

Cultural Dynamics of Social Representation

AN INTERDISCIPLINARY APPROACH TO THE HUMAN MIND

**SUBJECTIVITY, SCIENCE AND EXPERIENCES
IN CHANGE**

Line Joranger



An Interdisciplinary Approach to the Human Mind

One of the main aims of modern mental health care is to understand a person's explicit and implicit ways of thinking and acting. So, it may seem like the ultimate paradox that mental health care services are currently overflowing with brain concepts belonging to the external, visible brain-world and that neuroscientists are poised to become new experts on human conduct. *An Interdisciplinary Approach to the Human Mind* shows that to create care that is truly innovative, mental health care workers must not only ask questions about how their conceptions of human beings and psychological phenomena came into being, but should also see themselves as co-creators of the mystery they seek to solve.

Looking at the human being as a being with a biological body and unique subjective experiences, living in a reciprocal relationship with its sociocultural and historical environment, the book will provide examples and theories that show the necessity of an innovating, interdisciplinary mental health care service that manages to adapt its theory and methods to environmental, biological, and subjective changes. To this end, the book will provide an innovating psychology that offers a broad kaleidoscope of perspectives about the relations between the history of psychology, as a scientific discipline oriented to interpret and explain subject and subjectivity phenomenon, and the social construction of subjectified experience.

This unique and timely book should be of great interest to critical and cultural psychologists and theorists; clinical psychologists, therapists, and psychiatrists; sociologists of culture and science; anthropologists; philosophers; historians; and scholars working with social and health theories. It should also be essential reading for lawyers, advocates, and defenders of human rights.

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Cultural Dynamics of Social Representation

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University of North Carolina, Chapel Hill

The series is dedicated to bringing the scholarly reader new ways of representing human lives in the contemporary social sciences. It is a part of a new direction – cultural psychology – that has emerged at the intersection of developmental, dynamic and social psychologies, anthropology, education, and sociology. It aims to provide cutting-edge examinations of global social processes, which for every country are becoming increasingly multi-cultural; the world is becoming one ‘global village,’ with the corresponding need to know how different parts of that ‘village’ function. Therefore, social sciences need new ways of considering how to study human lives in their globalizing contexts. The focus of this series is the social representation of people, communities, and – last but not least – the social sciences themselves.

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An Interdisciplinary Approach to the Human Mind

Subjectivity, Science and
Experiences in Change

Line Joranger



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Series editor's preface

Structuring experience: health as representation

Line Joranger's book is a masterful integration of history into general epistemology of the social sciences. She demonstrates how contemporary research on representation processes needs to start from theoretical synthesis, rather than from common sense discourses about appealing but fuzzy notions like 'mental health' or the like. Contemporary psychology has forgotten the importance of theoretical primacy in its ever-vociferous calls for 'more data.' Joranger demonstrates that before getting more data one needs to know what the data could do for our knowledge. And this is the message the readers need to consider with full seriousness.

In the social sciences are historical particulars. What that means restores the relevance of historical contexts for human social representations to the center of our science. The corresponding general notion to *representation* is *participation* – on the basis of our representing our goals-oriented standings in our life-worlds we participate in something we loosely call 'society.' Such looseness is the weakness of our social sciences – as the intricate manifold of the forms of social relationships in which the person is involved needs to be presented in its kaleidoscopic totality, Joranger's book attempts to accomplish precisely that.

In order to participate we have to present the context for such participation. My personal goal to join the organization of 'volunteers for X' requires that I present – to myself and to others – what X is. To present X I need to represent some image of X – and it is precisely here where the societal tacit knowledge and my personal goal-oriented striving meet. Still, it is necessary to go beyond locating where and when they meet and answer the question of how they modify each other. Sometimes such modification is lethal – the young men who volunteered to join the armies of European countries at the beginning of World War I were operating with the social representation of the poetic image of the 'Great War.' Their bones – carefully accumulated in the Verdun War Memorial – may be the only remaining proof of the hazards any person encounters when 'joining the society.' Social representations – at least some of them – may be detrimental to our health.

Interestingly, the notion of *health* – in all of its versions (physical, mental, public) – is a social representation of fuzzy and indeterminate nature. The only

clear feature of this representation is its implicit value – *health* is *good* (rather than non-good, or ambivalent) and if it falters the unquestionable goal to be put to place is its restoration. This goals-setting is replicated at all levels of organization. The immediate agent in the evaluation of one's health and its restoration or improvement is the person who lives one's life – and dies in the end. Reflexivity about health is thus a basic hyper-generalized sign-making activity that is fully in the service of personal life course philosophies (Zittoun et al., 2013). It is a deeply subjective meaning system in which it is impossible to make comparability assertions about any other person than oneself. My way of 'being healthy' is different from each and every other's subjective notions of similar kind – despite the fully comparable objective indicators of our blood tests.

The subjective notion of health becomes generalized to abstract conglomerates of different individuals characterized by some socially desirable or undesirable activities. Thus, at the level of societal communities, the abstracted and stigmatized category 'smokers' evokes the discursive use of the social representation of *health* in ways very different from that of the category 'active users of treadmills.' The societally negative valuation of the given activity becomes accentuated through the discourses of 'health concerns' by the socially powerful ingroup towards the marginal and powerless outgroups. *Health* becomes a rhetoric device in the relations of special interest groups and individual human beings for both increased segregation and for potential actions towards them for 'saving' them from their 'bad habits.' The former is exemplified by administrative forcing of the 'smokers' in airports to special 'smoking rooms' where they can make their personal decisions to smoke sharing the smoke with other 'smokers.' There is no concern about the health of the smokers – risks for diseases are increased by inhaling of 'secondary smoke' in this sharing context.

The world today is also filled with various missionaries for health. These are persons and community institutions that claim to 'save the health' of active 'risk-takers' (e.g., 'smokers') or ill-informed wide public by way of propagating various ways of abstinence from 'bad habits' or prescriptions for the 'right ways' of living. The number of various dietary advices – all in the service of 'healthy living' – and all kinds of dietary supplements become economically profitable on the basis of the internal self-dialogues of persons who are successfully made into worriers for their health. The power of internalized worries about one's own health are the basis for social success of the restless fighters for the health of the others.

Finally, there are the governments and their ministries – among which the issues of health operated at the social policy level. The social representation of *health* is here juxtaposed with other ministerial-level uses of social representations – of *justice*, *defense*, *education*, to name a few. These hyper-generalized representations become schematically defined through various legal documents that regulate the activities of both the community organizations and particular individuals. The inherently fuzzy – both at individual subjective level and in communal rhetoric uses – becomes politically defined as 'health policy.' New borders between acceptable and non-acceptable medical treatments (e.g., abortions made

available – or not – and at this but not other level of gestation) are introduced and implemented. The subjective understanding of *health* is no longer relevant at this level – the feelings of disgust by a young pregnant woman feeling that abortion is the killing of a baby and the feelings of another woman who considers availability of abortion as the freedom of personal choice, are dismissed similarly at the societal policy level. The use of performance-enhancing drugs in sports becomes the witch-hunting grounds for various societal institutions for concerns for ‘fairness’ and ‘athletes’ health’ while the directives by a ministry of defense prescribe the use of such drugs to soldiers sent on a combat mission. Politics of ‘health’ is as selective as any other politics – with individual citizens left far behind.

In the middle of such three-level confusion about the shared theme of health remain social scientists – trying to satisfy the various interest groups by evidence-based scientific materials. The present book is an eye-opener to many of them who are sincerely involved in their helpful efforts towards society and people in it. The need for theoretical conceptualization that is the central message of this book should lead them to new understanding of their benevolent social practices. And this would be the best social impact of this book. I hope that reading it leads to many new ideas that can transform current practices – in an ‘epistemologically healthy’ direction.

Jaan Valsiner
Aalborg, 29 June 2018

Reference

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Foreword

I have always felt that I do not belong to a Faculty or to a specific knowledge area. When colleagues ask what research group I belong to, or what Faculty I belong to, I have difficulty answering. I do not know what exactly to say. To request funding I have to choose an area, and I have to choose a Faculty and Department, but I never feel quite at home there. I always try to extend the research area where I work or the Faculty and Department in which I am situated. I meet people in everyday life who feel the same. Most of them are health care workers, therapists, and psychiatrists working with people in public offices and mental health care institutions. They feel themselves in situations of dependency and alienated in a language that is not theirs and entangled in various ways in unavoidable webs of bureaucratic behavior. Their language is medical and instrumental. By using it, they lose sight of the creative and soul-like parts of themselves and the human beings they are supposed to help.

Through life I have learned that people want simple things. They want to be a good person, a good mother, a good father. They want to be a good friend and a good colleague. They want freedom to think outside rigid systems of thought, to think and behave in unbureaucratic ways and according to their common sense. They want freedom to develop, freedom to speak up, freedom to stop following mechanical and unreasonable pedagogical and therapeutical systems and programs of advice. Paradoxically, all these wishes are hard to fulfill and realize inside the late modern welfare state and inside the late modern mental health care bureaucracy.

This book is directed to all those who feel that they are trapped in a restricted worldview and to all those who dream of having the freedom to develop their ideas along with those they are supposed to help or with those who are supposed to help them. This book is ultimately about people in everyday life. It is directed to those who love and want to understand every single rational and irrational bit of what is to be human being in everyday life.



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Introduction

I hope the book will bring out the artist and the dancer in you.

Mental health care workers and psychologists in public offices and public institutions in the Western world suffer from a deep frustration that seems to have taken up residence in their bodies and their minds. They feel dependent and alienated in a language that is not theirs and in a bureaucratic behavior that is indirectly and directly pushed upon them. Their language is medical and instrumental. By using it, they lose sight of the creative and soul-like parts of themselves and the human beings they are supposed to help. Schooled to adapt a total system of control and procedures, their behavior creates a welfare state system continually looking for evidence and evidence-based methods of treatment and facilitation. The frustration seems connected to the fact that within the novel political sphere of public welfare, health care workers, despite that they are expected to empower people, are also expected to reduce peoples' needs and expectations so as they fit into neat manuals and schemas for reporting and classifying. In parallel with facilitating user involvement and ensuring that the service users get what they are entitled to, today's health care workers are supposed to make savings according to principles of control and efficiency demanded by public investment in the welfare system.

Looking inside the Western welfare state there are different cultures and values confronting each other. There is a standardized, bureaucratic, and technical one and a humanistic and subjective one (cf. Habermas, [1968]1971; Snow, 1959). The bureaucratic and technical one is represented by rational aims and objective values. Rational aims and objective evidence-based values inside the health care system have two components: a methodological and a political. The methodological component consists of randomized controlled trials and their systematic review that make use of a difference-making conception of cause. The political component makes the recommendation for uniform intervention, based on the evidence from randomized controlled trials (Anjum & Mumford, 2017). The policy side of evidence-based health care praxis is basically a form of rule utilitarianism. A utility maximizer should always ignore the rule in an individual case where greater benefit can be secured through doing so. In the medical health care case, this

would mean that a mental health care worker who knows that the patient or service user would not benefit from the recommended intervention has good reason to ignore the recommendation. This is indeed the feeling of many mental health care workers and welfare workers who would like to offer other interventions but do not do so by reason of an aversion to breaking clinical guidelines (Anjum & Mumford, 2017). The regime of personal virtue and trust, and of subjective feelings and experience, seems in the bureaucratic welfare system to be a lost regime for orientation and development (cf. Bendixsen, Bringslid, & Vike, 2018).

By personal virtue and trust, I mean the personal strength to extend and go beyond the ordinary system of thought and practices. This involves a practical and interdisciplinary flexibility, and a historical and cultural knowledge. This also involves knowledge about how contemporary sociocultural and academic environments produce knowledge and concepts customized to political and modern scientific goals, that is, goals that often counter people's needs and wishes. Possessing knowledge about yourself and the world around you enables you to come to terms not only with your own limitations and potential but also with the limitations and potentials inherent in the bureaucratic system to which you belong. It means gaining self-possession, fearlessness, and independence, the conditions of all success and realistic goals.

By subjective feelings and experiences, I mean the authentic feelings and experiences belonging to our inner private selves, or what one generally refers to as the 'mind.' These are feelings and experiences expressing the painfulness of pain, the anxiety of anxiety, the strength of bodily and mental forces, and the polar experience of the sudden will to give up and the simultaneous will to fight forever. Or, as Goethe would have said it: If you don't feel it, you won't catch it (Goethe, 2003). These feelings and experiences can be triggered when you are forced to adopt a rigid or even inhuman bureaucratic system, or when you have lost everything in war, or when you are seeing a beautiful landscape, hearing a dog bark, tasting a mango, or hearing shots and bombs in the distance. Subjective experiences are related to memory, expectation, and intuition, and to the capability to dream and imagine. Such experiences relate to all those feelings and experiences that go beyond the external bureaucratic world and which express ultimately the 'me'-ness of me in action, and the fact that it is I, and nobody else, who is driven to action by these feelings and experiences (Joranger, 2015).

Although subjective experiences are related to intra-psychological phenomena, there is a reciprocity in these experiences. Experience not only has form, it has meaning.

As human beings, we attach meaning to the environment in which we are located, as well as to the behavior of others and to ourselves. We attach meaning to inhuman mental health care bureaucracy, to the ethical dilemmas that we encounter every day, and to irrational behavior. We need to figure out if someone is angry because they are bad-tempered or because something bad happened, or if the health care system in which we are located is inhuman because of the people who work there or because of bad political decisions. This meaning-making

process is connected to attribution. Attribution deals with how human beings perceive information arising not only from themselves but also from the environment in which they are located in order to arrive at causal explanations for events (Fiske & Taylor, 1991; Heider, 1958). It examines what kind of information we gather and how it is combined to form a causal judgment. Attribution then, deals with how and why individuals explain events as they do.

How and why individuals explain events as they do depends on the development of language and of conceptual structures and processes in which information from and about the environment is actively gathered, assimilated to appropriate concepts, and thereby interpreted (Foucault, 1972; Wozniak, 1993). Perceiving information, in other words, is a process in which experience is co-constructed in the interaction between an environment that provides structure over time and the subjective mind that provides knowledge and the functioning of knowing processes (cf. Wozniak, 1993). The cognitive processes through which structures relevant to incoming information are accessed, through which that information is assimilated to the cognitive system, are acts of meaning attribution. As a cognitive system, the human mind is the device for the generation of meaning.

However, “our understanding and our experience of our reality is constituted for us, very largely, by the ways in which we *must* talk in our attempts . . . to account for it” (Shotter, 1985, p. 165). We must talk this or that way because the requirement to meet our obligations as responsible members of a particular society has a morally coercive quality. Not only do we tell our lives as stories, but also there is a significant sense in which our relationships with one another are lived out in narrative form (Gergen & Gergen, 1988, p. 18). Language here is understood as a complex of narratives of the self that our culture makes available and that individuals use to account for themselves for events in their own life. Talk about the self is both constitutive of the forms of self-awareness and self-understanding that human beings acquire and display in their own lives and constitutive of social practices themselves, to the extent that such practices cannot be carried out without certain self-understandings.

(A) man is always a teller of stories . . . he sees everything which happens to him through these stories; and he tries to live his life as if it were a story he was telling. . . . While you live, nothing happens. The scenery changes, people come in and go out, that’s all. There are no beginnings . . . an interminable and monotonous addition. . . . But when you tell about a life, everything changes; . . . events take place in one direction, and we tell about them in the opposite direction. . . . I want the moments of my life to follow each other and order themselves like those of a life remembered. I might as well try to catch time by the tail.

(Sartre, 1964, pp. 56–59)

To Viktor Frankl (1963) storytelling weaves together scattered meaningless bits of life events into a coherent sense, to make a meaningful ‘history’ out of life

events, to make sense of life, and meaningfulness makes life whole – and to make whole is to heal. If we find ourselves experiencing ourselves as self-contained, self-controlled individuals, owing nothing to others for our nature as such, we need not, then, presume that this is a fixed or ‘natural’ state of affairs. Rather, it is a form of historically dependent intelligibility requiring for its continued sustenance a set of shared understandings (Foucault, 1972; Shotter & Gergen, 1989).

In an overregulated mental health care environment, there is no agreement about ‘who can speak,’ or from ‘what position one can speak.’ One can say a lot about a system by studying what relations are in play between the persons who are speaking and the object of which they speak, and those who are the subjects of their speech. One might think here of a regime that, at any particular time and place, governs the enunciation of a diagnostic statement in mental health care, a scientific explanation in biology, an interpretive statement in psychoanalysis, or an expression of passion in an erotic relation. They are not put into speech through the ‘unifying function of a subject,’ nor do they produce such a subject as a consequence of their effects: it is a matter here of “the various statuses, the various sites, the various positions” that must be occupied in particular regimes if something is to be sayable hearable, operable; the mental health care worker, the social worker, the scientist, the therapist, the lover (Foucault, 1972, p. 54).

From this perspective, language itself, even in the form of ‘speech,’ appears as an assemblage of ‘guided’ practices, from counting, listing, entering into contracts, singing, chanting of prayers, issuing orders, confessing, purchasing a commodity, making a diagnosis, planning a campaign, debating a theory, explaining a process. However, these practices do not inhabit a functionally homogeneous domain of meaning and negotiation among individuals. They are located in particular sites and procedures, and the affects and intensities that traverse them are pre-personal. They are structured into variegated relations that grant power to some and delimit the power of others, enabling some to judge and some be judged, some to be cure and some to be cured, some to speak truth and others to acknowledge its authority and embrace it, aspire to it, or submit to it. For Harré (1989, p. 34) “The task of psychology is to lay bare our systems of norms of representation . . . the rest is physiology.” Rules of grammar concerning persons, or what Wittgenstein termed ‘language games,’ produce or induce a moral repertoire of relatively enduring features of personhood inside the mental health care system.

Heider (1958) believes that people behave like naive psychologists trying to make sense of the social world, and that people tend to see cause and effect relationships even where there is none. He separates in this case between internal attribution and external attribution (Heider, 1958). Internal attribution refers to the process of assigning the cause of behavior to some internal characteristics rather than to outside forces. When we explain the behavior of others we look for enduring internal attributions, such as personality traits; that is, we attribute the behavior of a person to their personality, motives, or beliefs. External attribution refers to the process of assigning the cause of behavior to some situation or event outside a person’s control rather than to some internal characteristic. When we try

to explain our own behavior we tend to make external attributions, such as situational or environmental features. By using external attribution as an explanation of our behavior, it makes sense that our behavior inside a bureaucratic technical welfare system seems irrational and inhuman and in conflict with personal values and beliefs.

Because the environment plays a significant role in aiding meaningful internal processes, subjective experience and the environment act as a ‘coupled system.’ This coupled system can be seen as a complete cognitive system of its own. In this manner, subjective experience is extended into the external environment and vice versa, the external environment with its disciplinary objects such as institutional laws and equipment becomes mental institutions that affect our subjective experience and solutions (Clark & Chalmers, 1998; Gallagher & Crisafi, 2009). A subjectively held belief attains the status of objectivity when the belief is socially shared (Kruglanski & Orehek, 2011). That is, even if we are trained as hard-nosed health care rationalists, or no-nonsense bureaucrats, or data-driven scientists, research has shown that our decisions are influenced by various institutional practices (Gallagher, 2013). They include bureaucratic structures and procedures, the architectural design of health care institutions, the rules of evidence and the structure of allowable questions in a courtroom trial, the spatial arrangement of kindergartens and supermarkets, and a variety of rituals and practices designed to manipulate our emotions.

Invariant structure has the potential to inform experience, to give it a particular pattern of changing organization over time (Gibson, 1966, 1979). Sometimes the effects are unintentional and are accidental features of the institutional environment; sometimes they are the result of strategic planning. According to Gallagher (2013, p. 11):

The institutional practice of charities that specifies use of a successful presentation style may be an obvious and relatively innocuous example of how different media enter into the cognitive process, and how institutions may use media to elicit certain behavior. I take this to be a case of socially extended cognition because the process of decision making changes, indeed is manipulated, when one set of external factors is introduced rather than another – that is, when images plus narrative are part of the process rather than statistical data – and the whole process is mediated by a certain institutional practice.

Yet, although coupled systems can be seen as a complete cognitive system of its own, human beings rarely if ever experience wholeness in their lives (Simmel, 1918, 1971). The nature of culture, society, personality, and subjective experience is such that the most we attain are fragments of things. The separate and incommensurable worlds of cultural forms make competing claims on our attention. Having access to different knowledge areas and to a plurality of cultural forms and participation in a plurality of membership groups makes it easier for a person

to express his/her personality more fully. But wholeness in this endeavor is no less futile than in extra individual realms. Not only are we all fragments of the general cultural and social types we embody, but “we are also fragments of the type which only we ourselves are” (Simmel, 1918, p. 79).

It may be given to a few to devote themselves wholly to a single world, but most of us have an experience of constantly circulating over a number of different planes, each of which presents us with a world-totality according to different formula, but from each of which our lives take only a fragment along at any given time. As human beings, and as welfare workers, we are caught in the intersection of our crosscutting interests and expectations. Even within a single relationship, moreover, we will not find our experience shaped within a single form. A health care worker may relate to another primarily through one particular form, say, competition; but other forms are invariably involved in his/her experience, such as confidentiality, domination, gratitude, and possibly mutual exploitation or perhaps sociability on occasion.

Like the European political environment, the Western mental health care environment seems to be effected by uncertainty, rapid ideological changes strongly influenced by new technology and political disorders beyond European borders. It may be a fruitful hypothesis to suggest that it is the intense and accelerating normative uncertainties of late modernity that draw upon stress and mobilize these supposedly premodern resources. There is an uncertainty that reaches its highest pitch in many of the scenes in which new scientific knowledge and new technological artifacts are developed and used. According to Steven Shapin (2008, p. 5), late modernity proliferates uncertainties; “radical uncertainty marks the venues from which technoscientific futures emerge,” and it is in the quotidian management of those uncertainties that subjective experience flourishes. Weber never imagines that what the future held was a new age of charismatic persons, such as Margaret Thatcher, Donald Trump, Silvio Berlusconi, Charles de Gaulle, and Barack Obama. A new age in which the extraordinary is ordinary, in which changes in values and attitude led by the example and personal force of publicly acclaimed personalities, is a characteristic feature of the culture (Turner, 2003, pp. 23–24).

Charismatic persons, ideological changes, and cultural schism cause terms such as fake news, fake truth, and post-factual age. The post-factual age with its competing truths seems to increasingly dominate not only the political discourse of today (Dunt, 29 June 2016; Holmes, 26 September 2016), but also the mental health care discourse. Currently, there seems to be a huge discrepancy between the welfare system’s expressed values and ideologies, such as user involvement, humanity, information, and user adjustment, and the restricted and inhuman economic and rational values that the welfare system actually requires in order to support people (Joranger, 2009). There is also a striking growth of discrepancy inside the welfare system between those mental health care workers who have a medical neuroscientist’s approach to mental problems and those who have a more humanistic relational approach to mental problems.

According to Richard T. G. Walsh, Thomas Teo, and Angelina Baydala (2014), mental health care workers have defined the focal points of their study through either objectivistic natural science-oriented psychology or what they call interpretative human science-oriented psychology. They believe that those with a natural science orientation typically emphasize the prediction and control of behavior and those with a human science orientation generally stress subjectivity (Walsh et al., 2014, p. 6). Those with a natural science orientation often represent neuroscientists as working in laboratories in an attempt to understand the brain and body mechanisms tied to behavior. Those with a human science orientation often represent social and mental health care workers as working in institutions with a variety of human beings with different kind of mental and behavioral disorders.

Both groups, the natural science oriented and the human science oriented, have an understanding of the mind-brain problem but differ sharply in their take on its implications. The neuroscientists, because of their interest in neurology and the structure of the physical brain, are suspicious, sometimes to the point of contempt, of much 'mind' talk, suspecting that behind such talk is an effort to introduce ghosts into the machinery of the nervous system. Yet, these very scientists believe that through the contents of other forms of consciousness, such as thoughts, perception, and insights, it will be possible to move toward an accurate impression of reality.

The aim of the book

Taking into consideration that our perceptions and our notions of truth and fault, sick and healthy, are conceptually and contextually dependent, the book will provide a broad interdisciplinary kaleidoscope of perspectives about the reciprocal relations between the human mind and the living world with special attention to the problematic place of mental health care services in the modern welfare state. The book will not just be an account of modernity's multiple skirmishes against individual minds and experiences, but rather, by reason of its special focus, a more direct defense of the irreducible human mind and an analysis of how the contemporary and somewhat one-dimensional view of a generalized human being affects and reduces our human reality. Such a defense, properly pursued, would enable us to understand why it is that unique subjective experience persists and why we should take it seriously by facilitating its development and uniqueness.

Using language from different interdisciplinary knowledge areas as well as different historical epochs and worldviews, the book will broaden up the understanding of what it is to be a human being in everyday life, whose problematic status leads people to seek mental health care in many different ways. It will broaden up the understanding of what it is to be a mental health care worker and a service user struggling for power and recognition inside a mental health care institution. The reciprocal relationship between people in social and professional frames, such as those between mental health care workers and service users, will be highlighted as something that shapes both the mental health care worker and the service user

(patient), as well as their common environment.¹ As living beings, we are not passively adapting our social relations with other; we are creative, reflexive actors who have an impact on others and on cultural and scientific norms, which we also, consciously and unconsciously, adapt.

As a means of addressing the subject matter, I will turn to some exemplary intellectual traditions that ask questions about how particular conceptions of mental life came into being, and how this affects our approach to ourselves and others. Under these traditions, we find current philosophers, psychiatrists, critical psychologists, sociologists, and anthropologists (see Bruner, 1990; Danziger, 1990, 1997; Gergen, 2001; Hacking, 1995a, 1995b; Harré & Sammut, 2013; Kinderman, 2014; Martin & Sugarman, 2001; Moghaddam, 2003; Parker, 1989; Prilleltensky & Nelson, 2002; Robinson, 1986, 2015; Rose & Abi-Rached, 2013; Shweder & Sullivan, 1993; Smedslund, 1988, 2011; Taylor, 1989, 1991; Valsiner, 2014).

We also find the existential-phenomenological and interdisciplinary tradition, which refers to a group of European philosophers, historians, and psychologists/psychiatrists, whose works generally span the decades between the 1920s and 1960s (cf. Joranger, 2015). The European existential-phenomenological tradition will in this book mainly be represented by the German psychiatrist and philosopher Karl Jaspers, the German psychiatrist Ludwig Binswanger, the French intellectual historian Michel Foucault, and the French philosophers Jean-Paul Sartre and Maurice Merleau-Ponty.

The existential-phenomenological view of the human mind is connected with the emergence of the human sciences in the second half of the nineteenth century. In this period, there was a concerted effort to find a common denominator for issues concerning the human mind, expression, and thought. Such issues had not been afforded the same scientific status as traditional scientific disciplines, such as mathematics and physics. After the experience of war, terror attack, and the mass of displaced people in need of public social and mental health care services, the existential-phenomenologists were concerned with ideas related to discrimination, politics, language, biology, physiology, culture, class struggle, and subordination, that is, how it is to be a human being in everyday life. The revelation of the underlying ideas that led to discrimination against some groups with regard to both humanity and human rights was one of several reasons that the French and German postwar intellectuals had increasing interest in interdisciplinary ideas.

In addition to drawing inspiration from the German philosopher and historian Wilhelm Dilthey's history-oriented and hermeneutic philosophy, existential-phenomenology was strongly connected to thinkers such as Immanuel Kant, Søren Kierkegaard, Friedrich Nietzsche, Henri Bergson, Edmund Husserl, and Max Weber. Not least, Marx's notion of class struggle and Hegel's phenomenological and dialectic psychoanalytical thinking about the struggle for social recognition and the fulfillment of self and society were highly valued. Inspired by these thinkers, as early as 1913, Jaspers distinguished between *interpretative* (*verstehen*) and *explanatory* (*erklären*) mental health care in his 1913 seminal book *General*

Psychopathology (GP) (*Allgemeine Psychopathologie. Ein Leitfaden Für Studierende, Ärzte und Psychologien*) (Jaspers, [1913]1997). The distinction will be firmly highlighted as the distinction between the human sciences and the natural sciences throughout this book.

Like the artists and poets in the Romantic epoch, the existential-phenomenologists looked back at ancient times as representing the ‘quiet times’ where every human being could develop freely, without influence from the expansive state power. They saw in positivism and what they called dogmatic rationalism and empiricism a project of alienation, and something they should fight and protect themselves and others against (Joranger, 2013).

In their endeavor to establish an interdisciplinary and historical view of the human mind, they replaced Descartes’s introspective thinking with the notion that human consciousness cannot be separated from the society and culture of which it is a part. By linking individual experience and virtue to a unique reflexive actor, as well as to the biological body and the sociocultural and historical environment, the existential-phenomenologists focused on topics related to meaning-centered themes. Under the subject of meaning, they discussed the relationship between facts and values, language and meaning, subjectivity and objectivity, body and mind, etc. Instead of leaning on one single theory and one single historical epoch, they looked to several historical epochs and several academic disciplines and theories, such as history, art, and poetry; psychoanalysis; critical psychology; existentialism; surrealism; linguistics; semiotics; social anthropology; physics; gestalt theories; neurology; and phenomenology. Using literary and poetic reflections on existential themes, they, similar to the Romantic poets, sought to generate a view that could explore how the human mind stands in contrast to the concrete, objective, and experimental.

In a different vein, this book will describe epochs, from Antiquity through the Renaissance and Romantic period, and their pivotal authors that illuminate an interdisciplinary approach to the human mind as well as the distinction and the connection between natural sciences and the more interpretative humanistic sciences. The underlying idea guiding my discussion is that human life constitutes itself as a theater. This is a theater where the mysterious relationship between subjectivity and environment, world and word, inner and outer, night and day, facts and value, is played out. We are talking about a complete theater with front stage, stage lighting, curtains, backstage, wardrobes with costumes of the wildest variety. In this theater, we also find cellars with old sceneries and props, and lofts with trunks full of scripts and old screenplays that can be replayed again and again and reworked over and over, a place of memories, imagination, and dreams that connects past, present, and future events. Quoting Goethe’s poetic emphasis, one could say that:

You must, when contemplating nature,
Attend to this, in each and every feature:
There’s nought outside and nought within,

For she is inside out and outside in.
Thus will you grasp, with no delay,
The holy secret, clear as day.

(Epirrhema, Goethe, translated by Christopher Middleton)

With Goethe in mind, the book will highlight in a different register, in prose, the strength and point of the poetic language. With its aesthetic and rhythmic qualities, the poetic language extends the scientific language as well as everyday life language (Joranger, 2013). The way the poetic language uses forms and conventions, such as ambiguity, symbolism, irony, and other stylistic elements, to suggest differential interpretation to words, or to evoke emotive responses, leaves it open to multiple interpretations. Opposed to the bureaucratic, medical, and psychological language, the poetic language, through its openness, manages to express the human fragility, and the fragile and many times random distinction between right and wrong, sick, and healthy, not as a negative or default option, but as a positive real value that can never be reduced to a specific form.

The following chapters will explore the foregoing themes in the hope of establishing the possibilities of different types of psychological knowledge of human beings in general and the mental health care worker and their patient in special that is not restricted to a single method or single worldview. They will keep in mind concrete issues of mental health care and the need for theoretical frameworks adequate to the phenomena that put aside theoretical and ideological prejudice, which are the biggest threats to truth about human reality and its lived contexts.

Chapter 2, *Mind and epistemology*, seeks ways to describe the relationship between the physical ‘outside’ world and the psychological ‘inside’ world. It poses a double question: (a) Is the human mind so determined by its physical and cultural environment that it can be considered to be governed by universal laws or (b) are human minds so different from each other that psychology cannot give an account of our perceptions and behavior by exclusive recourse to general laws? The chapter sketches the origin of the history of the modern understanding of subjectivity and objectivity and how this history connects to the context of modern science and the distinction between natural sciences and human sciences and, further, to the contexts of knowledge in general. The aim of the chapter is to examine how the understanding of subjective experience and objective knowledge affect current mental health care praxis and research. Our understanding of the relation between what is real and what is fake, that is, truth and fiction, and of what it is to be a human being in everyday life is taken up.

Chapter 3, *A critical and interdisciplinary approach to the human mind*, takes up the history of modern mental health care and how it connects to sociocultural and historical contexts and changes. The chapter explores the meaning of critical, historical, and interdisciplinary thinking and highlights the reciprocal and sociocultural side of the human being. It shows that semiotic activity, such as making a diagnosis, the keeping of medical records, and the

wearing of uniforms have both a representational and cultural function. The dialectical relationship between the independent and acting individual (such as the mental health care worker or service user) and the socially dependent individual is analyzed. The chapter demonstrates how the need for social belonging directs attention to the existential meaning of self-reflection and to the nature of communication. It points out that without communication and without social units there will be no mental health care system, no welfare state, no political order, and no democracy.

Chapter 4, *Freedom and governance in socioeconomic status*, examines the relationship between socioeconomic status, subordination and domination, freedom and government. It highlights the fundamental facts which govern the course of moral action and the fight for social recognition. On the basis of the modern welfare state, our moral actions are exemplified and symbolized by various conceptions of the welfare state's economic assistance to the poor and to those who for some reason have stopped being economically productive. However idealistic this moral aid and social insurance may be, it has also shaped new human categories of social exclusion and deviation. The result has been that some people experience social anxiety being assigned low socioeconomic status, leading to an everlasting fight for social recognition. The chapter shows, by alluding to a philosophical theme, that because of a never-ending contradiction in the social environment, a fulfillment of the absolute self or an absolute consciousness, a dream of philosophy, will forever be utopian, an insight with great relevance to our discussion.

Chapter 5, *Body-mind-thinking*, argues that thinking is a type of expressive 'pointing' and that pointing needs a body in order to take place. Like the human mind, the body is the medium by which we represent ourselves and our unique manifestations as subjects. We think and feel with our bodies, especially with the body parts that constitute the brain and nervous system but also with other dimensions of the body manifesting itself as a somatic tonus. Our bodies are likewise affected by mental life and cultural ideas of what is thinkable and behaviorally possible. Most of the hostility toward people with mental and/or physical disabilities is the product not of rational thought but of deep cultural prejudices that are somatically marked in terms of vague uncomfortable feelings aroused by disabled bodies and facial features. These feelings are experienced implicitly and thus embodied beneath the level of explicit consciousness. By seeing the body as a kind of experiential tool, our physical body is revealed as intrinsically existential. Our body also functions as a surface toward the world that surrounds it. If the body is situated in an overregulated working place, such as a modern mental health care institution, or is governed by a disciplinary bureaucracy or by another person, the governmental structure will enter the body-mind structure and guide its thinking and forms of expressions to such an extent that it becomes alienated from itself and others.

Chapter 6, *The human mind in concept and experience*, provides a number of examples, historical and otherwise, of how language and concepts concerning the human mind and the modern mental health care, including conceptual metaphors, have come into being and how they govern our understanding of mental health

care, science, human beings, and the political order. Along with subjective experiences, concepts structure our interpretation of what we see and read, how we get around in the world, and how we relate to other people. By investigating the experiences, words, and concepts belonging to the conceptual history of mental health care, politics, and education, one can see that there is a multiplicity of factors and meanings existing behind the concepts representing their history. Psychological concepts and labels carry a great deal of implicit theoretical baggage because they come with rich connotations acquired through everyday usage.

Chapter 7, *Subjective minds and general laws*, highlights the restricted and one-dimensional focus that characterizes mainstream mental health care language and introduces an alternative ‘un-coded’ poetic way into the human mind that engages the following fundamental questions: What really is a person? Can a person be ‘found’ or conceptually mapped through general laws? The chapter concludes that the way that a person adapts to a situation is dependent on several conditions. Such adaptation needs to be looked at by different disciplines. From the side of the person we must take into consideration our forms of imagination, our life experiences, our biological body, our own unique personality, the persons we meet, and how we and the other person want to be seen reciprocally. It also depends on the situation itself. If no one knows how subjective experience is creative in situations, how can the mental health care worker be obligated to help people according to standardized manuals that know nothing about a person’s unique configurations of feelings, imaginations, and experiences? A mental health care service with little place for fantasy and imagination has little place for the psychic phenomena that rule our lives.

