To Become Ill on Life's Way

Possibilities of Philosophical Practice in Health Care and Mental Health Nursing*

By Anders Lindseth

Content:

A doctor can sometimes treat and cure, often relieve, but always console. The legendary Greek physician Hippocrates (approx. 460-370 BC) is supposed to have said this. For modern man this may sound as if consolation would just be an emergency solution; something the doctor can always fall back to if the treatment is not effective. However, there is reason to believe that Hippocrates did not mean it like that but rather wanted to stress consolation as the most important thing. He probably wanted to emphasize that consolation comes first, that the doctor can always console, that he can quite often relieve the patients' pains and that he can sometimes contribute to healing. He wanted to remind us that consolation is a prerequisite for treatment and not just a poor substitute.

In ancient times, a doctor was not the same as today, – after all, modern medicine had not been invented yet a long time. Today, we might see the Hippocratic physician as a naturopath. But Hippocrates was known for his unemotional view of illness, suffering and the medical profession. He distanced himself from the popular magical-religious conceptions of human health and understood disease philosophically as imbalance of the humors (blood, phlegm, black bile, yellow bile). Especially because of the ethics attributed to him, the doctors' Hippocratic ethics, he has been portrayed as a role model for today's physicians. But for the doctors in the Hippocratic tradition it was probably clearer and less controversial than for modern doctors that medical treatment means to assist the body's natural tendency to heal itself. And in this perspective we can

* Parts of this paper have been published in German, see Lindseth, 2010, and in Danish, see Lindseth, 2011. The paper has been translated from German to English by Patrick Neubauer.

understand more easily why consolation is of fundamental and perhaps even crucial importance for the doctor's actions: If the patient is inconsolable or in need of comfort, this means that he is so excited and unbalanced that the self-healing forces of the body are limited. It is clear that today's doctors have an important supportive role as well, together with nurses and health workers. And one can imagine that philosophers can also contribute to the health of humans. – We certainly do not find it easy today to see support and the philosophical dialogue as consolation. This may result from the fact that we do not understand consolation any longer as a balancing force in life but rather as an active, sometimes a bit presumptuous deed of people who are perhaps too benevolent.

What importance can Philosophical Practice have in the field of medical treatment and mental health? To answer this question I want to refer to the Greek idea of life as a dangerous way. I would like to understand Philosophical Practice as a reflection on our journey on life's way and try to clarify how we can proceed with this reflection. Based on that, I would like to discuss the challenges a Pilosophical Practitioner faces when meeting ill and suffering people, especially when it comes to mental suffering. I would like to point out that it is philosophy here that is consoling and that it is important for the effect of this consolation that the experience of being ill is recognized as an important life experience. The philosopher has something in common with the doctors at the time of Hippocrates: participating in the other's expression of life and of suffering in an accommodating and comforting way. In our world it may be more obvious to see such participation as an obligation of the nurses, although in today's health care they too get dragged into a busy treating that tries to present itself as "health production".

Dialogical Method: Encounter, Space, Place, Inevitable Life Topics

The word "method" is ancient Greek: *methodos*. It consists of the words *hodos*, meaning "way", and *meta*, what is translated with to, over, above etc. A method is a meta-way, a *meta-hodos*, a *methodos*.

A topic of ancient Greek poetry, especially the one of Hesiod, was the idea that life is a dangerous way. Everybody wants to achieve happiness and a good life, but hardly anyone finds it. Most people are striving for short-term gains or for immediate pleasures, for praise, glory, honour, power and wealth. They are taking the broad way, the way which can be walked most easily. While walking the broad way, you do not realize at once that it does not lead to true happiness and to a good life. In the beginning, everything seems to be fine, but after a while you can start having the feeling that something is going wrong, that the way does not lead you to where you wanted to go and where you believed you would finally come to. By striving for pleasure, you rather become dependent than really satisfied. Honour and wealth do not guarantee good health, glory awakens envy in others, power can lead to conflicts, and money and possessions are not the same as human richness. After some time on the broad way, you can realize that there is danger ahead if you do not change direction. You reach a point where you can fear the worst, but at the same time this point on life's way is the ground for hope because now it has become possible to enter a better, a more constructive way of life. Especially when being in danger, new possibilities open up, and this ambivalent point on life's way, this place which represents a danger as well as a chance, has its own term in Greek: *krisis*. Of course, this is the same as our term crisis. Things can be pretty bad in a crisis, but there is also hope for being rescued. It is possible to over-

come a crisis. In Hesiod's perspective, a crisis can imply to leave the broad way and take a narrow one. This narrow way is characterized by the will to achieve long-terms goals and by the ability to endure all kinds of discomfort on the way towards these goals. That is why it is a difficult and burdensome way. It is the way only few people follow, and that is why it is a narrow way.

This topic, the difficult and burdensome way of life, is a crucial topic in Plato's philosophy. When he founds the Academy in 385 B.C., the model for all further institutions for higher education in the Western culture, his motive is to improve and to secure the way of life by means of a meta-way, a dialectical method which closer examines the way of life. For this dialectical way of reasoning, Plato used the term *methodos* – a term that until then had been completely unusual but that later in history and until today has become a crucial term in all kinds of activities, (cf. Ritter, 1980, pp. 1304f).

We cannot re-walk the way of life; we always have to go on. But we can in principle repeat the meta-way, the methodical trying out and arranging of the way of life, as often as we want to. "*Methodos* means 'A Way of Following'", Hans-Georg Gadamer (1993, p. 48) writes. That holds true for all methods – for methods of practical activities as well as for scientific methods. In the meta-position of reflecting and planning, we can put on trial an action or an activity and find out how to proceed; and we can do this again and again.

When taking a closer look at actions which are carried out by use of methods, that is with consideration and a plan, it becomes obvious that the methods can take very different forms. The most striking difference seems to be that some methods offer space and almost invite creation and the unexpected, whereas other methods precisely want to exclude that something new or unplanned occurs when carrying out the activity. The first kind of methods we may call "dialogical" and the second kind "monological". Production procedures are examples of monological methods that occur everywhere these days.

The method of Philosophical Practice has to be a dialogical one. Because such practice presupposes an encounter between a philosopher and a person visiting the philosopher, the first step on the way will be to make a good encounter possible. Therefore, the philosopher expresses through his attitude that the guest is welcome at his place. The philosopher usually (but not necessarily) welcomes the guest in the room of his Practice and always in a space of attention in which the guest is invited to express his or her matter of concern. Who enters the room of a philosopher must feel to be welcome – especially to express himself or herself. That is why I think it is natural to call the person *guest*. By doing so, I intend to emphasize that he or she has come with the hope to be accepted and that I open up my attention and receive him or her with the best I have. My attitude expresses a Welcome!, which shows that the other can enjoy the protection and the privilege of a guest. And this is what this person needs, because in the beginning (s)he cannot be sure that (s)he will be accepted with what (s)he expresses.

