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# Sweet media death and assisted suicide: Two different experiences

*Pietro Barbetta, Ph.D.*[*], *Michele Mattia, M.D.*[**]

*Abstract.* The following essay is a reasoning concerning the assisted suicide in the media. The attempt of the essay is to create a line of flight from the mainstream argument "pro or against" suicide, the present ideological contrast that makes impossible to tell a life-script, in trying to understand why *this subject*, and not others, gives death to *It*self, transforming, through such a gesture, he/she into *It*. This reasoning affects psychology as well as history. Particularly the historical use of the term *euthanasia* as different from *assisted suicide*. The way out from the ideological argument of being pro/against is represented by the analysis of a clinical case concerning a patient named AP.
*Key Words:* Assisted suicide, Mental disorder, Ethics, Media, Clinical case.

**The emergence of the suicidal society**

Recent years have witnessed a surge in literature concerning the end of the World (Danowski, Viveiros de Castro, 2014). This new representation of the end, as in the song "This is the end" written by the group The Doors, and used by director Francis Ford Coppola in his movie *Apocalypse Now*, is the one in which the End of the World coincides with the end of the humanity: "my only friend the end", as in the words of the song.

We live in a period in which suicide finds a new expression in the idea that, since the end of the World is coming, the end of the Ego represents no more than a healing act to compensate not seeing the course of the events that are going to destroy the earth: the Apocalypse.

At the same time, as an event, suicide is impossible to deal with. There are at least two reasons which make it dreadful: the first is the radical and ideological contrast of two positions, "who is not with me, is against me". The second reason, which depends on the first, is the necessity to including suicide within the dominion of singularity.

The first reason renders the second impossible. The ideological contrast makes it impossible to recount a life-script, in trying to understand why the subject (this subject, and not others ) gives death to *It*self, transforming, through such a gesture, he/she into *It*.

Why *It*self, why we do not use her or himself, why do we use the capital letter in writing the word "It", and why do we use the italic in writing *It?*

The phenomenon of death transforms a living body (*Leib*), into a corpse (*Körper*), the subject into object. The italic character marks, on paper, the difference between one condition (living ) to another (the corpse ).

"It" is also the correct English translation of the German word "Es". Something which, in the psychoanalytical tradition, is used to mean an important part of the unconscious. For historical reasons, that we will not discuss here, the Latin word "Id" was preferred to "It" in the English translation of the German *Es*, in Freud's Work (Freud, 1924).

Notwithstanding a partial overlapping of the two words, the word *It* has an importantly different

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nuance compared to the Latin *Id*: *It* also means something vague or is a referent for something that happens or occurs. *It* announces an event, like: “it rains” or “it works”. In French the same word is “*ça*” (*ça marche*), in Spanish it seems to be “*va a*” (*va a funcionar*), in Italian, in many cases, “it” is not present at all, as in “it works” (*funziona*) (Bonaventura, 1938).

Such a difference in translation is very important. In fact, the Latin word *Id* means *This*: the ostensive gesture that accompanies the pronoun *This* consists in showing something specific: a specific thing, as, for example, a stone, or an inkwell.

At the very beginning of Hegel’s work *The Phenomenology of Mind* (Hegel, 1807), “this”, accompanied by the ostensive gesture, is the first step on the path of *Bewusstsein* (Awareness), the immediate, which, through the gesture, has already been surpassed through the mediation of the simple ostensive practice. The *This* is already a dialectical overcoming (*Aufhebung*), while the *It* is still, and forever will be, at my back. It is, in some way, as the final destiny of my life.

When I say: “I need this”, the *This* that I need is transcendent. The *It* is always immanent: *It* is desire (David-Menard, 2005). *It* comes before the ostension and is impossible to grasp. *It* accompanies me throughout my life, as time goes by and finally into death. As in ancient medicine there are four humors: blood, yellow bile, black bile and phlegm. Phlegm is the coldest one and represents the transition from life into death, from he/she into it, its narrative form is satire, its season is winter, when everything freezes (Barbetta, 2014).

*It* is not something that, through cognition, dissolves with awareness. *It* works, *It* exists, *It* is part of the reality “out there” (Pakman, 2014), although the Ego does not know *It*. The subject does not know how *It* works in theory. Subjects can only do *It* in praxis.

In his book concerning psychoanalysis, Enzo Joseph Bonaventura (2017) answers one of the major questions: how the unconscious works?

The unconscious is not awareness. Nevertheless, if the unconscious is not comparable or transformable in *Bewustssein*, as in Hegel’s *Phenomenology of Mind*, but relates simply to life-activity, how does *It* work?