Chapter 8, *Humans, science, and experiences in change*, concludes the book by appealing for an interdisciplinary revolution in mental health care services and in social work and research. If meaning and consciousness shall continue to be considered the central theme in mental health care services, researchers and welfare workers dealing with human beings need to join forces with the interpretive disciplines in the humanities and in the social sciences, a guiding theme of this book. As living beings, we are not just physical brains or marionettes on strings in a rational historical play. We are creative, reflexive actors who have an impact on cultural and scientific norms, which we also, consciously and unconsciously, adapt. This is why mental health care workers and scientists dealing with psychological phenomena should seek to become not only a positivist Sherlock Holmes, intelligently discerning the concealed and buried meaning that is awaiting discovery, but in contrast, the detective who finds him/herself part of the game and thereby a co-creator of the mystery she/he seeks to solve.

Note

- 1 The concepts ‘service user,’ ‘patient,’ and ‘client’ will through the book be used interchangeably.

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Mind and epistemology

We must consider the truth about the human mind in the context of the scientific advancements made by humans, attempting all the time, as humans become more and more highly evolved, to master and control more and more of the human universe. Throughout the history of psychology and mental health care different scientific environments have developed competitive truths and epistemologies that claim that their understanding of a human being represents the only objective truth. There have been psychoanalysts, anti-psychiatrists, resilience therapists, Marxist therapists, feminists, sociobiological therapists, radical behaviorists, all attempting to write their presumptions into and explanations of disabilities and mental disorders without a comprehensive study of the conditions themselves. J. B. Watson's (1878–1958) description of radical behaviorism, such as it is outlined in the *Psychological Review* in 1913, is an example of the struggle for objective knowledge in psychology:

Psychology as the behaviorist sees it is a purely objective, experimental branch of natural science. Its theoretical goal is the prediction and control of behavior. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent upon the readiness with which they lend themselves to interpretation in terms of consciousness. The behaviorist, in his efforts to obtain a unitary scheme of animal response, recognizes no dividing line between man and brute.

(Watson, 1913, p. 158)

This absolute observation seems to be an historical starting point for the contemporary notion that the main function of research on the human mind is to predict objective facts through empirical research on the physical empirically accessible brain. Today, the field of research on psychological phenomena is overflowing with brain concepts belonging to the external visible brain world, which are influencing our understanding of what is to be a human, forgetting the relationship between the more or less lived subjective mind-world relationships. The consequence of the many natural science-oriented debates has been to reinforce the concept of individuals as isolated from their culture and history. Not

only the subject of the psychological laboratory, but also the humanistic self is, in this context, seen as ahistorical and asocial. The ideal self has freed itself from tradition and authority and dissociated itself from the society it inhabits. To argue for the importance, even the centrality, of the subjective dimension in late modern academy, is directly to confront a sensibility that defines the academic notion of reliability and validity.

What has current mental health care practices to do with this? In our quest to understand a person's explicit and implicit ways of thinking and acting, it may seem like the ultimate paradox that current research on the human mind and behavior has been restricted to the external visible (brain) world. It seems that natural science-oriented scientists and their endeavor to provide exact objective knowledge of the human mind are poised to become the new expertise in the management of human conduct. Many now seem to believe that only the brain is what makes us human (cf. Rose & Abi-Rached, 2013). But, as Dewey (1916, pp. 13–14) once said

Thinking, or knowledge getting, is far from being the armchair thing it is often supposed to be. The reason it is not an armchair thing is that it is not an event going on exclusively within the cortex. . . . Hands and feet, apparatus and appliances of all kinds are as much a part of it as changes within the brain.

Opposed to Dewey's view, the predominant version of scientific naturalism maintains that all the basic theories of the social sciences, or perhaps more distinctly of psychology, are ultimately reducible to some suitable theory in the natural sciences. It is the last thesis that articulates a vision of the unity of the sciences, a unification in principle, via reduction of the theories of all the social sciences or at least of the basic one, whatever that turns out to be, to the theories of the natural sciences.

Human mind and natural science

What is mental health care and what is psychology? And what have these questions to do with natural science and interdisciplinarity? To get a proper answer one has to examine the complex relationship between natural sciences and human sciences. Here a bit of intellectual history is important. Kant claimed that the natural sciences focus on *nature*, including the physical human body as subject to physical laws. Human sciences focus on the *psyche*, a domain marked by the *pragmatic* and *intentional* structures proper to the human mind (Kant, [1798]2006, p. 3). Regarding our physical body, we can logically explain it using mathematical and physical terms and laws. However, when addressing our mind as belonging to the realm of *psyche*, we can only access it from the 'inside' through feeling and self-interpretation. In this way, when it comes to human beings and knowledge, one has to distinguish, as Karl Jaspers so forcefully argued, between two

kinds of scientific approach, an *interpretative* (*verstehende*) and humanistic, and an *explanatory* (*erklärende*) and naturalistic one (cf. Jaspers).

The separation between the ‘objective’ natural sciences and the ‘subjective’ human sciences is also connected to the distinction between the nomothetic sciences and idiographic sciences. The neo Kantian philosopher Wilhelm Windelband (1905, 1919) first outlined the distinction. Conceptually, the nomothetic sciences are based on what Kant (1787/1996) ascribed to the natural sciences, that is sciences that can generalize and describe the effort to derive laws and concepts that explain objective phenomena in general. Idiographic sciences are based on the humanistic sciences and what Kant describes as a tendency to specify, that is our efforts to interpret and understand the meaning of feelings and contingent, unique, and often subjective phenomena.

According to Dilthey we cannot distinguish between the natural sciences and the human sciences without including history. What is true about knowledge making should be true about particular historical moments of knowledge. Dilthey’s well-known aim was to expand Kant’s primarily nature-oriented *Critique of Pure Reason* into a *Critique of Historical Reason* that can also do justice to the social and cultural dimensions of the human mind and experience. Understanding the meaning of the human mind and behavior requires being able to organize these events in their proper historical contexts and to articulate the structural uniformities that can be found in this specific time period.

Dilthey, whose studies were rooted in the humanistic and social sciences of the nineteenth century, was one of the first to note how unsatisfactory modern philosophy was in the humanistic and social sciences and how all reform movements of modern logic and critiques of reason, whether related to Kant or British empiricism, were one-sidedly determined by natural science. Dilthey also confronted the question of the extent to which the new physiological and experimental psychology could satisfy these sciences of the mind and the extent to which this mental pretention was justified. He sought to show that, against this ‘explanatory or constructive’ psychology, there was a need for a ‘descriptive and analytic’ psychology. He attempted to sketch this idea in his continuing critique of the type of experimental psychology that had become dominant (Dilthey, [1894]1957). According to Dilthey, experimental psychology followed the ideal of the exact science of nature. As the latter does with physical appearances, experimental psychology wants to subordinate the appearance of the psychic life to a causal nexus by means of a limited number of univocally determined elements. For Dilthey, this entire process was completely inappropriate for the psychic essence; it emerged from an unjustified extension of natural scientific concepts of the psychic life and history.

More recently, Ian Hacking (1995) and Kurt Danziger (1997) follow Kant’s and Dilthey’s critical scientific view on the human mind, when they separate between what they call ‘natural’ kinds and ‘human’ kinds. Whereas natural kinds, such as physical objects and biological species, are defined as something that exists independently of those studying them, human kinds are described as defined and constituted, both intentionally and unintentionally, by the aims, methods, and

practices of human agents, such as mental health care workers and their clients. Danziger (1997, pp. 191–192) claims that:

Human kinds . . . are not natural kinds, but neither are they mere legends. They do refer . . . to features that are real. But it is a reality in which they themselves are heavily implicated, a reality in which they are a part.

Based on the distinction between human kinds and the natural kinds, one can presuppose that there are two kinds of scientific qualities and two kinds of scientific approaches when it comes to human beings. One varies with the perspective one has or takes, rooted in subjectivity and the felt sense of life such as in the human sciences, while the other remains constant despite any changes in perspective (objective seeing in the putative theoretical sense). The latter qualities are the objective properties that brain science and natural science study, which require that data be collected through direct observation or experiment. Empirical evidence, on this latter position, does not rely on merely personal arguments, beliefs, values, or feelings. All extraneous variables need to be controlled in order to be able to establish cause and effect. Objective properties support the predicting of future behavior from the findings of the research. As a consequence, it should be possible to replicate the research. As a consequence, that is, repeat it with different/the same people and/or on different occasions, in order to establish, among other things, whether or not the results are similar.

Thomas Nagel (1986) details how we arrive at the idea of objective properties in three steps. The first step is to realize (or postulate) that our perceptions are caused by the actions of things on us, through their effects on our bodies. The second step is to realize (or postulate) that since the same properties that cause perceptions in us also have effects on other things and can exist without causing any perceptions at all, their true nature must be detachable from their perspectival appearance and need not resemble it. The final step is to form a conception of that ‘true nature’ independently of any perspective. Nagel calls that conception the ‘view from nowhere.’

It seems that the frustration that has taken up residence in the public mental health care worker’s body and mind has something to do with what Nagel calls the ‘view from nowhere’ and the objective and absolute conceptual truth of the human mind. In their daily praxis with different people, mental health care workers find the absolute truth and the view of nowhere inappropriate and restricted. No matter how desirable the attaining of an absolute conceptual viewpoint may seem, it is clear that the mental health care workers’ ability to use scientific and evidence-based claims to represent all and only facts about their patients’ minds depends on whether these claims can be unambiguously established on the basis of evidence and the results of testing (Parker, 1992; Prilleltensky, 1994). These seem paradoxical when we know that researchers test scientific claims by means of their implications, and it is an elementary principle of logic that although the implications of claims are true this need not imply the truth of the claims

themselves (Longino, 1990, 1996; Popper, 1959, 1972; Putnam, 1987). Rather, the researcher's tests should be related to a specific sociocultural and historical context that more or less unconsciously pushes researchers as well as therapists to think according to certain values, whether moral, personal, social, gender-specific, political, or cultural. Based on this knowledge, language and concepts arrived at by sensation and personal and cultural experience can in very few cases be the bearers of an objective truth, neither in science nor in culture at large.

The cognitive revolution

Epistemologically, the different approaches to questions concerning the human mind and what it is to be a physical human being with a seemingly nonphysical meaning-making mind in reciprocal relationship to a specific physical and psychological environment point toward topics concerning language and logic, scientific ideals, meaning, and understanding. The discussion of language, interpretation, and the meaning-centered research was, according to Jerome Bruner (1990), the heart of the cognitive revolution in psychology and the public mental health care system at large, as opposed to radical behaviorism and neurology, the theoretical goal of which was classically affirmed to be the prediction and control of behavior and stimulus response theory of human action, à la John B. Watson (1913) and Ivan Pavlov (1941). To Bruner (1990, p. 2):

The aim of the cognitive revolution was to discover and to describe formally the meanings that human beings created out of their encounters with the world, and then to propose hypotheses about what meaning-making processes were implicated. It focused upon the symbolic activities that human beings employed in constructing and in making sense not only of the world, but of themselves.

In this declaration, still relevant, the seeds of an interdisciplinary and critical study of human activity were sown. For, as Bruner (1990, p. 2) goes on to say, if meaning were to become the central term of mental health care, then mental health care would need to “join forces with its sister interpretive disciplines in the humanities and in the social sciences.” To Bruner the cognitive revolution was intended to bring ‘the mind’ back into the human sciences after a long cold winter of objectivism. He now worries that the cognitive revolution, such as it has developed, has been affected by methods and techniques that may have cost scientists the loss of the original idea: “Indeed, it has been technicalized in a manner that even undermines that original impulse” (Bruner, 1990, p. 1).

The object of interest can be related to what Bruno Latour (1987) calls *technoscience*. The concept relates to Latour's rejection of conventional distinction between what belongs to reliable knowledge and science inside academic institutions, such as mental health care institutions, and what belongs to society (common sense) (Latour, 1987, p. 174)

There are reasons to reject, or severely to qualify, much of the academic logic that characterizes certain sectors of the later modern view of the human mind. While the irrelevance of the personal and the subjective in scientific knowledge making has been vigorously asserted at least since the seventeenth century, subjective experience and common sense knowledge have always been pertinent to the making, maintenance, transmission, and authority of knowledge, academic or not.

Whatever is true about knowledge making in general should be true about particular historical moments of knowledge about the human mind (Dilthey, [1894]1957). When considering the supposed ejection of the personal and subjective from late modern technoscience, the endemic problem of theoretical reductionism presents itself, taking the part for the whole, and account of certain aspects of late modernity for its range of quotidian realities, what is considered the essence or leading control of change for the way things are. Paul Rabinow (1996, p. 184) has observed that “in the sphere of meaning, the mark of modernity is fracture and pluralism. . . . Modernity is the principle of de-magnification, not its colonial triumph.”

Reductionism afflicts not only thoughts about the human mind, but practically all influential social and cultural theories – almost necessarily so insofar as theoretical representations are, almost, abstracts of the social and mental realities they purport to describe. Abstraction and reductionism alone produce science out of the complexity or the unity of reality. The move from noting those aspects of a present-day view of ‘depression’ to describing a person as a ‘depressed person’ or a state’s economy as a ‘depressed economy’ is an example of late modern de-magnification (reductionism). Remarking on the importance of quantification in late modernity to describing number as our privileged way of remedying problems of bias, interest, and mistrust, is another. The reductive bias is also present in the current tendency to characterize the human mind according to a set of medical categories called diagnoses.

Clearly, diagnoses, such as those charted in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), can be not just mistaken but delusional and even morbid, but they leave intact the presupposition of a universal framework of experience. As such, theoretical reductionism concerning the human mind is a problem to those wanting a more filled-in picture, rather than a pencil sketch, of the way we are and the way we live now. However, dissatisfaction with stories about depersonalization and demoralization amounts to more than that. One could say that the related resources of subjective experience and personal virtue are neglected aspects of late modernity knowledge making and that they survive in more vigor than some theorists allow.

For Bruner (1990) there cannot be any value-free technocratic science of the human mind in the sense of subjectivity; there exists no fixed relationship between the objective features of situations and responses and their meaning for the persons involved. Any objective story can have any meaning for a person and, conversely, any personal meaning can be expressed through any objective feature. Bruner shares the view that to achieve meaning, the study of history and

culture plays a pivotal role. Meaning is in this sense something neither determined (more or less) by innate biological drives nor created (however intrapsychically) in the individual mind. Rather, to speak of meaning, one must begin with the concept of ‘culture’ rather than ‘biology’ (Bruner, 1990, p. 20). Bruner remarks that a great divide in evolution was crossed with the introduction of language and culture. Quoting Geertz’s perception that “we humans are incomplete or unfinished animals who complete or finish ourselves through culture” (Bruner, 1990, p. 12), Bruner illuminates that culture is constitutive of subjective meaning and interpretation because everyday practices of meaning-making draw from symbolic systems already ‘there,’ in other words, deeply entrenched in culture and language.

Bruner’s emphasis on culture finds expression in contemporary cultural psychology. According to Richard A. Shweder and Maria A. Sullivan (1993, p. 498):

Cultural psychology is, first of all, a designation for the comparative study of the way culture and psyche make each other up. Second, it is a label for a practical, empirical, and philosophical project designed to reassess the uniformitarian principle of psychic unity and aimed at the development of a credible theory of psychological pluralism. Third, it is a summons to reconsider the methods and procedures for studying mental states and psychological processes across languages and cultures.

By relating subjectivity to medical concepts alone, it is, according to Foucault (1954, 2001), easy to overlook the fact that different mental states are a result of, and a reaction to, irrational intersubjective and sociocultural relations, all of which have evolved in step with democratic and sociocultural developments.

The appearance of thing and nature

Throughout the history of mental health care, scholars have eagerly sought ways to describe the relationship between the physical ‘outside’ world and the psychological ‘inside’ world and to find a model for this relationship. Is the physical world a mechanical world and a model for modern government and mental health care treatment, and is the psychological world a ‘minded world’ that stands in contrast to the outside world, or are they parallel, interacting, or inseparably linked? Do we possess different inborn and largely unchangeable temperaments and a fixed personality (genetic), as Plato, Descartes, and Kant seemed to believe, or are we, as individuals, born with minds similar to a *tabula rasa*, a blank tablet to be filled with experiences, as Aristotle, John Locke, and John Stuart Mill believe? These questions connect to the argument about describing the relationship between *nature* (genetic constitution) and *nurture* (the physical environment). In the modern world, the nurture view is espoused in such divergent perspectives as empiricism, behaviorism, neurology, and some areas of linguistics and semantics, anthropology, and ethnography, psychoanalysis, existentialism, and Marxist Hegelianism.

Within these nurture approaches, there is an ongoing debate over whether our mind, as individuals or as groups of individuals, can be determined by our physical and cultural environment and driven by universal and abstract laws, as the behaviorists, empiricists, and extreme Marxist Hegelians suggest, or whether we, as individuals, are so psychologically different that our perceptions and behaviors cannot be determined by either materialistic or structuralist universal laws. This anti-deterministic notion is shared by several existential-phenomenologists, although they also believe that our psychic world is dependent on our physical world and that we must complement our study of how a person psychologically perceives her- or himself and the world with a study of the phenomena perceived.

When we delve deeper into the relationship between the psychical and physical worlds, we meet an unexpected challenge concerning how the human mind experiences things in the physical world, that is, nature. In his *Critique of Pure Reason* ([1787]1996), Kant was one of the first philosophers to develop a thorough phenomenology of how our experience of nature is created through the filter of our mind. Kant's notion was that we can never have *direct* experiences of things in the nature, the *noumenal* world. What we experience is the *phenomenal* world as conveyed by our senses. To Kant we never see or otherwise perceive (or 'sense'), or anyhow we never directly perceive or sense, material objects (or material things), but only subjectively sense data or our own ideas, impressions, sense, and sense perceptions, such as color, taste, tone, temperature, resistance, etc. In themselves, they are not yet nature. They rather become nature, and they do so through the activity of the mind which combines them into objects and series of objects, into substances and attributes, and into causal connections. In their immediate givenness, Kant held, the elements of the world do not have the interdependence which alone makes them intelligible as the unity of nature's laws. It is this interdependence which transforms the world, fragments, in themselves incoherent and unstructured, into nature.

Kant was convinced that he had found the source. The human mind, in all its departments, has a structure of its own; therefore, whatever the human mind apprehends will always be grasped according to definite rules. These rules may be called *a priori*, that is, conditions to which all experience and reasoning are subjected. To Kant ([1787]1996) our common knowledge of things stems from the fact that our mind structures subjective experiences through the same *a priori* universal rule connected to the framework of time and space. Our experiences, psychical and physical, are thus always temporal, or in time, and most of them are in space. A thought or desire might be an example of a non-spatial but temporal experience, but taking a walk occurs in both space and time (Kant, [1798]2006, p. 3). The mind, understood transcendently, comes equipped with these forms; otherwise, Kant argues, we could not account for the coherence, structure, and universality of human experience.

In late modern welfare states and in late modern health care routines, time and space seems to be a guiding factor for thought and behavior in such a degree

that it become unbendable and universal in peoples' everyday life. Inside late modern bureaucratic mental health care routines, time and space are lodged in a mechanical worldview where every employee has to work according to a specific, sometimes unrealistic, time schedule, which breaks brutally with the employee's own mental needs and experience of time and space. However, running around helping patients in institutions and in hospitals and elderly people in their homes with unrealistic deadlines ahead of them, the health care worker of today normally experiences time and space, as well as their own physical body, not as universal but as a subjective inadequacy and as something that is flying away from them.

The experience of always running *after* time, rather than being in the middle of it, becomes both subjective and real for a health care worker in the sense that (s) he organizes his/her day accordance to his/her experiences of inadequacy, that is, of constantly passing out of spatial relationships with the elderly, because there is no room for sitting down in time and space, and being close to the people they are supposed to help.

Although the concepts of 'time' and 'space' have common human significance and will always be present as a type of *a priori* assumption regarding human life, they also depend on unique subjective experiences.

Looking at time and space from the traditional dichotomy connected to the natural sciences and human sciences, that is, from the physical angle and from the psychical angle, we can theoretically distinguish between two types of time: the mathematical physical time that belongs to the measurable natural and nomothetic world and the experienced psychological time that belongs to the ideographic and interpretative mind-world. *Psychological time* can be examined in the phenomenology of the sensation of time, describing the original features of the way we *experience* time, and in the psychology of estimates of and delusions about time, comparing a subjective view of time with an objective time.

In contrast, our understanding of *physical time* as *historical time* is based on chronology and a framework of objectively measurable time. In this sense, it is the possibility of appeals to our existence by a decision, an epoch, a crisis, a fulfillment. From an *objective* point of view, we live solely and exclusively in a common time, but *subjectively*, we can live timelessly in contemplation. We can 'forget time,' aiming for a world of timelessness and seeming therein to become timeless *ourselves*. In this view, the subject forms his or her own history.

Following the French philosopher Henri Bergson ([1889]2012), we could say that the mathematical time that currently exists inside the late modern (mental) health care bureaucracy exists passively, as a line on paper. The time we experience as a patient and a health care worker, however, is a one-way, floating range of interpenetrating conditions experienced as an undivided process. Bergson calls this time 'pure time' or 'real duration' (*la durée réelle*).

To Bergson, the difference between *space* and *duration* is essential. In *space*, things are separate from one another; they emerge with clear differences and in different locations and form an external, static, and mechanical composition. Conversely, in *duration*, phenomena overlap; they form an inner liquid and

overlapping motion, and each can only be understood through this internal context. In this way, the conditions of consciousness also overlap; they reflect each other and form what one might call an organic whole. This means that the personality is fully present in even the slightest phenomenon of awareness. In this sense, *time* is an endlessly reiterated becoming and passing, begetting and devouring, and there is no being in that. There is no longer a past in it, nor any future; nothing happens; nothing is decided. As such *duration* is not real time but a continuous not-now, a mere diffusion without being, a time that can never be a properly present time because it is always either gone or not here yet.

Bergson's notions are, in this sense, anti-deterministic. Because the different aspects of the human mind are interconnected and related to each other, they are colored and marked by each other. In this way, the human mind changes constantly as it receives new impressions from the inside and outside world; it exists in a constantly dynamic process. This philosophical point holds for the mental health care worker as for the service user. The desire to predict and measure the duration is, for Bergson, synonymous with the modern bureaucratic attempt to stop the unpredictable and creative side of the human mind.

The world as it appears to an observer

Since Kant, we have more or less accepted that our subjective perceptions lead to a perceptual or psychological environment that is often different from the physical one. Kant calls this dichotomy the *thing-in-itself* (*das Ding an sich*), as opposed to the *phenomenon* – that is, the thing as it appears to an observer. Consequently, we perceive the world and our self as *imaginings*, or in pathological cases deceptions of the senses. When a service user or a mental health care worker reacts to the bureaucratic environment, they are not necessarily reacting to the physical or natural reality; rather, they are reacting to a different psychological reality. Still, psychological realities such as imaginations, movements, dreams, and language represent the social and historical situation itself, that is, nothing unreal (Merleau-Ponty, [1960]1964).

In fact, to imagine can be the first step to create meaning out of meaningless things and to think creatively outside common structures. The ability to imagine enables us to broaden up every day restrictions. It makes us experience different types of meanings, situations, and phenomena that are not commonly shared and that do not refer to the common physical world.

Most of us find it difficult to understand the idea of 'imagination' because we assume that there are only two types of reality: objective realities and subjective realities, natural kinds and human kinds, and that there is no third and fourth, and so forth, options. In objective reality, things exist independently of our beliefs and feelings. Gravity, for example, can be seen as an objective reality. Gravity existed long before Newton, and it affects people who do not believe in it just as much as it affects those who do. Subjective reality, in contrast, depends on our personal beliefs and feelings.

If we understand that something not only belongs to our own subjective feelings, it is easy to jump to the conclusion it must be objective, such as the value of money, the faith in God, and the power of the state. But, our word and perceptions concerning ‘reality,’ ‘signs,’ and ‘meaning’ are much subtler and diverse in their uses and mark many more distinctions beyond subjectivity and objectivity than scientists and philosophers seem to have realized. It is essential, here as elsewhere, to abandon old habits of the deeply ingrained worship of tidy-looking dichotomies. As long as we have the power of transcendence in dream and imagining, and as long as we are dependent on intersubjective relations, that is, relations to the world, to words, and to other human beings, what is considered to be reality and what is not changes with circumstances, experiences, as well as time and space.

Outside the mental health care bureaucracy and outside academic institutions, that is, in common life, the very old debate whether things are supposed to be inside or outside, real or not, if it only works for its purpose, seems to have vanished. In the private sphere, the theory of relativity makes nobody angry, because it does not actually contradict any of our beliefs about the lived everyday world. Most people do not care whether space and time are absolute or relative. It does not normally occur to us that there is any need for us to justify our belief in the existence of material things. At the present moment I have no doubt that I really am perceiving the familiar objects, the bed, the flowers, the dress, the computer, and the books with which my room is furnished. I am therefore satisfied that they exist. I recognize indeed that people are sometimes deceived by their senses, but this does not lead me to suspect that my own sense perceptions cannot in general be trusted, or even that they may be deceiving me now (Austin, 1962).

Truth and fiction

When it comes to contemporary research on the human mind and behavior, important natural science-oriented brain research is clearly done, no doubt. It is important to keep in mind that criticism of scientism is not a criticism of science. It is a criticism of the contemporary attempt to make science a reductive materialism without including philosophical and metaphysical questions, such as how our conceptions of human beings and psychological phenomena came into being (cf. Robinson, 2015). Rationalism need not be a closed system; *a priori* assumptions are subject to change. It should, therefore, be of some interest to take a fresh approach to the philosophy of science, to examine the subject without preconceptions and free of the straitjacket imposed by the traditional vocabulary of philosophy. Science in effect creates theories about the world and the people in it. Theories about the human mind and behavior must therefore adapt and modify their language if they are to reflect the subtlety and movement of contemporary thought. It must also respect the oddly ambiguous requirement

that all scientific ideas be interpreted in both realistic and rationalistic terms. For that reason perhaps we ought to take as our first object of contemplation, our first fact-needing explanation, the metaphysical confusion implicit in the double meaning of the phrase 'scientific proof,' which can refer either to confirmation by experiment or to demonstration by logic, to palpable reality or to the mind that reasons.

Inside a well-regulated mental health care system where the aim is to come to a truth of the human mind and behavior in order to help and improve people's life, patients and their therapists are caught in a net of medical concepts and grammar. The blind belief in statistics, medical diagnosis and concepts, efficiency, things and substance, qualities, essences, independently acting and being acted upon; all these are the product of the concepts and language that people inside the late modern well-regulated mental health care systems cannot wholly escape. We cease from thinking if we do not wish to think under the control of language. The most we can do is to attain to an attitude of doubt concerning the question whether the boundary representing what is sayable or truthworthy, or not, really is a boundary. Rational thought such as medical and economic calculations, is a process of interpreting account to a scheme, which we cannot reject if we are representing them or have chosen to work inside a public mental health care system that works and thinks according to certain lines.

Nietzsche ([1901]1968, § 482) observes that where our ignorance really begins, at that point from which we can see no further, we set a word or a scheme. For instance the words 'sickness' and 'diagnose,' or words like 'control,' 'discipline,' 'mind,' 'freedom,' 'I,' and 'will,' set up perceptual schemes that work as the horizon lines of our knowledge. Still they are not 'truths.' It follows of course, that words as 'mind,' 'freedom,' 'I,' and 'will,' are not names of things. They are many words, as Nietzsche would have claimed, which appear name-like, but cannot work as names of physical things. These particular words are established and used when a certain complex of relationships has become manifest, such as those professional relationships that have grown up inside the mental health care system. There is not, for example, one concrete physical *will* lying behind the complex connections entailed by striving to control this or that bit of the bureaucratic mental health care environment. Nor is there an single 'I' which thinks, as a separate entity from the relations persons have to the world in general. We cannot separate inner things, such as 'mind' and 'will,' apart from their expression in relationships. If we try to separate them from their broader context, they will only become meaningless and not communicable.

We must, then, consider truths about the human mind in the context of the scientific advance of humans, attempting all the time, as humans become more and more highly evolved, to master and control more and more of the human universe. Pure science or pure knowledge about the human mind and its environment, mentally and physically, the pursuit of truth for its own sake, is not possible, if 'truth' actually means that which leads to practical mastery over people and

environment. When it comes to human beings and their eager seeking after ‘truth,’ Nietzsche remarks:

There is no question of ‘subject and object,’ but of a particular species of animal that can prosper only through a relative rightness; above all, regularity of its perceptions (so that it can accumulate experience) – Knowledge works as a tool of power. Hence it is plain that it increases with every increase of power. . . . In order for a particular species to maintain itself and increase its power, its conception of reality must comprehend enough of the calculable and constant for it to base a scheme of behavior. . . . A species grasps a certain amount of reality in order to become master of it, in order to press it into service.

(Nietzsche, [1901]1968, § 480)

Against positivism, which states: ‘There are only facts,’ Nietzsche would say that all facts about the human mind are only interpretations. We cannot establish any fact ‘in itself.’ ‘Everything is subjective,’ you would say; but even this is interpretation to Nietzsche. The subject is not something given; it is something added and invented and projected behind what there is. As far as knowledge about the human mind having any meaning, the world is knowable, but it is interpretable otherwise, has no meaning behind it, but countless meanings. It is our subjective needs of predictability and controlling our environment and ourselves that interpret the world, our drives, and their *For* and *Against*.

From a Nietzschean point of view, every drive is a kind of lust to rule; each one has its perceptive that it would like to compel all the other drives to accept as a norm. As subjects, we interpret from within ourselves, so that our ego counts as a substance, as the cause of all deeds, as a doer. The logical-metaphysical postulates, the belief in substance, accident, regulations, and attribute, etc., derive their convincing force from our habit of regarding all our deeds as consequences of our will, so that the ego, as substance, does not vanish in the multiplicity of change. As it stands today, we have no categories at all that permit us to distinguish a ‘world in itself’ from the ‘world of appearance.’ There is then, just one public mental health care system that appears when we think about it, not two, although there exist different cultures inside the system and differences between what it says it shall do and what it actually is doing. However, the categories that we apply to the mental health care system are not the only possible categories. Our contribution to, indeed our construction of, our public mental health care system is a fact; but we could construct it a different way.

What it is that we find effective and worth fighting for may change from time to time (Nietzsche, [1901]1968, § 488). To the extent to which knowledge about the world and the human mind has any sense at all, the world is knowable, but it may be interpreted differently. It has not one sense behind it, but hundreds of senses. Therefore, it follows that ‘truth’ about the human mind and environment may change. This is a sense of ‘true,’ however, which is very difficult to

adopt. Our medical language rebels against it because of the old meaning of ‘true,’ according to which ‘true’ means ‘as the facts are’ and according to which there is an implied contrast between a statement of fact and a hypothesis. Therefore Nietzsche ([1901]1968, § 452) can write,

Truth is . . . more fateful than error and ignorance, because it cuts off the forces that work toward enlightenment and knowledge . . . it is more flattering to think ‘I possess the truth’ than to see only darkness around one – above all; it is reassuring, it gives confidence, it alleviates life – it ‘improves’ the character, to the extent that it lessens mistrust. ‘Peace of soul,’ ‘a quiet conscience’: all inventions made possible only by presupposing that *truth has been found*.

Once this most general hypothesis is accepted, then, the question can be put in this form: How is the will to truth about the human mind related to the will to power? For since as we have seen, the whole notion of truth is necessarily to some extent a deception, the need arises for a critique of the will to truth. According to Nietzsche (2000), if we turn to the most ancient and the most modern thoughts, they all fail to recognize to what extent the will to truth itself requires a justification. Because up to the present the ascetic ideal dominating all philosophy and way of thinking about the human mind and the truth was fixed as Being, as God, as the supreme court of appeal. Because truth was not allowed to be a problem. From the minute that the God of the ascetic ideal is repudiated, there exists a new problem, the problem of the values of truth. The will to truth of the human mind therefore needs a critique; the value of its truth is tentatively to be called into question.

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A critical and interdisciplinary approach to the human mind

The outer world of circumstance shapes itself to the inner world of thought, and both pleasant and unpleasant external conditions are factors, which make for the ultimate good of the individual. As the reaper of his harvest, man learns both by suffering and bliss.

James Allen, *As a Man Thinketh* (1903)

To Richard Walsh, Thomas Teo, and Angelina Baydala (2014, p. 2) the questions ‘what is mental health care’ and ‘what is psychology,’ are best answered as: ‘It depends on history!’ Although authors of current introductory textbooks typically define psychology as the *study of behavior and mental processes*, in the past psychologists did not share that definition. In fact, our notion of psychic phenomena is embedded in sociocultural and historical contexts that push us to think along certain lines that keep other lines out of sight.

It is within these contexts that we can trace the distinction between the psychology with a upper case *P* and the psychology with a lower case *p* (Richards, 2010). The former refers to the mental health care praxis as an academic scientific discipline and its professions and institutions, such as developed in nineteenth-century Europe, the latter to psychological subject matter with ancient roots, practiced in diverse cultures through the philosophical inquiry of self-reflection, as scholars, philosophers, poets, and others have studied certain psychological topics for millennia. The view is similar to what Danziger (2013) calls the ‘historiography of psychology’ and ‘historiography *in* psychology.’ According to Danziger (2013, pp. 329–330) the ‘historiography of psychology’ attempts to provide a history of what is now clearly a scientific and academic discipline, the ‘historiography *in* psychology’ by contrast, covers a broader range of topics.

The modern way of thinking about the human mind begins with the Renaissance. In the time of the Renaissance, it is the autonomy of the self, and not its dependence on an external world or of an outwardly and inwardly accessible God, which comes to the fore. Nietzsche (2011, §61) praises the Renaissance period for its ability to think critically, in a holistic way, and to devalue the Christian values and asceticism of the Middle Ages and bring about the triumph of the human mind

in all its creativity and wealth. To Nietzsche (2011, §61): “This has been the one great war of the past; there has never been a more critical question than that of the Renaissance and the past.”

Niccolò Machiavelli (1469–1527) can function as spokesperson of the critical side of the Italian Renaissance. Machiavelli’s theories about human beings, health, leadership, and community represent a system of thought outside the previous frame. His more or less secular non-moral theory of states breaks with ancient and medieval thinking, which assumes a moral universe constituted by the will of God and governed by His eternal laws. To Machiavelli, there are no stable standards apart from political success and no institution lasts forever. However, ordinary individuals are bound by their time and place, which indicate their astrological fate, *Fortuna*. Only humans with superior strength and creativity could break *Fortuna*’s plans and seize the opportunity (‘*l’occasione*’) which is given them. When this happens,

his virtù is all within himself, and we are left with the image of extraordinary personal creativity imprinting itself on circumstance as on a *tabula rasa*, so that the contingent world becomes the inert matter on which virtù imposes form.

(Pocock, 1975, p. 174)

To Machiavelli, the ability to think critically and historically belongs to those who manage to combine objective knowledge with astrological fate and subjective skills and experiences. This knowledge is required if one wants to understand and foresee how people will think and act (Joranger, 2011). Machiavelli believed that people with critical and historical knowledge were virtuosos and would have the skills to behave flexibly and outside of established systems of thought. He expected persons of the highest virtue to be as capable as the situation requires. Machiavelli’s sense of what it is to be a person of virtue can be summarized by his recommendation that the person of virtue above all else must acquire a ‘critical hybrid mixed disposition,’ and the power to deal with uncertainty. The person best suited for office, on Machiavelli’s account, is the person who is capable of varying his/her conduct ‘as fortune (*Fortuna*) and circumstances (*Occasioni*) dictate’ (Joranger, 2006, 2011).