The philosopher demonstrates from the very beginning that the guest is welcome. When he enters the philosopher's room, it can be natural to offer him something to drink, a glass of water or a cup of tee. When the actual dialogue begins after that, the philosopher shows that he or she is now open to listen to what the guest has to say. Now it is important that the guest decides about the beginning. He plays the white pieces, says Achenbach (cf. 1984, p. 65) in an allusion to chess. The philosopher re-acts, he refers to the opening the guest chooses. That is why the philosopher does not start by asking for a problem. Such a question would already put the dialogue in-

to a frame which might easily limit it. The guest might feel asked to present a ”real” problem, a clearly expressed problem, a rather important problem, a problem which should then become the centre of discussion, and so on. But quite often it turns out that the first topic or issue of the guest is not the most important thing – regardless of whether it describes a problem or an experience, an event or a relationship. Something different and often less intended gains importance. That is why it is important for the philosopher not to begin with asking for a problem or with taking an order what the guest wants to talk about. The philosopher rather begins with an invitation: a sign that the guest can decide to express whatever he wants. For me, that is a principle of beginning a dialogue in the Philosophical Practice. But it is not a strict rule. Sometimes a philosopher can have a reason to ask for a problem or to take an ”order”. If the guest already remarks in the first contact that he has got a problem which needs clarification, then it might sometimes be unnatural not to focus on it. It is not only important what the philosopher does but even more what attitude he takes.

We know from our own experience what this attitude is about. We have all had the experience that we met or even visited a human being whom we wanted to tell something, but then it became clear that he was not open for what we had to say. Then we do not want to open up anymore. In case it is nothing personal we would like to talk about it will usually be rather easy to accept the other’s lack of receptivity, but in case we have something really important to say we might feel it as insulting when we are not listened to. Maybe the other has tried his best to listen to us so that we have started to express ourselves, but then we realize that we do not really reach him or her with what we have to say. Then we feel hurt; we feel rejected.

We have also all had the opposite experience: we are listened to, with openness and attention for what we try to express. We encounter a human being who is interested in listening to what we have to say, and therefore it is easy for us to speak. We are invited into a space of attention in which our expression finds its voice. There, we find words for what we want to say, often striking or even surprising words. We find an open ear and thus listen to ourselves. That can mean that only then we realize what we are saying, that we realize what we are truly troubled with. Life which finds an expression in what has been said gains a new option to re-shape itself in the dialogue. Perhaps we say something we have already said before, maybe even many times. Then, we know what we say. However, we might know it *all too good*. We are actually finished before we even said it. ”However, when words meet an attentive listener, something happens. They gain a new relevance” (Svare, 2002, p. 115).[1] We listen to them in a new way. We are somewhat infected by the listener’s attention who listens to what has been said *as something new*. ”Suddenly, what has been said appears with the quality of something new. This might explain what often happens in such a dialogue, namely that both partners afterwards have a better mood than before. And this is not only because something important was touched in the dialogue but rather because one has entered a movement in which life forces have been set free. One feels livened up. This is quite the opposite of a process where you try to put what has been said into a frame of systematic theoretical knowledge, such as medicine, sociology or psychology” (Svare, 2002, p.115).

Experiencing a space of attention, which can open up or close down when encountering a receptive or an unreceptive dialogue partner, is a fundamental human experience. In this encounter, which takes place in the space of the dialogue, life gets its shape. The encounter means help or obstacle for orientation on our way of life. We try to express ourselves, we dare to enter such an

[1] Here, I quote myself from a talk in Norwegian with Helge Svare in the journal *Samtiden.*

expression and we experience how exposed we are to the acceptance of the other, especially of those who are close to us. In this process, important conditions are shaped which make our life a happy or an unhappy one. Thus, it is an ethical demand to every one of us to accept the life expression of him who dares to express himself. K. E. Løgstrup (1997, pp. 17f) puts it the following way: ”Regardless of how varied the communication between persons may be, it always involves the risk of one person daring to lay him or herself open to the other in the hope of a response. This is the essence of communication and it is the fundamental phenomenon of ethical life. Therefore, a consciousness of the resultant demand is not dependent upon a revelation, in the theological sense of the word, nor is the demand based on a more or less conscious agreement between the persons with respect to what would be mutually beneficial.” The ethical demand the philosopher has to face is due to the vulnerable expressing-himself (or -herself) of the guest.

When life is at stake in a fundamental sense, each of us is confronted with the urgent question of how to take in the expression of the other. In many dialogues in different contexts of life it does not become obvious that so much is at stake. But in different contexts, in which the individual realizes in the encounter that he is ”holding a part of the other’s life in his own hands”,[2] we cannot escape from the ethical demand which is given in and by the encounter itself. How then can we open up the space of attention in which the other is listened to and can listen to himself? This is the crucial question for Philosophical Practitioners. In other relations, it might be better to do something practical. However, I think that it is difficult to take in an expression of life which dares itself towards an encounter without allowing oneself to be touched and moved by this expression. And it is this readiness to be touched which opens up the space of attention and which allows the movement of life to develop new energies.

I would like to try to describe the proceeding in Philosophical Practice in form of some methodical steps:

Epoché

The Philosophical Practitioner opens up the space of attention by refraining from knowing in advance what the expression of his guest is or could be about.

But what are we actually doing when we refrain from knowing things in advance? The ancient sceptics recommended refraining from knowing things with certainty. If we try to find out exactly what life is about, we do not find peace of mind. To let go off such certainty and exactness, that is *epoché*. Edmund Husserl took over this term and used it for naming a decisive element or a step in his phenomenological method: If we want to find out the fundamental meaning of phenomena, we first have to put *into brackets* the given opinions about the phenomenon. We have to refrain from using these. [3]

We refrain from knowing at once that the guest talks about a problem he would like to see solved. We also refrain from knowing in advance that the guest is talking about his desires or about his illness or about something else which can be fit into a field of knowledge we are experts in. Refraining from that does not mean giving up all knowledge. We should rather talk about a change of attitude. Instead of confronting the guest with the knowledge we already have, we rather take in what he expresses. We are prepared to let the expression of the guest leave an impression

[2] ”Den enkelte har aldrig med et andet menneske at gøre uden at han holder noget af dets liv i sin hånd“ (Løgstrup, 1956, p. 25).

[3] In my attempts of describing the method of Philosophical Practice, I largely follow the steps of the phenomenological method. On the topic of method in Philosophical Practice, see also Lindseth, 2005, pp. 67-79.

on us, being unprotected, without seeking refuge in a field of knowledge we are feeling save in. We do not reject fields of knowledge, we rather do without their protection in our direct encounter with the guest. This is something he feels. If we encounter the guest with openness and receptivity, a space of attention opens up, in which the guest's expression can find its voice and in which the guest finds orientation within his narration. If we instead confront the guest with our readiness to classify what has been said into categories, explanations and models, this space is closed – or remains closed. Then expression is reduced to information, which can or cannot be useful for the counsellor or helper. It then has become clear that the guest who is looking for advice and help is less competent to understand what has been said than the helper or counsellor. In Philosophical Practice, the expression would then no longer be an expression of his life which the guest can identify with, instead, the guest would rather be reduced to a carrier of information or even declared incapable to manage his own affairs. A dialogue community, in which the guest and the philosopher can meet to discuss their experiences – especially those of the guest – is subjected to a system demanding correctness and then collapses. A system has already colonialized the life-world.

Thus, we manage the first step of our method – refraining from knowing in advance – by allowing the guest's expression to leave an impression on us. This impression has an effect on the expression – not as a result of an active, controlling impulse but rather in the form of an invitation.[4] Only through taking in the impression, the expression can dare to become an expression of the guest's life. Only the impression constitutes the expression as an expression of life. This is something we can achieve in our relation through physical expression. That is why we cannot always decide for letting an expression make an impression on us; we have no instrumental control over our readiness for taking in impressions. Again, this is something we all have experienced already: Somebody might like to listen to what we have to say but then proves not to be receptive for what we would have liked to be said. And so we do not really get a grasp of our own concern. Sometimes we can realize somebody's lack of receptivity even before he has said a word, and therefore we do not even start to express ourselves. The readiness to let an expression make an impression on us is not subject to a conscious decision but rather presents itself as an attitude embedded in our bodies. That is why we can sense a lack of receptivity even before the other person has said a word. Our bodies "read" each other, without words and writing, and with the right sensitivity, they can see whether the space of attention is open or closed.