In a Freudian expression *It* shows *Itself nachträglich* (subsequently). Only post-mortem one can understand the sense of someone’s life (Kermode, 2000), so the sense of our lives dwells in the life of the others.

In the final act of Arthur Miller’s 1949 play *Death of a Salesman*, Willy Loman – the salesman - attempts to kill himself; when Willy succeeds in committing suicide, Charley, his best friend, says something that encompasses the meaning of Willy Loman’s life:

> «Nobody dast blame this man. You don’t understand: Willy was a salesman. And for a salesman, there is no rock bottom to the life. He don’t put a bolt to a nut, he don’t tell you the law or give you medicine. He’s man way out there in the blue, riding on a smile and a Shoeshine. And when they start not smiling back — that’s an earthquake. And then you get yourself a couple of spots on your hat, and you’re finished. Nobody dast blame this man. A salesman is got to dream, boy. It comes with the territory» (Arthur Miller, 1949).

This makes it impossible, from a life perspective, to tell a story which tries to understand how this subject (this subject, not the other ones) give *It*self death. In the context of radical judgement, whoever tells stories is dangerous, in stories lies the danger of doubt, dissent deviation from certitude. In suicide the life-script of the subject is under trial, two groups of lawyers clash one against the other, as in war. Justice seals the field of mercy, precludes mercy, by which we mean Shakespearean mercy, the one that seasons justice.

In the movie *Whose Life is it Anyway* (1981), by John Badham, a sculptor is left completely paralised after a car crash. In a good mental state, he is kept alive by dialysis, although an argument arises between him and the medical doctor, who wants to keep him alive against the sculptor's will.

The M.D. invites the artist to enter into psychotherapy, the psychologist intends to help him write a biography for young artists and students, the sculptor declines. To him life and sculpture are the same things: if he cannot work, he cannot live, he should let him die. The M.D. refuses to withhold medication, he wants to save the artist's life even against the artist's own explicit will. Disagreements become stronger and stronger, and the audience tends to take one or another side , as with ideology.

The movie continues: different psychiatrists are consulted as advisers concerning the artist's mental condition. They have to determine whether the patient's condition is "major depression" or "reactive depression", presuming such diagnosis to be differential in deciding the artist's right to die. There is a trial, and the court decides the sculptor has the right to stop medication. The artist decides to go to die somewhere else, nevertheless the M.D. offers to let him stay at the hospital in order to die in the best conditions. What apparently was a strong disagreement with the M.D. strangely turns into an act of hospitality. The patient thanks the doctor and asks why he is doing it, the M.D. answers: "Because you might change your mind".

There are a lot of other films concerning the "right to die". Within the philosophical panorama, particularly in the Anglo-Saxon world, the debate on this subject has been going on over the last thirty years, maybe more. Nevertheless this movie is one of the few ones that shows the painful relationship between the two polarities of life and death; two different images of ethics. The M.D. has lost his battle, nevertheless remains close to the patient until the moment of passing, in the hope he will change his mind.

### ***Media* and suicide**

This is the time of the emergence, in the media, of cases that periodically involve assisted suicide. Sometimes they are celebrities or individuals who attain celebrity after suicide, post-mortem, in media news.

*Dignitas*, one of the Swiss groups addressed by Italian citizens for assisted suicide, makes a distinction between assisted suicide and euthanasia. Following *Dignitas*, "euthanasia" means good death, while life and death cannot be considered good or bad as such. It is reasonable to consider death and life "beyond good and evil", nevertheless such an argument can be valid also for the term "right to die", for the same reason: life includes in itself rights, it is impossible to talk about personal rights outside of life, it makes sense for the others who remain alive, and deals with the mourning of deaths, the dignity of their funerals, the possibility of being buried in a tomb, with proper ceremonials and a proper name. With the exceptions of the burial ceremonial, in order to talk about rights one has to have a living body, the *habeas corpus*. But "habeas corpus" is a word that makes sense only in terms of a living body. We call this paradox: *the paradox of the It*. Whenever one uses the neutral pronoun It, one is already beyond the possibility of talking about life and, of course, death. *Dignitas* was founded in 1998 and at the present time has around 4.500 associates, although the number of associates increases year by year. Associates can be provided by a number of prevention services in order to help change their mind about suicide.

Not just *Dignitas*, but many associations, inside or outside Switzerland, refuse the use of the word "euthanasia" because the word recalls the eugenic practices during the Nazi period and the Western sterilization of handicapped children that resulted, during the Nazi era, in the death of disabled children and schizophrenic patients.

The name of the most important Swiss organization for assisted suicide is *Exit*, based in the German Switzerland area. *Exit* was founded in 1982, and at present has 80.000 associates. Nevertheless new clubs of this type are emerging throughout the Swiss territory.

