrosini and Stanghellini, 2012). Motherhood presents itself as an intrinsically conflicting situation. Women with a particular constellation of values (referred to in psychopathological literature as typus melancholicus) experience motherhood as a social duty to perform in conformity with the dictates of tradition. The adoption of this attitude is likely to turn motherhood into a traumatic event. The traditional values that shape this person’s social behaviour may have a pathogenic valence. This mother seems over-identified with social representations of a woman’s role that reflect time-honoured beliefs and have become for her embodied dispositions that fulfil the others’ expectations. Being a mother, a working woman, a good-enough wife, and a daughter faithful to her mother’s legacy who re-enacts her mother’s values and puts them into practice are obviously conflicting values and goals, especially in the post partum period. This person’s system of values, which shape the inner core of her personal identity, heightens her psychopathological vulnerability and leads to a clash of roles that paves the way to feelings of guilt and exhaustion—to the key symptoms of major depression.

As explained by Tellenbach (1980), the pre-melancholic situation is characterized by a self-contradiction of the person, insistent in the attempt to maintain an unchanged order. This constellation is called ‘inclusion’ since it includes the person in the unattainable project of maintaining her order and, at the same time, in the need to overcome it, exceeding her own limits. The person cannot transcend the order rigidly established by her values and the social roles that ensue from them. This is the moment in which the undesired is manifested and imposes on one’s existence (ibid., pp. 181, 192). The constellation of ‘inclusion’ is followed by a ‘remanence’ constellation that, in its own turn, is characterized by the impossibility of bringing one’s own duties to a successful conclusion and thus feeling in debt with oneself and with the others. Inclusion and remanence lead the person to a situation called Verzweiflung (a term that is inappropriately translated as ‘despair’ and that can be better deciphered as ‘disunion’) that indicates feeling pushed through the incompatible or totally exorbitant objectives, leading to a kind of paralysis of action. Indeed, the primary symptom of major
depression that follows the pre-melancholic situation is psychomotor inhibition, accompanied by affective anaesthesia and guilt. Psychomotor inhibition is experienced as a sensation of loss of vitality, of physical and psychic integrity, of strength, of vivacity, as well as a feeling of tiredness (dejection), of weakness, of fatigue, and of physical malaise. The patient also regrets a loss of capacity of affective resonance, of an affective void. Guilt feelings and delusions of guilt are the outcome of the patient’s feeling of lagging behind her duties and betraying her values. The patient is convinced of having transgressed the laws or betraying the faith of someone, having infringed the commandments of God or of a superior moral authority.

These values, or some of them, need not be repressed, or distributed across a line that divides consciousness from the unconscious. Rather, they reveal the many facets of an involuntary habitus that reflects social roles, each of them fulfilling social expectations. Among women who tend to abide by social norms, play established social roles, and hide their inner conflicts, the contradiction that is intrinsic to motherhood itself make this contradiction uncontrollable and potentially devastating.

To be a good-enough woman in the post partum period is a highly difficult task that consists in accepting that one will imperfectly perform each of these roles without over-identifying with any of them. Mental pathology is not the presence of conflicts; rather, it is their cessation. It is a crisis of the internal dialectic between different dispositions, and between the person and her dispositions. Without this dialectic between myself and my dispositions, and the capacity to transcend them, to attune them with the current situation, I am a mere What or Idem—a person that is nothing but its involuntary dispositions—or a groundless Who or Ipse—a person that is nothing but its projects. Without this dialectic, a disposition ceases to be a neutral characteristic and becomes a vulnerable trait.
Another illustration of the vulnerable duplicity inherent in the human condition can be taken from gender dysphoria, where the person suffers from a marked incongruence between his or her experienced gender and the assigned sex, for instance, a person living with a man's body who struggles to shape her body as a female body.

The point I want to make becomes clearer if I reformulate the dialectic between the person and her involuntary dispositions as that between form and matter. I am not merely the matter of which I am made. Rather, I am that matter plus the form that I impose upon it. Obviously, the matter of which I am made (into which I am thrown) delimits the possibility for me to assume the form that I would like to impose upon it as an autonomous person. In trying to shape my matter, I experience myself as an autonomous person and, simultaneously, as a person whose autonomy is limited by the matter itself.

Matter, in this case, is the body itself, the body into which I am thrown, its facticity, including its sex, as well as height, weight, colour, etc. My body is perhaps the most intimate part of the person that I am, but at the same time it can turn out to be the most extraneous. My material body is transcendental to me. At a certain moment in my life, I may realize that I have a material body that is clumsy, vulnerable, and mortal, and that impedes my ability to be what I want to be. My body manifests itself as alterity. This paradigmatically happens through the experience of shame. Shame is an affect that awakens and focuses my attention. When I feel ashamed, I am aware of being seen by another person whose gaze uncovers a part of who I am, usually a part that makes me feel embarrassed, inadequate, and humiliated. The effect of shame is that it reduces the complexity of the person that I am to one single aspect of it: when I feel ashamed I know that for the other I am nothing but that specific feature of the complexities of who I am. With the appearance of the Other's look—writes Sartre (1986)—I experience the revelation of my being-as-object. The upshot of this is a feeling of having my being outside: the feeling of being an object. Thus, one's identity may become reified, and reduced to the external appearance, to the matter or Whatness of one's own body.
In a famous movie by Pedro Almodovar, *All about my mother*, the transvestite Agrado offers a monologue about her becoming who she chose to be as an alternative to what she was born to be. 'Aside from being pleasant,' she says, 'I am also very authentic,' and she lists the various kinds of surgical operations she has undergone to become so authentic. Agrado's identity is not simply determined by her originally masculine body, rather she shapes that body according to her experience of being the person that she is. She ironically says: 'It costs a lot to be authentic' and continues, 'All I have that is real are my feelings and these pints of silicone.' Gender, according to Agrado, is not simply a physical fact, rather an accomplishment.

Gender to her has a moral value, since it is not confined to the physical manifestation of one's natural body, but entails a choice. In other terms, gender is a more complicated thing than what we consider to be more readily stipulated natural kinds, such as an apple, a pear, or a person's biological sex. Gender is a personal experience heavily sensitive to socio-cultural norms and conventions, which makes it a vulnerable part of a person's autonomy. Between sex and gender there is the same relationship as between matter and form. We can shape the matter we are 'thrown into' and give it the form we desire, obviously within the boundaries delimited by matter itself and by our capacity for autonomy. Being the person that I am is a task and a responsibility that consists in becoming who I am through what I am.

Being a person, that is, achieving personal identity, for Agrado is a fragile dialogue between assigned sex and desired gender. The symptom of this discrepancy between sex and gender is dysphoria. Agrado would perhaps be diagnosed as affected by gender dysphoria. Dysphoria is an emotional state saturated with a brimming constellation of feelings without any explicit object or target, a state of tension that may lead to spontaneously vigorous outbursts as well as to pale stagnation or emotional depletion. Dysphoria is empty intentionality devoid of the moderating power of language and representation that reflects the person's fragmented representations of herself and of others, and induces painful experiences of incoherence and inner emptiness, a threatening feeling of uncertainty and inauthenticity in interpersonal relationships, and an excruciating sense of the insignificance, futility, and inanity of life. Persons affected by dysphoric mood experience their own self as dim and fuzzy, feeling deprived of a defined identity, and unable to be steadily involved in a given life project or social role. Also, they may see others as cloudy, and their faces as expression-less. But it also entails a sense of vitality, although a disorganized, aimless, and explosive one—a desperate vitality. Dysphoric persons experience their mood as a disordered flux, an overwhelming power that is at the same time a disturbing, disorganizing, and compelling source of vitality. Dysphoric mood is felt as creative and destructive at the same time: a vigour that brings life as well as annihilation. On one side, this power is a violent spasm that takes control of
the body and destroys the organizing embodied structure of the intentional engagement with the world. On the other side, it is also a power that expresses vitality in touch with the source of all sensations. It augments the sense of being alive through an unmediated feeling of life in all its dynamic potentiality, before being committed to the structure and representation that shape and orient what we consider to be a ‘normal’ human life.

Dysphoria, that is, in the case of gender dysphoria—uneasiness and concern with one’s body facticity—is the symptom of the fragility of the dialogue between the person and the obscure intimations that stem from one’s body, especially in early phases of this disorder. The interruption of this dialogue might have caused Agrado to fall into being what she does not feel and want to be—a man—or vice versa to identify with what she is not and she cannot be—a woman. Agrado’s identity is the unstable point of equilibrium between these two poles. Falling into her Whatness, that is, not recognizing her uneasiness with being thrown into a male body and her desire to be a woman, will seemingly originate some sort of neurotic symptom, for instance a kind of phobia (e.g. so-called social phobia), or else more severe psychotic phenomena such as a delusion of reference.

Her remaining unaware of her desire may originate a distressing kind of bad mood like dysphoria and its *sequelae*. Unless she recognizes her desire to be a woman, she will be unable to decipher these disturbing experiences as expressions of the non-coincidence with herself; thus, she will be unable to appropriately make sense of and cope with them.

At the other extreme, the exalted fixation on being, or fully becoming, a woman—rather than the awareness that her desire will never become completely, but only partly, fulfilled—will also originate some sort of symptomatic phenomena. For instance, it may originate dysmorphophobia (body dysmorphic disorder) and (as the culture of late modernity promises that one can modify one’s own material body at one’s own will) an escalation of medical consultations and surgical interventions.

The fulfilment of Agrado’s desire consists on her satisfaction for having *decided* to become a woman (gender), based on her recognition of her desire, and for striving to achieve a female *form* that reflects her desire, rather than on her *being* a woman (assigned sex). In other terms, Agrado’s satisfaction is based on her mature awareness that she will never fully appropriate her identity as a woman, that for her it will remain a perennial task. In this sense, her satisfaction for her being-so with respect to her wished-for identity is by no means different from that of any other human being.

This is confirmed by the real case of Kate Bornstein, a transsexual (M to F) person who says about herself that she does “deceive herself about being a
woman” (Bornstein, 1998). To her, being a woman is a ‘performance’, a continuous task, rather than a fact. This is the case with all gender identity—she holds—and for all identity in general. “The bipolar gender system”, she writes, “serves as a kind of safe harbor for most of us, and I’m definitely including myself in that, even though I don’t personally identify as either a man or a woman, because I walk through this world appearing to be a woman for the most part. I pass as a woman. I can do that. And I do because it allows me to rest for a moment” (ibid., p. 37). This is nicely encapsulated in the following lines:

I grew this body.
It’s a girl body. All of it.
Over the past seven years every one of these cells became a girl, so it’s mine now.
It doesn’t make me female.
It doesn’t make me a woman.

(ibid., p. 233)

In a similar vein, gender identity is considered ‘performative’ by Ricky Wilkins (2004). These two seem to be cases of well-carried (rather than miscarried) transsexual existence—and, in general, of mature dialogue with alterity.

The challenge facing the clinician is how to offer the patient an insight into her fragile personhood, that is, into the alterity she experiences in herself—e.g. her feeling dysphoric about her ‘natural’ sex—as well as helping her to understand the way she tries to make sense of this and, moreover, to acquire the appropriate means to cope with her unease. Hermeneutical phenomenology is a resource when dealing with this challenge of therapy because of three basic features of this philosophical approach to human personhood.

First, the phenomenological character of the approach provides a theoretical framework to assess and explore the patient’s experience of troubled personhood. This is an important methodological contribution to therapy, since it is open to an unusual extent, in that it reveals aspects of experience that other approaches tend to overwrite or eclipse with their strong theoretical claims. In this sense, we can say that the ethics of this approach is based on the principle of letting the patient have his or her say. This principle admonishes the clinician to bracket her own prejudices and let the features of a pathological condition emerge in their peculiar feel, meaning, and value for the patient, thus making every effort to focus on the patient’s suffering as experienced and narrated by her.

Second, the hermeneutical articulation of the dialectics of selfhood and otherness gives the clinician an epistemic tool with which to understand how the struggle with one’s involuntary dispositions makes personhood not just a fact, but also a problem. The vulnerable character of personhood that is so dramatically expressed in mental disorders is closely connected with the problem of the fragility of human identity, that is, with the problem of our cares and
concerns. Making sense of what we care about and how we care about being the particular person we are involves the responsibility for one’s being-so, that is, for one’s vulnerable and troubled personhood. This responsibility implies how to respond to the challenges involved in discovering alterity in one’s own self, how to make sense of one’s troubled personhood, and how to become the person that one is.

Third, the hermeneutical character of this approach provides a framework by means of which the clinician can make sense of norms and values involved in a person’s struggle with her involuntary dispositions. We care about being persons, and the hermeneutical emphasis on both the What and Who of the person that we care about being and becoming—that is, both the a-rational, biological values and the rational, personal values at work in our care—provides the clinician with a framework with room for the ethical problems involved in being a person.
Chapter 7

The trauma of non-recognition

We live out a traumatic existence stained by the tragic experience of our failed encounter with the Other. Trauma is not just an episode that took place in the past, relegated by repression in our dynamic unconscious. Trauma is part and parcel of everyday existence, an ordinary experience that is one with our need and desire to establish relationships.

As argued in Part One, the kind of teleology at play in human relationships is the desire for reciprocal recognition. Our existence is inescapably conditioned by the spiritual value of recognition, alongside the organic values of our biological life. We desire to be recognized by the Other, that our being-so is acknowledged by the Other as a value in itself. Our most profound desire is to be loved as we are. Yet, recognition is a task, rather than an automatism. Recognition is set within and experience of relatedness in which I am aware of the Other’s concern and I try to attune with it. The capacity for recognition is a kind of emotional and intellectual readiness to acknowledge the reasons of the Other.

Also, the inaccessibility of the Other, that is, our incapacity to recognize the Other, is the mark of being human, not a flaw or a subjective inability. In our tending towards the Other we experience the Other as unattainable. My desire of the Other, as well as my pre-understanding of the Other, do not correspond to the Other as it is. We realize with despair that the essence of the Other is its otherness. We experience the autonomy of the Other, that is, the fact that the Other can never be fully appropriated, but only approximated, as a frustrating limitation for our desire and of our capacity for understanding. “The Other”—writes Levinas—“is neither initially nor ultimately what we grasp or what we thematize. For truth is neither in seeing nor in grasping, which are modes of enjoyment, sensibility, and possession; it is in transcendence, in which absolute exteriority presents itself in expressing itself, in a movement at each instant recovering and deciphering the very signs it emits” (Levinas, 1969, p. 172).

The way in which the Other presents itself is what Levinas calls the ‘face’. The Other’s face is inscribed in the ethical impossibility of grasping him in his
totality because he overflows every containing idea I can have of him. The Other cannot and should not be reduced to the same—that is, to my knowledge of him, or to my desire for him. Rather, the Other calls me into question. The deployment of this peaceful relation with the Other is produced in language. Language “is contact across a distance, relation with the non-touchable, across a void. It takes place in the dimension of absolute desire by which the same is in relation with an other that was not simply lost by the same” (ibid., p. 172).

We cannot bear the irreducibility of the Other to our own categories, when the Other is not compatible with the forms of relationship imposed on ourselves by our own prejudices and desires. Mental pathology from this angle is a miscarried attempt to deal with the suffering that stems from the intolerability of the awareness of the Other’s radical alterity—that is, as the effect of the reciprocal non-recognition between myself and the Other. This failure in encountering the Other generates defensive shelters which later develop into fixed forms of miscarried existence and become part of one’s personal identity.

“The good outcome of the relation with the Other expresses itself as a kind of failure. Only through the impossibility-of-power (Können) the Other can manifest itself” (Byung-Chul, 2013, p. 22). Crucial to man is his attitude to the failure of grasping, or possessing, or knowing the Other. “The way man approaches his failure”, Jaspers says, “determines what he will become” (Jaspers, 2003, p. 22). Instead of falling prey to the aphasia of scepticism, or to the impersonality of metaphysics—the blind alleys of positivistic or nihilistic fanaticism (Arendt, 1948)—he takes the risk of building, in the void that separates him from the Other, provisional, fleeting constellations of meanings. “The fall from absolutes which were after all illusory becomes an ability to soar; what seemed an abyss becomes space for freedom; apparent Nothingness is transformed into that from which authentic being speaks to us” (Jaspers, 2003, p. 38). Here is an analogy between what Jaspers calls the “leap to transcendence” (Jaspers, 1971, p. 26)—that is, the effort to “detach oneself from all determinate knowledge of being, after I have appropriated its full portent” (ibid.)—and what we might call the leap to the Other: deliberately striving to navigate the infinite space that separates me from the Other.

The failed encounter with the Other may generate different kinds of existential ‘shelters’. The sceptic finds relief from the anguish caused by the inaccessibility of the Other by arguing that the discourse of the Other may well hold some sense, but that any real attempt to reach the Other is futile. To the person who finds a shelter in cynicism the discourse of the Other is situated outside the realm of meaning and meaningfulness. The mystic is convinced that the reason why we cannot reach the Other is that, when we move towards the Other, we
are still wrapped and trapped in our own prejudices. Contemplation is another kind of shelter. The Other cannot be appropriated through the process of understanding. The Other and I stand face-to-face as the antithesis to the thesis.

These shelters, as well as several others that could be added to the list, represent the norm when compared to the spectrum of mental pathology.

Mental pathology is the incapacity to risk this leap to the Other. As I have argued, it can be seen as the effect of the intolerability of this painful awareness of tending towards the Other and at the same time of the inaccessibility of the Other. Some of the most vulnerable ones among us, tormented by this painful awareness, attempt to solve the problem of the inaccessibility of the Other in more drastic ways. They try to do so in a more or less explicit and voluntary way by dissolving the riddle of the identity of the Other, that of one's own identity and, finally, that of the authentic encounter with the Other. The clinic of mental disorders offers a spectrum of possibilities, a full nosology of defeat and of failed encounters with the Other.

In what follows, I will sketch only the most serious ones. It is important to note that values have a central importance in the description of these miscarried modes of existence. But before doing that, a few more words about the teleology of desire and its controversial position between normalcy and pathology.
Chapter 8

Erotomania and idolatrous desire

Our desire for the Other is not the desire for the flesh-and-blood Other. Rather, it is the desire for the image of the Other. It is an idolatrous desire.

In a seminal paper published in 1920, Gaetan Gatian de Clérambault presents the case of a woman named Léa-Anna affected with erotomaniac delusion.

Léa-Anna is a 53-year-old lady who believes that George V King of England is in love with her. Let’s recapitulate the steps that bring her to her firm and unshakable conviction. The first intimation dates back to twenty years before she could fully realize the existence of the ‘communion’ between her and the king. She used to work as a milliner in Paris when she received the visit of a lady who talked to her about her loneliness. This lady was the concubine of the duke of York and she wanted Léa-Anna to become the lover of the King of England. That evening, after Léa-Anna went to bed, someone knocked at her door and disappeared. Certainly it was the Prince of Wales who had, at that exact time, become George V. Once an English officer was sitting in a restaurant just in front of her. He was handsome and looked like Queen Victoria. He was certainly an emissary of the Queen who came all the way to Paris to harm her reputation.

The problem was—Léa-Anna thought—that she could not immediately realize all this, and comprehend that the King was in love with her. It took many years before she could make sense of the meaning of that lady’s confessions, or of all the other strange and thrilling events that happened to her during that period of her life. Obviously she was not indifferent to the King’s advances. By that time she simply did not understand what was going on. This was taken by the King as an insult. From that moment onward the King, feeling offended, started persecuting her. George V loved her and hated her at the same time. The King could hate her, but in no case could he be indifferent and forget her. Once she was walking in front of Buckingham Palace she saw a curtain moving. She was sure that the King was spying on her. Another time she saw a gentleman dropping the newspaper on the floor. That meant that the ‘affair was down’, that is, she will not meet the King.

Her basic ‘postulate’, that is, the ideational and affective element at the basis of Léa-Anna’s behaviour, is that she and King George are in a state of ‘special communion’ with each other. De Clérambault stresses that her basic emotion was not love, namely erotic love, but a mix of pride, desire and hope. ‘Erotic pride’ makes her build an image of the King as a person in love (although ambivalently) with her. With this image in mind, Léa-Anna takes all events that happen to her as a confirmation of the King’s sentiments. The paradoxical character of the King’s sentiments, and of his behaviour stemming from them, can be explained as a consequence of his disappointment following her initial misunderstanding.
Léa-Anna, we could say, is affected by a kind of idolatrous desire. Not in the sense that she believes she is in a ‘special communion’ with an outstanding, semi-divine person. Rather, in a much more literal sense, her desire is idolatrous since its object is not a person, the person of George V King of England, but an idol, a phantasm, an unreal object. We learn from her story that she never met the King as a flesh-and-blood person. This is always the case with people affected by erotomanic delusions, and this is not by chance. These people are not aware that the object of their desire is an image. She, although involuntarily, built this image out of a series of clues. The genesis of erotomanic delusion is no different from that of many other delusions. The cloud of a series of fragmented experiences suddenly hang together and the secret meaning that hides within all objects comes to a manifestation. All details hang together and point to the sudden revelation of a previously concealed meaning. As nicely described by novelist Robert Musil in The Man without Qualities (1996), in his description of the genesis of serial murderer Moosbrugger’s delusion, the patient’s “experience and conviction were that no thing could be singled out, because things hang together” (ibid., p. 259). The vague, fragmentary intimations that twinkle in the manifold of experience shape up into a full-blown revelation (Wetzel, 1922, pp. 422–4).

Yet, the case with erotomanic delusion suggests much more than that. First, it suggests that this phenomenon of hanging-together and revelation is driven by desire. It is desire that makes us build, although involuntarily, a picture of the world. This picture reflects our desire, rather than mirroring the world itself. We do not immediately relate to the world, rather we relate to our representation. I am not arguing here for the thesis that we relate to the world through our representation. This is, in some sense, quite trivial, common-sense philosophy. What I would like to discuss is that we merely focus on our representation. This is especially what happens in the case of our desire for the Other. The question is: Is focusing on the image of the Other, rather than on the flesh-and-blood Other, only the case with erotomanic desire, or rather a general rule of the teleology of desire?

The myths of Narcissus and Pygmalion have a lot to say about this chiasm of desire and image. Narcissus falls in love, not with himself, but with the image that he sees on the water. Narcissistic love is, strictly speaking, not love for oneself, but love for an icon, a picture, or a representation. Pygmalion fabricates an image of a partner and falls in love with it. His love is directed to his fetish rather than to the real person the fetish is meant to represent. Does all this indicate that the image is the real ‘object’ of desire? Desire and imagination go hand in hand. Indeed, when we desire something, we often close our eyes to better imagine it. Eyes Wide Shut, the title of Stanley Kubrick’s posthumous movie,
suitably portrays this. The movie is about the relationship between two upper-class people, Alice and Bill, and about all of the obscure forces that influence their relationship. Promotional images for the movie feature Alice kissing Bill but looking at herself in the mirror, almost as if she was more interested in the image than in reality. Does this mean that what we call ‘love’ is an *immoderata cogitatio* (Agamben, 2011, p. 96), that is, a kind of disease, endemic in human existence, consisting in an immoderate contemplation of the products of our own imagination?

Kubrick’s swan song is explicitly inspired by Arthur Schnitzler’s *Traumnovelle* (*A dream novel*). Schnitzler’s story starts with a description of a seemingly perfect marriage. Yet, both spouses perceive the lack of complete sincerity in the other’s words. They start verbalizing memories as well as concealed desires. The confessions affect them, and jealousy emerges. The husband, preoccupied with his wife’s disclosure, drifts further and further away from reality into a dreamlike state.

Is our love for an image, rather than for a person, a shelter from the suffering generated by the failed encounter with the Other?

Or is it the ultimate obstacle that obstructs our leap to the Other? Are Narcissus and Pygmalion so distant from de Clérambault’s erotomanic patient? The three of them are in love with an image. Their desire is directed to an idol fabricated by their mind. This idol impedes their relation to ‘real’ people and brings about a ‘phantasmatic’ satisfaction of their desire that, in Léa-Anna’s case, is clearly pathological (delusional) in nature. The image of the Other stands between her and the Other. This phantasm stands in the way of an accurate awareness and understanding of the Other’s (and one’s own) desire. Our focusing on this phantasm, rather than on the flesh-and-blood Other, disregards the Other’s freedom not to correspond to our own desire, and our incapacity to tolerate this.
Chapter 9

Depression and the idealization of common-sense desire

The main thing is that from the very first, though she tried to hold back, she threw herself to me with love, she would meet me with rapture when I came home in the evening, told me in her prattle (the charming prattle of innocence!) all about her childhood, her infancy, her parental home, her father and mother. But I immediately doused all this ecstasy at once with cold water. It was in this that my idea lay. To her raptures I responded with silence, benevolent, of course . . . but all the same she quickly saw that we were different, and that I was—a riddle. (Dostoevsky, A Gentle Creature, 2005)

In Dostoevsky’s short story A Gentle Creature (also translated as The Meek One), a young woman devoutly incarnates the common-sense idea of the wife. Her burning desire to honourably play the ideal representation of the wife of a man who stands before her not as a husband, but as an enigma, ends with suicide. In this story, the Other (the husband) is determined to prove that he is a mystery in order to frustrate his wife’s naïve intention to build a respectable bond. The Gentle’s creature’s husband is resolute in his intention to confirm his nihilistic thesis of the impossibility of a real bond. This makes the equally obstinate attempt of the Gentle’s creature to conform to the stereotype of the devoted wife even more futile. This stereotyped understanding of the conjugal relationship is assumed by her as a taken-for-granted, universally shared, undisputable value.

It must be emphasized that such an attempt is not rooted in the love for the Other seen as an individual person. Rather, it is fixed on an idea, on a common-sense prototype of the exemplary marriage. It is an idealization of common-sense desire. This is the first, and perhaps easiest to explicate, form that mental disorders offer as a vulnerable shelter as a defence from the missed encounter with the Other. Dostoevsky’s Gentle creature tries to solve the riddle of the Other by emptying the Other of his personal identity and reducing him to a stereotype. The complexity of the meaning of the Other’s actions is erased and the Other is identified with an external representative or surrogate of personal identity. The Gentle creature is affected by idioagnosia: she is unable to appreciate
the individuality of the Other. She distorts and takes to the extreme the device of common sense that already operates in normal life. The Other is nothing but an a priori image of the Other that coincides with its social role: a husband, a wife, as well as a child, a parent, a friend, a pupil, a teacher—and nothing but a husband, a wife, etc. This way of rephrasing the problem of the Other reduces the complexity of the Other. It also lessens the intricacy of the relationship with the Other, since such patterns of simplification also apply to the Self. A kind of universal matrix for the Self–Other relationship is built that takes the form of an interaction between social roles rather than individual persons.

Idioagnosia—which literally means the incapacity to know (agnosia) the Other as an individual person (idios)—can be taken as the essential symptom in the melancholic type of existence. It makes of the melancholic person’s shelter a highly vulnerable asylum. The Gentle creature’s story speaks of the inability to relate to the Other as otherness, the total loss of confrontation, and thus of recognition of the Other. It speaks of self-referentiality, an extreme and lethal kind of narcissism, not in the sense of love for oneself, but in the sense of being in love with one’s own representation of the Other. In this sense, love is love for an image—as explained by Agamben (2011). Love is idolatrous—immoderata cogitatio. Passion proceeds from an image placed in the mind of the lover. The phantasm is the real object of love. Love is a dangerous mirror (miroërs perilleus). “The place of love (…) is a fountain or a mirror” (ibid., p. 97)—a flat reflecting surface that merely returns the desire of the lover.

Yet, there is another kind of love that is not possession, not even the possession of a representation of the Other. Rather, it is “the sharing of this non-appropriable” (Agamben, 2014, p. 130)—exactly the opposite of the kind of love professed by the Gentle creature. Love is not an estate, but a landscape. The Gentle creature’s way of loving her husband embodies what Byung-Chul (2013) named the agony of Eros. The Gentle creature’s love is love for the same, for the already known, the already appropriated; it is a cramp in herself that does not allow her to see the Other as a stranger. Based on the need for recognition of the Other, this kind of love is a mortal one, as it does not allow her to see the world from another perspective. It confines her in the inferno of sameness.

The overall structure of this condition can be better understood if we consider the phenomenon of centricity, that is, the anthropological marker of the melancholic type of existence. The melancholic person continually follows in the footsteps of the faded image of her own existence. It is ensnared by common sense, seeking order, and consensus rather than being open to alterity. The melancholic person submits to the pressure of public opinion, to the icons of identity taken from common-sense stereotypes, and to the gravitational force of social norms as external guidelines for actions. The Other in question is never
the here and now, flesh-and-blood Other. Rather, he is a generalized Other, an abstract and absolute source on impersonal social norms and values. The melancholic person's values are characterized by heteronomia and hypernomia as she over-identifies with the public opinion (heteronomia), and her identity is welded (hypernomia) to its surrogate, namely her social role.

The melancholic crisis is a special kind of depersonalization characterized by the melancholic person's incapacity to continue incarnating her own role. She is not able to experience otherness as an event that shows another face of herself. She undergoes the event as a trauma that throws off her mask and reveals herself in her obscene, intolerable, unwitting, and despairing nakedness. Between the person and the otherness revealed by the event cannot be any dialogue, any narrative continuity. No dialectic relationship can develop out of the encounter with alterity since the melancholic person cannot tolerate any dissonant aspect within herself and with the Other. Her desperate complaint of not being able to love, although it may seem simply one of the many self-accusations that are typical during acute melancholic crises, indeed represents the melancholic person's overdue awareness of her incapacity to encounter the Other.

Love is a feeling whereby we feel displaced. It forces us to see ourselves and the others from another perspective. Love hurts (Illouz, 2011) because of its power to be an event in our life that forces us to reconsider our habits and jeopardizes our narcissistic identity. Our life is challenged by the experience of love, as in Lars von Trier’s movie Melancholia in which the stagnating life of Justine is challenged by a mysterious new planet that threatens to collide with Earth. This impending collision apparently rescues her from her melancholic existence. Contrary to Justine, the Gentle creature is unable to take the collision with her husband as a reason to emerge from her timeless and eventless existence. From her vulnerable shelter, she is unable to observe detachedly her conflicting situation, to change, to transcend the conflict between her and her husband’s roles, and to learn from experience. Existsences of this kind, in their apparent gentleness, spontaneity, innocence, devotion, and apparent You-orientation, are anything but submissive. Rather, they are inflexible, they lack nuance, and they are incapable of compromise and conciliation. They are rigorous, in the most literal sense of the term. And this rigour, sooner or later, leads them to clash with the enigma embodied by every person, by every human relationship.
There is also a second mode of vulnerability, typical of another emblematic form of existence called ‘borderline existence’. The kind of simplification of the teleology of desire that we find here is to a certain extent the reverse of the preceding one. It lies in the glorification of an oceanic encounter with the Other, an encounter that a certain rhetoric would define as ‘authentic’, in the sense that it takes place outside of the social roles: the mystical encounter of a flesh with another flesh, of a thrilled flesh with another thrilled flesh. Emotions, for such a vulnerable mode of existence, represent life in its purest form. Any other form of encounter is seen as a fall.

Ilse is a good-looking, well-read, divorced woman in her late forties from a well-off Catholic family. Tenaciously You-oriented. She enters my office with a grim face, as someone who has suffered several injustices. Something childish and tender tran-spires through her sullen behaviour, patent need to be recognized as someone with an unhappy life and, this notwithstanding, sensible and cultivated. Restless youth, dysphoric mood traits punctuated with angry outbursts. An episode of sensitive delu-sion of reference a long time ago. A preference for clandestine relationships ‘as married men give their best out of their marriage’, and for ‘dirty souls’, ‘as soul and dirt go hand in hand’. Marriage is not the right place to meet a man. Her week-end migraine is perhaps a symptom of an unresolved conflict between the wish for a stable relation-ship and for off-the-beaten-track love affairs.

Passionate and insightful, she divides her life between erotic passion and the attempt at self-recognition. Emotions are the epicentre of both these passions. ‘All that counts in life are emotions. Nothing else. Only emotions keep me alive. I know they can destroy me, but it’s worth taking this risk. Without emotions I would be simply dead. I mean the emotions that I only find in my way of being totally in love with someone.’