A lack of will or ability for letting an expression make an impression can have several reasons. Sometimes it are personal affairs which are closing down: burdensome experiences, emotional traumata, prejudices, lack of interest, insensitivity, stress or something the like. In other cases, a systematic knowledge seduces us to set the conditions of the encounter in such a way that receptivity is limited or blocked, in spite of all declarations of openness and helpfulness.

What can we as Philosophical Practitioners do in order to develop an open and receptive attitude towards our guests? There are no solid methods we can lean back to, there is no "quality control" guaranteeing the expression to make an impression. But through experience we realize that we can rely on our receptivity. Being open is nothing complicated. It is something natural we do not have to learn in a seminar. And still it can be shut down all too easily. Inexperienced practitioners can be tied down by anxiety: Will we "manage" the case? What is helpful here is gaining experience through a good training programme, which includes sample lessons, supervision of one's

[4] Such an effect is *structive*, not *causal*. Cf. Falter, 2005, and Lindseth, 2008a.

own practice, and especially through encountering the guests. We then realize how enriching the practice dialogues can be. With the guest's openness we get a gift which we can only receive through our own openness. However, this is also a challenge. Sometimes we feel that a certain topic can make us uneasy. Then it can be helpful to visit a practitioner ourselves in whom we have trust in order to express our unrest so that our own impression can become clearer and more explicit.

Eidetic Reduction

We lead back (Latin: *reducere* = to lead back) the guest's expression to a place which can appear as an image (Greek: *eidos* = image, appearance, form) in our impression.

In Husserl's phenomenology, *epoché* does only make sense in connection with *eidetic reduction*. The demand to refrain from knowing in advance what a phenomenon is has its reason in allowing it to show itself in greater vividness, so that we can examine better what the phenomenon essentially is about. *Epoché* becomes a condition of *eidetic reduction*, of the greater vividness in the phenomenon's appearance.

This corresponds to Philosophical Practice. If we refrain from knowing in advance what the guest's expression is all about by allowing the guest's expression to make an impression on us – unprotected by some kind of previous knowledge, so to speak – , we are doing so in order to allow the guest's narration and his fundamental topics appear more vivid and better to experience.

When the guest's expression can make an impression, something fundamental happens (just as we have described it in the first step of the method): A space of attention opens up, in which what has been said can show itself with greater clarity. It is as if speech was invited into this space so that what has been said gains a clearer form and a clearer shape. Then the guest can listen to himself in a more conscious way. This implies the option to find a new orientation in what he himself has said. It is as if the space of attention creates a *place* which allows orientation.

That the dialogue gains the character of a place is an experience from our dialogues in Philosophical Practice, (cf. Lindseth, 2008b). We see in front of us what the guest narrates. In our consciousness, images of what has been said are created – clear or unclear impressions of events or connections –, a kind of "landscapes". Such vividness might well be explained as result of a strong imagination; just as we can see in front of us what happens in a novel. But what we experience in such a vividness has its origin not only in ourselves. We experience to become familiar with a place which we can explore together with our guest. We feel what the guest's narration is about, and in our dialogue we can find the words which make appear more clearly the world in which the guest lives and out of which he speaks. As Philosophical Practitioners, we orientate ourselves by this place created through the dialogue, and in it the guest gets the possibility of orientating himself anew. The guest starts to see his life in a new light.

Even in the time between the dialogues we realize that the process of orientation continues. For instance, I can wake up the day after the initial dialogue, can take a shower and then I suddenly see an arm movement in front of my inner eye, or a view, and I start laughing out loud and say: exactly! What it was that has become clear to me I might not be able to describe exactly. But my readiness to further explore the place that exists in the dialogues has increased. So I often have the impression that I really get going only in my second session with a guest. And when the guest returns, I do not have to make an effort to recall what he had said because I feel like being at the same place again as the last time and can recognize again what it is about. That does not mean that everything has become visible. To stay within the metaphor of the place: I might see a way

and a junction, with houses along the way, but I can only guess what is behind the corner. Now it requires time to find out what is at stake in the dialogues with my guest.

Therapists, especially when they are inexperienced, often make the mistake of wanting to know too soon what the client or patient talks about. Here, there is a high danger that the space of attention does not open up in which a place could be created which allows to find orientation in life. The danger is a double one: On the one hand, the therapist can be so involved in his own understanding that he overhears what has been said. And on the other hand, the client or patient loses the option to find himself in his own narration.

We become familiar – with natural places and with places created within a dialogue or an activity; but that does not imply that the places are experienced as well-known and safe. The reality we are familiar with and which we relate to can be enigmatic, strange, unpleasant or discomforting. What is crucial however, is that we know this reality from within our experience. Only in experiencing this reality it can find its expression. Without such an expression and such experiencing, the world would mean nothing to us. We then would have no world at all. The world enters our consciousness in an original dialogue and an original familiarity. Familiarity is here a connection with the world, an experiencing participation in the world. Thus, in experiencing the world we are inwardly connected to her. We are participating without distance. That is why it often feels like a confirmation of something we already "knew before" when we gain distance and can clearly see certain connections. We can experience the connection as natural or as unnatural, as self-evident or as surprising, as good or as bad – but if we find it understandable, then we experience that a familiarity, a feeling or a suspicion was confirmed. Without such a feeling of the world, it would not be understandable; it would mean nothing to us.

Thus, the familiarity I am talking of is the foundation of our understanding. Our participation in it is given to us before words, before concepts, before all identified images, sounds, smells, tastes, feeling or sensations of pressure, gravity, balance and so on. But at the same time that what we are familiar with is nothing different from what we understand. The received does not stand in just an outer relation to the understood. Our familiarity with the world carries our relation to it *from within*.

As Philosophical Practitioner, I experience an inner connection with the guest's life expression already in the first encounter. I can even say that some familiarity with his life expression as a whole is present. However, I also experience that I do not have an equally good contact to everything. Maybe a lot is still waiting "behind the corner" (to stay within the metaphor of the place). And my understanding of the perceived can be tentative, incomplete, weak. Here, the dialogue has to become a process in which a life's narration can unfold. In this process, previous knowledge of all kind can be either helpful or an obstacle. Especially so-called scientific knowledge about the guest's experiences or reactions, about his personality, his role patterns and so on can be an obstacle, precisely because it is "correct" (or is expected to be correct). This correctness can tempt me to know "all too well" what an expression is about, so that the expression of the guest no longer makes an impression on me – so that I close down the space of attention and prevent a place from opening up in which the guest can find orientation on his way of life. Of course I can draw consequences too easily, but that does not have to be too dramatic as long as I do not stick to them and therefore become immovable in the encounter with the guest's expression. When I remain open for the movement of the experienced impression of the guest's expression, then the guest can get a decisive help to find his way out off different impressions he himself has struggled with to find their expressions. With that, the guest will be able to make important experien-

ces. A familiarity with the world (which might be inadequate or alarming) will be clarified and will be put into greater correspondence with the guest's life expression. A movement of experience will take place, so that the guest will better find his own place in the journey through his life. But such a development is not simple and not without complications, because the guest (together with the philosopher) has to take in the *inevitable topic of life* which will unfold in the dialogue. – Thus, I have come to the third and final "step" of the method I am trying to describe.