Any association has to follow the rules and spirit of the law. And this makes sense, and is consistent, with the practice of assisted suicide. Let us take those cases of people who are disturbed

and have been stuck by a physical disease, such as the before mentioned artist in Badham's movie, or as in the Spanish movie *Mar adentro*, by Pedro Amenabar: those people, in Switzerland, have the clear right to ask for help in committing suicide. In fact, in the first instance they have the right to stop the cure, even in a Catholic country such as Italy.

Another situation is the one in which one asks assisted suicide because of the diagnosis of a pending terminal illness. It is comprehensible that a subject asks to anticipate his/her death in order not to experience physical suffering, as in the case of the Canadian movie *Les invasions barbares*, by Denys Arcand. In addition, this case could be also be provided by sufficient drugs to reduce suffering (morphine or heroine). Where the administration of these drugs is insufficient, as happens in some Italian hospitals, the consequence could be to push people to kill themselves, death for sainthood does not edify anybody besides Catholics.

Nevertheless, suicide cannot be accepted in all circumstances. Human groups, communities and societies need particular reasons for suicide to happen. There must be exceptions, certain kinds of events or rituals, some kind of singular reason for a subject for put an end to his/her life. To quote Shakespeare: “There are more things in heaven and earth, Horatio, Than are dreamt of in your philosophy” - *Hamlet* (1.5.167-8)

We are not writing here about the many possibilities that are accepted, in different cultures, for suicide, such as, for example, to preserve dignity in the face of shame (as, for example, in Japanese Seppuku), for sacrifice (as in certain religions), for love, etc., nor is our question concerned with suicide in itself.

Our question, in the present essay, is: is the public staging of suicide something that is part of the burial ceremony, or is it something that, here and now, must be introduced into such a ceremony? Is the sweet media suicide is something that belongs to the new “psychotic social system”, or is it part of a normal change in our way of viewing suicide in the so-called post-modern society? Can we call the post-modern society a post-mortem society, without talking about a “psychotic society”?

Since Switzerland is a country where many assisted suicide agencies are located, let’s see how such practice is regulated in that country.

In Switzerland, the end of life on demand is a crime. Assistance in a suicidal action is prosecutable only when the assistant has selfish purposes. Amendment 116 of the Swiss Penal Code enacts that whoever for selfish reasons abets someone else in committing suicide or helps her/him in this direction must be punished for at last 5 years of prison or detention in the instance when suicide has been attempted.

Under Swiss law, full capability of consent to her/his act is required in assisted suicide, and the act must be carried out following such capability. In the presence of metal disorders, when such evidence involves an applicant for assisted suicide, assisted suicide is questionable. For children, Swiss regulations do not admit any possibility of this. The Swiss Academy for Medical Science, founded in 1943, in its Ethic Directives, sets out that suicide assistance in not obligatory for the M.D.

At present times, in the face of suicide on the media, we have to consider the borders beyond which suicide should not be morally acceptable. For example: in the case of depression, is it enough, as in the movie mentioned above, to have a differential diagnosis of major depression in requesting assisted suicide?

And what about a case of anorexia? And cases such as borderline disorder or impulsive suicide, in manic disorder; is some kind of prevention necessary?

All this raises discussion concerning nosology and diagnostic categories in clinical psychology and psychiatry.

It is widely known that psychiatric categories have been used in politics to seclude people, to deny them citizenship rights, to enclose them in asylums for long periods of time, sometimes life-

long, particularly in authoritarian or totalitarian regimes. During the Fascist and Nazi regimes, whoever “is not useful for human society”, this was the political definition, should be killed with gas. Such a practice was no more than the radicalization of North America and European eugenic policies from the second half of the 20th Century. In the US, the country where the “achieved status” should prevail over the “ascribed” one, *the land of liberty*, starting from 1917, there were established anti-immigration laws and sterilization programs for people who were “potentially dangerous”, such as disabled people, “weird children”, “easy girls”, the “mentally retarded” (Barbetta, Bella, Valtellina, 2015).

After World War II, starting from the 60s, psychiatrists started to discuss “the myth of mental illness” and liberate mental disease from a potentially political use of the Asylums, recognising citizenship for psychiatric patients.

It is current news that, in Italy, the CSM (*Consiglio Superiore della Magistratura*) has emanated a disposition (19 of April 2017) in which Criminal Asylums have to be definitively closed, explicitly mentioning that the enclosure of people in asylums makes mental situation of the subject worse.

Nevertheless, even if there are no more asylums, our impression is that we are entering in a era where madness is no longer something that belongs to an individual subject, but to society.

