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

Newsletter

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From the Editor

For that scattered library of books that do not deal directly with the philosophy/psychiatry theme but are relevant to the interest, I came across another candidate a few months ago. The book is a brief memoir, *The Diving Bell and the Butterfly* (Alfred Knopf, 1997), by Jean-Dominique Bauby. The author was the 43 year-old editor in chief of the French magazine, *Elle*, when in 1995 he suffered a brain stem infarct. The stroke, which in earlier decades would have been quickly fatal, in this case thanks to current medical care left the victim alive and eventually conscious (and cognitively intact) but totally paralyzed. In fact, not quite totally; he was able to control his left eye lid. With the aid of a speech therapist he devised an alphabet organized according to the frequency of character use in the French language and slowly, letter by letter and over a several-month period, dictated the memoir. He died two days after the French publication of the book.

The title (*Le Scaphandre et le Papillon* in the original) refers to Bauby's experience of being trapped in a totally non-functioning body. A diving bell (or bathysphere) is the apparatus or container in which a deep-sea diver descends to the ocean floor and out of which he peers through a narrow slit. Such is the author's body. The butterfly of the title is his vision and mind, peering out of the immobile, thing-like body in which he is encased. It is also his imagination, which takes flight from the cadaverous receptacle and does what the body can no longer do. Bauby introduces us to his mixed experience of the "locked-in syndrome" in the opening pages of the book.

> Through the frayed curtain at my window, a wan glow announces the break of day. My heels hurt, my head weighs a ton, and something like a giant invisible diving bell holds my whole body prisoner. My room emerges slowly from the gloom. I linger over every item: photos of loved ones, my children's drawings, posters, the little tin cyclist sent by a friend the day before the Paris-Roubaix bike race, and the IV pole hanging over the bed where I have been confined these past six months, like a hermit crab dug into his rock....
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> An ordinary day. At seven the chapel bells begin again to punctuate the passage of time, quarter hour by quarter hour. After their night's respite, my congested bronchial tubes once more begin their noisy rattle. My hands, lying curled on the yellow sheets, are hurting, although I can't tell if they are burning hot or ice cold. To fight off stiffness, I instinctively stretch, my arms and legs moving only a fraction of an inch. It is often enough to bring relief to a painful limb.
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> My diving bell becomes less oppressive, and my mind takes flight like a

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President's Column

Two items from our very enjoyable and I think successful Annual Meeting in Toronto come back to me as I write this column, more than a month later. The first was Michael Schwartz's moving AAPP Tenth Anniversary Lecture, in which he reminded us of the small beginnings in friendship and shared interests which spawned what we now like to see as an important international body and a strong presence within the fields of both psychiatry and philosophy, with its local groups, its panels, meetings and discussions, this Newsletter, and its own well-respected and widely-read scholarly journal. The second is the data introduced by Australian psychiatrist and PhD Carolyn Quadrio, data which for me at least served to justify the breadth of the conference's subject matter.

Our conference's embracing theme of gender and psychiatry allowed for a range of more specific interests to find a place on the program. There was the status of women in the profession, brilliantly summarized for us by Carol Nadelson, whose own status as the very first woman to head the American Psychiatric Association gave a particular poignance to her account of the glass ceilings recently shattered, and still to be shattered by women in medicine. There was the issue of gender-linked disorders, such as depression, the somatoform, hysterical and borderline disorders and anorexia nervosa. There was the 'gendering' of certain emotional responses and states which occur at the level of symptoms, as Sandra Bartky so tellingly demonstrated in her phenomenological and feminist analysis of shame. There were methodological issues about the models and presuppositions we employ within psychiatric practice and discourse. Feminist epistemologist Lorraine Code illustrated how this applied to evaluating patient's self narrative.

Other speakers introduced the methodology of research into gender differences, the presuppositions underlying cognitive science, and historical sources of gendering in the early science which grounds today's diagnostic categories. The meaning of gender identity itself was explored in discussions of the politics of gender identity development and the category of gender identity disorder. Some analyses acknowledged the broader cultural and political context, discussing the meaning of women's depression in the era of Prozac, the force of attempts to subsume post-abortion trauma under the diagnostic category of PTSD, and the significance in a medieval religious context of what would today count as frankly pathological symptoms. In addition, the theories and method of bioethics were introduced: some of the features making feminist ethics a departure from traditional ethical frameworks emerged from Norah Martin's illuminating sketch of what a feminist psychiatric ethics might look like.

Other than the focus on gender, it may be supposed, the ties linking these diverse issues, questions and concerns must be loose, and so indeed, in some cases, they are. However, a report on empirical studies in Australia and New Zealand allowed an exciting glimpse of connections hitherto - at least by me - unforseen. Quadrio showed data for Australia apparently contradicting the widely-accepted gender link between women and depression, which was intriguing in itself. But even more intriguing, she identified sources of differential treatment in factors relating to gender. The first of these was the sex of the

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treater - which brought us back to Carol Nadelson's discussion of women in psychiatry. The fate of women as the consumers of psychiatric services is not unrelated to the sex of their treater, and will be affected, at least in part, by the broad trends we see in the profession, where women now make up almost half of clinicians in psychiatric treatment settings. More specifically, Quadrio found that at least in Australia, the treatment for women patients is likely to be 'physical' regimens such as drugs and ECT when issued by men and likely to be psychotherapy when issued by women clinicians.

This troubling finding catapulted us back to the more frankly philosophical and theoretical papers from earlier in the day, about the meaning of women's depression, and about the connotations attached to women tracing to the sixteenth and seventeenth century scientific thinking from which modern medicine derives. Are there, as earlier speakers had suggested, sinister politico-cultural overtones to the widespread application of drugs like Prozac in the treatment of depression in women? And if psychotherapy is not deemed as useful or appropriate a treatment for women patients by male as it is by female treaters, might this judgement reflect attitudes about women's nature? As we try to understand the male treaters' profile must we at least consider the legacy of early science in which women were identified with the bodily rather than the cerebral, and rationality was considered a trait only present or more strongly present in men?

Certainly, alternative explanations may account for Quadrio's data; moreover knowing psychiatry's sensitivity to culture we must be careful when drawing conclusions about our setting from Australian data. But the most obvious explanation of a treatment 'double standard' - the fact that many disorders are gender-linked combined with the clinical truism that some disorders respond to psychotherapy better than others - is not available here. Quadrio's double double standard renders such explanations insufficient: they account for why women are treated differently, but not why women are treated more differently by men treaters.

So at the least we seem required to consider the kinds of explanations noted above, and introduced into many of the philosophical and theoretical discussions at this conference, which implicate patriarchal structures and sexism deep within the practice of psychiatry even in the present day.