Considering the normative uncertainty that characterizes our own time and current mental health care practices, it seems that the characteristics of critical personal virtue now matter more than they have for very many years and that it matters most in just those intellectual and institutional configurations from which the most consequential change of later modernity emerge. I am not talking about premodern survivals of vestiges but about accelerating late modern realities and values, such as discipline and control, which seems to reduce the service users’ and mental health care workers’ ability to think and act creatively and outside established system of thought. Zygmunt Bauman (1993, p. 34) remarked about ‘late modernity’:

Human passions used to be considered too errant and fickle, and the task to make human cohabitation secure too serious, to entrust the fate of human coexistence to moral capacities of human persons. What we come to understand now is that fate can be entrusted too little else.

Those mental health care workers and those service users who critically demand a more interdisciplinary and holistic mental health care system, and who actively resist the narrow-minded bureaucratic establishment by rejecting the one-dimensional techniques and norms imposed upon them by bureaucratic systems and thoughts, seem to be the more creative and autonomous members of the modern welfare state. These subjects are, very generally, often those whose struggles have given rise to new treatment systems, new theories, and to new ways of understanding and deal with standardized medical concepts, such as diagnoses. Resisting subjects respond critically and reflexively to problems related to disempowerment and marginalization of certain forms of knowledge and rationality, and to prevailing moral and social practices, which makes emancipation possible. Subjects who are creative and reflexive are often carriers of a personal virtue of a hybrid and flexible nature. However, these characteristics seem to be rare in a world where knowledge connected to specializing, universal models, job instructions, registration, and generalizing, seems to be more valued.

Jaspers's critical and interdisciplinary approach to the human mind

Karl Jaspers was one that, like Machiavelli, managed to break out of contemporary thinking when he was still working and studying inside a well-established nature science-oriented mental health care bureaucracy. In the academic environment at Heidelberg where Jaspers worked and studied, there was debate about prioritizing the study of the outer empirical (physical) world or the inner unconscious and psychological world of subjective experience. In addition to Freud's psychoanalysis, the German psychiatry pioneers, such as Wilhelm Wundt, Emil Kraepelin, and Paul Eugen Bleuler, developed their empirical and descriptive theories of the human psyche and behavior (Joranger, 2014).

Opposed to Freud, the German psychiatry pioneers came to be critical of every use of consciousness as a source of explanation for publicly observable behavior. They not only cast doubt on the reliability of applying personal experiences as psychological data but also promoted the notion that such data was unnecessary. The German behavioristic neuropsychiatry experienced explosive international popularity due to its empirical and neurological experiments on animals and humans after the two World Wars.

This new, radical behaviorism was influenced by the thought that human personality could be fully understood by observing an individual's physical behavior, whether functional or non-functional. The notion was that what a person *did* constituted his or her personality. From this perspective, behavior, and therefore

personality, was thought to be determined by the environment, particularly reinforcing or discriminatory environmental stimuli, in line with Marxist theory. With its introspective, controlled experiments of the brain (which should not be confused with a Cartesian introspection of the self), early German neuropsychology belonged strictly to the radical behaviorist and natural science school, which denied any connection between human inner workings and experience (cf. Watson, 1913).

According to Jaspers ([1913]1997), psychology and medicine should not adapt each other's methods and approaches to the human mind. Rather, they should reinforce each other by using each other's knowledge and methods to endeavor to understand the human mind from the perspective of the person and to explain his or her bodily reactions from a biological and behaviorist point of view. By advocating such a view, Jaspers believes that there is a close body-mind relationship that must be explained and that the body and the mind must be understood separately and in relation to each other. At the same time, he notes the importance of remembering, no matter how difficult it may be, that our knowledge and approaches to the human mind are affected by social, cultural, and historical ideas that continually change our opinion of what mental illness is and how it should be treated. However, Jasper points out that we must not confuse neurological reactions with regression or developmental disorders, as traditional evolution theories want us to believe. Rather, they should be connected to a specific situation and environmental causes. To Jaspers, our bio-psychological reactions are mostly natural, meaningful, and functional reactions; if we remove the stimulus from the environment, the reactions will probably disappear with it.

Considering the analytic and medical environment that Jaspers worked and studied in, it came as a shock to the German mental health care world when at the age of twenty-seven, Jasper (1910) wrote the paper "Paranoia – a Contribution to the Problem: 'Development of a Personality' or 'Process'?" (Eifersuchtswahn: Ein Beitrag zur Frage: 'Entwicklung einer Persönlichkeit' oder 'Prozess'?). The method of presentation was unexpected and remarkable. Jaspers related life histories at considerable length with many details from patients' lives prior to hospitalization and with an exhaustive description of their mental conditions during clinical observation. With this mode of presentation, Jaspers introduced the biographical method into mental health care, including a summons to regard a patient's mental challenges as part of his or her life history. In the papers that followed, he proved convincingly by means of well-selected case materials that phenomenology helps us to discover 'what patients really experience.'

Although Jaspers expended considerable effort throughout his career criticizing Freud's psychoanalysis and his concept of libido and instinct, he initially claimed that Freud made genuine scientific contributions to mental health care and to the human sciences (Jaspers, 1974). He credits Freud with helping him to clarify his own scientific viewpoint. Specifically, reading Freud forced Jaspers to carefully distinguish what science knows and what it does not know. In his autobiography, he characterizes Freud as a scholar who he felt compelled to study, but he also resisted Freud as someone who was "determined to effect something by way of

our science which is not science at all” (Jaspers, 1974, p. 25). In his autobiography, Jaspers explains his interdisciplinary view in the search for methods. He borrowed from Husserl’s phenomenological method and used the notion of intentionality as a way of describing patients’ inner experiences as phenomena of consciousness. He adopted Dilthey’s descriptive and analytical psychology as *Verstehende Psychologie*, and he specifically noted that Freud was already applying it.

In the preface to the seventh English edition of *General Psychopathology* ([1913]1997) Jaspers continued describing his interdisciplinary methodology of the human mind as something more than a trend of psychoanalysis, phenomenology, and existential psychology. According to Jaspers, his interdisciplinary view on the human mind reaches onto a far wider sphere: the clarification of psychiatric methods in general, their modes of comprehension and research practices. His procedure was to work through all the available empirical knowledge critically, by reflecting on the methods whereby it was gained, and then give it a general presentation.

Jaspers adapted the phenomenological view that people intentionally and consciously structure their environment so that it becomes meaningful and customized to their needs. We sow and harvest to get food, we are staying with family and friends to feel safe. In this view, physical and neurological reflexes stimulated by error and contradictions in the environment affect a person’s intra-psychological experiences and vice versa and affect their ability to structure their environment so that it becomes meaningful.

To Jaspers ([1913]1997) ‘mental life’ is connected to a dialectical process involving both environment, body, and psyche. By connecting neurology with phenomenology and existentialism with Gestalt psychology and socio-cultural-historical ideas, Jaspers contributed to a type of interdisciplinary thinking that, in many ways, changed the traditional and medical view of mental health care (Joranger, 2014).

In many ways, Jaspers’s interdisciplinary view on the human mind was unique for his time (Joranger, 2014). Today, several influential psychiatrists, such as the American psychiatrists Philip R. Slavney (McHugh & Slavney, 1986), Leston Havens (Havens, 1987), Paul McHugh (2006), have adapted Jaspers’s interdisciplinary view, although they are (or were) not especially interested in historical and cultural contexts and origins, as Jaspers was. However, like Jaspers, they believe that a mental health care worker should approach the human psyche in different methodological ways according to the person’s environment, personality, and existential difficulties.

The dependency of others

Although every human, whether a mental health care worker or a service user, is unique and has a mind of his/her own, every human being is dependent on others to become what he or she is or believes they should be. What we are and who we become depends not only on subjective perceptions and actions, but

on what other people do and think, and want us to be. Our social and professional networks, friends, family, and colleagues, define, protect, demand, and serve each other. Dyads, roles, settings, social networks, whether they are in a local community or in institutions, are all environmental interconnections that have an impact on our psychological growth and the way we think and behave. Social and professional relationships, a collection of human beings, such as the relationship between groups of mental health care workers and groups representing different service user groups, or groups of mental health care workers *and* service users, do not become a social unity because each of their members has an objectively determined or subjectively impelling life-content. Such a social unity is constituted only when the vitality of these contents attains the form of reciprocal influence.

Social and professional units exist where a number of individuals, such as mental health care workers and service users, enter into interaction and exchange. The welfare state and its mental health care systems represent a professional and social unity because its employees and clients show similar mutual belongings: “The whole world could not be called one if each of its parts did not somehow influence every other part, or, if at any one point the reciprocity of effects, however indirect it may be, were cut off” (Simmel, 1971, p. 23).

Reciprocal influence always arises on the basis of certain drives or for the sake of certain purposes: therapeutical, ethical, professional, economical, esthetical, educational, ideological, political, or merely associative impulses and for purposes of defense, attack, play, gain, or aid. These and countless other interactions cause human beings to live and to connect with other human beings, to act for them, with them, against them, and thus to adapt their needs, wishes, skills, and drives with theirs. In brief, every human being influences and is influenced by such interactions and exchanges on every level of their existence. Social and professional institutions, such as the late modern mental health care system, like cultural practices and legal systems, are pieces of the mind, externalized in their specific time and place. We create these institutions via our own shared mental processes. We then use these institutions instrumentally to do further cognitive work – i.e., to solve problems and to control behavior.

We can speak of an extended mind that is larger than anything to be found in an individual’s immediate environment. In this sense environment and institutions take on a life of their own and allow us to engage in activities, often cognitive activities, that we are unable to do purely in the head, or even in many heads (Gallagher & Crisafi, 2009). Such institutions are the result of human cognitive processes. They are externalizations of individual minds working collectively. They are also employed in a cognitive manner to solve problems and to control behavior. The institutions of civil society, the social, educational, and legal institutions that originate in human cognition are thus, ideally, not alien to the human being, but externalizations of individual minds working collectively.

Our need for belonging and being-in-the-world-with-others, indicates that an independently existing service user or an independent existing mental health care

worker does not go into an independently existing ‘objective’ world that the subject then experiences. Rather, a service user and a health care worker are always already defined by the world (institution) or by the forms of experiencing that make it up. The objects of these forms of experiencing are already revealed within one or the other subjective states or modes of relating to the world. That is, one requires a certain subjective or intentional state of being-in-the-world in order to appear as a service user and as a mental health care worker in the first place. As mental health care workers, or users of welfare services, we are living actors, not objects who passively react to stimuli, analogous to the mechanistic cause-effect relationships between objects.

In this scenario, the unity between subjective feelings and objective seeing cannot ultimately be conceived as merely contingent, as something whose existence depends for its realization solely upon the choices of individual agents. Nor can this unity take the form of some sort of imposition of an independently formed subjective end onto an objective domain that is otherwise external to this end. On the contrary, subjectivity and objectivity are intertwined in their very essence, such that, in the final analysis, one cannot ultimately understand one without the other. Thus, rather than conceiving of our subjectivity as essentially distinct from what is made objectively manifest through our actions, for instance, as an interiority that we may or may not successfully externalize in action, it seems that we must think of action as the very actuality of subjectivity, as that distinctive form of objectivity without which there would simply be no subjectivity. It is thus that Hegel (Hegel, 1991, p. 124) can say, for instance, that “what the subject is, is the series of its actions.”

What Hegel implies here is that any attempt of a human being to identify its true self with certain internal aspirations, commitments, or self-conceptions that were never made objectively manifest in actual deeds is ultimately disingenuous. It is only in its actual deeds, in its objectivity, that the subject shows itself for what it really is. While the contrastive sense of subjectivity and objectivity will presumably still have an important role to play in Hegel’s account, it seems that in the larger scheme of things this contrastive sense must be conceived, not as the fundamental state of things, nor as the ultimate starting point of action, but rather as a derivative, deficient mode of a more fundamental unity. The challenge is how to understand the precise nature of this unity, and to understand exactly how the basic concepts of subjectivity and objectivity, as well as the corresponding concept of action, are to be reconceived in its light.

As human actors we respond to our environment and our fellow human beings through our private existence consisting of past, present, and future expectations and experiences. Lived experience is thus neither a property of the person nor a function of the object, but the product of a ‘strife’ between the human world and the natural world (Valsiner, 2014). The philosophical concept of being-in-the-world defines here an experience that is primarily relational; it is not the pasting together of two separate entities that exist independently first and only subsequently enter into a relation with each other.

The human mind in between the individual and social

If we analyze a human being, such as a mental health care worker or a service user, we usually find that his/her existence belongs to a unity which we cannot designate other than as the synthesis of two logically contradictory characters. These two characters are connected to the human being as a product and carrier of a social unity and to the human being as an autonomous being, who views his/her life from its own center and for its own sake. Because of this connection, social unities consist of structures composed of unequal elements.

The 'equality' toward which the social unit is directed is an equivalence of people, functions, or positions. However, as Simmel says, "equality *in* people is impossible because of their different natures, life contents, and destinies" (Simmel, 1971, p. 18). Innate qualities, personal relations, and decisive experiences make for uniqueness and irreplaceability in both the individual's self-evaluation and in his/her interaction with others. The social human being, such as the service user and the mental health care worker, is one that understands its place within a larger social unity and community. In this way, social unities such as those we find in the mental health care environment require individuals, just as individuals require social unities and communities.

What it is to be social and what it is to be personal both arise within dynamic processes in ongoing mutable interaction. The mind of any individual is constantly emergent during the life span of that individual, while the accumulation of the actions of individuals and their sociocultural consequences keep social unities and cultures also in constant change (Martin & Sugarman, 2001, p. 401). This is clearly the case in the evolving situation of late modern mental health institutions.

However, the duality between the social and the individual are only two different categories under which the same content is subsumed (Simmel, 1971, p. 17). In the same way as a plant may be considered from the standpoint of its biological development or its practical uses or its aesthetic significance, the standpoint from which the life of the service user is conceived and structured may be taken from *within* as well as from *without* the patient or service user. Social structures and sociocultural relations put human beings into this dual position. The service user is contained in social relations with the mental health care worker and within the institution and at the same time (s)he finds him/herself confronted with them. The patient or service user is thus both a link in the organism of social relations of interaction and exchange and an autonomous organic whole, that is, someone who exists both for the therapists and for themselves. However, human nature does not allow the patient or service user to be tied to the therapist or to the system by one thread alone. This is one of the main weaknesses of various forms of reductionism.

The 'within' and the 'without' relationship between service user and the therapeutic environment defines together the fully homogeneous position of the service user and the therapist as social animals. However, although the ties between the patient/service user and therapist are indeed often quite homogenous, the mind

cannot grasp this homogeneity, and thus must construe it as the result of several elements (Simmel, 1971, p. 77). At every moment they are so complex and contain such a multitude of variegated and contradictory oscillations that to designate them by any one of our psychological concepts is always imperfect and actually misleading. When we are attracted and at the same time repelled by things, when nobler and baser character traits seem mixed in a given action, when our feeling for a particular person is composed of respect or fatherly and motherly impulses, or of ethical and aesthetic valuations, then certainly these phenomena in themselves, as real psychological processes, are often homogeneous. Only we cannot designate them directly.

Compared to the divided modern way of thinking, where knowledge about the subject, its experience and feelings, and knowledge about the social units, cultural and social relations belong to different knowledge areas: the humanistic, the naturalistic, or social knowledge area, the Renaissance framework did not divide its knowledge in this way. In the Renaissance framework, the relationship between the individual and the institutional was so connected that one could not think of the one without thinking of the other. If there was a division, it was between the macro level and micro level, that is, between the general and the particular (Parel, 1992, p. 11). The general part concerned the destiny (fortunes) and ethos of the environment: community and state. The particular part concerned the temperament and fortunes of the concrete, that is, of the individuals. Both parts, the personal at the micro level and the historical and sociocultural at the macro level, were seen as interconnected and used as knowledge and as background for strategic thinking.

When a physician in the Renaissance treated the patient's mental and physical disturbances, the health care worker took into consideration the entire patient's situation (the whole substance), that is, the micro and macro cosmos which represented the family situation, position in society, the month of birth, education/non-education, love life, temperament, astrological signs, etc. (Porter, 1999, p. 174; Lloyd, 2003, pp. 11–12). All of these causes were again linked to a central notion of balance and imbalance, inside and outside the human mind and body.

Thus, mental and physical disturbances were not only linked to symptoms in the individuals, but also to communities, states, and constitutions. In other words, it was not unusual to write that the body of the community at the macro level, like the human body at the micro level, suffered from fractions, injustice, evil, and imbalance. The imbalance at the macro level was supposed to influence the mental health of the citizen as the micro level.

Similar to the Chinese medicine, human beings in the Italian Renaissance represented a microcosm of the natural and social worlds (Porter, 1999). Bodily processes followed patterns comparable to those governing the workings of nature. A human body was seen as the counterpart of the state. The spirit, that is, the body's governing vitalities, was like the monarch; the blood was like the ministers; the nature was like the people. Loving care for one's people was what made it possible for a state to be secure; nurturing one's nature was what made it possible to keep the body intact. Mental and physical health was seen as dependent on the

preservation of harmony within the body, and harmony between the bodies, the environment, and the larger order of things. To heal was a question of knowing how harmony between the micro level and macro level, that is, between the subjective state of being and the community state of being could be restored; and the task of the physician was as much philosophical as technical (Porter, 1999, p. 151).

To explain the reciprocity and healing process between micro and macro, the health care worker as well as the political leader of the state used concepts from several knowledge areas, that is, medicine, politics, nature, and community, among others. According to Machiavelli (2006, pp. 40–41):

When trouble is sensed well in advance it can easily be remedied; if you wait for it to show itself any medicine will be too late because the disease will have become incurable. As the doctor say of a wasting disease, to start with it is easy to cure but difficult to diagnose; after a time, unless it has been diagnosed and treated as the outset, it becomes easy to diagnose but difficult to cure. So it is in politics. Political disorders can be quickly healed if they are seen well in advance (and only a prudent ruler has such foresight); when, for lack of a diagnosis, they are allowed to grow in such a way that everyone can recognize them, remedies are too late.

The interconnected and holistic worldview that characterized the Renaissance worldview ended with Descartes's theory of introspection. Opposed to the interconnected Renaissance worldview where micro and macro cosmos constituted each other's existence, the modern epoch took as a starting point the position of the individual. The self, as autonomous center of self-reflection, was to be the secure ground on which we should build further knowledge. Intrinsic correlation between self and cosmos was cut at its roots.

After Descartes and his ideas about introspection as the access point to absolute truth, direct evidence given to consciousness was enough for establishing the truth of the mind and the truth of the world. After Descartes's striking method of building the entire edifice of knowledge from the foundation of introspection, the substance of self was identified with consciousness. The foundation allowed for two radically different approaches to the human mind: one that includes introspection of bodily (somatic) feelings, habits, and manners, and one that includes introspection of the (psychic) distinctively mental thoughts. Currently, we have seen that these ideas have recurred problematically in later thought that bears upon our theme of background contexts of mental health procedures and treatment. The paradigmatic change that followed from Descartes made possible the institutionalization of modern mental health care. However, in the modern age, the relationship between the knowing subject and the ethical subject becomes problematic. Whereas traditionally the great cosmic plan at the macro level gave meaning to the life of humans, the modern knowledge area reverses the roles and expects the experiences of humans to give meaning to the cosmos. From a modern standpoint, humans must draw from within their inner experiences not only the

meaning of their own lives, but also the meaning of others and the entire universe. This is the primary commandment the modern knowledge context has given us: to create meaning and reason for and in a meaningless world.

From an historical point of view, there is a history of the modern idea of a meaning-making person just as there is a history of meaning and reason, but we can never demand that the history of reason unfold as a first and founding act of the rational subject, as Hegel proposed. That is, if we start from the human being in the present in order to reach our goal through an analysis of the present, we will fall short in our analyses if we reflexively think of the human being as an *aeterna veritas*, as something unchanging amid all turmoil, as a steady standard of things. Who we are and what kind of human being we want to become depend on several things and occasions, such as history, environment, our fellow human beings, our experience, socioeconomic status, and so forth.

By focusing on the processes that go on within a service user and a mental health care worker rather than on the processes that a service user and a mental health care worker 'go on within,' we misdirect the research on how culture and individuals develop, and how language and scientific knowledge govern our thoughts and actions in ways that are difficult to scientifically predict (Moghadam, 2003). Nevertheless, as living beings, as scientists, as service users and mental health care workers, we never cease to be constructed in social and cultural historical terms; as intentional agents capable of reflection, we have the potential to shape and reconstruct our sociocultural environment. If this were not the case, institutions, communities, cultures, and historical epochs would remain mostly static over time, unaffected by the activities of individual humans who could do nothing more than parrot what already exists in these contexts. The socio-historical individual is as such someone capable of placing individual experience and concerns within a larger perspective or horizon.

Crucial to the understanding of the independent, acting, and socially dependent individual, is Uri Bronfenbrenner's socioecological system where he connects every human being to different level of contexts, that is to micro-(individual), meso-(organizational), and macro-(societal) (Bronfenbrenner, 1979). Bronfenbrenner's ecological model, and Klandermans and van Stralen's theories of social mobilizing and participation in time of change (Klandermans & van Stralen, 2015), remind us that social participation in collective action, such as the participation between the mental health care worker and the service user, and the mental health care worker and the mental health care system, or that between the social worker and the client, is not assessed in a social vacuum, as participants tend to consider its costs and benefits.

Being a more flexible and sensitive part of the field than mere things, a mental health care worker is under demands from without. Inside the mental health care system it is the boss, the colleagues, and our professional contacts that direct the focus and make us respond the way we do. Physical reactions, such as nervousness, shame, embarrassment, excitement, or other such qualities beside general goal-seeking may develop when, for instance, suddenly we become aware that

we have stepped outside the ‘border’ of proper behavior for a mental health care worker.

In addition to experiencing and generating expressions that stem from feelings and expectations, human beings such as the mental health care worker act on the world. Action here refers to a system of hierarchically patterned sequences of movement organized in relation to a system of goals and supported by the affordances of the mental health care environment. The schemes underlying action and the goals toward which action is organized furnish hierarchical systems of expectations against which the success of the action can be evaluated. The meaning of any action inside the public health care bureaucracy, therefore, includes the specification of end states and expectations, knowledge of the general structure or scheme for that action, and some specification of the range of variation in the action necessary and permissible under different environmental conditions.

Within the broad category of actions inside the mental health care system, one particular class of actions stands out as unique: the category of interactions. Interactions differ from other actions in the nature of the expositional control that the cognitive system exerts as the interaction unfolds. When I reach out my hand to help someone, it can no longer be a case of acting only in terms of my own expectations. My action must now take into account my knowledge of the expectations that the other (my colleagues, my patient, my client) has concerning my action and, indeed, even my knowledge of the other’s expectations about my expectations for my action. Successful interaction, in other words, depends on a mutuality of expectation, on what is, fundamentally, intersubjective. These expectations, which are part of the normal functioning of the cognitive system and are therefore not in explicit or thematic awareness, serve to regulate our reaching action, to serve as parameters against which the results of our action will be evaluated.

The eco-chamber

Human intelligence, even as biologically motivated, must be organized in its function and in this development toward the acquisition of institutional and cultural meanings and toward our elaboration with others of a shared reality in conjoint activity around human beings and physical things. Our mental focus reaches out towards other parts of world, and does not stem from an isolated self. Most likely there are other human beings involved that suddenly make us change our focus and our choice of action. For example, your boss and your colleagues make you use some standardized concepts and schemes to describe your client, and you obey, although you know that these concepts and schemes will reduce your client from being a creative human being to a patient with diagnoses and a mental disorder.

During a meeting, in lively discussions, you suddenly feel that something is wrong; the others have become silent, people stare at each other. Somebody is about to say something important, and the force of the atmosphere around you makes all of you stop talking and become quiet. Are there any guidelines or

requirements in this situation? It cannot well be denied there are, but does it issue from the self only? Is it your thoughts alone that make you stop talking, only 'your thoughts' when other participants, like you, without expressing it loudly, also stop talking, or is it the other participants, the situation, and the environment that make you stop talking?

As human beings, as mental health care workers and as patients or service users, we develop, in short, through a constant adaption and striving to become a mental health care person and a service user person, like-minded and companions with others in the same profession and status. In a particular health care environment for example, the sentence we hear and the books we read will reflect and foster power and gender distinctions as well as different power relations between professionals and illnesses, such the somatic illnesses and mental illnesses. Relative to female nouns and pronouns related to specific health care professions, such as nurses, male nouns and pronouns related to another health care profession, such as physicians, might, for instance, be paired more frequently with action and mastery verbs such as exploring, diagnosing, fixing, etc.

A health care worker or a service user who develops concepts of 'male' and 'female' through experience with men and women inside the health care system synthesized in the context of gendered discourse will automatically come to possess a meaning system that reflects institutional values, implicit in their way of talking. The same adaption to values will happen when you experience that inside the mental health care system, illnesses are given different values, and that a person with mental illness has a lower service user status than a person with a somatic illness. As a consequence, institutionality, sociality, and historicity are embedded in the very core of our conceptualization (Wozniak, 1987).

In Vygotsky's view, common lexical items, such as 'mental health' and 'mental illness,' 'nurses,' 'service user,' and 'physicians,' serve as a nexus around which one abstracts and generalizes experiences with others and with sets of objects in the world (Vygotsky, 1997). Words, such as good and bad, normal and abnormal, women and men, etc., are embedded in language and discourses that convey cultural and medical meaning. This discourse, in turn, depends on the fact that the lexical terms that facilitate our synthesis of experience about illness, gender, and about human beings in general already preexist. The meaning systems exist in social and cultural structures at all levels of complexity inside a community and inside the mental health care system, and shape and produce different health care professions, client groups, socioeconomic classes, and so forth.

Expressive meaning-making and semiotic activity are not, then, solely or even primarily individual processes (Peirce, 1991; Valsiner, 2014). Although experiences have only a personal existence, symbolic expressions exist transpersonally. Semiotic activity, such as making diagnoses, medical records, and professional titles, as well as making architectural design, work uniforms, etc. have both a representational and cultural function (Peirce, 1991). Representationally, symbols stand for something other than themselves. Through symbols, we can bring to awareness objects and events not currently present to the senses. Culturally,

symbols, such as for example medical records, embody the historically derived system of institutional meanings held in common by members of the broader public mental health care system. Much of our ability to communicate interpersonally, to negotiate shared meaning, and to acculturate newcomers, depends on the fact that we possess shared systems of symbols inside the mental health care system.

Human beings, whether they are mental health care workers or service users, or someone else, become what they as far as they know the world they are in and become aware of themselves in this world. Each new object that comes in our way, if looked at well, opens up in us a new way to see the world and ourselves.

What critically differentiates the symbolic dimension from experience, however, is its uniquely individual yet transpersonal nature (Wozniak & Fischer, 1993). When a mental health care worker engages in the semiotic and meaning-making act of symbol generation inside a mental health care environment, such as diagnosis setting and treatment procedures, not only the meaning but also the form of the symbol can be generated from within. By contrast, in the co-construction of experience, while the meaning is provided by the perceiver, form is provided by the mental health care environment. This is a simple point, but its force is far reaching. It is part of the explanation for why human beings inside an institution can tell themselves or others that everything is functioning and based on evidence, despite that one knows that diagnoses fail to describe how and why a specific human being thinks and acts as it does. It is also the reason why we can formulate personal beliefs, symbolic representations about the nature of physical and interpersonal reality, that may or may not be truthful.

Indeed, welfare workers and service users are as everyone else related to a sociocultural world defined in large part by a system of historically developed social and academic meanings embedded in already existing forms of symbolic expressions about the human mind and behavior.

Knowledge and justified beliefs, shaped by powerful subjects and groups inside the mental health care environment, have a strong effect on our common concepts and perception. They control what we perceive as truth and what we should perceive as proper behavior, which makes this very knowledge hard to change. As Vygotsky (1997) pointed out long ago, the human being experiences the world in the context of communicative speech/action transactions. Research has shown that groups, such as those representing the mental health care system, develop and foster idiosyncratic group concepts and group epistemologies (knowledge and truth) for the sake of maintaining the group itself, that is, not for the sake of the patient or service user (Foucault, 1971; Vähämaa, 2015). It is therefore important to note that epistemic differences can also be intentionally maintained, even to the extent that competing approaches to knowledge about the human mind may be seen as threats. Once created, forms are rigid. They tend to be incapable of adapting to the continuous oscillations of subjective needs. The conflict between established forms and vital needs produces a perpetual tension, a tension that is nevertheless the source of the dialectical development or replacement of organizational structures and accepted knowledge inside the mental health care bureaucracy.

Like-minded groups and professions inside the welfare states, such as those representing therapists, physician, nurses, and social workers, among others, may constitute what is sometimes called an echo chamber inside the group, in which there reverberates a ruling one-sided perception of best praxis and perception of illness and its treatment. Due to the echo chamber effect official sources often go unquestioned and hardly no other ideas are allowed (Sunstein, 2001). Such a collective process is also often referred to as *groupthink*, first conducted by Irving Janis (1971). However decision-making in groups characterized by strong harmony and conformity may result in dysfunctional or irrational outcomes (Janis, 1972). Self-censorship of perceptions that are not in line with the group's norm is a frequent technique used to blend in with other members of the group.

The eco-chamber and the group thinking that occur inside the mental health care system direct attention to the conditions in which what is taken to be valid and reliable scientific knowledge making about the human mind is or is not considered credible, in which those responsible for that knowledge are or are not thought to be reliable sources, in which their way of life in making knowledge is or is not recognized to be one that is conducive to being a reliable base of knowledge. These facts also tell us something about how knowledge making about the human mind and behavior is thought of, dealt with, and managed by members of the mental health care institutions and those with which they come in contact.

However, for human beings in general, to get what we want and to become who we want to be requires that we are able to communicate our thoughts and wishes to others, and that we are able to give something in return for what we get. Although, in the later modern self-centered world we can be quite free and independent and maybe a bit narcissistic, looking at things from a sociocultural and existential-phenomenological point of view, we are nothing without being in communication and relation to others, struggling for social recognition and development of the self (cf. Foucault, 1954; Jaspers, 1951, [1913]1997; Sartre, [1943]2003). This is why we join eco-chambers, although it feels wrong sometimes, and although it forces us to think and behave in ways we do not like. It is through the other's gaze and communication that we recognize that we are living and aware. Without communication and without social unities, there will be no welfare state, no political order, no democracy, and no sense of logic behind our choice of living and acting. The welfare states' mental health care workers and their service users depend on advanced communication with others.

If we turn away from communication, we will only be led further away from the world and from ourselves. However, if our failure of communication drives us back into ourselves and makes us try for a consciousness based on ourselves alone, the sense of shortcoming will grow. Therefore, other human beings will always be a necessary source of affirmation of one's own existence. Wanting to rise above this social and intersubjective connection is the same as signing your own authorization to drop out or go into isolation. What we get and what we are depends on communication and participation in social contexts.

Most of us, representing a public system or not, have lived through the agonizing experience of a communication breakdown with clients, friends, and strangers. From this point of view, public welfare workers dealing with mental health care and social work are already embedded in other people's everyday lives and without this fact they would be unable to conduct their lives, experiences, and services in the company of and for the benefit of others. Although deeply immersed in our daily routines, informed by practical knowledge oriented to the social and cultural settings in which we interact, we often do not pause to think and reflect on the meaning of what we are doing or have gone through. Even less frequently do we pause to compare our private experiences with the fate of others, except, perhaps, to have private responses to social problems paraded for all to consume on Facebook or Snapchat. Here, however, the privatizations of social issues are reinforced, so relieving us of the burden of seeing the dynamic of social relations within what are instead viewed as individual reactions.

Critical self-reflection, self-presentation, and self-knowledge

The human being is unique in the sense that it can present itself in various locations and in various forms through open media, such as Snapchat, blogs, and Facebook. We can play out our life in fictive worlds, and pretend that we have knowledge, individual fates, and social connections we do not really have. In parallel, we can become famous and recognized experts inside an eco-chamber and inside a specific knowledge area, not because we are specially clever, but because we are socially wise and have the will to power to eliminate wiser colleagues, and to play out our 'fictive' knowledge roles in front of an audience. By contrast to the many recognized experts who wrongly believe themselves full of wisdom concerning things they did not really know, Socrates knew himself well enough to know he did not know what others claimed to know. His wisdom was appreciating the limits of his knowledge. Undeniably, he argues that the Delphic oracle of Apollo declared him the wisest so as to prompt his critical search for wiser men and thus show that the most reputed "human wisdom is worth little or nothing" (*Apology*, 23b).¹ Asserting his lack of interest in lofty speculations, he explains (in *Phaedrus*, 229e–230a), "I am still unable, as the Delphic inscription orders, to know myself; and it really seems to me ridiculous to look into other things before I have understood that."

The Greeks seem to be the first to grasp the expression mind as something which belongs to a trait of humanity. This was the case even if they did not attain, either in philosophy or in religion, to a knowledge of the absolute infinitude of mind. With the Greeks the relation of the human mind to the Divine is still not one of absolute freedom. It was Christianity, as Hegel pointed out, that by its doctrine of the Incarnation and of the presence of the Holy Spirit in the community of believers, first gave to human consciousness a perfectly free relationship of mind in its absolute infinitude.

Fearful that the Delphic maxim confines the mind to a stifling isolation that promotes ignorance, inaction, morbidity, and psychological self-torture, Goethe (1998) insists that the only way to approve the command to 'know thyself' is to interpret it as knowing the world in which one lives and acts and our restricted knowledge of this world and these actions. This includes knowing one's relations to other selves who provide enlightening reflections that help one know one's own self. "We mustn't interpret it," Goethe warns, in what he calls the ascetic sense of "our modern hypochondriacs, humorist . . . and *Heautonoimorumenen* (self-tortures), but (it) quite simply means: pay attention to yourself, watch what you are doing so that you come to realize how you stand vis-à-vis your fellows and the world in general" (Goethe, [1893]1998, p. 88).

To Goethe (1948) the maxim 'Know yourself' merits the suspicion that it was a device of secretly bound priests, who confused men with unattainable requirements and wanted to lead them away from the activities of the outer world to an inner false contemplation. Humans know themselves only insofar as they know the world and become aware of themselves only in it. Each new object, if looked at well, opens up in us a new way to see ourselves. Rigorous self-examination is especially unwise and unhealthy, Goethe argues, because it is perversely unnatural and its goal of self-knowledge is impossible. Nietzsche (1983, p. 129) follows Goethe and pointed out that "This digging into one's self, this straight, violent descent into the pit of one's being, is a painful and dangerous undertaking. A man who does it may easily take such hurt that no physician can heal him."

Given Nietzsche's notorious 'death of God' thesis, his mordant skepticism toward idealist notions of mind or soul, and his ferocious critique of the self-flagellation of Christian conscience, it is not surprising that he challenges the traditional injunction to self-knowledge as psychologically unhealthy, unnatural, and indeed impossible. Like Goethe, Nietzsche prefers the projective activity of self-cultivation to the introspective immanence of self-examination, hence his famous injunction "to become what one is." Rejecting the very idea of a fixed essential self to be known, Nietzsche (1996, p. 294) instead advocates a self that emerges through a process of perfectionist becoming: "Active, successful natures act, according to the dictum 'know thyself,' but as if there before them the commandment; 'will a self and thou shalt become a self' . . . whereas the inactive and contemplative cogitate on what they have already chosen."