Today it is no longer the State that decides to suppress needless people. Needless [?] is a social feeling that enters within the subject. In other words, needless is no longer something that belongs to the gaze of the Other; Big Brother has taken up a position inside the subject. As a claim of an anorectic young woman in a session: “There is a Hitler inside myself!”.

So, it is easy to shift from the right of the totalitarian State to suppress minorities, to the democratic State where, in recognising freedom for everybody, freedom for people who “feel needless” is also recognised: the freedom to commit suicide.

This it is enacted via the media society, the principal means of communication in modern society. The media show of suicide, even when understandable because of justified health reasons, is the problem we are focusing on here. This public spectacle recalls public executions, has the flavour of posing an issue of justice, of Human Rights, on one hand, and of propaganda, advertisement, on the other. It seems something that has to do with both politics and marketing at the same time.

Even though done without profit and for humanitarian reasons, selling death on the market has macabre and grotesque qualities.

**A clinical case**

AP is a man of 69. Married in second weddings. From the first marriage he had a daughter now 42. He has had no contact with her for many years. AP is retired.

Psychiatric Diagnosis: Recurrent Depressive Syndrome. Treatment: SSRI and regular psychotherapy.

Medical Diagnosis: Lung Adenocarcinom at 4th stadium, pervasive visible metastatic lesions, Sleep apnea syndrome.

On august 2016 AP was hospitalised in a Swiss Hospital where, for the first time, he received the following diagnosis: Adenocarcinoma at 4th stadium metastasized. During the sessions over these days he was aware of the severe situation he was facing. Pelvis and thightbone “are fragmented”, he said. Suddenly AP declared: “If it were not for my father and wife I would have wanted out”, his wife said “AP is my whole life… if he goes, I’m going as well”.

A month later, AP underwent a pelvic reconstruction. He regained mobility and his mood improved, with new hope for the future. For six months he passed a positive period of life. Then he had a new fMRI scan which revealed the presence of new metastasis, and with the associated angst of being paralyzed and mentally incapacitated.

AP underwent radiotherapy, but suffering increased and progressively reduced his autonomy. A month later the oncological situation became dramatic, with metastasis throughout the body, brain included. The autonomy of AP was lessening: he could not walk and the pain was unbearable. The presence of his father, who was 93, helped maintain his connection with life. A few days later, his father died and AP grew insistent in his desire to put an end to his life.

The Oncological Institute of the Italian Switzerland (IOSI), where AP was admitted, supported his request, facilitating contact with Exit, supplying a prescription for Pentobarbital:

«AP is suffering a lot, I cannot imagine how much, but it is up to him, I cannot do it… It is his decision. He is not functioning any more, because this bastard cancer is spreading faster and faster. Last Wednesday, I was able to help him to reach the toilet, he was walking. By Friday he was incapable of walking. Two of us were able to put him in an wheelchair to bring him to the car to get to the hospital… he already had a bad paraparesis, which condition has continued since Saturday. He cannot move and his right leg is lifeless, as is also the left one now, which was operated on but will lose sensitivity and responsiveness. The urinary apparatus is also blocked, and when they put the catheter on him, he released almost one gallon of water».

Theses were the words of AP's wife two days before the assisted suicide.

AP's mental state has remained constantly clear, with no further signs of angst or depression; he has simply expressed an informed choice regarding the desire of put an end to his life through assisted suicide. AP's wife has remained close to her husband, with no expression of angst nor any attempt to make him alter his decision. They spent the final days of their life together 24 hours a day in a room in the Oncological Institute hospital ward. On the day before the assisted suicide, AP showed dignity, emotional interactiveness, sensitivity, strength. He recalled the most important moments in his life, he was able to apologize and was able to reconcile himself in his mind with his father. AP asked his wife to inform his 42-year-old daughter, who he did not want to involve in his disease, the day after his death.

AP looked the others the eye, expressed feelings and words, he felt his wife's energy in supporting him. Peacefully and intensely AP said farewell to life. AP quitted his his life on a Saturday at 4 PM. On this day, AP drank Pentobarbital.

His wife took some months to deal with everything suspended during the illness, absolutely convinced she would join her husband through her own assisted suicide.

AP was able to choose assisted suicide because he demonstrated no egoistic intention, and had no other possibility of an oncologic cure. He always showed a full mental capacity.

Compared to AP's situation, his wife's condition was entirely different. In order to obtain authorization for assisted suicide, more than one symptom of metabolic disease would have to be present. However, she was suffering from no disease defined as incurable from a medical point of view. Even though she was experiencing major depression, at a level that might potentially be described as incurable, she faced a large number of legal obstacles in wanting to be admitted into a program of assisted suicide. What would happen to AP's wife if she were not be admitted into a program of assisted suicide? Would she kill herself?