Experienced, but not unfaithful or promiscuous: ‘I can give myself entirely. I’ve never been unfaithful. You’re right, I seem to jump from one partner to another. But I never had two partners at the same time. I literally fall in love. This is the only way I am able to love. I sense the desire of the Other with whom I’m in love. I plunge into it. And believe me I’m able to totally satisfy it!’

She may seem from time to time seductive, but this is a kind of involuntary habit of which she is only partially aware: ‘One of my previous partners ironically accused me of being a seducer. That made me think of Odysseus’ Sirens. You know? “Hither, com
hither, renowned Odysseus, great glory of the Achaean, here stay thy barque, that thou mayest listen to the voice of us twain.” Was he right? I do not do that on purpose. It’s stronger than me. If I seduce them it’s because I’m able to seduce them with their desire, as the Sirens seduced Odysseus with the promise to leave their island with a full knowledge of the gods’ design—exactly reflecting nosy Odysseus’ innermost desire! With me, men hear their desire “from my lips, the voice sweet as the honeycomb”. Since I sense their desire, and it’s my nature to become one with it. Do you call this “seduction”? This is my way to love. In this, I do not lose myself—rather I find my true self. I live from this emotion. I live from recognizing their desire. My life without emotions is not worth living.’

‘And now you tell me I should renounce my emotions to survive! You can’t understand. I don’t want to become as you want me to become. A corpse. You’d better kill me! I’d rather die!’

The borderline existence meets its defeat because it postulates as essential to life what is more alien and inaccessible to it, what in life itself is unstable and fleeting par excellence: the immediate encounter with the Other, the encounter between two desires.

In order to function you have to cut out at least one part of your mind. Otherwise you’d be chronically sane in a society that is chronically insane. That’s your choice: go mad and die or function but be insane.

That is what British playwright Sarah Kane sarcastically argued in an interview released shortly before her suicide (Saunders, 2009, pp. 87–8). They are part of “a report from a region of the mind that most of us hope never to visit but from which many people cannot escape” (Greig, 2001, p. xvii), telling about “the fragility of love” and “the search for selfhood” (Saunders, 2009, p. 113). This form of existence postulates the encounter as immediacy, and not as a patient approach. Being authentically with the Other implies a drastic aut aut: ‘Love me or kill me’. It desires and demands exactly the same impossibility that originally made it fly away in desperation: the encounter as an opportunity for recognition. Recognition by the Other is the basic need in this type of vulnerable existence. This fixed idea, this value that drives the borderline existence itself, undoubtedly opens the gates of perhaps the fiercest relational hell that we could possibly imagine—a burning hell of desire, expectation, and disappointment:

And I go out at six in the morning and start my search for you. If I’ve dreamt a message of a street or a pub or a station I go there. And I wait for you.

(Silence.)
You know, I really feel like I’m being manipulated.
(Silence.)
I’ve never in my life had a problem giving another person what they want. But no one’s ever been able to do that for me. No one touches me, no one gets near me. But now you’ve touched me somewhere so fucking deep I can’t believe and I can’t be that for you. Because I can’t find you. (Kane, 2001)
At the heart of this drama resides the excruciating experience of the Other. The Other is needed as a source of recognition. The absence of the Other makes the presence of the self impossible. The Other’s absence, or incomplete presence, is often the reason for feelings of un-recognition and desperate loss of selfhood. The absent Other, or the Other who does not donate his entire self, is an abandoning Other and an inauthentic Other. The Other is a partner with whom both loyalty and spontaneity are expected. The bonds of loyalty and the promise of reciprocal care must be accompanied by its antonym: spontaneity, that is, being free from social conventions and acting according to the logics of desire in the present moment. Borderline persons feel these as standard, basic aspirations—but we all know how unrealistic and almost unattainable they can be.

Since the otherness of the Other cannot be grasped, possessed, or known, the good outcome of the relation with the Other expresses itself as a kind of failure. Yet this failure is intolerable to the borderline person (as it is to the majority). The way one approaches one’s failure determines what one will become (Jaspers, 2003, p. 22). The borderline person, so to say, flies too high for her capacity to approach her failure. Her type of desire is apparently an iconoclastic one, since it does not accept any sort of compromise and is intolerant of any kind of reduction of the I–You relationship to an encounter situated within the limitations of each partner’s subjectivity. Yet, it is no less idolatrous than the melancholic’s desire. It has lost the dialectical mediation between Self and Other as historically situated persons, real possibilities and abstract illusions, one’s desire and the Other’s desire. And, ultimately, between one’s desire and the Other’s freedom.

It conceals the difference between oneself and the Other, and between one’s desire for love and love in its actuality. In short: between an idealized form of love and the actual relationship with the other person. What the borderline person idealizes is not the Other, but Love itself. It is a mystification of the failure in grasping the Other, overwritten with the jargon of authenticity. It celebrates immediateness as a reality, rather than as a task that can never be fully accomplished. It tends to block the autonomy of the Other while it inauthentically worships an ‘authentic’ relationship. It fulfils the visceral need for recognition with a heroic and empty claim for absolute communion. And, finally, it makes the non-avoidable discord between the partners into the trauma of abandonment of which she considers herself to be the only victim.

What the borderline person considers to be her most non-renounceable value is indeed her innermost symptom. The borderline existence is a dangerous shelter that meets its defeat because it postulates as non-renounceable in life what is more alien and inaccessible to it, what in life itself is unstable and fleeting par excellence: the immediate encounter with the Other, the encounter between two desires.
Chapter 11

Schizophrenia and the disembodiment of desire

Until now, we analysed two miscarried modes of being with Otherness: the disidentification of the Other, and the glorification of the immediate encounter with Otherness as a thrilled flesh. In contrast, the third relational hell is not a fiery hell but a Dantesque icy lake. It is an out-of-the-world shelter whose cypher is the dis-embodiment of Otherness.

And then fictions of a very old and free life, of enormous solar myths and massacres created themselves before my spirit. I saw an old image again, a skeletal form alive because of the great force of a barbarous myth, eyes abyss-like and changing glaring with dark blood, in the dream's torture discovering the vulcanized body, two spots two bullet holes on her extinct breasts. I thought I heard the guitars shudder over there in the board-and-branch shack on the lonely fields of the city, a candle throwing light on the bare ground. In front of me a wild older woman stared me down without batting an eyelash. The light was weak on the bare ground in the quivering of the guitars. To one side on the blossoming treasure of a young dreaming girl the woman now clung like a spider while seeming to whisper words in my ear I couldn’t make out, words sweet as the wordless wind of the Pampas that sinks you. The wild woman had grabbed me: my indifferent blood had certainly been drunk by the earth. (Campana, 2013)

Italian early twentieth-century poet Dino Campana’s La Notte (The Night) is an emblematic Odyssey-like search for the Other. A search that gradually penetrates into desert, spectral, and inanimate lands and encounters with the immaterial: spirits, shadows, mirages, incorporeal images, or fragmentary, thing-like, mechanical bodies and purely material figures—everything one could ever meet that is not real. Campana describes his condition as that of a deanimated body (“my indifferent blood”), or a disembodied mind (“enormous solar myths and massacres created themselves before my spirit”). Things, including other persons, are experienced as mere objects (“the vulcanized body, two spots two bullet holes on her extinct breasts”). Persons lose their incarnated givenness. They are stripped of their flesh, simply there. They may lose their three-dimensional givenness and appear as two-dimensional images. Not only do others appear as geometric entities in a purely geometric space, but the encounter with the Other may also take the form of the appearance of persons as mere representations (“fictions”, “I saw an old image again, a skeletal form
alive”). As object-like entities, or as flat representations, others appear as unfamiliar figures, as a source of enigmatic messages and intimations.

It is like a chilly and uncanny night of disembodied encounters with the Other. This is how the withdrawal from the intolerable failure of the relationship with the Other may appear in the schizophrenic existence. What emerges in Campana’s odyssey, and that in most schizophrenic narratives may remain concealed, is that there is a You-oriented story, although a story of failed encounters with the Other. Abnormal sociability is not simply one of the symptoms of full-blown schizophrenia, or one of the abnormal traits of schizoid personalities. Campana’s journey is emblematic in this sense. It moves from his desire to encounter the Other and gradually takes the form of a disembodied encounter with the Other. This form of disincarnated desire seems to grow out of the defeat of embodied desire, and intensifies as frustration increases. In the case of Campana, such apparitions, visions, or failed encounters with the Other do not extinguish the hunger for the Other. Rather, they support his journey in search for a disembodied Other.

There are two figures of desire in Campana’s poem. One is “the blossoming treasure of a young dreaming girl”. She is the image of the poet’s disembodied, dream-like desire. She is an evanescent, incorporeal ghost, who is simply there, and nowhere. She stands side by side with her double—the “wild woman”. The latter is a matron, the nightmare of the Mother-vampire, and that is why she “clung like a spider”, an insect which can first immobilize and then devour you. The matron whispers sweet, incomprehensible, and seducing words in the poet’s ear. She represents the Dionysian orgy, whereas the blossoming girl stands for the Apollonian beauty that can simply be contemplated. Whereas the young virgin allows me to desire her at a distance, the matron is the emblem of the Other who voraciously desires me and destroys me with her desire.

Quoting Strinberg, Kretschmer (1925) writes that schizoid people spin themselves into the silk of their own souls in search of protection for their own hyperaesthesia. This is the case when autism—the core symptom of what we would call nowadays the schizophrenic spectrum, a “painful cramping of the self into itself” (ibid., p. 157)—is predominantly a symptom of hypersensitivity. This kind of autism is a defence against the “thorn-bushes on the path of life, thorns which their tender hands were never made” (ibid., p. 193). Quoting Hölderlin, Kretschmer further explains that these people are “poor in deeds and rich in thought” (a kind of existence that in Minkowski’s parlance is named ‘rich autism’), as “they close the shutters of their houses, in order to lead a dream-life, fantastic, in the soft muffled gloom of the interior” (ibid., p. 157). Although next to this variant there is another kind of predominantly anaesthetic autism whose main character is unfeelingness and lack of affective resonance for the world,
The unsociability of schizoids—as was the case with Campana—is seldom mere unfeeling dullness. It typically is an admixture of hypersensitivity, displeasure, active turning away of a defensive (or sometimes offensive) character, and the construction of a philosophy in which abstractness and a theoretical orientation towards life prevail. Indeed these people suffer from a kind of emotional ataxia whose main features are psychoaesthesia or coldness, lack of affective contact with other persons, mixed with irritability and hypersensitivity to social stimuli. Kretschmer sorts out two main groups of ‘schizoid temperaments’: the hyperaesthetic variant, including the hypersensible, the cold but sensible aristocrat, and the pathetic idealist, and the hypoaesthetic variant, including the cold despotic, the passionate-insensible, and the unstable vagabond. Campana would perhaps fall into the Kretschmerian category of the pathetic idealist:

Franz Bau, a young artist and student at the Conservatoire, is full of burning affects within and an affected politeness without. He spoke fragmentarily, elegiacally, and yet full of passion when he came to his terrible love experiences. He describes himself as an idealist, a tender soul, and a lover of ‘all that is higher’ in search for ‘the little girl’ that would have done for him. He sees this phantom girl ever before him in the streets and it torments him with painful and weird bodily experiences: ‘It storms over me. It completely oppresses me. It comes through my body and up my spine, it travels over me like a fear’.

He meets a kind-hearted Sister who, he admits, has a great influence on him. ‘I was completely under her sway.’ He is not in love with her, but he clings to her with his very soul. ‘For the first time I felt that someone liked me.’ She runs away from the convent and for a few months they live together in a quiet corner of the mountains. Their affair remains indeed a disembodied and spiritual one. When he kissed her, he felt ‘fearfully excited physically (…) I had completely lost my head, and knew no longer what I was doing. The loveliness of nature made me drunk—I saw that everything was a terrible mistake’ (ibid., p. 189).

After several vicissitudes, he realizes that the Sister is not the right person for him since she does not fulfil his spiritual desire: ‘I realized that, spiritually, she was too simple for me (…) I needed someone to whom I could be spiritually bound.’ He begins a new liaison, and this kindles a psychotic breakdown. He had the feeling that the Sister knew everything about his new affair and that people were spying on him through the landlady and the doctor. He is totally desperate. He thinks that his girlfriend does not understand him, and if she does not understand him then the Sister must come back again, as he is in need for spiritual help.

Franz Bau’s existential trajectory reflects the intolerable mixture of his desperate need for the Other and his hopeless attempts to orientate in human, and especially erotic, relationships. As it was the case with Campana, it takes the form of a disembodied desire that seems to grow out of the defeat of embodied desire. Franz Bau is a hyperaesthetic temperament whose narrowed circle of emotions—a burning and aggressive eroticism, plus the fear to be overwhelmed by the Other from without and by one’s own excitement from within—drive
him to a series of miscarried attempts to establish an erotic liaison that finally determines his turning away from reality to the ideal of a spiritual relationship with the Other. Franz Bau is neither a person who can recognize the Other in its otherness and deal with the frustration of an incomplete encounter, nor one of those persons who can satisfy themselves in distant dreamy love for a stranger passing by. “An all or nothing ecstatic enthusiasm at one moment, and overt coldness and umbrage at the next. A violent rush forwards, and a violent catastrophe, again and again” (ibid., p. 191). He may resemble the borderline kind of existence depicted in the previous chapter. Yet, his “natural talent for tragic experience”, unlike the borderline’s, leads him to “a cramped, wounded withdrawal into himself”. He turns away from actual reality into a mystical-romantic ideal centred on what he calls “the Higher”—“a ringing word without any content at all, but filled with a burning affective value” (ibid., p. 192). Sex, religion, and art are conglobated into ‘the Higher’ like a dim mist protecting him from the immediate encounter with the real Other.

Two features seem to best characterize Franz Bau’s type of existence. One is his philosophy of life. He indulges in cramping reflections concerned with spirituality, that is, rectitude, fidelity, nobility, and purity. Spellbound to ultimate questions and never-ending ontological and anthropological enquiries, he loses the vital contact with his here and now reality. Minkowski’s (1927) morbid rationalism precisely captures the deliberate option at work here: an intellectualistic attitude that disparages all skill to shape knowledge in a contextually relevant manner. The search for a real person with whom to establish an imperfect but factual relationship is taken over by the pursuit for an ideal image of the Other. In Franz Bau this takes the form of the spiritual quest for ‘the Higher’. In Campana, this takes the form of the poetic journey into the immaterial. Each of them abandons his You-oriented existence. Yet, the object of their quest becomes more and more disembodied after each defeat.

The second distinctive feature is indeed disembodiment. In the case of Franz Bau (and of Dino Campana), the lived body is the theatre of an uncanny theology of desire. Sexual excitement is experienced as a storming, oppressing experience of something going through and travelling across one’s own body. A mysterious feeling is tormenting them that is like an emotion (‘a fear’), but is not totally and incontrovertibly recognizable as that. This distressing feeling accompanies the epiphany of the Other, as a flesh-and-blood person (the ‘Sister’) or as a phantasm (the ‘girl’). It oppresses from within (uncanny bodily feelings) and from without (an invading Other).

In Franz Bau’s metamorphosis of experience, the ideal called ‘the Higher’ seems to downplay this intolerable feeling and transform sexual excitement into a disembodied type of desire (see also Dibitonto, 2014). The essential
feature of this type of existence is its being disembodied. The crisis of body-to-body attunement or intercorporeality can be a primary phenomenon in schizophrenic existence, non-secondary to traumatic life situations, but with a causal role in the determinism of schizophrenic dissociality, conveying a third-person perspective on the interpersonal world. Due to dis-attunement, the encounters with other people lose their characteristic as relationships among bodies moved by emotions, turning into a cool and almost incomprehensible game from which the schizophrenic person feels excluded, and whose meaning is sought through the discovery of ‘laws’ and the elaboration of impersonal rules. The other person is no longer encountered in flesh and blood, but as a disembodied self. And the self who encounters the Other is also disincarnated.

Yet the cases of Bau and Campana, among many others, will hopefully be remembered by clinicians as examples of traumatic interpersonal situations that may stand as causes or motivations for disincarnation and dis-attunement. Disincarnation and dis-attunement can arise as secondary, defensive involuntary strategies in a kind of existence faced with the awareness that the Other can only be approximated, not appropriated, and that our need for reciprocal recognition is an unlimited struggle and a spring of frustration.

The disembodiment of desire can be a shelter, although an extremely vulnerable one, and in its own turn the source for a progressive withdrawal from social encounters and conflicts, as it is the case with Campana’s epiphanies of the Other as objectified persons looking like mere disincarnated images or deanimated objects in *La Notte*. Or as a fugue into abstract spirituality and pseudo-philosophical abstractions like Franz Bau’s ‘the Higher’, which strips human relations from their disquieting erotic component, as it is the case with Kretschmer’s pathetic idealist.
Part Three

Therapy: what is care?

An aged man is but a paltry thing,
A tattered coat upon a stick, unless
Soul clap its hands and sing, and louder sing
For every tatter in its mortal dress,
Nor is there singing school but studying
Monuments of its own magnificence

(W. B. Yeats, *Sailing to Byzantium*, 1928)

This ideal citizen should be able to care for the lives of Others, to imagine what it is like to be in the shoes of another person, to view the Others’ actions as meaningful expressions of their form of life, to possess a method to help the Others’ to unfold their stories, and to make sense of them not just as aggregate behavioural data. This epitome should be the ability to see other persons, especially marginalized people, as fellows with equal rights and look at them with respect (Nussbaum, 2010, pp. 25–6).

As citizens who are trained to confront human vulnerability, the evidence of our animality and fragile rationality, the anxieties for our mortality, the dilemmas of autonomy and authority, and the conflicts of inclusion and exclusion, and in general with the encounter with Otherness that characterizes human life, psychiatrists and clinical psychologists are ideal candidates to embody Nussbaum’s ideal globally minded citizen. To be sure, this is an overly optimistic portrait of ‘real’ clinicians, who are obviously not so virtuous as reported above. Nonetheless, few would disagree that such a portrait does mirror the kind of person a good mental health professional should be trained to become. Indeed, Nussbaum’s representation is far from being an achievement; rather, it is an ideal educational goal, and as such it is suggested that it should be taken by the clinicians’ community: a challenge to current educational curricula.

This issue, exciting and puzzling, is perhaps destined to be a perennial source of disagreement. On one side, there are those who are convinced that mental health is simply a branch of the biomedical sciences and thus we, as mental health professionals, should only aim to refine our scientific knowledge and technical skills. On the opposite side, there are those who hold that mental
health is part of the humanities. This dispute is childish and sterile as we all know that both scientific education and humanistic formation are necessary to practice in mental health care (Fulford et al., 2013).

It is also a matter of fact that training curricula are more and more oriented towards the first type of agenda. The growth of the neurosciences, although it has not yet produced relevant knowledge in the area of causal explanation, classification, and diagnosis of mental disorders, has beyond any doubt contributed to cost-effective biological treatments. Another very important issue is that published research, which is the second main source of education (and the first as continuous medical education), as laboratory rather than clinical research, is too often not continuous with the world outside, in general, and within the clinic, in particular (e.g. Stanghellini et al., 2012). Also, practitioners rarely actively participate in the growth of knowledge, if one were to judge from publications, and the division between practitioners and researchers seems to grow without control. It is a common experience to hear from practitioners that they simply cannot understand, and are thus tempted to deem irrelevant (or, at least, clinically irrelevant), research published in journals. One would be tempted to join the Mental Health Care-as-Human-Discipline sect and polemically attack the Mental Health Care-as-Neurosciences team. As Heidegger (2010) would have affirmed nearly one century ago, in a time of dazzling scientific development like our own, science can inform us of all sorts of interesting details about human nature, but can never solve the problem involved in being human. Practitioners know very well what often researchers and theoreticians from both sides forget: we need a scientific knowledge of the human as well as a fine-tuned humanistic culture to cross the territories of mental illnesses without getting lost. We need a richer conception of education.

Taking for granted that practitioners need a thorough scientific education, the question is what kind of humanistic learning is needed, and why. The concept of Bildung makes a good starting point. Bildung is an almost untranslatable German word that approximately means cultivation or formation—rather than education restrictively understood as skill training—that cannot be achieved by any merely technical means. Bildung zum Menschen—cultivating the human—is to Gadamer “[t]he properly human way of developing one’s natural talents and capacities” (Gadamer, 2004, p. 16). It is a process of ‘forming’ one’s self in accordance with an ideal image of what it is to be human. Cultivating one’s self is a complement—a necessary balance—to acquiring skills, learning procedures, absorbing supervening competence, memorizing pieces of professional equipment, and so on. Or, perhaps, we could better say that Bildung provides the indispensable ground for technical skills to be developed and put to use in a proper
way. Bildung implies participation rather than indoctrination, and questions rather than assertions. It is a process of appropriation through which what is “formed becomes completely one’s own”: (ibid., p. 11) because through it, rather than acquiring a capacity, the “human gains the sense of himself” (ibid., p. 13).

There are two general characteristics of Bildung. The first is keeping oneself open to what is other. This embraces a sense of proportion and distance in relation to oneself (ibid., p. 17). We already admired this virtue in Nussbaum’s portrait of the globally minded citizen. The second is that it contributes to developing a sense, rather than acquiring an explicit, cognitive knowledge. An example of this is tact.

Tact is not a piece of knowledge, but rather a kind of sensitivity, namely the sensitivity to what is appropriate in dealing with others, for which knowledge from general principles does not suffice. It first includes the ability to feel an atmosphere (the elusive and often almost indefinable ‘air’, ‘mood’, or ‘ambience’ that envelops a given situation in which is sited our global awareness of that situation), rather than to grasp unequivocally what is already explicit. Thus, tact is a prerequisite for attuning with a situation that is not yet plainly and unambiguously defined. Being tactful means to keep an eye on something that is felt and cannot be said, so that knocking on it can be avoided. Hence, tact implies an ability to act without offending. Tact helps to preserve distance, but not averting the gaze from what was felt; rather, minding what was felt about another person and avoiding intrusion into her intimate sphere.

Also, tact touches upon the very origin of the moral law (Levinas, 1969) as it expresses a kind of relationship that is not that of physical (take hold of the Other) or intellectual (grasp the meaning of the Other’s behaviour) possession. Tact is a kind of grace, to capacity to feel an atmosphere and to wait until the moment is ripe for making explicit what I felt.

Without tact, the other person is stripped of her possibility to signify her uniqueness. Tact is the condition of possibility of all politics of inclusion, and lack of tact is at the basis of any politics of exclusion. I have the responsibility to extend my hand to the other and welcome the difference and the signification it brings (Horowitz and Horowitz, 2006).

Tact is the capacity to feel the atmospheric and to attune with it. Not to intrude into the Other’s sphere, to avoid instrumental relationships, and to let the Other manifest its uniqueness are essential qualities of the clinician. This ‘dexterity’ is not instrumental to diagnosis (e.g. diagnosis by penetration) as is the case with Praecoxgefühl (Rümke, 1990), or compliance, or treatment procedures—although it seems to be a prerequisite for all of them. Rather, its purpose is tactful orientation in all those kinds of patient–clinician encounters that cannot
yet be objectified and analysed in terms of diagnostic criteria. It is the capacity to sense something *status nascendi* and to fine-tune with it before any kind of handbook knowledge is possible. We too often attribute clinical failures to the patients’ lack of compliance. Indeed, compliance as flexibility and plasticity is required from the side of the clinician to approximate the patient without getting too close to or too distant from him.

Prodromal psychosis is an excellent case study to illustrate this. In times of early diagnosis, candidates may communicate elusive changes in their existential feelings, a quasi-ineffable altered relationship with the world, the failure to express what is ‘really going on,’ and vague complaints of being stripped from the world. These feelings cannot easily be ‘pinned down,’ either by the person who experiences them or by the clinician. Also, these persons may become ‘noncompliant’ if the clinician tries to reduce their complaints to symptoms of an illness, and feel dispersonalized and deprived of their unique individuality if the clinician wants to objectify their uncanny sensations. (Stanghellini and Ballerini, 2007).

Suspending one’s clinical judgement and preserving a space of ambiguity to facilitate reciprocal approximation between the clinician and her interlocutor may be the best clinical choice, especially if the clinician does not have enough clinical data to establish—or to exclude—a valid and reliable diagnosis, and to start any sort of ‘technical’ therapeutic procedure. In this situation, when evidence-based guidelines are unavailable, tact seems to be the principal (if not the only) resource.

Studying and practising mental health care is a unique opportunity to develop one’s sensibility for complexity and diversity in human existence, one’s capacity for understanding other persons, being tolerant and coexisting with them, and helping other persons to be tolerant and coexist with the diverse—and, in general, to keep oneself open to what is other and to be able to sympathetically imagine the experience of another.

Bringing the humanities into mental health care is not the anachronistic affirmation of an elitist ideal of education. We can contribute to the foundation of citizenship if we completely surpass our former social mandates: social control and normalization via symptom-reducing strategies. We can help citizens to see the world through the lens of human vulnerability, avoid marginalization and stigmatization, and enhance tolerance and compassion.

To develop these virtues, however, educational curricula based on learning clinical knowledge and skills may not be enough. Cultivating one’s Self is a complement to memorizing pieces of professional equipment. *Psychopathology* (Jaspers, 1997; Stanghellini and Fuchs, 2013)—with its emphasis on human experience, on meaningfulness, and on valid and reliable methodology to approximate the Other’s subjectivity—is the *organon* of the humanities in
mental health care, and perhaps in medicine in general. To psychopathology, being sick is a subjective experience of the person. Psychopathology has as its centre the experiencing person and subjective experience. The psychopathological discourse is about understanding a given type of experience and the world in which it is situated.

This obviously does not exclude seeing abnormal phenomena as symptoms caused by a disease to be cured, but it includes the exploration of personal meanings next to the hunt for causes. The patient is an active partner in the diagnostic process, capable of theorizing and interpreting her own complaints. Symptoms are conceptualized as the outcome of mediation between a vulnerable embodied self, on the one side, and the sick person trying to cope with and make sense of her disturbances and complaints, on the other. There is no need to import new disciplines into the training curricula. We just need to give psychopathology the place it deserves.
A 38-year-old woman reports that since she was about thirty she has been shocked by inexplicable 'strange bodily sensations'. She does not know what these mysterious and upsetting bodily feelings are exactly; she does not have a name for them. They seem to show up in her as if coming from an alien place. These feelings are extremely distressing for her and led her to a state of profound somato- and allo-psychic depersonalization—self-body and self-world falling apart. This state of depersonalization recently developed into a full-blown episode of euphoric mania.

During one therapy session, she sees a connection between these bodily sensations and the 'orgasms' she has when 'telepathically' in contact with me. She first wants me to confirm that when she's having her 'orgasm' I am thinking of her. She thinks I am 'the author' of these 'orgasms', that I willingly 'send' her these sensations. She texts me several times to ask me if in that very moment I am telepathically making love with her. I let her do so, and I tactfully use her messages as a way to show her from a third-person perspective her beliefs and feelings as they occur during these crises. The outcome of my availability is that she soon develops an erotomanic delusion about me. She mistakes my availability for an erotic interest.

Later she reconsiders her beliefs about telepathic connections when she fears that her death 'premonitions' about me may cause me harm. She asks me to be reassured that no such things like telepathy are possible at all. I explain that she cannot harm me telepathically, but that she is 'harming' me by reducing my freedom with all her 'projections' on me. I explain that she is attributing to me intents that are not mine and that she is imposing on me a kind of image with which I cannot identify.

A micro-narrative linking her uncanny bodily sensations to her arousal in the presence (or thought) of the therapist is patiently established. At this moment she realizes that the strange bodily sensations affecting her were from the beginning emotions taking place in the 'I–You' relationship. Indeed, she realizes that they started when she fell in love with a boy that she defines as 'a schizophrenic' because of his ambiguous and cold behaviour. A real relationship was impossible with that boy and when they met what she 'received' was 'crude sex'. The same sort of sensations she had with that boy also happened after she became emotionally involved in the therapeutic relationship. She also realizes that she was overwriting on my person a 'role and intentions' that were not my own. Only now she recognizes that what she used to call 'orgasms' are strong sensations of emotional arousal. She also recognizes that I (the therapist) am not the author of her sensations, that they are not 'made' or imposed on her by me. She finally acknowledges that these sensations are her own feelings, that they arise when she is strongly involved with other people, and that they include a mixture of excitement and fear.

She recovers a sense of being situated in the world and her experiences of being telepathically in contact with her therapist gradually disappear.
This case study can be taken as the paradigm of two topics we developed earlier, and of a third that will be the subject of this last section.

The first topic is the centrality of alterity in the human condition in general, and in mental disorders in particular. Here is encapsulated the chiasm between internal and external alterity, and its connection with the vicissitudes of self- and other-recognition. This person is impaired in self-recognition. She cannot recognize the sensations that arise in her body as her own feelings. She fails to recognize her feelings as her own, and to acknowledge that these feelings are emotions, that is, embodied motivations to act in a given way that arise from the involuntary side of her person. Emotions (as we saw in the first part of this book) are kinetic forces that drive us in our ongoing interactions with the environment. To be a person means to articulate and interpret one’s emotional experience. It involves a permanent confrontation with the alterity that becomes manifest in emotional experience, that is an inescapable part of the person that I am. Lacking this capacity for self-recognition, our patient undergoes a state of profound depersonalization whereby she feels alienated from herself (not only from her body) and passive with respect to other persons.

This lack of self-recognition implies the lack of other-recognition. She fails to understand that her bodily sensations are emotions. She also fails to recognize that these sensations are elicited in the I–You encounter, and she mistakes them as voluntarily produced by the other persons. Being unable to decipher her emotions, she cannot orientate herself in the I–You encounter. She cannot recognize the alterity of the other person, that is, the unfathomable complexity of the Other and the Other’s autonomy. Hence, she experiences the others as impersonal entities who behave with each other in a mechanical way. Her former boyfriend and her therapist are reduced to some sort of machines producing uncanny feelings, and in particular as ‘orgasm machines’. The thoughtful behaviour of the therapist is mistaken for a sign of erotic involvement. She finally constructs persons as entities who can only manipulate each other’s bodies at their will.

Also, this patient’s story is paradigmatic of the importance of the teleology of love in human affairs and its pathogenetic importance. We developed a tentative nosology in the previous chapters centred on the idea that mental disorders can be read as failed attempts to come to terms with the wounds inflicted by Eros. The discourse about mental disorders can neither simply assume the centrality of a missed encounter with alterity as an unsexed entity, nor can it reduce the agony of Eros to an unfulfilled sexual drive. Eros is the principle of opacity in human life, the epicentre of human suffering and pathology, since it includes organic as well as spiritual values: the need for sexual satisfaction as well as for recognition, for lust and for intimacy, for possession and for proximity. In short,
Eros is the principle of human vulnerability, for it bases its aspirations on the conflicting values of identity and of alterity. As Ricoeur put it,

Eros carries in himself that original wound which is the emblem of his mother, Penia. And this is the principle of opacity. To account for the aspiration for being, we need a root of indigence, of ontic poverty. Eros, the philosophizing soul, is therefore the hybrid par excellence, the hybrid of Richness and Poverty. (1987, p. 10).

Love is also the hybrid of reality and imagination. The lover’s discourse adheres to the image like a glove, much more than it adheres to the loved one (Barthes, 1977). The real Other is just its pretext. Her desire is idolatrous since its object is not the clinician as a person, but an idol, a phantasm, an unreal object. Focusing on the image of the Other, rather than on the flesh-and-blood Other is not just the case with erotomanic desire, but a general rule of the tel-eology of desire. Desire is directed to an idol fabricated by the mind. This idol stands between her and the Other. Her focusing on this phantasm, rather than on the flesh-and-blood Other, disregards the Other’s freedom not corresponding to her own desire, and her incapacity to tolerate this. Mental pathologies can be seen as miscarried attempts to seek refuge in vulnerable shelters as a defence from the missed encounter with the Other.