The great success of our conference, I think, for which all the participants deserve credit, was that it allowed for a respectful and thoughtful appeal to such theoretical material. This in turn allowed us to begin to frame a new set of links between, and even hypotheses relating, the divergent directions, ideas and approaches represented in our two days of papers and presentations. Ten years old, and AAPP continues to foster the goals enunciated in the founding president Michael Schwartz's first column in this Newsletter: to promote 'collegial support, cross-disciplinary collaboration, and sympathetic critique' for those clinicians and philosophers working in the area of philosophy and psychiatry.

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The Neurohermeneutic Forum

Mind Over Gene

The "sociobiological" idea that heredity fixes human behavior seems to have seized the American media's attention. Almost every month another claim about genes regulating fear, depression, assertiveness, sexual orientation, intelligence, or morality appears in the national press. Books by journalists like Robert Wright and Paul Johnson also promote the notion that a DNA-encoded blueprint shapes crucial aspects of our psyche. Television hammers the message home.

Last year the popular writer Tom Wolfe, both in an article for Forbes and during a PBS interview by Charlie Rose, made a pronouncement that epitomizes this trend. He anointed sociobiology's founder, Edward O. Wilson, as the principle prophet of twenty-first century thought about human nature.

Mr. Wolfe's enthusiasm seems to echo the prevailing views of his educated mass audience as the year 2000 approaches. In fact, sociobiology resonates almost perfectly with the wider cultural prejudices of fin-de-siecle America. It dovetails especially with our mushrooming penchant for market economics.

Adam Smith, patron saint of the laissez-faire right, extolled free markets because they allow "unfit" businesses to die off, making room for the growth of efficient enterprises. Smith's understanding of commerce parallels the Darwinian concept of biological evolution, in which only the fittest organisms survive to reproduce. Sociobiologists have extended Darwin's ideas to psychology, arguing that survival and reproductive success today determine which behavioral traits will spread among our progeny tomorrow. Hence, a direct Darwinian link connects the economic biases of America's political culture with the genetic determinism of pop trends in current psychological thinking.

It was not always so. Fifty years ago, behaviorism, which saw learned experience rather than genetics as the main force shaping behavior, ruled American psychology. Psychoanalysis also enjoyed wide influence: its founder, Sigmund Freud, had argued that an individual's life experiences can actually override and change inherited behavioral traits passed on to offspring. Unfortunately this aspect of Freud's outlook bore an uncomfortable resemblance to the "Lysenkoism" promoted by sinister Soviet ideologues under Stalin.

Behavioristic, Freudian and Marxist perspectives on human nature have all fallen into disrepute. Their collapse appears to have left sociobiology without any effective constraints. The ominous racial overtones of books like *The Bell Curve* have elicited only weakly argued ethical rebuttals based on egalitarian ideals but few hard facts. As a result, sociobiologists, both benign and potentially malignant, seem fated to win out over all opposition.

But perhaps not. After all, sociobiology first and foremost depends on a highly tangible molecular model of the gene for its plausiblity. It also relies on a one-way route for the expression of genetic codes in behavior. DNA is assumed to harbor some sort of brain map, but internal brain dynamics are deemed to have no significant impact on gene action.

Late breaking findings from the laboratory have begun to show that such unidirectional assumptions are false. As a prominent NIH researcher, R. Douglas Fields, has summarized in *The Neuroscientist*, electrical brain activity exerts many powerful effects on DNA readouts through "second messenger" chemicals. Hence, the gene's causal relationship to the neurobiology of behavior is not a simple, linear, one-way street. Positive feedback loops may even render some gene-brain interactions chaotic, thereby creating new

"strange attractor" configurations not predictable from genetic information alone.

These observations and insights might well end up packing enough clout to derail the entire sociobiological juggernaut. Since genetic determinism has profound political implications, reverberations from its derailment may affect aspects of our entire culture. The American media therefore has a duty to follow relevant scientific developments closely and report them widely.

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Philosophy and Psychiatry in the Literature

Jaspers K. 1997 (1959). *General Psychopathology: Volumes 1 and 2.* Baltimore, MD: Johns Hopkins University Press.

For years, many of those interested in philosophy and psychiatry have been fruitlessly wandering used book stands in search of the last published English-language translation of Karl Jaspers' masterwork, the *General Psychopathology*. Out of print since the last year John F. Kennedy was president, the book which many consider to be the single greatest descriptive textbook in psychiatry remained elusive to the non-German reading public. Now, Paul R. McHugh and the Johns Hopkins University department of psychiatry appear to have spearheaded a welcome new printing of that translation. That university's press has just printed the original text in two paperback volumes, making it easily accessible. It can be bought on the internet easily, as well as directly through the publisher. McHugh has written an excellent foreword that recreates the place and the time. The setting in which Jaspers lived and worked may be new to some of us. Apparently, he suffered from a serious illness that inhibited his clinical activities; this led him to convince his chief, Franz Nissl, to allow him to conduct library-based studies on the conceptual basis of psychiatry, resulting in the *General Psychopathology*.

The translation appears quite competent, and is liberally studded with German words along with their closest English translations. For those with a working familiarity with the scholarly German vocabulary, the text is quite approachable in this translation.

It is difficult reading, as might be expected. But it should reward those for whom Jaspers is now available first-hand and unedited.

Kandel E. 1998. A new intellectual framework for psychiatry. *American Journal of Psychiatry* 155: 457-469.

In this special cover article, Kandel expands on ideas he previously expanded in his 1980 article, "Psychotherapy and the single synapse." He provides a highly readable account of how psychiatry has evolved from the years of his early training in the late 1950s at the Massachusetts Mental Health Center, Harvard's premier psychiatric residency of that era. Where research and scientific investigation was then discouraged, Kandel leads the reader into a fascinating review of the farthest frontiers of current research in neuroscience and its implications for psychiatry. He seeks to provide a theoretical framework that will link psychiatry to progress in neuroscience, on the basis of five principles:

> *Principle 1.* All mental processes, even the most complex psychological processes, derive from operations of the brain...*Principle 2.* Genes and their protein products are important determinants of the pattern of interconnections between neurons in the brain and the details of their functioning...*Principle 3.* Altered genes do not, by themselves, explain all of the variance of a given major mental illness. Social or developmental factors also contribute very importantly...*Principle 4.* Alterations in gene expression induced by learning give rise to changes in patterns of neuronal connections...*Principle 5.* Insofar as psychotherapy or counseling is effective and produces long-term changes in behavior, it presumably does so through learning, by producing changes in gene expression that alter the strength of synaptic connections and structural changes that alter the anatomical pattern of interconnections between nerve cells in the brain. As the resolution of brain imaging increases, it should eventually permit quantitative evaluation of the outcome of psychtherapy...

This way of thinking is on the neuroscience wing of psychiatrists and philosophers, in line with the philosophical writings of the Churchlands, among others. Kandel goes on to provide illustrations of his five principles. The concept of the environment affecting the brain, central to the relatively new concept of neuronal plasticity, is a unique idea that may have important implications for theories of the relationship between mind and brain.