The controversy on suicide is religious, philosophical, political and historical, and we do not claim here to solve it in any way. Neither shall we discuss the right to die of a person who has a terminal illness or a completely invalidating disease. Although the majority of general practioners and nurses in Switzerland, and a large number of them in Italy, agree with the practice of assisted suicide in cases such as oncological or neuro-vegetative disease, opinion concerning assisted suicide in the presence of severe mental disorder switches dramatically to the opposite position. Why?

Our focus is on two main questions. Firstly: is mental disorder, at least in some extreme case, to

be considered a terminal disease or a completely invalidating illness? In such a case, all discussion over the last fifty years, at least, between libertarian anti-psychiatrists and conservative bio-medical-psychiatrists concerning mental disorders must be reversed. We are dealing with a kind of oxymoron: conservatives, who usually are against suicide, consider the biologically invalidating state of major depression to justify assisted suicide, as, for example, in the case of complete motor paralysis. Libertarian anti-psychiatrists, who consider mental illness to be a myth (Szasz, 2010), should reject any possibility of assisted suicide in cases where there is no disease at all. Even though they usually recognise suicide as a "free choice". Suicide, but not assisted suicide.

Secondly, what is the purpose of the public exhibition of suicide in the media, although assisted in a clinic? Is it a moral issue? Does it represent some form of moral claim concerning the right to die under certain circumstances? Or is it a macabre marketing practice? Why does the media feel the need to show it so frequently and not to show the surgical intervention of Mrs. X, the vaccination practices of Mr. Y, or some other medical practice?

A new investigation on the topic of assisted suicide (Kim, De Vries & Peteet, 2016) analysed 66 dossiers of patients in the Netherlands. These patients were all allowed to participate in a program of assisted suicide between 2011 and 2014. The subjects were diagnosed with severe and chronic psychiatric disorders (major depression, very severe anxiety disorders, psychosis, addiction, consequences of trauma, etc.). All patients were resistant to any kind of treatment, 80% of them were hospitalised repeated times, and all of them had attempted suicide. The majority of them reported solitude and a lack of any relationship with family members or friends. All of them were considered fully mentally capable, all expressed a wish to die, to put an end to their lives. Each considered her/his own life during recent years to have been a prolonged agony.

The moral issue arising from this investigation is: is it possible, at juridical level, for the State to authorize assisted suicide in relation to specifically psychic (or moral) suffering, and not exclusively for severe permanent invalidating or terminal bodily disease?

We are faced with the choice of whether or not to consider psychological (moral?) suffering as a basis on which an individual might be admitted for assisted suicide. Although no biological data, or neuroimaging exams can demonstrate the "material" existence of such suffering, can society consider the possibility of assisted suicide in these cases?

To sum up, it seems to us the two positions conflict. One claims, more or less: suffering depends on severe psychiatric disorders and sufferers deserve the same treatment as other comparable medical conditions. The other position claims: this is moral grief, it is something that cannot be legislated for by the State, that even though not against suicidal practices, "assistance" in suicide, as a legal practice, should not be permitted through the risk of reintroducing something similar to euthanasia.

For a large number of people, even for many practitioners, psychiatric disorders are confused with a "deficit of will", as in a certain historical tradition of psychiatry (Janet, 1929/2005), or self-deception (Fowler, 1869). So assisted suicide in psychology and psychiatry is still controversial. Even in the Netherland, where euthanasia is authorised, only 30% of practitioners agree with the practice of assisted suicide.

In term of public health there are still many question to be raised

1. How to conciliate, with the same State and with the same legislation, assisted suicide and suicide prevention.

2. Is there any impact of a legal euthanasia or a legal program of assisted suicide on suicidal averages in a given country?

3. Legal suicide is considered more acceptable in places where the Catholic Church has less influence, yet what does this mean at present times, when people who commit suicide are allowed a regular religious funeral by the Catholic Church, and why in Catholic countries is difficult to have

proper medication for reducing pain?

4. The Jewish Conservative Committee stated, in 1998 that proper response to pain should not be suicide, but pain control with pain medication. Many doctors, it asserts, are deliberately keeping such patients in pain by refusing to administer sufficient pain medications: some out of ignorance; others to avoid possible drug addiction; others from a misguided sense of stoicism. For what reason?

"Some of these reasons, is written in Conservative Judaism, are less than noble, involving, for example, children's desires to see Mom or Dad die with dispatch so as not to squander their inheritance on 'futile' health care, or the desire of insurance companies to spend as little money as possible on the terminally ill."