***Transcendental* Reduction**

We want to "lead back" the guest's expression to the issue or subject matter which is at stake: the inevitable topic of life we encounter in the place of the dialogue – and on the way of life.

According to the Norwegian philosopher Hans Skjervheim (1996, p. 71f), every dialogue is a threefold one: A person A is talking to another person B, but at the same time both have to refer to the *topic* the dialogue is about. Not only do A and B influence the course of the dialogue, also the topic does because both A and B have to do justice to it. If they do not, the dialogue easily becomes irrational. It can then be shaped by A's or B's arbitrary opinions. Or it becomes a twofold dialogue, because one partner chooses the other as the topic of the dialogue. This can happen when A thinks that B has said something awkward. This also happens within the health service when a patient addresses a medical expert to find out what his problem is. Then, the patient become as source of information in the first place, not a partner in a dialogue. Such twofold dialogues can be useful, but they are no dialogical process in which both partners try to do justice to the topic which is at stake.

The most simple case of a threefold dialogue is when two persons discuss a topic they are both interested in. But the dialogue between the guest and the philosopher is also a threefold one. The topic of this dialogue is only rarely given in advance. The guest's narration of his life and of his situation expresses a concern which is unclear at first and this therefore has to be clarified in the course of the dialogue. Thus, a topic of life is at stake which neither the guest nor the philosopher can define at his own will. That is why the dialogue has the character of an examination, an exploration of a familiar place and of a testing-out a way of life. But it is not an empirical examination in a scientific sense. This becomes clear from the following: When the guest or the philosopher thinks he knows what the issue or subject matter, the inevitable life topic of the dialogue is all about, then his understanding does not have the character of an explaining hypothesis, which can be falsified or verified by new events or new data. It rather is an insight which can express itself more or less appropriately.

Let us have a look at a (not really easy) example: A guest in my practice has told me how out of desperation and frustration she buys food which is suitable for vomiting and how she then prepares and eats the food – to experience a kind of satisfaction through vomiting. What now is at stake? In the language of science this is about bulimia, and we have empirical-scientific hypotheses (or theories) explaining bulimic behaviour. Such hypotheses (and theories) are uncertain by nature; the latest research may always modify or even reject them. If the guest however, understands that her bulimia has to do with a natural self-assertion which has been obstructed and therefore had to find an unusual outlet, this understanding is no hypothesis, but an insight.

Then the task is not to find empirical evidence which contributes to verifying or falsifying a hypothesis, but to find words and descriptions which capture the experience in an appropriate manner and thus give better orientation in life. You cannot talk about rejecting or accepting an insight after examining or testing it. Insights do not need verification (in form of positive empirical evi-

dence), and they also cannot be falsified (as result of negative empirical evidence). This does not mean that the wording of the insight is necessarily true. Sometimes it becomes obvious that the description of it is inappropriate or unfortunate, while in the case of a possible appropriateness, we do not feel the same certainty. This corresponds to the situation in empirical testing (within the frame of so called hypothetic deductive method), in which falsification is more certain than verification.[5] But when we realize that an insight has not found its best expression, then we realize it *from within*, out of the insight itself. It is not necessary to find proof which introduces elements to the argumentation *from outside*.

Sometimes we realize that something we have thought to be an insight is not really an insight. We were mistaken. We might have been subjected to an illusion, a prejudice, a seductive ideology, or maybe every once in a while to a mistaken perception. But when we realize that, *this* is an insight in itself. Insights are not necessarily true or infallible. They are interwoven in a felt contact with different topics which are at stake in the dialogue in Philosophical Practice, in activities, in lived experience. Outer proof can not lead to such a familiarity or connection with the world, with life's topics, with the issues which are at stake. And outer proof cannot contribute to the process in which familiarity reveals itself as expressed insight. In a certain way, all insight is "independent of experience" – in the sense that empirical data as positive or negative evidence cannot contribute to the insight, on the contrary: they presuppose insights. However, that means that the life's narration which is at stake in Philosophical Practice is *a priori*, not empirical (or *a posteriori*, "after experience, that is justified by knowing it better afterwards on the grounds of empirical proof).[6]

What can be examples for knowledge *a priori*? As I have defined (meaning: clarified) the term, a lot of knowledge, maybe most of the knowledge we rely on in life, is knowledge *a priori*. Empirical-scientific knowledge has less importance than we think. We might be impressed by empirical-scientific research results and by the technological opportunities opened up by them, but this knowledge alone does not enable us to lead a happy or good life.

First of all, mathematical knowledge is an example for knowledge *a priori*. Nobody can claim that 2+3=5 is a hypothesis which needs empirical evidence. Mathematical knowledge is not "evidence-based" in the same way as medical knowledge. It is characterized by a certitude and necessity which presents itself as a strictness and consequence we do not know from other fields of knowledge *a priori*. The knowledge of the human sciences, as far as they give orientation in life, is knowledge *a priori*. And the evidence this knowledge is based on is no empirical proof but rather the consistency and the persuasiveness of a flexible and clarifying insight which is rooted in lived experience.[7] Such evidence, such clarity is related to the evidence of mathematics, but it cannot be demonstrated in the form of well-ordered proofs which reconstruct the insight step by step. A hermeneutic approach to texts, activities and cultures and a phenomenological approach to life's phenomena are not axiomatic-deductive, but still they are knowledge *a priori* in the form of insights offering orientation in life. The insights I have tried to unfold and to develop in this

---

[5] Falsifications rely on the form of a valid logical inference, whereas verifications do not.

[6] I have tried to clarify above what I understand as *a priori* insight or *a priori* knowledge. It is *a priori,* "before experience", because it does not rely on empirical data. But of course it arises from lived experience. I am fully aware that many will think of this definition as going too far. But I would like to emphasize that this insight out of lived experience represents a foundation in life which rises and falls with our wisdom, not with empirical data. I will not deal any further with the extensive and terminologically complex discussion of *a priori* statements and *a priori* justifications (cf. Kompa, Nimtz & Suhm, 2009).

[7] On different forms of evidence cf. Martinsen & Eriksson, 2009.

essay are knowledge *a priori*: of the space of consciousness opening up in the dialogue – of the place appearing in this space – of our inner connection with the world through an original and sensual familiarity – of our insecure journey on life's way – and so on. And all insights into an inevitable life topic which appear and unfold themselves in the dialogues of Philosophical Practice are also *a priori* by nature.

There are numerous examples for an inevitable topic of life. It becomes inevitable in the connections life confronts us with. So it is not surprising that Marianne Walderhaug, who is employed as philosopher in the Bjørgvin prison in Bergen, always refers to certain topics in the dialogues with the inmates: What does it mean to lead a "normal life"? What is freedom about?

A topic which comes up again and again in my practice are the problems related to the fact that we want to live in a community and in intimate relationships whereas we want to preserve independence at the same time. Another, closely related topic is commitment and love. A topic which is of special interest for me is how to live in irreconcilability. We might have an irreconcilable relationship with other human beings, but also – and maybe above all – with ourselves – or with life. Irreconcilability can be understood as a movement away from a fundamental pain, a movement which cannot succeed and therefore starts circling around itself. In how many different ways can we remain circling – and thereby arrange ourselves with the irreconcilable? How do we draw others into our irreconciled and irreconcilable circling? What does it mean to find reconciliation? I finally believe that my own practice is about finding and enabling reconciliation.