Twentieth-century thinkers as different as Ludwig Wittgenstein (1980), Foucault (1988), and William James (1962) adapt this notion of a malleable, constructed self that is always in the making together with the perfectionist ideal to become a different, better self. James radically dispenses with the idea of a transcendental ego, while defining the self as a bundle of habits and instruction how habits could be changed. His reformist ideal of self-development advocates a "strenuous mood" heroically exercising "active will" toward the "character of progress" (James, 1962, p. 143). Wittgenstein (1980, p. 27) went to war in 1914 not for the sake of country but through an intense desire "to turn into a different person," and his continuous striving to improve himself and his philosophical

positions helps explain why most of his works were published posthumously and why his notebooks include the injunction: “you must change the way you live,” as also proposed by Rilke.

According to Foucault (1988, p. 9), self-transformation rather than self-knowledge is the guiding goal to the envisage life: “The main interest in life and work is to become someone else that you were not in the beginning.” As Wittgenstein acknowledges that self-examination can be painfully difficult, so Foucault highlights the tormenting interrogational practices of our culture that have been inspired by the ideal of self-knowledge, and instead privileges self-cultivation as the higher ideal. However, are we capable of such a self-cultivation; that is, are we as historical and sociocultural human beings free to make of ourselves what we truly and personally want to be, or are our desires affected predominantly by environmental and cultural desires and influences beyond our control? Such questions will be examined in the next chapter.

Note

- 1 See (Cooper, 1997, p. 22). All references to Socrates through Plato are quoted from this source.

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Freedom and governance in socioeconomic status

Does a mental health care worker exist that can be said to be responsible for his/her own behavior and of all objects whatsoever including other human beings? Phenomenally there are no such objects since the phenomenal self is decidedly not felt to be responsible for the existence of its objects, which also includes other human beings. Regardless of content, form, and governmental level, we are all linked to a dialectical intersubjectivity in which we rely on the opinions of others and their power. Power in any form, whether physical, vital, intellectual, or authoritative, brings human beings into relations of superiority and subordination (Jaspers, 1951). This is especially apparent in the realms of mental health care services, where patients or service users often stand in a subordinated-superiority relationship to each other as therapist and clients, both fighting for their authenticity and recognition.

Looking back at the history of mental health care it may seem as we have read its history in an unhistorical and unsocial manner, with the consequence that we have been unable to explain the roots of the clients' subordinated status in relation to the therapist and to the public mental health care system. The phenomena of subordination and domination inside the Western mental health care system were especially studied after the Second World War. After the war, French and German scholars, including Foucault and Jaspers, started searching for the origins of the relationship between subordination and domination, that is, the relationship between service user and therapist and different socioeconomic classes, and how this relationship is related to health and socioeconomic status. They wanted to figure out how Western states and Western culture have come to subordinate and exclude, as well as produce, people with bad health and low sociocultural and socioeconomic status. Foucault's research dealt with how late modern Western states have come to dominate and control people who do not fit in because they cannot adapt to the modern welfare state's demands of user involvement and reporting.

According to Foucault (1954), we cannot understand this late modern praxis of subordination without referring to the social structures that are found in people's real socioeconomic and historical situations. Foucault believes that late modern Western societies have emerged not as a rational product of some functional historical needs, but rather as a particular stage in the confrontation between people's

struggle for social belonging and recognition. Whatever, according to Foucault, the status of a person is in a society, whether the person is placed at the center of religious life or outside of social life, the society expresses itself positively in relation to the praxis of subordinations, and uses this praxis as an indirect warning on undesirable behavior.

Today we know that both high socioeconomic status and low socioeconomic status groups maintain inequality, not only those more interested in maintaining it (the high socioeconomic status), but also those most harmed by inequality (Jetten, Mols, Healy, & Spears, 2017; Owuamalam, Rubin, Spears, & Weerabangsa, 2017). Clearly, those living in poverty suffer the most from economic recessions. Members of different social classes display their class belonging, which others in turn perceive (Becker, Kraus, & Rheinschmidt-Same, 2017). Making clear one's social class, voluntarily or not, defines interactions between classes and perpetuates class divisions. People indeed express social class in their behavior and experiences (e.g., through Facebook profile photographs) and others accurately perceive these signals. These cultural practices affect ingroup-related behaviors. Specifically, low socioeconomic status individuals are socialized to show cultural practices that relate to lower group efficacy and, in turn, a tendency to remain politically inactive. Cultural practices from class upbringing solidify class boundaries and legitimize the economic hierarchy.

The systematic and modern way of subordinating people with disabilities and low socioeconomic status came into being in the middle of the Christian Reformation, when the idea of an immaterial free soul ceased to exist as a protective factor (Foucault, 1954). After the Reformation, persons with low socioeconomic status and dysfunctional and anti-social behavior were defined as not countable. According to Foucault, they were subordinated and chased out of the human universe and considered as a human category of deviants in a society pursuing the concrete, the social, and the economic functional. Under the religious concepts of mercy and goodness, people that could not contribute to economic growth and exchange were seen as outcast because they could not follow the same rules and conceptions as the flock, or the common human universe as the many did.

The human category of subordination and deviancy that developed as a result of welfare aid was the beginning of an extensive use of internment and control manuals (Foucault, 1954, p. 81). From the time that the public health care system expanded to include all sections of society, the disabled person's fate has been sealed in this estrangement for hundreds of years. It has become manifested in all of the disabled person's social relations, in all of his/her experiences, and in all of his/her existential relations. Consequently, because the alienated and disabled person constantly is identified as a subordinate and as foreigner, (s)he can no longer recognize his/her own true will. As such, the alienation has become a kind of imputed legal status and a real experience of difference in the new liberal and democratic society.

To Foucault (1954), the nineteenth century responded to this praxis of subordination by depriving the poor and disabled person of his/her freedom in the form

of the civil and legal rights that were given to them as human rights under the civil French revolution. Similar to the current practice, the devaluated and disabled persons were considered non-capable of controlling themselves or their assigned rights. Consequently, their civil and legal rights were transferred to a guardian, who was either the person's physician, a person appointed from the patient's own family, or another person close to the patient (Foucault, 1954). The practice led to a new penal law regarding 'voluntary' internment that had the family's wishes in mind, not the client's. The poor and the disabled person cannot in this case even be considered as a means to this end, which would improve their position, for the society does not make use of their resources, but only of certain administrative means aimed at suppressing the dangers and losses which the poor imply for the common good.

Looking into the late modern welfare states, it seems to be a norm that the late modern welfare services are a prerequisite of social and economic intercourse in which equality or relationships facilitate and ensure potential social and economic exchanges. Of all kinds of exchange and transaction, the exchange of economic values is the least free of some tinge of sacrifice. When we exchange love for love, we release an inner energy we would otherwise not know what to do with. Insofar as we surrender it, we sacrifice no real utility, apart from what may be the external consequences of involvement. When we communicate intellectual matters in conversation, these are not thereby weakened. In all these exchanges the increase of value does not occur through the calculation of profit and loss. In contrast, economic exchange, whether it involves substances, labor, or labor power invested in substances, always entails the sacrifice of some good that has other potential uses, even though utilitarian gain may prevail in the final analysis.

Persons who cannot participate in the socioeconomic exchange because the world with all its exchanges and transactions has become too complicated will often transform socioeconomic exchanges into monolog and isolation to avoid the gaze and domination of others. In late modern welfare states where socioeconomic exchanges and social transactions are what all values and administrations depend on, a human being who cannot interpret social signs, economic exchanges, and rituals, and all that is allusive and referential in the late modern socioeconomic world, has lost his/her ability to take part in these socioeconomic transactions. In such cases, the socioeconomic and historical situations are transformed into bodily and psychological expressions and incorporated into the person's life experience and life history, something that can lead to extreme and ongoing bio-psychological conflict and anxiety reactions. In a somewhat Marxist manner, Foucault (1954, pp. 86–87) explains:

The system of economic relations attaches him (the alienated and disabled person) to others, but through negative links of dependence; the laws of coexistence that unite him to his fellow men in a common fate set him in opposition to them in a struggle that, paradoxically, is merely the dialectical form of those laws; the universality of economic and social links enable him to

recognize, in the world, a fatherland and to read a common signification in the gaze of every man, but this signification may also be that of hostility, and that fatherland may denounce him as a foreigner.

Living as a social and economic deviant in a well-organized welfare state together with people that are highly social and economically functional causes stress and negative affect, which in turn may lead to short-term and risk-averse decision-making (Haushofer & Fehr, 2014). In a more cognitive line, living in poverty produces a mindset of scarcity, pushing people to focus on salient and pressing issues, at the expense of others that may be just as important but not equally urgent in the moment (Mullainathan & Shafir, 2013). The effect of scarcity is so strong that it impairs cognitive performance even in general, irrelevant domains, and relieving scarcity reverses the cognitive effects. Many other aspects of our daily lives are also influenced by our socioeconomic status: the ways we talk and dress, our interactions with authority, the trust we place in strangers, our religious beliefs, our achievements, our senses of morality and of ourselves . . . all are marked by social class, a powerful factor affecting every life domain (Fiske, Moya, Russell, & Bearn, 2012).

Looking back at the history of mental health care, Jaspers ([1913]1997) shows how people who are subordinated and excluded from daily life because of their socioeconomic position, race, drug addiction, etc. are exposed to real socioeconomic conflict situations that put them in a state of bio-psychological imbalance. Although Jaspers is highly critical of a purely biomedical approach to the human mind, he acknowledges that biology has an effect on the unique existential experience that influences and shapes all of our experiences. Constitution and environment operate initially through biological events that lie outside consciousness, and we attempt to understand causal relationships at that level. In conscious life, such relationships function in a psychologically comprehensible way. In this view, physical, objective visible reflexes, stimulated by error and contradictions in the environment, affect our intra-psychological experiences and feelings, and vice versa, and they affect our ability to structure our environment so that it becomes meaningful. Nevertheless, out of this conflict situation can emerge individual life philosophies and self-reflection. In this case, problem solving and restoration is simply a way of restructuring a situation that has a poor or misleading environmental structure. The restructuring occurs when the person involved is mentally and physically able to manipulate the key factors in the environment to produce a mental link between them.

From the analysis of responses from more than 139,000 people in 131 countries about relationships between income and psychology it emerges that richer individuals in a given country are more satisfied with their lives than are less wealthy individuals; average life satisfaction is higher in countries with greater GDP per capita; and as countries experience economic growth, their citizens' life satisfaction typically grows (Sacks, Stevenson, & Wolfers, 2010). In World Value Survey data from 114,378 respondents in 43 countries, low-income individuals show less

intrinsic motivation, lower trust, more feelings of loneliness and meaninglessness, lower risk-taking, and more short-term thinking than wealthier individuals (Haushofer, 2013).

Social discrimination and social insurance

Because people who belong to the same socioeconomic class tend to work together, to live in the same neighborhoods, to attend the same schools, to establish close relationships, and to engage in similar leisure activities, people from the same socioeconomic class also share norms, values, expectations, identities, and social orientations (Kraus, Piff, & Keltner, 2011; Stephens, Markus, Townsend, & Dovidio, 2007). Social class contributes to people's views of themselves and their social identity. Social class potentially supplies a negative social identity or social stigma among low-income individuals, and a positive social identity among high-income individuals (Croizet & Claire, 1998; Spencer & Castano, 2007). Moreover, high socioeconomic status individuals usually have economic independence and higher personal control over their life choices. In contrast, low socioeconomic status individuals experience a reduced sense of control over their own life outcomes (Johnson, Krueger, & Carver, 2005, 2006; Kraus, Piff, Keltner, & Simpson, 2009).

Virtually all societies are divided into groups distributed across a social hierarchy. Social class refers to a system of stratification based on access to resources such as wealth, property, power, and prestige, and in the social sciences the combination of these factors is usually conceived as one's socioeconomic status. We know that horizontal inequalities are inequalities between groups with different identities, like blacks and whites, women and men, Muslims and Hindus, or Hutus and Tutsis, among many examples. Blacks in the United States have been poorer than whites since they first arrived as slaves. Despite emancipation, they remain less well educated, poorer, and discriminated against in multiple ways (Stewart, 2017). Similarly, the Romany people have been deprived throughout Europe for centuries. There are very strong forces holding back deprived groups. Being poorer, they have less money to invest in assets and in the education of their children, and have weaker access to loans as well.

As social networks tend to be concentrated within groups, people from poorer groups have fewer useful contacts for access to good schools or jobs (Stewart, 2017). There is also considerable societal discrimination, both formal and informal. Formal restrictions on people because of their identity was critically important in determining access to education, assets, and work, for example, in Apartheid South Africa. Such inequalities are extremely resistant. They are unjust and resented, and not surprisingly, severe, horizontal inequalities can cause violent conflict.

Persons who have become alienated and socioeconomically deviant according to the late modern welfare state's norms will become subordinated and foreign to others. Opposed to those who enter a socioeconomic setting and leave a short time

after (a seller, a beggar, etc.), the socioeconomic foreigner comes today and stays tomorrow. The socioeconomic subordination is an element of the socioeconomic unit itself, an element whose membership within the group involves both being outside it and confronting it.

Social insurance and mental health care

Currently, social work and health care services, correlatively, operate within a strategy in which security is to be obtained by enjoining the responsibilities of citizenship upon individuals who are alienated and subordinated members of society. It acts on specific problematical cases, radiating out to them from locales/locations of individualized judgment on particular conducts reckoned to be pathological in relation to social norms. The juvenile court, the school, the childcare system, etc. operate as centers of adjudication and co-ordination of these strategies, targeted not too much at the isolated individual citizen, but at individuals associated within the matrix of the family. The everyday activities of living, the care of the hygienic conditions of household members, the previous trivial features of interactions between adults and children, were to be anatomized by experts, rendered calculable in terms of norms and deviations, judged in terms of their social costs and consequences, and subject to regimes of education or reformation.

In the new formula of government, social insurance and mental health care can be exemplified in two axes: one inclusive and effecting solidarity, one individualizing and enjoining responsibility. Social and health care insurance become an inclusive praxis of government. It incarnates social solidarity in collectivizing the management of the individual and collective dangers posed by the economic riskiness of capricious system of wage labor, and the consequent riskiness of a body subject to sickness and injury, under the stewardship of a 'social' state. And it enjoins solidarity in that the security of the individual across the vicissitudes of a life history is guaranteed by a mechanism that operates on the basis of what individuals and their families are thought to share by virtue of their common sociality.

Social insurance thus establishes new connections and association between public norms and procedures and the fate of individuals in their private economic and personal conduct. It was only one of an assortment of ways in which, at the start of twentieth century, the privacy of the private sphere of family and factory was attenuated. Together with other regulatory devices such as public housing schemes, health and safety legislation, and laws on childcare, the autonomy of both economic and familial spaces is weakened, and new vectors of responsibility and obligation between state and parent, child, and employee carry them along and join them together.

Without an overall interdisciplinary insight on how people live their lives according to their personal and environmental opportunity and history, we cannot understand how to help and change peoples' lives. By gaining an overall interdisciplinary insight the welfare state can equalize economic and educational differences by providing special opportunities for members of deprived groups: school

scholarships, quotas in education and employment, assistance with loans and housing, etc. To use universal policies that reach everyone, but by design help poorer groups most, is another example. Regional policy can be directed towards giving special assistance to poorer regions and groups. Effective universal social services and cash transfers help those who were previously without access (Stewart, 2017).

However, it seems like a fact that while formal restrictions are increasingly outlawed in many countries, much informal discrimination remains. People with names or appearance that suggest they are from a particular group often find it more difficult to get access to housing or jobs. Where groups face political inequalities because they are in a minority or because they lack voting rights as non-citizens, it makes it more difficult to secure changes in government policy to counter their disadvantage: indeed, government policy may deliberately discriminate against them. In many cases, these forces trap people from deprived groups in permanent deprivation. The big question is whether and how this situation can be changed.

As Marx (1844) pointed out, the existence of different classes is a constant throughout history; also relatively constant is people's felt belonging to a particular social class. Thus, despite the belief widely shared in some countries about social mobility, that is, about the ease of changing from one class to another (Kraus & Tan, 2015), belonging to a certain class remains relatively stable from one generation to the next (Bowles & Gintis, 2002). According to Bourdieu ([1979]1984), this stability happens because of what he calls 'habitus': schemas about acting, thinking, and feeling associated with social status all make people of a homogeneous social class and environment tend to share similar lifestyles. Belonging to a certain social class has profound consequences for individuals in practically all areas of life, and especially in crucial ones such as education, employment, and health (Moya & Fiske, 2017). Regarding health, low socioeconomic status is associated with an elevated risk of mortality and morbidity from diverse causes (Matthews & MacDorman, 2008), as well as decreased mental health and physical functioning before age 60 (Jokela et al., 2010).

Rights and obligations – assistance to others

Insofar as human beings are social and cultural beings, to each of our obligations there corresponds a right on the part of others. Perhaps even the more profound conception would be to think that originally only rights existed; that each individual has demands which are of a general human character and the result of a person's particular conditions, which afterwards become the obligation of others. But since every person with obligations in one way or another also possesses rights, a network of rights and obligations is formed, where right is always the primary element that sets the tone, and obligation is nothing more than its connection in the same act and, indeed, an inevitable connection.

For Simmel (1971, p. 150), inasmuch as all relations of prestation are derived from a right, in the widest sense of this concept, which includes legal rights, the

relationships between human beings have totally permeated the moral values of the individual and determined their course. As such, it seems that the modern humanistic ideas and the modern social and mental welfare aid have replaced the divine laws and the cosmic plan. Situated in the late modern Western world, we are seen to be the only ones responsible for the morality of our acts. We are responsible for them only to our better selves, to our self-esteem, or whatever we wish to call this enigmatic focus which the mind finds in itself as the final judge that decides freely up to what point the rights of others are obligations.

Sartre ([1943]2003) points out that our basic anxiety is related to the freedom and obligation that is given us through birth, and the fact that each choice we have to take for ourselves commits us and makes us responsible not only for ourselves but also for others, from the moment that we are “thrown into this world” we are responsible for everything we do (Sartre, 1946, p. 40). A human being is as such not only what (s)he conceives him/herself to be but also what he/she wants to be. We are in this sense nothing but what we make of ourselves. To Sartre, no *a priori* morals, values, or injunctions exist to support us in life, and there is no materialistic or libidinous determinisms or rational social development. Instead, a human being is freedom. In this respect, we live constantly in relation to a desired future through our projects, expectations, beliefs, and desires. Sartre would have proclaimed that even though our freedom within a bureaucratic system is limited, we have to some extent the freedom to choose between restricted amounts of alternatives within the system. How we choose and what we prioritize says a lot about our expectations and beliefs and what we want to achieve in life. It also says something about the rights and obligations we have as human beings.

The fundamental facts which govern the course of moral action is exemplified or empirically symbolized by various conceptions that exist in relation to the welfare state’s economic assistance to the poor which includes immigrants and refugees as well as citizens, and to those who for some reason, in an employable age, have stopped being economically productive. The obligations we have toward the poor seem to appear as a parallel to the rights of the poor. This is, according to Simmel (1971, p. 151), especially evident in countries where begging is a normal occupation: especially in these countries “the beggar believes more or less naively that he has a right to alms and frequently that their denial means the withholding of a tribute to which he is entitled.”

However, as soon as the welfare system of society requires assistance to the poor, the motivation turns away from the giver without thereby turning to the recipient (Simmel, 1971, p. 154). Public economic assistance to the poor, which also covers health and social services, is imposed by law so as to prevent the poor or the disabled person from becoming active and dangerous enemies of society (Foucault, 1997). The poor or disabled human being as a person, and the perception of his/her position in his/her own mind, is in this case of no interest to the welfare system that gives helps for the sake of protection and socioeconomic values. In this case, the intentions of the latter is overcome not for the sake of the poor, but for the sake of society. The fact that the poor and the disabled person

receive assistance is not, then, an end in itself but merely a means to an end: the function and protection of the state and community.

Assistance to the poor, as a public institution, has a unique socioeconomic and historical character. It is strictly personal. It does nothing but alleviate individual needs. In this respect, it differs from other institutions, which pursue public welfare and security. These institutions attempt to fulfill the needs of all citizens: the schools and public social and health care work, the administration of justice, the army, the police, and the church. They are not directed toward persons considered as differentiated individuals, but rather toward the totality of these individuals: the unity of many or all is the purpose of these institutions. Assistance to the poor, or disabled persons, on the other hand, is focused in its concrete activity on the individual and his/her situation. Simmel (1971) points out that this individual, in the abstract modern type of welfare, is the final action but in no way the final purpose, which consists solely in the protection and furtherance of the community. Somewhat paradoxically, in order to protect the society from crime and violence, social and mental health care workers have to devaluate as well as to support people who are found worthy of public aid.

It could be appropriate to cite Martin Luther King's speech in 1967, where he reminds us that there are some things in our society, some things in our world, to which we must always be maladjusted if we are to be people of good will. We must never adjust ourselves to racial discrimination and racial segregation. We must never adjust ourselves to religious bigotry. We must never adjust ourselves to economic conditions that take necessities from the many to give luxuries to the few. We must never adjust ourselves to the madness of militarism, and the self-defeating effects of physical violence. There comes a time when one must take a stand that is neither safe, nor politic, nor popular. But one must take it because it is right.

The human being in freedom and government

In an open democracy where responsibility, freedom of expression, information, and user involvement is the ideal, there should be room to freely negotiate meaning and feelings, as well as to construct the environment according to our needs. When there is no freedom and no room for negotiation and flexibility, people find themselves in a paradoxical situation, when they are supposed to be responsible for a praxis, a method and a language that are not theirs, and which they don't trust. In such paradoxical situations, people get frustrated and start acting as machines in order to fulfill bureaucratic obligations and expectations and their duties as a health care worker, a service user, a parent, a pupil, and so forth.

Human beings, insofar as they are free, are neither under the guidance of the intellect nor under the dictate of the will, although they need both for the execution of any particular goal. Their freedom consists in the possibility for action, the possibility of establishing a new reality, and where action interrupts the automatism of life it is unexpected, a miracle, an improbability that constitutes the texture

of reality. To have freedom is to have the faculty of beginning, and this beginning has to be in collaboration with others. Where this capacity to begin anew is articulated, political action occurs and appears; freedom develops fully only when action and bodily pointing has created its own worldly space where it can come out of nothing, as it were, and make its appearance. True freedom is practiced, then, via the coupling of beginning and concerted accomplishment.

In her essay 'What Is Freedom?' the German philosopher Hannah Arendt (1961) problematizes the paradox by which people such as mental health care workers and their service users orient themselves to the world as if they had the capacity to act responsibly, to be free, although at the same time there is a sense that such an actor is never a credible figure, since everyday life is an experience of causation. Especially in political and bureaucratic matters, our freedom is evoked, and it is "on this axiomatic assumption that judgments passed" (Arendt, 1961, p. 143). In scientific and theoretical endeavor, however, the no less self-evident truth is constantly underscored that

even "our own lives are, in the last analysis, subject to causation" and that if there should be an ultimately free ego in ourselves, it certainly never makes its unequivocal appearance in the phenomenal world, and therefore can never become the subject of theoretical ascertainment.

(Arendt, 1961, pp. 143–144)

Arendt attempts to revise the psychological and philosophical tradition that has posited freedom as essentially an inner domain identified as a person's capacity to do what s/he wills, via a notion of an inner sense of freedom that has become politically speaking irrelevant. Such a sense is retreat from the world, an inwardness that finds absolute freedom within one's own self. Historically, Arendt suggests, this sense of freedom was one propounded by those who had no place or property in the world, the prerequisites for freedom. It is a conception of freedom that values an inner dialogue, an isolated solitary contemplation. For Arendt any retreat to an inner bodily and mental sense of freedom is not a solution but merely a response to a lack of freedom in intercourse with other. Freedom "is actually the reason that men live together at all. Without it, political life would be meaningless. The *raison d'être* of politics is freedom, and its field of experience is action" (Arendt, 1961, p. 146). This is the point at which Arendt indicates her commitment to a concept of discursive space, a space within which human beings meet in order to speak and act freely as a body politic:

Without a political guaranteed public realm, freedom lacks the worldly space to make its appearance. To be sure it may dwell in men's hearts as desire or will or hope or yearning; but the human heart, as we all know, is a very dark place, and whatever goes on in its obscurity can hardly be called a demonstrable fact. Freedom as a demonstrable fact and politics coincide and are related to each other like two sides of the same coin.

Arendt argues this position against one that would regard freedom as the opposite of politics, as defined by an absence of politics. The modern age has attempted to divorce freedom from politics, she argues, placing freedom outside or beyond the sphere of the political and regarding people's engagement in politics as the result of a mistrust of those with power, rather than the result of a love of freedom. Engagement within the public sphere enables freedom to become manifested. For freedom is not, according to Arendt (1961, p. 151), about the ability to choose between two given things, but is about the ability to "call something into being which did not exist before, which was not given, not even as an object of cognition or imagination."

Although Arendt, like Machiavelli, thought virtuous and brilliant individuals should be able to appear, she believes that political action cannot take place in isolation. Real political action takes place as a sociopolitical group act. And you join that group or you don't. Whatever you do on your own you are not really an actor, you are an anarchist. Arendt's argument appears to revert, ultimately, to the machinery of institutionalized politics as the site of the concerted action of beginning anew. Her focus is on clarifying that space and improving it as the stage of freedom. She is critical of those who believe that modern politics has been invaded by too many social questions, and that social issues and life questions should be separated from the sphere of the political. Greatness will be prevented from appearing where politics becomes concerned with the administration of things: the uniqueness of human being, of *Existenz*, had been denied in the passivity of a twentieth century shocked by its experiences of totalitarianism. Attempting to respond through a system of liberal representation Arendt saw, at her most Nietzschean, as paving the way for mediocrity.

Opposed to Arendt's view of freedom, Foucault's notions of freedom, such as he dealt with in the '70s and '80s, concern themselves with a kind of struggle between the public and private self. That the political has become involved with the administration of life is, he suggests, a condition of modern human beings, who have taken their existence as the target of political life such that politics is bio-political, attempting to govern people as populations to be known, measured, or monitored. Freedom, for Foucault, takes the form of liberating the individual from subjection and freeing the individual for new types of subjectivity, although both power and knowledge about well-being and mental health will continue to influence and shape it. Foucault does not hold a distinction comparable to Arendt's attempts to distinguish social from political questions, but he does on occasion suggest that there is a limit to governability of the populations constituted through a bio-political form of government.

In the *History of sexuality*, vol. 1. Foucault (1978) argues that life escapes biopolitics. Without forcing a coherence on Foucault, one might reflect upon whether it is at that moment of escape where the possibility of practicing one's liberty, of presenting one's self, differently opens up. Yet, implicitly, the performance takes place in order to be looked upon; that is, there is an aesthetic at work that implies the returning importance of communication.

Arendt's position would refuse to call an aesthetics of existence political unless it could communicate something publicly and something beyond a personal existence. If in mental health care politics, not life but the world is at issue, how can techniques of the self as practices of liberty engage politically? This is the point at which commentators have suggested that an aesthetics of existence requires a conception of public space (cf. Fraser, 1989; McNay, 1992). A politics of solidarity that one finds in the Habermasian vision, however depleted his image of the embodied self is, is in some ways a move away from a politics of introversion that Foucault's ethics of the self slides toward. Such a critique has a tonality of realism about it and is an attractive 'solution' to the question of the political Foucault. On the other hand, one might argue that there is a notion of public space in Foucault's philosophy. It is not the public space of politics of which Arendt writes, nor what the Frankfurt tradition upholds, rather one might consider it a discursive space, or a space of imagination.

Subjective perceptions and imaginations offer not only an escape from specific and undesirable situations but also an escape from all the constraints of the world. They seem to be presented as a *negation* of the condition of being-in-the-world, as an anti-world. In fact, it seems that our imaginations and expectations influence our daily life to such an extent that they become real and part of our perceptions and identity, that is, the 'me'-ness of me in action. What we are and what we will be, what we have done, and what we want to achieve, produce internal images and expectations of ourselves and others.

No matter how limited and inhumane the bureaucratic mental health care environment must seem, as meaning-making subjects and as historical actors, every individual, every health care worker and every client seem to be able to constitute and change themselves through various forms of self-mastery, imaginative or not. That is, despite environmental and historical restrictions and heavy cultural and bureaucratic influences, as living actors we are more or less continually struggling to construct our environment according to our needs. This applies to all of us: health care workers, social workers, service users, politicians, parents, singles, and so forth, although the ability to wield influence is not equally distributed.

The human mind is always in a state of change

In late modern mental health care systems, the service user and the mental health care worker live in, reduce, and adapt to their sociocultural and historical environment by being put, and by putting themselves, in various positions of domination and subordination. Living in a dynamic environment of different social conditions of domination and subordination, our notion of who we are and who we want to be will unconditionally and consciously change according to these adaptations by being put, and by putting themselves in various positions of domination and subordination. Influenced and changed by our relationship to others, our perception of best praxis, our ideas and ideals of rationalism and logic also change.

In the encounter with others and the fields of dominations and subordinations, we learn that the self does not exist all at once but is alternately lost and then recovered. Concretely, this is the very essence of human beings. As human actors, as service users, as mental health care workers, as parents, playing out or in our theater of life, we are never what we are; we always exceed ourselves and are always beyond ourselves; we have a future; and we reject all permanence except the permanence of our desire to become more of our true selves and less dependent of other. Thus, the fact that we never will conform to another human being and the fact that intersubjective forms of cohabitation cause considerable interaction challenges for the development of the self, "To cultivate oneself is not to develop harmony, as in organic growth, but to oppose oneself and rediscover oneself through a rending and a separation" (Hyppolite, 1974, p. 385). Looking back at the history of humankind, there seems to be no rational, dialectical struggle in which the oppressed enlightens the overlord and vice versa and that will end in equality and stability, such as Hegel believes. Life leans more in the direction of what Kierkegaard and Sartre describe as self-agitation, anxiety, and suffering.

We first and foremost meet others as rival consciousnesses, as rival sources of freedom and power, because our relationships with others are *intersubjective* in the sense that we, in our development of the self, are dependent on others' judgment (Sartre, [1943]2003). This is something we fear and would prefer to escape. We are talking about an intersubjective interaction that leads to a predictable interaction of dominance and submission in which we either attempt to overpower the other (the sadistic strategy) or to surrender to the command of the other's mastery (the masochistic strategy). In both cases, we confirm that we are a living thinking subject, that we are powerful or weak, and that we are authentic.

To exemplify the dynamic between the feeling of being empowered and the feeling of being reduced and embarrassed by the other's judging gaze, we can imagine the situation where a curious mental health care worker observes another mental health care worker in his/her private office during a therapeutic session through the window beside the door. The observer enjoys the feeling of having the body of the other mental health care worker as an object in his/her power. However, what the observer does not know is that (s)he is also an object of observation by a third person (another mental health care worker) while (s)he is spying through the keyhole.

This sensation of suddenly being discovered promotes a feeling of shame that is perceived as humiliating because the observer is reduced from being the one who observes and has power to being the observed (the object of other) at the mercy of a negative judgment of others. Nevertheless, the sensation of being discovered by another leads us from the unreflective consciousness for itself in isolation to the reflective consciousness in the world of others. "It is shame or pride which reveal to me the Other's look and myself at the end of that look. It is the shame of pride which makes me *live*" (Sartre, [1943]2003, pp. 284–285).

In this mirror state, where another person makes you see yourself as you are in a particular situation, in this case, a mental health care worker who without any

permission spies on a colleague, you meet yourself in an existential border situation where you start asking questions about yourself, such as, who am I? Why did I spy on my colleague in his/her private office? Why could I not just talk to my colleague without spying? In this situation, you have several options, you can for example choose to continue your plans of spying, or you can give up your plans and constitute yourself at a higher level of understanding and reconciliation. Such a kind of flexible and dynamic response to the situation can lead to personal growth and a new recognition of yourselves and the others that are acting out their role in this actual scene. To be flexible and adaptable is the same as to master the situation by changing perspectives. This flexibility is also a type of individual health that can lead you to a new level of cognition and equilibrium. To be a dynamic, critical, and adaptive person means being able to respond in a well-ordered fashion and this is possible despite the previous impossibility of accomplishing this or that (Goldstein, 1995, pp. 332–333). However, the new cognition is not the same as the old. This will amount to a new individual standard.

In situations where respect and recognition are absent and we attempt to reduce the other as subject to object, an equal ‘we’ is impossible to achieve. In such cases, it is understandable that one wants to withdraw from social communication with other. However, to withdraw from social communication with others is an impossible solution in the end. We need discursive and social battles because we are nothing if not in an intersubjective relationship with others; this applies to everyone, be it the mental health care worker, the patient or service user, etc. (cf. Sartre, [1943]2003).

Patients who resist treatment, and mental health care workers who refuse to perform certain types of procedures because they do not believe in it, should be seen as a necessary source of affirmation of one’s own existence and integrity. Like the case above, to deal with the conflict by discussions will cause people representing it to move from unreflective consciousness for itself in isolation, to reflective consciousness in the world of others, which ultimately will help to keep the different discussions on what is to be best praxis alive and conscious.

Because of the never-ending contradiction in our behavior and (mental health care) environment, a realization of an absolute and ideal mental health care worker or an absolute and ideal patient will always be deferred. To speak of an absolute constituted mental health care worker or an absolute knowledge of oneself and our praxis is to speak of something outside reality. Before we can speak of an objective knowledge, or anything whatsoever having to do with an objective science of social relations and subjective feelings, we have to realize that our longing for homogeneity and objectivity may have something to do with winning the battle for recognition.

Although service users, who are seemingly in the same situation, often respond very differently (van Stekelenburg & Klandermans, 2010), they take reactions of others into account when making decisions to participate in what the situation demands. The importance of being understood correctly as an individual entitled to one’s own opinions within its ecological, cultural, medical, and political contexts is crucial to identity processes and self-integrity (Sherman & Cohen, 2006).

There is, then, an obvious connection between human mental life and different social realities of which every person is a part. Social environments provide service users and mental health care workers with living conditions and with traditions that awake our mind and make us what we are. It remains a condition of our existence, in the same way as our personal power and our environments influence our self-awareness and our experience of the world and the other.

Jaspers ([1913]1997, p. 12) believes, above all, that the environment fosters situations. These provide the service user and the mental health care worker with opportunities, which (s)he may make use of or waste or in which (s)he may reach decisions. The service user and the mental health care worker can contrive situations themselves, letting them arise or not arise in some meaningful pattern. They can submit to the ordered regularity and conventions of a world and at the same time, we can convert them into meanings of escape. These may awaken in us something that we can call Existence itself, a reality of selfhood. What happens as a result of it (the situation) is partly determined by the person who is in the situation, and by what (s)he thinks about it (1951, p. 28). The 'grasping' of a situation modifies it, insofar as the grasping of it renders possible the adoption of a definite attitude towards it and an appeal to the tribute of action.

To grasp a situation is the first step in the direction of its mastery. In this sense, history and sociocultural environments foster learning situations which we approach and restructure (change) so as to adapt these situations to our needs and expectations (cf. Jaspers, [1913]1997). The ability to change our own perception as we learn from our environment (*milieu*) represents each individual's freedom, as long as we are physical and psychologically capable of making use of it. Learning is thus not only about measurable reflexes, but also about gaining an overall insight into a situation's structure, which includes political insight as well as personal, global, and scientific insight. Learning and problem solving are primarily about gaining insight into a situational structure (Jaspers, [1913]1997). Jaspers believes that individual life develops from constitution (*Anlage*) and environment (*milieu*).

Taking as a starting point that human beings in everyday life both expend and adapt their sociocultural and historical environment by being put, and by putting themselves, in various positions of domination and subordination, what we are and who we become depends not only on subjective perceptions and actions, but on what other people do and think. Living in a dynamic environment full of contradictory conditions of domination and subordination, our notion of who we are and who we want to be, will change according to which condition we at any given time are in. Being influenced and changed by the relationship to others leads to our perception of rationalism and logic also changing. In a changing world of coincidences and contradictions, the fulfillment of the absolute self, will in the late modern world always be deferred because of a persistent contradiction in the social and cultural environment.

