AA P&P Association for the Advancement of Philosophy and Psychiatry

Bulletin

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From the Editor

Let me first express my appreciation to Françoise Dastur and Jean Naudin for sharing their rich discussion of the applicability of Paul Ricoeur's work on ipseity for the field of psychiatry. The founding premise of AAPP is that the disciplines of philosophy and psychiatry/psychology have much to offer each other, and this discussion is a strong reminder - on this occasion with a Continental accent - of what philosophy can offer to psychiatry. Their discussion poses a strong challenge to some of the dominant shibboleths of contemporary psychiatry.

In contemporary psychiatry we live, quite famously and unabashedly, in the era of the brain. Neuroscience, psychopharmacology, DSM-IV, and the medical model reign, and woe to the practicing clinician who does not at least try to ground his or her practice on its neuroscientific plinth. In this context what should we make of Naudin's remarks that "With this concept of self [ipseity] psychiatric experience is no longer centered on nosological categories or symptoms but on the manner in which the subject reappropriates to itself what it encounters, the manner in which it reassumes the world in its own way to give it meaning (it is in that way that Merleau-Ponty defined transcendental activity). Diagnostic categories, because they - like the Ego - are already constituted, teach us nothing about the subject as such...With the idea of ipseity there is nothing of nosology, there is simply human beings, their suffering, their capacities and incapacities, the tension - always paradoxical - between their fragility and their responsibility." Diagnostic categories and our beloved DSM-IV are for sure taking something of a beating here. To this challenge to the familiar psychiatric categories Dastur adds: "To see mental disorders as disorders of ipseity allows us effectively to understand that what we call 'mental illness' does not consist in the disintegration of certain faculties but in a global disequilibrium of the existent, who is no longer able to maintain his own identity through change."

Now a question emerges from these statements: are the authors simply rejecting the medical/disease model of psychiatric illness? The answer is, I think, ambiguous. On the one hand, Naudin the psychiatrist, says that "The disorder is then only one aspect among others through which the psychiatrist can penetrate further into the existence of the subject." He recognizes the disorder but does not make it primary. On the other hand, Dastur the philosopher, in suggesting in the above citation that we should see mental disorders as disorders of ipseity moves closer to a frank rejection of the disease model. Certainly for both of them what is important is the notion of a disorder of ipseity as opposed to anything like the traditional notion of a diagnostically based psychiatric disorder. Presumably, to say that someone suffers from an anxiety disorder or a depres-

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President's Column

Over the years, I have noticed a cyclic tendency on the part of professions and organizations to go through the angst of self-questioning and self-definition. The topics are all variations on a theme: Who are we really? What is our task, our mission, our passion? What are our boundaries and how do they overlap with our near-neighbors? What are our ideals and how shall we compromise them with the demands of reality, however defined?

The self-defining must be part of homo cogitans, for it appears in a broad range of endeavors from political parties (what is conservatism or liberalism, what is the core of the Democratic or Republican party?) to anthropology (do we go native or do we remain the observer?) to nursing (what is a nurse? What does a nurse do?) to philosophy (do we chiefly clarify meanings or do we delve into the nature of underlying reality?) and psychiatry (are we strictly medical practitioners or are we physicians to the soul/psyche?). The executive committee of AAPP appears to be going through a self-defining process at this time. Assuming that such reexaminations must reflect some underlying identity crisis or debate between contending visions of a profession's or organization's mission, what might it be in the case of AAPP? It might also reflect dissatisfaction for the lack of purpose or progress in meeting the goals of the earlier position and mission statements.

Reading over the mission statement embodied in the Web site and included in the brief pamphlet and membership application form, it struck me that the statement reflects the thinking of the original founders of AAPP, some of whom have moved away from the Executive Committee and/or active involvement in AAPP itself. During these years, newer members joined AAPP and the composition of the Executive Committee changed. The newer members do not necessarily have the same vision of what they want from and are willing to give to AAPP, nor is there necessarily agreement among themselves, certainly not in sharing the near-unanimity of our 'founding fathers'. Among the obvious differences between new and old are more women (there were only 'fathers' until Jennifer Radden joined the Exec Committee) and more philosophers. The interest in phenomenology, continental philosophy, and the characteristics of abnormal experience, so dear to the hearts and minds of the founders, does not hold the same fascination to many of the other and newer members. The focus of interest appears to have changed to involve more social and political issues, as evidenced by the meeting topics for 2006 (The Moral Emotions), 2007 (Racism and Mental Health) and the forthcoming one for 2008 (Political Extremism and Psychopathology). To place this in perspective with other organizations, the theme of the XIV World Congress of Psychiatry in Prague (September 2008) is "Science and Humanism," and the announced topic of the INPP International Conference to be hosted by John Sadler in Dallas in 2008 is "Psychiatry and Freedom." The Executive Committee, aware of this pendulum shift toward social issues, has short-listed a number of more tightly scientific topics for future meetings, such as DSM-V (categories vs dimensions, embedded values, proliferation of categories, what counts as illness), Evidence-based Psychiatry, Child Psychiatry, and the impact of functional mapping of the brain on theo-

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Ipseity and Psychopathology: Françoise Dastur and Jean Naudin in Discussion

This issue of the AAPP Bulletin features a translation of "Ipséité et pathologie mentale: Debat entre Françose Dastur et Jean Naudin," published in Psychiatrie, Sciences Humaines, Neurosciences (PSN), Vol. III, March-April, 2005, with commentaries on the PSN article and a response by Jean Naudin. The article takes the form of a discussion of the importance for psychiatry of the notion of ipseity, developed, by Paul Ricoeur in his Onself as Another (published as Soi-même comme un autre in 1990, and in translation in 1992). Translation of the PSN article and of Jean Naudin's response are by the editor.

...editor

Interviewer (INT): Françoise Dastur, what is the origin of the notion of ipseity and how would you define the concept today?

Françoise Dastur (FD): We know that the notion of the "subject" only truly appears in the modern era, that although in antiquity or the middle ages man was certainly conscious of himself, he did not posit himself as an isolated *ego* constituting the foundation of all possible experience of the world. The appearance of the notion of self or ipseity in contemporary philosophy with Heidegger derives precisely from the impasses to which the notion of the subject or ego had finally led. Rather than defining himself on the basis of his relations with the world, modern man centers himself exclusively on himself, which has as its consequence the impossibility of accounting for the existence of other subjects. It is in that manner that we see in the wake of Cartesianism the absurd theory of solipsism, which consists in asserting that the ego of the thinking being is the only verifiable reality. It is Husserl, the founder of phenomenology, who is the first to undertake (in the fifth of his *Cartesian Meditations*) to explicitly surpass Cartesian solipsism and to develop a theory of intersubjectivity–that is to say, of a plurality of subjects–in showing the constitutive importance for the human being of his relations with time and with his fellow humans. It is in taking off from the same critique of solipsism that Heidegger will be led in *Being and Time* to substitute for the notion of subject that of ipseity or self. The being of man is defined for him in its essence by the *relations* he forms with the world and with others–which no longer allows a definition of man as pure interiority cut off from any relation with what is exterior. Merleau-Ponty, who positions himself in the same perspective on this issue, will even go so far as to declare in the Introduction to the *Phenomenology of Perception*: "There is no inner man; man is in the world, and only in the world does he knows himself."

To define man as ipseity and no longer as subject implies a passage from the notion of ego to a *reflexive* notion of self. What is primary, then, is not the substantial being of an ego but rather the ensemble of relations which the human being has with the exterior; and it is thus only afterward, secondarily, that he succeeds in constituting himself as an identity. Such an identity is then not given in advance; it does not have the form of an invariable substantial ego; on the contrary, rather, it constitutes itself over the course of a history–which is to say, over the course of time and through the relations with others.