Last but not least, this case study is also paradigmatic of the vicissitudes of Eros that are enacted within the therapeutic relationship. In the previous sections, I have argued that to be human is to be in dialogue with alterity, and that mental pathology is the outcome of a crisis of one’s dialogue with alterity. This case history emblematically shows that therapy is a dialogue with a method whose aim is to re-enact one’s interrupted dialogue with alterity. In the next chapters, I will open the toolbox and describe the instruments that are at work in the therapeutic relationship. As it is clear from this example, these include devices and practices that belong both to logic—e.g. the method for unfolding the Other’s life-world and to rescue its fundamental structure—and pathic—e.g. the readiness to offer oneself as an object for the Other’s manipulations and the capacity to resonate with the Other’s experience and attune/regulate the emotional field. I will call these two complementary sides of therapeutic dialogue ‘logocentric’ and ‘anthropocentric’. Whereas the first is the search for the precise description of a given phenomenon of experience and an agreement about it, the second consists in a shared transcendental commitment to cross the space between each other. This dimension of the therapeutic dialogue is an act: the sharing of an intention whose transcendental referent is not a fact, but the relationship itself.
The person-centred, dialogic approach I will describe is sensitive to the constitutional fragility of Who and What we are and thus conceives mental pathology as the result of a normative vulnerability intrinsic to being a human person. It also insists that to assist a suffering person is to help that person with the responsibility involved in what she cares about. To help a suffering person is to deal with the obscure entanglement of freedom and necessity, the voluntary and involuntary, that is the result of the collapse of the dialectic of selfhood and otherness.

The psychopathological configurations which human existence takes on in the clinic are the outcome of a miscarried hermeneutic of one’s abnormal experiences and of the transformations of the life-world that they bring about. The stations of the pathogenetic trajectory can be summed up as follows: (1) an extreme disproportion of experience and understanding, of emotions and rationality, of pathos and logos bringing about an uncanny metamorphosis of the life-world; (2) a miscarried auto-hermeneutics of the transformed life-world; (3) the fixation in a pathological life-world in which the dialogue between selfhood and otherness gets lost.

This understanding of our vulnerability to mental illness contains a framework for engaging with this fragility by means of therapy. The aim of such a therapy is to re-establish the dialectic of selfhood and otherness that will allow the suffering person to become who she or he is.

The main principles of this approach can be summed up as follows:

- It focuses on the patient’s subjective experience as the point of departure of any clinical encounter.
- It encourages the patient to reflect upon his experiences, express them in a narrative format, and identify a core-meaning, or meaning-organizer, around which his narrative can become meaningful for him.
- It supports the patient in making explicit his personal horizon of meaning (values and beliefs), within which his narrative is set.
- It suggests the clinician’s making explicit to the patient his own understanding of the patient’s narrative (assumptions, personal experiences, beliefs).
Through this process, the clinician also makes his own set of theoretical assumptions, personal experiences, values, and beliefs explicit (at least, that part that is relevant for therapeutic purpose).

The clinician promotes a reciprocal exchange of perspectives and emotions with his patient, as well as the shared commitment to co-construct a new meaningful narrative that includes and, if possible, integrates contributions from both the original perspectives.

The clinician tolerates diversity and potential conflicts of values and beliefs.

Finally, the clinician facilitates coexistence, when it is not possible to establish consensus.

The practice of care that derives from this is based on the integration of three basic dispositives, synthesized in the acronym P.H.D.:

- **Phenomenological unfolding (P):** The basic purpose is to empower clinicians and patients with a systematic knowledge of the patient’s experiences. This is done through a process of unfolding, which means to open up and lay bare the pleats of the patient’s experiences. What comes into sight is the texture that is immanent in the patient’s style of experience/action, although it may remain invisible to or unnoticed by her. Unfolding enriches understanding by providing further resources in addition to those that are immediately visible. The main aim of this process is to rescue the *logos* of the phenomena in themselves, which is immanent in the intertwining of phenomena. But it also helps to recover the implicit (not necessarily rejected), automatic (not censored), forgotten (not forbidden) sources that make phenomena appear as they appear to the patient, his drives, emotions, and habitus—the three emblematic components of the obscure and dissociated spontaneity that make up the involuntary dimension in human existence.

- **Hermeneutic analysis of the person’s position-taking towards her experience (H):** The central idea of clinical hermeneutics is that there is an active interplay between the person and her basic abnormal experiences. As self-interpreting animals, we continuously strive to make a *logos* out of *pathos*. Attention is paid to the active role that the person has in taking a position and interacting with her abnormal, distressing, and dysfunctional experiences. The patient, with her unique strengths and resources as well as her needs and difficulties, has an active role in shaping her symptoms, course, and outcome. Rescuing from the implicit the active role that the patient has in shaping her symptoms is the *via regia* that helps the patient recalibrate her dysfunctional, miscarried position-taking and, finally, to recover her sense of responsibility and agency.

- **Dynamic analysis of the life-history in which experiences and position-taking are embedded (D):** To make sense of a given phenomenon is finally to posit it in a meaningful context, and this context includes the personal history of the patient. The basic presuppositions of psychodynamics, endorsed by the P.H.D. system, are psychological continuity and psychological determinism. The former assumes that all of any person’s psychological events (including those that look inconsistent) are lawful and potentially meaningful in a particular way for that person. The latter presumes that all psychological events have at least as one of their causes a psychological cause and can thereby be explained on a psychological basis.
A phenomenologically–hermeneutically–dynamically oriented framework for care includes five steps corresponding to five levels of meaningfulness.

*Unfolding the phenomena of the life-world and rescuing its implicit structure:* The first step considered here is unfolding the details of a given psychopathological world as a text—the explication of the case material. Unfolding means to exposit, open up, or lay bare the pleats, creases, or corrugations of a text. The opposite of this is to garble, pervert, distort, or twist/stretch/strain the text itself. What comes into sight is the texture that is immanent in the text itself, although it may remain invisible to or unnoticed by the author. Explication enriches understanding by providing further resources in addition to those that are immediately visible. The product of unfolding is a text that reflects the phenomenal world, the world as it appears to the subject of experience, including all those details that resist standard semiological classification. In a given psychopathological text, there is much more than what can be mapped using the catalogue of psychopathological symptoms (like phobias, formal thought disorders, or delusions). The aim of this process is to rescue the *logos* of the phenomena in themselves, by “bringing unnoticed material into consciousness”—as Jaspers (1997, p. 307) would put it. The *logos* that is immanent in the intertwining of phenomena is called sense, i.e. the internal coherence between the clinical (as well as subclinical and existential) phenomena found in a given condition of suffering. Phenomenological psychopathology advocates the idea that the phenomena embedded in a given (normal or abnormal) form of existence are a meaningful whole. This has an important clinical implication. The standard understanding of the concept of ‘syndrome’ in psychiatry is one which views it as a cluster of symptoms which happen to hang together not by any mutual phenomenological implication, but by their being otherwise unrelated effects of a common neurobiological cause. This alternative perspective holds that the manifold (abnormal) phenomena in a syndrome are meaningfully interconnected, that is, they form a structure. A psychopathological syndrome is not simply a casual association of (abnormal) phenomena. To have a phenomenological grasp on these phenomena is to grasp the structural nexus that lends coherence and continuity to them, because each phenomenon in a psychopathological structure carries traces of the underlying formal alterations of subjectivity.

Although this discourse is imbued with visual metaphors, it is important to note that this process of unfolding is profoundly rooted in hearing—or even better: listening and dialoguing—and in the power of the spoken word. The kind of seeing implied in this practice is—to adopt Levin’s (1988) distinction—“aletheic” rather than “assertoric” since it is “multiple, aware of its context, inclusionary, horizontal and caring” (Jay, 1994, p. 275). Hearing contributes to an ethics based on reciprocity and belonging, as well as to establishing a kind of knowledge focused on subjective experiences and personal narratives.

*Rescuing the implicit structures of the self:* The second stratum made visible by this process consists of the invisible conditions of possibility of the world disclosed in the first level. By rescuing the map of the world that is depicted in the text, we can approximate the architecture of the mind that projected it. This is an exploration of the implicit structures of experience, or into the structures of the self as the tacit and pre-reflexive
conditions for the emergence of mental contents. It looks for the way the self must be structured to make phenomena appear as they appear to the experiencing self. Looking for structural relationships consists in the unfolding of the basic structure(s) of subjectivity, that is, the way the self appropriates phenomena. The guidelines for reconstructing the life-world a person lives in are the so-called existentials, the basic categories, or categorial characteristics, of the fundamental features of human existence, namely, lived time, space, body, otherness, materiality, and so on (Heidegger, 2010). In this way we can trace back this transformation of the life-world to a specific configuration of the embodied self as the origin of a given mode of inhabiting the world, and perceiving, manipulating, and making sense of it. In order to grasp the transcendental framework of one's experience, one must turn one's gaze away from one's 'mind', and also from the 'world' as it appears in straightforward cognition, and look for the world's spatiotemporal architecture which reflects it. The reconstruction of the patient's life-world, and of the transcendental structures of his self, allows for the patient's behaviour, expression, and experience to become understandable.

**Narrating the transcendental origin of the life-world:** This kind of practice connecting a given experience (abnormal or not) with its transcendental condition of possibility may have etiological or pathogenetic implications, thus linking the research on meanings to that on causes of mental symptoms. The path to genetic understanding in psychopathology was opened by Jaspers, who described it as the “[i]inner, subjective, direct grasp of psychic connectedness” (1997, p. 307). Genetic understanding, according to Jaspers, is a kind of knowledge that establishes meaningful connections between psychic phenomena. Jaspers argued that psychic events emerge out of each other in a way that we can immediately understand. For instance, we immediately understand that attacked people become angry and spring to defence, or a cheated person grows suspicious. The philosophical paragon inspiring Jaspers is Nietzsche's understanding of morality as connected to weakness: the awareness of one's weakness, wretchedness, and suffering gives rise to moral demands and religion, because in this roundabout way the psyche can gratify its will to power. Jaspers offers several examples of genetic understanding in psychopathology, among them psychic reactions and the development of passions. Jaspers insists on the character of immediate-ness and self-evidence in grasping meaningful connections in someone's life. To him, genetic understanding in psychopathology “is a precondition of the psychology of meaningful phenomena (…) just as the reality of perception and of causality is the precondition of the natural sciences” (ibid., p. 303).

Husserl also developed, beyond static or descriptive phenomenology, another kind of genetic or constructive phenomenology that he called “explanatory” (Sass, 2010). This is a kind of developmental or diachronic understanding studying the way complex modes of experience are constituted via the synthesis of more basic modes or lived experiences. The key dispositive of Husserl's explanatory phenomenology is motivation or motivational causality. It has been argued that “analyzing the basic constitution and explicating the implicit structure of experience, phenomenology offers another way of developmental understanding: it allows for a comprehension of the pre-reflective dimension of experience (…) from which manifest symptoms arise” (Parnas and Sass, 2008, p. 280). In
this way, the dialogue moves beyond pure description and static understanding towards “an understanding of both the overall unity of that person's subjectivity and its development over time” (ibid., p. 264). This kind of narrative, based on the understanding of the basic architecture of the life-world, and on the structures of subjectivity which allegedly generate them, may allow us to both make sense of (rescue the personal meaning) and explain (rescue the personal motivation of) a given symptom, be it an action or a belief.

Appropriation (by the clinician) of the patient's life-world: The fourth level of meaningfulness made manifest by this exploration is the world that the text opens up in the patient when it is appropriated by the interviewer. The clinician appropriates the sense of the patient's experience and suggests his view of it. To appropriate a text means to acknowledge the way the text belongs to the reader, the way the reader could inhabit it. It is an attempt at reducing the distance between the text and its reader. If the interpretandum were completely extraneous, the understanding enterprise would be condemned to a checkmate, and if it were completely familiar, there would be no sense in making an effort at interpretation. The interviewer makes explicit his understanding as his own, that is, the vantage point from which he sees the patient's situation. This implies, in fact, a tension between extraneousness and familiarity. In this way, and only in this way, the clinician may become a ‘You’ for his patient. The clinician appropriates the patient's world by means of his own imagination when he tries to reply to the question: ‘To make sense of the patient's otherwise absurd and otherwise meaningless behaviour, I must imagine myself as if I were living in a world that has the following characteristics.’ This approximation to the patient's life-world is carried out by the clinician via as-if experiments that are metaphorically expressed.

Grasping the importance of the patient's life-world: We have seen that the meanings that we find in a text may exceed the intention of the author. This is the case with the parapraxis, and more generally for any kind of symptom. By unfolding the structures of a text, we can understand an author better than the author himself. Also, during this process of unfolding, the text lays in front of its author who can adopt a third-person stance over the text itself—and in the case of the symptom the patient can take a reflexive stance over the feel and the meaning of his experience, thus reinforcing his subjective and intersubjective sense of being a self. The importance of a text reaches beyond this level of understanding and discloses the mode of being in the world of that individual patient as a universal problem. It reveals the way his existence belongs to human existence as a whole, to the condicio humana. The text may display meanings that transcend the situation in which the text was produced. To grasp the importance of a text is to unfold “the revelatory power implicit in his discourse, beyond the limited horizon of his own existential situation” (Ricoeur, 1981, p. 191). The importance of a text is what “goes beyond” its relevance to the initial situation” (ibid., p. 207). In virtue of its importance, a text acquires a universal (not merely contingent) meaning, and its author embodies a universal problem (he stops being a merely contingent sufferer).

With all this in place, care focuses on five basic domains of analysis:

(1) The patient’s personal style of experience and action: It consists in an in-depth, tactful exploration of the patient's experiences, perceptions, feelings,
emotions, cognitions, and actions, of the personal meanings that the patient attributes to them, and of the life story in which they are embedded (it corresponds to the outcome of the P.H.D. exploration).

(2) The pathogenetic situation: It indicates the life situation that kindles the existential crisis or psychopathological decomposition. The notion of situation shows both the active role (the person actively concurs in creating the situation) and the passive role (the person does not consciously intend or desire to create the situation). The pathogenetic situation is a limit-situation during which the housing of everydayness and commonsensical assumptions of the life-world are jeopardized and the vulnerable structure of the patient comes to light. Limit-situations uncover the basic conditions of existence, that is, its being at risk of failure: guilt, death, financial ruin, etc., but at the same time they offer the person the possibility to know and to become herself.

(3) The patient’s vulnerable structure: It indicates a significant combination of stable characteristics that make up the ontological constitution or core Gestalt around which the vulnerability of the person is organized. The role that the values have in putting the meaning of existence per se into order is stressed. Values are attitudes that regulate the significant actions of the person, being organized into concepts that do not arise from rational activity but rather within the sphere of feelings. They are organized according to the ontological constitution, that is, from a certain type of relationship that the person has with him/herself, with others, and with the world.

(4) The therapeutic situation: It aims to make visible what happens in the clinician, in the patient, and in the situation in which both are embedded and engaged. In the therapeutic situation, lived time, space, body, and otherness get a typical physiognomy for the clinician and for the patient that can be acknowledged, described, and analysed. The therapeutic situation may actualize ways of being with the other in which thoughts, memories, emotions, values, and expectations of both the clinician and the patient are enacted. It is a protected experiment of we-ness during which hidden aspects of being with the Other can become explicit objects of visioning and discourse.

(5) Finally, the re-construction of the patient’s world-project: It is assumed that psychopathological phenomena are the outcomes of a disproportion between experiencing and understanding (pathos and logos), emotions and rationality, otherness and selfhood, and the consequence of a miscarried self-interpretation. Once this disproportion has been enlightened, a more functional world-project may start.
Chapter 4

Empathy and beyond

According to Jaspers, psychopathology has two major aims. First, it offers “clarification, order, formation” (Jaspers, 1997, p. 38), i.e. concrete descriptions, a suitable terminology, and methodical groupings that allow us to bring order into the chaos of disturbing mental phenomena. The second, and perhaps more important, aim is “psychopathological education” (ibid., p. 50), i.e. endowing clinicians with a valid and reliable methodology, and thereby providing them with a philosophically sound background for the encounter with their patients.

This second aim involves two basic features: (1) to render clinicians more aware of the characteristics of the tools they use when trying to grasp, assess, and make sense of their patients’ experiences and behaviours; and (2) to point out the limitations of these tools. In Jaspers’ sense, psychopathology is the exploration of the patient’s perspective. This exploration is methodologically based on two distinct but interrelated endeavours: one is empathic understanding, and the other is establishing meaningful connections between mental abnormal phenomena. When combined, these endeavours bring into focus the object of care, i.e. the patients’ abnormal experiences lived in the first-person perspective and embedded in anomalous forms of consciousness and existential patterns.

Jaspers characterizes his conception of empathic understanding in the following way: “Since we never can perceive the psychic experiences of others in any direct fashion, as with physical phenomena, we can only make some kind of representation of them. There has to be an act of empathy [ein Einfühlen], of understanding” (ibid., p. 55). Empathic understanding can be characterized as a particular kind of intentional experience in which my perception of the other person leads me to grasp (or to feel that I grasp) his personal experience, and to feel that—and how—he is an embodied person like me, animated by his own feelings and sensations, and capable of voluntary movements and of expressing his experience.

Jaspers’ conception of empathic understanding is clearly guided by a phenomenological attitude that Jaspers sees as the most fundamental method in our attempt to access the disordered mind: “This phenomenological attitude [Einstellung] is something we have to attain to again and again, and involves a continual onslaught on our prejudices” (ibid., p. 5). Nevertheless, empathic
understanding as a phenomenological attitude can, for Jaspers, only be a first descriptive step that needs to be combined with a second explanatory attempt to make sense of the “basic patterns of human life” (ibid., p. 31). In other words, empathic understanding is a necessary but insufficient means in our approach to the mind of other people, and to abnormal mental phenomena in particular.

Phenomenological accounts of empathy are an integral part of the more general debate in contemporary philosophy about how to understand the mental life of other people (Gallagher and Zahavi, 2012; Overgaard, 2012; Ratcliffe, 2007). Empathy is a highly controversial notion with a relatively short conceptual history (Strueber, 2006). Coined and introduced into the English language by Edward Titchener in 1909 as the translation of the German word *Einfühlung* (‘feeling into’), the notion of empathy has had a rather turbulent life in the philosophical discussions of other minds. Having been considered the principal means of assessing and understanding the mind of others in the initial decades of the twentieth century, the notion disappeared almost entirely from the philosophical debate for most of the remaining part of the century, only to return with renewed force in the contemporary discussions about folk psychological mindreading and the so-called mirror neurons.

Two main approaches to interpersonal understanding have dominated the debate for years: theory-theory (TT) and simulation-theory (ST). Although both theories come in various shapes and forms, it is possible to glean a basic claim constitutive of each approach. While TT operates with the idea that we understand other minds by implicitly employing a theoretical stance (Nichols and Stich, 2003), ST argues that we do not theorize about the mental life of another person but use our own mental experience as a model for what goes on in the mind of another person (Goldman, 2006). The phenomenological proposal differs from these two influential accounts in several ways, but particularly with respect to one basic assumption. ST and TT operate with a sharp distinction between external and internal, between what goes on inside the mind and how this internal affair is expressed in external bodily behaviour. While TT and ST both assume that the mind of another person is entirely hidden from me and therefore inaccessible to anyone other than the experiencing person herself, the phenomenological proposal argues that a sharp distinction between an internal mind and an external body is both conceptually and experientially unwarranted (Gallagher and Zahavi, 2012), and that such a view is detrimental to our understanding of intersubjectivity, and, consequently, also to our conception of empathy (Gallagher, 2012; Zahavi, 2001). A phenomenological approach is therefore opposed to TT and ST, and to any theory that wants to explain our understanding of others as primarily a matter of first perceiving the bodily behaviour, and then theorizing (TT) or simulating (ST) that
behaviour as caused by inner mental states similar to those that cause the same kind of behaviour for ourselves.

Jaspers’ concept of empathy goes in a quite different direction and is based on three main assumptions.

First, empathy is a matter of direct perception. Rather than relying on cognitive processes such as inferences, projections, or simulations, we have a pre-reflective experiential understanding of other people that is constitutive of our experience of the world and ourselves. That is, seeing other people as intentional creatures, as opposed to mindless creatures or inanimate objects, is constitutive of how we perceive the world. This is not to say that we experience other people as we experience ourselves. First-person experience of thoughts, feelings, and desires is basically different from second- (and third-)person experience of those psychological states, but my experience of another human being is nevertheless perceptually more intimate than my perception of, say, a dog or a coffee table, in that I perceive the other person as endowed with experiential features similar to my own. Hence, my experience of other persons is not an experience of the matter, movements, and interactions of meaningless objects. Rather, it is an experience of particular expressive phenomena. I see the expressions of another person as meaningful human behaviour because “expressive phenomena are already from the start soaked with mindedness” (Zahavi, 2001, p. 55).

Empathy is the basic dispositive through which we understand the Other’s mind. When we come to understand the Other’s state of mind, since we cannot directly perceive their state of mind, we approach it through the Other’s self-descriptions. In the clinic, empathic understanding relies on a dissection and explication of the patient’s field of consciousness as recounted by the patient himself, the aim of which is to bring into view his subjectivity. The basic purpose is to empower clinicians with a systematic knowledge of the patient’s experiences as recounted by the patient. This is the task of phenomenology sensu Jaspers:

phenomenology ( . . . ) gives a concrete description of the psychic states that the patients actually experience. It reviews the interrelations of these, delineates them as sharply as possible and creates a suitable terminology. We confine ourselves solely to the things that are present to the patients’ consciousness. Conventional theories, psychological constructions, interpretations and evaluations must be left aside. (Jaspers, 1997, pp. 55–6).

Avoiding theoretical explanations, as well as presuppositions and prejudices, is the quintessential methodological prerequisite for understanding other minds. How successful a genuinely theory-free approach can be in the face of arguments as to essential theory-ladenness of data is a matter of debate (Thornton, 2007). This is the third point of Jaspers’ concept of ‘empathy’. It
concerns the relation between perception and representation. In 1912 Jaspers described the phenomenological approach to the meaningful expression of other people as the attitude that clinicians must constantly acquire in their relation to their patients:

As children we first picture the things not as we see them, but in the way we think them; likewise as psychologists and psychopathologists we pass from a level on which we somehow think the mental, to an unprejudiced and immediate understanding of the mental as it is [zur vorurteilslosen unmittelbaren Erfassung des Psychischen so wie es ist]. And this phenomenological attitude is a constantly renewed effort and an acquired good which demands a constant overcoming of prejudices. (Jaspers, 1963, p. 318)

The condition of possibility of the intuitive experience of the other person's mental life is the phenomenological attitude, that is, the capacity to become aware of one's own pre-existing mental images that affect the way we resonate with the Other and finally, the way we experience the fundamental emotional and cognitive features that constitute the Other's life, such as his beliefs and desires (Jaspers, 1997, pp. 93–108) together with the basic feelings and affective states (ibid., pp. 108–17). Empathic understanding, then, is a way to bring into a privileged focus the concrete world of human behaviour and expression, since “phenomenology actually designates just what is immediately given [unmittelbar Gegebenes]” (Jaspers, 1963, p. 32), and to understand empathically is to insist on and give radical attention to the irreducible and ultimate character of this givenness of human existence.

An initial distinction between two kinds of empathy will enable us to bring out the core of this conception of empathic understanding. The most basic form of empathy does not require any voluntary and explicit effort. We may call this type of empathy, which is at play from the very beginning of our life, nonconative—a kind of spontaneous and pre-reflective attunement between embodied selves through which we implicitly make sense of the Other's behaviour (Rochat, 2009; Stern, 2000). But in some cases the Other's behaviour becomes elusive: while performing this act of imaginative self-transposal, we experience the radical un-understandability of the Other. In some cases—maybe the most relevant in clinical practice—we do not feel immediately in touch with the Other, we do not immediately grasp the reasons and meaning of his actions, and as a consequence we purposively and knowingly attempt to put ourselves in his place. While attempting to transpose ourselves into the Other, we experience the radical otherness of the Other. In this vein, early clinical phenomenologists (like Jaspers) and early psychoanalysts (like Freud) rejected empathy as an adequate tool for understanding the subjectivity of patients affected by severe mental illnesses like psychoses.
In these situations, while we experience the limitations of this mode of understanding, we deliberately put forward all our efforts to thematically understand the other person. Whereas nonconative empathy mainly involves the implicit resonance between my and the Other's lived body as a means of understanding, conative empathy (Stanghellini, 2007) requires something more than a resonating body: it puts into play my personal past experiences and my personal knowledge of commonly shared experiences (common sense). Conative empathy is, then, a more cognitive and reflective task than nonconative empathy as conceived in phenomenology. Here I actively look inside myself for stored experiences to make them resonate with those of the Other. It implies a kind of understanding by analogy. An important epistemological concern arises here: How do I know that I am not projecting my own experiences onto the Other? Also, a perhaps even more important ethical concern is at issue: How do I know that the Other wants to be understood by me, i.e. assimilated to my own experience?

Jaspers was deeply concerned with both the epistemological and ethical aspects of the attempt to understand the other person by means of analogy. His concern for both these aspects of our endeavour to empathically understand the other person’s mental life is closely connected to the basic conception of what it means to be a human person developed in the first section of this book. In fact, Jaspers, like his favourite past philosophers—Kant (1996) and Kierkegaard (1980) (and Levinas (1969) afterwards)—argues that human nature must be understood from the normative perspective of an indefinable and restless autonomy (Batthyány, 2011): “Know thyself is not the demand to look in a mirror in order to see who I am, but to work on myself so that I become who I am” (Jaspers, 1956, p. 37). In other words, being an individual person is not a fact, but a constant task of becoming who I am (Stanghellini and Rosfort, 2013a). Being a human person is trying to exist as myself in and through the challenges of all those features that make up what I am (my facticity, e.g. my brain, my past, my parents, my nationality, my job), but which cannot define who I am. This philosophical conception of human nature as “an unending processual movement” (Seubert, 2011, p. 69) is part and parcel of Jaspers’ psychopathology. The limits, and dangers, of empathy—nonconative as well as conative—stem from this ‘original source’ of autonomy that makes the person in front of me into the unique and irreplaceable individual that he or she is. The suffering of illness that this person undergoes consists, so Jaspers argues, in a constant “comprehending appropriation of it, relating to the foundations of the patient’s own true existence” (Jaspers, 1997, p. 426). The fact that a human person is more than what we can describe, explain, or predict ensures that my understanding of a person—myself as well as the Other—basically takes place
against a background of incomprehensibility. This is not to say that our endeavours to empathically understand the other person are epistemologically in vain or ethically wrong. On the contrary, those endeavours are part of what makes us human. Jaspers simply insists that without acknowledging the irreducible autonomy of the other person in our attempt to empathize with her we slide into epistemological illusions and, coincidentally, cross the dangerous ethical border that separates respectful care from explanatory patronizing.

This does not imply that our empathetic endeavours are unnecessary. On the contrary, while discovering the limits of empathic understanding we realize that we need to adopt a different approach if we want to move towards and try to understand the patient’s experiences. Jaspers’ attitude towards knowledge in general consists in the idea that all knowledge must have an asymptotic character: “In the instantaneous certainty the humility of an enduring question is indispensable” (Jaspers, 1950, p. 68). In other words, Jaspers’ “theorem of incomprehensibility” is not a defeat of understanding, but Jaspers’ way of ensuring that “understanding stays inside the sphere of possibility”, and “offers itself in a tentative way and remains mere proposition within the cool atmosphere of knowledge that comes from understanding” (Jaspers, 1997, p. 359). Following this Jaspersian lead, in this chapter I will sketch an alternative proposal for how to conceive of empathic understanding. In the next chapter, I will give a concrete clinical example of the use of this conception.

Understanding severe aberrations of experience requires a kind of training that goes beyond a conception of spontaneous nonconative empathic skills, and at the same time avoids the pitfalls of conative empathy based on the clinician’s personal experiences and common-sense categories. The achievement of this training can be named second-order empathy (Stanghellini, 2013a, 2013b). To achieve second-order empathy is a complex process. First of all I need to acknowledge the autonomy of the other person, and consequently that the life-world of the other person is not like my own. Second, I must learn to neutralize my natural attitude that would make me try to understand the other’s experience as if it took place in a world like my own. Third, I must try to reconstruct the existential structures of the world the other lives in. Fourth, I can finally attempt to understand the other’s experience as meaningfully situated in a world that is indeed similar to my own, but also constantly and indelibly marked by the other person’s particular existence, and by that person’s endeavour to become who she or he is. The supposition that the other lives in a world just like my own—i.e. he experiences time, space, his own body, others, the materiality of objects, etc., just as I do—is often the source of serious misunderstandings.
Take the example of lived time: existential time—as Erwin Straus (1967) wrote—cannot be detached from the life and history of the individual. One day for a young man can be lived as growth and fulfilment, whereas an old man may live it as consumption and decline. An anxious person may be afflicted by a feeling that time vanishes, inexorably passes away, that the time that separates her from death is intolerably shortened. Another patient in an early stage of schizophrenia may experience time as the dawn of a new reality, an eternally pregnant ‘now’ in which what is most important is not present; what is really relevant is not already there, but is forever about to happen.

In order to empathize with these persons, I need to acknowledge the existential difference, the particular autonomy, which separates me from the way of being in the world that characterizes each of them. Any forgetting of this difference, for instance between my own world and that of an anxious or a schizophrenic patient (but we would say, also, *mutatis mutandis* between my own and an adolescent’s or an old man’s world), will be an obstacle to empathic understanding since these people live in a life-world whose structure is (at least in part) different from my own. Achieving second-order empathy thus requires me to set aside my own pre-reflexive, natural attitude (in which my first-order empathic capacities are rooted), including my own way of experiencing time, and to approach the Other’s world as I would do while exploring an unknown and alien country. As Jaspers writes:

> To get to know the individual is comparable to a sea-voyage over limitless seas to discover a continent; every landing on a shore or island will teach certain facts but the possibility of further knowledge vanishes if one maintains that here one is at the centre of things; one’s theories are then like so many sandbanks on which we stay fast without really winning land. (Jaspers, 1997, p. 751)

The other person is not simply an alter-Ego, i.e. someone like me. He or she is an autonomous person whose existence constantly disrupts my understanding of who she is. We live in a common world constituted by the basic intersubjective structures responsible for how we experience and interact with the world. This remains the firm background against which we should approach the question of interpersonal understanding. By insisting on the irreducible, and basically incomprehensible, individual character of every person’s life-world, I argue that the particular life-world of a person is forever beyond my empathic endeavours, conative as well as non-conative. In other words, I—as did Jaspers, as a philosopher and as a psychopathologist—subscribe to a heterologist view. I should presuppose difference rather than resemblance in my endeavour to understand the Other’s mind. Presupposing an analogy between me and the Other involves the risk of reducing the Other to my experience of her, i.e. depriving her of her status as, and her right to be, an individual person. With Jaspers, incomprehensibility is not merely an epistemological concept that sets the boundaries of understanding, but rather an ethical principle that stems from his conception of
human existence as basically an indefinable and restless autonomy that escapes definitive knowledge.

Jaspers’ ill-famed theorem of incomprehensibility, if viewed from this perspective, provides the basis for a respectful attitude in clinical practice, as well as in human affairs in general, that enables us to care for the Other as another person. This attitude is antithetical to psychological or psychopathological nihilism, i.e. abandoning all attempts to understand the Other’s mind. Rather, it sets the stage for an authentic dialogue as the prerequisite for understanding the Other’s existence. We named this approach to other people second-order empathy. The achievement of second-order empathy is a complex process based on the acknowledgement of the other person’s autonomy and the heterology of the other person’s life-world. This paves the way for exploring and reconstructing the implicit, transcendental structures of the other person’s subjectivity underlying the manifold phenomena and symptoms.
A woman in her forties, hospitalised in a surgery ward of a general hospital, behaves restlessly, and is impatient, irritating, and complaining. She attacked a nurse for no apparent reason when she tried to give her medication, refuses drugs, makes a fuss, asks for special treatment, etc. Nurses say that the patient is over-demanding, continuously looks for attention, and tries to manipulate them.

Some qualify her behaviours as ‘acting out’, saying that she behaves thoughtlessly and impulsively.