The contradictions will cause all the individuals in a society to move in and out of an experience of alienation and fulfillment of self. The alienation of self means that one never agrees with oneself because one continually becomes another in

the endeavor to be oneself. The self never coincides with itself, for it is always other in order to be itself. It always poses itself in a determination and, because this determination is, as such, already its first negation, it always negates itself to be itself. It is human being “that never is what it is and always is what it is not” (Hyppolite, 1974, p. 150).

These means that the finite human being is not limited in the way that an object can be limited. Where the object does not know its own limit, which is external to it, the human being, such as the service user and the mental health care worker, continually seeks to transgress its limit; it tends toward the infinite, the unconditioned. This understanding is reason, but by the same token, it transgresses the very sphere of objects. The infinite human being cannot be limited as an object because it is a task whose accomplishment is forever deferred. It is no longer the concept of reason that regulates experience but that of the idea and the infinite practical task in relation to which all knowledge and all knowing are organized. Because a human being always fails in its endeavor to become whole and united (Simmel, 1971), its basis remains always in an unsatisfied consciousness (Hyppolite, 1974, p. 191). The experience of the self becomes inadequate and incomplete and ceases to correspond with the objects of truth, and our knowledge of death enforces our knowledge of limited time.

These and several other examples, show that our psychological life carries with it our historical past, attitude, and lifestyle, which makes it necessary to look at the human being from several empirical, theoretical, and scientific angles in order to understand it. When dealing with human beings, a mental health care worker cannot then use the same methods and abstraction as in the field of somatic sciences and mathematics. In the endeavor to understand another human being and what he or she at any time considers functional, a mental health care worker has to combine knowledge of different sciences and knowledge areas, which includes the study of the meaning of language, artificial expression, subjective experience, neurological reaction, as well as cultural and historical analyses. (S)He also has to acknowledge that historical and cultural development is not rational in nature but more or less culturally constructed. Far from attempting to seek authenticity in this development, which is still prevalent in the positivist historiography of pure facts, one should underline the specificity of the emergence of a certain person and of a certain social and cultural event and outline the conditions of possibilities in light of the unrepeatability of the past and intervention in the present.

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Body-mind-thinking

In the last chapter, we discussed the freedom and restriction of thinking and acting and of being oneself. No doubt, our sociocultural environment and our socioeconomic status have an impact on the way we think and act. However, the sociocultural environment and our socioeconomic status is not the only thing that influence the way we think and act. Thinking is a ‘pointing,’ in a sense that will become clear, that drags your attention to a particular thing, and pointing is irretrievably linked to the body. Thus the mind, the body, and pointing become synonymous. Connecting the human mind to the human body, the human body is much more than a thing among things, an indifferent collection of sensations as seen biologically. The body is not just a physiological substance. It is our limbed life and our body proper.

Like the human mind, the body represents oneself, be it as a service user, or as a mental health care worker: It is one’s lived unity, one’s sensed self, one’s unique manifestation of ourselves a vital subject precisely as a subject. We can see through the others’ eyes only on the basis of our felt embodiment; as such, our body is the condition for our common ‘objective’ world. In any case, all this vividly indicates that I am in my active experience of being me a subject, both as a service user or as a mental health care worker. I experience in my body how it is to be me as a service user, me as a mother, me as mental health care worker. Therefore, I *am* also my body and do not just have one. As such, the human body, like the mind, is what holds things together. It lets things appear as things, the vibrant locus of expression of ourselves in situation in things. Our body is our dynamic vehicle of knowledge, making possible various empirical definitions of things. Our body further expresses the ambiguity of our human existence as both shared species being an individual difference.

Seen historically, Hegel, and others before him, admired the Greek sculptures for capturing the way the harmonious proportions of the human body express the dignity of our rational mind (Shusterman, 2012). In late modern society, respect for the body’s dignity forms part of our basic respect for personhood and human rights. It is implicit in the right to life and in our tacit sense of respecting a certain physical distance from each other to allow some free space for the body, our basic habitat. Even in death the body is – or is to be – respected; most cultures dispatch the corpse with some dignifying ritual of burial or cremation.

Opposed to the divine view of the human body, moralists often inveigh against the body as the enemy of righteousness:

Therefore do not let sin reign in your mortal body so that you obey its lusts, and do not go on presenting the members of your body to sin as instruments of unrighteousness; but present yourselves to God as those alive from the dead, and your members as instruments of righteousness to God. For sin shall not be master over you, for you are not under law but under grace.

(Romans 6:12–14)

We should realize that all our ethical concepts and norms, even the very notion of humanity that underwrites them, depend on social forms of life involving the ways we experience our bodies in different situations, that is, in front of the service user, in front of the therapist, in front of the boss, in front of our colleagues, and so forth, and the ways that others treat us. Seeing the body as both divine and dirty, the body-mind-thinking, exemplifies our multiform ambivalent human condition between power and frailty, worthiness and shame, dignity and brutishness, knowledge and ignorance. We invoke the notion of humanity to urge a person toward moral excellence and rationality that transcend mere animality, but we also use the predicate human to describe and excuse our flaws, failures, and lapses into base or even bestial behavior. These are all human weaknesses, limits linked to the frailties of the flesh we share with common beasts. Yet despite its animal nature, the body serves as a symbol of human dignity, expressed in the irrepressible desire to depict the body in art's attractive forms and to portray even the gods in human shape.

Through history, different scholars, such as Wittgenstein, Austin, Danziger, Rose, Nietzsche, and Foucault, have emphasized rationality and language as the distinguishing essence of humankind; but human embodiment seems at least as universal and essential a condition of humanity. You cannot help but call up the image of the human bodily form when imagining a human being.

If we imagine creatures displaying human language and behavior but having a very different kind of body, we would think of them not as humans but as monsters, mermaids, robots, aliens, angels, or persons whose humanity has been somewhat robbed or diminished . . . though our bodies unite us as humans, they also divide us through their physical structure, functional practices and sociocultural interpretation into different gender, races, ethnicities, classes, and further into the particular individuals that we are. We may all use legs to walk or hands to grasp, but each person has a different gait and fingerprint.

(Shusterman, 2012, p. 29)

To Shusterman (2012) our experience and behavior are far less genetically hardwired than in other animals. A bird of the same species will sing much the

same in Peking and in Oslo, whereas human vocalization patterns vary quite widely because they depend on learning from the experiences environment.

The essential characteristic of the bodily self is that the body is, or has, a pre-objective relationship with its surroundings. This relationship has intentionality, in Kant's and Merleau-Ponty's sense of the word, in that the body is directed toward comprehending different kinds of environment including the society it is part of. Herein resides the title and significance of Merleau-Ponty's work *Phenomenology of Perception*. The 'phenomenon' that Merleau-Ponty refers to is what comes into view, and one should regard the phenomenon carefully with as little prejudice as possible. What stands out for a trained phenomenologist is a perceptual field that opens up the perceptual body, and this area contains many layers of meaning. In the first layer are the pre-objective phenomena themselves. These phenomena are open, ambiguous phenomena to which the human body responds. The body and its surroundings constitute an internal relational structure in which the two elements mutually refer to each other. This structure is the meaning of Heidegger's concept of being-in-the-world, which Merleau-Ponty later refers to as being-to-the-world (*être au monde*).

To Merleau-Ponty ([1945]2002) mental life relies on the body and its somatic experience. Mental life cannot then be wholly separated from bodily processes, even if it cannot be wholly reduced to them. We think and feel with our bodies, especially with the body parts that constitute the brain and nervous system. Our bodies are likewise affected by mental life and cultural ideas of what is thinkable and behaviorally relevant, as when certain thoughts and behavior bring a blush to the cheek and change our heart rate and breathing rhythms because we are ashamed of what we think and how we behave according to something and someone.

However, whether we speak of body-mind or body and mind, we are dealing with what is fundamentally shaped by culture. For culture gives us the languages, values, social institutions, and artistic media through which we think and act and also express ourselves aesthetically. Culture gives us the forms of diet, exercise, and somatic styling that shape not only our bodily appearance and behavior but also the way we experience our body, whether as a holy vessel or a burden of sinful flesh, a pampered personal possession for private pleasure, or a vehicle of labor to serve the social good. Conversely, culture, its institutions and humanistic achievements, cannot thrive or even survive without the animating power of embodied thought and action. And one measure of a culture's quality of life and humanity is the level of body-thinking harmony it promotes and displays.

The body as tool to experience

In a modern welfare community, the body, be it the body of a service user, or the body of a mental health care worker, is molded by a great many distinct regimes and experiences. Our experiences are affected by the fact that our late modern body is broken down by the rhythms of work, education, new therapies, research,

meetings, applications, bringing children to school and kindergarten, and leisure time occupied with Netflix series, snapchat, meditation, electronic play, internet, rest, and holidays. Our body is also intoxicated by food and values embodied in our eating habits and moral laws.

As a 'tool' for experiencing, a tool inseparable from our very being, our physical body functions as a surface open to and in contact with the world that surrounds it. If the body is situated in an overregulated working place, or is governed by a disciplinary bureaucratic power or another person, the governmental structure will enter the body-mind structure and guide the way we think and act. Historically, we can, according to Foucault (2006) distinguish between two types of governmental power structures that through history have entered the body and formed its pointing and experience. Foucault calls the first governmental power 'the macrophysics of sovereignty,' the other, 'the microphysics of disciplinary power.'

The macrophysics of sovereignty stems from post-feudal and pre-industrial governmental power structures. It is connected to a physical and hierarchical power structure, which is guided by explicit signs and symbols. It is your biological heritage, your money, your crown, your clothes, your jewelry, your beard length, your access to empower and disempower people that characterize your position and possibilities in this regime. The regime is held together and protected by continual and repetitive rituals, where the sovereign, the king and queen and feudal lord, can show their power and remind their subordinates who is sovereign and who is in command.

We are talking of a regime where the sovereign and the subordinates are placed in very different universe of possibilities and dependencies. The power structure that characterizes the macrophysics of sovereignty is currently visible in states such as The Islamic State and in North Korea, but also in overregulated bureaucracies, and in some treatment institutions in the late modern Western welfare states. The other governmental structure Foucault refers to is the microphysics of disciplinary power. Opposed to the macrophysics of sovereignty, this power structure is manifested in the development of the human sciences and in the development of the first premodern democratic bureaucracies, such as the military, and in various religious and moral communities. The premodern religious communities and the military bureaucracies, with their strong moral pedagogy and their control and subtle methods of physical and psychic punishment, are characteristic signs of the microphysics of disciplinary power regime at the end of the 1600s and throughout the 1700s.

In the army during the time of sovereignty, the training that soldiers received could not be defined as disciplinary. Rather it consisted of activities such as jousting and other games, competitions of strength and courage. It was not until the mid-1700s, with Frederik II and the Prussian army, that we see the emergence of a completely new type of physical military training. The training demanded that soldiers showed a talent for marching and performing a variety of elementary disciplinary physical and symmetrical movements. This disciplinary and symmetrical movement was quite unlike the earlier cyclical repetition of jousting and games.

With the new system of discipline and symmetry, the need to control the soldiers' body, time, and thinking became exigent. It resulted in a comprehensive observation and registration culture where one started to observe and write down everything the soldiers said and did. The need of control soon spreads to all public institutions, such as schools, workplaces, health care institutions, apprenticeship schools, etc. Thus, the military discipline becomes a general seizure of the civilians' bodies, lives, and time.

The main feature of disciplinary power is its scientifically structured character of classification and subordination systems. In the army there are established ranks and, likewise, in eighteenth-century schools age-specific classes and ability levels arrange individuals according to a category of hierarchical skills. In mental health care institutions, diagnosis and registrations manuals become a tool for disciplinary treatment and mental training.

To control the recruits, the pupils, or the patients' behavior, the Western seventeenth- and eighteenth-century's institutions started to use the same system of control and discipline as the military. They started to record, write down, and systematize everything that the pupils or the patient said and did. The records were later registered and codified in legal and political health care systems, reminiscent of today's medical records, and sent on to a centralized observation point. The visibility of bodies and the permanence of written records go together. The effect is a schematic and centralized individualization that currently characterizes the late modern individual, the late modern health care worker, the late modern service user, the late modern welfare state, and the late modern mental health care institutions.

Not very surprising, the perpetual regimes of classification, hierarchization, and observation that we find in modern society will necessarily create a residue of unclassified individuals who cannot be integrated in this restricted and disciplinary power regime. Thus, in modern welfare states a number of deviance systems are established with their own specialized institutions set up to care for deviants. The deviance systems and the modern mental health care systems, together, pin the subject-function exactly to the human body.

Looking at the late modern welfare state regime from a social democratic point of view, such as the Scandinavian welfare state model, irregular thinking and irregular bodies are studied, administered, and taken care of as soon as they become visible for the public system (Bendixsen, Bringslid, & Vike, 2018). In the social democratic environment, human bodies become psychologized and normalized to fit into the modern welfare state demands of adaption, participation, and communication. In the late modern mental health care institution as well as in the late modern welfare state regime, the human body is always visible and under constant surveillance. Because of its monitoring structure, late modern mental health care institutions and late modern governments have no need to refer to a single act, to a God, an event, or an original right, to discipline their citizens. People, who get help from public health services as well as people who work there, need only to show gratitude and the will to adapt, not to God, but to the

welfare system in form of subordination to the system. An inner disciplinary self-justice, a final self-constituting optimal state, has in this case replaced the power of sovereignty. In this sense, the whole welfare society becomes an economic and pedagogical project whose function is to project norms into the subject's body and mind and in that way distinguish the normal from the abnormal.

Although the Western late modern welfare state and its late modern mental health care institutions are regulated and governed by democratic rules, such as elections and user involvement, the same welfare state is also producing explicit and implicit disciplinary mechanisms in form of pedagogic practices and massive public controls to measure and control people's mental and physical health and capacity (Rose, 1990). In addition there are hundreds of forms of rights and obligations that influence our way of thinking and acting. A body situated in a regulated welfare environment is guided and regulated not only by self-regulation but by democratic, pedagogical, and disciplinary practices that are common to all citizens. The governmental guidelines are transferred to living individuals and populations; it implies pursuing control of the deployment and shaping of bodily, mental, and social faculties of human beings. That is, the power structure representing the microphysics of disciplinary power is a form of power, which sneaks into the human body as a kind of invisible microorganism. The microorganism of disciplinary power subjugates individuals, challenging their independence and forcing them to conform to a particular type of person. Disciplinary power primarily threatened individuals with the loss of their ability to define themselves differently *vis à vis* prevailing social norms. What is at stake in disciplinary power is subjectivity itself.

Foucault argues that power relations in the modern age are ordered toward subjection. However, the verb 'subject' has two meanings: being subject to someone else by relations of control and dependence and being a subject by being tied to one's own identity by conscience and self-knowledge. In the modern age, power 'subjugates and makes subjects to' (Dreyfus & Rabinow, 1983, p. 212).

By means of the technique of subjection, a new (late) modern body object is being composed. This new body object represents the natural observable body under the influence of a new kind of power, the bio-power. This new body has its order, its time, its internal conditions, and its constitutive elements, which offer itself to new forms of power-knowledge regimes concerning health, discipline, and learning. Under control of the bio-power, the new body becomes the body of control, exercise, and symmetry, rather than the body traversed by animal spirits.

To Foucault (1975b), the training and discipline of the body and its increasing specification by various forms of knowledge is exactly what contributes to the advancement of the welfare state's capitalist economy. The discipline that we see in the microphysics of the disciplinary power regime and in the late modern welfare states regime is the unitary technical procedure by means of which the body's power is most cheaply reduced as political and economic force and maximized as a useful force. The growth of a capitalist economy called for a specific political framework and a specific knowledge that could facilitate and increase the

productivity of the economically productive body. In the capitalist economy, characteristic for late modern welfare state regimes, an 'anatomy-body-knowledge-politics' is put into play by diverse apparatus and institutions.

In Foucault's 1970 works, economic and political power and knowledge of the human body interact in such a way that it is often impossible to tell which has priority. Over the past two or three centuries, the human body has become one of the most privileged sites for the exercise of power and knowledge (Foucault, 1975a, 1978, 1980). Together, power and knowledge form what Foucault calls a 'dispositif' (apparatus) which consists in "strategies of relations of forces supporting, and supported by types of knowledge" (Foucault, 1980, p. 196). In the modern dispositive, it is especially the social sciences that link up with discipline and dictionary power. The modern dispositive exercises itself on 'humans' or on that body whose form has been shaped by social scientists and the medical profession so as to fit into the disciplinary welfare state regime and into the disciplinary mental health care system.

This is the formula of rule somewhere between classical liberalism and nascent socialism. Its most contested plane of action is the economic domain itself, where interventions would prevent the privacy of the market and enterprise while rationing their formal autonomy. But the security of the economy is also to be assured by acting upon the social milieu within which production and exchange occur by governing society itself (cf. Procacci, 1989). Within the socialist liberalistic formula of welfare, the political authorities, through their utilization of the financial, technical, and juridical possibilities of the state, become the guarantor of both the freedom of the individual and the freedom of the capitalist enterprise. The state takes responsibility for generating an array of technologies of government that would 'socialize' both individual citizenship and economic life in the name of collective security.

Resistance, in the modern age, then, is directed against the modern economic system and dispositive, which traps the body-subject in its net. The aim of resistance is "to promote new forms of subjectivity through the refusal of this kind of individuality which has been imposed on us for several centuries" (Dreyfus & Rabinow, 1983, p. 216). Resistance takes the form of a struggle whose main objective is to attack not so much 'such or such' an institution of power, or group, or elite or class, but rather a technique, a form of power. In the modern age, power tends to "tie the individual to himself and submit him to others" (Dreyfus & Rabinow, 1983, p. 212). This includes all of us, the service user as well as the mental health care worker. As a point of resistance, the possibility that it might contest disciplinary power, the social sciences, and the *scientia sexualis* by using the resistance against them is very real. Invested with the force that created it, the body itself has a derived power which it might turn against institutions, discourses, laws, and the apparatus that sustains it. The struggle of the body against power may also serve simply to strengthen power by forcing further investments or a reorganization of investments. To Foucault (1980), in late modern democracy, mastery and awareness of one's own body can

only be acquired through the effect of an investment of power in the body: gymnastics, exercises, muscle building, nudism, and glorification of the body beautiful.

All of this belongs to the pathway leading to the desire on one's own body, by way of the insistent, persistent, meticulous work of power on the bodies of children or soldiers, the healthy bodies. But once power produces this effect, there inevitably emerge the responding claims and affirmations, those of one's own body against power, of health against the economic system, of pleasure against the moral norms of sexuality, marriage, and decency. Suddenly, what had made power strong becomes used to attack it. Power, after investing itself in the body, finds itself exposed to a counter attack in the same body.

(Foucault, 1980, p. 56)

In the model of omnivisibility and the internal control mechanisms, one can see the contours of a welfare society with its own psyche that can predict where the body of the citizens is pointing and thereby what kind of changes that will occur in people's minds before they even happen. To ordain the future in advance in this way, human beings, be it the service user or the mental health care worker, must first have learned to distinguish necessary events from chance ones, to think causally, to see and anticipate distant eventualities as if they belonged to the present, to decide with certainty what is the goal and what it means to it, and in general be able to calculate and compute. A human body must first of all have become calculable, regular, necessary, even in his/her own image of his/herself, if (s)he is to be able to stand securely for his/her own future, which is what one who promises does (cf. Nietzsche, 1967).

Mental health care institutions as well as historical events, thus, impress themselves not only on things and events but also on the human body. With its ability to manifest the stigma of past experience and also give rise to desires, failings, and errors, the body becomes a surface of inscription of events. It establishes that nothing is stable. Not even our nature and physiology escape the play of historical forces. A world of circumstances and events will necessarily be incorporated in the relationship between the original 'I know,' 'I will,' 'I shall do,' and the actual discharge of the will, its act. Historical developments are thus not considered culminations of historical processes, intentions, or designs; rather, they constitute episodic manifestations of a series of dominations for which no subject, no service user, no mental health care worker, may be held responsible.

The existential body

Seeing the service user's body and the mental health care worker's body as event and as history, their bodies do not signify only the flesh; they signify a much larger existence in the temporal sense as well as in the spatial sense. In terms of time, their bodies have an existence that runs through them and even extends further to their 'ancestors.' In terms of space, their bodies have an existence that runs through their flesh and extends further to the environment that sustains that flesh,

that is, everything that touches their body: therapeutic climate, food, architecture, furniture, medical records, etc. (cf. Foucault, 1984). This means that the extension of the service user's and the mental health care worker's body is identical to the extension of material existence. It is the natural symbol as well as the existential basis of (mental health care) culture. Because their body is 'being-in-the-mental-health-care-world' and because their body is their being-there in the mental health care world, any description of their body has as its correlate a disruption of the mental health care world.

To get a broader understanding of the body being-in-the-world and the body's ability to manifest the stigma of past experience that also gives rise to desires, failings, and errors, we can follow Sartre ([1943]2003) who relates the body to a three-dimensional body as such – that is, the body in relation to society or *for others*, the body in relation *to itself*, and, lastly, the body in relation to an *ontological* notion. The body as being-for-others is a body in a social situation. In this case, the other's body is meaningful and is not perceived as a thing among things, as if it were an isolated object, a service user with purely external relations with other objects (*objets*). In a social context where one exchanges information and experiences, there is a radical difference between objects and human beings. Sartre ([1943]2003, p. 278, italics in the original), explains this in this way:

Suppose that we see a girl in a public park. If we were to think of her as being only a puppet, we should apply to her the categories which we ordinarily use to group temporal-spatial 'things.' Perceiving her as a girl, on the other hand, is not to apprehend an additive relation between the chair and her; it is to register an organization *without distance* of the things in our universe around that privileged object.

Although, in this example, the other is a body by virtue of the fact that we are looking at the girl and not vice versa, the other is perceived as a situated object around whom society is organized. The other's body is seen as a center of his/her own fields of perceptions and actions and the space (s)he inhabits is the space in which (s)he lives. This interpretation indicates two dimensions of the body: the body as being-for-itself (your own body as it is normally for you) and the body as being-for-others (your body as it normally appears to the service user or to the mental health care worker or, equivalently, the body of the service user or mental health care worker as it normally appears to your body). A third ontological dimension is then generated, so to speak, by the interaction between these first two dimensions: "My awareness of being an object for others means that I also exist for myself as body known by the others" (Sartre, [1943]2003, p. 375). Being-with-others follows, then, from being-for-others (Frie, 1997, p. 60).

Opposed to Sartre's three-dimensional body, Merleau-Ponty's understanding of the body is that the body is not an object of the surroundings (Merleau-Ponty, [1945]2002). The mental health care environment is not objective in the sense of something unambiguous and measurable; nor is the service user's or mental health care worker's body a type of machine, as Descartes suggests. To Merleau-Ponty

([1945]2002) there exists no dualism such as the service user's and mental health care worker's body as being-for-itself and the service user's and mental health care worker's body as being-for-others, which is an observable, physical body in a social unity with others. If you thought of yourself and your body in this vein, you would not call it yours and you would not be you. Merleau-Ponty suggests that it is better to say 'you are your body' – that is, your meanings and experiences are found in the structures of your body's behavior, and it is the center of the world in which you exist. To Merleau-Ponty, we cannot speak of different realities and different self-consciousnesses or body awarenesses.

Merleau-Ponty ([1945]2002) believes that it is because of the sub-consciousness of the bodily self that we can 'install' ourselves, so to speak, in a mental health care context, or in a therapeutic praxis that we know very well, and so to speak melt into it without becoming an object to other or to ourselves. Our intersubjective social relations with the environment, be it with a technical instrument or with others, are thus a physical and bodily connection, which is crucial for understanding ourselves in relation to a praxis, an instrument, an environment, and to other people.

True reflection presents me to myself not as idle and inaccessible subjectivity, but as identical with my presence in the world with others, as I am now realizing it: I am all that I can see, I am an *intersubjective* field, not despite my body and historical situation, but, on the contrary, by being this body and this situation, and through them, all the rest.

(Merleau-Ponty, [1945]2002, p. 525)

By showing how the human body, be it the service user's body or the mental health care worker's body, is not mechanically, biologically, or intellectually related to the (mental health care) environment, but, rather, is existentially related to it, Merleau-Ponty outlines a new way of examining and reinterpreting the body that extends beyond Heidegger's notions, which do not fully examine the body-mind relationship and the problem of perception. However, by placing body consciousness before ideational consciousness, Merleau-Ponty might seem to approach radical behaviorism, which asserts that the human psyche cannot be examined and, thus, that only external and visible behavior remains as the subject of science. Merleau-Ponty himself was aware of the seeming similarity between his work and behaviorism. But in his work *The Structure of Behavior* ([1942]2011), Merleau-Ponty claims that behaviorism and Pavlov's reflexology misinterpreted existence by understanding it in response to stimuli, analogous with the mechanistic cause-effect relationships between objects.

In Merleau-Ponty's view, the existential body is melted into the mind of the service user's and mental health care worker's experience and into the world of their experience, so to speak. However, it is inaccurate to say, such as Merleau-Ponty does, that we insert ourselves in the world, or that we are thrown into the world, such as Heidegger and Sartre suggest. For these phrases are really expressions of

your surprise when you find yourself already somewhere ('here') in the world. After all, to 'insert' and 'be thrown' into the world you have to be there already. About your being-there-already you can do nothing; every thinking and every theme for thinking begins here, including your 'inserting' and your being 'thrown' into the world. And this your being-there-already is your body, your living-you-body. There is no 'bond,' no 'opening,' no 'availability' that unties you to your body. You are your body, not the body you see but the body you feel. For your body is always present in your experience, giving you a point of view, so as to experience things. We can also see it this way:

We turn things into objects and objects are us. . . . By bringing objects close to us and making them meaningful we are involved in the act of psychological distancing. . . . Through meaning-making – assisted by cultural objects – human beings as rapidly distance themselves from a given setting, as well as equally rapidly immerse themselves in it.

(Valsiner, 2014, pp. 172, 173)

Normally, we do not see ourselves seeing or walking or dressing: we are the lived act of seeing. All things seen are gathered and organized by the center of global reference, our body. Your eye is your possibility of reading the medical record, or of observing the service user or the therapist. Your teeth are your possibility of chewing your food. Your body is your possibility of forever going out toward something out there, in your acts. 'You are your body' means, then, 'you are you' in perceiving, experiencing, and acting out as a service user and as a mental health care worker. You perceive, therefore you are; or rather, for you to perceive is to exist as yourself as a service user or as a mental health care worker. You are your perception. 'You are' is 'you act.' This is your active ontological inter-involvement with the (mental health care) environment and what is really meant by 'intentionality' that is your consciousness that, in turn, is your body. Somatic consciousness, that is, body thinking and body pointing, is always shaped by culture and social environment, and thus admits of different forms in different cultures, or in different subject positions within the same institution and social environment.

As human actors, we move beyond the natural world and rediscover the social and institutional world, not as an object or sum of objects but as a permanent field or dimension of existence and experience. Our relationship to the (mental health care) environment that we find ourselves in every day, like our relationship to the world, is deeper than any expressed perception or judgment. It is as false to place ourselves in a social environment, like the mental health care environment, as an object among other objects, as it is to place the social mental health care environment within ourselves as an object of thought. In both cases, the mistake lies in treating the mental health care environment as an object that can be exactly scientifically measured. Our identity and our behavior are presented in such a fundamental and profound way that we only explicitly become aware of them when our usual interaction with the environment is disturbed by something that is

forced upon us. This can happen when your boss, against your better knowledge, orders you to fill out standardized reports about the service user so as to measure and stipulate the service user behavior, or when your psychiatrist treats you with drugs against your will, or when you are under scientific investigation, that is, when your doctor looks and measures your body against standardized medical measures, as if your body was a physical object.

These are the alienated feelings many health care workers and service users experience every day. They feel trapped inside a restricted and controlling public welfare system where they are measured and objectified. When this happens, their body is designated as alienated (cf. Sartre, [1943]2003). The experience of social alienation is then achieved in and through affective bodily structures, such as high blood pressure, shyness, blushing, and sweating. These are all signs that together with other signs, such as words and clothing, etc. make the body part of a larger semiotic meaning system, which all human beings are involved in and constructed by. “Signs do not occur in isolation” (Valsiner, 2014, p. 100). They are made to present their object in sign complexes that may include a combination of signs and bodily expressions. As human beings, as service users and as mental health care workers, we experience ourselves, more or less indirectly from the particular standpoints of other individual members of the same social group, or from the generalized standpoint of the social group as a whole to which we belong.

In Foucault’s first published book, *Mental Illness and Personality* (1954), he presents two different approaches to the alienated self and the alienated body-mind-environment relationship: one that highlights a humanistic phenomenological and interpretative approach, and another that highlights a naturalistic, explanatory, and neurological approach. Using the humanistic phenomenological first-person perspective, Foucault refers to contemporary phenomenological psychiatrists such as Binswanger, Kuhn, Séchehayé, and Minkowski to offer examples of an alienated body-mind experience that would seem unbelievable for most people but that has become *real* for the alienated person.

The body as an object among other objects

To Foucault (1954), for an alienated person, the body often ceases to be a point of reference against the opportunities in the world of other human beings. The body becomes unrecognizable to consciousness because its impulses stem from a fixed image of the world. In this state, the body can be experienced as hard as wood, or hard as brick, or as a body black as water, or as a body where the teeth are perceived as ends in a drawer made of hard oak tree. Occasionally, the full body awareness (that is, the awareness of a physical body in time and space) disappears to the extent that one ultimately has only an awareness of a disembodied life and an unrealistic idea of an immortal existence.

In cases where one’s body becomes alienated and unrecognizable for oneself, the body appears to us as the body-for-other and as an object among other objects. In this situation, the body finds itself on a new plane of existence (a psychic

body) (Sartre, [1943]2003, p. 361) and in situations similar to what Jaspers (1971) calls *boundary situations* (*Grenzsituationen*). To Jaspers boundary situations constantly affect our psychic and physical lives. If we attempt to escape boundary situations by managing them with rationality and objective knowledge, we must necessarily flounder. Instead, boundary situations require a radical change in attitude in one's normal ways of thinking. The proper way to react within boundary situations, according to Jaspers, is not by planning and calculating to overcome them but by the very different activity of becoming the person we potentially are. This happens when we enter the boundary situation with open eyes, that is, externally. "To experience boundary situations is the same as *Existenz*" (Jaspers, 1971, p. 179). Through boundary situations we enter our own experience as a self or as an individual, not directly or immediately, not by becoming a subject to ourselves, but only insofar as we first become an object to ourselves just as other individuals becomes objects to us or in our experience (cf. Mead, 1934).

To explain what actually happens when our body becomes alienated, that is, a body for other, and a body alienated to itself, Foucault (1954) turns away from the phenomenological inward analysis to a naturalistic neurologic and sociocultural approach. To Foucault there are anatomical reasons for how we experience ourselves in relation to other. The precise makeup of an individual's nervous system is partly a product of individual experience and sociocultural conditioning. As we already have seen, Foucault points out that the objectified and alienated body has a tendency to transform sociocultural and institutional conflicts and present historical conditions into inner personal life histories, which can lead to paradoxical defense reactions in the body's nerve cells, such as anxiety, blushing, and sweating. Sartre ([1943]2003) describes these bodily physical sign reactions as a constant consciousness not of the body as being-for-itself but of the body as being-for-others. He suggests that the explanation here is that we attribute to the body-for-other as much reality as we do to the body-for-us – or, more accurately, the body-for-other *is* the body-for-us, but it is inapprehensible and alienated.

When we become an object for others, and we experience social alienation and isolation, we can find in the disintegrated self an illustration of the body-pointing-thinking parallelism in which conscious states run parallel to isolated bodily occurrences. In such a state, the isolated body may causally affect our perception so that what one perceives may serve as a subjective veil between ourselves and the real things around us in society or in the institution where we work or stay. However, the mind and the body of the integrated person are not allowed to disintegrate in this way. An integrated person's body does not act as a separate cause to introduce distortions into his/her perceptions. A disintegrated self may be parallel to an isolated cycle of physical events, but true consciousness is parallel to society or the institution and can hardly be explained logically or by scientific concepts (Sartre, [1943]2003, p. 224). Because the human mind, the human body, and the human environment is integrated in the human self, we cannot understand the development and change of the self by seeing the mind, the body, and the environment as separate unities. The self will not be experienced as a self if one

divides it into separate parts because we are our mind and body (our behavior) and environment; my mind and body (behavior) are the center of the environment in which the self exists and cooperates with other selves.

Taking the alienated public health care worker and their service users as examples of a disintegrated self who experiences their bodies as objects among other objects, it appears to them that the other accomplishes for them a function of which they are incapable but that nevertheless is incumbent on them: to see themselves as they are. Still they engage in resistance. In this case, we are talking about a confrontation between forces, that is, the domination and subordination of bodies and the confrontations, conflicts, and struggles that produce individual and historical changes and events. To Valsiner (2014, p. 153)

Human relations are filled with turning another person – an autonomously functioning human being – into an object. . . . Young adolescents become objects for governments and warlords to recruit to fight for one or another more or less desirable social objective. Persons of all ages are made into consuming objects who actively as autonomous and intentional subjects – buy and consume consumer products. Wives consider their husbands their property and the husbands may believe the opposite. Slave-owners and soccer club owners treat their slaves and players as objects that can be re-sold and whose lives should be insured. Pet owners have their pets as objects of adoration. Grooming, and walking. And so on.

Alienation, ethical codes, and prejudice

Social groups and the mental health care environments where one's body is situated are constituted by way of diverse bodily habits, language use, rules, norms, and values. Behind each concrete bodily experience that would shape ourselves as an interdependent service user or as an interdependent mental health care worker, the standpoint of others represents the social and institutional codes that allow or prohibit acting in a certain manner. In this affectation, our actions are not only conducted according to our personal will, but also potentially affected by the collectivistic dimension of the environment in which we are located.

The example above shows that the commonality and difference of our bodies are deeply laden with social meaning. We appeal to our shared somatic form, signs, reactions, experience, needs, and suffering when charitably reaching out to people of very different social talents, ethnicities, and cultures. However, the body, through its skin and hair color, facial features, and even its gestural behavior, conversely, is the prime site for emphasizing our differences and for uncharitable profiling.

Most of the hostility toward people with mental and/or physical disabilities is the product not of rational thought but of deep (cultural) prejudices that are somatically marked in terms of vague uncomfortable feelings aroused by disabled bodies and facial features, feelings that are experienced implicitly and thus engrained

beneath the level of explicit consciousness. Such prejudices and feelings, therefore, resist correction by mere discursive arguments for tolerance, which can be accepted on the rational level without changing the visceral grip of the prejudice. We often deny we even have such prejudices because we do not realize expunging them is to develop the somatic awareness to recognize them in ourselves.

Intersubjective social relations and prejudice, then, involve a historical, physical, and bodily connection that is crucial for understanding ourselves in relation to others. The bodily self is both psychologically and physically active and influential, alienated, infinite, and restricted. Because the natural and bodily self will always resist becoming an object of its surroundings, the self will always strive for development and integration with the world of the other. In this vein, because we cannot escape the judgment of others if we want to become real (cf. Sartre), we shape an illusion of invulnerability. This illusion of invulnerability becomes an additional world that we connect to reality itself. The self – that is, the mind, the body, and the surroundings – constitutes, in this case, an internal relational structure in which they mutually refer to each other and become part of what we are and human life itself.

In a world where bodies are mutilated, alienated, starved, and abused, our familiar concepts of duty, virtue, charity, and respect for other can get no purchase and make no sense. Bodily abilities set the limits of what we can expect from ourselves and others, thus determining the range of our ethical obligations and aspirations. If paralyzed, we have no duty to leap to the rescue of a drowning child, a refugee, or a very sick person. Virtue cannot require constant labor with no rest or nourishment because these needs are physical necessities. Besides grounding our social norms and moral values, the body is the essential medium or tool through which they are transmitted, inscribed, and preserved in society and in institutions, such as different kinds of health institutions.