It is difficult to make objection to this position. From this post-modernity, a fixation on usefulness persists in the unconscious. A usefulness that no longer exists, a hidden God who cannot be reached. For the sake of usefulness people consume psycho-stimulants, perform fifteen hours a day, their income is cut, they die. All for a usefulness that is never achieved. Like an exhausting sexual act, in which one frantically attempts to reach an orgasm that, inevitably, will never be achieved, as in a play by Beckett. And everyone talks about the "right to die", nobody mentions the the sacred "right to be lazy".

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# The Rationale of the Clinical Process*

*Pier Francesco Galli***

*Abstract.* Several issues regarding the rationale that is behind the clinical process are critically examined. Some of these issues are the following: the transmission of psychoanalytic technique and its misunderstandings, the problem of truth in psychoanalytic interpretation, measurement and verification in psychotherapy, the gap between theory and technique in psychotherapy, the role of the therapist's personality factors, the problem of "classical" psychoanalytic technique and its "as if" relation with theory, "classical" psychoanalytic technique as a mark of credibility of a social group, the shift in psychoanalysis from the criterion of "truth of interpretation" (a strong concept) to that of "truth of the therapeutic frame" (a weak concept), the role of insight and the concept of the "function" of insight, the role of empathy and of unconscious communication, the conception of *Praecoxgefühl* (a feeling or experience of the schizophrenic patient on the part of the therapist) formulated by H.C. Rümke in the 1940s as a threat to classical nosography within traditional European psychopathology (i.e., the use of a criterion associated with experience and affects has been employed even in the realm of descriptive objectivity), and so on.
*Key Words:* Psychoanalytic theory, Theory of psychoanalytic technique, The "truth" of psychoanalytic interpretation, H.C. Rümke's conception of *Praecoxgefühl*, Relation between theory and technique in psychoanalysis.

My address has basically three objectives which intersect in different ways. From a clinical perspective and according to the psychology statute, it is first necessary to give the right of citizenship to the clinical process within the field of scientific psychology and eliminate sterile comparisons from the debate. I will endeavour today to demonstrate, through the identification of specific areas subject to verification, how, within the history of psychological thought, the clinical process plays a central role within the theoretical discussion on the method in general. My second goal is to provide a tentative contribution which particularly stimulated reflection on the facts, revelations, and observations that derive from the clinical process. My third aim is to underscore that much too often (and it has happened as well at this meeting[1]), when psychoanalysis is alluded to, it seems as if we know what is being referred to. Herein lies the basic error: psychoanalysis has passed through a series of vicissitudes that have undermined the establishment itself of a theoretical discourse within the discipline, in particular after the identification of the limitations of the criterion of "the truth of interpretation". The specific moments of the evolution of psychoanalytic thought are presented in a series, often without an in-depth grasp of their implications, therefore possibly causing the impression of solidity in the body of doctrine. This fact, coupled with the omission in Italian history that still lingers in the absence of a specific critical culture, fosters the misunderstanding of an apparent synchronicity, both in terms of concept and methodology, and ultimately plays a deeply misleading role.

I will now attempt to point out some problems internal to the clinical issue in order to give it as lucid a character as possible, by pointing out, with a minimum of conceptual specificity, those

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[1] This meeting is where this paper was originally presented: "La qualità dell'uomo: psicologi e filosofi a confronto" [The quality of man: Psychologists and philosophers meet with each others], Venice, Italy, May 24-26, 1985. See the footnote on this page.

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questions and doubts that could still be raised to this day. I would like to start with an old definition that I used in 1964 (Galli, 1964; see also Galli, 1962, 2006) when once again the clinical discourse had been inserted in every respect into the realm of *Science* after the crisis of the radical neo-positivistic approaches. The criterion of *a priori* verification of each and every fact that was inputted into the creation of hypotheses had resulted in methodological sterility and redundancy. The so-called position of *empirical realism*, defining the historical function of scientific discoveries, had applied the concept of individual human ability to *carry out operations of prediction with a minimum of information.* From this perspective, the specific and unique role of the human individual constitutes the centrality of the issue of clinical process. I saw this position as linked to the learning of this *ability* and therefore to the mechanism of making it possible for some to maximize this ability: in this way I classified the issue of training in psychotherapy and the establishment of psychotherapeutic practice in all their implications with regard to the problem of measurement, in terms of an *a posteriori* verification, and therefore with regard to a crucial theme in psychology.