Kandel ends by a discussion of psychoanalysis. He indicts it with lacking a scientific culture, especially in the generations after Freud, resulting in the "anti-intellectualism" he suffered in his training. He holds out the hope that psychoanalysis

Call for Abstracts

1999 Annual Meeting

May15 and 16, 1999
Washington, D.C.
(in conjunction with the American Psychiatric Association Annual Meeting)

Theme:

The Problem of Evil

The conference invites papers examining the relationship between mental illness and abnormality and the human capacity for evil. Papers attending to the theme may include a variety of foci: experimental, theoretical, historical and case-oriented. Submitted abstracts and their corresponding papers may focus on any area of philosophy in psychiatry, but preference will be given to those papers that focus on the conference theme. Abstracts should be 600 words or less, and must be accompanied by the author's name,mailing address, and telephone number. Please attach a separate cover sheet with the identifying information. Submissions must be postmarked by November 30, 1998 to be considered. Abstracts must be ssubmitted in triplicate to (and further information may be obtained from):

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might be willing to subject itself to the search for an underlying neurobiology of the types of unconscious mental processes its theories entail. Much as academic psychology has rebounded from periods of drought and closed-mindedness, Kandel hopes psychoanalysis will turn itself into a more scientific and neurobiologically-based discipline, thereby leading to some consensus on which of its theories are true and which are not. One might hope that this will be the case; this will be up to the psychoanalysts and their skeptical friends.

Tien A., Gallo J. 1998. Clinical diagnosis: a marker for disease? *Journal of Nervous and Mental Disease* 185: 739-747.

These authors, from the school of public health of Johns Hopkins University, discuss how psychiatric diagnoses can become more valid. They make the point that many pathophysiological studies in psychiatry fail to fall along diagnostic lines. One of their main ideas is that clinical diagnoses may be too general and too abstract to correspond directly with underlying pathological changes in the brain. Since psychiatric diagnoses are polythetic (requiring x number of y symptoms to be satisfied to meet diagnostic criteria), they hypothesize that focusing on a symptom or group of symptoms may cut clinical symptoms along the same fault lines as their underlying neural substrates. They provide some theoretical background for this view from measurement theory. The psychiatrist Hermann van Praag, whom the authors do not reference, has proposed these same views over the past 2 decades. He has used the term functional syndromes as opposed to categorical diagnoses. The authors of this paper provide another perspetive on this idea from the standpoint measurement theory.

Roberts L. 1998. The ethical basis of psychiatric research: conceptual issues and empirical findings. *Comprehensive Psychiatry* 39: 99-110.

This paper is a competent literature review of relevant issues in the ethics of psychiatric research. It provides good references, particularly historical and legal sources, and it describes some interesting empirical studies on such subjects as the motivations of research subjects.

This is an important topic. Unfortunately, important matters not addressed include the issue of placebo treatments in schizophrenia and bipolar disorder, where standard accepted treatments are available. Also, the role of federal regulations, as opposed to purely scientific considerations, in the directions research methods (such as blinding and placebo controls) is an open secret that ought to be discussed in the context of ethics.

This paper is not original. But it is workmanlike and a good source for further reading.

Kendler K., Karkowski L., Walsh D. 1998. The structure of psychosis. *Archives of General Psychiatry* 55: 492-499.

This is an excellent scientific paper. It consists of rigorous scientific methods, and an equally strict focus on answering difficult questions of nosology.

The authors are well-known and highly regarded psychiatric geneticists. For full disclosure, I should mention having studied under Kendler, whose work over the years has influenced psychiatric nosology to an appreciable degree.

This report stems from the Roscommon family study, a community-based genetic study of the families of individuals with psychiatric illnesses in the Irish county of Roscommon. Earlier reports had described the prevalence of psychiatric illnesses based on careful face-to-face interviews with family members and probands. In this paper, the authors conduct a "latent class analysis," a kind of "categorical factor analysis," which compares the symptom, course, and family history characteristics of their probands. With this statistical technique, they fail to confirm a unitary psychosis theory in psychiatry, as opponents of Kraepelin proposed, and they fail to confirm a view of nosology based on a continuum of illness with only quantitative differences in symptoms among categories, as proposed by Timothy Crow. Their data do not neatly fall into a Kraeplinian dichotomy of schizophrenia and manic-depressive illness either. Yet the results are much closer to Kraepelin than to his opponents: six categories of illness emerge - classic schizophrenia, major depression, schizophreniform disorder, bipolar-schizomania, schizodepression, and hebephrenia. These terms are shorthand for the clinical and diagnostic pictures they found. The authors go on to discuss the characteristics of each of these categories in comparison with each other

Crow T. 1998. From Kraepelin to Kretschmer leavened by Schneider: The transition from categories of psychosis to dimensions of variation intrinsic to homo sapiens. Archives of General Psychiatry 55: 502-505.

Unfortunately, Timothy Crow had the opportunity to hold a reasoned scientific discussion, and instead delivered a lecture. He does not provide much of a critique of the above study. This may be because there is not much that can be criticized on grounds of scientific methodology. Instead the only argument that one can discern from his response is that the authors of the above study failed to show that any symptom or group of symptoms was *pathognomonic* of any of the proposed illnesses. His whole argument seems to come down to this. As the authors respond in their reply to Crow, this is not too convincing, given that many illnesses fail to have pathognomonic signs, and in fact, it is a minority of diseases that possess pathognomonic signs or symptoms. Crow proceeds to repeat his theories, but of supporting data he provides nothing compared to the article he was charged with critiquing.

Kendler K., Walsh D. 1998. The structure of psychosis: syndromes and dimensions. *Archives of General Psychiatry* 55: 508-509.

The authors responded with a relatively gentle rebuke to Crow's speculative response to an empirical study. They rightly point out that Crow has long crowed that empirical studies that directly assess the Kraepelinian paradigm have been rare. This empirical study is an excellent addition to the scientific literature that fills that need.

Readers can judge for themselves who is more convincing. But the lead paper and the back and forth responses that accompany it are important articles that strike to the core of psychiatric nosology. They should be studied carefully and discussed vigorously.

S. Nassir Ghaemi, MD
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Essay

Empathic-Experiential Responding in Psychoanalytic Psychotherapy: Wittgenstein's 'Further Descriptions'

In a paper in a collection of centenary essays on Wittgenstein, Cioffi (1991) writes that Carl Rogers' approach to empathically based exploration carries out what Wittgenstein terms "further descriptions" (p. 170), which can be described as making implicit meanings explicit. Cioffi states that "further descriptions are internally related to the impression they explain whereas hypotheses are externally related to them" (p. 173). He suggests that psychoanalysis may fail to assist in elucidating in the former sense and even undermine this kind of reflection and its elaboration (pp. 175, 177) as it ignores "themes implicit in the manifest content of the patient's communications ... " (p. 186). According to Cioffi, this is in part a consequence or manifestation of psychoanalysis' fundamental "conception of lived life as epiphenomenal to processes which must be laboriously excavated ... " (p. 192).

