

Psychopathology of the present: the case of gender dysphoria

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Summary

Dialectic, person-centred psychopathology acknowledges the vulnerability constitutive of human personhood. It assumes that the person is engaged in trying to cope and make sense of disturbing experiences stemming from the encounter with alterity. Each patient, urged by the drive for intelligible unity of life-construction, with their unique strengths and resources, plays an active role in interacting with these experiences. The product of this yearning for meaning can be either the construction of a new identity, or vice versa mental symptoms. Mental symptoms are the outcome of a miscarried attempt to make sense of one's disturbing experiences.

The crisis of the dialogue of the person with an alterity that inhabits one is at the heart of mental disorders. So-called 'gender dysphoria' is an exemplary case study of this interrupted dialogue

between the person and oneself. In gender dysphoria, the person suffers from a marked incongruence between his or her experienced gender and the assigned sex, for instance, a person living with a man's body who struggles to shape his body as a female body. This provides an illustration of the vulnerable duplicity that is inherent in the human condition and of the emergence of symptoms as the cypher of a miscarried dialogue with alterity. In gender dysphoria, the dialectics between one's sexual body as alterity and one's identity comes to a stop. Dysphoria, which is an unpleasant mood state characterised by uneasiness, irritability, restlessness and despair, is the core symptom of this disorder.

Key-words

Autonomy • Dialogue • Gender dysphoria • Person-centered psychopathology • Phenomenology

Introduction

We are a dialogue: of the person with oneself, and with other persons. Mental disorder is the interruption of this dialogue through which we strive to build and maintain our personal identity and our position in the world. The crisis of the dialogue of the person with the alterity that inhabits him/her, and with the alterity incarnated in the other persons, is at the heart of mental disorders. So-called "gender dysphoria", that is, the pathological feeling of uneasiness a human may experience when he/she is at odds with one's sexual body, is an exemplary case study of this interrupted dialogue between the person and oneself in the general framework of the psychopathology of the present.

Human existence is a yearning for unity and identity. Yet, this attempt is unfulfilled in the encounter with alterity, that is, with all the powers of the involuntary: unwitting drives, uncontrolled passions and automatic habits leading to unintended actions, as well as needs, desires, impulses and dreams. Finally, alterity can be encountered in one's body, the impersonal and pre-individual element that is to each of us the closest and the most remote at the same time¹. One may feel forced to live in the intimacy with an extraneous being – one's own body, that is, the a priori determined Whatness of Who we are. One

may feel stuck with one's sheer biological body, its facticity, the raw material that constitutes the unchosen and sedimented part of one's being and sets the boundaries of one's freedom. Who stems from the fragile, complex and obscure dynamics of the voluntary efforts to make sense of the involuntary What that is inherent in human personhood.

All this generates feelings of estrangement. Mental symptoms can be read as miscarried attempts to struggle for a sense of reconciliation to heal the wounds of disunion. Only as I recognise the alterity that inhabits me as an incoercible datum can I begin to use it in my service. Care is an attempt to re-establish such a fragile dialogue of the soul with oneself and with others. Such an attempt is based on one pillar: a dialectic, person-centred understanding of mental disorders. Its aim is to improve therapeutic practice in mental healthcare.

Dialectic, person-centred psychopathology

The dialectic understanding of mental disorders acknowledges the vulnerability constitutive of human personhood. It assumes that the person is engaged in trying to cope, solve and make sense of new, disturbing, puzzling experiences stemming from an encounter with alterity.

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Each patient, urged by the drive for the intelligible unity of his/her life-construction, with unique strengths and resources, plays an active role in interacting with these experiences. The product of this yearning for meaning can be establishing a new identity, or vice versa mental symptoms. These are the outcomes of a miscarried attempt to make sense of one's disturbing experiences². Mental symptoms are not simply the direct outcome of some kind of dysfunction or of a "broken brain". A person's symptom is not generated as such – as it was the case with Minerva, who sprang fully armed from Jupiter's head. Rather, it is the outcome of the need for self-interpretation that each person has with respect to his/her encounter with alterity, that is, with challenging, unusual or abnormal experiences.