You, as a clinician, are asked to interview the patient. During the interview you exclude all sorts of disorders of consciousness (e.g. lowered, clouded, narrowed, or expanded consciousness) and orientation (in time, place, situation, etc.), as well as psychotic phenomena (e.g. delusions, hallucinations). Feeling more at ease, at a given point the patient tries to clarify: ‘Nobody wanted to explain to me what was going on. I could not understand what they were doing to me. Everything was so obscure. I felt nervous, worried about that. I just wanted to know. Do I have the right to know and to decide? Or should I go away?’

During the staff meeting that follows your interview with the patient, you try to shed light on the motivations of the patient’s behaviour, and on the staff’s interpretations thereof. What is the purpose of this behaviour, if any? What is it about?

The first reaction is deeming her behaviour ‘irrational’, ‘illogical’, and ‘unmotivated’, thus ‘incomprehensible’ and ‘almost crazy’. The majority, after further reflection, suppose that her intention is ‘manipulating’, ‘controlling’, or ‘manoeuvring’. Someone more softly assumes that she tries to ‘persuade’ the nurses to act the way she wants. As to her innermost reasons for behaving in this manner, some conjecture that it is because of her ‘need to dominate’ the others. A doctor speaks of ‘sadism’—she needs to get pleasure from harming the Other. Someone speculates that she may be driven by her ‘fear of the Other’ and her ‘need to control’ the Other who is supposed to be harmful. ‘Egoism’ is another nurse’s explanation for the patient’s comportment—she has no concern for the Other. ‘Pure meanness’, no respect for the Other, is another interpretation.

In order to answer the question about the motivation or purpose of the patient’s behaviour—you explain—we need to consider the case from another angle: What kind of experience underpins this behaviour? Does the patient experience that given situation—being hospitalised in a surgery ward—as we do, or as we could expect ourselves, or ‘everyman’, to do?

Let us concentrate on the first interpretation: manipulation. A vast range of behaviours is labelled by the term ‘manipulation’, both in clinical and non-clinical situations. This word is used to stigmatize morally wrong ways of interacting,
lumping together bullying, intimidation, physical violence, building special relationships, corruption, creating divisions, conning and lying, deceiving, and threatening (Potter, 2006, 2009). Manipulativity, although not an official diagnostic criterion for borderline personality disorder, is often used by clinicians to deplore the way in which these persons interact with others. Manipulation in people with borderline personality disorder is deemed deliberate and morally blameworthy rather than ill. Also, it is considered maladaptive since it reduces the other person’s empathy towards the manipulator, undermining his/her desperate search for relationships and attention. Thus, manipulation is a term that tends to be over-inclusive and is affected by conceptual cloudiness, conflating moral values with clinical judgement.

Potter proposes a working definition of ‘manipulativity’ that can be summed up as follows: it is a behaviour that dramatizes the manipulator’s needs/emotions in ways designed to target a perceived vulnerability in the Other, in order to effect desirable responses by the other in an indirect way, although the other feels/thinks that the manipulator is overdoing his/her own need/emotion, s/he (the Other) feels trapped by them (Potter, 2009, p. 109).

This definition highlights the alloplastic purpose of manipulativity: producing a belief in or action by the Other. This is only one side of the coin. A complementary aspect of manipulative behaviour is that manipulation can serve an epistemic, rather than alloplastic, pragmatic motif—the attempt to establish contact with the Other in order to achieve a more distinct experience and representation of the Other. This tentative hypothesis is based on the meaning of manipulation as touching (manus=hand) in infant behaviour where manipulation is a means to explore, rather than a way to modify the other’s state of mind.

Reflecting upon these issues produces more questions: Is this behaviour embedded in a life-world like our own? Does the patient’s life-world—the reality she lives in, her experience of the surrounding world—bear some analogy with the life-world we live in? Or is it, in part, different from our own life-world? And in the case that this behaviour was the expression of a different life-world, of a kind of world in its own right but unlike our own, what can we do to approximate the world the patient lives in? Can this difference between my life-world and the Other’s, which makes understanding and communication difficult, be overcome? And how?

Let’s start with the first question. It seems self-evident, as is implied by the ‘shock experience’ kindled by the patient’s behaviour, that her conduct must be situated in a life-world that does not (at least, in part) overlap with our own. If so, in what sort of life-world is this behaviour embedded? Before answering this question, we need to clarify a preliminary issue: What do we mean by ‘life-world’, and why is that concept relevant for us? This is the definition of
‘life-world’ by Schütz and Luckmann (1973): “The reality which seems self-evident to men remaining within the natural attitude. This reality is the every-day life-world. The region of reality in which man can engage himself and that can change while he operates in it by means of his animate organism”. The life-world is what each of us takes for granted as the objective reality and meaning of the surrounding world—at least until we reflect upon the way in which we contribute to establishing this ‘objectivity’ and meaning. Although the majority of people belonging to a given culture are situated in a shared life-world, there are several other private life-worlds that are different from the ‘every-day’ life-world, e.g. fantasy worlds, the dream world, and what we may call psychopathological worlds. Schütz and Luckmann (1973) further explain that each life-world is characterized by a given “pragmatic motive”, by a “meaning-structure” and a “style of subjective experience”. The pragmatic motive is the implicit or unconscious reason/drive that motivates us to experience the world and to construe its meanings in that given way. As a consequence of this, the ‘objects’ and ‘events’ which a person finds in his/her life-world are structured according to a given style of experience that limits his/her potential for free action.

Thus, the life-world is a province of practice in which the structure of meaning is deeply intertwined with one's necessity for action. Our previous question, then, can be rephrased as follows: In what sort of ‘province of meaning’ and ‘style of subjective experience’ is our patient’s behaviour embedded? If we are able to answer this preliminary question, then we will be able to render her behaviour meaningful and understandable.

Since the patient’s behaviour is patently an ‘antipathetic’ one (as we can see from the staff’s emotional reactions, comments, and interpretations), in order to rescue its meaning we cannot confine ourselves to standard empathic understanding (Stanghellini, 2000). We cannot simply rely on our spontaneous capacity to put ourselves in her shoes, since the effect of her behaviour on ourselves is rather one of rejection. It seems rather impossible to empathize with this behaviour, at least in the standard meaning of this term; although the patient herself said, ‘Nobody wanted to explain to me what was going on. I could not understand what they were doing to me’, and that is key to comprehending her behaviour (and thus of empathizing with her). It will nonetheless remain difficult to empathize with her inability to grasp and make sense of what was happening to her. What exactly does she mean by, ‘I could not understand what they were doing to me’; and why did she have that kind of experience? It seems clear that her ‘experience’ of the situation was quite different from the staff’s understanding. Instead, we need to seek another kind of understanding. We need to rescue the implicit structures of her life-world in order to make her
behaviour understandable. Then, we can also try to empathize with it—or, at least, not to blame her for it.

As we have seen during the staff meeting, many agreed that the patient’s behaviour was ‘manipulative’. Manipulation is usually understood as an alloplastic behaviour, the attempt to modify external reality of an antipathetic kind. As such, usually manipulative people are blamed for that. A negative feeling (antipathy) and a negative-value judgement (blame) stand in the way and threaten attunement and understanding.

However, the interpretation changes, and with it the clinicians’ attitude, if manipulation in this person is understood as explorative behaviour rather than as alloplastic. Manipulation is a kind of touching. This is the metaphorical and at the same time concrete domain of the stigmatized behaviour called ‘manipulation’. Touch is the primordial source of knowledge and acquaintance—contact. Through touch, we explore, inspect, scout, check, examine, and scrutinize the world around us, including other people. Doubtlessly, this is childish behaviour in the sense that it is proper to children before they develop other ways to get to know and evaluate reality. Nonetheless, nobody would deem manipulation in a child as comportment that should be blamed or discouraged, since one knows that this behaviour has a specific pragmatic motive and meaning in that province of reality and meaning that we call ‘childhood’. Children live in a world unlike our own; their practical possibilities for action are different from our own. Time, space, and meanings are structured in a way dissimilar to our own, as everybody knows—and as masterfully described in the novel The Child in Time by Ian McEwan (1987). When we see a child manipulating something, we usually experience a feeling of sympathy and tenderness.

So what are the implications if our patient manipulates in order to get to know the Other, and to make sense of the situation she is in? The related question is: What sort of experience/image/representation of the Other and of the situation does she have so that she needs to be manipulative?

In truth, we need to revisit what she said about that (although it appeared quite obscure) before making the hypothesis that the meaning of manipulation was not manoeuvring the others, but rather an attempt at establishing some sort of contact with the others by exploring their behaviour. Now it is quite easy to see that manipulating for her is not just a strategy to control or persuade the others. It could very well be a way to get in touch—although in a quite clumsy way for our standards. Handling, laying hands on someone, fingering, touching, contacting, feeling, stirring, tapping, caressing, soothing, pressuring, squeezing, scratching, stretching, hurting, irritating, scraping, etc., are all ways of getting in touch, meeting and linking with other people—although some of them may be annoying, exasperating, frustrating, and vexing.
Second-Order Empathy

if performed by an adult and not by a child (or an animal, e.g. a primate) as we would expect.

Seen from that angle, the manipulative behaviour of our patient stops being a nuisance that has no clinical relevance. Rather, it becomes the mirror of her life-world and a heuristic device to get to know in great detail the province of meaning that she inhabits. It becomes a phenomenon that speaks of her way of being in the world and paves the way to our understanding of her being situated—and not simply a behavioural symptom to be eliminated.

The tentative hypothesis we explored—based on the meaning of manipulation as touching and on child behaviour—is that manipulation with some patients may be more exploration, less modification, of the Other.

Of course, this is neither the only nor the ubiquitous meaning of manipulation, since manipulation in ‘healthy’—and even in some ‘unhealthy’—people may very well be about modification. Although I do not have the ambition of establishing a ‘diagnostic criterion’, I suggest that this side of manipulative behaviour may be rather typical of people with borderline personality disorder.

Manipulation is often a kind of behaviour attributed to people with severe personality disorder, including borderline personality disorder. Of course, it is not legitimate to make a diagnosis on the basis of one single feature, especially if it is a behavioural one. What is at issue is the style of subjective experience that subtends this behaviour. In our example, the patient says something relevant about this, namely that she was unaware of ‘what was going on’, that ‘everything was so obscure’, and that she felt ‘nervous’ and ‘worried’ about that. All this is not enough to reconstruct her style of experience. The appearance of the Other as a dim and fuzzy person or as a tenebrous and suspect one is a key feature of the life-world of persons affected by dysphoric mood (Stanghellini, 2000; Stanghellini and Rosfort, 2013, 2013c). Although the term ‘dysphoria’, in the narrower sense of irritable mood, is often used to designate mood states in different psychopathological conditions (including several personality disorders, affective disorders, organic psychoses, delusional disorders, and schizophrenias)—and not only in borderline personality disorder—the quality and the consequences of dysphoric mood in borderline persons is rather common.

Dysphoria is an unfocused mood and not intentional; it does not possess directedness and aboutness. It is felt as unmotivated, rather indefinite and indeterminate, and often inarticulate. Dysphoria in people with borderline personality disorder exerts a centrifugal force that fragments their representations of themselves and others, thus contributing to their painful experience of incoherence and inner emptiness, their threatening feeling of uncertainty and inauthenticity in interpersonal relationships, and their excruciating sense of insignificance, futility, and the inanity of life. In the befuddled atmosphere
of their dysphoric mood, borderline persons often experience their own self as dim and fuzzy, feeling deprived of a defined identity and unable to remain steadily involved in a given life project or social role. Dysphoric mood brings about a formless and immaterial sense of one's own self.

Also, people affected by dysphoric mood may see others as cloudy, and their faces as expressionless. The Other is an "expressionless face staring blankly at my pain"—as playwright Sarah Kane (2001) wrote.

In the penumbra of dysphoria, the Other may appear as the ‘shade of a shadow’—it is Aeschylus speaking here. To use the words spoken by the patients themselves, the Other is experienced as indefinite, indeterminate, indistinct, ill-defined, and out of focus. The following is a clinical example of that:

A patient enters my consultation room. When I stretch out my hand in her direction she lays her inanimate hand in mine and watches me in an interrogative way. During the therapy session she sits restlessly, remains silent and answers my questions in a provocative way. During one of the following sessions she explains that she needed to test my interest in her, seeing if I really cared about her, and the extent of my intention and capacity to understand her on her moody days.

The indefiniteness of the Other is the norm in dysphoria. When the dysphoric mood turns into anger—as is the case in people affected by severe personality disorders like borderline personality disorder—the Other changes from being opaque to being tenebrous: he is ambivalent, obscure, puzzling, and suspect.

During another session, the same patient looks at me right in my eyes in an angry way. She sits in a state of tension, as if she were on the point of attacking me. She remains silent for the whole session and at the end she accuses me of being the source of her problem, and being responsible for her feeling so bad.

What is relevant here is that when dysphoric moods fade away (and with them, the indeterminate representation of the Other), anger brings about a clear-cut representation of the Other as a persecutor.

People affected by borderline personality disorder have biases in mental state attribution (emotions, thoughts, and intentions) (Preißler et al., 2010) and may evaluate others as malevolent. Impaired social cognition or deficits in ‘mentalization’ are hypothesized to underlie disturbed relatedness, a core feature of borderline personality disorder (Roepke et al., 2013). We may argue that disturbed relatedness, through impaired social cognition, is the outcome of dysphoric mood (Stanghellini and Rosfort, 2013a, 2013b). In other terms, dysphoria sets a person in a kind of life-world dominated by cognitive indecision and a lack of grasp on the meaning of things and on the intentions of others—as is indeed the case with our patient. In this kind of world, the principal ‘pragmatic motive’ is to achieve a more distinct experience and representation of the world and of
other people. Manipulation, as the attempt to establish contact with others and explore their behaviour, may serve this purpose.

Can we empathize with manipulation? I described manipulation as an anti-pathetic behaviour. Indeed, we are not keen to feel sympathy for people who manipulate others and this is an obstacle to empathizing with them and to engaging in understanding the motivations of their behaviour. Rather, we are tempted to stigmatize their behaviour. The most basic form of empathy does not require any voluntary and explicit effort. We called this type of empathy (Stanghellini, 2007), which is at play from the very beginning of our life, non-conative—a kind of spontaneous and pre-reflective attunement between embodied selves through which we implicitly make sense of the Other’s behaviour (Rochat, 2009). Sometimes, the Other’s behaviour becomes elusive. While attempting to transpose myself into the Other, I experience the otherness of the Other. If I remain in the natural attitude, I am tempted to stigmatize the Other’s behaviour, which means to experience negative feelings like repulsion and aversion and to judge it ‘meaningless’ and ‘illogical’—as is the case with our clinical example.

In order to empathize with these persons, and to make sense of their behaviour, I need to acknowledge the existential difference. Any forgetting of this difference—for instance between my own world and that of a person who ‘manipulates’ the others—will be an obstacle to empathic understanding, since these people live in a life-world of which the structure is (at least in part) different from my own.

In addition to severe aberrations of experience such as those that can be encountered in schizophrenia, more common phenomena like manipulation would also seem to require a rather sophisticated and counter-intuitive kind of empathy and understanding. To achieve this kind of understanding requires a kind of training that goes beyond spontaneous (non-conative) empathic skills, as well as standard conative empathy and common-sense categories. We named this ‘second-order’ empathy. As shown in the case study, I first need to acknowledge that the life-world of the other person is not like my own, neutralizing the natural attitude that makes me approach the Other’s experience as if it took place in a world like my own. In the case of our patient, if we did not abandon the preconception that her manipulative behaviour had the meaning that such comportment first and foremost may have in our own life-world, then we would have simply deemed this behaviour inappropriate and irritating. If we considered it at face value, then we would characterize it as behaviour aimed at surreptitiously producing a belief in, or action by, the Other.
But, if we try to reconstruct the existential structures of the world that the Other lives in, then his/her behaviour may emerge as meaningful and appropriate to the pragmatic motive that dominates his/her existence—the epistemic motive to achieve a more defined representation of the Other. In this way, we can then finally attempt to understand the Other’s behaviour in the light of his/her style of experience—in this case, the experience of the Other as dim and out of focus—and, as such, as meaningfully situated in a world that is indelibly marked by the person’s particular existence.

The case study of manipulation confirms that the supposition that the Other lives in a world just like my own is often the cause of serious misunderstandings—the source of negative emotions and of misleading value judgements and stigmatization that grossly interfere with one’s capacity to care for other persons and to make sense of their behaviour.
Chapter 6

Unfolding

The world the Other lives in is other with respect to mine. What must be assumed is the difference, not the analogy. We are accustomed to speaking of ‘normality’ when it concerns our own home-world, whereas we ascribe the attribute of ‘abnormal’ to the foreigner. Yet, ‘abnormals’, provided certain conditions are fulfilled, can be apprehended as members of a foreign normality (Zahavi, 2003, p. 135). Thus, we must assume a ‘different normality’ (i.e. hetero-logy), that is, the existence of a norm that is valid within another framework of experience. Understanding another person requires reconstructing her framework of experience. A fortiori, understanding a patient’s symptom requires reconstructing the framework of experience in which it is embedded.

Although the majority of people are situated within a shared experiential framework, there are several other frameworks of experience. The framework of experience is the everyday world in which one lives, eats, works, loves, suffers, gets sick, and dies. Reconstructing the Other’s framework of experience needs a preliminary deconstruction. This deconstruction is made through a phenomenological unfolding of the experiential characteristics of the life-world inhabited by the other person. We need to identify, beyond the symptoms that the Other manifests, the fundamental structures of his existence. Abnormal phenomena and psychopathological symptoms in general are generated within the framework of an abnormal life-world. The specificity of a symptom is only graspable at this comprehensive structural level (Parnas, 2004; Stanghellini and Rosfort, 2013c). This overall change in the ontological framework of experience transpires through each single symptom. The experience of time, space, body, self, and others, and their modifications, are indexes of this change in the ontological framework within which each single abnormal phenomenon is situated (Stanghellini and Rossi, 2014).

The phenomenological unfolding is the exploration of the implicit structures of experience, or into the structures of the mind as the tacit and pre-reflexive conditions for the emergence of mental contents. It looks for the way the mind must be structured to make phenomena appear as they appear to the experiencing person. Once the world of the patient has been disclosed with the greatest possible detail, the task becomes to reconstruct his mode of being in the world
from its existential organizers. In this way we can trace back the patient’s normal or abnormal experiences and behaviours to a specific architecture of the mind as the origin of a given mode of inhabiting the world, perceiving, manipulating, and making sense of it. The reconstruction of the patient’s life-world, and of the transcendental structures of his mind, allows for the patient’s behaviour, expression, and experience to become understandable.

The case with manipulation shows that the phenomenological unfolding of abnormal human subjectivity suggests a shift of attention from mere symptoms (i.e. state-like indexes for nosographical diagnosis) to a broader range of phenomena that are trait-like features of a given life-world. These abnormal phenomena can be used as pointers to the fundamental alterations of the structure of subjectivity characterizing each mental disorder. Through the process of unfolding, the manifold phenomena surface in all of their concrete and distinctive features, so that these features emerge in their peculiar feel, meaning, and value for a patient.

The primary object of care is the patient’s subjectivity, the patients’ mental states as they are experienced and narrated by them. The focus on the patients’ subjective experiences aims to reveal aspects that other approaches tend to overwrite with their strong theoretical and ontological claims. Unfolding is prior to any causal accounts addressing subpersonal mechanisms. Theoretical assumptions are minimized and the structures of the patient’s experience are prioritized.

Psychopathological modes of being in the world are not mere aggregates of symptoms. This holistic approach bears little resemblance to the current atomistic operational definitions. The fundamental alteration of subjectivity, that is, the ‘core Gestalt’ of a given life-world, is the secure ground on which understanding can be based.

Unfolding starts with words. Phenomenology is the science of subjectivity; clinical phenomenology is the science of abnormal subjectivity. Its basic concerns are the following: Question 1: What is it like to be in a certain ‘mental’ state, e.g. to be sad or to hear voices? Question 2: What is the personal meaning of that certain state, e.g. what does it mean to that person to be sad or to hear voices?

The first question explores the experiential level, the raw feeling of an experience. Experiences do not only have information content, they also have a certain feel (Metzinger, 1995). This property is often called (after Nagel, 1974) the what-it-is-like of a certain experience. Other frequently used expressions to address this qualitative and almost irreducible aspect of subjective experience are qualia, sensory qualities, subjective quality of experiences, experiential properties, subjective character of experiences, phenomenal contents—but also simply conscious experiences (Varela and Shear, 1999). The relevance of this to the assessment of a psychopathological state and to its understanding is obvious.
One patient says: ‘I feel depressed.’ What exactly does he mean by that? In each interview, two kinds of approximations are always implied: one is performed by the interviewee, who tries to communicate his raw experience by approximating it to a word or a sentence; the second is performed by the interviewer, who tries to understand the meaning conveyed by the interviewee’s words by approximating it to the meaning these words have for himself. This double approximation may entail errors and misunderstandings. In standard interviews, which are devised following the model of the stimulus-response paradigm, shared meanings of words between interviewer and interviewee are assumed, not investigated. An interview is a linguistic event where language cannot be used as a set of formal classes or boxes (Mishler, 1986). Some patients may use the word ‘depressed’ to describe themselves as feeling sad and downhearted, but others may use it to mean that they feel unable to feel, or also to convey their sense of inner void, lack of inner nucleus and/or of identity, or feelings of being anonymous or non-existent (Parnas et al., 2005). This implies that most coding requires an enquiry and an interpretation.

Each psychopathological experience is also accompanied by a personal meaning or value that the patient attributes to his abnormal experiences (Wyrsch, 1949; see also Mundt, 1991 and Stanghellini, 1997). The meaning and value attribution of each patient towards his experiences is obviously a relevant clinical feature, since it contributes to shaping distinct clinical pictures and prognoses. Its knowledge also contributes to attuning treatment plans to individual patients (and not to diagnostic categories).

For instance, the very same raw experience of ‘depression’ as a sense of inner void may be valued by different persons either as the effect of a change in one’s body and thus explained as the effect of a somatic disease; or passively suffered, thus leading to apathetic and disorganized behaviour; or may kindle a ‘fight’ reaction leading to dysphoria and auto/hetero-aggressive comportments; or else it may be accompanied by an ‘exalted’ reaction so that the person will say that this experience revealed to him his true nature as a disembodied automaton.

The unfolding involves two further steps that specifically address the structure of the patient’s life-world (Stanghellini and Rossi, 2014). The first—called phenomenal exploration—is the gathering of qualitative descriptions of the lived experiences of individuals. As lived experiences are always situated within the grounds of body, self, time, space, and others, we adopt these basic dimensions of lived experience to organize the data. In order to investigate these dimensions, the inquiry will be oriented by questions such as:

How does the patient experience his world? How does he express, move, and define space as an embodied subject?

1. What is the patient’s experience of existential time? Is there a sense of continuity over time, or are there breaks of self-awareness? Does he experience a sense of self-sameness or diachronic identity over time? What is the prevailing dimension of existential time, the past (e.g. memory), the present moment, or
the future (e.g. hope, expectations)? Is he able to learn from experience? Is he able to project himself into the future?

(2) Does the patient feel effective as an agent in the world, or rather as being passively exposed to the world?

(3) Does he feel delimited from the external world? Does he feel submerged or invaded by objects or events that are usually experienced as existing outside the boundaries of the self?

(4) Is there a tendency to take an external perspective on one's experiences and actions? Do the knowing and the feeling subjects coincide or diverge? Does the patient feel his own perceptions and actions as his own?

(5) What is his experience like as an embodied self? Does he feel his body as his own? Does he feel his body or part of it as detached or extraneous from himself? Does he sometime become explicitly aware of the functioning of his body, or of parts of it? Does he have an immediate coesthetic experience of his body, or is that experience mediated by other senses, like for instance sight, or touch?

(6) How is space organized for the patient? Are things experienced as distant or at-hand? Does he feel in a central position with respect to other individuals? Does he perceive his situation as a coherent scene, or as fragmented? Is space a flat and homogenous extension lacking magnitude and salience, or are there some points of interest in it?

(7) How is the patient's ability to empathize with others, to take their perspective? How does he experience his relationships? What are his feelings when he is with other persons? Are the others experienced as a source of protection, or of danger?

The result will be a rich and detailed collection of the patient's self-descriptions related to each dimension, for example, temporal continuity/discontinuity, space flat/filled with saliences, bodily coherence/fragmentation, self–world demarcation/permeability, self–other attunement/dis-attunement, and so on. In this way, using first-person accounts, we detect the critical points where the constitution of experience and action is vulnerable and open to derailments.

The second step implies a shift to phenomenology proper that seeks the basic structures or existential dimensions of the life-worlds patients live in. Any phenomenon is viewed as the expression of a given form of human subjectivity; abnormal phenomena are the outcome of a profound modification of human subjectivity. Phenomenology is committed to attempting to discover a common source that ties the seemingly heterogeneous phenomena together, from which we can make sense of the relevant lived experience. This is done by finding similarities among the manifold phenomena and, possibly, the deep or structural change in the form of experience/action related to that specific existential dimension (spatiality, temporality, embodiment, and so on) that would offer an explanation for the various changes that occur in the patient.

A girl in her twenties. Blue eyes and ash-blond hair, she looks pretty, although she lacks something to be erotically attractive. Simply dressed, but with a personal taste, it's clear
that she chooses her clothes with great care and attention. The kind of clothes she wears is reminiscent of 'grunge', a rebel style that was fashionable long before her birth. It is usually defined as the 'I don't give a shit' style. Clothes are ripped and tattered. 'Grunge' people usually wear lots of layers, large flannel shirt, etc. It appears to be cheap and messy. She has a tidy face and a thin body. No piercings, or tattoos. Highly insecure, nervous, diffident, and reticent.

Overt symptoms, spelled in the crude language of diagnostic manuals, include the following: eating problems, avoidant behavior, and occupational dysfunction.

I ask her to describe her 'eating problems', especially dietary restrictions. This is her explication: 'Sometimes I starve myself in order to feel myself better.' Feeling herself is indeed a serious problem: 'I don't feel my body. I don't feel myself. My emotions remain extraneous to me and I remain extraneous to them.' She speaks of her own body as 'something insensible and extremely sensible at the same time'. 'You know: I often do not know whether I like something or not. I cannot rely on my feelings. They are distant, and changing. I guess people can say, “I like this, I don't like that,” since something in them gives a sign of attraction, or of repulsion. This is not the case with me. I lack the basis to establish my identity.'

In this person, the disturbance of the experience of one’s own body is interconnected with the process of shaping her personal identity. She reports her difficulties in feeling herself and in perceiving her emotions. Indeed, feeling oneself is a basic requirement for achieving an identity and a stable sense of one’s self (Stanghellini et al., 2012). The experience of not feeling one’s own body and emotions involves the whole sense of identity. Indeed, we construe our personal identity on the basis of our feelings, that is, of what we like or dislike. For her, since she can hardly feel herself and her feelings are discontinuous over time, identity is no longer a real psychic structure that persists beyond the flow of time and circumstances. She also feels extraneous from her own body and attempts to regain a sense of bodily self through starvation.

I ask her to describe the way she spends her days, and I learn that she avoids contact with other persons in order to elude their negative judgment. 'The way I feel depends on the way I feel looked at by the others.' 'I’m extremely sensible to the others’ judgement. It's like a verdict for me. It can make me change my mind in a second. That's why I spend much of the day in my room. Because of this, I’ve not been able to work in the last couple of years.' 'I feel clumsy in my body’—she further explains. ‘It is as if it was a mere aggregate. Like a wobbling liquid. I have no boundaries.’ This makes her feel embarrassed when in front of other persons.

Paradoxically, she used to have a walk at sunset, strolling exactly on the pavement opposite a bar. At that time of the evening a small group of young men sit there to have a drink. When she passes in front of them, they watch her and say ‘Ciao’ to her. This is the only time of the day she leaves the house. ‘When I started I did not know why I did so. I felt something strange. Then I realized that I had a sensation of “unity” when I felt they were watching me. It was as if their looks were “condensing” me. I “focalize” myself through their gaze.’
I tell her that the scene makes me think of a famous snapshot, American girl in Italy, taken in 1951 by American photographer Ruth Orkin. It portrays a lovely young woman walking down the streets of Florence and all around her a group of men are playfully gawking at her. This photo perfectly captures the embarrassment of the girl and the excitement of the men who seem on the point of crossing the line. Together we look at Orkin’s snapshot. This is her comment: ‘Her feelings are apparently like my own. She seems to shrink within the boundaries of her body, her shoulders seem to get smaller, her body getting stiff, her neck too is getting stiff, her face and her movements rigid.’ This is, she explains, what happens to her too. But in her case, it has a positive effect on her, since the boys’ gaze helps her to pass ‘from a semi-liquid state to a semi-solid one.’ She notices: ‘We are both harassed and embarrassed, but I seem to enjoy it better than she does.’

The unfolding of this person’s experiences documents another essential dimension of her life-world, namely corporeality and its relationship with the Other. We realized that she experiences her body as a ‘wobbling liquid.’ Also, we understood that this sensation may change when she is in the presence of other persons. In order to better understand these phenomena, we can draw on Sartre’s (1986) analyses of lived corporeality. Phenomenology has developed a distinction between lived body (Leib) and physical body (Koerper), or body–subject and body–object. The first is the body experienced from within, my own direct experience of my body in the first-person perspective, myself as a spatiotemporal embodied agent in the world; the second is the body thematically investigated from without, as for example by natural sciences as anatomy and physiology, a third-person perspective (Husserl, 1989; Merleau-Ponty, 1996). One’s own body can be apprehended by a person in the first-person perspective as the body-I-am. This is the coenesthetic apprehension of one’s own body, the primitive experience of oneself, the basic form of self-awareness, or the direct, unmediated experience of one’s own ‘facticity’, including oneself as ‘this’ body, its form, height, weight, colour, as well as one’s past and what is actually happening. First and foremost, we have an implicit acquaintance with our own body from the first-person perspective. The lived body turns into a physical, objective body whenever we become aware of it in a disturbing way. Whenever our movement is somehow impeded or disrupted, then the lived body is thrown back on itself, materialized, or ‘corporealized’. It becomes an object for me. Having been a living bodily being before, I now realize that I have a material (impeding, clumsy, vulnerable, finite, etc.) body (Fuchs, 2002).

In addition to these two dimensions of corporeality, Sartre emphasizes that one can apprehend one’s own body also from another vantage point, as one’s own body when it is looked at by another person. When I become aware that I or my own body is looked at by another person, I realize that my body can be an object for that person. Sartre calls this the ‘lived-body-for-others’. With the
appearance of the Other’s look, writes Sartre (1986), I experience the revelation of my being-as-object. The upshot of this is a feeling of having one's own being outside, the feeling of being an object. Thus, one's identity becomes reified by the gaze of the Other, and reduced to the external appearance of one's own body. In short: the Other is reduced to its gaze, and the self to a reified body. This seems to express our patient's experience. Let's start from the side of her experience of her Self, and then analyse what happens to her experience of the Other.

The basic phenomenon seems to be that this person experiences her own body first and foremost as an object being looked at by another, rather than coenesthetically or from a first-person perspective. Since she cannot have an experience of her body from within, she needs to apprehend her body from without through the gaze of the Other. This is the source of her exaggerated concern to take responsibility for the way she appears to Others. Of course, she is angry and ambivalent about this, and that is probably why she wears 'I don’t give a shit' grunge clothes.

The Others’ gaze may pave the way towards an experience of shame for her body—as described by Sartre—or even of disgust for all her Self being reduced to her body or to an uncomfortable or disgraceful part of it. This indeed happens sometimes, and that’s why she avoids contact with other persons. Yet, it is not always shame and alienation from her body that take place when she is looked at by other persons. The Other’s gaze is for her the only possibility to feel herself as a ‘lived-body-for-others’ (Stanghellini et al., 2012). Protected by semi-obscurity, when she strolls in front of the bar crowded by young people having their drinks and watching each other, she can finally feel herself as a body being looked at. She usually lacks the possibility of feeling herself in the first-person perspective. The Others’ gaze helps her recover a sense of ‘unity’ and ‘condensation’—though not a full sense of identity. Experiencing her body through the gaze of the others is the latent, yet not repressed, background of this person's being in the world, the powers that constitute her life-world precisely by fading into the implicit yet operative background.