To the extent that psychoanalytically informed therapies do include this realm of reflection and its elaboration or "further descriptions" as well as the realm of hypotheses regarding causal connections (and there are good reasons to do both), it would seem that the work of Rogers and experiential therapists offers a good deal that may be helpfully integrated.

Freudian-oriented, inner-directed, uncovering therapies place an emphasis on therapist interpretations that focus on genetic reconstructive material and transference and resistance phenomena. They go beyond the descriptive-phenomeno-logical level and elucidate "to the patient how behaviors have been determined by certain dangerous, but gratifying, wishes and thoughts, which formerly the patient had to keep secret from himself or herself and others" (Crits-Christoph, et. al., 1993, p. 363). Free association also plays a critical role here, as described by Fenichel (1941): "By observance of the fundamental rule we attempt to eliminate as much as possible the regulating activity of the ego ... Then the 'derivatives' of the unconscious must become more clearly recognizable as such" (p. 32). But however clearly derivatives of the unconscious may be recognized, they do not typically present themselves in such a way that the analyst can dispense with interpretations that provide the patient with a viewpoint outside of his or her current perspective or frame of reference and immediate experience. That is, however recognizable the derivatives of the unconscious may be to the analyst within his or her frame of reference, they are often not so readily recognizable from the patient's experience and perspective, although this may change as the patient comes to increasingly utilize the therapist's frame of reference or a frame of reference to some extent jointly created by patient and therapist.

In fact it has often been suggested that one danger of analytic therapies is that of inappropriate interpretation on levels far from the patient's felt experience. Even friendly critics have noted that interpretations too often appear to be not only unsupported regarding their being grounded in and emerging from the patient's experience, but to actually contradict the patient's experience and felt sense, moving the patient away from felt experience rather than deeper into it (see Peterfreund, 1983, for an analysis of what might be termed unempathic interpretations by analysts working within various theoretical orientations). That is, they do not follow the guideline that "analysis must always go on in the layers accessible to the ego at the moment" (Fenichel, p. 44), or as some of us might say these days, the guideline that interpretations be experience -near.

In their attempt to enter into a patient's experience, analytically oriented therapists make great use of imaginative empathic responses. There is a high value placed on an intermediate mode of experiencing and knowing, a middle sphere or middle faculty between more concrete, primitive impressions and intuitions on the one hand and regular, uniform abstract concepts on the other. This sphere includes the realm of metaphor and what might be called the artistic elaboration of metaphor in an attempt to symbolize what has been largely subsymbolic, better connecting it to words as well as images (see Bucci, 1997, p. 184). However, when using this kind of empathy for interpretive purposes one can easily slide into unwarranted causal inferences that are not grounded in a patient's experience or based on other compelling evidence. For example, Kiersky and Beebe (1994) may (with the help of recent infant and early childhood research) have found a way, through empathic imagination, to sensitively and helpfully generate and share an image, "a model scene," of a "patient as infant in face to face interaction with early objects" (p. 393), with the result that the patient begins to experience related feelings and recall relevant memories. However, under such circumstances nothing necessarily follows that would indicate that the postulated early interaction structures of infancy are determinative of the patient behaviors in question. To have a therapist suggest to (and vividly imagine with) a patient that current behaviors, such as closing one's eyes in session, derive from a traumatic infancy and serve the understandably needed function of calming and regulating, may be experienced by a patient as warm, supportive, and making sense of patient behaviors in a way that may thematically or formally fit with current behaviors and potential experiencing that has been inaccessible. It may be an effective way, particularly with the more troubled and difficult to reach patients described by Kiersky and Beebe, to make contact and to help patients open to new areas of experiencing. But none of this directly relates to compelling evidence of causal relevance or to the patient's experience and awareness regarding the events that are cally inferred.

Although analytically oriented therapists have placed great emphasis on various uses of empathic imagination, there has been a relative neglect of the kind of empathic response that attempts to convey to the patient or client that one has understood, from the client's perspective or frame of reference, what the client has been (sometimes implicitly) experiencing or attempting to convey at the moment. While there has been an acknowledgment within certain analytic orientations of the value of sometimes working at the, so called, surface as well as the value of close empathic attunement in certain contexts (for a discussion of the relationship of Kohut and self-psychology to Rogers, see Kahn, 1989), analytic orientations tend not to place as great an emphasis on the unfolding richness of meaning to be found in conscious and near conscious or implicit experience through focused empathic responding and careful attunement to the nuances of experiencing as do experiential approaches. They also tend toward regarding such responses as primarily preparatory and toward encouraging more general inferences and interpretations that are grounded neither in the patient's experience nor on other compelling empirical evidence.

The empathic-experiential responses (and accompanying attitudes and ways of being) that I have in mind are important ways of engaging the client's experiencing. This kind of empathic response aims at the client's concrete feeling. For example, the response may entail directing the client to attend to a specific aspect of experience or involve an empathic attunement and response to the client's thoughts and feelings. One possibility, developed by Gendlin, is that the therapist may draw the client's attention directly to his or her own felt sense. There is an assumption that

as the client focuses on his or her felt sense it can shift and, from it, further aspects can emerge. Gendlin (1968) has used the term "felt meaning" to refer to the fact that a felt sense of a situation isn't something only felt but is also intellectual and involves, implicitly at least, thought, learning, perception and construing. A felt sense may at first be slight and easily missed. From Gendlin's particular focus, with its emphasis on the body, "usually, to let it come, one must be willing to attend quietly to inward physical sentience for a while, when as yet, nothing much is there." Yet even though a felt sense may at first be unclear, "it is already just so, 'symbolized' *interaction*, and it does not budge unless one finds those rare words, images, or moves that 'fit' ... a fit is a carrying further ... " (Gendlin, 1991, pp. 269, 270). According to Leslie Greenberg (1993), "with therapeutic development, the unsure felt sense progresses from a state of relative globality and lack of differentiation to one of increased differentiation, articulation, and integration ... " (p. 306).

More generally, we can consider that if the therapist's moment by moment attunement points to implicit (that is, sensed, but as yet conceptually not clear and articulated) complex experiencing, it is much easier for the client to continue to feel and move toward that potential experiencing and symbolize it: "What we seek to do with therapeutic responding is not at all a mere fact-finding or explaining. Instead, we seek that sort of clarifying which involves more and further living and feeling than the individual was able to do when he was stuck ... " (Gendlin, 1968, p. 214). The therapist attempts to foster the emergence of new facets of experiencing by following the client's experiential track. It is assumed that the individual knows, or has a sense of, his or her track, and that one goes by this sense of experiential track. It should be clear from such descriptions that this approach is no mere mechanical reflection of feeling, but an attempt on the part of the therapist to sensitively and accurately understand the internal world of experience and meaning of the client (see Rogers, 1976, p. 515).