My topic of reconciliation is (almost) never a direct and explicit topic in the dialogues of my practice. The same holds true for all other inevitable life topics which can show themselves. Implicitly, the topic might be present from the very beginning, but it needs time, often more time than the dialogues can offer, to make the topic explicit and clear – and to maybe bring it to an end or to fulfilment. A life topic first of all has to be expressed within a narration. In the dialogues of my practice, it appears again and again, and slowly an astonishment about implicit life topics can unfold itself. Where does such a topic live on the guest's way of life, and how does it become predominant there? Within this frame, when time is ripe and when the guest is open, the philosopher can illuminate the topic by introducing thoughts of philosophers, theologians, poets and scientists.

Thus, the method of Philosophical Practice shall not guarantee that a fixed goal will be achieved, it shall rather allow urgent life topics to be reflected upon. Such a reflection of inevitable life topics means finding one's own way of life and at the same time a becoming-conscious of the essentials of life. Clarifying these questions of life which are methodically addressed in all practice dialogues is a task for Philosophical Practice which reaches beyond every procedure. Such a clarification has to lead to a narrative or systematic expression of life topics.

Philosophical Practice in the Field of Medicine and Mental Health

If we get ill, this illness is an inevitable topic of life. But it is not certain that we want to reflect on this topic, how it affects us in our life experience. We do not have to deal with it. We can deny and repress the illness. But we can not conjure it away as a topic on our life's way. The illness will show itself, and the experience of being ill forces itself onto us. Thus, illness is an inevitable life topic. But we often need the help of the dialogue in order to deal with it. This applies mostly to the inevitable life topics.

Having a Disease or Being Ill

We like to distinguish between disease and being ill. The disease is a diagnosable condition, while being ill is rather a condition as we experience it. In English, there are different terms for these conditions: disease and illness. The latter we know from personal experience. We have all experienced being ill, but it is difficult to say what that is about. Apparently we mean by "disease" something objective, whereas "being ill" is something subjective. The following little story may illustrate in how far we see disease as something objective and measurable: A patient is about to be discharged from hospital, but an experienced nurse, due to her professional opinion, thinks that the patient is not well enough to be sent home. However, the lab results of this patient are not too bad, so his release is prepared. But then someone comes running from the lab, with a late result that is very bad. Thus, the patient has to remain in hospital for some more days. The clinical view which had realized that the patient was not well had been considered as subjective and without relevance.

That diseases are objective means that they can become a subject of empirical scientific research. They provide a platform for observations that can be arranged in a data matrix. Diseases are understood as variables belonging to a population of organisms, e.g. human beings. To make a diagnosis means to decide whether an individual has a certain disease variable and to determine an exact value of this variable. Here, the objective understanding of diseases claims validity: in the collection of data – to provide a diagnosis, or for the purpose of research on the disease. Next, an explanation of the disease is looked for: it might be a failure of a structural nature – a genetic, anatomical or other structural defect. Or it may be a malfunction. If we turn to psychiatry, where the concept of disease is even more problematic, it becomes difficult to assess the clinical pictures you see there as structural or functional defects. Here you might prefer to speak of behavioural disorders, which is also a central concept in psychology. Both in psychiatry as well as in somatic medicine one furthermore tries to find the underlying causes of failures and disorders.

What is a disease? In past times in our culture, we have seen a disease as disturbance of the natural order. Characteristic disorders were described and attributed to an essence which gave them a certain course: a beginning, a development and an end, which was quite often death. To the extent that modern medical practice developed and people began to observe the course of diseases systematically and to interfere with them by various forms of treatment, it could hardly be maintained any longer that diseases have a certain essence responsible for its effects. When taking a closer look, it turned out for instance that it was actually two diseases where one had thought it was only one, and so on. Recently (cf. Juul Jensen, 1986, p 227) it is stressed that one should rather speak of *types of diseases*, of which one can indeed provide a standard description but which remains open to a rather large variability, so that a certain type of disease can be expressed quite differently, depending on personal circumstances and other conditions. But although the old understanding of diseases which assumed certain essences has been overcome, one still is of the opinion that there is something objective which is effective and has its own development.

And what about the more subjective condition we all know: being ill? That is something we experience. Of course, we experience it as negative in the sense that we would rather not be ill. But we might also experience it as almost superfluous. We should have avoided to get ill. Sometimes it can be quite welcome, e.g. when we are getting a flu and can stay away from work for a few days. But if we experience something more painful or serious, we almost feel that this should not have happened. It might be an experience to be ill, but mostly we do not directly see it as an important experience in life. On the contrary: It is an experience that we should not have had. There

is almost a feeling that you should go to the doctor to deliver this experience and to be bothered by it no longer. The experience of being ill has no actual validity. It does not really count. This is what we express when we call it ”subjective.” If we tell the physician of our condition of being ill, he will probably be interested in what we say; whereas at the same time he will have to be careful, because our report is also a possible source of errors. Patients express themselves inaccurately and might convey impressions which lead the doctor onto the wrong track. A common psychosomatic thinking recognizes that the experience has some relevance for understanding a disease. If the patient is optimistic and if his life situation is good, the disease might be less severe than if he is depressed and very stressed. But still you think that the disease itself – this ”something“ that takes its course and is influenced by the subjective condition of the patient – is something objective. We must conclude from this that the experience of being ill as a life experience has no place in the medical understanding of disease. The experience of being ill is irrelevant here, because it says nothing about the disease itself. This experience remains "merely subjecttive" and almost invalid. So we are easily tempted not to take it seriously as an important life experience.

Friedrich Nietzsche has pointed out that in our culture we value exact knowledge very high but have only little esteem of living experience. With rhetorical brilliance he describes in the first section of his *On the Genealogy of Morals* how we have been fascinated by knowledge at all times. We were looking for knowledge but lost sight of ourselves. We have almost learned to look away from ourselves, away from our lives and our life experience. But sometimes the experience of life comes down upon us, whether we like it or not, like a clock whose strikes come suddenly and shake us awake from the proclaimed and traditional knowledge, and we begin to ask ourselves: What actually was it I just experienced? But even if we are shocked, we can not cope with the experience. It does not fit easily into the categories, schemes and models of knowledge.

»We are,« Nietzsche (1887/2007, p. 3) says, »unknown to ourselves, we knowers: and with good reason. We have never looked for ourselves, – so how are we ever supposed to *find* ourselves? How right is the saying: ”Where your treasure is, there will your heart be also“;[8] *our* treasure is where the hives of our knowledge are. As born winged-insects and intellectual honey-gatherers we are constantly making for them, concerned at heart with only one thing – to ”bring something home“. As far as the rest of life is concerned, the so-called ”experiences“, – who of us ever has enough seriousness for them? or enough time? I fear we have never really been ”with it“ in such matters: our heart is simply not in it – and not even our ear! On the contrary, like somebody divinely absent-minded and sunk in his own thoughts who, the twelve strokes of midday having just boomed into his ears, wakes with a start and wonders „What hour struck?“, sometimes we, too, *afterwards* rub our ears and ask, astonished, taken aback, ”What did we actually experience then?“ or even, ”Who *are* we, in fact?” and afterwards, as I said, we count all twelve reverberating strokes of our experience, of our life, of our *being* – oh! and lose count… We remain strange to ourselves out of necessity, we do not understand ourselves, we *must* confusedly mistake who we are, the motto[9] ”everyone is furthest from himself” applies to us for ever, – we are not ”knowers” when it comes to ourselves…«

Nietzsche points out an influential idea in our culture: namely that it should be possible to know exactly how the world is composed, or constructed, and thereby obtain power and control over

---

[8] The Gospel according to Matthew 6.21.