Let's now turn to the unfolding of her experience of the Other. As we have seen, the Other is reduced to its gaze. The Other is not a partner with whom one can dialogue. It is another part of its body, like for instance its mouth or its hands. The Other is first and foremost a gaze looking at her. This look only seizes what is visible, that is, her appearance. Also, it only seizes what is present here and now. The temporal dimension of the gaze is the present moment. The gaze does not even expand into the nearest future, as it might in the case of someone gazing at someone else while the latter replies with her own gaze. Indeed, she does not look back at the men. There is no dialogue of gazes between them. She looks in front of her, just like the girl in Orkin's snapshot.
What can the Others’ gaze express? It can simply express like or dislike, the two sides of desire. The Other, then, in our patient’s life-world is stripped of all the characteristics of an embodied and situated person and reduced to a here-and-now desiring (or not desiring) gaze. She is a body looking for visual recognition. The Other is a gaze that may (or may not) recognize her. When she strolls in front of the bar she gains a sense of identity, since she feels desired. Although it is her body, and not her entire person, that is the object of the Others’ desire, this helps her recover a sense of her Self. She feels recognized, at least in her aesthetic dimension as a body-object of desire.

*Post scriptum.* Ironically, Ruth Orkin’s amateur model Ninalee Craig later explained in an interview that the photo in which she is portrayed is not, to her, a ‘symbol of harassment’. Rather, it is a ‘symbol of a woman having an absolutely wonderful time’. She never felt in danger while walking among the admiring men and ‘none of them crossed the line’.
A human person is both a rationally governed self and a biological organism subjected to the a-rational laws of the involuntary. Thus, human thinking, feeling, and actions are shaped and formed by two kinds of causality: an a-rational causality, rooted in our organism and determined by the laws of biology and history, and a rational causality (de Sousa, 2007, pp. 6–12). The complexity of my identity as a person consists in the fact that besides the impersonal changes that I undergo as the consequence of the sheer fact of being a developing biological organism situated in a historically determined environment that I did not choose, I also autonomously relate myself to these changes. These personal attitudes, in turn, affect the person that I am. This dialectics between person and otherness is in every feature of human existence. An example is emotional experience. Emotions are the most embodied and situationally embedded of mental phenomena. Emotional experience is permeated with feelings and sensations that constantly elicit and challenge our attempts to make sense of and cope with it. Although human emotions are sometimes characterized by intentional and cognitive contents in the sense that I assess and comprehend my emotional experiences by means of intentional and conceptual analysis, there is more to our emotional experience than is disclosed and explained by intentional and conceptual analysis (de Sousa, 2011; Prinz, 2004; Rosfort and Stanghellini, 2009; Stanghellini and Rosfort, 2009, 2013a; Wilson, 2002). Moreover, there is more to the person that one is than the emotions that one feels. To be a person means to articulate and interpret one’s emotional experience. In short, to be a person involves a permanent confrontation with the otherness that is an inescapable part of the person that I am. This ontological dialectic of involuntary and voluntary aspects of personhood discloses the normative challenge of being a person. This is experienced as the challenge that to be a person is not a fact, but a continuous task (Grøn, 2004, 2011). We are the same person throughout our life, but the sameness of our identity as a person is continuously challenged by the otherness that all persons experience through time. Being a person is trying to exist as myself in and through the challenges of all those features that make up what I am (e.g. my anonymous biology, my past, my present uncanny experiences, the way I feel defined by people while they look at me), but which cannot describe who I am.
While in normal or neurotic forms of existence the manifestations of otherness are confined to mild forms of otherness (e.g. fears deemed ‘irrational’ by the person who experiences them, as is the case with phobias), in more severe pathologies, as for instance schizophrenia, patients are confronted with the most threatening manifestation of otherness as they entail a profound sense of alienation from oneself, one’s own body, and the world, as well as uncanny emotional experiences. In the case of schizophrenia, these experiences may throw the patient into a new ontological position that qualifies that person’s sense of reality and existence by producing a new ‘eccentric’ existential perspective (Stanghellini, 2008), often with a solipsistic framework, no longer ruled by reliable axioms of the ‘natural attitude’ (Henriksen and Parnas, 2014). When the basic sense of self is disturbed, the person is inclined to experience both a kind of exaggerated self-consciousness (Sass, 1992) and a concomitant diminished self-affection, that is, a fading in the tacit feeling of existing as a living and unified subject of awareness. These changes in the basic structures of subjectivity are accompanied by an alteration of the very structure of the field of awareness. This, in turn, leads to a particular way of experiencing marked by a change in the ‘salience’ with which objects and meanings emerge from the background context; an altered emotional and conceptual ‘grip’ on the world; an amplification of the growing dissolution of the sense of existing as a subject with a more pronounced, disturbing, and alienating self-scrutiny; an increasing objectification and externalization of normally tacit inner phenomena, with a morbid objectification of one’s own psychic life.

The extreme variability of schizophrenic phenotypes is a paradigmatic case study for explicating the dialectics between uncanny feelings of de-personalization and derealization and the attitude of the person who experiences them. Why do persons who suffer from these kinds of anomalous self-, body-, and world-experiences develop either a psychotic (e.g. delusional) form of schizophrenia or a non-psychotic, ‘negative’, or “pauci-symptomatic” (Blankenburg, 1971) type of this illness, or a schizotypal personality disorder, characterized for instance by magical thinking but not by disorganized speech, delusions, and hallucinations? Why do delusions in people with schizophrenia take on so many different themes, and not only ontological ones (Kepinski, 1974; Parnas and Sass, 2001; Stanghellini and Fusar-Poli, 2012), but also, for example, persecutory, hypochondriac, of reference, of agnition (filiation), external influence, etc.?

If we subscribe to the ‘one root–many branches’ conceptualization of the manifold of schizophrenia, then we must be able to explain why, arising from the common root of self-disorders, schizophrenic phenotypes take on so many different features.
A plausible answer is that self-disorder, being at the core of the vulnerability to schizophrenia, is refracted through the prism of the person's background of values and beliefs that determine what things and events in the world mean for them. This personal background is a pre-reflective context of meaning and significance within which and against which persons understand themselves, others, and their world.

Jaspers was one of the first authors to introduce this idea in his General Psychopathology. 'Position-taking' (Stellungnahme) is the phrase he uses to describe the process of ‘working-through’ and self-interpretation, as the patient, reflecting on his anomalous and disturbing experiences, “can see himself, judge himself, and mould himself” (Jaspers, 1997, p. 424). In describing the onset of schizophrenia, Jaspers writes that we may find patients for whom their experiences introduce new significance into their lives, others for whom the content of their abnormal experiences is linked with their pre-onset personality structure, and yet others for whom the content of their incipient psychosis remains entirely alien and brings no added significance. These different attitudes in the face of their abnormal experiences depend on each person's history and sense of identity, which determines different kinds of position-taking, e.g. 'despair', 'renewal of life', 'shutting out' (as if nothing had happened), 'conversion' (the psychosis offered something fresh by means of a revelation), or 'integration'. Delusions are just one attempt to make sense of and explain the aberrant experiences taking place during the initial pre-delusional stages of schizophrenia. Wyrsch (1949) gave probably the most detailed account of this person-centred dialectical (PCD) model of schizophrenia (Bleuler, 1911; de Clérambault, 1942; Huber, 1983; Mayer-Gross, 1920; Minkowski, 1927; Simkó, 1962). Describing the relationship between the person and the onset of acute schizophrenia, he distinguished four groups of patients: patients who try to objectify their own sufferings and conceive them as symptoms of a somatic illness; patients who are passive and incapable of any reaction; patients who engage in a fight against their pathological experiences, displaying a stubborn and often desperate attempt to fit such experiences into the meaning context of their life-story; and a last group who are exalted by the novelty of the psychotic experience, which acquires for them a cosmic meaning: it is significant in the world order and not just for him (Wyrsch, 1949).

If we assume that a given set of abnormal experiences originating from structural changes of subjectivity are the core Gestalt or psychopathological trait marker of schizophrenia, then we can assume that the manifold, fluctuating, and state-like schizophrenic phenotypes are the consequence of the schizophrenic person's individual position-taking in response to this state-like, structural core anomaly. The basic tenet of the PCD model is that the
The concept of position-taking can be a help in understanding the pathogenesis of full-blown symptoms and syndromes tracing back their origin to the patients’ miscarried self-interpretation of more basic anomalous experiences like derealization and depersonalization phenomena. It allows disentangling basic vulnerability from full-blown symptoms and from the person’s attitude towards her vulnerability. Also, it can help in dealing with the significant concerns regarding therapeutic interventions at a time when an orientation towards recovery is being advocated for psychiatry (Maj, 2012). This has several therapeutic consequences.

It contributes to enhancing insight and awareness of illness in patients by shifting their focus from full-blown symptoms (e.g. delusions and hallucinations), to
more basic manifestations of vulnerability (e.g. abnormal bodily experiences). This change of perspective can become instrumental for prevention and treatment. Full-blown symptoms, like psychotic ones, are experienced by patients as Ego-proximal, while basic anomalous experiences (derealization/depersonalization phenomena) are experienced as Ego-distal. This means that patients typically experience and consider full-blown symptoms, e.g. verbal–acoustic hallucinations or paranoid delusions, as part of their own identity, and as such not as abnormal phenomena to be diagnosed and treated. On the contrary, basic anomalous experiences are usually not experienced as parts of one's own identity, rather as disturbing one's sense of selfhood, i.e. unity, continuity, demarcation, myness, and agency. They are spontaneously (or almost spontaneously) recognized as something wrong with one's self-, bodily-, and world-experience. Patients need awareness and insight to recognize experiences that (according to clinicians) depart from normality. This awareness is better achieved with basic anomalous experiences than with full-blown psychotic symptoms. Patients feel basic anomalous experiences as abnormal phenomena that reduce their quality of life. As such they can become instrumental symptoms for prevention and treatment, whereas full-blown symptoms may not.

To transmit this type of experience requires that the patient construe the clinician as both open for unusual experiences and capable of recognizing that he (the patient) has a remaining alter-ego apt to get an insight into his vulnerability. In this way, cooperation and intimacy between the clinician and the patient can be achieved. An in-depth, tactful, and sympathetic exploration of the patient's subtle and pervasive changes in life-world experience, including the way he perceives his own body, others, space, time, etc., may help to reach this intimacy. All this helps the patient to give his disorder a format, to prevent symptom manifestation, and finally, to alleviate it. These experiences may be fleeting, perhaps even verging on something ineffable. Also, many patients may consider their experiences to be uniquely private. Clinicians may use their knowledge of these subtle experiential changes to help their patients find a language capable of expressing their experiences in this therapeutic alliance. A fine-grained knowledge about the patients' basic experiences (unfolding) and the way they make sense of them (position-taking) is an essential prerequisite for establishing an effective therapeutic relationship. It is a resource in modulating distance in the therapeutic relationship, especially in early stages of the disorder, during which it is essential to avoid stigmatization, social isolation, and the person's identification with the role of the patient.

An in-depth exploration of the patient's subtle and pervasive changes in self- and world-experience may help the person take a reflective stance with respect to her vulnerability, that is, to articulate it in a more expressive and
Therapy: What is Care?

communicative format, and to construe it as situated in a personal–historical as well as a relational–interpersonal context. An attentive focus on the patient’s attitude may help enhance her own effort to modify her position-taking. Different and more effective narratives of illness may derive from this change in the patient's perspective and self-interpretation of her anomalous experiences.

Care is based on a detailed knowledge of the founding structures of the patient’s life-world. The first step is unfolding the details of a given psychopathological world as a text. All clinical interventions, including the attempt to make sense of the patient’s abnormal behaviour and experience, as well as the structuring and restructuring of the setting and the use of metaphorical domains in the patient’s narration, take this aspect into account. In the preceding example, we focused on metamorphoses of embodiment as the source of the delusional transformation of the patient’s life-world. The kinds of delusions developed by each patient become understandable if seen from the angle of the dialectic between basic abnormal bodily phenomena and the way each patient works through them. In the following example (taken from a quite different psychopathological domain), becoming aware of the way a given patient experiences time helps the clinician and the patient grasp the meaning, motivations, and purpose of her behaviour.

This patient experiences with despair, and then with anger, and then again with persecutory anger, my refusal to anticipate our session on her request. She turns this into a conflict of values—feeling that she is on the side of those who defend the ‘right’ values (e.g. the other’s availability)—and into a chance for recrimination (I, as all the others, do not behave with her as she would behave with us). All this leads her to play the role of the victim and to assign to the Other the role of the persecutor. The generative moment of this series of symptoms (hopelessness, anger, persecutory feelings, recrimination, victim/executioner scheme) lies in the temporal experience of instantaneity.

The patient says: ‘Each time it’s like I have to jump on a moving train.’ This is the mark of her lived temporality—that is, of a fundamental structure of her existence—revealed by the analysis of the existential structures of her life-world. Due to this constitutive moment of her existential temporality, she experienced the time elapsed between her request to anticipate our session and the session as if it were an eternity, then experienced despair, followed by anger, and finally, by the crystallization of the relationship in the victim/executioner scheme. Note that in this clinical example the sequence of symptoms is generated, not surprisingly, as a consequence of the inability to tolerate the suffering caused by the failed encounter with the Other.
This is an example of a reconstruction of the generative moment of the symptoms as it manifested itself in the life-world of the patient. This reconstruction highlights the roots of the symptoms, that is, the patient’s lived temporality characterized by instantaneousness. Once this awareness is shared with the patient, it allows her to connect her symptoms to her vulnerability—that is, to her way of experiencing the therapist in relation to her way of experiencing time; and, more generally, to the temporality of the relationship with the Other. It also allows her to take a position about this generative, structural, involuntary, implicit moment.

What is the clinical benefit of the unfolding of the patient’s life-world? When the patient is placed in front of the image of her world generated as part of the therapeutic relationship, and can clearly see the founding structures of such a world, she can take a position about the world she lives in. Taking a position allows her to embed her symptom in its generative moment, to become aware of its origin and genesis—that is, to become aware of her own vulnerable life-world.

In the case of this patient, what makes her life-world vulnerable is a particular mode of temporal experience, that is, she experiences all that is important to her as fleeting, ephemeral, and evanescent. First and foremost, what she experiences as evanescent is the relationship with the Other. She further explains that she experiences the Other’s desire for her as momentary. ‘I need to take the chance. In a while, he will give his attention to someone else. As it happened with my father. He used to listen to me intensively, but all of a sudden he was distracted by something else.’ Her desire for the Other, she realizes, is momentary too.

Taking a position about her vulnerability allows her to take a better position than the one which gave rise to the symptoms (despair, anger, persecutory anger), as the symptom is the outcome of a miscarried interpretation of her experience of vulnerability (Stanghellini and Rosfort, 2013). The generative moment, which for this patient lies in a specific and typical structure of temporality, represents an irreducible alterity that inhabits the person.

Alterity, in this case, is her way of experiencing her relations with other persons, and the other person’s desire for her, as fleeting, ephemeral, and evanescent. This is the generative moment, the habitus, the implicit and involuntary source of the ethics of the patient. Her behaviour, and her symptoms, follow from this. The patient has come to feel this ethics as her own (which ultimately explains her taking on the role of the victim). But what would happen if the patient could see her ethics arise from this moment of vulnerability, which is in itself ethically neutral (it is neither right nor wrong to live time as a series of instants, or as nostalgia for the past, or as the premonition of the future)? What if, in other words, she could see her ethics as a consequence of an involuntary element (rooted in temporality) that over-determines her?
The consequence would be that she would be able to see it from a third-person perspective, broadening her perspective on herself that until that moment was dominated by an over-identification with her values and habits. She would be able to see her way of experiencing time, on which her ethics is based, as an essential (‘I cannot and I do not want to be different from that. I don’t want to suppress my desire and my emotions. I would not be myself without them’) and at the same time a contingent part of her identity (‘Yet now I realize that, although I did not decide to be like this, it is time for me to decide whether I want to continue being like this or not’).

What would help her to see her ethics not as the only right way to be, but as one among the available ethical positions? She would need to take a position about her way of living time as instantaneous (‘It is as if I should always jump on a moving train’) and of conceiving of relationships as necessarily emotionally intense and unstable. In order to be able to say ‘This is my ethics’, she would have to take the responsibility of choosing her lot—that particular way of living time. To reduce this alterity that inhabits her to a totally external other is as wrong as to regard it as part of one’s self. The logic of alterity, in fact, contradicts the principle of the excluded third. The Otherness that inhabits her is at the same time extraneous to her self and part of it. It is an indomitable fold of one’s being, which, as such, encloses a space that is at the same time external and internal (Deleuze, 1988). It is external since it belongs to the involuntary dimension of her being the person that she is, the raw material that constitutes the sedimented part of her being, and sets the boundaries of her freedom: her past (e.g. a traumatic experience), body (e.g. emotions and desires), and world (e.g. its rules and values) into which she is thrown. But at the same time, this involuntary Otherness that inhabits her is part of her Self since she is responsible for it. Although originally she did not decide to be-so, at a given moment in her life she realized she had become-so, and decided to continue being-so.

If and only if she takes the Otherness that inhabits her as part of her Person—to paraphrase Ricoeur—can what sedimentation has contracted, responsibility redeploy.
Responsibility is the capacity to be held accountable for one’s deeds. First and foremost, we are held responsible, thus accountable, for our deeds—even if we did not act according to our will. This is the case with the founding myth of our civilization—the myth of Oedipus.

Oedipus, at Colonus, says that he did not really do the things for which he blinded himself: ‘I suffered those deeds more than I acted them.’ According to Bernard Williams, these words express Oedipus’ attempt to come to terms with what his deeds have meant for his life. The question is: Did the things that happened come about through Oedipus’ agency or not? The whole of the Oedipus tragedy—‘that dreadful machine’—moves towards the discovery of just one thing, that Oedipus did them. We understand, and share, Oedipus’ terror of that discovery. The reason for that is because we know that in our lives we are responsible for what we have done, and not merely for what we have voluntarily done.

We can be held responsible for what we have involuntarily done. All conceptions of responsibility make some discrimination between the voluntary and the involuntary. Different cultures lay different weight on voluntary or on involuntary actions. At the same time, no conception of responsibility confines it entirely to the voluntary (Williams, 1993, p. 66). Oedipus is, indeed, the paradigm of Man in Western civilization precisely because he embodies the tragedy of responsibility for one’s deeds beyond one’s intended will.

As we discussed in the chapter about Hegel’s concept of ‘recoil of action,’ there are two sides to action: that of deliberation and that of result. And there is a necessary gap between them. Every action involves a recoil of unintended meanings and intentions back upon the actor. The consequences of our actions inevitably express something beyond what was intended. This throws the actor into question. The question is about the entanglement between the voluntary and the involuntary, and the answer is the story we can tell about ourselves when confronted with this entanglement.

In particular cases, we are not held responsible for our deeds. This is the case with madness. The various forms of madness can be seen as miscarried attempts to solve the riddle of responsibility. From a third-person perspective,
to be deemed ‘mad’ is to not be held accountable for my actions. From a first-person perspective, to be mad is to feel/believe that my deeds are not my own, thus not to consider myself responsible for the deeds that seen from another perspective are attributed to me. Opposite this, another form of madness consists in feeling/believing that I am responsible for deeds that, seen from another perspective, are not my own. In both cases, there is a crisis of the dialectic between the voluntary and the involuntary. In the first case, there is an expulsion of the voluntary into the sphere of the involuntary. In the second one, there is a flattening and collapsing of the involuntary into the voluntary.

The vulnerability to madness, as the cypher of condicio humana, imbues responsibility: loss of responsibility (alienation from oneself) and excess and distortion of responsibility (delusional guilt) are the extreme polarities of the dialectics of answerability in human existence. Alienation implies loss of agency and myness, as is the case with schizophrenia: ‘It’s not me who killed her, it was that knife’. Morbid objectivation and externalization of parts of one’s body or self, imposed thoughts and drives, and imperative voices are typical examples of schizophrenic phenomena in which the sense of being the author of one’s actions and the owner of one’s mental processes and contents is jeopardized.

Vice versa, one can feel/believe that one is guilty for deeds that are not one’s own. This is typically the case with guilt delusions in melancholia. Guilt is not responsibility. Responsibility is a relation with alterity, a relation with the source of one’s actions, and a relation with other persons asking you to respond for your deeds. Both these relations can be dealt with. On the contrary, guilt ‘becomes a thing or an object the patient is identified with’. The melancholic patient is identified with his guilt to the extent that he is ‘guilty as such’. There is no remorse, recompensation or forgiveness, for the guilt is not embedded in a common sphere which would allow for that (Fuchs, 2014).

Schizophrenia and melancholia represent two opposite polarities of distorted agency and of responsibility. In the former, the person, while performing a given action, does not feel that he is the one who is voluntarily acting. He feels that the source of his actions is external to him. The source is placed beyond the boundaries of the Self, and thus is out of control. He feels and believes himself to be passive with respect to the cause of his action. Persons affected by melancholia, vice versa, attribute to themselves the cause of effects that, from another perspective, cannot be attributed to them. But, even more typically, they experience a total passivity with respect to their capacity and possibility for modifying a given state of affairs. Time has come to a stop, thus ‘What was once done cannot be undone’ (T. S. Eliot).

In order to understand the reasons for these opposite stances with respect to agency and responsibility we need, once more, to reconstruct the life-world in
which these distortions take place. The literary case of Robert Musil’s serial sex murderer Christian Moosbrugger is an excellent case study for this.

In his masterpiece novel *The Man without Qualities*, Musil (1996) subjects leading figures of fin-de-siècle Vienna to intense ironic scrutiny. By drawing on his extensive knowledge of philosophy, psychology, politics, sociology, and science, he works into his novel essayistic statements which record the state of contemporary European civilization. It follows through an extraordinary literary experiment in which Musil immerses Ulrich, his hero, in the inner experiences of a murderer and rapist, called Moosbrugger, and identifies Ulrich’s determination, despite many entanglements (one with a flirtatious nymphomaniac, another with a frenzied female follower of Nietzsche, another with a campaign to assert the cultural supremacy of moribund Imperial Austria over upstart Prussia), to fulfil his primary task, namely to find the vital link between thinking and doing, and so discover the right way to live.

A central concern in this novel is what is reality (Wirklichkeit). The phase of *The Man without Qualities* in which Ulrich is preoccupied with Wirklichkeit is also the phase in which Moosbrugger plays a central part. Moosbrugger is, for the younger Ulrich, intellectual dynamite to blow up the common-sense concept of Wirklichkeit (Payne, 1988).

The judge—Musil writes—comes to the conclusion that Moosbrugger was a universe. And he himself had to admit that it is very hard to say something convincing about a universe. During the trial—Musil explains—two strategies were here locked in combat, two integral positions, two sets of logical consistency. The strange, shadowy reasonings of his [Moosbrugger’s] mind (…) rose directly out of the confused isolation of his life, and while all other lives exist in hundreds of ways—perceived the same way by those who lead them and by all the others, who confirm them—his own true life existed only for him. It was a vapour, always losing and changing shape. Standing before the court, everything that had happened so naturally in sequence was now senselessly jumbled up inside him (Musil, 1996, pp. 75–6).

In a nutshell, the judicial assessment of the accountability of a person is incomplete until it takes into account her ‘universe’, and a person can be held not responsible for her deeds if and only if they emerge out of an ontological framework that radically differs from our own.

Musil’s novel is considered a study on applied subjectivity:

[I] am concerned […] with the scientific study of psychology […] and [I believe] that, in the fine reports of the French psychiatrist, for example, I […] can […] both experience vicariously, and […] depict every abnormality […], transporting myself into the corresponding horizon of feeling, without my own will being seriously affected. (Musil, 1996, Briefe 1, p. 24)

If we submit Musil’s descriptions of Moosbrugger to the method of the unfolding, this will show that Moosbrugger’s adventures are set in a
life-world radically different from our own. First, Moosbrugger's lived space is a non-Euclidean space:

Moosbrugger heard voices or music or a wind, or a blowing and humming, a whizzing and rattling, or shots, thunder, laughing, shouts, speaking, or whispering. It came at him from every direction; the sounds in the walls, in the air, in his clothes, in his body. He had the impression he was carrying it in his body as long as it was silent; once out of it, it hid somewhere in his surroundings, but never very far from him. The important thing was that it is not at all important whether something is inside or outside; in his condition, it was like clear water on both sides of a transparent sheet of glass. (Musil, 1996, pp. 257–8)

Second, the way he experiences entities in the world radically differs from what is customary in our world:

'A squirrel in these parts is called a tree kitten,' it occurred to him, 'but just let somebody try to talk about a tree cat with a straight face!' ‘In Hesse, on the other hand, it's called a tree fox.

But oh, how curious the psychiatrists got when they showed him a picture of a squirrel and he said: ‘That's a fox, I guess, or it could be a hare, or maybe a cat or something.’ Moosbrugger's experience and conviction were that no thing could be singled out, because things hang together. (ibid., p. 259)

Third, the way Self and world are related to each other also diverges from common-sense experience:

The table was Moosbrugger. The chair was Moosbrugger. The barred window and the bolted door were himself. There was nothing at all crazy or out of the ordinary in what he meant. It was just that the rubber bands were gone. Behind every thing or creature, when it tries to get really close to another, is a rubber band pulling. Otherwise, things might finally get through one another. Every moment is reined in by a rubber band that won't let a person do quite what he wants. Now, suddenly, all these rubber bands were gone. Or was it just the feeling of being held in check, as if by rubber bands?

Fourth, the interrelations between things, images, and words has undergone a profound change:

It happened that he said to a girl, 'Your sweet rose lips.' But suddenly the words gave way at their seams and something upsetting happened: her face went grey, like earth veiled in a mist, there was a rose sticking out of it on a long stem, and the temptation to take a knife and cut it off, or punch it back into the face, was overwhelming. Of course, Moosbrugger did not always go for his knife; he only did that when he could not get rid of the temptation any other way. (ibid., p. 259)

Moosbrugger’s case study demonstrates on a macroscopic scale that the assessment of a person's responsibility is incomplete until it takes into account his ‘universe’ or life-world. Our notion of responsibility is tied to our concept of agency. A person's experience of agency is dependent on the life-world he lives in—as is the case with Moosbrugger, whose deeds emerge out of an ontological framework that radically differs from our own.
Is Moosbrugger to be held accountable for his deeds? Does he himself feel responsible for them? Also, and what is more relevant for us here, how could one help Moosbrugger recover a sense of responsibility and agency?

Responsibility literally means to be capable of responding for one’s own deeds, that is, to narrate them as one’s own deeds, situating them within a story, in search of their causes and meanings. Following the perspective I have taken in this book, in order to recover a sense of responsibility and agency one has to regain a dialogue with alterity. I argued that this dialogue with alterity can be regained through a process of unfolding of the life-world or ‘universe’ one lives in. Alterity first and foremost becomes manifest in my deeds, that is, in the world in front of me, rather than through an introspective search inside me. Another way to put it is that, in order to recover a dialogue with alterity, one has to achieve a third-person perspective on oneself. This means: to see oneself in the mirror of one’s own life-world. Quite paradoxically, in order to recover a sense of intimacy with oneself one has to go through an experience of estrangement from oneself. In order to feel oneself one has first to see oneself from without. The condition of possibility for this is an empowerment of the patient’s capacity to adopt a reflexive stance towards the feelings and the meaning(s) of his experiences, thus reinforcing his subjective and intersubjective sense of being a self. This is achieved through position-taking. Position-taking allows the person to embed his experiences/actions in the vulnerable life-world they belong to, and to rescue the generative moment of the life-world itself.

Even in the case of Moosbrugger, it is very difficult to disentangle responsibility from non-responsibility—and we may wonder if standard therapeutic practices are really helpful for this.

And the temptation to take a knife and cut it off, or punch it back into the face, was overwhelming. Of course, Moosbrugger did not always go for his knife; he only did that when he could not get rid of the temptation any other way. Usually he used all his enormous strength to hold the world together. (ibid., p. 259)

Agency and responsibility reveal a fold in human existence. There are several reasons for this.

First, agency and passivity cannot be easily disentangled on the ontological level. To be human is to be at odds with agency, that is, with the involuntary dimension of our being. Not even in the case of Moosbrugger can the voluntary be fully separated from the involuntary. Their contiguity implies a struggle. Musil uses the language of dialectics to depict the struggle within Moosbrugger between himself and his involuntary. A ‘temptation’ is not simply an impulse, especially when it is ‘overwhelming’, and not merely absolute and all-encompassing. Moosbrugger is not one with his temptation, and that allows
him—in some occasion—not to go for his knife. He did so only in those cases in which his enormous efforts were insufficient to control his temptation, or divert it in another direction.

Second, responsibility reveals a fold in human existence since it is at the same time a presupposition and a task. It is a presupposition since society expects a person to feel responsible for her deeds. It is a task since responsibility is not an a priori in human existence; rather it is an achievement to be obtained through education. As Ricoeur puts it: ‘Education is education to responsibility’ to be achieved via the integration of responsibility and vulnerability.

Third, the fold that unites responsibility and non-responsibility cannot easily unfold on the ethical level. To be human is at the same time to be aware that we cannot fully control the involuntary dimension of our existence, and that we are held responsible for it. That’s why Musil deems the standard forensic notion of accountability an ‘anaemic concept’. That’s also what we learned from the myth of Oedipus, who suffered his deeds more than he acted them, yet he held himself responsible for them.

Fourth, there is a fold between normality and pathology. Alienation at one extreme, guilt at the other, are miscarried modes of responsibility since they attempt to disentangle the fold where the voluntary is in touch with the involuntary, selfhood with otherness. Persons with schizophrenia and melanchoelia experience, together with different forms of passivity, a total distortion of responsibility. To recover from these abnormal conditions one has to recover a better sense of agency and responsibility.

This fold is primarily felt and experienced as an obscure and perturbing entanglement of voluntary and involuntary, selfhood and otherness. The unfolding in the process of care reveals the pleat before it unfolds it. The unfolding, before unfolding the pleat, shows the fold where the voluntary and the involuntary are continuous with each other. Explication reveals complication.

To fold means to cover or wrap, to conceal. To unfold is to renounce to ‘cleany coined excuses’ (Shakespeare: ‘Nor fold my fault in cleany coined excuses’). Therefore, the fold is the locus geometricus for conscientia in its double meaning—self-knowledge (thetic consciousness) and responsibility (moral conscience). Unfolding is both an act that pertains to the domain of knowledge and of ethics.

The seeing of this zone of undecidability generates, depending on position-taking, guilt or alienation, or other moral emotions like shame, etc. The fold itself is ethically neutral, or better ethnically ambivalent and totipotent. Position-taking decides whether I’m responsible or not. Whether I see myself as guilty or alienated from the source of my actions depends on the side of the fold that is visible from my perspective. To restore a full sense of responsibility,
that is, to overcome alienation or guilt, I need to acknowledge the presence of the fold, to recognize it as a necessity, to move around the fold and take a different perspective on it, and finally, to achieve a panoramic view on the fold. “Folding–unfolding no longer simply means tension–release, contraction–dilation, but enveloping–developing, involution–evolution. To unfold is to increase, to grow” (Deleuze, 1988, pp. 8–9). Unfolding is thus an act that opens up possibilities—developments and evolution—for the future. Unfolding is a practice that restores a sense of agency, and with it a sense of responsibility. The choice to unfold is an ethical one, an act of care, a choice that has practical consequences, not a mere act of knowledge.

The borderline condition is a paradigmatic case study of the entanglement of the voluntary and the involuntary, and of the way we may help patients deal with their fold. In Emotions and Personhood, we (Stanghellini and Rosfort, 2013a) have discussed the puzzling manifestation of otherness, in terms of an involuntary source of one’s actions, in the existence of borderline persons. In discovering otherness in themselves, borderline persons discover in themselves an amorphous and untamed presence. This presence is felt as a spring of disordered vitality that is a menace to autonomy in the sense of self-organization. Otherness is an impossibility for borderline persons. It is both a threat to the Self and the source of vitality, the vital force that they cannot renounce. Thus, it is impossible both to appropriate one’s otherness and to distance oneself from it.