I will now present a second aspect of this problem into which I would also like to insert the element of psychoanalytic activity. If we accept the centrality of the operation carried out by an individual human, this centrality must be subject to a deconstruction, which allows for a recognition of its components. From a research perspective, we can define the field along a bipolar axis. One pole is represented by the close tie between therapeutic behaviour and theoretical indications; the other pole is represented by the degree of maximum freedom with respect to theory. Along the axis we place the various levels of transformation that the therapist achieves in practical terms, with respect to the operations that he/she should achieve in theoretical terms. These transformation levels are: a) an indicator of the gaps within the theory of technique, something that is verifiable for any theory including the most rigorously behaviouristic; b) an indicator of the personality factors of a given clinician in general and in a given particular situation.

Therefore we have two possible types of measurement: one which concerns the gaps in theory, the other which concerns personality factors. Both of them refer to specific characteristics of the clinical process. These aspects can be studied in the psychoanalytic realm, inasmuch as we can prove that the clinical operations achieved in practice have a rather minimal link to theory. In fact when examining the history of how much it has been considered as a prescription of the so-called *classical technique*, it becomes clear that therapeutic behaviours were actually generated in an "as if" type of relationship with theory. This "as if" type of relationship has been transmitted in dogmatic terms and creates the fantasy of the existence of a *classic psychoanalytic technique*. In fact the system of consensus of a particular social group has been passed down as a derivation of theory. Hence the term *classical technique* only demonstrates the mark of credibility that a given social group has been able to attain as a result of factors that have little to do with the validity of the theoretical system. Moreover, as soon as some concepts considered fundamental were subjected to critical investigation, they were abandoned in favour of others without changing the acritical and dogmatic relationship with the theoretical proposition. In this respect, we have an indicative example in the shift from the criterion of the *truth of interpretation* to that of the *truth of the therapeutic setting* (i.e., the ground rules of therapy, the concrete arrangements between analyst and patient such as the couch, the weekly frequency, etc.). A relationship of this kind with theory certainly serves to maintain the identity of the psychoanalyst and therefore of the *specialist-practitioner* social group. This factor however must not be mistaken as an indicator of theoretical coherence. When in the 1950s David Rapaport, a theoretician who was trained in psychology, began to explicitly explain the theoretical implications of psychoanalytic formulations, he was accused of neo-rationalism, of neo-Aristotelianism, for presenting abstract theoretical proposals in relation to the so-called clinical "reality". He had not elaborated an overarching theory with respect to the existing one, but he simply drew attention to the rational criteria of the psychoanalytic system of connections. Consequently, the rejection of metapsychology, seen as a leftover of the nineteenth-century culture of Freud, came into being. And beyond this: when philosophers such as Ricoeur (1965) subjected a certain kind of theorization of the concept of

interpretations to critical attention, and the vagueness of the conceptual apparatus of this psychoanalytic criterion of truth became evident, the loss of specificity in this area defined a relativization, the implications of which, for the stability of the theoretical system in its entirety, were not evaluated in full. Thus began the dismantling of the concept, later presented in terms of the relativity of a history, the construction of a history, the construction of a history that has its own internal character of plausibility. The concept of interpretation, that had been the indicator of the specificity of the method against the tendency to emphasize the importance of the emotional relationship, was however a strong concept with respect to theory. It was substituted by a weak concept, currently in revival mode, with which to define the method—namely the concept of *therapeutic frame* or *setting*. This concept is particularly weak whether in its relationship to theory or its implications. It is however a kind of "watchword" that has substituted the foundation of the concept of interpretation.

With respect to the verification criteria of the psychoanalytic process, it can be said that a keyword has practically disappeared from the literature—the term *insight*—a relevant concept, for instance, for issues in cognitive psychology. But we should not forget that, precisely in reference to the problems of *insight*, a line of demarcation had been drawn between *real and genuine psychoanalysis* and *child psychotherapy* or the *psychotherapy of psychosis.* The latter types could not be called psychoanalysis, in that it is believed that structures capable of receiving *insight* may not exist in either the child or the psychotic. This theoretical difficulty has been tackled by means of the concept of the *function* of insight. The clinical observation that an insight could be forgotten, therefore once again repressed, while the function that it had had, from the perspective of the formation of intrapsychic structures, could persist, has brought about the need to change the point of view of theory, moving from an approach in topical terms to the repositioning of the concept of *insight* from a structural perspective. The theoretical relevance of this problem for psychology in general is demonstrated by the connection, identified by the writers that dealt with it, to Piaget's ideas on the formation of structures.