The psychopathological configurations that human existence takes on in the clinic are the outcome of a disproportion between the person and the encounter with alterity, and with the disturbing experiences that stem from it. The person is engaged in trying to cope, solve and make sense of the basic disturbing experiences stemming from the clash with alterity. Alterity is made manifest as a kind of estrangement from oneself and alienation from one's social environment. Faced with new, puzzling experiences, the person tries to make sense of them. The attempt to achieve a self-interpretation of perplexing experiences characterizes the person's attitude, alongside a comprehending appropriation, that is, the constant search for personal meaning.

The encounter with alterity may offer the advantage from which a person can see oneself from another, often from a radically different and new perspective. Thus, otherness kindles the progressive dialectics of personal identity. Narratives are the principal means to integrate alterity into autobiographical memory, providing temporal and goal structure, combining personal experiences into a coherent story related to the self. Yet, the encounter with alterity is also the origin of mental symptoms. The production of a symptom is the extrema ratio for alterity to become discernible. The symptom is the last chance for the person to recognise alterity in oneself. The patient, as a self-interpreting agent who interacts with her anomalous experiences, "works through" them in such a way that they become symptoms. Psychopathological symptoms are the outcome of miscarried attempts to give a meaning to distressing experiences, and to explain and cope with them.

The main difference between this person-centred understanding of mental disorders and a reductionist model is that in the latter the patient is conceived as a passive victim of one's symptoms, whereas the former attributes to the patient an active role in shaping symptoms, course and outcome. Urged by the painful tension that derives from the drive for the intelligible unity of life-construction³,

each patient, as a "goal directed being", plays an active role and stamps his/her autograph onto the raw material of basic abnormal experiences. When a clinical syndrome emerges, the line of the pathogenic trajectory is the following: 1) a disproportion of alterity and the person's resources for understanding, of emotions and rationality, of pathos and logos, of otherness and selfhood bringing about a disturbing metamorphosis of self and world experience; 2) a miscarried auto-hermeneutics or self-interpretation of one's abnormal experiences and of the transformations of the life-world that they bring about; 3) the fixation in a psychopathological structure in which the dialectics between the person and alterity gets lost.

This person-centred, dialectic approach helps us to see the patient as a meaning-making entity rather than as a passive individual⁴. The patient "can see himself, judge himself, and mould himself"⁵. His attempts at self-understanding are not necessarily pathological and are potentially adaptive.

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

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

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

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

What is a symptom?

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

Of course, there are different psychopathological paradigms (among which biomedical, psychodynamic, phenomenological, etc.), and each paradigm has its own hierarchy of priorities (which should be the clinician's focus of attention) as well as its own concept of symptom. As a consequence, the concept of symptom covers a vast array of indexicalities. In biological medicine, a symptom is the epiphenomenon of an underlying pathology. Red, itchy and watery eyes, congestion, runny nose and sneezing, sometimes accompanied by itchy ears and buzzing sound, itchy and sore throat, cough and post-nasal dripping are known to be the manifestation of an inflammation of the respiratory apparatus.

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

The principal utility of any system of medical taxonomy relies on "its capacity to identify specific entities to allow prediction of natural history and response to therapeutic intervention" ⁶. The biomedical understanding of "symptom" is clearly coherent with this. Biomedical research aims to sharpen its tools to establish increasingly more reliable and valid diagnostic criteria. Its real ambition is not simply to establish a diagnosis through the assessment of clinical manifestations (i.e. symptoms), but to discover the causes of these symptoms (aetiology) and the pathway that leads from aetiology to symptoms (pathogenesis). "Ultimately, disease specification should be related to events related to causality rather than simply clinical phenotype" ⁶. It is assumed that progress in medicine is dependent on defining pathological entities as disease based on aetiology and pathogenetic mechanism – rather than as clinical syndromes based on symptom recognition. In the biomedical paradigm, the truth about a symptom is its cause. The main, more or less explicit, assumptions in the biomedical paradigm are the following: 1) each symptom must have at least one cause, 2) this cause lies in some (endogenous or exogenous) noxa affecting the living organism, 3) the presence of a symptom causes some kind of dysfunction (cause → symptom → dysfunction). Also, 4) if we want to eliminate a symptom, we should eliminate its cause or interrupt the pathogenetic chain that connects its putative aetiology with the symptom itself. Thus, the biomedical paradigm is a knowledge device based on the concept of "causality". In general, causality (in the biomedical paradigm) goes from aetiology (in our example, the presence of a