Ethical codes are mere abstractions until they are given life through incorporation into bodily dispositions and action. Any properly realized ethical virtue depends not only on some bodily act, speech act included, but also on having the right somatic and facial expression, indicative of having the right feelings. A stiffly grudging, angry-faced offering cannot be a true act of charity or respect. Moreover, by being inscribed in our bodies, social norms and ethical values can sustain their power without any need to make them explicit and enforced by laws. They are implicitly observed and enforced through our bodily habits, including habits of feeling, which have bodily roots.

All these habits, feelings, and social ethical codes are values and norms that socialistic and democratic welfare states depend on to survive as an open community where all citizens indirectly are part of the same coexistence and decision-making. Nevertheless, one must not abandon body-mind-thinking, and the fact that one's thinking does not necessarily involve a grounding of disciplinary body-politics. One must not adopt a thinking that turns away from thought in its elevation of bodily action, but struggle to stay, however wearily, on the vector that extends toward re-construction and re-interpretation of the environment, that is,

to ploddingly pave it anew. The openness to the future, the coming up of action and the beginning anew of performance are not found in thought *per se*, but its possibilities lie in the surprise of being.

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The human mind in concept and experience

Language and concepts that govern our thinking are not just matters of the intellect. They also govern our everyday bodily action and functioning, down to the most mundane details. Like the human body and mind, our concepts structure what we perceive, how we get around in the world, and how we relate to other people. Our conceptual system thus plays a central role in defining our everyday realities, as a service user, as a mental health care worker, as an individual unemployed, and so forth.

Like our daily body movements, however, our conceptual system is not something we are normally aware of (Lakoff & Johnson, 1980). In most of the little things we do every day, we simply think and act more or less automatically along certain lines. Just what these lines are is by no means obvious. One way to find out is by looking at our language and concepts. Since communication is based on the same conceptual system that we use in thinking and acting, language is an important source of evidence for what that system is and is like.

Investigating words and concepts belonging to the conceptual history of mental health care and politics, one can see that there are a multiplicity of factors and meanings existing behind the concepts representing their history. If we look closer to the concept 'health' and 'sickness,' for example, and what we consider to be 'good' and 'bad,' we discover that our understanding of these concepts has changed constantly through history. Stoicism placed health above all in its resistance to any attempt at enthusiasm, the exceptional, and the dangerous. In contrast, the hedonistic Epicureans defined health as complete satisfaction, where all needs were met. Unlike the Stoics, who defined all passions as disease, and the hedonistic Epicureans attempted to allay their perturbations through moral laws and various forms of therapeutic activities in hopes of restoring psychic equilibrium, Plato and Nietzsche, although they represented different historical time, associated health with both passion and creativity. Opposed to current understanding of epilepsy as a neurological disease, epilepsy was once seen as a sacred disease caused by the influence of a holy spirit or a demonic force, that is, a kind of 'healthy' neurosis (Nietzsche in Jaspers, [1913]1997, p. 786)

The conceptual history of mental health care shows that a perceptual change occurred during the nineteenth century, when modern psychology and modern

mental health care adopted concepts from the natural scientific knowledge area to reach an objective understanding of mental phenomena without including ethical and philosophical questions. The consequence of excluding ethical and philosophical questions from their knowledge areas was that physicians and mental health care workers basically stopped searching for the meaning of the words 'health' and 'disease,' and became totally concerned with these vital phenomena from a purely objective point of view (Canguilhem, 1989; Jaspers, [1913]1997). Consequently, a modern mental health care system grew up that asserted that one could apply exactly the same scientific and medical concepts and methods used to investigate the human body to the human mind. The modern mental health care system, like the somatic field of knowledge, has for a long time now divided diseases into abstract concepts and categories, leaving little room for personal experience and expression that do not fit into these neat concepts and categories.

Nothing has influenced the Western mental health care paradigm more than these reductions and conceptual changes, although the starting point of this trend started in the scientific method that originated over 2400 years ago in ancient Greece. The line goes from Hippocrates via Aristotle, Descartes, Freud, and Darwin, to name just a few. The ancient influence on modern medicine did not only influence modern mental health care from a scientific and rational point of view, the medieval concept of the struggle between the healthy and the sick, understood as good and evil, seems to have survived from the Renaissance into modern times. Consequently, disease, such as mental illness, is still understood as something to be combated, eradicated, and warred against. Opposed to the modern trend in leaving ethical and philosophical questions out of the mental health care knowledge area, ethical and philosophical questions were in Antiquity an integrated part of the Hippocratic and Aristotelian way of thinking about the human mind.

By adapting concepts and methods from the medical research area, modern mental health care research ceased to develop its own autonomous intellectual history of its origins. Rather, from the time it was melded into the history of medicine, it disappeared into the classical medical concepts of symptomatology (observable evidence theory) and nosography (disease descriptions), which postulate that psychological symptoms can be isolated and assembled like physiological symptoms, and that mental illness is just a natural essence manifested by specific symptoms. In the mid-nineteenth century, a focus developed that exclusively concentrated on abnormalities and pathologies in mental health care. The physical-chemical models, à la J. S. Mill and Newton, which searched for abstractions and universal laws in relation to the human mind, are examples of this focus. The organic models presented by behaviorists such as Wundt and Fechner, and the evolutionistic models developed by Spencer and outlined by Jackson and Ribot, are other examples. It seems that these medical abstractions are exactly what makes today's mental health workers lose sight of the creative and soul-like part of themselves and the human beings they are supposed to help.

However, every trend seems to evoke an anti-trend. Subsequently, a critical anti-trend or anti-thesis grew up in the same period as the mental health care knowledge

area was taken up into experimental research and physical-chemical models that were highly skeptical of the abstract scientific categories and concepts entering into the field of mental health care. The strongest and most critical voices of this anti-trend came from Janet, Dilthey, Husserl, Jaspers, and Freud. They were all critically concerned with the contemporary idea that one could use the same medical concepts and methods used on the body for understanding the human psyche. In his book *The Crisis of European Sciences and Transcendental Phenomenology*, Husserl aimed to protect the European scientific knowledge areas from the naive thought that everything, also the human psyche, could be measured and objectified. Husserl wanted to rescue modern psychology and modern mental health care from being trapped in this naiveté. What, he asked, have modern European sciences to say about reason and unreason or about us human beings as subjects of freedom with regard to our capacities for rationally shaping ourselves and our surrounding world? To Husserl ([1936]1970, p. 6) it seems obvious that

the mere science of bodies clearly has nothing to say, it abstracts from everything subjective. As for the humanistic sciences, on the other hand, all the special and general disciplines of which treat of man's spiritual existence, that is, within the horizon of his historicity; their rigorous scientific character require, we are told, that the scholar carefully exclude all valuative positions, all questions of the reason or unreason of their human subject matter and its cultural configurations.

Husserl ([1936]1970, p. 6) points out that scientific, objective truths, are exclusively a matter of establishing what the world, the physical world, as well as the mental world, is in fact. Can the world and the human existence in it truthfully have a meaning if the sciences recognize as true only what is objectively established in this fashion, he asked. Is it possible to develop a language that is historically neutral and so objective that we ever can speak of a pure objective reason or a pure objective science? Can human beings live in a world where historical occurrence is nothing but an unending concatenation of illusory progress and bitter disappointment? To excavate this hidden level of theory, to make it visible, do we not need an historical analysis of the concepts and discourse from which psychological categories derive their sense?

To Husserl, the problem with modern scientific explanations are that they inevitably end up with reductionism. The appeal of reductionist thinking lies in its ability to offer clear and concise explanations for problems that might otherwise defy explanation. However, once psychological phenomena are reduced to their scientific component status, they are essentially removed from the wider social and cultural common sense language in which all human action takes shape. As a result, the language we use to describe and explain human agency is curiously absent in psychological research.

Even though scientists dealing with mental phenomena devote a great deal of effort to making their theoretical language and knowledge clear, objective, and

empirical, that is, non-historical and non-subjective, one has to acknowledge that the meaning in which psychological phenomena are categorized carries an enormous burden of unexamined and unquestioned sociocultural and historical assumptions and preconceptions (cf. e.g., Binswanger, 2004b; Foucault, 1954, 2001a, 2003; Jaspers, [1913]1997). When one consults current scientists in psychology and mental health care, they seem to treat language (including numerical language) and concepts as if they were the bearers of truth through which they inform their colleagues and their culture of the results of their observations and thoughts (Gergen, 2001). For most scientists investigating the human mind, the world and the individual mind are simply out there, available for observation. However, “by the time explicit psychological theories are formulated, most of the theoretical work has already happened – it is embedded in the categories used to describe and classify psychological phenomena” (Danziger, 1997, p. 8).

Common sense and brain talk

Without a doubt psychological concepts and labels carry a great deal of implicit theoretical baggage because they come with rich connotations, acquired through everyday usage. Experimental practices in laboratory settings still fail to address adequately the fact that neither animal nor human brains exist in isolation or can be understood outside their environment and form of life. Rose and Abi-Rached (2013, p. 23) state that:

Conceptions of social in social neuroscience are frequently impoverished, reducing social relations to those of interaction between individuals, and ignore decades of research from the social sciences on the social shaping and distributed character of human cognitive, affective, and volitional capacity.

Although in the mental health care and psychological field of knowledge one deals with semantic primitive concepts, which cannot be defined by other concepts and are therefore necessary if one wishes be understood by others (cf. Wierzbicka, 1996), these concepts are linked to concepts developed by individual feelings in open systems continually interacting with an environment.¹ Humans continuously learn from their experiences, which means that we are changing in ways partially dependent on these random events, and hence in ways that are also unpredictable.

This is why “the limitations of the empirical project of psychology are becoming gradually more visible, and the merits of stronger theoretical analysis of what is given a priori are becoming more plausible” (Smedslund, 2011, p. 134). Still, researchers who investigate the human mind always try to *understand* the persons they investigate in logical terms, in terms of the brain, although the meaning of what is said remains a psychological mystery. To Smedslund (2013, pp. 93–94) “one cannot be said to understand the irrational, because the concept of understanding presupposes rationality.” Instead of brain talk, Smedslund (1988) suggests that one should use common sense, that is, a collective source of knowledge

and rationality, when approaching the human mind. To Smedslund, a common conceptual basis for human languages and cultures makes it possible, to some extent, to describe, explain, predict, and control what persons do. If someone asks: How can there be a science and a profession dealing with persons, if persons are so changeable and unique? The answer would be that people also are very predictable because they speak the language and follow the social rules of their group or culture. Since language is shared, we can predict innumerable things about every competent speaker. "For example, everyone will answer, 'yes' to the question 'Is a dog an animal?'" (Smedslund, 2004, p. 8).

The Polish linguist Anna Wierzbicka (Goddard & Wierzbicka, 1994; Wierzbicka, 1992, 1996) states that there are many basic psychological concepts embedded in ordinary language, which also appear to be lexically present in all human languages, something that makes psycho-logic a transcultural framework for mental health care and psychology. Among them are the concepts: 'I,' 'you,' 'can,' 'know,' 'think,' 'want,' 'feel,' 'good,' 'bad,' etc. These concepts relate to each other in definite ways, that is, what a person 'feels' in a situation follows from that the person 'thinks' and 'wants' in that situation. To Smedslund (2004, p. 8),

if the person can do something and tries to do it, then the person does it, by means of the axiomatic system called psycho-logic (Smedslund, 1988, 1997a, 1997b), formed by these and other concepts, one can describe, explain predict and control what persons do, given information about her situation.

If we take Smedslund's (1988) view that instead of brain talk one should approach the human mind with common sense, it seems like a paradox that several scholars today are concerned with how contemporary academic brain talk has become a collective source of common sense knowledge in which we construct ourselves. With inspiration from Foucault's post-structuralist thoughts from the 1970s, one should be aware of how psychological and neurological brain talk has become the primary source of knowledge by which we explain ourselves as subjects. By articulating specific kinds of persons and selves, one can see that the psychological and neurological disciplines have been complicit in creating a perception of self-understanding as something upon which others can act (Rose, 2013, 1990). Technologies through which we are controlled by others can be turned toward ourselves and thus become means of self-control (i.e., Foucault, 2008). Psychological disciplines have come to be a vital means of making us intelligible to ourselves. It is important to be aware that the psychological disciplines are intimately involved in assembling the kind of 'governable subjects' required of modern liberal democracies.

Ian Hacking (1995) points to the fact that when the multiple personality disorder entered the nomenclature of the DSM-III in 1980, a wholly new kind of person came into being, with a set of memories and behaviors. He finds multiple personality a compelling example of the dynamic interaction between naming and the historical appearance of a person. Hacking's (1995, p. 236) historical ontology

reveals how the multiple personality became viable as “a culturally sanctioned way of expressing distress” and how it “provided a new way to be an unhappy person.” His examples show that psychology does not merely adapt to social demands. The science of psychology also contributes to shape the individuals of the current culture.

However, taking historical events and concepts and their ability to change our view of the world seriously, it has not always been the case that science understood its demand for rigorously grounded truth in the sense of that sort of objectivity which dominates our positive sciences in respect to method and which, having its effect far beyond the sciences themselves, is the basis for the support and widespread acceptance of an ideological positivism. The specifically human question has not always been banned from the realm of science; their intrinsic relationship to all the sciences, even to those of which human being is not the subject matter, such as the natural sciences, has not been left unconsidered. As long as this had not happened, science could claim significance, indeed, as we know, the major role, in the completely new shaping of European humanity in the Renaissance.

Why science lost this leadership, why there occurred an essential change, a positivistic restriction of the idea of science, to understand this according to the deeper motives, is of great importance to our understanding of the way we think and use the concept science inside the mental health care system today. The positivistic concept of science in our time is, historically speaking, a residual concept. It has dropped all the ancient philosophical questions which had been considered under the now broader concept of metaphysics, including all questions vaguely termed ‘ultimate and highest’ (Husserl, 1970). Looking closer, these and all these philosophical and epistemologically excluded questions have their inseparable unity in the fact that they contain, whether expressly or as implied in their meaning, the problems of reason, reason in all its particular forms. Reason is the explicit theme in the disciplines concerning knowledge of true and genuine valuation and of ethical action.

In our preoccupation with constructing exact concepts, models, and ideal states of the human mind, scientists who investigate psychological phenomena seek to suppress the crucial dimension of experience and intuition. Like Husserl’s critical view of modern science, the existential-phenomenological school rejects much of this suppression, arguing vigorously that one must begin any analysis with one’s own ‘phenomenal’ experience, one’s own living reaction to events, persons, objects, the immediate givens of life. To the existential-phenomenologists, the perception of self is central, and so is its inherited content and qualities of concepts and objects, and the appearing and construction of things. Language, intention, interpretation, organization, meaning-making, directedness, attractiveness is in the existential-phenomenological tradition accepted as valid phenomena which required no demonstration except, perhaps, to satisfy stubborn scientists.

Unlike the introspectionists, who had minimized the value of raw, unanalyzed consciousness and stressed the need for trained self-observation, the existential-phenomenologists honored spontaneous and uncritical human responses. The existential-phenomenological perspective, then, includes a radical critique of modern scientific and positivistic thinking, which is viewed as introducing unnecessary and artificial bifurcations and divisions into human experience, creating barriers between subjects and objects, becoming embroiled in futile terminological disputes, deductive entanglements, and ‘facts,’ instead of confirming the essential nature and unity of experience. The view is that all perception and use of concepts, even that of the logician or physicist, must begin with momentary experiences and interpretations.

Taking into consideration how the productive power of concepts and language is shaped and invented according to subjective experiences and historical and sociocultural environments, there is reason to believe that traditional ‘epistemic’ values, such as consistency, logic, objectivity, simplicity, breadth of scope, fruitfulness, etc. are not purely epistemic after all. Their use imports political and social values into contexts of scientific judgment that can lead to biases and to adverse research results. Although we are self-defining actors, our involvement with other human beings and situations affects how we understand and use language and concepts, also in science.

Because of the dialectical relationship between people and environment, scientists who study the human psyche, as opposed to scholars in the natural sciences, cannot describe human nature independently of one’s own interpretation, cultural practices, and history. A researcher or therapist working with mental health care issues will always use their concepts and descriptions to shape and interpret the person(s) under investigation and it is here that the relationship between psychological objects and historical sociocultural practices lies. This is why an alternative mental health care praxis would move out of the archeology of the psyche and into the cultural landscape of the present world (Kvale, 1992). This would involve facing the rootedness of human existence in specific historical and cultural situations and being open to the insights on the human condition provided by the arts and the humanities. The main topic of study would include the linguistic and social construction of reality and the interrelations of a local context and the self in a network of relationships. This would require accepting the open, perspectival, and ambiguous nature of language and knowledge and validating knowledge through practice:

It would involve a multi-method (interdisciplinary) approach to research, including qualitative descriptions of the diversity of a person’s relation to the world and a deconstruction of texts that attempt to describe this relation. The question remains whether such changes are too radical to find their place within a psychological science with strong individualistic and rationalistic roots.

(Kvale, 1992, p. 53)

To illuminate the ambiguous nature of language, and how researchers' concepts and descriptions are related to the researcher's everyday life and experience and to a specific historical and cultural environment, I will show how Foucault's 1970's military concepts and description of modern mental health care praxis relate to his life experiences and to a specific historical and cultural environment. I will also show how new experiences shape new concepts, and how new concepts shape new experience.

Concepts and experience in change

When it comes to experience, no book, no idea, according to Foucault (2001b), has been written and developed without there having been, at least in part, a direct personal experience, which again constitutes new experiences, while writing. Foucault (2001b, pp. 860–861) points out that he never thought exactly the same, because his books constitute experiences, in the widest definition of the word. “An experience is something that leaves you changed. . . . I am an experimenter in that I write in order to change myself and to not think the same as I did previously.”

When Foucault, in the 1970s suddenly changes his view on the history of the origin of modern mental health care, from being a system of Christian morality, such as he describes in *History of Madness* (Foucault, 1961), to being a system of ‘micropower’ and ‘battlefields,’ such as he describes in his 1973–1974 lecture series on psychiatric power (Foucault, 2003), we can assume that his personal experiences, and thereby his interpretation of the history of the origin of modern mental health care, has changed since he wrote *History of Madness*. In *History of Madness* Foucault presents his investigation of this history of mental health care as an investigation “under the sun of the great Nietzschean inquiry” (Foucault, 2001a, pp. 189–190). Specifically, Nietzsche's inquiry into the birth and death of tragedy as outlined in Nietzsche's book *The Birth of Tragedy from the Spirit of Music* (*Die Geburt der Tragödie aus dem Geiste der Musik*).

In this book, Nietzsche (Nietzsche, [1872]2000) asserts that by affirming the Socratic aesthetic equation of morality, intelligibility, and beauty, Euripides destroyed the Greek tragedy and reduced the tragic character of human existence to its intelligible components by moralizing it. From Nietzsche's assertions, Foucault concludes that to understand how the conception of madness became a medical diagnosis, that is, a mental illness, one has to examine the conceptual changes in text and medical records that have occurred on the horizon of cultural and ideological changes, such as those initiated by the Christian Reformation, and the moralization that came with it.

During his 1973–1974 lecture series on psychiatric power, Foucault makes it clear that although his notion in *History of Madness* must be regarded as the starting point for his lectures, his thinking has over the years undergone a significant number of theoretical and conceptual changes (p. 14). He no longer believes that modern mental health care praxis stems from *moralization*, as he himself claimed in *History of Madness*; instead, he believes that the history of modern mental

health care develops from military and disciplinary asymmetrical *power mechanisms*, adopted from modern military praxis and strategies in the mid-1700s.

The total change of focus and concepts that we see in Foucault's 1973–1974 lecture series on psychiatric power can be related to Foucault's new life experiences. In the period between *History of Madness* and the 1970 lectures, Foucault had gained new personal experiences of war and mental health care institutions, and participated in the late 1960's liberation revolutions in Tunisia and Paris, and systematically and clearly began to describe his work as genealogical. In the 1970s Foucault became a figurehead for social activists and militants who sought to fight social injustice in France. Groups he assisted included those fighting for prisoners' rights, immigrants, and asylum seekers. During his lectures on psychiatric power he worked with *Groupe d'information sur les prisons* (GIP), a group that provided legal information to prisoners. He was later to help an organization that assisted asylum seekers, *Groupe d'information sur les asiles* (GIA). Given his own military and political experiences, it is not strange that he should see the techniques of war in peacetime and turn Clausewitz's maxim that "war is politics by other means" into "politics and mental health care is war by other means."

We can assume that Foucault's new personal experiences with prison, mental health care institutions, war, and liberation revolutions affect his mental focus and thereby his interpretation of the history of modern mental health care in such a way that he begins to apply military and political concepts to the medical health care knowledge areas. That is, a knowledge area where they had not normally been used. On a number of occasions, Foucault refers to his experiences of war and revolutions when he explains his 1970s worldview. In an interview from 1980, he says:

The experience of the war had shown us that there was an acute need for a society radically different from the one we lived in . . . the society that had permitted Nazism. . . . Great sections of young Frenchmen reacted with total contempt. We wanted a world and a society that was . . . different than ours . . . we wanted to be totally different in a totally different world.

(Foucault, 2001b, p. 868)

To Lakoff and Johnson (1980), all areas of experience (such as 'mental health care experience,' 'war experience,' etc.) constitute structured wholes in our awareness. These appear natural because they are experienced through our bodies, that is to say, our sensory and motor apparatuses, mental capacities and emotional dispositions, as well as through interaction with our physical environment and interaction with other people in social, political, economic, and religious institutions.

In his lecture series on psychiatric power, Foucault makes it clear that his new concepts and interpretations of the history of modern mental health care are taken from military concepts and war strategies. He also points out that he became retrospectively aware that during his re-interpretations of the history of modern mental health care he had replaced concepts from the psychological field of knowledge

with military ones, and that he did this in order to describe the origin of the modern mental health care praxis in a more truthful manner. What can the field of military concepts and knowledge explain that the field of psychological concepts and knowledge cannot?

Foucault's goal is to describe what actually happens in the first modern mental health care scenes. He wants to give a real history of mental health care, and consequently he cannot use the non-verifiable discourse (*doxa*) of the human sciences and their notions of 'function and norm,' 'conflict and rule,' 'meaning and system.' These, he believes, are mere representations of the more empirical knowledge fields of biology, economics, and philology (Foucault, 1966). He needs a field of knowledge that contains concrete concepts such as 'intervention,' 'attack,' and 'encroachment' in its discourse.

Foucault clearly believes that it is the field of military knowledge that one can best illustrate what really happens in the first modern mental health care scenes. It seems that Foucault believes that concepts from the military field of knowledge can cast more light on what he wants to describe than the human sciences and current psychology are capable of doing. The concepts he uses clearly indicate that he does not wish to take his starting point in the human being and its experience of the world, or in its 'functions and norms,' as the psychological and sociological knowledge area does. In Foucault's new perspective on power, norms are not manufactured in individual institutions or subjects; they are created in the interaction between institutions, in a society that is becoming more and more institutionalized. With the help of the military field of knowledge, Foucault draws attention to the concrete exercise of power, which for him is about the power strategies of the politics of knowledge, which includes knowledge of the human mind and its mental health.

Knowledge of humans and discipline appear to Foucault to be mutually dependent. It is through a detailed knowledge of human beings that discipline really becomes effective. Similarly, Foucault does not wish to take his starting point in structural power constellations where specific groups have power over other disempowered groups, which would be the sociological approach (Foucault, 1966). He does not rule out that class conflict exists; his point is that all of those who talk about class struggle have failed to analyze what that struggle actually consists of (Foucault, 2001b, pp. 140–160, no 192). He therefore finds in the field of military matters a repository of concepts and knowledge that he can draw upon and apply as analytical tools. All of his lectures about the history of mental health care are thus structured, interpreted, oriented, understood, performed, and discussed with the help of military terms. Foucault's war experience and war concepts orient him and tell him what he should perceive as right and wrong. His experiences and concepts permeate all his thinking; they glide unmistakably and silently into his epistemological, political, and mental health care ideas. His experience and concepts set goals and motivate action. They identify hidden power mechanism in the modern mental health care system and in the community body and shape subjects' positions, such as the late modern service user and the late modern mental health

care worker, who through invisible micropractices shape themselves according to the welfare system's and the mental health care system's need of control and economic exchange.

Foucault's project is historical. By means of a genealogical approach, he wants to show that modern mental health care practice is built upon specific historical power structures and needs. In one of his lecture, he states:

What I would like to do this year is basically a history of these psychiatric scenes. . . . The game of power which is sketched out, should be analysed before any institutional organization, or discourse of truth, or importation of models. . . . It seems to me that if we want to produce a true history of psychiatry . . . it will be by situating it in this series of scenes – scenes of the ceremony of sovereignty, of rituals of service, of judicial procedures, and of medical practices – and not by making the analysis of the institution the essential point and our point of departure. Let's be really anti-institutionalist. What I propose to bring to light this year is, before analysis of the institution, the microphysics of power.

(Foucault, 2003, pp. 33–34)

Using military concepts and knowledge to describe modern mental health care, Foucault manages to make dramatic changes in not only his own understanding and interpretations, but in other people's understanding of the relationship between mental health care, power, and knowledge. Foucault's military power concepts seem to be effective tools in changing long-established perspectives and understanding of the modern mental health care as something that is governed by scientific ideals and evidence-based research, that is, not by disciplinary power technics.

Foucault's use of military concepts manage to explode contemporary concepts and meanings of what is believed to be true according to modern mental health care. When Foucault in his first lecture says that he wants to replace standardized medical concepts, such as 'evidence-based treatment' and 'diagnoses,' with a concept such as 'discipline and power,' a third meaning and a new conception arises: a mental health care system administered by a welfare politics with a desire for control and discipline.

Frequently, our ability to change our own and others' perception and interpretations occurs when we describe one area of knowledge/experience in light of another, that is, in an interdisciplinary way. By doing so, our concepts and language become metaphorical and arbitrary, such as Foucault's military 1970s concepts. The nature and power of metaphors is such that they are linguistic pictures that makes two different things alike and in so doing create a third (new) meaning (Lakoff & Johnson, 1980). For example, when Foucault describes the modern mental health care system as an arena for political discipline and control, a third perception or opinion arises, that is, the mental health care system as a quasi-medical arena for political 'discipline' and 'control.'

Lakoff and Johnson (1980) point out that understanding and knowledge come from experience and not from isolated scientific concepts. When Foucault in the 1970s uses metaphorical concepts such as ‘psychiatric knowledge is power’ and ‘mental treatment is war (battle),’ this immediately tells us something about Foucault’s experiences with ‘psychiatric knowledge’ and ‘mental treatment.’ Foucault’s experiences are thus conceptualized and defined in terms of other basic areas of experience, such as ‘power’ and ‘war.’

In an attempt to explain how concepts manage to change our perception of truth, Paul Ricoeur (2003) argues that conceptual metaphors are the rhetorical process by which discourse unleashes the power that certain fictions have to re-describe reality. By linking fiction and re-description we restore the full depth of meaning. Ricoeur (2003, p. 6) writes that:

From this conjunction of fiction and redescription I conclude that the ‘place’ of metaphors, its most intimate and ultimate abode, is neither the name, nor the sentence, nor even discourse, but the copula of the verb to be. The metaphorical ‘is’ at once signifies both ‘is not’ and ‘is like.’ If this is really so, we are allowed to speak of metaphorical truth, but in an equally ‘tensive’ sense of the world ‘truth.’

It is Ricoeur’s view that our experience and self-understanding, and indeed history itself, are ‘fictive,’ that is, subject to the productive effects of the imagination through interpretation. For Ricoeur (2003), experiences and thoughts are primarily linguistically defined and mediated by language and symbols. The issues of experiences are given in language and must be worked out in language. This is why Ricoeur (2003) calls his method a ‘hermeneutics of suspicion,’ because discourse and conceptual metaphors both reveal and conceal something about the nature of being situated in a social and cultural environment.

However, in order to succeed in the task of changing traditional understandings through the employment of concepts and interpretations, it is necessary to exhibit a number of qualities. One needs patience, a certain flexibility in one’s worldview, a generous tolerance towards misunderstanding, and a talent for finding the right conceptual metaphors of change. Lakoff and Turner (1989, p. 214) make the following observation:

To study (conceptual) metaphor is to be confronted with hidden aspects of one’s own mind and one’s own culture. . . . To do so is to discover that one has a worldview, which one’s imagination is constrained, and that metaphor plays an enormous role in shaping one’s everyday understanding of everyday events.

Our ability to retain the potential to affect and restructure our knowledge in ways that cannot be objectively predicted is often overlooked. New knowledge is constantly constructed in an interaction between existing cognitive schemes and new ideas (Piaget, 1972). As such, existing epistemic schemes about the

human mind both limit and enable the prospect of learning something new about it. Accommodation to the world (learning) takes place only in relation to what is already assimilated (Smedslund, 2012, p. 296). In other words, we can learn about mental health care and the regularities of the world only in the way we interpret or understand it at a given time and in a given sociocultural setting.

A rather new influential position has emerged in philosophy, linguistics, and literary theory, which argues that necessary and intrinsic meanings (fixed essences) are few, difficult to locate, and perhaps even nonexistent (Shweder & Sullivan, 1993). Meanings represent a fluid multiplicity of possibilities, but within this multiplicity of what can be thought, i.e., of what a reader or researcher in mental health care can find meaningful, and hence expect to find, not everything is possible. If we fail to hear what the other person is really saying, we will not be able to fit what we have misunderstood into the range of our own various expectations of meaning.

Thus, there is a criterion here also. A researcher trying to understand something in a scientific theory or text will not resign him/herself from the start to relying on his/her own accidental fore-meanings or prejudices, ignoring as consistently and stubbornly as possible the actual meaning of the text, until the latter becomes so persistently audible that it breaks through what the interpreter imagines it to be. Rather, a researcher who tries to understand a text or a theory is prepared for the text or for the theory to tell him/her something. That is why a hermeneutically trained consciousness must be, from the start, sensitive to the theory's alterity. Nevertheless, this kind of sensitivity involves neither 'neutrality' with respect to content nor the extinction of one's self, but the foregrounding and appropriation of one's own fore-meanings and prejudices. The important thing is to be aware of one's own bias, so that the theory or the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings.

Methodologically conscious understanding of a theory or text will be concerned not merely to anticipatory ideas but to make them conscious, so as to check them and thus acquire right understanding from the things that we study. This is what Heidegger means when he talks about making our scientific themes 'secure' by deriving our fore-having, fore-sight, and fore-conception from the things themselves. It is not a matter of securing ourselves against the tradition that speaks out of the theory or text, then, but, on the contrary, of excluding everything that could hinder us from understanding it in terms of the subject matter. It is the tyranny of hidden prejudices that makes us deaf to what speaks to us in tradition.

Concepts, experience, and sociocultural context – the art of hermeneutic

Although Foucault in his lectures and books uses concepts from personal experiences, he often uses the concept 'us' when describing what 'he' himself has experienced (i.e., the quote: "The experience of the war had shown *us* that there was an acute need for a society radically different from the one we lived in")

[Foucault, 2001b, p. 868]). His use of the inclusive first-person pronouns ‘us’ shows that Foucault is not alone in having experienced war and the techniques of military power. He shares many of his war experiences with his fellow students and other intellectuals of the time. As a result of the revolts of 1968, large sectors of the Parisian intellectual community underwent a similar ‘power focusing’ as Foucault. Since the revolts of 1968, there is a clear tendency for power analysis to replace the position that structuralism previously had in the media and in the intellectual arena. Foucault’s military concepts, then, are loaded with common experiences and notions that are shared by those who read his books and follow his lectures about the origin history of mental health care.

In many ways, Foucault’s conscious and unconscious use of military concepts became shared cultural experience after the ’68 revolt in Paris, which made Foucault’s use of military concepts understandable for common people with the same experience as Foucault. Their common experience with war and revolution represents underground knowledge configurations, which Foucault, through his re-interpretations, military concepts, and war experiences, manages to make visible through his books and lectures.

When Foucault lectured and wrote about the origin history of mental health care as a history of power and battle in the 1970s, the readers felt that the story was about them, the world today, or their relations with ‘contemporaneity,’ in the forms by which the latter is accepted and recognized by everyone (Foucault, 1991). When Foucault’s re-interpretations of the history of mental health care were published in books and talked about in his lectures, various readers and listeners, particularly mental health care workers, prison guards, and social workers, came to see the current mental health care system in a clearer and changed way (Foucault, 1991). The case demonstrates that Foucault’s books and lectures of the origin history of modern mental health care express an experience that extends beyond his own, and that his books and lectures seem to be merely inscribed in something that was already in progress.

To Gadamer ([1960]2013), the meaning of a text or a theory cannot be restricted to the researcher. Tradition builds upon what he calls the excess of meaning that we find in the theory or in the text. This is an excess that goes beyond the researcher’s explicit or implicit intention. The real meaning of a theory or of a text as it addresses the interpreter does not just depend on the occasional factors that characterize the researcher or the author of a theory or text and his/her original publications:

for it is always co-determined also by the historical situation of the interpreter and hence by the totality of the objective course of history . . . the meaning of a text goes beyond its author. That is why understanding is not merely a reproductive but always a productive activity, as well.

(Gadamer, [1960]2013, p. 307)

Underlying these comments is a view of the meaning of the theory or the text as both eliciting and including in itself the varying interpretations through which

it is transmitted, and it is this point that it connects to Gadamer's hermeneutical theory (Linge, 1976). A theory or a text, then, cannot therefore be regarded as solely dependent on its researcher or on its present performer or interpreter, so that by reference to one of these we might get a definitive perception of the theory or the text 'in itself.' Like a game, a theory or a text lives in its presentations. It represents different interpretations and possibilities of meaning-making. The variety of performances of interpretations is not simply subjective variations of a meaning locked in subjectivity, but belongs instead to the ontological possibility of the theory or the text itself.

Thus, we cannot speak of a canonical interpretation of a theory or a text about the human mind or the modern mental health care system. Rather a theory stands open to multiple new comprehensions and interpretations. The encounter with a theory belongs within the process of integration given to human life, which stands within a certain knowledge area or a certain tradition, such as the mental health care knowledge area. Indeed, it is even a question whether the special contemporaneity of a theory or a text does not consist precisely in this: that it stands open in a limitless way for new integration and interpretation. It may be that when he held his lectures Foucault intended a particular audience of his/her time, but his new interpretation of the history of modern mental health care and what these interpretations were able to say stretches fundamentally out beyond every historical limitation. To Linge (1976, p. xxvi),

The subjective intention of the author is an inadequate standard of interpretation because it is nondialectical, while understanding itself . . . , is essentially dialectical, a new concretization of meaning that is born of the interplay that goes on continually between the past and the present. Every interpretation attempts to be transparent to the text, so that the meaning of the text can speak to every new situation.

The case demonstrates that texts and concepts can be understood as engendering experiences that change us, that prevent us from always being the same, or from having the same kind of relationship with things and with others that we had before reading them. Foucault's re-interpretations of the history of mental health care worked for this transformation – as an agent. More than expressing the truth, Foucault's re-interpretations represent experiences opposed to 'the truth' or 'demonstration.' Foucault (2000, pp. 239–240) seems to be perfectly aware of the reciprocal relationship between his own experience and use of concepts, and how these contributed to change his perception and worldview:

Many things have been superseded, certainly. I'm perfectly aware of what I'm interested in and to what I've already thought. What I think is never quite the same, because for my books are experiences, in a sense, that I would like to be as full as possible. An experience is something that one comes out of transformed. If I had to write a book to communicate what I'm already

thinking before I begin to write, I would never have the courage to begin. I write a book only because I still don't know what to think about this thing I want to think about, so that book transforms me and transforms what I think. Each book transforms what I was thinking when I was finishing the previous book. I am an experimenter and not a theorist. I call a theorist someone who constructs a general system, either deductive or analytical, and applies it to different fields in a uniform way. That isn't my case. I'm an experimenter in the sense that I write in order to change myself and in order not to think the same thing as before.