At this point I would like to touch upon something else which concerns both psychoanalysis and classic psychopathology, and which, to my mind, has interesting ramifications from a philosophical point of view. I am referring to the issue of empathy. Freud adopts the term *Einfühlung* for the first time in 1921. The concept was again picked up by Helen Deutsch in 1926 in relation to unconscious communication, and it should be highlighted that, upon *reflection,* the analyst recognizes his/her affective state as not his/her own but as derivative of the other. We are therefore dealing with a knowledge based on the recognition of lived experiences. From the indications emerging from psychoanalytic study, emphasis is placed on the therapist's experience as a tool for increasing knowledge. This experience also becomes a diagnostic category at the moment in which one recognizes that there exist non-diagnosable pathologies in relation to their formal characteristics, but only through the feelings they provoke within the therapist. Psychoanalytic investigation therefore contributes in this way to the enhancement of the subject of the objectification of experience. It is interesting to note how the current problems of the self and narcissism in psychoanalysis, alongside the interest in the issue of experiences, entail an accentuation on the interest in the individual understood as a global being. Regarding the concept of self in psychoanalysis, we basically have two views on the matter: one, present for instance in Kohut (1971, 1977, 1984), considers the self in terms of maturation, as subject to the relationship, able to be transformed within the relationship, with a specific history in the relationship. The other position leads us to the centrality of a nucleus of survival removed from relational vicissitudes. Winnicott (1960), through a clinical study on serious child psychopathology, provides a dual definition of the self: he speaks of the *true self* and the *false self*, assigning to the *true self* a character of nuclearity subtracted from the principle of reality, one which is non-transformable and which is annihilated if reached. The *false self* is structured on the other hand in the relationship as a modality of protection of the *true self.* In this sense, as Professor Emanuele Severino (1985) has pointed out, a nucleus of persistence continues to draw philosophical attention to the problem of psychosis as the focal point of the exploration into subject formation.

Now I would like to propose placing this topic into a completely different conceptual realm, that of descriptive psychopathology. During the 1950s, traditional European psychopathology was in crisis in the face of the attacks coming from the results of the psychotherapies of psychotics, which had shown how even the most serious forms of pathology could be *reducible* to something else in the relationship. This threatened the foundational pillars of classical nosography, in that it cancelled out the qualitative differences in favour of the quantitative ones. Among others, the psychopathologist Henricus Cornelius Rümke (1957) tried to oppose this tendency, basing his line of defence on the hypothesis of the separate clinical entities around the schizophrenia diagnosis. In order to do this, he identified a factor which he considered crucial, in accordance with the so-called "first-rank" formal symptoms of Kurt Schneider. He identified this factor as a feeling, as an *experience of the schizophrenic patient*, naming it *Praecoxgefühl* and therefore referring to a criterion that harks back to the subject of the objectification of experience. Let us see what the ramifications are. Rümke says that above all we are dealing with a tool that only an expert observer can utilize. Thus this implies that it is subjected to the category of learning and detached from that of intuitive knowledge. This tool makes it possible to assign the character of "schizophrenicity" in the presence of symptoms that alone do not make it possible to differentiate the various schizophrenias from those he called pseudo-schizophrenias. (It is interesting to note how he has inserted into these latter a "Sechehaye-type schizophrenia" in contrast to the hypothesis of the reducibility of the schizophrenia arising from the therapeutic outcome achieved by Marguerite Sechehaye [1947, 1950, 1955, 1956, 1960] in her famous case *Renée* using the technique of "symbolic realization"). This tool, in addition, makes it possible to recognize schizophrenia anywhere, in any geographic location (therefore removing it from socio-cultural influences). As Hemmo Müller-Suhr has pointed out in a paper published in the journal *Nervenarzt* in 1958, given that it is not about indicating its placement on a scale between determinate and indeterminate, this type of recognition has the character of phenomenal indeterminateness and makes it possible to recognize the *schizophrenic*—not schizophrenia, but the *schizophrenic*.

It is also in this way that one arrives at the identification of a foundation nucleus, pertinent to the issue of subject formation, assigning cognitive value to the emotional component. Beyond the heuristic value of these considerations, I have wished to point out, as a conclusion to my participation in this discussion, how, even in the realm of descriptive *objectivity,* a criterion associated with experience and affects has been employed. It has been employed in this context in order to uphold a position that made it possible to redefine in terms of *necessity* the biological study into the schizophrenic as a specific entity in support of a particular system of thought. In view of the fact that the current tendency in the psychoanalytic field is often one of assigning to empathy the character of something free, spontaneous, and detached from the limitations of *rationality,* it is important to recognize that empathy is not something more human, and affects are not, in and of themselves, more *spontaneous.* The signs of affect are only such if *recognized* in their differentiation and cannot be separated from successive reflection. This does not represent a constraint on knowledge, and the emotional life can be subjected to the same categories of stereotyping, rigidity, and repetitiveness of which we accuse the rational mental function.

In conclusion, I hope that I have been able to demonstrate how psychological-clinical exploration is not inevitably only a scattering into the winds of the ineffable.

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