This approach may be somewhat analogous to, congruent or compatible with, the common rule of analytic technique "that therapist interpretations containing material slightly beyond the patient's recognition (that is, moderately deep) are more beneficial than interpretations that go far beyond that patient's awareness (that is, very deep) or that stay very close to the patient's awareness (that is, superficial)" (Crits-Christoph, et al., 1993, pp. 366-7). In other words, experiential therapists are not simply or only carrying out analytic clarification defined as simply more precisely restating what the patient has already said.

There may be analytically oriented and experiential therapists who believe that a joining of approaches is undersirable, that analytic interpreting and empathic-experiential responding derive from different assumptions, beliefs, theories, and values. An intermingling, it might be thought, would just detract from whatever the benefits that each may offer. I believe that such a point of view is neither inevitable nor helpful.

The concern of some therapists regarding such experiential responding as general practice is, as Wachtel (1993) has put it, that it may "place restraints on the therapist's intensive probing of issues in which anxiety and conflict have led to defensiveness and consequent distortion or self-deception ... " (p. 111). But Wachtel acknowledges that such an approach "is itself a way of delving more deeply into the person's experience" that "can lead to a gradual increase in the ability to articulate experience and to clarifying and bringing into focus aspects of experience that were inaccessible" (p. 111, n. 1). Then why not learn to resonate with the client's account in this way, attend to a felt sense or pick up on the nuances of conscious and implicit experience, allow the gradual ability to articulate previously inaccessible experience to unfold in such a way? Why not sometimes utilize such a response as a baseline, so to speak, from which one moves out and to which one returns? The moving out may entail intensive probing, deeper interpretation, imaginative uses of empathy, self-disclosure, silence or more active intervention from which one would return to resonating with the patient's account, including the experience of the moving out and return. There may be points in a chain of associations at which a move to just such listening, attending, and responding may prove productive. Gendlin (1990) suggests that the Rogerian moment by moment attunement is "the central thing *with which* to use everything else" and that it is "something that one can *add* to whatever one is doing" (p. 207). The idea here is not that one maintains or returns to an empathic-experiential response because of the patient's narcissistic vulnerability or because it is good technique to start at the surface before moving deeper. It is that this kind of responding is one of the very important factors that may foster a relationship and an unfolding process in which, as Wachtel states, previously inaccessible aspects of experience are brought into awareness. The concreteness and specificity of such responding may be of particular importance in evoking previously unavailable emotional experience that can be linked to words and images.

Experiential therapists, with their process orientation, may suggest that their approach is incompatible with analytic intensive probing and assumptions about content to be explored and interpreted. It may, however, at times be a respectful, prizing thing to confront, challenge, and intensively probe with a client as long as one does so sensitively and returns to and follows where the client goes with such explorations. As Wachtel and others have suggested that empathic understanding and exploration can delve deeply, so Greenberg, Rice, and Elliot (1993), although cautious in regard to what they believe to be the often disempowering and even punitive impact of interpretations, acknowledge that interpretations outside of the clients's current, immediate frame of reference "may be experienced by clients as empathic when they are perceived as accurately representing some aspect of the client's experience" (p. 122). (And there is always the matter of finding an optimal distance and the most helpful form of empatic responsiveness with each person.) Psychoanalytic theories regarding content that may be usefully explored may be used flexibly and creatively as helpful guides to sensitize one to potential areas of exploration. They do not have to be regarded as inflexibly determining where one must go, what one must be on the outlook for, or what the patient must be experiencing on some level. Utilized in flexible and creative ways, they can help one to find the words and images that fit the experiencing, explicit and implicit. So that, for example, when Mitchell (1994) states, regarding a patient under discussion, "I would always be looking for hints of transformations of the pattern with the mother in the relationship with me ..." (p. 368), one might maintain such a consideration as an available conceptual frame that can sensitize one to certain facets of the patient's behavior and its significance without being overly constrained by always looking for hints of a particular pattern. The therapist's use of such frames and, more generally, theory should foster, not detract from, what Ghent (1994) describes as the analyst implicitly conveying (in a form that is helpful to this specific individual) that "I know you want to go deeper into your experience, and I will go with you one step at a time, always staying as close as I can to your immediate experience, knowing that

if I can 'get it,' you will point the direction to the next level of depth" (p. 485). This recommendation is not made on the basis of the severity of patient difficulties or with the assumption that one only starts in this way or at this level. (Although, again, there are considerations of matters such as optimal distance. On some related matters, see Lehrer, 1994.)

Psychoanalysis and depth-psychotherapy approaches to psychotherapy can be grounded in, among other things, empathic, experiential, focused listening, attending and responding. To the extent that recent approaches in psychoanalytic therapy encourage such listening, attending, and responding, and associated ways of being and relating, these are welcome developments. Such therapy is less likely to encourage interpretation in intellectualized fashion far from the patient's experience, more likely to find a wealth of significant meaning in the patient's conscious and near-conscious experience, and more likely to encourage exploration of the psychological depths in less abstract, more concretely felt ways. Of course where relevant knowledge is reasonably secure there may be good reasons for assumptions, beliefs, areas of focus, etc. on the part of the therapist that are not congruent with a patient's experience or frame of reference. There is always the possibility, the likelihood, that the therapist may have good grounds for believing that he or she has knowledge of aspects of the patient's unconscious beliefs, potential feelings, and motivations that are not available to the patient. As in many areas of psychological functioning, there will be implicit learning and tacit or unconscious knowledge which the patient will not be capable of verbalizing (see Reber, 1992) and in regard to which the therapist may have good grounds for making inferences. But when inferences are utilized that point and lead beyond the patient's experiencing or frame of reference, this should be, although often it is not, as clear as possible to therapist and client, as should be the basis or support for such inferences. And when offered to the client, they can be presented in an empathic way, in a way that takes account of how they are likely to be received and then with careful attunement to how they are received.

Empathic-experiential responding may encourage conditions in the therapist -client relationship that will foster more optimal use of a variety of interventions, and it may increase the number of persons who will be responsive to the therapy. It may also make more likely, in the words of Emde (1990), the kind of "therapeutic action [that] involves amelioration through a special form of developmental experience. It is interactive, it rests on empathy, and it mobilizes fundamental modes of development" (p. 900). Finally, it may provide a check against any inclination to regard lived life as merely epiphenomenal.

(After completing this paper, I came across the excellent volume on empathy edited by Bohart and Greenberg (1997). Everyone interested in the topic will learn much from the fine chapters, and those who may be thinking, "What's all the fuss? We know all about empathy and its value for therapy," or are under the impression that the topic has received its fair share of empirical research in recent years, will be in for a surprise. In a chapter on empathy in psychoanalysis, Eagle and Wolitzky suggest that "the psychoanalytic literature on empathy is characterized by a virtual absence of research and of systematic empirical data" (p. 242).

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Review

Divided Minds and Successive Selves: Ethical Issues in Disorders of Identity and Personality, by Jennifer Radden. Cambridge, MA: MIT Press, 1996.