Foucault's use of concepts shows that concepts and ideas concerning the human mind and public mental health care system do not sail through space like particles of dust caught by the wind. They arise from traditions of thought and habits of mind deeply embedded within a social and historical context. Throughout history and traditions, knowledge and explanatory models, the human mind has been created and interpreted. Extensive global processes leading to different mental health care traditions have met and exchanged experiences. However, as far back as we can read and observe, psychological knowledge has been strengthened and articulated by political power and strategical directives and ideas (Joranger, 2015). Foucault cannot, therefore, be said to be a pioneer when he uses military concepts and strategies to describe the origin history of current mental health care.

Foucault seized the opportunity time gave him. The postwar human being was ready for new perspectives on reality. Foucault seems to play in the terms of his time by mingling concepts from different but commonly known knowledge areas, such as war, power, history, medicine, disease, politics, and leadership. Through his interdisciplinary and creative use of concepts and interpretations, Foucault manages to build a bridge between his own thoughts and his fellow beings and by this process to lead himself and his fellows into re-interpretations and new insights into what actually happened in the very first mental health care scenes or institutionalized 'scenarios.'

Foucault's re-interpretations or the history of mental health care origins demanded metaphorical and interdisciplinary definitions, because his new interpretations were controversial and new compared to contemporary ideas about mental health care. His aim was to refine and clarify his new interpretations of the history of mental health care's origins, so that they satisfied his purpose, that is, to illustrate how the use of military concepts shaped a story of the first modern mental health care scene filled with political ideas of control, discipline, and fight for recognition.

However, it is no accident that it was the postwar world that produced Foucault. Foucault used his postwar experience and his military conceptual metaphors as a mirror and as an intellectual guideline to re-interpret the modern European mental health care praxis and to construct a new understanding of history of modern mental health care's origins. His historical readings helped him from being absorbed in individual self-knowledge alone. To think historically means, in fact,

to perform the transposition that the concepts of the past undergo when we try to think in them. As Gadamer ([1960]2013, p. 415) wrote:

To think historically always involves mediating between those ideas and one's own thinking. To try to escape from one's own concepts in interpretation is not only impossible but manifestly absurd. To interpret means precisely to bring one's own preconceptions into play so that the text's meaning can really be made to speak for us.

To interpret requires a fusion of horizons. Every theory, every text, and every concept is made to speak through interpretation. However, no theory, no text speaks if it does not speak a language that reaches others. Thus, interpretation must find the right language and the right concepts if it really wants to make the theory or the text speak. There cannot, therefore, be any single interpretation of a theory or text that is correct 'in itself,' precisely because every interpretation is concerned with the theory or the text itself. The historical life of a tradition, such as the mental health care tradition, depends on being constantly assimilated and interpreted. An interpretation that is correct in itself will be a foolish ideal that mistakes the nature of tradition and the nature of a sociocultural environment, such as the modern mental health care environment. Every interpretation has to adapt itself to the hermeneutical situation to which it belongs. "Being bound by a situation does not mean that the claim to correctness that every interpretation must make is dissolved into the subjective or the occasional" (Gadamer, [1960]2013, p. 415).

The central ideas of hermeneutics is that interpretation is the act of understanding itself that is realized not just for the one for whom one is interpreting but also for the interpreter, and it take place in the explicitness of verbal interpretation. Thanks to the verbal – in the extended sense – nature of all interpretation, every interpretation includes the possibility of a relationship with others. There can be no language and no speaking that does not bind the speaker and the person spoken to. Undoubtedly, psychological concepts and labels carry a great deal of implicit theoretical baggage because they come with rich connotations, acquired through everyday usage. As mentioned before, experimental practices in laboratory settings still fail to address adequately the fact that neither animal nor human brains exist in isolation or can be understood outside their environment and form of life.

Note

- 1 The perspectives forwarded in Smedslund's discussions of Wierzbicka's collections of semantic primitive concepts are shared by Shweder (2013).

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Subjective minds and general laws

“*Your* virtue is the health of *your* mind.” For there is no health as such, and all attempts to define a thing that way have been wretched failures. Even the determination of what is healthy for your body depend on your goal, your horizon, your energies, your impulses, your error, and above all on the ideals and phantasm of your mind. Thus there are innumerable health of the body; and the more we allow the unique and incomparable to raise its head again, and the more we abjure the dogma of the ‘equality of men,’ the more must the concept of a normal health, along with a normal diet and the moral course of an illness, be abandoned by medical men.

Nietzsche, *The Gay Science*, 1882

Our minds and bodies consist of subjective experience, which involves sensorially or perceptually accessible ‘givens’ expressed in different sign systems – such as oral and written languages – and kinds of desire common to all human beings, such as the desire for safety, the desire for love, the desire for recognition. The question of what is the relation between the language we use to capture the forms of experiencing and the material-object-language of the natural sciences seems to be without any clear or real answer. Even though we have better and better knowledge of regular correlations between specific patterns of neuron firing, on the one hand, and instances of conscious experience (data accessed through the senses, conscious, emotional, cognitive, or conative states), on the other, no fully satisfactory explanation of the relations between neural processes and the subjectively experienced character of mental states is yet available. Nobody knows, at this time, just what such an explanation might look like. At the same time, we still talk of the veracity of subjective experience. Although, thoughts and attitudes for some people need correction, we cannot assume that subjectivity and consciousness are naturally misdirected, a mask for defensive selfishness, or a distorting mirror of the truth for all of us (Joranger, 2015).

In fact, consciousness often provides an experience so insistent, so telling, and so truthful that its message about reality is as emphatic as a punch in the nose. Far from a ‘folkish’ mirage or a self-serving mask, subjectivity and personal minds exist to reveal and impel us toward the truth, to liberate us more and more from

biological, psychological, and social burdens, and to permit our best intentions to blossom. So, how can we change and extend the late modern view that we can understand the mind of a person by studying his/her physical brain? How can we think other ways when it comes to mind and subjective experience?

To answer these questions, one has to understand the mind from an interdisciplinary point of view. Different from the soul, the mind is not some supernatural eternal entity. Unlike the everlasting soul, the mind has many parts, it constantly changes, and there is no reason to think it is eternal. The soul is something some people accept while others reject. Nor is the mind an organ that can be empirically investigated, such as the eye or the brain. Rather, the mind is not a thing. It is a flow of subjective experiences, such as pain, pleasure, anger, and love. These mental experiences are made of interlinked sensations, emotions, and thoughts, which flash for a brief moment and immediately disappear. Then other experiences flicker and vanish, arising for an instant and passing away. When reflecting on it, we often try to sort subjective experiences into distinct categories such as sensation, emotions, and thoughts, but in actuality they are all mingled together without, however, being the same. This frenzied collection of experiences constitutes the stream of consciousness. The stream of consciousness is the concrete reality we directly witness every moment. It is the surest thing in the world (Harari, 2017; McHugh, 2006).

The lived truth of the mind relates to existential experiences of our own personal thoughts, perceptions, and feelings as those features belong to our inner selves. We saw in Chapter 1 that this implies feelings expressing the painfulness of pain, the anxiety of anxiety, the redness of red, the delightfulness of love, the reflectiveness and successions of thought, the discomfiture and drive of hunger, and ultimately the ‘me’-ness of me in action. All phenomena obtain their meaning through a subjective first-person perspective, the ‘I’ and ‘oneself.’ In this sense, the subjective mind is the most immediate of our experiences, that of which we are most certain. Our mind in its ‘ownness’ impresses itself upon us at every waking moment and intermittently in dreams during sleep and in our imagination when awake. In fact, there is nothing ‘I’ am more sure of than my consciousness; I am much more sure of it than any person over against me is conscious of me. Yet, there seems no bigger mystery than consciousness and the mind in its ownness. Nevertheless, this mystery is what introduces freedom into life by enhancing choice and robust unpredictability, that is – the radical contingency of insight and truthfulness.

Natural sciences know surprisingly little about mind and consciousness. Anger and love are not abstract terms we have decided to use as a shorthand for billions of electric brain signals. Anger and love are extremely concrete experiences which people were familiar with long before they knew anything about electricity or electrical discharges. Anger and love point to very tangible feelings. If you describe how a chemical reaction in a neuron results in an electric signal, and how billions of similar reactions result in billions of additional signals, it is still worthwhile to ask how these billions of events come together to create my concrete

feeling of anger and love. “Scientists don’t know how a collection of electric brain signals creates subjective experiences. Even more crucially, they don’t know what could be the evolutionary benefit of such a phenomenon. It is the greatest lacuna in our understanding of life” (Harari, 2017, p. 128).

If no one knows how brain signals create subjective experience, it is hard to understand why the public mental health care system is obligated to help people according to standardized manuals that know nothing about a person’s feelings, imaginations, and experiences. Standardized manuals do not take into account that human consciousness is based on subjective experience and interpretations that vary with time, place, and intentions and therefore cannot be understood or treated with standardized medical methods and concepts. There is surprisingly little resistance to the use of these standardized diagnoses and manuals. It seems that social and mental health care workers, who experience the dilemma of using manuals and diagnoses every day, are afraid to oppose the public manual system.

However, there are exceptions. Birgit Valla, a Norwegian psychological specialist, working in a local mental health care system in Stange municipality in Norway, is one of very few mental health care workers who has opposed the public diagnostic system. Valla has established an alternative free mental health care service ‘The Stange Help,’ in Stange municipality. The Stange Help offers services to everyone in the municipality. It is a place to come and talk freely about worries without getting diagnosed. No diagnostic labels are used in The Stange Help. User involvement is taken seriously and the language and methods are based on common sense, that is, people’s needs and wishes come before evidence-based methods and theories.

The Stange Help and Valla’s critique of mainstream psychology

Valla’s opposition to the diagnostic system and mainstream psychology, such as psychoanalysis, started when she was a young psychology student (Valla, 2014). At the end of her psychological training, Valla started asking questions about the effect of evidence-based psychology and mainstream psychology. The same critical questions followed her in the years to come. In her book *Further: How Mental Health Care Services Can Be Better (Videre: hvordan psykiske helsetjenester kan bli bedre)*, she writes that through the years, people have been telling her many stories of how they got better. Her idea was to build a local mental health care service based on what people told *mattered* to them, and what gave them the desired outcome. Valla’s impression was that if she had these two things in mind, and started to develop the mental health care service this way, she would discover what a successful mental health care service would look like as a result of achieving successful outcomes. Instead of inventing new ways of helping people beforehand, the idea was to detect the solutions along the way. Valla’s experience of mainstream mental health care had shown her that one cannot decide and

discover beforehand through research what a person needs. On the contrary, her experiences had shown that the path to better outcomes had to be discovered, along with the specific person in need for support and help.

Starting with this new and innovative idea, Valla's challenge was to get other mental health care workers on board with her idea. Because the whole psychological field is caught in the evidence-based paradigm, it seemed almost impossible for Valla to get mental health care workers to think differently. However, her objective was clear; they had to get better outcomes in the field of mental health services. The path was more uncertain. When Valla tried to talk about her ideas, people kept asking for the recipe for this new and different way of doing mental health care. If they were to abandon the old way, they had to know the effect of the new way. But, Valla's idea was anything than rock solid.

According to Valla (2014), people want to be good and kind and come along with others. They want to be good parents, a good friend, and a good employee. They want to get along with their families and have friends. They want their children to be happy. They want to be able to manage a job or do something of use to others. They don't want anxiety and depression or to be ruined by alcohol or drug abuse; they want to get out of such states and situations. If they hear voices, they want help to manage the voices so that they don't bother them as much. They want help to sort out hurtful things that have happened to them in the past. People want to live ordinary lives and feel good about themselves and others.

Keeping it simple has become The Stange Help's motto. Sadly, the business of psychotherapy and mainstream psychology has become anything but simple, according to Valla. On the contrary, it has become complicated, diverse, overloaded, and operates within a logic that simply does not apply to the field of mental health care. Valla does not want to be in the business of mainstream psychology and psychotherapy anymore, so she is ending her relationship with it. She wants to be in the business of helping people get better and do whatever they have to do to achieve just that.

Seven years after The Stange Help was established, The Stange Help has more than thirty employees helping people of all ages with all types of mental disabilities and substance abuse in the municipality of Stange (private conversation). After years of feedback Valla is utterly convinced that mainstream psychology and its medical model is taking us nowhere. It simply does not work. Many professionals agree with her on this, but somewhat paradoxically the field continues to adopt its medical and reductionist logic when services are designed. To many bureaucrats, standardized manuals and evidence-based thinking are easier to understand than Valla's flexible user-based approach to the human mind. Manuals and evidence-based thinking is linear and orderly, and fits with the idea of guidelines and regulations. Through manuals, you assess to find the proper diagnosis and the assigned treatment. Contextual perspectives, however, such as life experiences and cultural factors are messy and uncontrollable. But, according to Valla, life experience and cultural factors are essential to understand what people are struggling with. By establishing an alternative approach to the human mind,

Valla, and The Stange Help are openly breaking up with mainstream psychology and the medical model under which it operates.

However, Valla's road to establish an alternative and more human friendly mental health care service has been hard and problematic. According to the Norwegian public mental health care system, not diagnosing people is against rules and regulations. The Stange Help has therefore been under public investigations and found guilty in breaking public mental health care duty. The message was that The Stange Help had to correct its way of working according to public medical standard. Luckily, the Norwegian Minister of health and care services and his ministry came to rescue by approving the way The Stange Help works. The Norwegian Minister of health and care services has concluded that assessments and diagnoses are not always necessary. The approval is quite revolutionary in its message and opens doors that have previously been locked. But it was a close call.

Valla's critical voice directed to mainstream psychology is echoing other voices representing critical psychology and culture and community psychology. Ian Parker, Peter Kinderman, Isaac Prilleltensky, and Dennis Fox are all known for raising their voices against mainstream psychology. Fox and Prilleltensky (1997) define mainstream psychology and mental health care as the psychology most often taught in universities and practiced by clinicians, researchers, and consultants. It is psychology portrayed as a science, with objective researchers and practitioners who uncover the truth about human behavior and help individuals adjust to the demands of modern life. Mainstream psychology reinforces, according to Prilleltensky and Fox, Western society's unacceptable status quo, even when psychologists propose tinkering with social institutions. Because psychology's values, assumptions, and norms have supported society's dominant institutions since its birth as a field of study, the field's mainstream contributes to social injustice and thwarts the promotion of human welfare. Indeed, according to Prilleltensky and Fox, the field of psychology itself is a mainstream social institution with negative consequences of its own.

Of course, if existing institutions ensured social justice and human welfare, minor alterations to smooth out the rough edges might be good enough. In our view, however, the underlying values and institutions of modern societies (particularly but not only capitalist societies) reinforce misguided efforts to obtain fulfillment while maintaining inequality and oppression.

(Fox & Prilleltensky, 1996)

Parker (2007) highlights that critical psychology alerts us to the limitations of mainstream research in the discipline. It promises to put 'social' issues on the agenda in the whole of Psychology. He points out that people or

a group or culture do not behave or think like the model would predict, and, more importantly, we find that our awareness, our reflection on a process described by a psychologist changes that process. It is in the nature of human

nature to change, to change as different linguistic resources, social practices, and representations of the self become available, and for human nature to change itself as people reflect on who they are and who they may become. That means that any attempt to fix us in place must fail.

(Parker, 2007, p. 1)

Parker wants us to step back and look at the images of the self, mind, and behavior that mainstream psychologists have produced, the types of practices they engage in, and the power those practices, those ‘technologies of the self’ have to set limits on change. When we appreciate this, we can start to look at what psychologists might do instead as part of a genuinely critical approach.

According to Kinderman (2014a, 2014b), the biggest issue with introducing the medical ‘disease model’ into the field of mental health care is that the treatment of human’s stress and anxiety rests heavily on diagnoses without taking other matters into account. In the book *Prescription for Psychiatry: Why We Need a Whole New Approach to Mental Health and Wellbeing*, Kinderman (2014a, p. 48) states that: “We must stop regarding people’s distress as merely the symptom of diagnosable illnesses and instead develop a more appropriate system of describing and defining people’s emotional problems.” To Kinderman, traditional psychiatric diagnoses are arbitrary and invalid, and do not map onto biological processes or describe real illnesses. They are also circular concepts, attempting to explain human behavior merely by labeling it as pathological. This reinforces a reductionist biological view of mental health and well-being and encourages discrimination and the use of inappropriate medical treatments. The groundbreaking properties of the human mind challenges the medicine method and the diagnostic concepts.

We must move away from the ‘disease model,’ which assumes that emotional distress is merely a symptom of biological illness, and instead embrace a psychological and social approach to mental health and well-being that recognizes our essential and shared humanity.

(Kindermans, 2014a, p. 1)

Humans are humans, creative and unpredictable

In light of contemporary discussions about whether an objective science of psychological phenomena is indeed possible, one can conclude that after one century the experts still do not agree on how to explain the human mind as a distinctively psychological phenomenon and not something belonging to a different order. Based on this fact, the rhetorical questions arise: Can we ever find out what a person is through reliance on general laws? Can we ever objectify or diagnose the way a person experiences things in his/her own mind that is rooted in their feelings or opinions? Does a psychological language or philosophical and psychiatric term exist that can express mental phenomena without reference to categories applicable to the external world? (Joranger, 2015)

What we know is that the diagnostic examination does not establish the fact of our identity by means of the interplay of distinctions. It establishes that we are different, that our reason is the difference of forms of discourse, our history is the difference of times, that our selves are the difference of masks (Foucault, 1972; Goffman, 1959). To Nietzsche (1968) there is a list of psychological states that are signs of a flourishing life but that are currently condemned as mental illness even though, under favorable circumstances, they could be defined as healthy. These states include (a) feelings of enhanced power and the inner need to make one's life a reflection of one's own fullness and perfection; (b) the extreme sharpness of certain senses, which creates a type of sign language, a condition that seems to be a component of many nervous disorders; and (c) a certain suspension of the will, a species of deafness and blindness toward the external world.

The range of perceived stimuli is sharply defined. Seeing creative thinking as a form of neurosis is an objection to modernity, according to Nietzsche, not to imagination or artistry. Inartistic or non-artistic states are for Nietzsche a component of the modern notion of normality. These include objectivity, mirroring, receptivity, and suspended will. Artistic states, in contrast, tend to be defined as mental illnesses in modern medicine. These include subjectivity, ingenuity, imagination, and powerful will.

Looking at the human mind from an interdisciplinary and multi-historical point of view, it seems like a general law that all human beings have at least some degree of fundamental capacity to think and behave like what one in the modern world would call a mentally disabled person. We have an urge to imagine things that are disconnected from the objective or external world. Alienation and morbid experiences that close the world in a fixed image affect people of all ages, races, religions, and incomes. The experiences occur when you least need it, i.e., when you are very stressed, in shock, in love, in great sadness, or in great joy. As such, morbid experiences are not the result of personal weakness, lack of character, or poor upbringing. Instead, they show incredible creativity in terms of behavior and thought. They can hurt and damage our mind enormously. They can disrupt a person's thoughts, feelings, mood, and ability to relate to others, as well as the capacity to cope with the ordinary demands of life. However, the understanding of mental morbid experience and the feeling of alienation as a medical condition reduces the human mind to diagnoses, such as major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD), and borderline personality disorder.

Jaspers shows (Jaspers, 1977, p. 203) that our understanding of mental illness and mental disorder continues to change with time and place. This makes it difficult to understand what diagnostic preferences actually are. Jaspers believes that:

We live in a time of false imitation, of the transposition of all that is spiritual into bustle and institution, of the sheer will into most any kind of existence, of intuition into doing something of dramatic sensation; we live in a

time of people that are not only alive but know that they are, yes, of men with intentioned simplicity, of imitated Dionysiac experience, and creative discipline, both, at one and the same time, serving them satisfactorily. Is it possible that in such times schizophrenia is the condition for genuineness in spheres which, in more restricted times may be considered genuine even in the absence of schizophrenia? Do we see something in a dance which is intentional and farfetched, but which expresses itself only in screaming, in mere activity, in brute force, in self-intoxication and cumulative tension? Do we see in that dance actually merely superficial immediacy and a stupid desire to be primitive or even enmity incarnate to culture, while it is genuine and of depth only in a few schizophrenics.

If we take a step back and envisage that the common human mind is drawn toward polar and paradoxical experiences, such as those between the Dionysian and Apollonian, the rational and irrational, our hanging on to generalization will destroy our understanding of these psychic phenomena and connections. Instead, morbid mental images are images that should be studied and interpreted in order to understand how people think and act, in their daily life. If polar and morbid mental connections, not being able to be referred to standardized method and theories, effect people's life to such an extent that they also can destroy it, should we not at least design our methods and theories according to the principles of user involvement, which includes people's mental experiences, expressions, and desires? We should remind ourselves of the sources on which the freedom, richness, flexibility, and depth of our mental experiences depend.

An alternative and valuable source of information of understanding personality and character, is according to the American psychologist, Gordon Allport (1937), to read literature, such as biography, poetry, and fiction. Allport claims that whenever a psychologist succeeds in capturing something of personality, one can find some great author who had already made that observation. Scientific psychology and literature, to Allport, differ in how they approach personality. Literature is concerned with the individual case and generalization is left up to the reader. The psychologist seeks general principles and lawful generalizations beyond individuals. To Allport, literature involves complex social settings, in which many factors are operative in the flow of life, whereas the psychologist prefers highly constrained situations and surroundings in which complexity is controlled or eliminated. Literature, such as poetry, is unconcerned with replication of observation, statement consistency, or whether observations test some theory. Psychology is concerned with all three.

Mind and poetry – the escape from medical language

Through history scholars, authors, and painters have illuminated the diffuse intersection between dreamlike imaginings and poetic literature. The Romantic poet

Novalis followed Johann Gottfried Herder in conceptualizing dreamlike imaginations as the original moment of genesis. To him morbid dream and imaginations were the primary source of *poetry*, and poetry was the most primitive form of language, the maternal language of man.

Using literary and poetic reflections on existential themes, Foucault in the 1950s, similar to the Romantic poets, sought to generate a view that can explore how consciousness is manifested that is not psychological in the objectivistic sense and that stands in contrast to the concrete, objectivistic, and experimental (Joranger, 2013). To Foucault, the histories of mental health care confirms that the objectifying medical and logical language cannot eliminate the distinction between experience, subjective meaning, and language.

Like Valla (2014), Foucault, in his quest to approach an understanding of the human mind in the mid-1950s, turns away from the medical and objectivistic psychological language. But, unlike Valla who turns to people's experience, needs, and wishes, Foucault turns to Antiquity and to the Romantic era's knowledge areas of dreams and poetry to find a suitable entrance to the human mind (Foucault, 2001). By using different forms of poetic reflections, Foucault works to create a new definition of the relationship between experience, meaning, and language without slipping into the restricted scientific paradigm. To Foucault the poetic language is similar to the human mind because it is not obligated to imitate the external world.

Seen like this, our imaginary world is the world whose discharges are the poetic expressions. It cannot be isolated from their ethical content because in their common language everything says 'I'. This is not because they both uncover secret inclinations and inadmissible desires, but because they restore the movement of personal freedom and creativity, showing how we as living actors establish ourselves and alienate ourselves and how we exist as radical responsible actors within the world.

There are, according to Foucault, at least three specific forms of poetic expression that employ a type of language that reflects the inner subjective world of polar morbid phenomena and imaginations, that is, the *epic*, the *lyric*, and *tragic* poetry (Foucault, 2001). He points out that these three forms of poetic expression (language) in different ways can express how meanings and experiences are manifested in the human mind and how the relationships between experience, meaning, and language are constituted. Not least, they have the ability to express the huge mental contrasts and the polar emotions that we all experience at times. These are the contrast between light and dark, day and night, and the polar experiences of being in vertical trajectory from heaven and hell, rise and fall, ascent and descent, near and distant, at the same time. In the epic form, Foucault suggests we encounter our existential odyssey in the vertical trajectory from near and distant spatiality through what he describes as those "great cloths woven of the dreamed and the real" (Foucault, 2001, p. 133).

By contrast, lyric expression is possible only in the alternation of light and darkness, through which existence plays itself out:

If the lyrical can survey all the changes of the world, all its motions, if it can, itself immobile, search out in every direction, this is because it seizes everything in a polar play of light and shadow. In the pulsations of day and night, which tell, upon the shifting surface of things, the unchangeable truth.

(Foucault, 2001, p. 134)

Finally, the axis of tragic expression is located on the polar vertical axis of existence. Tragic movement is defined by ‘ascent’ and ‘descent,’ ‘high’ and ‘low.’ It emphasizes that privileged moment in which the narrative completes its ‘rise’ and balances there, wavering imperceptibly, before the descent begins. This is why tragedy, according to Foucault, does not require time and space in which to extend itself – why it need not be set in a foreign land or even under the cover of night; it aims to represent the vertical transcendence of destiny.

In his poetic verse entitled *A Strange Dream*, the German poet and dramatist Friedrich Christian Hebbel (1813–1863) visualizes the tragic feeling of ascent and descent, when describing a nightmarish dream in which Hebbel himself moves vertically along a rope that God has fastened between heaven and earth (Hebbel, 1965, pp. 729–730). Each time Hebbel has solid earth under his feet, he is thrown into the sky again and forced to grasp the rope tightly to avoid descending into the abyss. Tragic expression has in this morbid dream the task of manifesting the destinies of vertical transcendence of the inner feelings of ascent and descent.

The world of Ellen West

As already pointed out, in lived experience, space ceases to function as a divider that dissociates one thing from another (cf. Bergson). It is no more than the movement of shapes and sounds that come and go according to the flux and reflux of their appearance. This flux and reflux is artistically described by one of Binswanger’s patients, Ellen West, when she in her diary visualizes the end of her own life as tragic vertical movements of ascent and descent. Ellen West, who by Binswanger (2004) has got the diagnoses anorexia nervosa and schizophrenia, explains in her diary how the whole movement of her existence channels into a phobic fear of a *fall* into the grave and into the delirious desire to soar into the ether, finding its gratification in the immobility of pure *movement*. This spatial orientation and its affective polarity designate the very form according to which her existence temporalizes itself. Ellen West does not take on the future disclosure of a fullness and anticipation of death. She already experiences death, there, inscribed in an aging body which is more burdened each day. In Ellen West’s experiences, the spatial vertical dimension of existence (that is, the dichotomy between ascent and descent) plays a greater role than her understanding of the temporality of existence.

Based on the spatial vertical axis of experience, the world of Ellen West is divided between the underground world of burial, symbolized by the cold dark of the tomb that she resists with all her might by refusing to gain weight, grow

old, or be trapped in the crudely materialistic life of her family and by the ethereal, luminous world in which, in a single moment, one could attain a completely free existence without the weight of living, in which one would know only that transparency of love totalized in the eternity of an instant. Life has become possible for Ellen West only as a flight toward that distant and lofty space of light; the earth, in its dark closeness, holds only the imminence of death. The solid space of real movement, the space where things come to be, has progressively disappeared. It exists only beyond itself, both as if it did not yet exist and as if it already existed.

The subjective space that Ellen West occupies is that of life suppressed by the desire for death and the myth of a second birth. It already signals the suicide by which Ellen West was to attain the culmination of her existence. In her diary, West expresses her polar feelings in her own language:

I'd like to die just as the birdling does/That splits his throat in highest jubilation;/And not to live as the worm on earth lives on,/Becoming old and ugly, dull and dumb!/No, feel for once how forces in me kindle,/And wildly be consumed in my own fire.

(in Binswanger, 2004, p. 246)

What every human being understands is a matter of his/her human stature. Polar experiences, such as those Ellen West describes, are experiences of creative understanding and have been ingeniously understood by all great poets and artists. A close association between literature and human reality can provide the horizon within which the simplest everyday occurrence can become interesting and vital. The levels reached by one who wishes to understand and by what (s) he understands will decide whether (s)he is oriented towards the ordinary or the extraordinary, the plain and uncomplicated, or the complex and manifold. Meaningful connections are, as such, a matter of poetic expressions, not diagnostic and medical explanations.

The uncoded world of the human mind and poetry

The French writer Antonin Artaud (Artaud, [1978]1999, p. 49) expresses better than anyone the idea of the relationship between the psychological life and poetic literature in his text 'Umbilical Limbo':

I am as much myself in a letter written to explain the inner contraction of my being and the meaningless emasculation of my life, as in an essay outside me, which seems like an indifferent gestation of my mind. I suffer because the Mind is not in life and life is not Mind. I suffer because the Mind is an organ, the Mind is an interpreter or the Mind intimidates things to accept them in Mind. I hold this book up in life, I want it to be attacked by things outside, primarily by all the shearing jolts all the twitching of my future ego.

Unlike medical explanations of the mind, Artaud's text, similar to other expressive texts, shows how different literary genres can express qualities of the mind that can depict life as we are living it, whether that mind is affected by mental disabilities or by normal polar experiences. Artaud's text visualizes that literary poetic expressions to a greater extent than medical concepts manage to communicate the essential aspects of the human mind. However, it seems that the literary genius, such as Artaud, takes his description from a real, essential, ontological structure. A person who manages to express the mind in such an artificial and truthful way, according to Dilthey (1997), is like a traveler in a foreign land, who, with great enjoyment and complete freedom, abandons him/herself, without any utilitarian motives, to the surrounding impressions. This lends him/her the character of childlike naiveté, evident in artists, such as Mozart and Goethe, and many other great artists, a naiveté that is very much compatible with an accompanying system of goal-direction actions. (S)He is then further set apart by the clarity of delineation, strength of sensation, and energy of projection peculiar to his/her memory images and their formations.

The vivacity of an impressionable lively interpretation of the human mind in its ownness depends on the original force of feeling, emotions, and volitional processes. Second, an impression differs in various degrees from the original processes with respect to their distinctness, energy, and the resonance of one's own inner state. However, we can assume that the interpretation and re-creations of a mind's impression, be it the service user's or the mental health care worker's, can never be separated from the memory of external perceptions or from the intensity of memory images. Thus, the interpretation and the re-creation that a service user gives of a feeling seems to be twisted together with his/her own life. Charles Dickens (in Forster, 1873, p. 132) once clearly described the connection between re-creation (in this case, a text) and life itself when approaching the end of his story 'The Chimes,'

Since I conceived, at the beginning of the second part, what must happen in the third, I have undergone as much sorrow and agitation as if the thing were real; and have wakened up with it at night. I was obliged to lock myself in when I finished it yesterday, for my face was swollen for the time to twice its proper size, and was hugely ridiculous.

Goethe (1850, p. 259) explains in similar way that: "I have never affected anything in my poetry. . . . I have never uttered anything which I have not experienced, and which has not urged me to production, . . . I have only composed love-songs when I have loved. . . . How could I write songs of hatred without hating!"

Goethe and Dickens express here how the lived power of interpretation and re-creation of inner feelings and experiences are interwoven with reality itself. Although we can assume that a great poet or a great therapist has the capacity to truly enliven images and depict higher cognitive functions of another person's imaginations and feelings (i.e., a service user's), we can also assume that the

expressive creation and taste that a therapist manages to express never can conceive of a virtue as perfectly as it actually appears in the person who is the original owner of these feelings and imaginations. The therapist's re-interpretation of a service user's feelings conceives of it more vaguely, hazily, indeterminately, and less sharply delineated, but never with the completeness characteristic of 'reality.'

Seen like this, a service user's expressions uttered in their language must be seen as every human being's spiritual homeland: "For it is language that 'poetises and thinks' for all of us before any one individual brings it to the service of his own poetic and thought-provoking powers" (Binswanger, [1930]1993, p. 81). To Binswanger, when we in our imagination experience 'falling from the sky' or 'flying up to it,' one can assume that this experience reflects the concrete physical and psychological dichotomy between descent and ascent in one's own life.

To Jaspers (1971), the *transcendent code* of imaginations and artificial expressions have the ability to manifest the *real* wealth of the world. It allows us not only to read the different codes in *time* and *space* but also to read them in light of other potential realities, including other forms of art. The poetry's codes can help to redeem us from our expected and fixed social role and bring us closer to how we confront our being there in the world in reality. Like Foucault (Foucault, 2001), Jaspers (1971) believes that our aesthetic life is a life in which the *imagination* eliminates all bonds. Such a life is divided into details of exciting moments. Through aesthetic expression one can seek to shape one's own real experience as if it were a work of art and to make our reality free from fixed social roles. The only way we know how to do this is to realize ourselves in the form of the particular; to enjoy this process of realization, we must continually take up new and different experiences to ensure that *my* life will depend on variety and polarity.

Our perception of variety and polarity is all-pervasive in our mental life. We perceive activity and passivity, consciousness and unconsciousness, pleasure and displeasure, love and hate, self-surrender and self-assertion, that is, all dichotomous psychological states and drives. We also find a will to power and an urge to submit, self-will and a social sense (I and We), an urge to move toward the light, toward self-direction, safety, responsibility, peace, activity, and life, and an urge to move toward self-destruction, dark, irresponsibility, war, passivity, and death. We also experience an urge to disrupt order and an urge to conform. All of human psychology, according to Jaspers ([1913]1997), must address this type of polarity without necessarily seeing it as a sort of mental disorder. When today's mental health care workers cannot allow themselves to look at a person's experienced polarities without putting them into the rigid frame of diagnoses and general medical descriptions they lose sight of the poetic parts of themselves and the human beings they are supposed to help.

In their existential-phenomenological works, Jaspers, Foucault, and Binswanger are critical of all forms of inappropriate generalizations. They criticize positivism for its inability to understand that every object of study is essentially founded on an intentionally chosen perspective. What someone sees as abnormal and wrong may be normal and right for another person, depending on the experience gained

and the cultural framework of one's experiences. The same applies to our present perception of mental disorder and morbid images: what one today sees as mental disorder would have been understood by the ancient Greeks as a shock from Apollo and would have been seen in medieval times as a diabolical obsession. We have to understand mental disorder and morbid images on the basis of such a relativistic understanding of history. Our autistic *being-in-the-world* is inextricably linked to a historical perspective on life.

However, diving into the poetic language, one should be aware of not diving into a purely romantic worldview, or still another story. In our try to grasp the inner world of a person, one can easily slip into raw romanticism. The romanticist tendency in psychotherapy is to rely upon feelings for evidence, on metaphors for reality, on inspiration and myth for guidance. Such romanticism has been a recurrent temptation for therapists confronted by service users with perplexing problems (McHugh, 2006). A long-growing dispute about fifty years in duration has been fought and is now ending between romanticists and the empiricists. The latter continue to insist that all the practices of mental health care be based upon observation and methodical study of service users. It seems that the empiricists are winning because their approaches have expanded our knowledge of mental disorders in a clear and gratifying way. The romanticists are losing not because they fail to provide helpful proposals for psychotherapy. This is their strength. They are losing because, as romantics will, they can be blind to reality.

However, it seems that every imagination and every feeling is an imitation and a re-creation of the intersubjective relationship between mind and culture, which symbolizes a meaning-making process that cannot be expressed psychologically (Dilthey, 1997; Gadamer, [1960]2013). Dilthey (1997) holds out that the relations established between feeling and expression, meaning and imitation, inner and outer, can be freely employed to produce music in the domain of aural representations, and arabesques, ornamentations, decorations, and architecture in the domain of visual representations (ideograms). However, when employed according to the law of imitations of the inner and outer world, poetry arises in the first domain and sculpture and painting in the second.

Dilthey's approach to the poetic expression is not psychological in the commonly held subjective sense, for he never isolates the psychic life of the poet or of the creator from his/her lived life and in his/her historical context. Thus, in accordance with a cultural psychological point of view (Shweder, 1991; Valsiner, 2014), representation of life and history are always the soil from which language and concepts draw their essential constituents. The elements of poetry, motif, plot, character, and action, are transformations of imitations and representations of lived life. To Dilthey, we immediately sense the difference between heroes constructed from stage props, paste, paper, and glitter, no matter how their armor may shimmer, and those composed from reality. Particular or general representations of characters whose elements already exist either in ourselves or in reality as constituted by others need only undergo a transformation for the personae of a drama or a novel to be created. Similarly, the nexus or events provided by our

experiences of life need only undergo a transformation in order to become an aesthetic plot.