At the centre of the mindscape borderline persons live in, there is a moral question: ‘Whose fault is it?; ‘Who is to be held responsible for my own and the other’s sufferings?’ Shame and guilt, the voluntary and the involuntary, fate and necessity are the folds in which the borderline person is involved. Borderline persons may see this fold from three different angles—victim, perpetrator, bystander—and typically oscillate between these perspectives.

In the traumatic situation, one may identify with the role of the victim, and in this case feel passively involved and totally without responsibility for what happens. If I am the victim, then the other is the perpetrator: ‘He is bad, I am the victim.’ Feelings of abandonment, or lack of attention, acceptance, help, protection, reciprocity, support—or in short, lack of recognition—are typical in the borderline traumatic existence. The borderline person looks primarily in the direction of the Other. It is the Other who is guilty, since he or she acted out of voluntary intention. These feelings may kindle acute emotional states characterized by anger, resentment, and indignation. The Self–Other relationship may take the form of a transitory persecutory delusion. Usually, the persecutor is a significant Other. This makes the persecutory delusions of borderline persons radically different from paranoid delusions in persons with schizophrenia, which typically involve anonymous others. Borderline persons, who are more
vulnerable to developing feelings of shame, are probably more prone to assume the role of the victim rather than other types of traumatic identities, thus to exhibit persecutory delusions. We may then suppose a habitus, established in the course of one's personal history, in making them prone to assume the role of the victim rather than another type of traumatic identity. A mixture of anger plus shame may trigger persecutory delusions in borderline persons, and especially delusions of reference, which typically arise in the type of borderline persons who are particularly vulnerable to narcissistic rage associated with feelings of humiliation.

From another angle, one may identify with the role of the perpetrator. The patient may admit she misbehaved. Nonetheless, she thinks she cannot be held entirely responsible. It was for her a sort of reflex, an automatic response she simply could not control: 'I am bad, but I am not guilty because it's not my fault'. Indeed, borderline persons seldom develop feelings of guilt or guilt delusions as melancholic persons do. From this vantage, one may not hold oneself responsible for one's actions, since one basically experiences these as re-actions. If asked about the source of the harm she did, she would respond that it was a kind of fit, or seizure—like an epileptic seizure, kindled by the wrong she previously suffered. Rather than feeling guilty, she may feel under the spell of some malignant power coming from within herself. This perspective does not allow for development, as is typically the case with persons with schizophrenia, of delusions of alien control (that is, they do not feel under the influence of an agency coming from without their Self). The cause of one's actions is placed neither on a flesh-and-blood Other (one's partner, the therapist, or a friend, as is the case with borderline persons who identify with the role of the victim) nor on an anonymous, generalized Other, or a mechanism (as is the case with schizophrenic paranoid delusions of alien control). Rather, one may experience the influx in one's life of an uncontrollable destructive force that comes from within. A subpersonal force that cannot be separated from one's own Self is responsible for one's deeds. Borderline persons are the witnesses of an ultimate truth: they feel the alienating power of the involuntary, that is, of the otherness that is constitutive of our personhood.

Finally, from another vantage persons may identify with the role of the bystander, a merely passive spectator of the ineluctable and unpredictable events. One feels one cannot decide, control, or change the course of one's life: 'It always goes like this. This happened again. I can do nothing to avoid it'. One feels prone to develop feelings of impotence and helplessness, and to conceive of life as nonsensical. Oppressed with tedium, one's mind becomes a mirror that reflects the ineluctability of the world and one's own powerlessness, that is, the futility of existence. The world and life itself simply are; they
just happen. Tedium may be interrupted by cynical, sarcastic, or auto-sarcastic remarks. In this case, neither is the Other construed as a perpetrator nor is the Self felt as dominated by otherness. The responsibility is on sheer life itself, on its inescapable as well as unpredictable nature. Existence is a tragic existence. One feels near to one’s own destiny, so much that one can see it, touch it, nearly manipulate it, and maybe avoid it. Nonetheless, one can merely watch oneself thrown into this without any brakes. The nightmare is the most common paradigm of the tragic. In every nightmare there is always a moment in which powerlessly I see myself being hurled into the jaws of the destructive power from which I was trying to escape. Borderline persons construe themselves as the bystanders of their tragic destiny.

A common experience with borderline persons is that they feel blamed if the therapist advocates their responsibility in the course of actions in which they are involved. The therapist should therefore adopt a stance that we could call after Hanna Pickard (2013), responsibility without blame. It consists in holding the patient responsible and accountable for harm or wrongdoing, including self-harm, without blaming him for it. Obviously, the idea of responsibility that sharply distinguishes voluntary from involuntary behaviour is not applicable here—as it is not applicable to human existence in general. It leads to miscarried generalizations, to which the patient himself is prey when he identifies with the role of the victim or of the perpetrator. However, it is important to recognize with the patient that his choices can be limited and control diminished relative to the norm, though not as a fault of the patient himself. The clinician’s attitude should reflect the recognition of the complex equilibrium between the voluntary and involuntary dimensions in human action, and take seriously the patient’s tragic awareness of this. The awareness of the fold that holds together the voluntary and the involuntary must be kept in mind to acknowledge with the patient that his degree of responsibility is reduced, yet that he could not have behaved in that given way, so he is at least partly responsible for his deeds. Responsibility is essential to help the patient restore a sense of self-cohesion and agency.

The emotional weather in which this process takes place should be free from blame and reflect the therapist’s awareness that he himself undergoes the same destiny of the patient, although in a milder degree. The fold of voluntary and involuntary, selfhood and otherness is the cypher of human existence. In this zone of undecidability, potentially tragic and despairing, the borderline person is nothing but the extreme expression. Thus, the patient is held responsible, but not blameworthy for his deeds, as we as human beings are responsible but not to be blamed for our vulnerable condition.

Perhaps—as suggested by Pickard—the most important counter to blame within clinical contexts is proper attention to the patient’s past history. Care
can involve helping patients to explore their past and recognize its effects on
the person they are and their present experiences and behaviour. If a fuller
life-story comes into view, patients in all likelihood come to be seen not only
as people who harm others, but as people who have been harmed by others.
This capacity to see patients both as victims and as perpetrators can help both
patients and clinicians avoid blame. ‘It requires keeping in mind the whole of
the person and the whole of their story, which undercuts any single attitude or
emotion, forcing any blame to exist alongside other attitudes and emotions,
such as understanding and compassion.’

It is essential to maintain responsibility and to avoid blame in order to enable
the patient to re-establish a dialogue with himself, that is, with the chiasm of
voluntary and involuntary, selfhood and otherness that constitutes a human
person. Patients cannot even begin to embark on this dialogue if they and those
who work with them do not believe it is in their power to do so—that is, in their
capacity for agency. This is why responsibility is essential for engagement and
effective treatment, especially for patients with personality disorders. This can
include encouraging them to see the fold of the voluntary and the involuntary
from different and multiple perspectives.
Perspectivism is the counterpart, in the world of human relationships, of what we have described as position-taking in the intrapsychic world. In the intrapsychic world, the person can take a perspective over her own experiences. This perspective can change through time and this determines different subsequent ways to format one’s experiences. The present Who may take a different stance towards its experiences, and consequently, it may also regard the point of view of the former Who as a distinct perspective on itself. Position-taking allows the person to say of herself: ‘That was once me’.

There is a connection between time and sociality that parallels the connection between position-taking and perspective-taking. This parallelism was not unknown to Husserl: “Somewhat as my memorial past, as a modification of my living present, ‘transcends’ my present, the appresented other being ‘transcends’ my own being” (Husserl, 1999, p. 115). In the world of relationships, it is the Other in flesh and blood that allows me to take a different perspective on myself.

Perspectivism is the device through which each one of us, who first and foremost sees the world from his point of view, is able to recognize that precisely as just one point of view, and thereby to change it. A healthy mental condition implies the ability to change one’s point of view and temporarily take the perspective of another person. The stronger the reciprocity of perspectives between my former and my present Ego, and between my own vantage and the Other’s, the weaker the tendency to perceive my motivations as absolutely valid and necessary. This implies that the capacity to move from one perspective to another dethrones me (as Husserl would say) from my prejudice to hold an absolute and objective stance on the world. But at the same time it allows me to see myself as not strictly determined by the past and by the involuntary. It allows me to restore a sense of agency.

The reciprocity of perspectives allows people to interact with each other since it presupposes that objects of the world are accessible to other people, but they may mean something different to other people because they can perceive things I can’t and vice versa, and that we have different biographically determined situations and purposes. In the reciprocity of perspectives I assume the
interchangeability of standpoints: if you were where I am, you would see what I see and vice versa. I also assume that the practice to momentarily give up my biographical uniqueness and attend to what is relevant to the present situation allows me to recognize the Other’s system of relevance.

However, the capacity to take another person’s perspective does not mean to adopt a different point of view, much less the point of view of the Other. Perspectivism is not heteronomia. Nor does it mean to assume that no truth is possible and that all truth is relative to a given point of view. Perspectivism is not relativism. Rather, it is the assumption that truth is *in between us*. Perspectivism is the condition of possibility for integrating one’s views with other views, which one learns about precisely by changing one’s perspective, especially through the dialectics of the reciprocity of perspectives between oneself and the Other. This is the meaning of Deleuze’s statement: “The status of an object exists only through its metamorphoses or in the declension of its profiles; of perspectivism as a truth of relativity (and not a relativity of truth)” (Deleuze, 1988, p. 21). Truth is not relative to a person’s perspective. Rather, truth is found in the relation between different perspectives.

We know that there are some patients, whom we call schizophrenic, who are unable to adopt the point of view of the Other. In reality, they are also terrified by such possibility. As heteronomically vulnerable, they refuse to adopt the point of view of the Other (Stanghellini, 2008): taking the point of view of the Other represents for them a serious threat to their fragile ontological constitution, their fragile constitution of the Self (Stanghellini and Ballerini, 2007).

The experience of heteronomic vulnerability is not entirely unknown to the non-schizophrenic life: we all feel dethroned from our position at the centre of the world when we must recognize that the world can also be seen from a different perspective. The concept of perspectivism has led us back to the foundation of my argument: the mark of humanity is the awareness of the inaccessibility of the Other. This concept has gradually become enriched with an ethical value: to attempt to reduce the Other to the same is unacceptable because it is tantamount to depriving the Other of its autonomy by imposing our discourse on its discourse. But it is equally unacceptable to make him the absolutely Other, because the Other touches and inhabits us in the very fold of our finite being.

Let us now reverse the perspective developed so far. One wonders whether it is possible, and what it means, to adopt the point of view of the Other. The question is not if one can get to know the Other, that is, from the Other’s perspective, but if one can get to see things with the eyes of the Other without abandoning *one’s own* perspective. Once again, in order to see things from the perspective of the Other, it is essential to assume that his view is other than one’s own; it is necessary to suspend one’s judgement (clinical, but also ethical
judgement) on such a different view. And it is essential to let the Other speak so that it may unfold his point of view.

The goal is the realization that there is nothing but perspectives. What we have is only a perspective (or at most a range of perspectives) on the Other to whom we tend, but who remains noumenally unreachable.

Only the exchange of perspectives renders our perspective, at least in part, three-dimensional. This explains why the reciprocity of perspectives is a therapeutic goal and perspectivism—the attempt to see things from the point of view of the Other—is a therapeutic device.
Chapter 10

What is a story?

The last therapeutic device, which I will only address briefly, recapitulates all the other devices. The therapeutic situation represents the concrete evidence of the availability of an ‘I’ (the clinician) to encounter a ‘You’ (the patient), sharing the painful consciousness of the inaccessibility of the Other. The therapeutic situation inhabits the (narrow) space separating the objectification of the Other (the reduction of the Other to an exemplar of a category) from his subjectification (the reduction of the Other to an aspect of oneself). The tools one has to rely on and gradually learns to share (and make do with) are the patient and respectful (and unending) reconstruction of the point of view of the Other, and the responsible assumption of one’s own point of view about oneself and on the Other. With these tools we move in search of a kind of knowledge that has the power of truth. A truth that, in accordance with the premises, is not to be searched for within the subject, but is part of the relationship—a truth that is the relationship. It is not the truth about something, but the truth with someone. This approach has abandoned the idea that the truth is a form of correspondence (between one’s narrative and reality) or revelation (of an essence), and pursues an idea of truth as intersubjective accord, as an appointment between two people looking for a place to share.

The therapeutic truth comes close to a kind of communicative action, that is, a project that recon structs a concept of reason that is not grounded in instrumental or objectivist ic terms, but rather in an emancipatory communicative act (McCarthy, 1981). The goal is to bring about an agreement [Einverständnis] that—rather than aiming at a shared construct—terminates in the intersubjective mutuality of reciprocal understanding, mutual trust, and accord with one another (Habermas, 1979).

Communicative action serves to transmit and renew cultural knowledge, in a process of achieving mutual understandings “that rests on the intersubjective recognition of criti cisable validity claims” (Habermas, 1984, p. 17). It then coordinates action towards social integration and solidarity. Finally, communicative action is the process through which people form their identities (Habermas, 1987).

It is precisely in the context of the method that implies perspective-taking that disagreement gains a vital constitutive significance. It allows for the
unfolding of a parliament of forms of understanding whose orchestration is
dialogue itself.

The experience of discrepancy between normal subjects (including the experience of a
plurality of normalities, each of which has its own notion of what counts as true) does
not merely lead to a more comprehensive understanding of the world, insofar as we are
able to incorporate these different perspectives. The disagreement can also motivate the
constitution of scientific objectivity, insofar as we aim toward reaching a truth that will
be valid for all of us. (Zahavi, 2003, p. 135)

This statement helps to focus on a long-standing prejudice: conflicts of
truths as well as of values are signs of imperfection, not a normal part of life.
Indeed, we do not need an ideal based on rational consensus, or on the best
way of life, or on reasonable disagreement about it, “but instead on the truth
that humans will always have reason to live differently” (Gray, 2010, p. 24).
Accord is not consensus. The accord does not consist in an empirical search
for an agreement on a particular issue. This truth is not the outcome of a
negotiation, nor is it a shared construct. It is the act of tending to the Other,
purified from its goal.

The question that follows, then, is: How can the awareness of this shared ina-
bility to understand the Other turn into a therapeutic device, into an effective
therapeutic attitude?

“The other as alter ego signifies the other as other, irreducible to my ego”,
writes Derrida (1967, p. 157). There is, Derrida continues, an “empirical dis-
symmetry” between me and the Other, such that the understanding of the
Other becomes an infinite, impossible task. Trying to accomplish this task
would mean to reduce the Other to myself—and this is the source of all misun-
derstanding and of all violence. However, beyond this empirical dissymmetry,
beyond this unbridgeable distance between me and the Other, there is also a
‘transcendental symmetry’ that makes the Other another Ego who, just as I see
him as Other, sees me as Other. The Other, just like me, is about to cross the
desert that separates him from whoever is his Other.

This transcendental symmetry or analogy between me and the Other per-
fectly describes the encounter between those who care and those who are
cared for. There is a fundamental similarity between them: both are on their
way to the Other not to possess, use, and abuse it, but—as Levinas would
say—to build something right, “to learn about the life of heaven [. . .] to
ascend into heaven” (Levinas, 1968, p. 109). There won’t be an encounter if
the Other is seen as a destination to be reached. On the contrary, this will be
the source of constant wandering. Care lies in the act of tending, of crossing,
not in claiming to have reached the final destination. Incidentally, this may
be one of the reasons why one chooses to care: sympathy for those who, like me, are engaged in the same journey, in the same ‘leap’ (to use Jaspers’ expression) towards the Other. With a bit of arrogance, both (the patient and I) look down upon those who ignore the problem and seem satisfied with reassuring but superficial solutions. This shared hubris holds a positive value because it lays the foundation of the therapeutic relationship and alliance. In concrete terms: we are on the same boat, and I as a clinician must be aware that I cannot understand the patient. I am not suggesting that this sentence should be spelled out, since patients are often motivated to ask for our help, as they assume we know about them, and about other people in general, more than they do. Yet, this awareness must be in the air—it must shape the atmosphere of the therapeutic encounter: I, as Other, tend to you, the patient, but I tend to you knowing that I cannot reach you.

The therapeutic discourse is that which serves to clarify systematic misunderstandings, rather than self-deceptions, inappropriate behaviour, or dysfunctional emotional reactions. The ideal aim of care is to become an exchange of views that admits no external referee, but only the responsibility shared by the two partners to define the terms of one’s own discourse. This reciprocal explanation of one’s own discourse, the exposition of the values at play in it, and the elucidation of the words through which one’s position is expressed, pave the way to an exercise of cooperation during which no vantage prevails over the other. Its final aim is not validation or invalidation aimed at some form of consensus, rather clarification aimed at coexistence. Perspective-taking is not one part of an entire process of care, rather its very essence: an exercise of approximation between the clinician and the patient that aspires to re-establish a broken dialogue. The very essence of therapy is this very dialogue, and the manifold tools in use in the clinics of mental disorders (from empathy to drugs, from compulsory treatment to voluntary psychotherapy) are just means to the end that is dialogue itself.

We should recognize, embrace, and take seriously the role of values, alongside symptoms, in the therapeutic process. Values are attitudes that regulate meaning-bestowing and the significant actions of the person, being organized into concepts that do not arise from rational activity but rather within the sphere of feelings. Thus, grasping the values of a person is key to understanding her way of interpreting her experience and representing herself. In general, it is key to understanding her ‘form of life’ or ‘being in the world’, that is, the ‘pragmatic motive’ and the ‘system of relevance’ that determine the meaning structure of the world she lives in, and regulate her style of experience and action.
Care is the occasion to start a shared project of reciprocal understanding between patient and clinician and this project implies taking each other's values into account. Also, it is the occasion to acknowledge that each partner has his own values, and practise how to live with irreducible value conflicts. Coexistence, rather than consensus, is the framework within which this encounter is posited. Ethnography helps us think of the clinical encounter as a meeting of cultures or of different forms of life. De Martino's (1977) concept of 'critical ethnocentrism' argues for the necessity of a cultural self-assessment on the part of the clinician as a means of optimizing analyses of the patient's culture. Conceptualizing the clinician as an 'ethnologist', clinicians should be able to describe and acknowledge patients' cultural backgrounds, while remaining aware of their own culturally rooted prejudices. They should remain open to a hermeneutic dialogue that aims for the acknowledgement of different values and to understand one's style of experience and action within the framework of one's own value-structure.

Through 'critical ethnocentrism' (see also Saunders, 1993) the Western ethnologist adopts the history of his own culture as the baseline for his analysis of the history of the other culture, but while he is engaged in the act of understanding the other, he is also gaining knowledge of the limitations of his own set of categories. Ethnocentrism is an attitude that develops inside any cultural world. The tendency to assume that the categories and modes of expression of one's own culture are naturally given, obvious in themselves, and universal has its origins in a human need for identity and for identification (Lanternari, 1983, p. 39).
This ‘ethnocentric (or noncritical) attitude’ operates, moreover, on an implicit level, predisposing the individual to formulate interpretations that are linked to his own cultural models. The individual, however, can exercise control over his own criteria for knowledge gathering and evaluating. In order to do so, he needs to be cautious and self-critical and to have a general—as well as a particular—knowledge of the Other (ibid., p. 21).

In a cultural encounter, the experience of being faced with a person who has different values, and a different perspective of the world, has the advantage of throwing light on one’s own values and perspective, which normally remain implicit. In the ethnographic encounter, according to De Martino, a ‘double thematization’ is accomplished, involving one’s own interpretive categories as well as those of others. A relevant consequence of this is the equalization of the relationship between the ethnologist and her informant—through its transformation from a subject–object relation into a subject–subject partnership (Stanghellini and Ciglia, 2013).

As shown in the first part of this book, conflicts of values go with being human. Some of them have no satisfactory solution. This view is not a form of scepticism, or relativism, that paves the way to some sort of therapeutic nihilism; rather, it is the starting point for developing an idea of care based on value-acknowledgement and value-pluralism. Persons have reasons to live differently. And our patients’ values depart from common-sense values, as they are embedded in life-worlds that are different from each other and from our own. This statement reflects the ideal of *modus vivendi* (Gray, 2010), whose aim is not looking for consensus about the best values, or sharing common values in order to live together in peace. Rather, it aims to find terms in which different forms of life can coexist.

*Modus vivendi* has several points in common with critical ethnocentricism. “The aim of *modus vivendi*”, Gray writes, “cannot be to still the conflict of value. It is to reconcile individuals and ways of life honouring conflicting values to a life in common. We do not need common values in order to live together in peace. We need institutions in which many forms of life can coexist” (ibid., p. 25). Our inherited ideal of toleration accepts with regret the fact that there are many ways of life. The good is plural. There is no one good that is right. And there is no one solution between conflicting goods that is right. “It is not that there can be no right solution in such conflicts. Rather, there are many” (ibid., p. 26). The idea of dialogue as a means to universal consensus should be given up. The project of *modus vivendi* among ways of life animated by permanently diverging values should take its place.

The practice that derives from this supports the patient in the search for value-acknowledgement, that is, insight, understanding, resilience, and development
of self-management abilities, rather than merely focusing on symptom assessment and reduction. Also, this practice enhances value-pluralism, that is, an idea of care that aims towards a relation of coexistence rather than consensus.

Most of our current, supposedly ‘humanitarian’ or ‘dialogic’ therapeutic practices are based on the ideal of establishing some form of consensus between patients and carers, or between patients and the social milieu. Yet, consensus is a woolly kind of ‘dialogic’ value. While it looks for agreement and harmony, it implicitly holds that some values are better than others and builds on the metaphysical belief that conflict of values is just a stage on the way to sharing universal values. In this vein, conflicts of values are signs of imperfection, rather than a constitutive part of human life. This unrealistic idea promotes pseudo-dialogic practices that downplay the person’s subjectivity and surreptitiously endorse one-sided values. Examples of this are ‘social rehabilitation’ (which endorses prevailing social values), or potentially intolerant techniques to enhance ‘compliance’ (which endorse the distinction illness/health based on the clinician’s values)—both taking for granted that ‘good’ values are on the side of the clinician.

Coexistence with mental sufferers and with the values each of them embodies is better practice. This practice is produced in dialogue, which is contact across a distance. It aims to acknowledge, understand, and respect different ways of life, enlighten our ethical conflicts, honour conflicting values—and finally, negotiate reciprocal recognition.
Chapter 11

Personal life-history

The P.H.D. method is only in part a ‘how to’ framework for care—and not at all a technique to be applied in the therapeutic dialogue, or a rigorous device to attain an objective truth about the patient.

These understandings of ‘method’ are merely attenuated versions of scientism. Its real concern coincides with what Gadamer wrote in the Preface to the second edition of Truth and Method: “[it] was and is philosophic: not what we do or what we ought to do, but what happens to us over and above our wanting and doing” (Gadamer, 2004, XXVIII, emphasis added).

The P.H.D. method is the framework for understanding what happens when one dialogues with another person. Indeed, the P.H.D. method is the result of the phenomenological analysis of what really occurs when a clinician strives to apply the dialogic principle to the clinical encounter. It is not just the a priori codification of a routine for clinical care, but the consolidation of a practice shared by a group of clinicians moved by similar principles based on phenomenology and hermeneutics. It is the bottom-up effect of a phenomenology of a kind of practice committed to understanding, rather than a top-down, theoretically established agenda to be applied to psychotherapy.

What actually happens during the kind of practice at issue here can be described as a process of progressive decentring of two partners taking part in a dialogue.

What is called phenomenological unfolding (P) is in a nutshell the taking of a third-person perspective on one’s own experiences. Unfolding is the moving from the first- to the third-person perspective over oneself. It is a process of gradual objectification of one’s own facts of consciousness. In order to say ‘You’ to oneself one needs first to see oneself as an ‘It’. This process engages both partners; not just the patient, but also the clinician should be able to describe and acknowledge his own experiences, while remaining aware of his own historically rooted prejudices.

The hermeneutic moment (H) consists in position-taking and perspective-taking with respect to one’s own experiences and their meanings. This is the second step of self-objectification. It requires the capacity to distance oneself from one’s own habits in interpreting and understanding the ‘facts’ of one’s own life,
and to make of these very habits the object for reflection and for understanding. The patient and the clinician should also remain open to acknowledging their interpreting habits within the framework of their own value-structure.

To become acquainted with oneself one has to take the path of dispossession. The psychodynamic moment (D) consists in positing both P and H in a larger historical context, according great importance to the role of life events, of tradition and prejudice in the development of any form of *habitus* in interpreting one’s experiences, and of boundary situations in jeopardizing one’s defensive ‘housings’ and showing their vulnerability (Fuchs, 2013). This means acknowledging and accepting contingency as the necessity of one’s own story. It also means positing the existence of an intimate interconnection between the manifold of a person’s experiences and self-interpretations, that is, the unity of the person’s life-history (Binswanger, 1928).

Let’s first develop the issue of the meaning of the unity and coherence of experiences and self-interpretations, and later the interlacing of contingency and necessity in the person’s life-history.

We call ‘spiritual person’—writes Binswanger (1928)—the point from which experiences spring, and ‘personal life-history’ the intimate interconnection of the contents of the person’s experiences.

The purpose of D in the P.H.D. method is not an archaeology, that is, the rescuing of an *arché*, a remote cause that is posited in the past. The psychodynamic moment is not the search for a *big bang*. What is searched for is not a datum, an event that has taken place at the origin of a person’s story. It is not something that can be chronologically hypostatized, or a fact that has actually happened (Agamben, 2008, p. 93, 2010, p. 16). Rather, it is a phenomenon that allows the intelligibility of the other historical phenomena. It is something that belongs to a person’s life-history that helps make intelligible a string of phenomena whose association might have passed unobserved. This something enforces the coherence and synchronic comprehensibility of the system (Agamben, 2008, p. 93).

Looking into a person’s past has not the purpose of finding a traumatic event that causally explains (to explain technically means *scire per causas*) the following events that have taken place. Rather, the purpose is looking for the *Urphänomen* that can lend coherence to the person’s life-history. The *Urphänomen* is not chronologically original, but hermeneutically so. It may not be a traumatic event that has taken place in the remote past and gave origin to a given personal development. It is better understood as a *paradigm*. The word ‘paradigm’ comes from Greek and literally means an example (*paradeigma*) that exhibits, shows, and points out (*paradeiknumi*). In grammar, it is a set of forms (for instance, of a verb) all of which contain a particular element or theme. If someone (for instance, the student of a given language) knows the paradigm
(for instance, the Latin verb ‘amo, amas, amavi, amatum, amare’) he will be able to recognize and use this verb and all the verbs of the same declination.

A paradigm is the best exemplar of a group of analogous phenomena whose characteristics are clarified by the paradigm itself. For its transparency and completeness, a paradigm can help to illuminate all the other exemplars, according to the rule ‘one speaks for many’. Following Agamben (2008), a paradigm is a single case (say, a single phenomenon in a person’s life-history) that being very perspicuous in its singularity can make intelligible an entire group of phenomena, whose semantic homogeneousness it has contributed to creating. If I discover the paradigmatic phenomenon in a person’s life-history, this will shed light on all other previously opaque phenomena by means of the analogy between itself and the other phenomena. A paradigmatic phenomenon can transform a set of phenomena that, at face value, were unrelated into a *Gestalt* of meaningfully related phenomena.

A quite ordinary example is the following: an adult person describes an episode of his life when he started a close romantic relationship. He portrays himself as both desiring and feeling uncomfortable with emotional closeness. He says he started to distrust his partner and to fear abandonment, and to interpret most of his partner’s behaviour as signs of her intention to end the relationship with him. He develops painful feelings of unworthiness and tends to suppress all of his feelings, including his desire and need for intimacy. He discovers that this pattern of self-with-other relationship dates back at least to his childhood and describes episodes that confirm this. He also uses this paradigmatic episode to illustrate similarities between previously unrelated episodes including his romantic, parental, and peer relationships—as well as the transference relationship with the clinician.

The recollection of my life-history also helps me to recognize that the position and the perspective—in one word: of the H moment of the P.H.D.—I take over my experiences are *historically determined*. The awareness of the historicity, and finally of the contingency, of the stance I take in front of my experiences dethrones me from my prejudice to hold an absolute and objective stance on the world. This paves the way towards the reciprocity of perspectives and towards achieving a three-dimensional view of my experiences. At the same time, it allows me to see myself as not strictly determined by the past and to restore a sense of agency.

As we have seen in the first part, our identity as a human person is a narrative identity that stems from the dialectics between what we are and the alterity that we encounter in our life. Narrative identity is the basic form of dialogue with alterity. Alterity challenges my life not only from without, for instance, as an unexpected event, but also from within in the form of the sedimented, obscure texture of my identity (my past, my parents, my nationality, my character, etc.).
Through narratives we are able to articulate the reasons of our character and the meanings of the events that we encounter in our life. Narratives are patterns of meanings that contribute to make sense of my character and the via regia to work through the meaning of a given event in my life. They moderate the ossification of the character and the traumatic potential of the event. They make our involuntary dispositions and the alterity contained in the event a dynamic part of our personal history.

The encounter with alterity is a necessary precondition for mental health, yet we know that this encounter may become pathogenic. A vulnerable trait and a trauma are the effect of a disproportion between a given disposition and a given event, respectively, as well as the capacity of the person to dialogue with them. Vulnerability is the underside of an involuntary disposition, and trauma is the underside of an event. We called ‘vulnerability’ the alterity that I find in myself when I as a person cannot dialogue with it. We called ‘trauma’ the alterity that I encounter in my dealings with the external world when I as a person cannot dialogue with it. Failing to dialogue with alterity means failing to appropriate it, to cope with, modulate, and make sense of it.

Binswanger provides a celebrated example. It is the story of Augustine of Hippo told by the Berliner theologian Karl Holl. Although Holl’s account is deemed a legend rather than the true story of St Augustine’s path to Christianity, the way Binswanger reports it can be considered a classic in the phenomenological understanding of the relation between a potentially traumatic life-event and its successful integration into a person’s life-history.

Augustine was a master of rhetoric and an acknowledged teacher and orator when he became affected by severe lung problems. This ‘storm changed course to his ship and forced him to take another direction’ (Holl, quoted in Binswanger). He understands that this event is an end to his professional career as an orator. He acknowledges his new condition and ‘accepts his disgrace as a liberation.’ His decision to meaningfully integrate this potentially traumatic event into his life-history paves the way to his conversion, to his new life. Augustine appropriates this event and makes a virtue out of necessity.

The condition of possibility for Augustine’s appropriation of the potentially traumatic life-event is his acceptance of being decentred by it and transformed by it. Without this, Binswanger would suggest, Augustine of Hippo would not have become Saint Augustine, and would have developed a symptom—for instance, a psychogenous reaction.

What is a story? It is the working-through of a person who accepts being decentred by an experience. A story is the effect of a person’s acceptance of being decentred from a given experience, that is, from the way a given event previously affected him. To build a story, a given experience must be decentred from the meaning it previously had for the person who underwent it. Every
noteworthy life-event requires a *conversion*. The power to appropriate a life-event in one's life-history depends on two conditions: the person's acceptance that it may change his life, and the person's capacity to grasp a new meaning in the event itself. The meaning of the event must change, and the person must accept that he is changed by his experience. In sum, a story is a discourse of an Other about an Other.

Clinicians know that when a patient says that he is bored of repeating his own story over and over again this may be the prelude to a change. The patient who is bored of the story he used to tell the clinician (and every person) is on the point of accepting being decentred.