virus), to symptom(s) (breathing difficulties), to dysfunction (poor physical performance due to blood hypo-oxygenation, thus reduced adaptation of the person to his or her environment).

An important, implicit assumption is also that symptoms are considered accidental, i.e. non-essential to the living organism, whereas the absence of symptoms is considered essential – i.e. normal to living organisms. In other terms, health is considered normal, whereas disease is considered abnormal.

Many of these assumptions – if we apply this paradigm to the field of mental pathology – are at least controversial, or even counterfactual. What is of utmost interest here is the fact that in the biomedical paradigm, symptoms have causes, not meanings. Moreover, we can assume that a symptom is not an accident to that person; rather, it displays his true essence. As such, it is the contingent opportunity of a possible encounter between the person and alterity. Symptoms are the *via regia* to recognition as they express the person's vulnerability. Someone's *vulnus* displays what is most personal and intimate to him. "Come inside – says Eumeus to Ulysses when he arrives at his hut – and when you have had your fill of bread and wine, tell me where you come from, and all about your misfortunes" (Homer, *Odyssey*, 2005, XIV, p. 47). Only after Odysseus had a hearty meal of pork does Eumeus ask about his story: "And now, old man, tell me your own story; tell me also, for I want to know, who you are and where you come from. Tell me of your town and parents, what manner of ship you came in, how crew brought you to Ithaca, and from what country they professed to come – for you cannot have come by land".

The recognition of Ulysses in the episode of Euryclea – Ulysses' wet-nurse – comes with the recognition of his scar. As Euryclea is putting Ulysses' feet in a basin of water, she notices a scar on one of his feet. She immediately recognises it as the scar that he received when he went boar hunting with his grandfather Autolycus: "As soon as Euryclea had got the scarred limb in her hands and had well hold of it, she recognised it and dropped the foot at once. The leg fell into the bath, which rang out and was overturned, so that all the water was spilt on the ground; Euryclea's eyes between her joy and her grief filled with tears, and she could not speak, but she caught Ulysses by the beard and said, 'My dear child, I am sure you must be Ulysses himself, only I did not know you till I had actually touched and handled you'" (ibid., XIX, p. 392).

This myth has a clear correspondence in Karl Jaspers' concept of "cypher" ⁷. "Cypher-reading is the primary requisite of manhood" ⁷. Cypher-reading is an essential character of being a man. Cyphers show what without

them would remain implicit for us. Symptoms are a special category of cyphers: through them alterity, that is the hidden yet operative (and perplexing, or disturbing) dimension of our existence, is made manifest. Like a patient's symptom, which is not accidental to that patient but is rather the manifestation of his or her true identity, cyphers are the contingent opportunity of recognition, that is, of a possible encounter between the person and the encompassing dimension of her existence.

The cypher must keep on an inexhaustible signification with which no definite interpretation is commensurate⁷. If the cypher "becomes fixed and definite and turns into an object, then it loses its essential force. It collapses into a sign"⁷. Cyphers must not be crystallised into a kind of definite, categorical concept. The meaning(s) of the cypher must be kept "in suspension" – remain unsaturated⁷. The defection from the cypher to the pure concept (as occurs when the cypher grows a single meaning), as well as the interpretation of a cypher as if it were a symbol (such as when the cypher is interpreted through an 'other'), destroys the force of the cypher.