What is a self? Psychiatrists are fairly comfortable with such concepts as self esteem, self confidence, self assertiveness and self destructiveness. Many find it useful to think clinically in terms of self -objects, disorders of self, cohesive and fragmented self, or a sense of self. But the nature of the self,...well,...itself has not been easy to establish. Is it an entity or system in the mind, or a synonym for all mental life? What are its characteristics and functions? In fact, although psychoanalysts continue to explore questions concerning the self, general psychiatrists have all but excluded such questions from their focus of concern. It seems that we can successfully characterize important psychiatric syndromes, describe and treat psychiatric disorders, without referring to the self, at all.

But the philosopher, Jennifer Radden, in her recent book, *Divided Minds and Successive Selves: Ethical Issues in Disorders of Identity and Personality*, asks us to reconsider this contemporary psychiatric approach to, or withdrawal from, the self. She asks us to re-open the question of what a self is and, even more, to consider seriously the question of whether a single person or body can be home to more than one self, either contemporaneously, or successively. Are the 'alters' of patients with dissociative identity disorder (DID) separate selves? What about the successive phases of manic-depressive illness: should we speak of a manic self, a depressed self or a euthymic self? Would it be proper, as well, to say that the various phenomena reported by patients with schizophrenia, such as inserted thoughts or made actions indicate, as such patients believe, the existence of several selves within the same body? Radden also asks us to consider a wide range of more 'normal' psychological states and processes, including ideological conversion, spirit possession, even changes of mind and impulsive behaviors, and to ask whether some or all of these phenomena might not usefully or correctly be described in terms of what she refers to as a 'multiple selves metaphysics'. (Her answer tends to be 'yes' to the alters of DID, the phases of bipolar disorder, the cases of conversion and possession, 'no' to the others.)

Most psychiatrists, I think, will want to resist a line of thought which seems to lead to the existence or postulation of multiple selves. As Radden acknowledges, the presumption of 'one self to a customer' is deeply held in our culture. Within psychiatry, especially, with its traditional emphasis on acceptance of previously unacknowledged or disowned aspects of the self, a metaphysics which seems to sanction multiple selves will initially be met with skepticism. It is important, however, to understand the reasons which underlie Radden's analysis of the self and of multiple selves and which lead her to argue in favor of a metaphysics of multiple selves. Selves, or persons, are the units or entities to which many of our most cherished attributes are attached. It is selves or persons, for example, who enjoy rights and who incur obligations. It is selves or persons who engage in actions and who, therefore, are said to have beliefs, plans and agendas. It is selves who are both the subject and subject matter of self-understanding, an important goal of psychotherapy. It is selves that other people praise or blame, trust or hold responsible, who are, to use a term which Radden introduces from contemporary philosophy, subject to the 'reactive moral attitudes' - ethical and other value judgments made of acts and of character.

Because of these features a 'metaphysics of the self' can be developed. Such a metaphysics may be thought of as spelling out the 'grammar' of selfhood - the implications of selfhood, the ways in which the concept of self is embedded in our various 'forms of life'. If we can do this, then we can ask such questions as: Is there a self present here? (yes, if it seems to have plans, awareness and a certain style, and continues through time, no, if it is merely a transient impulse) and, If there is a self present here, what implications will that have, for example, for our attitudes toward it? (such as holding 'it' responsible, or praising 'its' actions)? Radden thus uses a metaphysics of selves analogously to the use of moral principles in other branches of ethics. Principles - or a metaphysics of selves - are derived and then applied to actual ethical situations. The principles are used to answer particular ethical questions. For example, if I wonder whether or not to do x (pay back the money I owe), I may try to subsume x under some more general principle (always keep promises) and act accordingly. On the other hand, we also compare our pre-theoretic, intuitive ethical judgments to the conclusions which are drawn from ethical principles, to evaluate the principles themselves (the promise to repay Peter may be overridden by a particularly desperate cash flow situation of Paul's; so the principle to "always keep promises" may need modifying). This is the process which John Rawls has called, 'reflective equilibrium' in ethics, and Radden is engaged in a similar process in this book with respect to some of the many quandaries which are found in the difficult overlap areas between clinical psychiatry, ethics and legal theory.

Consider, for example, the problem of whether to honor advance directives made by persons with certain psychiatric conditions, such as bipolar affective disorder. In such an advance directive, an individual with bipolar disorder who believes that he may become manic at some time in the future explicitly asks to be given medication, or some other form of treatment, even though, at the time he is manic, he may refuse it. Should such an advance directive be honored? If the person in a state of mania is incompetent to make medical decisions, then his wishes at that time should be overridden. The problem is that standards of incompetence may not apply. Patients who are manic frequently drive their families and clinicians to despair by the many self-destructive things they do, which others must stand by helplessly and watch, because the individual, though manic, cannot be judged incompetent (for example, he may be fully aware of the consequences of his actions, but choose to exercise what to most others would seemto be extremely poor judgment).

For many clinicians, our intuitions are that such advance directives should, in fact, be honored: they clearly seem to be in the patient's best interest. But how can the patient's expressed wishes, expressed during a manic or hypomanic state though they may be, be overridden? That would seem a violation of basic liberty.

If the person is thought of as having a single self, extending through the phases of his disorder, it is difficult to find an ethical justification for honoring the advance directive. Radden considers a number of alternative approaches to doing so (for example, the claim that the earlier wish is what the patient would have wanted or would thank us for honoring, when his normal state is restored, or the claim that the earlier state represents a more authentic attitude on his part) and finds them all too ambiguous and hard to define to be useful. In general, among competent individuals, present expressed wishes are to be honored, not those made in the past (for example, we don't honor the wishes of ourselves as adolescents over our preferred choices as adults).

Even a 'metaphysics of multiple selves', Radden argues, would not provide an adequate justification in most cases: there is no ground, in general, for honor-

ing the wishes of earlier 'selves', over later. But in disorders such as bipolar affective disorder (and schizophrenia and dissociative identity disorder) there is, Radden points out, an additional factor: recurrence. In all these conditions, the 'earlier self', the 'self' which executes the advance directive is not merely acting, paternalistically, in the interests of the 'later self' who is manic (or whose judgment is otherwise impaired). The 'earlier self' can expect to return in the future. Thus the 'manic self' is not only harming himself. He is harming another 'self' as well, the 'earlier self' who executes the directive. And it is this fact, Radden claims, which may justify adhering to the advance directive, and overriding the expressed wishes of the 'manic self'.