[9] ”Jeder ist sich selbst der Fernste“ is a reversal of the common German saying, ”Jeder ist sich selbst der Nächste“, ”Everyone is closest to himself“ i.e. ”Charity begins at home“.

life. But that is an idea that tempts us to believe in structural and causal knowledge in such a way that we abandon a knowledge that could give us orientation in life. We might think that 'evidence-based knowledge' (i.e. empirical knowledge based on external evidence) is so important that we (as is the case in Norway) have to build several knowledge centers for its preservation (which are independent of the established universities and colleges). But this knowledge is and will remain a tool for action. It is no knowledge for orientation meant to support the understanding of our own experiences. No one will deny that we can have objective knowledge of what we observe and measure, or that such knowledge can provide a theoretical understanding that is technically useful and important. But the biggest problem with this knowledge is that it contributes to disqualifying our living experience.

How Can We Understand the Experience of Being Ill?

We experience being ill. And we experience what effects that has. What meaning can this experience have in our lives? – Seen phenomenologically, the experience of being ill is one of many life experiences. Therefore, understanding the meaning of being ill is in its essence not different from understanding other life experiences, such as growing up, entering into relationships with others, falling in love, the pursuit of career, or whatever there may be. If we think of the experience of being ill, as we all know it, there are probably cases where it arrives suddenly, where it comes to us quite surprisingly and where it can be serious and dramatic. But often the illness comes not so suddenly. Often it is gradual. Before you have a diagnosable disease, you might have been plagued with something for many years, without anyone finding out what was missing. Or it could be that you live with an evil without really feeling it. You try to function ”as always”, maybe in top form, as if there were no problems at all. This is a complex picture. However, an illness always has a history. Even if it comes suddenly, something has happened before. Of course, it might be very difficult (if not impossible) to understand the illness in its context. The point is though that a life experience is always a historical experience. It does not present itself without context; it has a history, a development, and consequences. The experience of an illness is part of a life context; it is caused by events and actions which happened before, and it will shape the life afterwards.

If we want to understand the experience of being ill, it might be helpful to ask an unusual question: Who are *we*, making such an experience? An answer might be*: we are organisms taking in the world and ”digesting” it*, and thus participate in a life history. We are not purely biological beings, let alone machines with structural defects and malfunctions, but living beings that are set in motion by impressions, towards understanding and action. Problems occur since some of these impressions are pretty indigestible. And it seems obvious that our illness and our health depends on *what* we want to take in and to digest from this world, and on our *ability* to digest it.

But what now does it mean that we take in the world and digest it? First, we take in food. We are known to be ill if we eat something poisonous or something that harms the organism. Here, the dosage is crucial. Even poison may be healthy in very small doses, whereas even the healthiest foods can be harmful in too great amounts. However, we do not just take in food. We also breathe air, and we take in the world by the senses. How important this sensory perception can be for our health is described by Løgstrup (1987, pp. 87-94) in an article about architecture. We often think that it does not matter how our houses look like architecturally, if they only have the necessary functions. We think the most important thing is that the house has a kitchen, refrigerator, stove, microwave oven, bathroom, bedroom, sufficient space and television, and if there are many levels, then a lift. It might be a plus if the house is beautiful, but we believe the aesthetic to

be of minor importance for our well-being and our health. People must be particularly sensitive if they suffer from the looks of a house, as long as it is otherwise neat and functional. But here we deceive ourselves, Løgstrup says. The looks, the aesthetic mean far more for our well-being than we think. We can feel that immediately, perhaps best in Europe's larger cities. They have an old town center and a bunch of modern, functional buildings in the outskirts. Where do we go for a walk when we visit these cities? Of course in the old town center with its beautiful atmosphere, and not in the sterile suburbs. Here the purely functional architecture can almost insult our basic aesthetic sensations, so that we feel uncomfortable.

We therefore depend on taking in food (and to digest it) as well as air and a world which touches our senses. ”With our respiration and our metabolism, we are emplaced in the cycle of nature. With our senses, we are emplaced in the universe”, writes Løgstrup (1995, p. 1). But also what we understand is something we have to digest – and this can be strenuous. A particularly fundamental dimension of our understanding of the world, which lies somewhere between sensory perception and imagination, is taking in the affection that other people present us. How are we perceived? If we express ourselves in word and in deed, if we ”venture to be accepted”, how are we then received and recognized? Acceptance or rejection of others can be expressed in distinct ways, very positive as well as very violent and destructive, but it can also be very subtle. We can exclude each other in the most painful way from the ”good society”, without being rescued by anti-bullying programs at school and without society’s alarm bells starting to ring. In many ways we understand to make each other feel that we are probably not very important. And if we have not yet found inner anchorage and security in life, an accusation we experience can also turn into self-accusation. We feel that our existence is questioned. It is difficult to live with such doubt, which is essentially a doubt of our own justification to live (even if we do not want to see it like that). Such a doubt sets into motion what Løgstrup (1968, p 94) calls ”circulating thoughts and feelings.” If we could live in a world in which we were accepted immediately, life would probably be shaped by the unproblematic direct encounter of other human beings, by open give-and-take relationships, by a free exchange. But it's not that easy after all. If we turn to other people, we find that we do not recognize each other, that we are not accepted. Thus we are thrown back onto our own experience, not to be accepted, not to be recognized – and then we are circulating around this experience. Then our thoughts start rotating: What did he mean by saying that? Why has she looked at me in such a way? Why did I behave like that? Why could I not say something else? And so on. Consciousness is caught in something circulating. But the most fateful circles occur when we do not endure the pain of an experience, when we do not endure the feeling of shame related to one’s own worthlessness, and thus become shameless – and then shamelessly drag others into our unconscious circles.

This brings me to the next point, which is important for our health, for illness and health: our *ability* to take in the world, to ”digest” it, to cope with it. On the one hand, this ability is a very natural thing. We do not have to be trained to master the digestion of the world. It is something we are able to do from the moment we arise as living beings. In a way, we are the more secure the younger we are. But by and by problems arise with digesting this world. So even though we have a natural capacity for such digestion, it is something we must make our experience with, becoming more or less secure on the way. Among other things, it is the ability to live in natural rhythms. For example, we are awake, become tired in the evening and sleep at night. We also know from social relationships that life happens in natural rhythms. When we talk to another human being, the main task is to find the appropriate tone, to find a rhythm and to find into a relationship with the other. It's not just about sharing information, as one tends to think in this age of informa-

tion technology. Rather, the essential point is to find the right tone so that the dialogue opens up the channels which are important to us. It is true for any social life that it is about finding a rhythm and a tone. This is something social life has in common with biological life. It has room for a natural rhythm, which you can not resist without negative consequences. That is why life cannot be made more and more effective without limits. That seems to have been forgotten in health care, in these times of effectivity and quality control.

Our sense for natural rhythms is an ability to listen to the *signals* of nature. If you want to be effective and for example have to transmit only the necessary information, then these signals are not important. What you have dreamed of at night, what you feel when you get up in the morning, how you react to the person with whom you talk, how to find the right tone in the conversation – things like these are of minor importance. In the name of technological efficiency, we tend to ignore these signals. But by doing so, we do not give ourselves enough time to digest the world, and are therefore circulating. The ”thought-feelings, taking their unfree and circulating course” (Løgstrup, 1982, p.105) keep us trapped in an issue which can not be completed and which drags us along in its own dynamics. We lock us up into ourselves and are no longer open to the events of the moment. We are stuck in something ”undigested”, in ”left-overs” (Holen, 1981, p.51) of something that was and that the organism is struggling to cope with. In the centre of what is undigested lies a pain, an injury which can be very difficult to deal with. Meeting the feeling of having been hurt so that the left over expressions can be cleared up and the circulating can stop is a difficult thing.