It is Paul Ricoeur, following Heidegger, who has developed in an extremely suggestive manner the idea of ipseity, distinguishing clearly in *Oneself as Another* two different types of identity: *idem*-identity, the mode of identity of a thing, which depends on the permanence of a substratum; and *ipse*-identity, the mode of identity of the human being, an identity that maintains itself over time and by way of fidelity to oneself.

One could then give the following definition of ipseity: it is that which constitutes the identity of that *existent* which is the human being, an identity that, far from being given in advance, has on the contrary to be constantly conquered and constantly recovered over the course of time and through one's relations with others.

INT: In what way does this philosophic concept appear pertinent to the understanding of mental disorders?

Jean Naudin (JN): Ipseity allows us to draw in the limits of psychological understanding. As Françoise Dastur has just reminded us, it is a concept that directs us how to orient ourselves no longer toward the Ego but towards the world, and toward the self as relation to the world. Orienting ourselves toward the world is to abandon popular psychology–which believes itself able to understand everything by focusing on the Ego–through a veritable reversal of clinical focus. Psychotherapy is no longer so centered on the client–as one says following Rogers–as centered on the world. The ego, identity, even when they are making progress in the eyes of the psychologist–of the coach, as one sometimes says these days–appear in the world as already constituted objects, personality traits, objects that one can construct or model at one's wish because one believes oneself able to know what they have been, what they are, or what they could be. The self as ipseity, on the other hand, is entirely a process of becoming, of coming-into-the-world. The Lacanians will no doubt say that their leader had said that a long time ago: one possible illustration of the concept of ipseity is certainly Lacan's critical translation of Freud's "*Wo Es war soll Ich werden*." Marie Bonaparte's translation falls into the trap presented by the Ego, that of Lacan not, which moves the entire problematic of psychoanalysis to the becoming of an I always-already to be constituted. With its entire past, its anchorage in the present and its corporality, the self is paradoxically always already *in a state of coming to be*. That is why one cannot reify it. All our interest in such a concept is that one cannot make it into a thing. With this concept of self, psychiatric experience is no longer centered on nosological categories or symptoms but on the manner in which the subject reappropriates to itself what it encounters, the manner in which it reassumes the world in its own way to give it meaning (it is in that way that Merleau-Ponty defined transcendental activity). Diagnostic categories, because they - like the Ego - are already constituted, teach us nothing about the subject as such. With the concept of ipseity phenomenology gives us the means to consider how each of us in his particular manner embodies the paradoxes of human identity. In an issue of *Psychiatric Information* (*Information Psychiatrique*) of 1996 we find a text of Paul Ricoeur, a lecture presented to psychiatrists that expounds this theme in an admirable way. With the idea of ipseity there is nothing of nosology, there is simply human beings, their suffering, their capacities and incapacities, the tension - always paradoxical - between their fragility and their responsibility. The concept of ipseity assists in the comprehension of mental disorders because it allows us to see, on this side of the disorder, the *paradox constitutive of human identity*. The paradox of identity precedes the disorder, it is a transcendental anteriority and not simply a chronological one. It is no longer an issue of pathology but of style. Ipseity is the structure upon which the very style of an existence is formed. This notion takes into account at once both the manner in which

a disorder can modify an existence and the manner in which the subject, as being-in-the-world, can appropriate the disorder through giving it a meaning. The disorder is then only one aspect among others through which the psychiatrist can penetrate further into the existence of the subject.

FD: It is clear that to say of a human being that he is a "subject" or an "ego" is more immediately comprehensible than to say that he is a "self" or an "ipseity." And in this regard one could consider that such a vocabulary smacks of the "jargon" affected by philosophers. To assume, however, as does the entire classical philosophy, that the "ego" is a given from the outset, does not allow us to take account of the *actual place* occupied by the "subject," of which one could say that it arises always - and as it were constitutively - after the fact of its own experience. It is this *delay* - or *secondary* quality - of the subject in relation to its own occurrence that we suggest with the notion of ipseity. And therein, in my opinion, resides the fertility of this concept for psychiatry. It is not a question of trying to restore to the mentally ill person an "ego" considered as a regulatory agency or synthetic faculty deficient in him, but rather of permitting him to recover what Ricoeur names his capacity for receptivity or openness, which alone allows him a real identity. It is this capacity that is altered in mental illnesses and not the "ego" as a rational agency, distinct from the "passions," as psychoanalysis still believes, prisoner that it remains to the classic distinctions. To see mental disorders as disorders of ipseity allows us effectively to understand that what we call "mental illness" does not consist in the disintegration of certain faculties but in a global disequilibrium of the existent, who is no longer able to maintain his own identity through change. It is essential, as Jean Naudin has forcefully underlined, to understand that the human being is a being in a constant process of becoming, that it is never able to support itself on an identity that is fixed and already full constituted, but that on contrary it has, daily as it were, to reconstitute its identity against the disturbances that inevitably confront it from the passage of time, from the world, and from others.

INT: What kinds of disorders could be more particularly defined as disorders of ipseity?

JN: There is, *a priori*, no place for defining a new category of mental disorders that one could call "disorders of ipseity." That would be philosophical nonsense: kick nosology out through the door, it slips back in through the window - even when the house is occupied by a phenomenologist. Phenomenological psychiatrists experience a lot of difficulty fighting this nostalgia for diagnostic categories that has until now led them to describe "the world of a schizophrenic" or "the lived time of a melancholic." I have myself participated in this process, but I think that fundamentally it is a misunderstanding. It's not worth the trouble to add another level in inventing another label. Phenomenology can only be of service to us in not allowing us to sink into the ruts that our profession, through the force of its tradition, has carved out in advance. I would like at this point to invoke Arthur Tatossian as an example. Shortly after the appearance of *Oneself as Another* Tatossian found in the heuristic richness of the notion of narrative identity the idea of a parallel between types of literary narrative and types of psychological disorders. He saw in the style of existence of the *typus melancholicus* described by Tellenbach and Kraus a form of reduction to sameness (*la mêmeté*), the self entirely absorbed by an overidentification with it social role, and in the lost sameness of the schizophrenic a nakedly exposed ipseity. But the most interesting thing is that Tatossian qualifies this idea, which is indeed his own, as *simplistic*. How can such an idea, so rich, be qualified as simplistic? Because it retains without really discussing it the notion of a disorder, and even the idea that the disorder can be divided into several categories. Tatossian finds a compromise solution, perhaps the only one possible: apart from the fact that ipseity is not reducible, in the question of mental disorders it is a matter not of categories but of types. No person exists in a pure state of one type or another; there is a continuity among mental disorders, but also between these disorders and normalcy. I believe that, to pursue this still further, we would have to reformulate the question in bringing it back to the subject: for example, how do his problems (or his disorder) allow him to still be himself? How, if that is the case, do they hinder him? The paradox of identity is read here in terms of capacity and incapacity. What is the person capable of, and what not? With respect to schizophrenia it is quite evident that the more a person is capable of a philosophical questioning, the more he is able to define in his own words his disorder as a disorder of ipseity, and from that fact to recognize himself as much in his disorder

as in the limits they impose on his development. Like Anne, the patient of Blankenburg, schizophrenics in speaking of their pathology often know better than anyone else how to speak about ipseity. I don't know whether we need to conclude from that that their disorder is specifically one of ipseity. I tend to think that, but it needs to be proved, and here we leave the domain of philosophy for that of the empirical sciences.