A person's mind – what is it and how can we reach it?

What is a person? The question has been understood and answered differently through history. Aristotle, whose *De Anima* is the first 'scientific' psychology, which also underlay his analysis of the political order of existence, stated that a person is a *zoon logikon* or a *zoon logon echon* – a living thing made rational by the power of speech, the locus of rationality. The human being 'divides its voice' in a way not found in all of nature. And by the power of speech the human being takes up a position in the cosmic and social order. The ancient philosopher Boethius sees the 'person' as an individual substance of a rational nature, which became canonical in scholastic philosophy and its aftermaths. Another way of describing a person is based on relationships with other persons. This direction was started in the theological writings by St. Augustine and taken by Martin Buber who held that the human is a person only because of the existence of another interacting person to whom one responds as a 'Thou' as opposed to an 'It.' In the world of illness and its treatment this is a crucial distinction.

For Buber ([1923]2000) the I–You relation is a relation of subject-to-subject, while the I–It relation is a relation of subject-to-object. In the I–You relationship human beings are aware of each other as having a unity of being. In the I–You relationship, human beings do not perceive each other as consisting of specific, isolated qualities, but engage in a dialogue involving each other's whole being. In the I–It relationship, on the other hand, human beings perceive each other as consisting of specific, isolated qualities, and view themselves as part of a world which consists of things. I–You is a relationship of mutuality and reciprocity, while I–It is a relationship of separateness and detachment.

To Jaspers ([1913]1997) and Foucault (1954), when a mental health care worker approaches a person with a medical gaze, an I–It relationship will occur and the person who needs to be found will no longer be a person but a thing that can be measured as an object. In Jaspers's and Foucault's points of view, human life is more than the sum of its parts. In the case of a person one can never understand a mental or accompanying physical phenomenon by exclusively relying on an empirical analysis of the body's responses to stimuli. Physical responses will always be influenced by psychological choices and beliefs and our personal feelings and our environment, which, in turn, will affect how we physically respond to our surroundings. No fixed relationship between objective features and their meanings for the persons involved can therefore be drawn.

If we are going to understand a person's various forms of subjective expression as something other than purely organic or diagnostic, we must attempt to put ourselves into another person's unique life history (narrative), experiences, and different forms of expression. Through the unique power of imagination and

interpretation one can approach the other person's experiences and behavior and hopefully get a little access to his/her life world. I am not talking about a naturalistic and objective life world, but about a subjective personal 'inner' life world that shapes the human's being-in-the-world as well as being shaped by it. This is a world that does not distinguish between the *inner* and *outer* world, but instead manages to unite different scientific and artificial worldviews. When it comes to the human mind in general it does not allow for general causal laws. Rather it depends on what we could call an interdisciplinary awakening.

As opposed to the naturalistic sciences, there is the view, often related to the human sciences, which takes into account that scientific claims, although they are subjected to the empirical tests of researchers, are related to unique subjective perception and experiences that cannot be outlined in general laws. Rather, they could be related to a specific sociocultural context that more or less subconsciously pushes us to think according to certain values, whether moral, personal, social, gender-specific, political, or cultural. These are systems of premises taken for granted which make up the framework of 'conviviality' that Michael Polanyi (1958) explored. In his book *Personal Knowledge*, Polanyi (1958) states that all knowledge claims, including those that derive from rules, rely on personal judgment and that we believe more than we can prove, and know more than we can say. As such, a knower does not stand apart from the universe, but participates personally within it.

However, there are types of psychological phenomena that can be generalized as common for all people. They are what we term sensory phenomena that we understand as expressions of the psyche. They consist of the human physiognomy presented in such forms as shape and expression, appearance, involuntary gestures, speech, and writing, artistic productions and conscious purposeful behavior, among others. When we speak of somatic expressions, we can, if we so choose by a process of abstraction, simply register a general relationship between, for example, fear and dilation of pupils, smile and friendliness, blush and certain emotions, isolation as anxiety, etc. We can register it, scientifically or not, and make it part of our common knowledge, which nevertheless is socially distributed and conditioned.

Expressive phenomena are as such general as far as they can be perceived by the senses and manifest themselves as matter of fact, which can be measured, photographed, recorded, or counted, etc. On the other hand, the interpretations of somatic expressions are always subjective and unique since actual perception of them is highly personal. Insight into expressive phenomena, therefore, requires rather different evidence beyond the simple registration of purely objective physical facts. They are situation-dependent. In these cases, naturalistic sciences, which aim to generate general laws, will not alone be sufficient for understanding the meaning of the content of the expression that a person gives.

Just as every person must 'find' themselves through the various forms of language, self-reflection, and action, what does it mean for a social worker or a mental health care worker to 'find' a person? Is it possible to find a person, who by

nature is in constant psychological movement according to a constantly changing sociocultural environment, through general laws? And, why should we bother to 'find' someone who is constantly moving from the inside-out to the outside-in? According to Kierkegaard ([1851]1998), if we want to help a person "One must first and foremost take care to find the person where the person is and begin there." To Kierkegaard, all true helping begins with a 'humbling.' The helper must first humble him- or herself before the person he or she wants to help and thereby understand that to help is not to dominate but to serve. To help is not to be the most dominating but the most patient. To help is a willingness for the time being to put up with being in the wrong, and not understanding what the other understands. We must, as Buber ([1923]2000) states, establish an I and You (I–Thou – Ich und Du) relationship, which is the opposite of what Buber calls an I–It relationship.

Smedslund and Ross (2014) point out that insights about a human being, whether born of empirical work, thoughtful analysis of history or experience, or deductions from an understanding of human goals and capacities, do not offer formulae or algorithms that can be applied automatically or mindlessly. Rather, they suggest that these insights essentially provide interdisciplinary 'tools' for potential use. Like any tools, their effective use, whether conscious or non-conscious, involves some combination of experience and skill. The wise practitioner also recognizes the importance of changing tools when the ones currently being used are not getting the job done.

Looking from a subjective point of view, every attempt to uncover the reality of a specific person through general laws will be met with resistance by this specific person. To be subjected to general laws and methods is against the nature of autonomy and self-governance. This is a fact that I suggest can itself be outlined as a general law. First, although there are similarities in behavior and thinking, every person, as an embodied being into which all its life experiences have been enfolded and qualify it as 'this' being, is different. Second, not even a single individual is the same in every situation. In social encounters we automatically and sometimes unconsciously expand and change in order to adapt to the situation. We are self-reflexive, dynamic, social, historical, and cultural human beings.

Foucault shows in his 1960 and 1970 works how subjectivity is formed in various historical periods. For him, the subject is not pre-given, just as sexuality, the body, or 'human being' is not 'always already' there waiting to be discovered. When Foucault speaks of the formation of the subject, he means quite literally that the subject does not exist as a determinate form with specific qualities before the practices that make up the *rapport à soi* in different historical periods bring it into being. Just what the subject is thus depends on the practices that bring it into being. The problem with Foucault's 1960 and 1970 use of the term 'subject,' is somewhat obviated by the fact that, for Foucault, the subject is never any one particular thing before its historical instantiation.

In the course of our understanding another person, a good deal of what is sociocultural is incorporated into both our pre-reflexive, intentional action and the more advanced reflexive consciousness that emerges as development unfolds

(cf. Jaspers, [1913]1997, 1971; Foucault, 1954, 2001; Binswanger, 1993, 2004). We cannot therefore understand persons merely in terms of individual subjects, because a great deal of a person's action happens only insofar as the person understands and constitutes him- or herself as an integral part of a 'we.' In this case, we can never understand a person independent of social and cultural contexts, which always have an agonistic element of some sort.

Following the interdisciplinary and interhistorical existential-phenomenological view on subjectivity, which also includes Foucault's view, we can conclude that the way we adapt to a situation is dependent on several conditions. Such adaptation therefore needs to be looked at by different disciplines. It concerns our imaginations, life experiences, our biological body, our personality, the persons we meet, and how we and the other person want to be seen. It also depends on the situation itself, that is, what kind of expectations and possibilities it holds. Every entrance into a situation is as such unique and reveals different sides of our personality.

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Humans, science, and experiences in change

Man himself is the best and most exact scientific instrument possible. . . . The greatest misfortune of modern physics is that its experiments have been set apart from man, as it were; physics refuses to recognize nature in anything not shown by artificial instruments, and even uses this as measure of its accomplishments.

Goethe, *Maxims and Reflections*, 1833

Quite independent of issues with the welfare state and its health care services, the human psyche has moved back into the historical scene. That is, the human psyche and its determining historical and existential settings have moved to the foreground, but have mental health care services moved along with it? As we have seen, public mental health care services result from a vision given by its historical, geographical, and cultural location. When we currently ask, “what is a mental health care worker? What is mental health care? Tell me its definition, its stuff and problems and methods,” all the answers given by whatever school still refer to the same foundation and concepts that appeared with its historical origin, the Christian Reformation. Intentionality, will, drive, motivation are as crucial now as then, and so too is the reflexive self, the anal character, the independent ego in the middle, whether examined in behavior or worshiped as inwardness.

It seems that it does not matter whether we are behaviorists or strict Freudians, whether we are engaged in self-mastery or self-surrender, introspection or statistics, or whether we try to break loose with glossolalia, creative painting and nude encounters, psychology and mental health care services remain true to its Reformation background. The mental health care workers and the mental health care services for which we erect great education institutions and great therapeutic methods and theories, too, have been and still are impotent. However, we must ask, what treatment and what cure have they provided for the human mind of our late modern world?

Mainstream mental health care services have shown little care for history, art, beauty, sensuality, eloquence, poetry, myth, and imagination, the great Renaissance and Romantic themes. Its vulgar pragmatism, whether in clinic or in laboratory, kills fantasy or subverts it in the service of instrumental goals. Love becomes

a sexual problem; creativity and aggressivity become AD/HD; religion an ethnic attitude; mind a political symbol. The Renaissance and the Romantic periods showed us how fantasy and imagination can be understood as the human capacity to distance oneself from the here-and-now situation in order to return to it with new possibilities (Foucault, 2001, Dilthey, 1997).

The modern mental health care praxis, such as it developed from medicine and the Christian Reformation, continues to shape its course even if it is unaware of its background. It is not strange that current mental health care workers feel trapped in a situation and in a language that is not theirs. On the one hand, it presents itself as therapy, a way of self-reflection and self-improvement. This introspective subjectivism, whatever the school of therapy, is sustained by deep pietistic hopes of personal salvation and the moral benefit of working on oneself. The weight and seriousness of psychotherapy create in its participants new loads of guilt, now in regard to the morality of its therapeutic aims (Foucault, 1961; Kinderman, 2014; Parker, 1997; Prilleltensky & Nelson, 2002; Rose, 1990). Now we are called defensive or resistant to the therapeutic process where once we might have been blamed for closing ourselves against the mainstream mental health God's grace or turning from the will of the mainstream God (cf. Valla).

Either way the various mental health care services turn, they do not leave their medical and Protestant origin. To move toward a renaissance, a re-visioning, of public mental health care means first a recognition of the death of the mainstream mental health care 'God' and the consequent death of the soul of mainstream psychology as a viable carrier of mind-making. A renaissance of mental health care can only come about if the psyche is given a chance to find itself against the fullest of possible backgrounds. Psychic complexity requires recognitions of all the Gods as well as of all knowledge areas. The history of mental health care since the Reformation shows the movement of its reason and the strengthening of its ego, but the history of civilization shows as well the movement of unreason, of dreams and fantasy, that is, our imaginal powers irrupting into reason, inflating it with ideologies and thereby steering its course. The modern mental health care system has had no means of reflection on these imaginal psychic powers, and that is a primary cause of its failure.

A mental health care service with little place for fantasy and imagination has little place for the psychic phenomena that rule our lives. Although the ancient concept of fantasy has survived in modern jargon, its modern meaning diverges from the original meaning in important ways (Cornejo, 2017). Whereas during the eighteenth century and until the first half of the nineteenth century, the ancient and romantic meaning of fantasy played a central role in the mental health care praxis, its importance and original meaning disappeared after the empirical natural science research program developed by Wilhelm Wundt and others. The consequence is that the concept of fantasy, as it currently is used in mental health care, has become technified and reduced so as to fit in with mainstream theories and models of the human psyche. "A specific scientific term makes sense only within the entire language used by a discipline to approach its knowledge domain" (Cornejo, 2017, p. 4).

It seems that art and imagination, the game of truth and fiction, evidence and fabrication, are linked to the same area of experience. The power of art and poetic fantasy permits us to see clearly what links us to our modernity and at the same time single out certain mechanisms that help us to separate ourselves from them by perceiving them in a totally different form. The difficult relation with truth is entirely at stake in the way in which truth is found used inside an experience, not fastened to it, and which, within certain limits, destroys it (Foucault, 1991, p. 36). Everything that is possible to think or imagine is as such related to experience.

The expansion of the mechanical-objectifying view toward society and human beings is currently associated with the rise of intellect and reason as the central powers of the human mind. This is a growing view which we should fight against. If the aim of the mental health care services is to find the person where the person is, they need to integrate the common sensuality and the beautiful but illogical imagination (fantasy) with the rational powers of the human mind.

Modern psychological science conceives a rationally ordered universe whose unveiling requires the methodical exercise of reason and intellect. Such unilateral emphasis leads only to the impoverishment of mental health care services, since analyses need syntheses in the same way as breathing is both inhalation and exhalation. Mind, reason, and unreason make up a totality, whose division may generate quarrels and biases that distort the original harmony among the parts of the whole.

By introducing imagination and fantasy into the mental health care sciences, I do not mean an imagination which goes into the unclear and imagines things that do not exist, but the imagination that enlarged tranquil minds, that has at its command a wide survey of the living world and its laws. This is a kind of imagination that does not

abandon the actual soil of the earth, and which steps to supposed and conjectured things by the standard of the real and the known. Then it may prove whether this or that supposition be possible and whether it is not in contradiction with known laws.

(Goethe, 1850, p. 220)

Opposed to the interdisciplinary Greek and Renaissance approach to the human mind, a modern experimental mental health care worker or scientist will always look for logical connections between doing experiments and the goal of finding generally valid laws relating the independent and dependent variables. To the Norwegian psychologist Jan Smedslund (1985, p. 228): “Experiments are carried out in order to find laws.” Smedslund (2009) believes psychological research and practice both start from what we all know about being human because we are human, what we know about each other because we participate in a shared meaning system (language and culture), and what we know about unique individuals. To Smedslund, practitioners rely on these three sources of knowledge, but researchers try to establish a fourth kind by looking for a limited number of

general and empirically based uniformities. However, the wise practitioner recognizes the importance of changing tools when the ones currently being used are not getting the job done (Kvale, 1992). Because a therapist has to deal with different worldviews, one should skip the quest of a reductive objectivity and approach the human mind and behavior from different worldviews and from interdisciplinary knowledge areas (cf. Frie, 2008; Kvale, 1992; Smedslund, 2012; Smedslund & Ross, 2014).

In his second book, *The Psychology of Worldviews* (*Psychologie der Weltanschauungen*), Jaspers (1919) suggests that when the universality within a specific domain of science is conflated into a worldview colored by psychological attitudes, this results in the ambiguity of worldviews or ‘meaningful psychic connections’ (*verstehende Psychologie*) that are neither science nor philosophy. Jaspers (1919, p. 14) defends this typology of worldviews not as a type of picture at an exhibition but as the largest possible realm in which “existentialist decisions occur which no thought, no system, no knowledge anticipates.” According to Jaspers (1919, p. 1), a worldview is

something whole and something universal. If, for instance, one is speaking of knowledge, it is not particular forms of knowledge in particular domains, but knowledge as a whole, or totality, as it manifests itself in values, forms of life, destiny, in the lived rank-order of values. Or, to state both in other words: when we speak of worldviews, then we mean ideas, the most final and the whole of man, both subjectively as experience, force, and reflection, and objectively as the objectively formed world.

In his autobiography, Jaspers (1974) took offense when a critic described this psychological typology as an interdisciplinary gallery of worldviews from which people were free to choose. For Jaspers (1974, p. 27), ultimately, the problem with *The Psychology of Worldviews* was the lack of a clarified viewpoint because the book was a psychological inquiry not into the reality of worldviews but rather into “the philosophic interest in the truth of various philosophic points of view.” This view corresponds closely with Knauss (2008), who believes that Jaspers’s perception of philosophical questioning is to ask and to think in terms of totalities without becoming totalitarian.

Asking critical questions and philosophizing about the human mind is close to what Jaspers (1971b, [1913]1997) believes to be a proper approach to the human psyche, a mental activity that transcends objectivity to grasp the human being in its everyday life. This is a task that is always merely particular and never universal. It is also the transcending to what cannot be known but still is present in the life of a human being. Jaspers saw science as an activity, not merely as a collection of facts and theories that urge one beyond itself to philosophy. The scientist and the mental health care worker can also be a philosopher, but that does not turn science in its narrow sense into philosophy. To Jaspers, many scientists and mental health care workers do not want to burden themselves with critical thinking and

philosophical questions. They believe that their scientific disciplines and work are not related to philosophy or in need of its criticism and guidance. Jaspers points out that mental health care workers do not understand that the exclusion of critical thinking and philosophy would be disastrous for the mental health care system, because

any ordering of knowledge into a comprehensive whole and any clarity over Being as a whole from which the object of research emerge, can only be attained under the guidance of philosophy. . . . It is only by being clear about the relationship between psychological understanding (as a means of empirical research) and philosophic illumination of Existence (as a means of appeal to freedom and transcendence) that a purely scientific psychopathology can come about which fills the entire canvas of its possibilities but does not transgress beyond its limitations.

(Jaspers, [1913]1997, p. 769)

The decisive element in philosophizing and critical reflection is the relation between the thinking subject and the non-thinking object of thought. The ontological gap between the thinker and the thing is a substantial issue that separates philosophy from mainstream science. Jaspers repeatedly argues that both Marx and Freud failed to introduce the metaphysical relation between reason and human being in everyday life in their scientific understanding of natural objects in the world (Jaspers, 1951). To Jaspers (1971a, p. 185), “to know reality we must know the unreal.”

Although our attempts to fit subjective experience into neat scientific, cultural, and political projections are certainly part of experiential reality as we live it, they account for only one half of the truth. This is because life is bound to eventually erupt through the layers of such projections and reveal its novelty despite the best intentions to shut it out. In science as well in the public mental health care system, this happens most profoundly through ‘paradigm shifts’ (Kuhn, 1962), shifts in the common understanding of right and wrong, healthy and sick (see e.g., Foucault, 1954, 1961, 2006; Jaspers, [1913]1997), and the insufficiencies of scientific prediction. For the person, e.g., the patient or service user, such novelty brings to light the fact that when (s)he experience life most fully and most intensely, we experience the world not in terms of old categories but in terms of life’s surprises, and in terms of an imaginary future that points toward something new (Joranger, 2015).

Our intellectual skills are driven by passionate commitments that motivate discovery and validation. A great scientist not only identifies patterns, but also chooses significant questions likely to lead to a successful resolution. Innovators risk their reputation by committing to a hypothesis. Bruner (1990) states that contemporary mental health care will fare better when it recognizes that its truths, like all truths about the human condition, are dependent upon and relevant to the point of view that it takes toward that condition. This is where mental health care

starts and (wherein it is) becomes inseparable from cultural sciences. In this case subjective experiences need to be explained, not to be explained away.

When it comes to subjectivity, we can conclude that the ambiguous and elaborate psychological and poetic concepts that correspond well with the ambiguous enigmatic human mind (Joranger, 2013, Innis, 2016a, 2016b) can never offer mental health care what physiology can offer the somatic area, that is, an abstract analytical tool that makes it possible to see and isolate the psychic problem in relation to the rest of the personality. Psychic life, opposed to organic life, involves a different organization, which manifests itself in extra-linguistic experience that moves beyond and between people. As my discussions suggest, human beings can never be reduced to solely nature (in other words, the brain and physical body), because our uniquely reflexive and existential constitution as mind/body (cf. Joranger, 2014) is continually shaped and changed by history and sociocultural contexts. As long as we are dealing with persons in everyday life, there exists no fixed relationship between objective features of situations and responses and their meaning for the persons involved. This applies to mental health care workers and to researchers, as well as everyone else.

Our course of action and way of being is affected not only by the classifications of societies and academics, but also by our own conceptions of and reactions to such classifications. This understanding reflects a life of immersion in available sociocultural practices, but it also is based on the inevitably somewhat unique set of experiences of any thinking individual. As Jaspers (1951, [1913]1997) claims, environment fosters and nourishes situations. Although we are not totally free, situations provide the actors, whether they are mental health care workers, therapists, service users, parents, children, etc. with opportunities, which they may make use of or waste, or through which they may reach decisions. To grasp a situation is the first step to mastering it instead of being mastered by it.

Viewed in this way, scientists and mental health care workers dealing with human beings with different political and socioeconomic status and with different life situations will fare better when they recognize that their methods and truths, like all methods and truths about the human mind and condition, are relative to the point of view that it takes toward these conditions. This is where mental health care issues start and where mental health care issues are inseparable from intellectual history, anthropology, and the other cultural and social sciences. If we agree that a person is distributed uniquely in manifold contexts, that is, a product of 'strife' between individual experiences, nature, and the sociocultural world of others, we have to search everywhere to find where a person really is (cf. Smedslund, 2012).

We have, accordingly, to establish an interdisciplinary gaze that can go from the individual to the sociocultural, from the physical body to the specific mind, from the rational and logical to the unique and general, from a specific situation to a broader historical and global overview. My appeal can be related to C. P. Snow's still relevant 1959 essay *The Two Cultures* (1959). According to Snow, the intellectual life of Western society is divided into two cultures. We are

stranded between the nomothetic and idiographic sciences, that is, between natural sciences and the humanities. To Snow, this is a major hindrance to solving the world's problems, and to finding the person where the person is.

Snow (1959) is right that the natural sciences and the humanistic sciences over the years not only have diverged, but also developed a tension in relation to each other. If the scientists are in favor of social reform and progress through science and technology, then the humanists are backward looking in their understanding of development. Snow's intention is not to force potential physicists to read a bit of Dickens or to force potential humanists to conjure up some basic theorems (Joranger, 2015). Instead, he encourages the growth of the intellectual bilingualism and the capacity to attend to and learn from, and eventually contribute to, wider cultural conversations. This involves not only understanding how one's own special area of study fits into a larger cultural whole, but also a recognition that interdisciplinary questions which include the investigation of ideas in a broader historical context should become part of a professional achievement in the given field. In sum, the most effective way to reach an understanding of a person is to confront different sciences with a rival consciousness, in the sense of rival knowledge areas and rival experiences that can sharpen and open up the gaze concerning psychological phenomena, thereby doing greater justice to the irreducible side of the person.

I think we can conclude that there are external facts and that we can say what they are. What we cannot say, because it makes no sense, is that these facts are *independent* of all conceptual choices (cf. Putnam, 1987). In the course of our development a good deal of what is sociocultural is incorporated into both our pre-reflexive, intentional action and the more advanced reflexive consciousness that emerges as development unfolds (cf. Jaspers, [1913]1997). We cannot therefore understand human life merely in terms of individual subjects, who frame representations about and respond to others, because a great deal of human action happens only insofar as the agent understands and constitutes himself or herself as an integral part of a 'we.' Much of our understanding of the self, society, and world is carried in practices that consist of dialogical action.

Dialogical actions and the encounters of and with rival consciousnesses are unpredictable and will cause new and unexpected experiences. By using dialogical actions and different knowledge areas to clarify and sharpen our different arguments on how to approach the human mind, one can reach the best possible approach to human beings without losing the most essential part of it. Experience, as a concept and question, models future action. Science helps us understand that culture and dialogue is what we have made to change ourselves. Neuroscience in particular can take the effects of challenging art, or the under-determined stimulus of triangles and disks moving in a black-and-white film, as exemplary of how the common is measured, stretched, stitched, and shared. How we might evolve differently, pressured by our own shortsighted and long-term disasters to tune ourselves more attentively to the social resonances rather than the predatory selfishness in our 'nature,' will be up to culture. Art, which

includes metaphorical concepts and poetry, is the kind of modeling that can effect the change (Innis, 1985).

There is an art in communicating the relevant aspects of experiences that are not shared, or in emphasizing the experiences that are common and de-emphasizing the others. Through their different works Machiavelli, Jaspers, and Foucault demonstrate this mastery of this art. The ability to imaginatively employ metaphor is a valuable quality if one wants to create sympathy and communicate experience that is not shared. When it is necessary, as in Machiavelli's, Jaspers's, and Foucault's cases, one must negotiate meaning; one slowly discovers what is shared, what one can safely talk about, and how one can pass on unshared experiences in order to create a shared understanding. With the sufficient flexibility to alter one's worldview, and with luck, skill, and goodwill, it is possible to reach a common understanding.

Toward an interdisciplinary approach to the human mind

As regards my discussions and conclusions, I believe it is time to introduce an interdisciplinary revolution in mental health care services and in social work, as well as in mental health care research, such as the frameworks of psychology within which it conducts its investigations. If meaning and consciousness shall continue to be the central theme in mental health care services as well as research, researchers and welfare workers dealing with the subject matter would need to join forces with the interpretive disciplines in the humanities and in the social sciences. Meaning, in the interpretive disciplines, is not something determined by innate biological drives nor solely created in the individual mind. Rather, to speak of meaning, one must include the concepts of 'culture,' 'history,' and 'living in the world with others,' which represent the three key concepts in European existential-phenomenological thought, as well as in critical, social, and cultural psychological thought.

I have drawn so much attention to the interdisciplinary Renaissance knowledge areas in order to offer a background adequate to the forces threatening our individual psychic welfare and our own civilization. Our time and its consciousness are in many ways like those of the Renaissance, as we imagine it. Now, as then, there is opportunity in the midst of falling apart to re-vision our way of thinking about the human mind. Especially, we have the opportunity to re-vision mental health care services so that it can offer understanding and shape to the chaos of the Western human being's teeming underside. This area of knowledge has long been cursed by the one-dimensional vision of monotheistic consciousness, so that the unpredictable, adaptive, and flexible human mind is merged into a single mammoth figure, the Devil. For what happens to our culture happens to and in our individual fantasies and images, whether we moralize and repress them, diagnose and imprison them, exploit and betray them, drug and manipulate our fantasies. The mind of our civilization depends upon the civilization of our mind. The imagination our culture calls for is a culture of the imagination.

We shall have to build a new imaginal arena for the human mind, new imaginal circuses for the crowd of persons and theaters for the images, new imaginal processions for the driving mythical fantasies that now overrun us, racing through our night on psychopathic motorcycles. Human beings from the Renaissance, the shadow, must be met in this human's style, in the human territory. But now as consciousness disintegrates into many modes of envisioning, its shadow too differentiates into multiple images. As happened during the Renaissance, we are discovering that concealed in the shadow are the old Gods. To recognize these imaginal powers and to find a precise, intelligent, and cultural way of providing for them – 'or not to be – that is the question.' Discern or perish, wrote Nietzsche (Nietzsche, [1878]2009, § 237, [1895]1972, §61). To begin that discerning of the images on which our survival may depend, I have been sinking a taproot into a tradition which offers our native polyphony of voices an interdisciplinary alternative.

A closer look at the history of mental health care reveals that there are few fixed, essentialist categories to be found in the various, ongoing, dynamic processes of interaction between sociocultural practices and individual actors, but that meaningful distinctions still can be made. Throughout the book, I have shown that it is in this never-ending sociocultural interaction that all individuals, be the service user or be it the mental health care worker, are lodged. However, as living beings, we are not just physical brains or marionettes in a reasonable sociocultural-historical development; rather, we are creative, reflexive actors who have an impact on cultural and scientific norms, which we also, consciously and unconsciously, adapt. This is why mental health care workers and scientists dealing with psychological phenomena should not only seek to become a positivist Sherlock Holmes, intelligently discerning the concealed and buried meaning that is awaiting discovery, but in contrast, the detective who finds him/herself part of the game and thereby a co-creator of the mystery she/he seeks to solve. To Goethe (1998, pp. 45–46):

We are well enough aware that some skill, some ability, usually predominates in the character of each human being. This leads necessarily to one-sided thinking since man knows the world only through himself, and thus has the naïve arrogance to believe that the world is constructed by him and for his sake. It follows that he put his special skills in the foreground, while seeking to reject those he lacks, to banish them from his own totality. As a correction, he need to develop all the manifestations of human character – sensuality and reason, imagination and common sense – into a coherent whole, so matter which quality predominate in him. If he fails to do so, he will labour on under his painful limitations without ever understanding why he has so many stubborn enemies, why he sometimes meets even himself as an enemy.

As long as we believe that an objective research and an objective knowledge of the human being can be reached and come true by following certain rules, this

will necessitate first of all a realization on our part of how our perceptions are caused by the actions of things upon us. It will also require an understanding that the same properties causing perceptions in us also have effects on other things and therefore must be detachable from their perspectival appearance (Nagel, 1986). However, as nature and things have few straight lines in space, so they have few predictable happenings in time. History has shown that things just happen without rhyme or reason, but we must manage them with rhyme or reason, for both methods are all we have to manage things, that is, the methods of making literary and theoretical sense or logical sense of things around us that affect and determine our perceptions. We love to make logical sense of human thoughts and behavior and we would have loved to manage nature, things that just happen, by law. This is why we keep trying to find laws in everything that we see and experience. If we could just accept that things just happen without rhyme or reason, we could make a science that is both coherent and open, a link (coherent and open) that seems to be an embarrassment in current mainstream science and mental health praxis.

Watching events, we come to realize that ‘randomized experiments’ constantly happen to make up life. They are quite inconceivable, often tragically unspoken. Young Ann Frank wrote in her diary, “I still believe people are basically good,” as she perished by people’s hands in Auschwitz. Such tragic incongruity is unthinkable until told as a broader life history. Life has many tragic Auschwitizes so unspeakable and so persistently repeated in so many lands, so often in the history of the world. Viktor Frankl’s loss of all his family in Auschwitz produces his ‘search for meaning’ that heals people. Many Socrateses and Jesuses encountered similar fates, part of the great configuration of sad events that make up the matrices of our lives, all again seemingly without rhyme or reason. We have no way of making sense of them until hearing their everyday life stories that give them rhyme and make it possible for us to sense their reason. In deep sighs, we appreciate that such is life.

I would venture to assert that the biggest threat to truth concerning human beings and mental health care is exclusive and systematic recognition of a single knowledge area or a single worldview (cf. Watson, 1913). This is a point that perhaps deserves special emphasis within that portion of contemporary society overly influenced by certain ideas of self/personal development and psychotherapeutic change that place a strong emphasis on psychological empathy. This empathy seems to be constructed as the idea that significant, authentic forms of self-understanding may be fostered by others’ (e.g., psychotherapists, friends, coaches, colleges, spouses, etc.) attempts to adapt the ‘worldviews’ of individuals as a means of assisting those individuals to better understand themselves (Brinkmann, 2011; Madsen, 2011). From the perspective advanced herein, any possible value of psychological empathy for fostering genuine self-understanding will not be realized unless such empathy is joined with a kind of supportive, yet also critical, interpretative intersubjectivity that asks individuals to take seriously other worldviews and as a result of such genuine consideration to elaborate, develop, and better understand their own theories of the self and world in a more

authentic manner (cf. Jaspers, [1913]1997; Kvale, 1992; Martin & Sugarman, 1999; Sartre, [1943]2003; Shweder, 1991; Shweder & Sullivan, 1993).

Based on the discussions that have been charted in this book, I think we can conclude that human consciousness is primarily linguistically defined and mediated by symbols (see also Innis, 1994). Opposed to physical sciences, which seek pure, basic, or eternal laws, like generalizations about a small number of abstract objects or forces whose interrelations can be stated in quantitative mathematic form, sciences studying things that have meaning for meaning-imposing human beings cannot escape the involvement with the semiotic sciences (e.g., linguistics, social and personality psychology, cultural anthropology, history, etc.). The issue of meaning and existence is given in language and must be worked out in language. The productive power of language and concepts shows that the type of language and concepts we use to explain/understand a system, a government, or a person's inner feeling and consciousness will be crucial for how we approach and understand this system or this person (Joranger, 2013).

In this book I have tried to show how sociocultural contexts preexist and push us to think and use concepts and language along certain lines. We are thrown into sociocultural-historical relations at birth and compelled to engage with others simply to survive. As embodied agents, the ways in which we (the service user and mental health care worker) learn to think and behave, in the context of development, are largely expressions of our immersion and participation in sociocultural contexts, such as the public mental health care context.

However, as embodied biological beings, we must deal with existential needs and contexts that are physical and biological as well as sociocultural (cf. Binswanger, 2004; Foucault, 1954; Jaspers, [1913]1997; Merleau-Ponty, [1945]2002; Sartre, [1943]2003). The existential basis of every human being, be it the service user or be it the mental health care worker, lies in the fundamental human condition of activity, consisting in a charge to act and in the capacity of embodied agents to execute this charge. Still, while sociocultural contexts shape the expression of human action, they do not create it. Institutional and sociocultural conventions and practices rely on the action of the individual (be it the service user and the mental health care worker) within them for their influence on the development of human psychology. This is not just to make the claim that social phenomena can be discerned and made manifest as real. The social exists as a field of possibilities and constraints structured by human agents in their practices and participations.

On a number of levels, intimate and public language itself serves to set up spaces of common action. This means that our identity is never simply defined in terms of our individual properties. It also places us in some social spaces that never will be fulfilled as long as there are humans involved (Joranger, 2014). However, to avoid tumbling into a strong relativism and nihilism associated with the subjectivism of modern life (cf. Nietzsche, [1895]1972, [1878]2009), our interaction with incomplete institutional and sociocultural contexts requires a particular kind of ethical, critical attitude and commitment to understanding through interdisciplinary dialogical activity and exchange.

With this assumption in mind, I will end this book with an appeal to those who concern themselves with human beings and the relation between subjectivity, science, and experiences in change, to arrange for an interdisciplinary collaboration, which also includes humanistic disciplines such as (intellectual) history. The particular research strategies and sensitivities of the historian could enhance the understanding of sociocultural psychological phenomena, such as meaning and subjectivity, in both the past and present. Particularly useful would be the historian's sensitivity to causal sequences over time. According to Gergen (1973), most social psychological research focuses on minute segments of ongoing processes. Gergen (1973, p. 319) states that social psychological research concentrated very little on the function of these segments within their historical context: "We have little theory dealing with the interrelation of events over extended periods." Similarly, (intellectual) historians could benefit from the more rigorous methodologies employed by the social and cultural psychologist as well as his/her particular sensitivity to psychological variables.

However, the study of history should be undertaken in the broadest possible framework. Political, economic, institutional, and global factors are all necessary inputs to understanding in an integrated way (jf. Walsh et al., 2014). This requires us to stand at the border of our own area of knowledge, asking critical questions and philosophizing about its (the knowledge area's) properties and coherence. It requires that we search for the extent to which a given explanation adds to the vocabularies of cultural and historical understanding. It also requires that we ask questions about how particular conceptions of mental life came into being, and what role they have played in cultural life. For example, is it really so that the production of a mental health care *episteme* cannot be detached from political disciplinary power mechanisms, both because these power mechanisms make possible and bring about the production of truth, and because the production of truth itself has the power to bring the mental health care *episteme* together in a specific worldview? Such sociocultural and historical analyses are pivotal in casting light on the function played by conceptions of the human being within Western culture today, while they can also open our eyes to what is good and bad in our way of thinking about what it is to be human in everyday life and even beyond.

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