This case, then, is one example in which a metaphysics of multiple selves, serving as a background principle (along with the principle that we are justified in preventing harm perpetrated by one person against another), may help guide is in tough ethical decisions. Another such case, also discussed at length by Radden, is the problem of whether and how to apportion moral and legal responsibility to the acts of patients with dissociative identity disorder. If one 'alter' commits a crime, should 'she' be held accountable for it? Should the other 'alters', or the person these alters 'inhabit'? Radden begins her discussion with a principle of Locke's that "continuity of memory is necessary for ascription of responsibility" (p. 93). Radden extends this, however, to show that I must not only remember that I have done a particular action ('It was *my* action'), but I must also (to borrow a locution from Richard Wolheim) remember *my doing it* ('It was my *action*''). Because these conditions are often not met in cases of dissociation (though Radden also distinguishes the case of culpable forgetting), $self_1$, who inhabits person A's body at $time_1$, may not be held responsible for the blameworthy acts of $self_2$, who inhabits A's body at $time_2$.

But 'holding responsible' is itself an ambiguous term, and it has more than one meaning. In a therapeutic context, a goal may be to hold different selves responsible, or to bring them to a point where 'they' acknowledge shared responsibilities for the acts of one or more of their number. It may also be to help the individual recognize her relative innocence and lack of culpability. But a legal context, as Radden emphasizes, is 'dispositive' (p. 117): in law, "Something must be done: a legal disposition is required." Radden considers the several possible arguments for excusing the behavior of the badly behaving $self_2$, and finds them all unconvincing. This 'self' may not be psychotic or limited cognitively, and it is certainly not unconscious (to itself, at least). 'She' may, Radden concludes, simply be guilty. But if $self_2$ is punished, what about $self_1$? Won't 'she' suffer, too? Punishing the innocent may be an unavoidable consequence of the facts in dissociative identity disorder, but it is not unique to this condition: innocent families of the guilty may suffer more harm when the criminal is punished, than she would herself. This, by itself, is not a reason to withhold punishment, although it may be a strong reason to temper it.

The metaphysics of multiple selves thus has application in ethics. It may also, Radden suggests, have clinical applications. In addition to the clinical syndromes of DID, bipolar disorder and schizophrenia, multiple selves can also be identified in non-pathological states: ideological conversion, weakness of the will (akrasia), and acts of self deception. Although psychiatrists now tend to see these various phenomena as belonging to separate clinical entities and, therefore, as distinct, Radden suggests that they may have much in common, phenomenologically. A particularly intriguing suggestion is that DID is actually a form of self deception. Self deception 'involves holding conflicting or contrary beliefs knowingly' (p. 71). Extreme self deception, Radden suggests, leads to patterns of internally inconsistent behavior and is, when accompanied by disordered memory or limited awareness, DID.

This is a suggestion which one wishes Radden had drawn out further. The idea that DID is an extreme form of self deception seems to imply that it is learned, or practiced and that it is, or was initially, motivated. While none of these characteristics makes DID easy to change, it does seem to imply a different model of the disorder than one which hypothesizes an individual's inherent tendency to dissociate which, mechanically, as it were, can lead to DID as a reaction to overwhelming trauma.

This difference highlights one of the important challenges of Radden's work for clinicians. For DID, and also, as we saw for bipolar disorder, Radden is concerned to re-acquaint us with the self or selves who do the behaviors and manifest the symptoms which we classify as being parts of psychiatric disorders. Selves are the subjects of what philosophers have called "reactive moral attitudes." Such reactions are attitudes - having both cognitive and affective aspects - which we hold toward others, including resentment, gratitude and forgiveness, based upon their acts, that is, based upon our seeing them as free and responsible agents (p. 96). Thus, to see an alter or a person in a manic phase of bipolar disorder as a self is to make such reactive attitudes applicable to them. Selves are also people we trust or mistrust, praise or blame, hold to a promise or not.

If we follow Radden and begin to think of our patients who dissociate or have severe mood disorders or psychosis as having multiple selves, are we keeping faith with them, or breaking it? The presumption of an underlying organic etiology has not only guided research and treatment in our field, it has also significantly shaped how patients and families think about themselves and, in many respects, this influence has been salutary. Bipolar affective disorder and schizophrenia, clearly, and dissociative identity disorder in some conceptualizations, are thought of as 'organically based' illnesses. And this has meant, for one thing, that as in other organic disorders such as diabetes or cancer, no one is blamed for them (or praised, as for a particularly effective or ingenious solution to a horrendous familial or intrapsychic conflict). It has also meant that, as in other organic conditions, therapeutic approaches are directed to 'coping with the illness', 'modifying its course', 'improving compliance' with medical regimens, and providing 'psycho-education' (presumably as opposed to education itself?). But, on these conceptualizations, the 'illness' or 'disorder' itself is not directly amenable to psychological intervention, even to the application of psychological concepts, because it is not, any more than are diabetes or cancer, an act or inherently psychological event or process. We should not (and, mostly, do not) ask, What does the manic self want? Much less do we wonder whether it should want this, or ask such questions about the self who is depressed, or delusional. We do not inquire whether the violent self in DID is wholly or partly responsible for her actions. Rather we treat these behaviors as stress reactions, try to understand their antecedents and suggest more 'adaptive' alternatives.

Here is another key point at which, I think, one wishes that Radden had spelled out her argument more fully. She claims that such 'functional disorders' as bipolar affective disorder and schizophrenia, have only a presumptive organic etiology, "the assumption or expectation that future research will disclose abnormalities of the brain to be the origins of functional condi-

tions [such] as schizophrenia and mood disorders" (p. 86). But, if organicity implies a form of disease and if "diseases excuse," then this presumption provides an explanation for possible intuitions to excuse behavior which "competes" with the kinds of explanations Radden offers. Radden seems to be saying that we should not follow this line of speculation, but, instead, should draw a clear line between functional disorders and those of known organic etiology. However, this suggestion is not immediately plausible and needs more defense. So, too, do the claims that the presence of an "organic cause" necessarily excuses behavior (what about alcohol intoxication?), or competes with other, metaphysical exculpatory principles. Radden seems to be basing her conclusions on arguments made elsewhere, and this leaves the reader uncertain whether or not to agree with her.

Nevertheless, Radden's proposal that we consider a metaphysics of selves does seem to lead to different approaches to clinical problems and to patients, than does the "presumption of organicity." A metaphysics of successive selves is not necessary for thinking of symptoms and behaviors as the acts of persons, with agendas and styles. We do not have to conceptualize bipolar disorder in terms of manic selves, depressed selves and euthymic selves, to view its various symptomatic manifestations as expressing desires and purposes. But it does seem that taking a language of multiple selves seriously, i.e., not figuratively but literally, will encourage us to direct our attention to selves and to think about the 'selfhood' of patients or of aspects of their behaviors.

The concept of self is intricately woven into many of the most valued activities of our lives: acting, holding accountable, praising and blaming, trusting, promising, evaluating the past, planning the future. Even enumerating this list highlights how completely consideration of these key 'forms of life' has been expunged from much of contemporary psychiatry. Is this a favor to our patients? When we see behaviors as reaction-patterns, or as manifestations of organic illness, we may deprive them of these meanings, and we may deprive patients of opportunities to be appraised on these evaluative dimensions. Is this objectivity? Is it therapeutic?