Joseph Parnas has expressed the idea that the disorders of the schizophrenic spectrum, in the initial phase of the illness, would be in a sufficiently specific manner disorders of ipseity. Through case presentations presented in a very subtle manner, he describes in these patients as a kind of dilemma tied to their experience of self, always at the same time reflexive and prereflexive, what one could call an autoaffection: if the disorders of ipseity remain thus defined as dilemma, and not as deficit pure and simple, if they manage not to be reified into a new diagnostic category, then I subscribe clearly to this idea. The idea of helping the patient to express such difficulties in a semi-structured interview does not shock me, quite the contrary. The field can be freed up for the personal expression of the disorder or problem, which is the case in the scale of ipseity proposed by Parnas and which Michel Cermolacce has just translated. In contrast to the majority of available scales, this instrument singularly puts the accent on the participation of the subject in the world and on the relation of the embodied subject to himself. The philosophic concept of ipseity certainly loses something in this, notably its most ethical dimension, tied to its temporal dimension. Values such as fidelity to oneself, loyalty, or of course the famous example of a promise, are obviously not measurable entities. But psychiatry gains here a remarkable tool. The relations of psychiatry and philosophy are thus formed from a cross-fertilization, and without any doubt - I don't know if one can say it in this manner - from a mutual and necessary *denaturalizing*.

FD: I am in complete accord with Jean Naudin on the fact that there are no specific disorders of ipseity that would be distinct from other pathological disturbances. We can simply consider that certain psychopathologies make apparent, more immediately than others, that what is essentially in question in a psychopathology is the relation of the patient to himself. That is the reason for which I gave as an example in my article [from same journal issue] the condition of PTSD. It seems to me indeed that the experience of trauma is precisely that of an impossibility to remain oneself in the face of an overwhelming event. It's the self in its capacity for receptivity and openness that is here in question. There is certainly in every traumatic experience a moment of brute suffering where this capacity for openness is blocked, and it is only gradually, and through a narrative process - which consists in recounting to oneself as well as to others what has happened - that this moment of disintegration of the self can be surmounted. It is when this narrative capacity is deficient that PTSD sets in. In the case of melancholy, it is equally a matter of an incapacity to be open to events, precisely because, through their unpredictability they strongly shake up the defenses the melancholic has erected to set spacial-temporal limits on his action. The overidentification of the melancholic with his social role manifests in equal fashion his incapacity to freely determine his own identity. Here it is an issue of a contraction, a sclerosis of ipseity. With the schizophrenic it's the very foundation of ipseity, the soil on which consciousness of one's identity can be identified, that is deficient. One can in fact only be a self on the foundation of a community with others, of a sharing of the world with other beings like ourselves. This is what Blankenburg appropriately calls the "loss of natural evidence." It is thus the very constitution of the self that is here impossible, and with that the encounter with others as well as of events.

INT: Without its being pathological, are not certain individuals able to think of themselves and their lives apart from any narrative, without living as the agent of a personal history with a meaning. In other words, does ipse-identity necessarily imply a self-maintenance across time?

FD: I have a hard time imagining a human existence that does not possess this narrative structure. It is of course necessary here to take the term narrative in a broad sense: it indicates less the construction of a scenario taking account of all the vagaries of a life than the fact of attributing, at times even in an exclusively retrospective manner, a meaning to one's actions in a manner to give them at least a temporal coherence. A human existence that would unfold in a pure juxtaposition of unrelated moments would be devoid of any memory or foresight and would in that way approach the status of a pure unconscious. We can no doubt consider that mania comes dangerously close to what would be a style of existence totally "unglued" from a temporal point of view, since the patient in the manic state no longer succeeds in tying his present either to his immediate past or his near future. But this is precisely only a matter of a state within the context of a global disorder that is a possible form of human existence. To sustain oneself across time - that is in some manner the fundamental task that human beings take on, a task undoubtedly not always (and even perhaps never) correctly accomplished, but which remains the ideal to which all aspire, including the psychotics, of which we know that they seek precisely that identity that is lacking to them.

JN: I don't have anything to add to what Françoise has said. I am in complete agreement with her. I have never met such a person, a person absolutely without history. Wilhelm Schapp, one of the inspirations of Ricoeur's philosophy, says that there is never a history isolated onto itself. If I thought I had ever in my life met a person so isolated that he was no longer connected to any history with others, I believe that I would be better off finding another profession. That said, one can invoke limit-situations in which only the other can take on the task of assisting in constituting a narrative tissue. The emptiness of certain individuals immersed in states of apathy or derealization following a cerebral vascular accident can constitute an organic model of psychosis. Even more than in the case of PTSD invoked by Françoise Dastur, here there is not any possibility of a memory of the trauma. The entire therapeutic work is to help these individuals, in whatever measure possible, to recover some narrative threads with which to weave a tapestry of their lives, to search for whatever still persists of a continuity between the trauma and the aftermath. I think here of the work of Hélène Oppenheim with respect to what she calls "shipwrecked thought." It is necessary that something happen for the person to be able to recover a narrative thread. It often becomes apparent that the narrative capacities of the individual were not fully developed before the traumatic event. But in every case, as Françoise Dastur has clearly told us, to want to integrate any trauma into the context of our life defines our very humanity. I don't consider myself as having the right to think that someone could escape that task.

INT: Identity is not a given from the outset. It has then a fragile character; it is to be constructed, but with what margin of

freedom?

FD: We must emphasize that this fragility is something everyone experiences in the course of his existence. One could then say that no one ever completely eludes an identity crisis that is prolonged through the duration of one's life. In my view, the fact that one's identity remains in crisis in no way constitutes an exception but is on the contrary the normal state of the subject, whose identity is not that of an immutable substance, enduring through all change and given once and for all, but rather a fidelity to oneself, or more a maintenance of oneself through change. We certainly do not choose in an arbitrary manner what we wish to be, and each one of us has to reckon with certain factual givens such as one's sex, the physical character one has inherited, the culture into which one was born, the language one speaks since infancy, the name one bears, etc. But what one is "by nature" or "in fact," one must still and always "become," that is to say, "assume" it in a positive or negative manner; and it is in that precisely that consists human freedom. We must see that it is precisely because our freedom is in this regard total that our identity remains a problem for us throughout our life. Ipseity is not a given from the outset; it is on the contrary a conquest, and thus a work of freedom.

INT: Human identity is not automatic. It rests on a certain temporal continuity, but a temporality structured by isolated events, unpredictable, at times events of rupture, or indicative of a contradiction with the idea one has of oneself. Is this not a way in which psychopathology might insinuate itself?

FD: We are indeed all fundamentally exposed to the unpredictability of events, and it is in trying to protect ourselves from this that we construct the defenses we call habits, and that we also elaborate an image of ourselves to which we force ourselves to remain faithful. But these protections do not always prove to be sufficient, and every human existence knows those moments of crisis when the entire edifice of an existence can witness itself being put back into question. Temporal continuity is then never assured in advance, it can always experience interruptions, and it is indeed in those moments that one runs the risk of turning toward psychopathology, that is to say, in the impossibility of insuring *by oneself* the continuity of one's own existence.

JN: The way in which anxiety surprises us at the moment we least expect it makes me think that the verb "insinuate" is well chosen. But the word 'psychopathology' is here still problematic. Anxiety in itself has nothing of the pathological about it. Was Kierkegaard sick? Today would we have given him antidepressants or anxiolytics? Would we have recommended psychotherapy? Being ill presupposes a qualitative difference - not just a fundamental upheaval of one's existence but also an incapacity to think through the upheaval in the categories that until then were available to the subject, who, with the assurance of their availability, guaranteed his freedom. Psychopathology begins with the incapacity to think freely. As psychopathology becomes chronic and in its particular manner impedes the free flow of one's life, it squelches the ability to discern the nature of the psychological crisis. Our habits, in their character of "sameness," are like a soil that guarantees our freedom; they are the place from which our distant flights from them are possible. They become a brake when they are associated with psychopathology and close off a little more the horizon of existence. The entire problem turns upon the capacity to think. It is when we are not longer able to think, most often in the immediate aftermath of the crisis, (in the following instants, hours, and days) that, to speak properly, we fall ill. Ricoeur himself has said that the discordance between idem-identity and ise-identity can extend "all the way to a rupture." When the psychological crisis can not longer be thought through on the basis of a renewal of 'sameness', psychopathology emerges from this rupture and installs itself in the gaps of one's life in an effort to fill them. Psychopathology is like a bad reprise on the thematic material of one's life. In order to reconstruct one's world, one has to show oneself once more able to think, that is to say, able to reconnect the bonds of one's life. Thinking presupposes formulating the event into narrative. Byron Good, inspired by Ricoeur, has said some striking things in this regard. The reconstruction of one's world will have to pass through the formulation into narrative of the illness itself.