Becoming ill is also experienced as humiliating. This is witnessed by language, e.g. in German where *krank* (ill) is related to *Kränkung* (humiliation). Being ill is a form of humiliation. That illness is a humiliation finds a clear expression in a rather archaic understanding of illness, where it is believed that an illness is caused by ”the evil eye” or that someone has imposed a curse on you. The offense is linked to someone humiliating you, which may make it easier to come to terms with the fate of being ill. Thus, the experience of being ill is *externalized*. It is removed from the life of the patient. It is linked to and explained by an external cause – a humiliating person, a witch, someone who has imposed a curse on you, someone who has thought badly of you. This way you can fix the bad *out there*.

One might now be tempted to claim that modern medicine has overcome all that. You do not think in such patterns anymore; that is progress. But on closer inspection it turns out that the modern understanding of disease, in which the disease is not understood and evaluated as a meaningful life experience but rather as a defect, expresses an even higher degree of externalization. Being humiliated by others is something we can experience; but a disease is placed outside of any meaningful and tangible life context. We do our best to see the root of evil ”out there”, in a cause outside of our life-world. And then the cause is no longer the witch or the sorcerer or the evil eye. These we could somehow integrate into our life-world. No, the cause is something really mysterious which is called ”disease” and which is expected to be diagnosed, fought, and defeated. This demonstrates that modern medicine is in a fight. It is no longer the fight against witchcraft, but the fight against the disease. And in this fight it can be very important not to deal too much with the illness as an experience, because this would require to be able to become sensitive, compassionate, and maybe desperate. However, if you want to fight you can not afford too many sensitive reactions. Then you have to know what to fight, and you have to prepare yourself – with shield and sword, so to speak – and attack that what is to be fought. Thus, therefore is a challenge to modern health care, especially to nursing, not to be swept away in this fight from one’s own

premises, but rather to step out of this process of externalization – in order to win back the experience of being ill as an important life experience. Then it is no longer about finding a ”cause” for the ”disease” but rather about something that is perhaps more important: to be questioning and searching in one’s own life as it presents itself to us anew in each moment.

Winning Back the Experience of Being Ill as an Important Life Experience

In Philosophical Practice, the experience of being ill is an inevitable topic just as other life topics, but at the same time it represents a particular challenge. The experience of being ill is incomprehensible to a large extent. This is not only because of modern medical thinking, which reduces the experience of being ill to a subjective and emotional reaction. It is also because the experience of being ill is about opaque processes of life. But at the same time we have much to say when we have become ill. We might be desperate, we might be aggressive, on the hunt for a ”solution”, or we might be more reconciled with our fate. We might have the hope that the illness is a crisis that will pass by; we might have to accept that we have to go on living with permanent restrictions because of the illness; or we must recognize that we are going to die in the near future, a little earlier than we might have imagined. In any case, the question of the meaning of life becomes relevant for us. Before we got ill, we may have had a theoretical relationship to this question. Being ill however, we experience a sense of life which is difficult to put into words. If the situation is serious, we may need to say goodbye or to settle practical matters. It may be important to achieve greater clarity in close relationships, to mark boundaries, to show love. We find ourselves in a life situation which one could not prepare for. This can be terrible. But it can also be seen as an essential experience. We recognize in another way what is going on in life, what is important, what is at stake in life.

If illness becomes a topic in Pilosophical Practice, it is about regaining the experience of being ill as an important life experience. Here there is a danger that we want to learn more than can be proven by the experience of being ill. We may have heard that grief results from experiencing loss, that stomach ulcers are caused by stress or bacteria, that cancer comes from the fact that feelings could never be expressed, and so on. However, such explanations are not helpful if they become conclusions – and because of that stop an astonishment and prevent us from really feeling what a restlessness says, what a sadness expresses, what an anxiety is about. In Pilosophical Practice, the challenge is to capture the wonder and the feeling. As a philosopher, I can not encourage simple explanations. Mostly it is not important to find clear answers to the questions raised by the illness. It is more important that the dialogue in which the experience of being ill is expressed can be kept open. Because then it is possible to complete an internal flight movement away from a stressful experience, which we carry with us, away from a difficult life issue, away from a life of pain.

If we ask ourselves what this pain of life is about, we can get into contact with a feeling of worthlessness, of shame, the feeling of being rejected, of not to be loved. We may not really know where this feeling comes from. We might have experienced contempt in life, undervaluation, rejection, humiliation, but the feeling might now appear to us as ”exaggerated”, a bit irrational, so that we do not have to take it too seriously. But if we accept this pain of life, then there is perhaps nothing in life what is as terrible as this feeling of worthlessness and shame. It is therefore not surprising if we escape in panic, away from the pain. But the pain is sitting somewhere in us, in the body, in the soul, so that we do not get away from it. Thus, we are caught in a circular motion, which is about not having to feel the pain. But if we avoid the pain, we are affected by an inner split, which prevents the pain from becoming a part of ourselves. Then we are not recon-

ciled with ourselves and start to settle in the irreconcilable. Then we are shaped by circulating thought feelings such as envy, hatred, pride, etc. We perhaps avoid to feel a profound pain in life, but we can not prevent us from causing humiliation and pain in others.

In an illness we can experience to be shaken out of the irreconcilable. Together with the illness, our pain of life has become inevitable, too. This gives us the opportunity to end an internal flight movement. But to end this flight can be difficult. It can lead us into a despair about life experiences that are related to the pain. We might experience such despair when loved ones have died. Because in sadness we often not only mourn, we also despair about what we did not get in the relationship but had been longing for. Pure sadness is a praise of the good things we have lost. It is painful, but good. To reconcile with the despair is much harder, because this is about disappointments we have experienced, about accusations we are caught in, and these become an obstacle for mourning. The illness is also about mourning, and again a despair can prevent us from mourning – and from reconciling with our lives. Despair demands an energy of rebellion. However, when being ill we might become to weak to rebel. We no longer manage to escape from the pain, and so it becomes painful enough to lead to reconciliation – with ourselves, with our fellow human beings, with life. We might call this the mystery of reconciliation. It is also about consolation.

In the German etymological dictionary of the Brothers Grimm, we read that the German word *Trost*, i.e. comfort or consolation, has two meanings: In a recent sense, consolation is an active deed. But in an older sense consolation is a life force giving us inner support, trust, and hope. (See Grimm, 1952, p 903). In the original meaning of the word, consolation is a dimension of our life that we can call a ”spontaneous expression of existence” (with Løgstrup, see 1968, pp. 92ff). Consolation is the existential power which puts us back to our feet when we are depressed, which allows us to find back to us when we have lost ourselves, which can unite us again when we are internally divided. It is not certain that a man who tries to comfort us can really give us consolation. It might be nature which gives us comfort, an evening breeze, a nice view, the smell of the woods – or a pet. But mostly we need the human encounter to find consolation. In such an encounter you can show that you listen to the other, perceive him or her, accept him or her in his or her expression, so that (s)he does not have to despair. Even with the despair we carry with us we can find reconciliation. If we do not deny and suppress the pain, we can be healed in the encounter with the other.[10]

Explanations of diseases, especially diagnoses, may help us to accept the illness and thus give us some comfort. Last but not least family members might be in need of this comfort. But at the same time, these explanations can also impede a process in which the experience of being ill is important. Explanations stating that our condition is caused by experiences of loss, stress, frustration, lack of emotional expression – or by bacteria, viruses, hormones, genes, etc. do not help us a lot with our inner reconciliation and therefore do not give us real consolation. If we realize, however, that a sadness dominates us, that our condition is related to fear and shame, that we feel depressed due to the grief over our own physical condition – then that is something else. Then sadness, fear, shame, etc. become the foundation for amazement and deeper thoughts, – for a sensitive self-reflection. This might lead us to *a priori* insights, even though we may be unsure how to express and communicate them. When we realize that we find reconciliation with ourselves in the illness, so that life becomes richer and more joyful, then that is an *a priori* insight. It tells us

[10] About the phenomenon of consolation as analysed on the basis of narrative interviews, cf. Norberg et al., 2001.

something fundamentally important about life – something that can be recognized by others. If, however, we emphasize an empirical theory about the five stages of the dying process, with reconciliation as the final stage, then knowledge remains problematic and hypothetical.[11] When eager helpers want to ”help” the patient to get from one stage to the next, it can become pretty bad.