We certainly do not want to 'blame' patients inappropriately for the behaviors which they cannot control and do not, fully, intend. But is it honest to treat the beliefs of manic or delusional or dissociated 'selves' as merely symptoms, without *any* intentionality, motive or meaning? The intimation of hidden connections in paranoia, the grandiosity or sexual preoccupations of mania, the protective need for extreme denial and self deception in dissociation - are these really so difficult to understand and appreciate? What is most difficult, however, is to recognize and understand the implications of, for example, taking behaviors as intentional acts, or, conversely, as symptoms. There are, as Radden shows us, types and degrees of action, self deception, responsibility, authenticity and self awareness. Even in everyday life, ownership of our experiences may be incomplete and inaccurate, as when I recognize an unwelcome thought or impulse as in my mind, but alien, impulsive, mere biology. What, then, will it mean to accept it fully as mine, authored by me, reflecting my own agendas and personality characteristics - the expression of a self? It may mean acknowledging greater responsibility for what I think and say, accepting evaluations as an intrinsic par of life, and seeing more clearly the shifting patterns of gratitude and hostility, anxiety and commitment, comfort and isolation, arousal and fear, stubbornness and timidity, concern and ignorance which characterize our relationships to one another. As Radden helps us to see, these are the activities in which the concept of self has its use. The self is a concept we use to refer to aspects of our relationships to others.

In the latter part of the book, Radden considers in detail some possible objections to her metaphysics of successive selves. She fully endorses the importance of preserving the many aspects of our lives which appear to depend upon the existence of a self which persists through time. As we have noted, these involve the reactive moral attitudes as well as concepts of self understanding, acknowledgment of agency and other non-moral attitudes such as fear, praise, pride and trust - all of which seem to require a single, persisting self.

Radden's position is that we can maintain these most important attitudes, and can maintain our conviction in a persisting self (though not, perhaps, in DID or bipolar disorder) upon which they depend. That self, however, will not be a transcendental or metaphysical entity which underlies and is the subject of experiences. This will not be the self of Descartes or Kant. Rather, the self is a construction from the continuities which exist among experiences and among the skills and dispositions of a particular person. It is the links and overlaps among experiences which generate selves - "not only memories, dispositions and personality traits but also other, more general capabilities, like how to speak or swim" (p. 189). This conception of the self originates with Hume, and is endorsed, with important modifications carefully detailed by Radden, in the work of William James, Wittgenstein and, more recently, H.P. Grice and Derek Parfit.

Neither such a constructed self nor the activity of construction are directly observable. In this respect, my "eyes are shut" (Wittgenstein) and I simply act: these language games - the language games involving selves - are played. But neither is my "belief" in selves an opinion or something I can choose to give up. Again, as Wittgenstein puts it, "I am not of the *opinion* that he has a soul." Radden argues forcefully that we can and should continue to use the concepts relating to selves in the multiple important ways we do, without postulating an unobservable or mystical entity which is the subject of all experiences.

This clear, provocative book should be a wake-up call to psychiatrists to reconsider our patients as selves - active agents with hopes for the future, values and ongoing appraisals of how they are doing so far. It is a textbook application of recent philosophical theory to real clinical and ethical dilemmas. For the clinician, the book is a carefully reasoned, comprehensive introduction to a fascinating world of philosophical thought, just across the border from everyday clinical work, but for most of us, a world away.

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(Continued from page 1)

butterfly. There is so much to do. You can wander off in space or in time, set out for Tierra del Fuego or for King Midas's court.

You can visit the woman you love, slide down beside her and stroke her still-sleeping face. You can build castles in Spain, steal the Golden Fleece, discover Atlantis, realize your childhood dreams and adult ambitions...

Students that we are of Maurice Merleau-Ponty and Erwin Straus, we have a genre in which to place this memoir, that of the lived body. The book reminds one of Merleau-Ponty's analyses in *The Phenomenology of Perception*, the use of extreme cases of physical incapacity to bring out the unnoticed and taken-for-granted assumptions of lived-body experience. Of course Merleau-Ponty could not draw on a case history like this because in his day people did not survive massive, brain-stem strokes. A case history, that is, of someone who is fully conscious and cognitively intact but whose body is almost completely non-functional.

At first glance Bauby's experience seems almost a contradiction of the so-called lived body. He seems reduced to *not* living through his body. He seems more like Descartes' cogito, leading its independent, interior existence, disconnected from the extended body—in Bauby's case a particularly inert one. Merleau-Ponty could write that "...my existence as subjectivity is merely one with my existence as a body and with existence of the world, and..., when taken concretely, is inseparable from this body and this world." The words seem not to apply to Bauby, whose existence has lost its bodily expression, and whose motoric projects are reduced to the most minimal conceivable. "But for now, I would be the happiest of men if I could just swallow the overflow of saliva that endlessly floods my mouth. Even before first light, I am already practicing sliding my tongue toward the rear of my palate in order to provoke a swallowing reaction." In his unintended mockery of lived-body experience, Bauby spends his day being lifted, dressed, bathed, fed, wiped, and even breathed by others.

But of course it is completely wrong to say that his experience gives the lie to descriptions of human existence as essentially corporal. His agony is precisely that of being stripped of all *active* existence and having to submit to bodily existence as completely *passive*. It remains for all that a bodily existence; and its particular pain is felt only against a background of lost active existence. At his children's visit he writes: "Hunched in my wheelchair, I watch my children surreptitiously as their mother pushes me down the hospital corridor. While I have become something of a zombie father, Théophile and Céleste are very much flesh and blood, energetic and noisy. I will never tire of seeing them walk along-side me, just walking..." Even his escape from the diving-bell body into imagination is meaningful only against a horizon of remembered activity. "By means of a tube threaded into my stomach, two or three bags of a brownish fluid provide my daily caloric needs. For pleasure, I have to turn to the vivid memory of tastes and smells, an inexhaustible reservoir of sensations. Once, I was a master at recycling leftovers. Now I cultivate the art of simmering memories."

As you may gather from the quotes, Bauby is to the end a writer trying to articulate his experiences. To our benefit, he does this extremely well. And of course, the memoir is a project in which he reasserts an active existence. Reviewers have called him resilient and heroic. He is also curious, stoic, and wry, letting us in on his sorrow, but always understating it. To my amazement he does not seem to get depressed. Whether he fears that abyss and does not allow himself to get close to it remains unclear.

One final impression of the book. I find the author a remarkably secular man—and in that sense I suppose typical of our fin de siècle. In the memoir he is exquisitely attuned to nuances of his current existence and to the memories they evoke, but there is not one word about larger meanings—life, death, afterlife, God, etc. Moreover, since for me at least the image of the butterfly caught in the diving bell evokes three millennia of imagery of spirit and soul, starting with the Greek *pneuma* and passing through Christian, gnostic, and neoplatonic traditions, I am surprised to find no echo of this imagery in the book. For late-twentieth century man the butterfly/spirit has become imagination and memory.

James Phillips, M.D.

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