INT: Françoise Dastur, you indicate that the relation to others is constitutive of ipseity. How do you conceive of this relation to others?

FD: There are no doubt two dangers to

Xth International Conference on Philosophy, Psychiatry and Psychology

(Preliminary Announcement)

Psychiatry and Freedom

October 6-8, 2008
(*tentative dates)*
Dallas, Texas

This international conference combines invited and submitted papers and structured debates on a range of themes concerning the relation of psychiatry and human freedom. The intended audience would be the public, mental health professionals, philosophers, social scientists, ethicists, humanities academics, and policymakers. The conference is organized around topical sections encompassing the "Psychiatry and Freedom" theme. We are currently developing a call for abstracts and need volunteers to serve on review committees for each of the topical themes. We also welcome proposals for novel topical sections relevant to the general theme of Psychiatry and Freedom. For further information and questions, please contact John Z. Sadler, MD, contact information at bottom of notice.

Hosted by the University of Texas Southwestern Medical Center and the Association for the Advancement of Philosophy and Psychiatry.

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avoid in relations with others: an authoritative stance of oneself toward the other, which leads to the misrecognition of the other and the construction of a fantasy-ridden, all-powerful "self"; and a passive submission to the other, which can lead to the total disintegration of personal identity. We see quite well in the two cases described above the psychopathologies that can develop. The relation to the other is in fact always destabilizing, and when the destabilization does not take place, we are no doubt witnessing an identification with the other, or on the other hand an immoderate swelling of the self, both of which are in themselves pathogenic. But what we must understand well, I believe, is that the other is always already "with" me, which is to say that a large part of what constitutes my so-called personal experience is founded on that of the other. The face-to-face encounter with the other, which can be at times disturbing even for the individual considered normal, and which is all the more disturbing for the psychotic, presupposes in fact a bodily complicity that has already been established since infancy, and which forms the background of every new encounter with another. It is then not "against" the others that one can form one's identity, but on the contrary in close relations with them. Which implies a capacity to receive that which the other brings, and which is alien to the one receiving it. Now to receive is not to let oneself be invaded by the other or to submit passively to him; it is rather to *respond* to what is thus given, which means to integrate it into own's own experience. Here there is what could be called a "dialectic" of self and other that is at the foundation of every possible community with others. It is precisely this capacity to share the world with others, to exist with others in a common world, that is fundamentally altered in the various psychopathologies.

JN: Here again I can only endorse Françoise Dastur's statements. An interrogation regarding this idea of "community": I'm struck by the fact that our discussion of ipseity tends spontaneously to orient itself toward the patient, but seems never to be directed toward the psychiatrist, or any other interlocutor of the patient. Now, psychiatry involves an encounter. Ipseity presupposes reciprocity, and notions like loyalty, justice, promise, and fidelity imply an appeal coming from the roots of the other. As psychiatrists we also have to respond to the other, to respond to what come from the other. What we experience in the community formed by the patient, his surroundings, and our team, directly implies our own capacity to recognize the other as such, and especially to recognize him, the patient, as a person in all his singularity. Unfortunately, the first to be unready to share his experience is not necessarily the patient, but often the psychiatrist himself. Before thinking of the possibility of "disorders of ipseity," we need to consider that ipseity, being-in-the-world, are common structures, structures shared in their universality but also in a singular fashion by the patient, his surroundings, the physician, or the treatment team. Ipseity is the starting point of any possible authentic encounter.

INT: Is it not in the different types of difficulties in opening oneself toward the other that we could rediscover the grand categories of psychopathology in psychiatry?

JN: There can not be a being-with-others specific to particular psychopathology. It also is a common structure, what Heidegger called an existential. Certainly one can invoke the *typus melancholicus* in indicating that certain individuals are particularly oriented toward others and more desirous to please than to think of themselves - I am intentionally exaggerating the trait. But here the being-with-others occurs in an atmosphere of obligation, and it is by virtue of the rigidity associated with this sense of being required that the *typus melancholicus* fits into the framework of a specific type. With the melancholic the other is often experienced in the mode of identification rather than in the mode of reciprocity that characterizes a real encounter. We have all known melancholics whose concern for the other could extend as far as suicide or denial of their own existence. I have also known individuals carrying a diagnosis of schizophrenia who are oriented toward others with a genuine loyalty. The autism of schizophrenics does not necessarily manifest itself as a disengagement vis-a-vis the other. It can be a position of withdrawal, a flight in the face of the conditions established and thought by the others, but it is never an indifference purely and simply. When in invoking terms like autism or *typus* we are tempted to thus specify clinical differences in the capacities of these individuals for openness toward the other in the latter's own world, we run the risk of uncovering only the tip of the iceberg and of thoughtlessly neglecting a value hidden under the surface, the very one with which we would have to be able to work together - physician, family, patient, treating team - the question of ipseity.

FD: I am in complete accord with Jean Naudin regarding the fact that there is no specific being-with-others for a particular psychopathology. Indeed, it seems to me that this openness to others, always in question in *all* the psychiatric disorders, is closely tied to the capacity to sustain oneself across time that defines ipseity. For, in order to open oneself to the other, one must already be a self, that is, possess the reflexive structure that is at the foundation of all experience. Here we can use a simple image: in order to receive the other, to practice hospitality, one must already have an "at home," a place of reception. This place of reception and dialogue is not the ego, which always feels "invaded" by the other and threatened by him in its integrity; it is rather the self, in that it has no fixed boundaries, is open on principle to the passage of time and to others, and can thus succeed - which could constitute the ideal of every truly human existence - in 'lodging' the other in oneself.

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From the Poverty of Psychiatric Nosology to 'The Style of an Existence'

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As noted by Françoise Dastur, the term "ipseity" comes from Paul Ricoeur. His *Oneself as Another* (1992, Fr. 1990) takes up the problem of the "immediate positing of the self", as in the "I think, I am" of the Cartesian *cogito*, discussing philosophers from Descartes' time on, and especially within the tradition of phenomenology that starts with Husserl. Looking at how the grammar of ordinary language, and differences of meaning between different languages, reveal parts of "the essential meaning sought" in the notions of "I" and "self," he uses the Latin pronouns *ipse* ("he himself" "she herself" etc) and *idem* (the same) to designate selfhood and identity – not as essentially oppositional (as for example between Sartre's "in-itself' versus "for-itself") but as a triple dialectic: in reflexivity, within the self, and between self and others (pp.1-4).

As Dastur says, this is an original way of grouping and tackling the inadequacies of philosophical terms for the thinking and acting "I", such as "man", subject, ego, intersubjectivity, Dasein, self, and other. Ricoeur says that he sees the quarrel over the *cogito* where the "I" is by turns in a

position of strength and of weakness as "the best way to bring out the problematic of the self" (4). So the issue is a centuries' old one of how to consider the self – as transcendent power of thinking or as incapacity to hold its many meanings together because every effort of language and concept can only include just so much. The notion of personal identity as holding "idem" or "same-ness" in a dialectic relation with "ipseity" or "oneself-ness" gives a basis in language, with its many nuances of sense, to the tension between concepts of durable meaning and the capacity for free action and creation. Charles Taylor said in a discussion with Ricoeur in 1995 that his own *Sources of the Self* published in 1989 - a year before Ricoeur's book - had come out too soon: "What had to be thought of was the capital distinction between the *ipse* and the *idem*. It's a question we had been wrestling with for a long time " (Dosse, 1997, p. 768).