Symptoms in phenomenological psychopathology

Phenomenology is essentially concerned with laying bare the structure of the life-world inhabited by a person. A symptom is a feature of a person's life-world whose meaning will be enlightened by grasping the deep architecture of the life-world itself and the person's invisible transcendental structure that projects it. Life-world is the original domain, the obvious and unquestioned foundation of our everyday acting and thinking. In its concrete manifestations it exists as the "realm of immediate evidence". Although the majority of people are situated within a shared life-world, there are several other frameworks of experience – for example, fantasy worlds, dream worlds, and "psychopathological worlds"⁸. Abnormal mental phenomena are the expression of a modification of the ontological framework within which experience is generated. The overall change in the ontological framework of experience transpires through the single symptoms, but the specificity of the core is only graspable at a more comprehensive structural level⁹. The experience of time, space, body, self and others, and their modifications, are indexes of the patient's basic structures of subjectivity within which each single abnormal experience is situated.

Before we proceed in this direction, I need to clear the ground of a possible misunderstanding. To consider phenomenology as a purely descriptive science of the way the world appears to the experiencing subject is a serious mistake, although it is true that phenomenology sponsors

a kind of seeing that relates to something already there, rather than to what stands before, beyond or behind what is existent. "Making the invisible visible" can instead be taken as the motto of phenomenology, just as it was the passion that possessed many of the artists of the twentieth century and the intellectual motor of the major scientists of the "invisible century," including Einstein and Freud, in their search for hidden universes.

The symptom is conceived as a part of a discourse, to be deployed and analysed as a text. The issue, then, is how to rescue its invisible and unintended meaning. All human deeds can be produced or reproduced as a text. The text – be it oral or written – is a work of discourse that is produced by an act of intentional exteriorisation. One of the main characteristics of a text is that once it is produced, it is no more a private affaire, but is of the public domain. It still belongs to the author, but it also stays there independent with respect to the intention of the author.

The externalisation of one's actions, experiences and beliefs via the production of a text implies their objectification; this objectification entails a distanciation from the person herself and an automatising of the significance of the text from the intentions of the author. Once produced, the text becomes a matter for public interpretation. Now, the author's meanings and intentions do not exist simply for-himself, but also for-another.

This process of objectification and of automatising is nicely described in Hegel's theory of action¹⁰ that was explored in the previous section. Indeed, there is a parallel between a text and an action. Just as every action involves a recoil of unintended implications back upon the actor, every text – including symptoms – implies a recoil of unintended meanings back upon its author.

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

himself an external reality by producing a text, and after reflecting upon it.

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

This is a kind of understanding that “seeks to find the logos of the phenomena in themselves, not in underlying subpersonal mechanisms”¹¹. The symptom, then, is an anomaly, but not an abnormal, aberrant or insane phenomenon in a strict sense. Rather, it is a salience, a knot in the texture of a person’s life-world, like a tear in the matrix. It is a place that attracts someone’s attention, catches one’s eyes and awakens one’s care for oneself in a double sense. The symptom reflects and reveals alterity in oneself – in it alterity becomes conspicuous. From the vantage offered by the symptom, one can see oneself from another, often radically different and new, perspective.

The case of gender dysphoria

An illustration of the vulnerable duplicity inherent in the human condition and of the emergence of symptoms as the cypher of a miscarried dialogue with alterity can be taken from gender dysphoria, where the person suffers from a marked incongruence between his or her experienced gender and the assigned sex, for instance, a person living with a man’s body who struggles to shape his body as a female body. In gender dysphoria, the dialectics between one’s sexual body as alterity and one’s identity comes to a stop. The core symptom of this disorder is dysphoria, that is, an unpleasant mood state characterised by uneasiness, irritability, restlessness and despair.