Telling, and listening to, a story is being suspended between boredom and surprise. Usually, in a clinical context, surprise is wished for as much as it is feared. In telling my story I come to the point at which I realize that it is not my story. There is a feeling of extraneousness that immediately precedes a feeling of boredom. In order to avoid boredom I can only tell another person's story. Only when I realize that, while I believe I’m telling my own story, I’m indeed telling another person's story—either my story told by a person different from myself, or the story of a person who is not me—my own story may come to me with surprise. The story I tell about myself becomes itself an event and moves the dialectics of my identity. It is the point of departure from the *idem* and the leap to the *ipse*. 
Chapter 12

Intimacy

Next to a eulogy of narrativity as the dispositive that helps articulate the reasons for our character and dispositions, as well as the meanings of the events that we encounter in our life, there is an aporetics of narrativity that points to the limits of narratives in relation to the unrepresentability, inscrutability, or inappropriability of certain aspects of alterity. Narrativity comes to a zone where alterity cannot be appropriated, and especially cannot be appropriated through language. In this twilight zone, narrativity becomes the name of a problem at least as much as it is that of a solution. Where narrativity ends, intimacy may begin.

An example of intimacy with the alterity of an Other comes from Martin Buber in a paragraph entitled ‘The communicative silence’ (1954, p. 110):

Two men are sitting one near the other. In silence. They do not know each other. They do not look at each other. One is a cordial man, affable and jovial; the other is rigid, shy and reserved. Let’s imagine one of those moments in which the ‘seven seals that fasten his heart’ break down. Unexpectedly his rigidity dissolves.

The shy man does not say a word, he does not move. No action. Yet, now some kind of communication flows between the two.

‘Nobody will be able to tell what happened not even to himself. What do they know of each other? Knowledge is no more necessary. For where immediate communication between men is there, even a dumb communication, there the sacramental realization of dialogue takes place’.


In order to understand intimacy one needs to understand what an atmosphere is, as intimacy with a person is a kind of atmosphere. Both happen in the in-between. They do not involve language, or at least ordinary forms of language. Rather, they involve the sense of tact as a means for sharing. Intimacy, as an atmosphere, has a “fragile architecture” (Pallasmaa, 2013)—or “haptic architecture” (Campo et al., 2014)—and brings about a fragile understanding.

This has obvious clinical implications. Tellenbach considered that during the interaction with a patient, the clinician is led to feel certain atmospheric qualities that permeate the process of understanding. This led him to develop the
concept of “diagnostic atmosphere” (Tellenbach, 1968). Minkowski used the term *diagnostique par penetration* (‘diagnosis through penetration’) to refer to the importance of intuition (the non-cognitive grasping of the meaning of an object) in the process of diagnosing (Minkowski, 1927).

The clinical encounter is an aesthetic experience. One must dodge the scientific rationalism in order to preserve the phenomenological understanding and achieve an understanding of the meaning of a clinical situation as felt, rather than simply assessing objective signs and symptoms. Deleuze and Guattari’s (2001) concept of *haecceity* provides an insight on the nature of this in-between that constitutes the atmosphere of intimacy described by Buber. Haecceities consist of relations of movement and rest between particles, capacities to affect and be affected, but are nonetheless concrete individuations that have a status of their own and direct the metamorphosis of things and subjects. The atmosphere of intimacy resembles a haecceity in the fact that it exists fleetingly as a nomadic crisscross or network of experiences between two (or more) persons. It fills the space, changing the intervenients, whilst having no concrete origin or destination.

The understanding of reality is first and foremost considered through an ‘estranged epistemology’ as if the subject cognitively delved into his experience. Recently, Gibbs discussed an ‘engaged epistemology’ which portrays two types of meaning in any given situation—a pre-reflexive (which is already imbued in experience) and a reflexive meaning (much like the cognitive interpretation of raw experience) (Gibbs, 2005). Through this epistemology experience itself is not ‘raw’, that is, meaningless and in need of being understood, but already imbued with meanings. *Felt meanings* are already present while experiencing a given object or situation, earlier than the appearance of cognitively appreciated meanings. This type of tacit meaningfulness has clear links with the idea of atmospheres. Minkowski uses the verb *aspirer* (breathe in) to portray this distinct mode of being in the world, i.e. the mode of experiencing an atmosphere, which is close to what Tellenbach calls the atmospheric mode of being human (Tellenbach, 1968). When a subject is assessing an atmosphere he is apprehending an emotional significance in an immediate and self-evident way. Atmospheres are readily meaningful. The relation between pre-reflexive and reflexive meaning is not straightforward, as (1) reflexive effort cannot replace pre-reflexive meaning and yet, (2) a person can reflexively elaborate on his pre-reflexive meaning. Yet, the latter is only accessible through active effort, as in our everyday performance it is embedded in such a way that it remains hidden (clinicians must actively undertake such effort).

The pre-reflexive meaning is a pre-conceptual assemblage of the assortment of all sensorial inputs available to the subject. Two consequences arise from the
nature of this type of meaning. First there is a threshold before which sensorial inputs from the body and from the world are merged as if they were one and the same. As Merleau-Ponty (1996) points out, it is as if there was a continuum between the objects being sensed in the sensing body: an objective sound reverberates outside me in the instrument, an atmospheric sound which is between the object and my body. Finally, this sound vibrates in me as if I had become the instrument itself (Merleau-Ponty, 1996). The atmosphere is indeed immediately perceived as an affective tonality that pervades space and simultaneously permeates the subject's body. “I felt that I breathed an atmosphere of sorrow. An air of stern, deep, and irredeemable gloom hung over and pervaded all”—Edgar Poe (1984) writes in *The Fall of the House of Usher*. Hence, atmospheres inhabit what Straus named the ‘pathic’ moment of perception (Straus, 1963), where subject–object distinction is fuzzy and so the sensorial domains are inchoate. The merged and pre-conceptual meaning is the integration of different sense modalities, where one sense mode automatically elicits other sensorial modalities. In this moment there are no mono-sensorial experiences, only a synesthetic experiential waltz.

As an example (see Costa et al., 2014): understanding pre-reflexively Marcel Duchamp’s ‘musical sculpture’ or some of Stockhausen’s pieces entails more than an acoustic experience—a kind of visual–tactile experience is at play, where sounds are felt as sculpting silence.

The second consequence of this pre-reflexive and pre-conceptual appraisal of the meaning of an atmosphere is that the pre-reflexive meaning ultimately accounts for the global awareness of reality, as the subject is moved by this bodily felt transformation. For instance, the scent of a perfume assaults us with images and forces us to experience the ineffable tonalities of the place or situation exceeding the accessible meaning and guiding us to an overall understanding. Tellenbach stresses this in the remark that “in nearly all sensory experiences there is a surplus which remains inexplicit” (Tellenbach, 1968).

In order to grasp atmospheres in clinical practice, one must be predisposed towards them (Costa et al., 2014). According to Schmitz, this predisposition is what allows the distanced influence of atmospheres (Böhme, 1993) and atmospheres are themselves the aesthetic objects to be phenomenologically experienced. The idea of predisposing oneself to aesthetically experience the clinical encounter is not farfetched. In 1907 Husserl wrote a letter to Hofmannsthal, comparing Hofmannsthal’s theory of aesthetics to the phenomenological method, which as he wrote “requires us to take a stance that is essentially deviating from the ‘natural’ stance towards all objectivity, which is closely related to that stance in which your art puts us as a purely aesthetical one with respect to the represented objects and the whole environment” (Hümmer and Schuster,
Therapy: What is Care?

2003). Husserl appears to be referring to the suspension of the natural attitude that would come to sustain the phenomenological method. The potential inclusiveness of an aesthetic attitude in the phenomenological method resides in two features that portray the aesthetic object and are also identifiable in the phenomenological object, which are: (1) the aesthetic properties of an object can only appear if one allows the object’s detachment from one’s intention; (2) the aesthetic properties only arise when the object is stripped of its ordinary meaning. The former resembles the ‘disinterestedness’ that Kant and more recently Stolnitz found essential for the ‘aesthetic judgment’ and the aesthetic attitude, respectively (Fenner, 2008). The latter implies that in order to experience any object aesthetically one must first adopt a stance that presupposes the predisposition of the subject and the displacement of the aesthetic object from its everyday setting.

Duchamp’s ready-mades like The Fountain or the In Advance of the Broken Arm are examples of this, for they appear to us aesthetically as soon as they are exposed in a gallery and consequently stripped out of their utilitarian everyday meaning.

Dickie (1964), who rejects the need for the concept of ‘aesthetic attitude’, admits there is an essential feature of the aesthetic experience, which is attention. Although the art critic or collector might have a professional intention or a purpose that risks to undermine the experience of aesthetic objects, in the moment of aesthetically experiencing an object his intentions must be put aside, otherwise his attention would simply be dislocated from the aesthetic properties of an object and the aesthetic experience would not take place. Neuroscientific research also supports this observation. Having found that aesthetic experiences are qualitatively different from everyday experiences it seems that at the utmost of aesthetic experiences attention is fully focused on a particular object and the object is stripped of its usual purpose, so that “the person is self-transcending, self-forgetful, and disoriented in time and space” (Marković, 2012).

Likewise, in the phenomenological method, the clinician has to learn how to avoid his intention of finding symptoms in order to allow for the appearance of atmospheres. The relevance of aesthetically experiencing the clinical encounter has long since been recognized. Tellenbach considered that during the interaction with a patient, the clinician is led to feel certain atmospheric qualities that exceed the factual, but nevertheless permeate the process of diagnosing. This led him to develop the concept of diagnostic atmosphere. Minkowski’s diagnostique par penetration refers to the importance of intuition (the non-cognitive grasping of the meaning of an object) in the process of diagnosing, particularly referring to the diagnosis of schizophrenia. These concepts are evidence to the
fact that the two authors acknowledged the role of atmospheres in the understanding of phenomena. No differently than in the arts, in the encounter with a patient it is also through the atmosphere into which the clinician is initially thrown that he apprehends the ‘world quality’ that will guide his comprehension. While the quest for objectivity might serve as an excuse to perform the over-detached positivistic act of collecting symptoms, this purpose compromises the entire understanding. The objectivity of atmospheres depends on the possibilities of feeling of the participants in the encounter. The clinician’s ‘being-in-the-world’ is not cancelled in the event, neither is his participation in the global awareness of the situation.

Heidegger’s concept of Befindlichkeit (situatedness) (Heidegger, 2010) seems useful to further clarify the idea of understanding through atmospheres. Befindlichkeit comes from the irregular and reflexive verb sich befinden (to find oneself). In his Commentary on Being and Time, Dreyfus (1991) relates the concept of Befindlichkeit to a mood, rather than a state of mind, that is neither subjective nor objective and is itself a source of attunement to the world, constituting the way we find ourselves in situations. Accordingly, while accounting for the global awareness of a situation, atmospheres have the ability to place us in that same situation through a sense of proportion and distance that takes into account the position of the other. This sense that allows us to find ourselves while attuning to the other is tact. Tact is what Gadamer depicts as

a special sensitivity and sensitiveness to situations and how to behave in them for which knowledge from the general principles does not suffice (…) One can say something tactfully, but that always means that one passes over something tactfully and leaves it unsaid (…) and it is tactless to express what one can only pass over. (Gadamer, 2004)

The relation between understanding and tact can be traced to Aristotle. For Aristotle, phronein, which means understanding the environment, comes from the senses, particularly from the sense of tact (Massie, 2013). Unlike other senses, tact needs tangibility; the medium is (in) our body. Thus, through the sense of tact one simultaneously senses an object (a thing or another sentient being) and one’s sensing body. Accordingly, tact embodies both ipseity and alterity, and it is only through the dialectics of the two that sensing is possible.

Phenomenologically, tact is the sense that is present in the moment of apperception when limits between body and world arise just before the differentiation of all other senses. When Merleau-Ponty tells us ‘through vision, we touch the stars and the sun’ he is showing us how the sensuous quality of the exterior captured through a single sense mode travels through a synesthetic continuum eliciting other sense modes. The relevance of atmospheres in the clinical encounter is ascribed to their ability to dislocate the limits between body and
space whilst traveling through this sensorial continuum, eventually meeting its haptic foundation as the statement by Merleau-Ponty suggests. In this sense, the space of atmospheres is experienced as a tactile space. Meanwhile, the changes in bodily feelings of the receiver are felt as a shared awareness of the situation placing him at the right distance, a tactful distance that is tacitly agreed.

Like the sense of touch, atmospheres exist in a dialectic space of resonance between self and other, allowing for the tacit/inexplicit understanding of a situation, and are also a prelude to knowledge. If on the one hand the whole that is experienced through atmospheres is perpetually irreducible to the concepts we use to understand a situation, the ineffability of the experience shelters a latent relevance, which invites the creation of metaphors that may bring about the disclosure of a new understanding.

The leading role of metaphors in the process of understanding atmospheres reflects the pre-reflexive nature of the experience. The embodied transformations impressed by atmospheres are not directly accessible by existing concepts, which means that they can only be indirectly made sense of by a process that is metaphoric in nature. This process brings experience to the reflexive realm, but will perpetually remain unfinished, as metaphors don’t pin down atmospheres. On the contrary they enhance atmospheres, amplifying them and enchaining other metaphors. In the attempt to get closer to the truth of the experience they enable a self-sustaining process of ‘understanding and experiencing one kind of thing in terms of another’, which has been considered by Lakoff and Johnson as the basis of our everyday conceptual system (Lakoff and Johnson, 2008).

Despite the frenzied concern for reliability that has expanded into the privacy of the clinical encounter declaring the third-person paradigm and its outlined preconceived interviews as the representatives of objectivity, mental symptoms have not been and cannot be fixed in time. They are neither strictly objective nor subjective, and rely on a constant negotiation of meaning that forcibly takes place during the clinical encounter. It is through the clinician’s engagement in the process of understanding that the accuracy of psychopathology is preserved. This is due to the fact that the basic process by which meaning is constructed is linguistic and prior to any Denkstill, including the scientific episteme (Costa et al., 2014).

Interview techniques designed according to the third-person paradigm focus the clinician’s attention on the search for specific symptoms. It is this same intention that compromises the attention needed to notice the aesthetic properties of the clinical encounter and restricts linguistic contexts, risking tautology. If one learns how to experience atmospheres, one could dodge the bias of this intention. Here resides the need to bring aesthetics to the clinical encounter: one
must dodge the scientific dogmatism through Kant’s ‘disinterested pleasure’ in order to preserve the phenomenological understanding.

Atmospheres arise through the actively endorsed aesthetic attitude adopted in aesthetic experiences, which shares with Husserl’s *epoché* the detachment from common sense and any preconceptions (including scientific preconceptions). Phenomenologically they belong to the pathic moment of perception, the moment when self and world/other are merged. Yet, their presence is felt to interpose a tacitly agreed distance between Self and Other. This apparent paradox is peacefully embodied by the sense of tact. Tact is the sense that is present when the person finds his limits in the limits of the Other. Hence, atmospheres are haptically experienced, driving the senses to a past, where the limits between oneself and the Other are constantly being defined and redefined according to the present situation, whilst hinting at the global awareness of that situation and anchoring the process of understanding. Although the experience of atmospheres belongs primarily to the pre-reflexive realm, it can be brought to the realm of the reflexive through the creation of metaphors. Metaphoric thinking generates and regenerates meaning in a permanently unfinished task of describing and redescribing that is truthful to the unfinished nature of atmospheres, bringing us closer to the original phenomena. The acceptance of atmospheres as clinically relevant phenomena is ultimately related to the acknowledgement of the ambiguous nature of the clinical encounter. The clinical encounter is an event suspended between the pathic and the linguistic domains of experience, an open event that invites participation, and must remain so in order to preserve the phenomenological precision. The bringing of aesthetics to the clinical encounter might be the means to preserving its nature.

Meares developed a similar argument in his conversational model of psychotherapy. Intimacy is to Meares a kind of at-oneness in which both partners feel a sense of connectedness and a shared understanding. It is not equivalent to fusion, since fusion is the desperate attempt to fill, with the figure of the Other, the emptiness left by the absence of the self (Meares, 2004). Meares encapsulates this in the formula ‘aloneness–togetherness’—sharing one’s own aloneness with another person. Intimacy is the meeting of two solitudes. The two partners’ orientation is not directed at themselves but at something else, a third thing that arises between them.

This relatedness is transformational. Transformation is mediated by dialogue consisting of more than its content, the simple transmission of information. Language is not only the content of language. Dialogue is not merely a vehicle for pieces of information. Of central importance is the *form* of language, that is, the way words are used, or the tone of voice. Language is non-linear, associative, apparently purposeless, and apparently its function is not communicative. It is
enveloped into the implicit atmosphere of intimate relatedness. It is like a kind of inner speech, or a poetic language. Privilege is given to feeling-tones and how they arise in particular forms of relatedness. And to emotions, out of which ‘meanings’ frequently come.

This kind of conversation both constitutes and manifests a form of being. The development of this experience of one’s self cannot be generated by ‘linear’ forms of language. This sense of self emerges as a resonance between my inner experience and the responses of the Other. Care through intimacy is directed towards a jointly created imaginative narrative arising out of play, a non-linear mental activity. Therapeutic interventions directed at ‘insight’ and the ‘unconscious’ risk invalidation and the creation of dependence. This experience is a form of relatedness that may correct maladaptive forms of relatedness and generate a kind of dialogical self as a self ‘between’ people. Care is directed towards the restoration of a disrupted sense of personal being. The success or failure of therapeutic conversations is not judged by its theoretical correctness, but by the evolution of aloneness–togetherness reflected (as we have seen in analysing Buber’s descriptions of the life-world of the I–You relation) in changes in the totality of experience of self, bodily feelings, and the sense of spatiality.

If we now look at the other side of alterity, there is an intimacy with oneself that is the mute dialogue with that part of oneself that cannot be appropriated and mastered. This part, as we have shown in Part One, is the most intimate and proper and the closest and remotest at the same time. It is my own life in as much as it does not belong to me. We may call this part the radical alterity. It is the obscure and unchosen side of my own existence from which stems an ethical paradox: if there is in the innermost zone of my life something that does not belong to me, then I must respond for something for which I am not responsible.

To live in the intimacy with this extraneous being is to keep in constant relationship with an unpleasant companion—oneself:

In Ingmar Bergman’s movie The Seventh Seal, disenchanted knight Antonius Block, embodying tortured doubt, returns after fighting in the Crusades accompanied by his squire Jöns, a realistic, down-to-earth man who has a sardonic relationship with his master. As the two of them travel to the knight’s castle in Sweden in the throes of the black plague, the knight is challenged by Death (‘I have been at your side for a long time’). Block offers Death a bargain: they will play chess for the knight’s soul.

Torn between his inability to believe and his dissatisfaction with unbelief, Block asks: ‘Why can’t I kill God within me? Why does he live on inside me, mocking and tormenting me till I have no rest, even though I curse him and try to tear him from my heart? Why, in spite of everything else, does he remain a reality—a maddening reality I cannot get rid of?’.

In one scene, Block says that he has to travel with an unlikeable comrade, and his interlocutor, Mia, responds that she understands the knight’s being disappointed with
such an unpleasant attendant. Antonius Block thoughtfully replies that the unpleasant
comrade he was mentioning is not his squire—but himself.

This unpleasant companion with whom I have to share my life is not simply
a non-knowledge zone in myself. It’s not the repressed unconscious. It isn’t
merely a doubt about myself that logic cannot solve or narrativity set into a
meaningful context. It is something much more physical than this, that ration-
ality can neither grasp and control, nor get rid of. *It is my life in as much as it
does not belong to me.* Philosophers have the right to say that the majority of
men flee from this irreducible part of themselves, or hypocritically try to reduce
it to their own minuscule height (Agamben, 2004, 2005). The more I try to
ignore or suffocate it, the more it cries to be heard. It may happen, then, that
this rebellious part reappears as a symptom—the disjointed and unheard part
of one’s identity. The part of one fold cannot be appropriated by the other part
unless the fold itself disappears.

To live in intimacy with this power is, first and foremost, to acknowledge
its necessity. It cannot be eradicated, as my being will be eradicated with it.
Second, I have to recognize its authority—its influence and supremacy. I have
no means—no means that belong to logic, language, or narrativity—to annex
this part to myself. I have to admit that there is nothing that can be under-
stood, metabolized, domesticated. Third, I have to realize that this part cannot
be cheated, but only respected and honoured. I must see it as an enemy worthy
of my value, a non-renounceable piece of my personality, out of which—as sug-
gested by Freud—things of value for my future life have to be derived.

This irreducible alterity can only be *put to use.* This, as we have seen, presup-
poses responsibility and implies a recovery of agency. The good life originates in
the recognition that part of myself cannot be appropriated. Intimacy is the use

‘I am the administrator of my life’—said one of my patients when he came
to acknowledge his being responsible for a part of his life that cannot be
appropriated.

The intimacy with what cannot be appropriated is an everyday mystical prac-
tice (Agamben, 2005).
Ricoeur, in a conference entitled *Le problème de la volonté et le discours philosophique* [The problem of will and the philosophical discourse] (2013), roots phenomenology in the dialectic method:

> la méthode dialectique au sens d’Aristote, c’est à dire [d]’une confrontation d’opinions arbitrée par le travail de la définition, peut être considérée comme l’ancêtre de la phénoménologie (ibid., p. 124).

>[The dialectic method in Aristotle’s sense, that is, a conformation of opinions refereed by the labour of definition, can be considered the ancestor of phenomenology].

This definition reflects three key characteristics of the phenomenological method: dialectic, or the art of conversational discussion; unfolding, or the ‘labour’ of definition; and confrontation, or the process of reciprocal enlightenment.

**Dialectic: the art of conversational discussion.** The phenomenological method is based on the highest form of philosophical activity named ‘dialectic’ (*dialegesthai*), the art of conversational discussion. Yet, a dialectician is not just a person who is skilled in conversation. Rather, dialectic is the capacity to distinguish things according to their nature. Ricoeur underscores that the aim of dialectic, that is, to obtain a sharper definition, is based on an exchange of views between two partners. Thus, dialectic can be defined as the activity through which we pursue the precise definition of something through conversation. Phenomenology, like dialectic, is about a ‘confrontation d’opinions’ about a given phenomenon—namely, a concept. It is, literally, an *inter-view*, a conversation, a comparison of two (or more) standpoints, pictures, or ideas about a given phenomenon. Stressing the dialogical nature of phenomenology, Ricoeur takes distance from all sorts of solipsistic understanding of the phenomenological attitude, including the opinion that phenomenology is about the idiosyncratic discovery of the essence or ‘eidos’ of a given object that takes place in a private, inner space of a contemplative subject. Phenomenology is not (or is not just) an eidetic practice. Rather, the kind of phenomenology at issue here is an activity that takes place in an open, public, interactive, intersubjective space. This version of phenomenology, namely *hermeneutic phenomenology*, is dialectic in nature, as its product is the outcome of a process of ‘confrontation’.
Unfolding: the labour of definition. This interaction builds on ‘le travail de la définition’—the labour of definition. This work is like childbirth and (as we will see) it requires an ‘art of midwifery’. Definition, like childbirth, is achieved through a process of unfolding, that is, bringing something out to the light. In the case of the labour of definition, what comes to light are one’s assumptions, including feelings, opinions, and experiences, and the personal meanings that one attributes to them. Explication (Auslegung) means displaying or unfolding the manifold of phenomena and their interrelation through language. Explication enriches understanding by providing further resources in addition to those that are immediately visible. Its product is a definition, that is, a discourse that reflects the phenomenal world, the world as it appears from the vantage of the subject of experience. The aim of this process is twofold: first, “bringing unnoticed material into consciousness”—as Jaspers (1997, p. 307) would put it. Explication is first and foremost to bring out or make explicit what is implicit in the person’s subjectivity. The subject of experience can take a reflexive stance or third-person perspective in front of the ‘raw material’ of her experience.

The second aim is to offer this material to one’s dialogic partner so that she can see the world as it appears from your own perspective. Each partner is a midwife for the Other. She will continue asking for clarifications and details until she gets the whole picture of her partner’s view in full light.

Confrontation. This is a process of reciprocal enlightenment. The purpose is not to impose one’s own view onto the Other. ‘Confrontation’ here is not simply a struggle or a battle. Although the art of dialectics was undoubtedly born from an agonistic terrain as the discussion between two opponents who strive to demonstrate whose knowledge is stronger than the other’s (Colli, 1975, p. 73), dialogue is not mere polemics. Rather, it is a mutual maieutic process whose aim is to lay bare one’s own view, to put it on the table, and submit it to one’s partner. Also, this process implies that through one’s questions one assists his partner in laying bare her own views. Self-phenomenology enhances and assists other-phenomenology and vice versa.

Here comes the last, and most striking, of Ricoeur’s declarations: dialectic dialogue is ‘arbitrée par le travail de la définition’. To say this with Colli’s words: “in dialectic no judge is needed to decide who is the winner” (ibid., pp. 76–7). Ricoeur is even more categorical in spelling out that the arbiter is the very process of definition. The phenomenological method radicalizes this principle: this practice does not admit any external referee or judge. No authority, no third party is needed, or invoked, or permitted. While participating in the process of definition, each partner’s characterization of the phenomenon at issue
becomes more and more explicit in the open space of discussion; it grows into a public object that can be seen from multiple and often conflicting perspectives. Thus, each partner becomes aware of the limitations of his one-sided discourse and of the intrinsic aporias of any attempt at overall definition. Being engaged in confrontation, each partner is driven to provide rectifications of one's own previous opinions in order to approximate a more appropriate view.

The ‘judge’ is the very process of definition taking place between the two partners. This is the democratic ethics of hermeneutic phenomenology: the space of dialogue is ideally a horizontal one. The clarity of definition, the non-ambiguous transparency of language, the effort to approximate the ‘object’, and the attempt to cooperate with one’s dialogical partner are the only sovereigns having the right to sit on the throne.

External authority vs sharing of conversational rules. Ricoeur’s discourse on the dialectic roots of the phenomenological method needs further discussion and clarification. Let’s focus on the principle of authority implied in this method; in the following I will discuss the issue of the object of dialogue and the question of the symmetric nature of dialogue.

As we have seen, the ethical core of Ricoeur’s understanding of this hermeneutic version of the phenomenological method is its refusal of any external authority. Two (or more) partners are engaged in a process of clarification of one’s own assumptions and of the other person’s assumptions. Nobody can and must decide who is right and who is wrong, since this is not the purpose of this kind of conversation. The purpose is that of clarification and definition of one’s own and of the other’s Weltanschauungen, that is, as Jaspers would put it, “the elucidation of the largest possible realm in which the ‘existential’ decisions occur” (Jaspers, 2002, p. 123).

The object of clarification, thus, is the frame of reference within which the discourse of the persons engaged in conversation takes place, including one’s world picture and the implicit patterns of mental existence by means of which the world is experienced. The former is the world as it is actually experienced and represented, reality as it appears to the experiencing subject in straightforward cognition. The latter is the subsoil of pre-logical and pre-reflexive validities that act as the implicit ground for conscious experiences and explicit cognitions. The purpose of this process of clarification is to foster possibilities for reflection and to present means of personal re-orientation.

This is a collaborative process of self- and other-phenomenology, or of mutual explication. To enter into this process of cooperation, the partners have to share some basic conversational rules. Grice’s (1975) maxims of cooperation nicely encapsulate this idea: Make your contribution such as it is required, at
the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged. Gricean conversation rules can be taken as the gold standard for the dialogic process implied in doing phenomenology. Indeed, adopting a phenomenological stance, especially in the context of care, entails a double effort of self- and other-phenomenology, i.e. of explicating one's own and one's partner's assumptions. If we decide to follow Ricoeur's advice, an external referee is rejected. From this we derive that for this process to become a good and fruitful practice it needs to rely on a method that assures collaboration between all partners. A short version of cooperative conversational rules includes the following:

**Quality**: Do not say what you believe to be false/Do not say that for which you lack adequate evidence.

**Quantity**: Make your contribution as informative as is required/Do not make your contribution more informative than is required.

**Relation**: Be relevant.

**Manner**: Avoid obscurity of expression/Avoid ambiguity/Be brief/Be orderly.

These conversational rules are totally different from the so-called Aristotelian fundamental laws of logic that need to be fulfilled in order to make rational assertions, e.g. the law of non-contradiction, of excluded middle, and the principle of identity. What is at issue here is not logical thinking, but a person's attitude towards conversation. What matters is not rational thinking, but rational conversational action. One can be totally illogical in his thinking and at the same time fulfil Grice's conversational rules.

The rules of dialogue are established in order to facilitate the process of explication through which each partner unfolds her assumptions and defines them—not to establish whose assumption must prevail. This reciprocal explication of one's own discourse, the exposition of the values at play in it, and the elucidation of the words through which one's position is expressed, pave the way to an exercise of cooperation during which no vantage point prevails over the other. The final aim is not validation or invalidation aimed at some form of consensus; rather, it is clarification aimed at coexistence.

**Symmetric vs asymmetric dialogue.** Before delving into the question concerning the aim of dialogue, we need to better focus on another question. Incontestably, dialogue is one of the most ancient principles of the search for knowledge and Socratic dialogue is one of the finest and archetypical forms. It is perhaps the constitutive principle of the original structure of all inquiry, and of the noblest form of care.

I concluded the previous paragraph by praising a kind of dialogical practice consisting in the mutual explication between two partners, as an exercise of
cooperation. Although dialectics was undeniably born as an agonistic discussion between two opponents who strive to demonstrate whose knowledge is stronger than the other’s, I also contended that at least one of its versions—namely, the one that is more relevant for us here—has as its purpose to foster possibilities for reflection and to present means of personal re-orientation for both partners.

This is the case with Socratic dialogues. The questions, roughly said, are the following: Are Socrates and his dialogical partners on a par? Are Socrates and his partners equipped with a comparable knowledge and dialectical capacity? To what extent is dialogue a confrontation between peers? In one word: are all partners equals in dialogue?

It is naïf to think that philosophical dialogue takes place in a community of equals, since this would mean in a community of blind persons among of whom no one is able to orient dialogue itself in a way that all the others may orientate themselves. The philosophical dialogue presupposes someone who has seen. (Sini, 1993, p. 76)

One of my patients recommended that I take a look at this essay, and I am very grateful for that. Indeed, I imagine that what he wanted to tell me is the following: ‘Although you do your best to set your therapeutic dialogues with me in a symmetric framework, this is not what really happens, and you must acknowledge that it would be unfair if you pretended that it were so’.

This was an ironic way to invite me to enquire about the asymmetric nature of our encounters—and of psychotherapy in general.

Socrates—and mutatis mutandis I myself when I am dialoguing with my patients—is not on a par with his partners. The kind of dialogue we are describing here is not a symmetric dialogue between peers. What makes Socrates different from his interlocutors?

I acknowledge that there are at least two main differences between Socrates and his dialogical partners with which I, as a clinician, feel sympathetic. The first concerns knowledge, the second responsibility.

In brief, Socrates knows what the art of dialogue is about. Indeed, he seems to know a lot of relevant things: that he does not know, that his interlocutors are convinced to know, that remaining open to questioning is more virtuous than trying to answer, etc. Also, he knows that in order to dialogue one needs a method. And, even more important, he knows that truth is not the aim of dialoguing, but that truth is the dialogue itself.

Logocentric vs anthropocentric dialogue. The next issue that needs to be focused on is that of the object of dialogue. Incontestably, dialogue is one of the most ancient principles of philosophy, perhaps the common root of a variety of philosophical strategies. Yet, there are at least two kinds of ‘dialogical principles’ at work in Western philosophy.
We may call *logocentric* this first version of the dialogic principle, as it is, first and foremost, the pursuit of the definition of a concept. Logocentric dialogue organizes its inquiry around a concept that must be focused, discussed, and finally, defined. Logocentric dialogue is driven by the subject matter to reveal something new about it to the interlocutors. Openness to new meanings is constitutive of dialogue. This kind of dialogue functions like Husserl’s phenomenological reduction: it is the means by which it becomes possible for things to show themselves to a subject (Vessey, 2000).

This seems, at least at first glance, the principle followed by Socrates while dialoguing with his disciples. The object of dialogue is, in this case, a *concept*, e.g. Virtue, Love, the Good, etc. A concept is something that lies in the space between two or more discussants. Although a great effort must be made to bring this concept into the light of reason and to rescue it from personal prejudices, the concept itself is *external* to each participant in the discussion and lives its life, so to say, in an impersonal space—the space of ideas. The outcome of this type of dialogue is a better definition of the whatness of a given idea or assumption about something. In short, “[t]his logocentric discourse is organized around well defined, distinct concepts, dialectically discussed during the debates between Socrates and his disciples” (Münster, 1997, p. 38).