The discussion with Françoise Dastur and Jean Naudin on the role of the notion of ipseity in psychopathology is timely in recognizing the significance of this new way of dealing with the problem of identity, both as a concept and as a practical issue for patients and mental health practitioners. It goes further by providing an application of Ricoeur's rethinking of the Self comparable to the application of his work in fields such as history, literature, symbol and religious issues by practitioners with distinct methodologies. The application here is to the field of mental health, and the discussion with Dastur and Naudin takes it to the core of the discipline as it is currently being practised.

Dastur, a specialist in the work of Heidegger and Merleau-Ponty, puts the term "ipseity" into its context in the phenomenology that stems from Husserl. She also has an interest in mental health and pathology. Her article of 1992 "Phenomenology and Therapy" on Heidegger's seminars at Zollikon in the 1960s for young psychiatrists, shows Heidegger offering participants in the seminars "a method which in no way consists of making doctors into philosophers, but … of making them attentive to what inevitably involves humans, and thus of forming doctors who think." (Dastur, 2004, 122, tr. JDB). This is a practical application of philosophy which is at the same time deeply thoughtful. She takes a similar approach in the present discussion when she relates Ricoeur's concept of ipseity to the sense given the human subject by Husserl, Heidegger and Merleau-Ponty: "The being of man is defined ... in its essence by the relations he forms with the world and with others." The strength of ipseity is to avoid the thinking ego's being confined within the circle of its own thought or mind. It offers an identity that is ongoing and dynamic: "to be constantly conquered and constantly recovered over the course of time and through one's relations with others."

For Naudin, psychiatrist, philosopher, and writer constantly engaged in public discussion of mental health, ipseity frees psychology from the limits of its own understanding. With Dastur he emphasises the self as "a process of becoming, of coming-into-the world", linking this idea to the work of Freud, Lacan and Merleau-Ponty. If "one cannot reify the self", then a major shift in psychiatric practice is implied: "experience is no longer centred on nosological categories or symptoms but on the manner in which the subject reappropriates to itself what it encounters, the manner in which it reassumes the world in its own way to give it meaning." This is the key issue in his contribution to the discussion. In a lovely phrase he adds: "It is no longer an issue of pathology but of style… the very style of an existence."

What does this idea of acknowledging the psychiatric patient's behaviour as the "style of an existence" entail? In endorsing the fact that ipseity allows us to see in psychopathology a suffering human's way of handling their world, Naudin throws a practical and political bombshell into the discussion. To focus on his challenge and follow it through to the end of the discussion brings out a key issue in the practice of psychiatry and psychotherapy.

He refers to a 1996 address of Ricoeur to psychiatrists (*Information Psychiatrique*, 1996) and summarises part of it: "With the idea of ipseity there is nothing of nosology, there is simply human beings, their suffering, their capacities and incapacities, the tension – always paradoxical – between their fragility and their responsibility. The concept of ipseity assists in the comprehension of mental disorders because it allows us to see, on this side of the disorder, the paradox constitutive of human identity (which) precedes the disorder…"

This challenge marks a clear distinction between the anthropology inherent in the concept of ipseity and that found in psychiatric nosology. Naudin's claim is debatable here because it is not based directly on the text but on his paraphrase of it, and it is an application of Ricoeur's work as noted above rather than explicit in his work as a whole. However it is a transformative issue, so worth discussing here for its own sake.

It is also consistent with the ideas presented and discussed so far, except for the excision of nosology from the world of psychiatric practice for the benefit of the patient's total experience as evoked by ipseity. It is true that ipseity does not involve nosology as such, because it is a fundamental concept, a concept of a different order, and belongs within a philosophical ontology as shown in *Oneself as Another*. The nosology evoked would be that of the *DSM* and similar manuals and the resultant atomised anthropology that facilitates uniform diagnosis and is put on a par with "ipseity" by practice worldwide. Examples of other attempts to deepen the view of mental suffering that follows from such an approach are the research of German Berrios (1995) into the history of psychiatry, and Jennifer Radden's (2000) presentation of the different understandings of Melancholy over the centuries.

I have not been able to access the text of Ricoeur's 1996 lecture Naudin refers to, though numerous other addresses to doctors and psychiatrists in the 1990s are available on the web. His many mentions of "the paradox of human identity" belong with ipseity, so the last part of Naudin's summary is a direct enrichment of the concept. Ricoeur might resolve Naudin's trenchant rejection of psychiatric nosology in favour of an "ipse"-style approach to patients by referring to his own emphasis on the term "ipse" ("himself", "herself" etc) as part of a *dialectic* with "idem" ("the same"). In this context "disorders" are associated with a classification of recognizable symptoms and behaviours ("nosology"). As such, within the structure of ipseity they belong to the domain of "the same" and can be related (usefully, or with bad outcomes) to the suffering human ("ipse"). It is clear that for Naudin current nosology facilitates uniform practice, but at the price of a distorted view of human experience and suffering.

On the other side, Dastur notes that "ipseity" is less familiar as a term than "ego" or "subject", and could possibly end up being used as jargon as they have been. The interviewer asks: "What kinds of mental disorders could be defined as disorders of ipseity?", demonstrating this very risk by implying that ipseity is itself becoming a nosological term - thus epistemological rather than ontological, and like "ego" or "subject" conceptually incommensurate with the many-faceted self.

Replying that ipseity is not reducible, Naudin takes up a theme of Ricoeur's not mentioned at the start of the discussion - "capacity" - to reinforce his view of the integral nature of the subject. This is a pivotal concept in Ricoeur, and a pivotal reply which moves the discussion back on to the central issue. "Capacity" is one's experience and realization that "I can," as expressed by Merleau-Ponty in his *Phenome-*

nology of Perception (1962, Fr. 1944, 137) and emphasised by Ricoeur throughout his work. As "I can", capacity is what falls away in the experience of "fragility" noted by Naudin and taken up again a little further on by Dastur.

Related in this way, the two ideas of fragility and capacity bring ipseity into fresh focus as the human experience of being both capable and fragile; living, feeling and thinking within a shifting balance of emotional, bodily, intellectual and relational wholeness. Implicitly, the "disorders" set out (and expunged, or reformulated) by mental health disciplines are revealed as constructs dependent on cultures and periods, while "capacity" is a fundamental experience and concept, independent of fashions in thinking. Capacity accounts for our acting over time in ways we can recognize and evaluate. This is why Naudin can say further on: "Values such as fidelity to oneself, loyalty, or … the famous example of a promise, are obviously not measurable entities. But here psychiatry gains a remarkable tool."

In terms of consistent use of the idea of ipseity, I would support Naudin's view here of a constructive relation between the "tools of psychiatry" and the strengthened conceptual base Ricoeur has provided by presenting *ipse* and *idem* in dialectical relationship, while I would question the immediate divorce implied earlier between the "tool" of nosology and patients' efforts to make sense of their world. To relate the two by debating and adjusting their approaches and aims fits better with Ricoeur's preference for dialogue rather than rupture with professionals' theoretical and ethical worlds, as shown in his parallel work with jurists in the 1990s. (Ricoeur 1995, 2001). However there is room for intransigence when concepts are clearly mistaken, and Naudin implies the need for serious work on the anthropology underlying contemporary psychiatry.

Following a brief general discussion of issues that are basic existential ones rather than specific questions of psychopathology - anxiety, unpredictability, interruptions of continuity, and relations to others in terms of community – towards the end there is a return to diagnostic topics such as PTSD and autism. Here Naudin shows the reason for his earlier refusal to tie ipseity to nosological categories. Starting with the Heideggerian term "being-with-others", he makes sense of his earlier position in terms of a strong clinical attitude: "When in invoking terms like autism or *typus* we are tempted to … specify clinical differences in the capacities of these individuals for openness toward the other in the latter's own world, we run the risk of uncovering only the tip of the iceberg and of thoughtlessly neglecting a value hidden under the surface, the very one with which we would have to be able to work together – physician, family, patient, treating team – the question of ipseity."