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

Matter, in this case, is the body itself, the body into

which I am thrown, its facticity, including its sex, as well as height, weight, colour, etc. My body is perhaps the most intimate part of the person that I am, but at the same time it can turn out to be the most extraneous. My material body is transcendental to me. At a certain moment in my life, I may realise that I have a material body that is clumsy, vulnerable and mortal, and that impedes my ability to be what I want to be. My body manifests itself as alterity. This paradigmatically happens through the experience of shame. Shame is an affect that awakens and focuses my attention. When I feel ashamed, I am aware of being seen by another person whose gaze uncovers a part of who I am, usually a part that makes me feel embarrassed, inadequate and humiliated. The effect of shame is that it reduces the complexity of the person that I am to one single aspect of it: when I feel ashamed I know that for the other I am nothing but that specific feature of the complexities of who I am. “With the appearance of the Other’s look – writes Sartre¹² – I experience the revelation of my being-as-object”. The upshot of this is a feeling of “having my being outside (...) [the feeling] of being an object”. Thus, one’s identity may become reified, and reduced to the external appearance, to the matter or Whatness of one’s own body. In a famous movie by Pedro Almodovar, *All about my mother*, the transvestite Agrado offers a monologue about her becoming who she chose to be as an alternative to what she was born to be. “Aside from being pleasant”, she says, “I am also very authentic”, and she lists the various types of surgical operations she has undergone to become so authentic. Agrado’s identity is not simply determined by her originally masculine body, rather she shapes that body according to her experience of being the person that she is. She ironically says: “It costs a lot to be authentic” and continues, “All I have that is real are my feelings and these pints of silicone”. Gender, according to Agrado, is not simply a physical fact, rather an accomplishment.

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

What is “dysphoria” in gender dysphoria?

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

Dysphoria, that is, in the case of gender dysphoria, uneasiness and concern with one’s body facticity, is the symptom of the fragility of the dialogue between the person and the obscure intimations that stem from one’s body, especially in early phases of this disorder. The interruption of this dialogue might have caused Agrado to fall into being what she does not feel and want to be – a man – or vice versa to identify with what she is not and she cannot be – a woman. Agrado’s identity is the unstable, yet mature, point of equilibrium between these two poles. Falling into her Whatness, that is, not recognising her uneasiness with being thrown into a male body and her desire to be a woman, will seemingly originate some

sort of neurotic symptoms, for instance a kind of phobia (e.g. so-called social phobia), or more severe psychotic phenomena, such as a delusion of reference.

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

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

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

This is confirmed by the real case with Kate Bornstein, a transsexual (M to F) person who says about herself that she does “deceive herself about being a woman”¹³. To her, being a woman is a “performance”, a continuous task, rather than a fact. This is the case with all gender identity – she holds – and for all identity in general. “The bipolar gender system” she writes, serves as a kind of safe harbor for most of us, and I’m definitely including myself in that, even though I don’t personally identify as either a man or a woman, because I walk through this world appearing to be a woman for the most part. I pass as a woman. I can do that. And I do because it allows me to rest for a moment”¹³. This is nicely encapsulated in the following lines:

I grew this body.

It’s a girl body. All of it.

Over the past seven years every one of these cells became a girl, so it’s mine now.

It doesn’t make me female.

It doesn’t make me a woman.

(*ibid.*, p. 233.)

In a similar vein, gender identity is considered “performative” by Ricky Wilkins¹⁴. These two seem to be cases of

well-carried (rather than miscarried) transsexual existence – and, in general, of mature dialogue with alterity.

Phenomenological psychopathology and care

The challenge facing the clinician is how to offer the patient an insight into their fragile personhood, that is, into the alterity one experiences in oneself – e.g., a dysphoric feeling about his/her “natural” sex – as well as helping one to understand how they try to make sense of this and, moreover, to acquire the appropriate means to cope with their unease. Hermeneutical phenomenology is a resource when dealing with this challenge of therapy because of three basic features of this philosophical approach to human personhood.

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

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

Third, the hermeneutical character of this approach provides a framework by which the clinician can make sense of norms and values involved in a person’s struggle with

their involuntary dispositions. We care about being persons, and the hermeneutical emphasis on both the What and Who of the person that we care about being and becoming – that is, both the a-rational, biological values and the rational, personal values at work in our care – provides the clinician with a framework with room for the ethical problems involved in being a person.

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