It remains beyond the intentions of this book to discuss whether this kind of logocentric dialogical praxis is the correct interpretation of the *sokratikoi logoi* or not. Indeed, Charles Kahn (1996) provides a substantially different understanding. According to Kahn, the principal aim of Socratic dialogues is not to assert true propositions *but to alter the minds and hearts*. Socratic dialogue is not meant to “replace false doctrines with true ones but to change radically the moral and intellectual orientation of the learner, who, like the prisoners in the cave, must be converted—turned around—in order to see the light” (ibid., p. xv).

What I want to focus on here is that, next to the logocentric one, there is a second type of dialogue whose object is not a concept, but the very persons—the I and You—involved in the dialogue itself. Whereas in the first kind of dialogical practice concepts are worked out and ‘manipulated’ as an artisan would manipulate a vase or any other kind of utensil to improve it, in the second type of dialogue the two partners literally put their hands on each other. The purpose is to define oneself, rather than a concept. What is implied is not changing an opinion, but a *conversion*, that is, changing one’s orientation. The scope of this kind of practice is modifying oneself through the dialogue itself, rather than obtaining a better shape for an external object.

In dialogue subjectivity is displaced. When one engages in dialogue, one does not control the progression of the dialogue; when one enters into dialogue one is literally unaware of ‘where’ the dialogue may bring one. This process does
not simply involve cognitions, but emotions. Lacking a better word to name it, we will for the moment call *anthropocentric* this dialogue in which two or more partners are engaged in defining themselves and allowing their dialogue to modify themselves. Perhaps a better term to define this type of dialogical practice would be *anthropo-poietic*, as it aims towards personal formation in the sense of *Bildung*. Socrates aimed towards “a research as formation and not to a path to truth” (Sini, 1993, p. 84). *Bildung* means cultivation or formation—rather than education—that cannot be achieved by any merely technical means. *Bildung zum Menschen* is “[t]he properly human way of developing one’s natural talents and capacities” (Gadamer, 2004, p. 16). It is a process of *forming* one’s Self in accordance with an ideal image of what it is to be human. *Bildung* implies participation rather than indoctrination, and questions rather than assertions. As we have seen, there are two general characteristics of *Bildung*; the first is keeping oneself open to what is other. This embraces a sense of proportion and distance in relation to oneself (ibid., p. 17). The second is that it contributes to developing a *sense*—namely, *tact*—useful for interpersonal relationships.

The Socratic dialogue spins around the question *ti esti*;—what is it? Yet, when Socrates raises this question about virtue, his aim is not the definition of ‘virtue’, but rather understanding himself and his interlocutor. The purpose of the dialogue is not defining the ‘what’ of virtue, but understanding the ‘who’ of the persons engaged in dialoguing (Sini, 1993, p. 85). The *ethos* of the Socratic dialogue is not knowing the thing called ‘virtue’; rather, it is to ‘know oneself’ while authentically engaging in trying to define the slippery concept called ‘virtue’. Virtuous—as Sini explains—is “raising this question” (ibid.).

Socrates was not a person exceptionally skilled in defining the essence of ‘virtue’, or of other moral concepts (indeed, many Socratic dialogues end up aporetically with unanswered questions). Socrates was a virtuous person. He was a virtuous person for two principal reasons: first, he was aware that he himself, as every other human being and principally those who were supposed to detain knowledge (*sophistoi*), was not knowledgeable at all. In this consists the difference between the *sophia* of pre-Socratic thinkers and *philo-sophia* as established in the Socratic practice of dialogue: the former is the presupposition of possessing knowledge about something; the latter is the longing for knowledge. Socrates does not fall for Oedipus’ tragic mistake when he answered the Sphinx’s question as he supposed he was able to do so. He understands the question as a question and does not respond to it; rather he corresponds to it (ibid., p. 79).

The second reason is that Socrates knows how to ask questions. He has a *methodos* for dialogue—or, as we call this here, a *method for care*, as dialoguing is the principal means of care.
We can rephrase this in the following way: the purpose of anthropocentric dialogue does not consist in the search for the exact definition of a concept based on the correct application of logic, but in the engagement of two or more partners, who, while looking for a better understanding of a concept, understand their own ignorance about it and in this way undergo a poiesis or transformation.

With this in place, another angle from which the anthropocentric dialogue can be enlightened is the following: it is not an empirical search for an agreement on a particular issue, but a shared transcendental commitment to cross the space between each other. The aim is neither the definition of a concept based on the rules of logic (as we have seen), nor the negotiation of a shared construct. Eternal values are “living realities that are given to men only in the immediacy of human relation” (Buber, quoted in Münster, 1997, p. 49). Anthropocentric dialogue is a gesture—the sharing of an intention. Its transcendental referent is not a fact (to which it is supposed to correspond), but the relationship itself. It is the act of tending to the Other, purified from its goal. A truth in which, to paraphrase Levinas (1969), the approaching of the two messengers is itself the message.
References


valuesbasedpractice.org


Index

Notes, vs. indicates a comparison.

A
abnormal sociability, schizophrenia, 102
accidental symptoms, 69
action
 P.H.D. method, 121–2
text as product, 77–8
aesthetic attitude, 182
affect, 40
dialectic of, 43–4
moods vs., 43
Agamben, G
intimacy, 187
language, 13
love, 96
paradigm, 176
pre-individuated alterity (genius), 32
agency
passivity vs., 159–60
transformation of, 16–17
agnostic way, 61
alterity, 1–3, 9–10, 22–4, 56, 80–1, 96–7, 159
anatomy of recognition, 50–2
awareness of, 90
centrality of, 115
dialogue with, 22–7, 31, 32, 60, 78, 116, 159
domestication of, 59
drive see drive
eccentricity see eccentricity
emotions as essential feature, 46–7
encounters with, 26–7, 65–6
extraneous nature, 30
habits see habits
intimacy, 179
meaning of, 33
mental health, 176–7
non-repressed, 31
pre-individuated, 31–2
radical, 186
recognition of, 58
recoil of actions, 48–9
relations with other people, 153
responsibility, 156
struggle with, 25
symptoms, 77–8
tact, 183
Ambrosini, A, 82
Ammaniti, M, 19
analogy, in empathy, 127–8
anthropocentric dialogue, logocentric
dialogue vs., 193–4
anthropology
of disunion, 81
of non-recognition, 57–61
anthropo-poietic dialogue, 195
antipathic behaviour, manipulation, 133–4
assumptions of psychodynamic thinking, 72–3
asymmetric dialogue, symmetric dialogue vs., 192–3
atmosphere, 180–2
arising of, 185
definition, 179
metaphors in, 184
attitude, empathy, 126
attunement to others, 20–1
Augenblicksgott (momentary god), 13
Augustine of Hippo, 177
authority, external, 191
automatization, 76–7
awareness of alterity, 90
B
Barthes, R, 116
Batthyány, P, 127–8
Bau, F, 103–5
Befindlichkeit, 183
behaviour, explorative, 134–5
Bell, J, 68
Bergman, I, 186–7
Berthold-Bond, D, 48–9
Bildung, 110
Bildung zum Menschen, 195
Binswanger, L
personal life-history, 177
P.H.D. method, 175
de Biran, M, 28
blame
patient past history, 163–4
responsibility without, 163
Bleuler, E, 149
Böhme, G, 181
borderline existence, 98–100
definition, 98
recognition by the Other, 99
borderline personality disorder, 136–7
feel blame, 163
Bornstein, K, 86–7
Bourdieu, P, 29, 36–7
Bracket, L, 72–3
Buber, M
limits of narratives, 179
primary world, 16
relation, 12–14, 15–18
bystander, identification with, 162–3
Byung-Chul, H, 90

C
Campana, D, 101–2
care, 54, 56, 121–2
definition, 1, 65
folding/unfolding, 160
object of, 123
patient’s life-world, 152–3
primary object of, 140
reciprocal understanding, 171
responsibility of, 67
through intimacy, 186
see also P.H.D. method
centrality of alterity, 115
centricity, 96–7
character, 44
Charcot, J-M, 71–2
chiasm, 114–16
Ciglia, R, 172
de Clérambault, GG, 92–3
PCD model, 150
schizophrenia, 149
clinicians, 109–13
as citizens, 109
humanistic learning, 110–11
opportunities, 112
scientific education, 110–11
tact, 111–12
training, 110
cognitive empathy, 127
Colli, G, 190
common sense, 58–9
communication, purpose of, 168
conflicts of values, 172–3
confrontation, dialectic, 190
contact with others, manipulation, 134–5
contemplation, 61
conversation
discussion, 189
model of psychotherapy, 185–6
rule sharing, 191
cooperation, maxims of, 191–2
Costa, C, 181
Crime and Punishment (Dostoevsky), 50
critical ethnocentrism, 171–2
cynical way, 60, 90
cyphers, 75–9
definition, 76
disembodiment of Other, 101
reading, 75
unsaturated, 76

D
Das Man, 58
de-attunement, schizophrenia, 105
decisions, gender dysphoria, 86
defensive strategies, Other, 59
De Jaegher, H, 21
Deleuze, G, 153
haecceity, 180
heterology, 55
delimitation, dialogue, 11
De Martino, E, 171–2
depression, 95–7
Derrida, J, 169
desire, 1–3, 16, 86, 116, 146
disembodiment of in schizophrenia, 104, 105
goals, 19
idealization of common-sense, 95–7
idolatrous, 92–3
need vs., 34–5
for reciprocal recognition, 89–90
for recognition, 34, 50, 53, 55
sexual, 72
suppression of, 153–4
unconscious see unconscious desire
de Sousa, R, 147
diagnosis, definitions, 69
dialectic, 1, 3, 28–9, 31, 39, 40, 150, 189–96
confrontation, 190
conversational discussion, 189
definition, 189
external authority vs. conversational rule sharing, 191
frame of reference, 191–2
hermeneutical reorientation of, 10
of identity, 22–7
meditation, 100
model of mental disorders, 65–7
moods and affects, 43–4
narrative identity, 45–7, 176
person and otherness, 147
position-taking, 55
relationship development, 97
rules of, 192
of selfhood, 87
unfolding, 190
voluntary vs. involuntary, 156
see also dialogue
dialogue, 9–11, 86, 97, 170–1
with alterity, 22–7, 31, 32, 60, 78, 116, 159
anthropo-poietic, 195
definition, 1
delimitation, 11
interpersonal, 21
interruption of, 2
life-history, 174
logocentric vs. anthropocentric, 193–4
philosophy, 10
Socratic, 193
subjectivity, 194–5
symmetric vs. asymmetric, 192–3
therapy as, 3–4
transformation and, 185–6
see also dialectic
Dickie, G, 182
Di Paolo, EA, 21
disembodiment of desire, schizophrenia, 104, 105
dissymmetry, empirical, 55
disunion, 81–2
Doerr-Zegers, O, 150
domestication of alterity, 59
Doppelganger (double), 30–2
Dostoevsky, F, 50, 95
double (Doppelganger), 30–2
Dreyfus, HL, 183
drive, 33–5
definition, 34
Duchamps, M, 181
Dynamic analysis (D), 118
dynamic unconscious, involuntary unconscious vs., 34
dysphoria, 135–7
E
eccentricity, 28–9
Einstellung (phenomenological understanding), 123–4
emotion, 39–41
affects and moods see affect; moods
definition, 39–40, 115
as essential feature of alterity, 46–7
narrative identity see narrative identity position-taking, 147
Emotions and Personhood (Stanghellini & Rosfort), 161
empathy, 123–30
aberrations of experience, 128–9
by analogy, 127–8
attitude, 126
cognitive, 127
conative, 127
definition, 123–4
with manipulation, 137
nonconative, 126–7
Other’s self description, 125
second-order see second-order empathy
simulation-theory (ST), 124–5
empirical dissymmetry, 55
Encompassing (das Ungreifende), 75
encounters with alterity, 65–6
epistemology
engaged, 180
estranged, 180
Eros, 115–16
estranged epistemology, 180
ethnocentrism, critical, 171–2
euphoria, 41
evolutionary perspective, symptoms, 69–70
existential dimensions, life-world, 142–4
experience
aberrations of, 128–9
feeling of, in unfolding, 140–1
frameworks of, 139
P.H.D. method, 121–2
exploratory phenomenology, 120–1
explorativ behaviour, manipulation as, 134–5
external authority, dialectic, 191
extimacy, 30
Eyes Wide Shut, 93–4
F
The Fall of the House of Usher (Poe), 181
feeling of experience, unfolding, 140–1
fold/unfolding, 3–4, 23, 56, 78, 109, 121, 139–47, 157–8, 169, 187, 189, 192
care, 160
clinical benefits, 143
definition, 160–1
dialectic, 190
feeling of experience, 140–1
foreign normality, 139
life-world, 119–20
manipulation, 140
methods, 116
narrative, 177
normality and pathology, 160
revelation of, 159–60
symptoms, 139
two sides, 30
words, 140
Fonagy, P, 73
foreign normality, unfolding, 139
frame of reference, dialectic, 191–2
frameworks of experience, 139
Freud, S, 30
psychodynamic theory, 72
recognition of alterity, 32
Friedman, MF, 13
Fuchs, T
guilt, 156
heterology, 55
P.H.D. method, 175
Fullford, KWM, 25–6
Fusar-Poli, P, 148
G
Gadamer, H-G
Bildung zum Menschen, 195
clinicians, 110–11
dialogue, 10
personal life-history, 174
phenomenology, 77
Gallagher, S, 124
Gallese, V, 19
Gehlen, A, 29
gender
moral value, 85
personal experience, 85
Index

gender dysphoria, 84–8
challenge to clinician, 87
decisions taken, 86
definitions, 84, 86
personhood, 87–8
symptomatic phenomena, 86
values, 88
General Psychopathology (Jaspers), 149
A Gentle Creature (Dostoevsky), 95
Geworfenheit (Dostoevsky), 33
Gibbs, JRW, 180
goals, desire, 19
Goldie, P, 43
Goldman, A, 124
Gray, J
modus vivendi, 172–3
story, 169
Grice, D, 191–2
Grön, A, 147
Guattari, F, 180
guilt delusions, 156
guilt, responsibility, 156

H
Habermas, J, 168
habits, 36–8
definition, 36–7
formation of, 26
haecceity, 180
Hahn, LE, 10
health care, humanities, 112–13
Hegel, GWF
actions, 49
objectification automatization, 76–7
theory of action, 48
Heidegger, M
Befindlichkeit, 183
clinicians, 110
common sense, 58
dialogue, 9–10
emotions, 40
idle chatter, 58
throwness (Geworfenheit), 33
Heimlich, 30–1
Henricksen, MG, 148
Hermeneutic analysis (H), 118
hermeneutic moment (H), P.H.D. method, 174–5
hermeneutic phenomenology, 189
personhood, 22, 28
heterology, 55–6
heteronomic vulnerability, 166
Hölderlin, F
dialogue, 9
schizophrenia, 102
Holl, K, 177
homo duplex, 29
Honneth, A, 54
Huber, G, 149
human beings as a juxtaposition, 29
humanistic learning, clinicians, 110–11
humanities, health care, 112–13
Hümer, G, 181–2
Husserl, E
atmospheres, 181
epoché, 185
explanatory phenomenology, 120–1
symptoms, 76
time–sociality connection, 165
unfolding, 144

I
I and Thou (Buber), 12
idea, 95–6
ideal citizens, 109–13
idealization of common-sense desire, 95–7
identification
with bystander, 162–3
with perpetrator, 162
with victim, 161–2
identity
dialectic of, 22–7

immoderata cogitatio, 94

inaccessibility of the Other, 55, 89–90
intentionality, 42–4
interpersonal dialogue, 21
interruption of dialogue, 2
intersubjective accord, truth as, 168
intersubjectivity, 19–20
neurobiological underpinning, 21
interview techniques, 184–5
intimacy, 30–1, 32, 81, 151, 159, 179–87
alterity, 179
care through, 186
clinical implications, 179–80
with oneself, 186–7
with the Other, 51
pre-reflexive meaning, 180–1
involuntary habitus, post-partum

depression, 83
‘I’ relation, 13
‘I–You’ relation, 12–14
life-world of, 15–18

J
Jaspers, K
aims of psychopathology, 123
approach to failure, 100
cypher, 75
dialectic, 191
empathy, 123–4, 125, 126, 127–8
heterology, 55–6
the Other as failure, 90
person-centred understanding of mental illness, 66–7
P.H.D. method, 120
position taking (Stellungnahme), 149
post-partum depression, 81
psychopathology, 112–13
Jay, M, 119
Johnson, M, 184
K
Kahn, C, 194
Kane, S, 99, 136
Kant, I, 127
Kepinski, A, 148
Kirkegaard, S, 127
Können, 90
Kretschmer, E, 102
Kubrick, S, 93–4
L
Lacan, J
extimacy, 30
symptoms, 73
Lakoff, G, 184
language
production of Other, 90
usage, 9–10
La Notte (The Night) (Campana), 101–2
Lanternari, V, 171
Law, 54
Léa-Anna, 92–3
Leoni, F, 71
Levinas, E
carer–patient relationship, 169–70
empathy, 127
inaccessibility of Other, 89–90
life-history
dialogue, 174
see also personal life-history
life, philosophy of, 104
life-world
appropriation of (P.H.D. method), 121
care of patient, 152–3
existential dimensions, 142–4
fold/unfolding, 119–20
importance of (P.H.D. method), 121
of ‘I–You’ relation, 15–18
manipulation, 132–3
phenomena and structure (P.H.D. method), 119
symptoms, 76
transcendental origin narration (P.H.D. method), 120
limits of narratives, 179
logocentric dialogue, anthropocentric dialogue
vs., 193–4
logos, 117
love, 94
as displaced feeling, 97
importance, 115–16
Love, 54
Luckmann, T
manipulation, 133
symptoms, 76
Lyons-Ruth, K, 21
M
madness, vulnerability to, 156
manipulation, 131–2
contact with others, 134–5
definition, 134, 135
empathy with, 137
as explorative behaviour, 134–5
personality disorder, 135
unfolding, 140
The Man without Qualities (Musil), 93, 156–60
Marković, S, 182
maxims of cooperation, 191–2
Mayer-Gross, W
patient active role in position-taking, 150
person-centred understanding of mental illness, 66
schizophrenia, 149
McCarthy, TA, 168
McDougall, J, 73
McEwan, I, 134
McGuire, M, 69
Meares, R, 185–6
medical taxonomy, 68–9
meditation, dialectic, 100
melancholia, 156
Melancholia, 97
melancholic crisis, 97
mental disorders/illness
attitudes to, 67
definition, 65
dialectical model, 65–7
vulnerability to, 117–18
mental health, alterity, 176–7
mental pathology, 56, 91
Merleau-Ponty, M
intimacy, 181
tact, 183–4
texts, 78–9
unfolding, 144
metaphors, in atmospheres, 184
Metzinger, T, 140
Miller, J-A
extimacy, 30
symptoms, 73
Minkowski, E
atmosphere, 180
intimacy, 180
schizophrenia, 149
mis-recognition, 38
Modernism, 77
modus vivendi, 172–3
momentary god (Augenblicksgott), 13
moods, 40–1
affect vs., 43
dialectic of, 43–4
incorporation into identity, 46
ontological sentiments vs., 42–3
Moosbrugger, C, 156–60
moral value, gender, 85
mother–infant interactions, 19, 20
Mundt, C, 141
Münster, A, 194
Musil, R, 93, 156–60
mutual understanding
common sense, 58
as a misconception, 58
mystical way, 60, 90

N
Narcissus, 93–4
narrative, 22–7
definition, 66
fold/unfolding, 177
limits of, 179
use of, 23
narrative identity, 23–4, 25, 27, 45–7
dialectic of, 45–7, 176
indications of, 45
personal life-history, 176–7
temporality, 23
narratives, limits of, 179
need, desire vs., 34
negative schizophrenia, 148
neurobiology
dialectical model of mental disorders vs., 66
intersubjectivity, 21
Nichols, S, 124
Nietzsche, F, 29
nonconative empathy, 126–7
non-psychotic schizophrenia, 148
non-recognition, 89–91, 161
anthropology of, 57–61
see also recognition
non-renounceable value, 100
non-repressed alterity, 31
normality
fold/unfolding with pathology, 160
foreign, 139
normative vulnerability, 67
norms, gender dysphoria, 88
Not for Profit. Why Democracy Needs the Humanities (Nussbaum), 109
Nussbaum, M, 109
O
objectification, 76–7
object of care, 123
Oedipus, 155
ontological sentiments, 42–3
ontological status, ‘I’ and ‘You,’ 16
Other
adopting point of view of, 166–7
alterity, 56
appearance of, 144–5
attunement to, 51
defensive strategies, 59
empathy as self-description, 125
inaccessibility of, 55, 89–90
intimacy with, 51
as source of recognition, 100
otherness see alterity
Overgaard, S, 124
P
Pallasmaa, J, 179
Panksepp, J, 19
paradigm
definitions, 176
Urphänomen, 175–6
paraplegia, 80
Parnas, J
explanatory phenomenology, 120–1
schizophrenia, 148
symptoms, 76
passivity, agency vs., 159–60
pathogenic situation, P.H.D. method, 122
pathology, fold/unfolding with normality, 160
pathos, 117
patient
clinician relationship, 151
experience, 151–2
pauci-symptomatic schizophrenia, 148
perceived vulnerability, 132
perpetrator, identification with, 162
personal attitudes, 32
position-taking, 147
personal experience of gender, 85
personal identity, 45
in gender dysphoria, 85–6
personal life-history, 174–8
narrative identity, 176–7
perspective, 176
traumatic events, 175
see also life-history
person-centred dialectical model (PCD), 149–50
personhood
characteristics, 25–6
continuous task, 39
definition, 22
gender dysphoria, 87–8
hermeneutical phenomenology, 28
identity problems, 24–5
perspective, personal life-history, 176
perspective-taking, 165–7
reciprocity of, 165–6
story, 168–9
perspectivism
adopting point of view of Other, 166–7
definition, 165, 166
schizophrenia, 166
domains of analysis, 121–2
dynamic analysis, 118
hermeneutic analysis, 118
hermeneutic moment (H), 174–5
phenomenological understanding (P), 174
phenomenological unfolding, 118
principles, 117–18
psychodynamic moment (D), 175
steps in, 119–22
phenomenal unfolding, 141–2, 174–5
phenomenological understanding (Einstellung), 123–4
phenomenological understanding (P), P.H.D. method, 174
phenomenology
definition, 76
explanatory, 120–1
philosophy
dialogue, 10
of life, 104
Pickard, H, 163
pleats, text, 78–9
Plessner, H
eccentricity, 28
personhood, 29
Plutchik, R, 40
Poe, EA, 181
position taking (Stellungnahme), 147–54, 149
emotional experience, 147
pathogenesis of schizophrenia, 150–1
patient active role, 150
personal attitudes, 147
in prevention and treatment, 151
post-partum depression, 80–3
unconscious desire, 80–1
Potter, N, 132
Präexistenzgefühl, 111–12
pre-individuated alterity (genius), 31–2
Preißler, S, 136–7
pre-reflexive meaning of intimacy, 180–1
presupposition, responsibility, 160
prevention and treatment, position-taking in, 151
primacy of relation, 18
primary object of care, 140
Prinz, J, 147
procedural memory see habits
psychic trauma, symptoms, 71
Psychodynamic Diagnostic Manual, 73
psychodynamic moment (D), P.H.D. method, 175
psychodynamic theory, 72
psychodynamic thinking, 71
assumptions of, 72–3
psychomotor inhibition, post-partum depression, 83
psychopathology, 112–13
accuracy of, 184
aims of, 123
education, 123
psychotherapy, conversational model of, 185–6
psychotic schizophrenia, 148
Pygmalion, 93–4
R
radical alterity, 186
Ratcliffe, M, 124
reality (Wirklichkeit), 156–60
understanding of, 180
reciprocal recognition, 2, 3, 187
desire for, 89–90
reciprocal understanding, care, 171
recognition, 50–2, 53–4, 65
of alterity, 58
alterity in, 50–2
basic need for, 53–4
definition, 50
desire for, 34, 50, 53, 55
logic for, 55–6
see also heterology
need for, 96
by the Other, 99
of the Other, 53
reciprocal see reciprocal recognition of self see self-recognition
story, 168
as value, 53, 54, 89
vision, 146
see also non-recognition
recoil (Rückschlag) of actions, 48–9
reconstruction of world-project, P.H.D. method, 122
relation, 12–14
‘I,’ 13
primacy of, 18
representation of, 18
representational body, 72
repression (Verdrängung), 34
responsibility, 49, 155–64
alterity, 156
of care, 67
definition, 155, 159
guilt, 156
individual blame, 161–2
presupposition and tasks, 160
without blame, 163
Ricoeur, P
alterity, 22–3
caracter, 44
dialectic, 189–91
eccentricity, 28
emotions, 40
engagement with the world, 26
identity, 45–6
involuntary side of human existence, 33
narrative identity, 23–4
objectification automatization, 76–7
ontological sentiments, 42–3
personhood, 29
symptoms, 76
text, 48, 77
Rizzolatti, G, 19
Rochat, P, 137
Roepke, S, 136–7
Rosfort, R
alterity, 161
borderline personality disorder, 136–7
disunion, 81–2
eccentricity, 28
identity problems with personhood, 25
manipulation, 135
narrative identity, 23
PCD model, 150
position-taking, 147
symptoms, 76
unfolding, 139
Rossi, R
symptoms, 76
unfolding, 139, 141–2
Rückschlag (recoil) of actions, 48–9
Rümke, HC, 111–12
S
Sartre, JP
emotions, 40
lived corporeality analysis, 144–5
Sass, LA
explanatory phenomenology, 120–1
position-taking, 148
schizophrenia, 148
Saunders, G
borderline existence, 99
critical ethnocentrism, 171
sceptic, 60, 90
Scheler, M, 40
schizophrenia
abnormal sociability, 102
de-attunement, 105
disembodiment of desire, 101–5, 104, 105
manifestation of alterity, 148
melancholia vs., 156
negative, 148
non-psychotic, 148
pauci-symptomatic, 148
perspectivism, 166
phenotype stability, 148
philosophy of life, 104
psychotic, 148
symptoms, 102
unsociability, 103
vulnerability in, 149, 150–1
Schuster, MO, 181–2
Schütz, A
attunement with the Other, 51
common sense, 58
manipulation, 133
symptoms, 76
scientific education/knowledge, 58–9
clinicians, 110–11
second-order empathy, 128–9, 131–8
manipulation, 131–2
self-awareness, structure of, 28
self-control, post-partum depression, 82
self-experience, patient, 151–2
selfhood
definition, 22
dialectic of, 87
self implicit structures, rescuing of (P.H.D. method), 119–20
self-interpretation, outcome of need, 65–6
self-knowledge, 49
self-recognition, 49
importance of, 53
lack of, 115
Seubert, H, 127–8
The Seventh Seal, 186–7
sexual desire, 72
Shear, J, 140
Sheets-Johnstone, M, 40
shelters, 59–60, 90–1
Siemer, M, 42
Simkó, A, 149
simulation theory (ST), 124–5
simultaneity, 52
Sinigaglia, C, 19
Smith, Q, 40
social adaptation, common sense, 58
sociality
abnormal in schizophrenia, 102
time connection, 165
Socrates, 195
Socratic dialogue, 193, 195–6
Solidarity, 54
Solms, M, 19
Sondergoetter (special god), 13
Stanghellini, G
alterity, 161
antipathetic behaviour, 133–4
borderline personality disorder, 136–7
conative empathy, 127
disunion, 81–2
eccentricity, 28
empathy with manipulation, 137
heterology, 55
identity problems with personhood, 25
manipulation, 135
narrative identity, 23
PCD model, 150
position-taking, 147
post-partum depression, 82
schizophrenia, 148
subject–subject partnership, 172
symptoms, 76
unfolding, 139, 141–2

Stellungnahme see position taking (Stellungnahme)

Stern, DN, 17
  attunement to others, 21
  habits, 37
  intersubjectivity, 19–20
Stich, S, 124
Stockhausen, H, 181
story, 168–73
  carer–patient relationship, 169–70
  perspective-taking, 168–9
  recognition, 168
  therapeutic discourse, 170
values, 170–1
Strauss, EW, 129, 181
Streuber, K, 124
subjectivity, dialogue, 194–5
  suppression of desire, 153–4
  symmetric dialogue, asymmetric dialogue vs., 192–3
symmetry, transcendental, 55
symptomatic phenomena in gender dysphoria, 86
symptoms, 32, 65–6, 71–4, 80, 82, 100, 182–3
accidental, 69
altered, 77–8
  causes, not meanings, 69
as cypher, 75–9
as defects, 70
  definition, 68–70
  evolutionary perspective, 69–70
  generation, 150–2
  life-world, 76
nomenclature, 68
objectification automatization, 76–7
origins, 2
psychic trauma, 71
psychodynamic approach, 73–4
schizophrenia, 102
as text, 77
vulnerability, 75

T
  tact
  alterity, 183
  clinicians, 111–12
  definition, 183–4
  understanding relation, 183
Target, M, 73
tasks, responsibility, 160
Tellenbach, H
  atmosphere, 180
  intimacy, 179–80, 181, 182
  post-partum depression, 82
temporal coordination, 52
temporality, 42–4
  definition, 43
  ‘I’ and ‘You,’ 17
narrative identity, 23
temporality, sociality connection, 165
text
  definition, 48
  pleats, 78–9
theory-theory (TT), 124–5
therapeutic discourse, story, 170
therapeutic situation, P.H.D. method, 122
Thornton, T, 125
thrownness (Geworfenheit), 33
Tichener, E, 124
training, clinicians, 110
transcendental symmetry, 55
transformation, dialogue and, 185–6
transsexuality see gender dysphoria
trauma
  definition, 89
  personal life-history, 175
  psychic, 71
Trevarthen, C, 19
von ‘Trier, L, 97
Troisi, A, 69, 70
Truth and Method (Gadamer), 174
three, as intersubjective accord, 168

U
The Uncanny (Unheimlich), 30–2
unconscious defence mechanisms, 73
unconscious desire
  manifestation of, 73
  post-partum depression, 80–1
undecidability, zone of, 160–1
understanding
  definition, 11
  mutual see mutual understanding
  reciprocal in care, 171
  tact relation, 183
unfolding see fold/unfolding
Ungreifende (Encompassing), 75
Unheimlich (The Uncanny), 30–2
unsaturated cyphers, 76
unsociability, schizophrenia, 103
Urphänomen, 175
Usener, H, 13–14

V
value, 3, 16, 32, 33, 65, 149
corrections, 172–3
desire for recognition, 50, 53, 54, 89
gender dysphoria, 88
identity, 116
non-renounceable, 100
post-partum depression see post-partum depression
production of, 25–6
story, 170–1
in therapy, 122
Varela, FJ, 140
Verdrängnung (repression), 34
Verzweiflung, 82
Vessey, D, 194
Vico, GB, 58
victim, identification with, 161–2
vision, recognition, 146
vulnerability, 3, 4, 26–7, 122
borderline existence see borderline existence
definition, 177
heteronomic, 166
to madness, 156
to mental illness, 117–18
normative, 67
perceived, 132

P.H.D. method see P.H.D. method
in schizophrenia, 149, 150–1
symptoms, 75
treatment of, 80

W
We-relationship, presupposition of
You-orientation, 51–2
Westen, D, 73
Wilkins, R, 87
Williams, B, 155
Wilson, T, 147
Wirklichkeit see reality (Wirklichkeit)
woman, performance as, 87
words, unfolding, 140
world-experience, patient, 151–2
world-project, reconstruction of
(P.H.D. method), 122
Wyrsch, J, 149

Y
'You,' 19–21

You-orientation, We-relationship
presupposition of, 51–2

Z
Zahavi, D
empathy, 124
foreign normality, 139
story, 169
zone of undecidability, 160–1