Summarising the crucial themes of this discussion, I would comment that where Dastur reads the issues raised by ipseity in terms of the theme of being, Naudin reads them in terms of what psychiatric practice can *destroy* in being, through uncritical or unthinking emphasis on constructed categories of pathology. It is the patient – with the "physician, family, team" and others who may be involved – who must come first, so nosology is not part of the basic approach: it provides "tools" for it. What is basic is *ipse*, the one concerned, in his, her or their world: "ipseity". Naudin's challenge holds, as a warning to a conceptual and cultural approach he sees as needing radical critique and reorientation.

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Ipseity in Recovery: A Response to Dastur and Naudin

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In their provocative efforts to apply Ricoeur's notion of *ipseity* to psychopathology and identity issues in mental health practice, Françoise Dastur and Jean Naudin offer us a wonderful glimpse of the synergy that can occur in philosophical discussion. I will not even attempt to summarize their perorations, but simply throw in some tangential comments.

The first, by way of preliminary, is that as portrayed here Ricoeur's *ipseity* shares much with conceptions of personal identity coming out of the last several decades of English-speaking, analytic philosophy. As the result of the influential writings of neo-Hegelians like Charles Taylor, what is sometimes called "characterization" identity, shows up in identity politics, and in theorizing about the narrative self and the like, to the point where it has become the dominant paradigm in much work within political philosophy, feminist and ethical theory. It is a radical departure from the *idem*-type identity derived, in these traditions, from Locke and Hume that has been explored – and exploded - by twentieth century neo-Lockean and neo-Humean philosophers such as Derek Parfit. So rather than speaking of something quite new to us, Ricoeur's notion of *ipseity* introduces much that is somewhat familiar, and even the distinction between *idem* and *ipse* has recognizable - though of course incomplete – parallels in the differences between the personal identity of the Locke-Hume tradition, and identity understood as characterization identity. (Ricoeur's emphasis on the ethical dimension in *ipseity* represents what is perhaps the most obvious disanalogy between characterization identity and *ipseity*, I should add, and English-language theorists might usefully explore this dimension.)

Are there disorders of *ipseity*? This is a question canvassed but eventually answered in the negative by both Jean Naudin and Françoise Dastur - although they illustrate that psychopathology can disrupt, incapacitate and forestall *ipseity,* often in devastating ways. Thinking about possible disorders of *ipseity*, I was reminded of Oliver Sacks's terrible cases where dementia or brain damage robbed his patients of even minute-by-minute continuity of memory. With only discrete, momentary experiences left, subjectivity was reduced to "Humean froth," in

his memorable phrase. This was loss of self, indeed. And it was certainly loss of *ipseity*. But perhaps it was loss of any coherent identity, *idem* or *ipse*, loss of personhood. Even this, then, is not a disorder of *ipseity* as such.

Yet dementia, at least, if not the other disorders Sacks treats, comes incrementally. And, arguably, Ricoeur's emphasis on oneself "as another" has application here in a separate, more practical way. It enables us to recognize why and how the *ipseity* of a person slipping gradually into dementia is prolonged through the ministrations of others. It is precisely *ipseity* which, at least for a while, the delicate interventions of loved ones often serve to sustain this way. As the dementia sufferer loses her own grasp on that central understanding of herself, others, at least for a little longer, are able to reinforce and reinscribe whom she is.

There may not be disorders of *ipseity* as such, but as both Jean Naudin and Françoise Dastur affirm and vividly illustrate, psychopathology often affects and serves to at least temporarily diminish the capabilities required for *ipseity*, including those without which the dialectic of self and other so essential to *ipseity*'s narrative task would be in jeopardy. And in the context of this broad discussion of the effects of psychopathology on *ipseity*, and particularly on the self-narrative, Françoise Dastur's references to patients recovering from trauma are especially apposite. For it seems to me that the concept of narrativity may be most useful in helping us understand not disorder as such, or experience of disorder, but recovery from disorder.

Patients in the throes of disorders like schizophrenia, mania and depression, experience the disruption, exhilaration, distress and terror of their condition. Here *ipseity* may well be eclipsed, the self "as another" lost from sight, and the self-narrative devastatingly fractured in the ways Françoise Dastur and Jean Naudin describe. Only afterwards, and sometimes only long afterwards, are these patients in a position to begin the process of, as we say, "recovering themselves." In this respect, PTSD is different. All therapeutic interventions occur during recovery. The initial trauma, at least, is in the past. True, there are lingering symptoms that are the sequelae of the trauma, perhaps symptoms that are indistinguishable, descriptively and phenomenologically, from those of other disorders (schizophrenia, mania, depression). But although they are sometimes framed as the symptomatic manifestations of an underlying disease process, the symptoms of PTSD more closely resemble the symptoms of bodily trauma than those of mental disease. Just as it does upon an injury, recovery immediately follows upon psychic trauma. Thus for PTSD symptoms, an injury model is more fitting than a disease one.

Whatever their incapacitating sequelae, then, and whether or not there is total recovery, as soon as injuries occur the victim's status is that of "recovering." And the task of recovery, when the injuries are psychic, is the narrative one: recounting - to oneself as well as to others, as Françoise Dastur emphasizes - what has happened.

In such recounting, when it is difficult, patients will need help. Jean Naudin speaks of assisting patients as they find the narrative threads with which to "weave a tapestry of their lives…[and] search for whatever still persists of a continuity between the trauma and the aftermath." This therapeutic challenge may prove very difficult indeed, and more daunting for some than others, because of the nature of the trauma itself, or of some inherent fragility. Jean Naudin is surely right also in pointing out that the narrative capacities of some individuals are just not as fully developed as in others.

This emphasis on the particular part played by narrative in recovery from, rather than experience of, mental disorder suggests one final comment. Survivors,' consumers,' service users' and mental health recovery movements, at least in English-speaking countries, have in recent years contributed a great deal of pertinent writing on these themes, and we would do well to pay attention to it.

I do not mean to suggest that such memoirs were unknown until recently. To the contrary, the tradition of writing about experiences of mental disorder from the first person goes back into the early modern and even late medieval period. But increased interests by readers, and the empowerment of more people with this unique perspective on mental disorder, have recently quickened the flow of such writing.

These texts provide a rich, often philosophically insightful depiction of the efforts to those who have had to put their lives and selves together again after major episodes of debilitating breakdown and depleted identity. Reading them, one is struck by the centrality of narrative to recovery. One is also struck by the force of Ricoeur's emphasis on receptivity, or openness - for recovering from mental illness can never be a mere case of returning to where one began. Françoise Dastur reminds us that no one remains fixed, unchanging and "fully constituted," so identity crisis is in some ways the normal state of every subject. Yet in lives and identities that are disrupted and transformed by mental disorder and recovery from it, these narratives illustrate that the reconstruction of self and restoration of *ipseity,* is a task of much greater (and often quietly heroic), dimensions.

In drawing our attention to the ways Ricoeur's notions of self and *ipseity* apply to the suffering and disrupted identity experienced with severe mental disorder, Jean Naudin and Françoise Dastur offer us a thought-provoking new dimension from which to view the phenomenology of disorder and the complexities of personal identity. It is a dimension which, coupled with a reading of these mental illness memoirs, should enable us to tap, and learn from, the profound insights embodied in Ricoeur's understanding of "oneself as another."

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(Editor, continued from page 1)

sive disorder is to reduce that person to a thing-like substance suffering from a thing-like condition, and it is more philosophically correct - and presumably more respectful of the individual - to recognize his condition as a particular disturbance of his ipseity.

I have much to say in favor of this position. The biomedical model in psychiatry is in a state of chaos. Psychiatric nosology is a shambles, with large rates of comorbidity among the various disorders, and most of the latter occurring with wide spectra of presentations. Add to this diagnostic confusion our current tendency to treat many patients with a smorgasbord of medications. The era of medication/ disorder specificity - a particular medication for a particular disorder - is long past. All of which leads to the conclusion that the formal diagnosis tells us less than we would like about the patient and brings us into agreement with the position taken by the French authors that the individuality of the patient, expressed here as his or her ipseity, should command more attention than the formal 'diagnosis'.

All that on the one hand. But is there not an 'on-the-other-hand'? In focusing so intensely on the ipseity of the patient and being so dismissive of traditional psychiatric nosology, have the authors, so to speak, thrown out the baby with the bath? Let me begin this line of questioning by quoting Merleau-Ponty at the beginning of his career, the first sentence of his first major publication, *The Structure of Behavior*: "Our goal is to understand the relations of consciousness and nature: organic, psychological or even social." For Merleau-Ponty

the terms of this discussion will change, but his goal of understanding the mysterious bond of consciousness and nature will remain with him throughout his career. At the end of his life, speaking of psychoanalysis and its need for philosophy, he said: "Does psychoanalysis render man intelligible? Does it allow us to dispense with philosophy? On the contrary, it poses more vigorously than ever a question that cannot be resolved without philosophy: how can man be at once, completely spirit and completely body? The technique of psychoanalysis contributes to resolving this question along with many other inquiries, and philosophy is again at the crossroads" (M. Chapsal, *Les Écrivains en personne*, Paris: René Julliard, 1960, 151-2). I quote Merleau-Ponty because in my opinion his challenge, focused at the end of his life on the relation of philosophy and psychoanalysis but even then reprise of that earlier question regarding the relations of consciousness and nature, may be posed for any effort at a coherent philosophy of psychiatry: how, in whatever terms we use, to reconcile spirit and body. Merleau-Ponty raised this as the central issue of philosophy, but it is also the central issue of a philosophic treatment of psychopathology. My question for our French colleagues is whether they have tilted the balance far toward the direction of spirit, and away from body.

We certainly need to be cautious about our terminology in this discussion, since the various polarities addressed in a philosophic treatment of psychopathology do not necessarily map onto one another. Consciousness/nature, spirit/body, brain/body, and brain/mind allow a loose mapping; but *idem/ipse?* Is that not something different? Ricoeur's *idem* identity vs *ipse* identity does not readily map onto brain (or body) vs mind (or consciousness). In her discussion Dastur, following Ricoeur and Heidegger, opposes two views of personal identity, an isolated, substantial ego or subject - itself an interpretation of Ricoeur's *idem* - versus a non-substantial self that is fully intersubjective and that "constitutes itself over the course of a history - which is to say, over the course of time and through its relations with others." The Cartesian, solipsistic subject under attack in this discussion can hardly be equated with the brain or body in the brain/mind or body/spirit polarities (indeed, the Cartesian subject is precisely *not* the body). We are then left with a choice: either the critical discussion of psychopathology, posed in terms of the *ipse/idem* polarity will take place with no account of bodiliness or corporeality; or all that is other than the worldly, historical self described as *ipse*, will fall on the side of *idem*. In either case it seems to me that in their privileging of ipseity over traditional psychiatric categories Dastur and Naudin do end up positioning themselves on the side of mind, consciousness, spirit - whatever term we choose to use. However inadequate our current psychiatric categories, what they point to is that we are selves with bodies; and this means body not merely in the sense of embodied self (*Leib*) but also body as that which is not self (*Körper*). In other terms, we are not only selves but also organisms, and the psychiatric categories, with their admittedly failed efforts at specificity, plunge their roots down into our organic bodiliness, with its disturbances of genes, neurons, and neurotransmitters. Have Dastur and Naudin left this dimension of our being entirely out of their discussion of psychopathology?

Above I quoted Dastur to the effect that "[T]o see mental disorders as disorders of ipseity allows us effectively to understand that what we call 'mental illness' does not consist in the disintegration of certain faculties but in a global disequilibrium of the existent, who is no longer able to maintain his own identity through change." Now certainly many in our field would argue that in a condition like schizophrenia what is at stake is precisely certain deficits - "the disintegration of certain faculties" - and that the "global disequilibrium of the existent" is in fact the consequence of those deficits. This is not to say that we know precisely what schizophrenia is, or that it will not unfold as a spectrum of related conditions. It is an argument, however, that there is an organic basis for the condition and that efforts to privilege phenomenological description over organic deficit are one-sided. When I prescribe olanzapine to the disorganized, deluded patient and he shows symptomatic improvement (in his eyes and mine), I certainly seem to be altering a "disintegration of certain faculties" as much (or more?) than correcting a "global disequilibrium."

If the challenge of a philosophy of psychiatry is to strike a balance between the individual as self-constituting *ipse* and as embodied organism, I fear that Dastur and Naudin run the risk of tilting too far toward the former. A couple generations ago Medard Boss attempted to rethink psychiatry in Heideggerian terms and reframed traditional psychopathology as failures to achieve Dasein's openness (*Lichtung*). The effort failed by virtue of its extreme abstraction. It did not prove fruitful to understand everyone's problems in terms of the one category of *Lichtung*. What was intended to be an emancipation of the suffering human from the reductive strictures of traditional psychiatric categories proved to be itself yet one more reduction. My question for Dastur and Naudin is whether they are in danger of doing something similar in their focus on *ipse*ity? And whether indeed *ipse* in their account ends up as a reprise of Boss's Dasein? We are certainly self-constituting, world-open, historical selves, but we are also material, organic, constituted (*geworfen*), historically conditioned beings. I don't think that in writing *Oneself as Another*, Ricoeur intended to abandon the conclusions of *The Voluntary and the Involuntary.* Let me end by citing Merleau-Ponty yet one more time, again at the end of his life. In an implicit critique of Lacan he warned that psychoanalysis, once beset by objectivism, was now veering toward its opposite, idealism: "Thus there is an idealist deviation of Freudian research alongside the objectivist deviation (and perhaps they are not so opposed as that" (Preface to Hesnard's L'Oeuvre de Freud). In their treatment of psychopathology are our French colleagues vulnerable to the warning Merleau-Ponty issued to the psychoanalysis of his day?

James Phillips, M.D.

Response to Commentaries
Ipseity: Psychiatry or Philosophy?

We wish first to thank James Phillips for his excellent translation, as well our three commentators for their useful discussions. In this brief exchange we want primarily to hold fast to the notion that there is a danger inherent in the very practice of psychiatry in dispensing with founding philosophic questions while seeking from philosophy, along with other disciplines, answers to concrete problems posed by mental illness. That is why our position is in fact full of ambiguity. We assert this ambiguity with vigor, in opposition to a psychiatric world that, in idolizing science, tends to exclude it. A strictly diagnostic position, such as that of the dominant contemporary psychiatry, excludes ambiguity. But to let the concept of ipseity slip into that of a thing, to the point of confounding the two in speaking of a disorder of ipseity - that is to commit an error on an epistemological level. There is, so to speak, one genitive to many. It would be preferable to say: there is at the same time disorder and ipseity.

We are not opposed to the medical model as a mode of scientific access to

illness as such, as something to be known: a thing, a fact. But we are opposed to its tyranny, which attaches itself to the tyranny of the illness itself and renders it more complicated to endure. We believe in the nature of the illness, we have nothing against such a concept, quite the contrary. One part of the research effort carried out at Marseille follows the direction opened by Merleau-Ponty and pursued by Francisco Varela in the idea that the natural sciences and a philosophic attitude, far from excluding or dismissing one another, should exercise a mutual constraint in the service of advancing both philosophy and science.

We can thus only be in accord with the idea that every man is at once entirely body and spirit. The discussion reproduced here is too short; it gives the impression that we share a form of antipsychiatry, of idealism or of spirtualism, that we would distance ourselves from the body in asserting an anti-organist ideology. But that is clearly not the case. There is indeed missing in our discussion an explication of the corporal foundations of ipseity, of that which renders it possible and which determines itself as affection: auto-affection and other-directed affection at the same time. There is also missing a discussion of what in our psychiatric classifications allows us to distinguish personality traits from the symptoms that define the illness as such. It is easy, for example, to situate personality traits in the *idem* and to situate in the *ipse* that which belongs to the subject as such, in its relation to others and to itself, in its intersubjectivity; but it's much more arduous to decide if a symptom like a thought echo belongs to the *idem* or the *ipse.* In our discussions of these disturbances we usually leave out the importance of two phenomena: 1) the act of passive synthesis, purely intuitive and prereflective, which founds the unity of our Self and our lived body; and 2) the act of thought that in the patient himself reflects on both the disorder and at the same time the Self. The disorganization tied into the illness affects these types of syntheses, but it is not possible because of that to reduce the disorder to this disorganization alone without considering the fact that the Self as such is affected synthetically from the beginning once the disturbance touches our living body, our carnal body. It is not possible to lose the property of thought, as one sees in a "thought echo," without losing a bit of oneself. But the thought echo does not become for all that a disturbance of ipseity: it is obviously a disturbance of the flesh, but not a disturbance of ipseity. Ipseity is not something like consciousness, the personality, or identity. We all of us live our own body at once as a subject and as a thing. The person who suffers from a mental illness lives his symptoms in the same manner, and it is precisely that which makes him register them as symptoms and makes him slip imperceptibly from *ipse* to *idem*. And from *idem* to *ipse*. There is a moment where the person thinks that another understands truly what he is thinking, and other moments where he asks himself if it is not a matter of illness, or of something that affects his capacity to experience the world. *Idem* and *ipse* interact here in a dialectical manner, in a total ambiguity. What interests us is this moment of slippage, of the play of *idem* and *ipse*. Our argument is ambiguous because it is necessary to preserve the ambiguity as such. We are completely prepared to recognize that the play of *idem* and *ipse* is rooted in the flesh and at the same time gives it a meaning. We find a pure form of this sense of lived ipseity, for example, in the amorous caress. But what does "ipseity' mean when I prescribe olanzapine? The example chosen by Jim is perfect. Quite obviously, I am working on the organism. But the meaning that the patient and I are going to give to this therapeutic action, and the multiple syntheses it will allow each of us to accomplish - and in the best of cases both of us together - will not allow a clear differentiation between what belongs to the biological and what belongs to the spiritual. Ipseity is situated between us, between myself and the other, in intercorporeality, in intersujectivity. It is only in the encounter with the other that ipseity is truly distinguished from that which strictly derives from the "same" (*même* [*idem*]*),* from "sameness" (*mêmeté*). An isolated individual who takes olanzapine to counter the disintegration of his faculties - such a person doesn't exist. And what is important in the therapeutic act as such is the restoration of existence and not simply the restoration of the organism, as if the latter could be isolated in the *idem* and as if it sufficed to restore the possibility of repetition of the "same" [*idem*] to render the encounter with the other again possible.

The philosopher doubtless feels much affinity with the Dasein of which Boss speaks. But the psychiatrist knows that he does not encounter that Dasein if he denies the very existence of the organism. The concept of ipseity has the merit, compared to Boss's Dasein, of not proposing any idealization of existence but rather of proposing a framework of thought at once ethical and relational for situations which we meet with concretely in the practice of psychiatry. I personally feel closer to Tellenbach's style of Daseinsanalysis than to that of Boss. The "Typus malancholicus" descried by Tellenbach represents for me the archetype of Daseinsanalytic research in medicine: far from denying organicity and nature, he reunites them in a concept, the "Endon," which determines our style of existence but does not completely constitute the latter.

This is also why we have particulary appreciated the comments of Jennifer Radden concerning the role of consumers. We indeed depend on the associations of consumers to valorize their experiences in the first person: these experiences are for the phenomenological movement in psychiatry the very basis of all research. As Jennifer Radden's commentary properly underlines, in relying on the work of the consumer associations or on the first-person experiences reported by consumers, we are able to gain access to questions posed by the patients themselves regarding ipseity as such. This is one approach to research among others, but it is basic, for example, in research into the phenomenon of common sense in schizophrenia to compare the actual performances of the subjects and the relevance of their understanding of their complaints. On sees at times, as one of my collaborators, Michel Cermolacce, has shown, that the subject who describes most strongly an absence of an intellectual understanding of the illness that the schizophrenic is forced to suffer is the one who shows the most competence in such understanding in tests carried out in the neuropsychological laboratory. The response to this problem comes from the concept of ipseity, and from its creative ambiguity. The two commentaries of Jennifer Radden and Jocelyn Dunphy-Bloomfield properly insist on this point: it is the patient who reappropriates her own problems, and it is in this manner that she will get better. There is more to study in the concept of ipseity from the perspective of "recovery" than from the perspective of disorder. I would readily add that it is the play of *idem* and *ipse* that permits the subject to recover a bit of *ipse* in rejecting the disorder once it has been confined to the *idem*. The idea proposed by Dunphy-Bloomfield that nosology is in the end only a tool aiming at restoration of the *ipse* is one with which we are in total agreement.

Jean Naudin, M.D.

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(President, continued from page 1)

retical and clinical psychiatry. While the dichotomy of social versus scientific import of philosophy is clearly artificial and simplistic, there is a sense in which philosophy too has moved away from formal (logical) analyses of the subject matter of scientific disciplines into the messier as-

pects brought in by deconstruction and historical relativism.

At a more mundane level, there has been a barely articulated sentiment among psychiatrists within AAPP that topics, meetings, and even PPP are no longer relevant or central enough to the clinical concerns of daily practice. This has especially been the case during the past decade when the unrelenting corporate model of psychiatry (as all of medicine) has created a class of salaried professionals yoked to rigid time and efficiency productivity schedules that leave little time or energy for the old fashioned notions of looking for larger issues. This has taken its toll especially on the younger psychiatrists, whose need to master the art of rapid medication management, under non-medical administrators and third-party payers, threatens to take the joy out of psychiatric practice. Speaking personally, part of the joy of psychiatry has been the proximity of philosophical thinking. I say this with humility and a small "p" to philosophy; nothing elegant, just the things that philosophy has always given me: some semblance of critical thinking; some perspective on the 'meta' issues underlying accepted truths; some awareness of the need to examine assumptions that are taken for granted but are nevertheless very questionable; some tools with which to argue better; and the enthusiasm of going on intellectual journeys not knowing where they will end. I personally have found the annual meetings exciting, even when I had little initial interest in the announced topic and did not expect to find myself pulled in. It is naïve to think that the mission of AAPP can be described as simply to provide a space and forum for philosophers and psychiatrists/psychologists to talk and work together over areas of mutual interest. If philosophy has taught me nothing else, it is for the need to stick with a topic to the exhaustion point (hopefully it is the topic that gets exhausted, not the philosopher), to turn a topic over and over, think about it in depth, tease it apart, unpack it, gnaw it like a dog with a bone. This has been the test of my mettle and I have come up short too many times. So I will leave my version of the mission statement in its simple form, to provide a space and forum for philosophers and psychiatrists to work together, and invite general members of AAPP, and the Executive Committee, to think over what they want from and can give to AAPP, put it in writing as commentary or critiques on the mission statement, and send it in to the Executive Committee, as we wrestle with ourselves to find common ground and stimulating differences.

Jerome Kroll, M.D.

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MEMBERSHIP APPLICATION

Membership in AAPP is open to all individuals interested in the subject of philosophy and psychiatry by election through the Membership Committee. The Association welcomes Student Members (enrollees in degree-granting programs in colleges and universities and physicians enrolled in approved psychiatric training programs and post-graduates in post-doctoral programs). In order to join AAPP please detach this form and mail to: Ms. Alta Anthony, Journal Subscriptions/ Memberships, The Johns Hopkins University Press, P.O. Box 19966, Baltimore, Maryland 21211.

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