The care of mental health

The problems on the way of life can certainly become big, serious, distressing, and frightening. I think I have shown so far that philosophers can reflect on these problems and thereby take on a task. But what if the problems of life belong to the field of psychiatry? Should the philosopher then not better reject the task and pass it on to a psychiatrist? I do not think that he should do that. In some circumstances it might be appropriate to try to arrange in health care and social services the necessary support and help for the patient, which dialogues in the Pilosophical Practice cannot provide. The philosopher might have to tell his guest that they should stop their dialogues for the time being. However, under no circumstances should he stop them by giving his guest the feeling that normal dialogues with him or her would not be possible because of his or her illness.

People can become psychotic if they have to make experiences that are so threatening that the mental pain can not be endured anymore. The pain can become so frightening and shocking that it cannot even be controlled anymore by circulating around it. The physical conditions to deal with this pain fail – so the person is forced to find shelter in mental processes which we all know from dreaming and often call ”primary processes”. The person starts to dream while awake, so to speak. This can happen to us all when we get into a situation that we experience as a severe threat to our existence. What is crucial here is not so much the potential danger for life but rather the painful experience of losing any possibility of self-determination. Even with a high fever, especially when children are affected, it can happen that the normal control of impressions fails, and that something is seen or heard what other people in the same situation do not perceive. When one of my sons was little, he called me one evening and told me that a wasp (which in my opinion could not be around) had circled around him and had finally flown away through the ceiling. I touched his forehead, which was red hot, and the temperature measured was above 105 degrees Fahrenheit, that is 40 degrees Celsius. Such feverish fantasies have usually passed by after a while, just as dreams are gone after waking up.The surreal dreams while being awake, however, as far as they are not caused by fever or drugs, do usually not pass by that quickly and easily and frequently have fatal effects.

One woman told me that she first became psychotic at an airport. On the return trip home after a seminar she had to change the plane, and she imagined that war had broken out and acted accordingly. But when the police arrived and they wanted to put her into psychiatry, she put together all her strength, as she told me, and behaved normally. She asserted that she was able to continue her journey, and she pointed out that she had the company of a friend; and this friend also confirmed that the further journey would not be a problem. But after her arrival she was still put into psychiatry, for reasons I cannot explain here in greater detail. That was, as she said, an experience almost more shocking than the imagined war. She was put into a large, threatening building where people were behaving strangely and where the doors were locked behind her. Because

[11] An objection against the five stages of the dying process (denial, anger, negotiation, depression, reconciliation) developed by Elisabeth Kübler-Ross (cf. 1997) could be that these stages are not really stages of a natural process but rather periods we can experience in different ways and successions after we got the diagnosis of a deadly disease.

of that, she found no reason to leave her dream world too quickly. The real disaster however, she said, happened after she had left her psychotic condition and was back home. She called this disaster a social avalanche. She lost her well-paid and socially highly respected job, friends stayed away from her, her husband divorced her, she felt that it was widely doubted whether she was sane. Her social position was thrown into an abyss, so to speak. The description of this problematic situation might sound dramatic, but in fact it is almost trivialization, the woman explained to me, because the consequences of even the most terrible avalanche of the material world can at least be fixed and repaired so that a so-called normal life is possible afterwards. The avalanche she speaks of, however, destroys a world. With this statement I think she points out something very important, something really crucial. I want to say that the social avalanche she speaks of destroys the life-world in which she could have her place. I will illustrate how this happens with a brief description borrowed from a psychiatrist's lecture. With this presentation, he opens an art exhibition and refers to a painting called "border walkers". In psychiatry, we know "borderline" patients, he says, and he understands these "borderline" patients as a special form of border walkers: They live on the border between what we can understand and what we can not understand anymore. I think everything important is said. Without realizing it himself, this psychiatrist with his short remark had named the fatal idea which makes psychiatry a devastating avalanche: that we can not understand anymore what is going on in the world of the mentally ill.

On this side of the "borderline", we find healthy normality. Here we can assume that we can approach the other's expression from our own experience. What we express, communicate, or do can be understood on the basis of the life we experience. If in our own lives we try to express what we feel, we constantly make the experience that the expression fits more or less, applies more or less, satisfies more or less. We take a look at the expression that we have given our feelings and e.g. think: No, not entirely true. Or: That's the thing pretty much. Similarly, we can approach the expressions of the other. We e.g. tell him: I do not quite understand what you're saying, you need to explain that to me in greater detail. Or: Oh, yes, that makes sense. Or: Well, I think I understand what you're saying, but I do not quite know what to make of it. We assume that the statements of others express feelings we can understand. We certainly do not know exactly what the other feels, but we are touched and affected by his expression. We trust our feelings to understand those of others. Thus, we share the same life-world.

But if somebody is seen as being beyond the "borderline" of psychiatry, the disaster happens. He is banished from the common life-world, so to speak. He is suffering the fate of becoming incomprehensible, insane. We think that we can not understand anymore what he expresses. His expression, we imagine, is about disease. And the essence of diseases is, as I have already emphasized, nothing we can experience. We can realize it only by its symptoms and effects. We might understand and experience these effects, but our understanding and our experiences, as important as they might seem to us subjectively, tell us nothing about the disease itself. Therefore there is no point in approaching the problem of the disease from one's own life experience. Then, we have to take "stronger" methods, we have to be scientific, we have to gather data systematically and create new theories and models that help us explain and hopefully handle the effects of the disease.

It is certainly difficult to understand why some people become psychotic and others do not. That living conditions are difficult, threatening or humiliating can obviously not explain everything, because some people experience the worst but still do not become psychotic. Others experience something that does not seem so bad, and yet they become psychotic. It looks as if some people are more vulnerable than others. They are so much affected and shocked by life experiences most

people could cope with that they can not digest and control their impressions anymore, and so they are swept away by imaginations that are carried by the sea of the unconscious.

Løgstrup makes clear how vulnerable we are as human beings when he describes human life as daring to step forward to be met by whom we encounter. We know this vulnerability from our own lives and can understand it quite well when we see other people being rejected, persecuted, humiliated. In psychiatry, however, it is stated that vulnerability is the factor causing psychoses and mental illness. This causal relation is then no longer comprehensible. It becomes a scientific hypothesis which must be verified empirically. Then vulnerability is no longer an experienced vulnerability but rather a defined one, observed according to certain criteria and supposedly leading to mental illness. This approach corresponds to the logic of empirical research; so we might think that nothing is wrong with it. Nevertheless, I have two objections to the psychiatric concept of vulnerability: First, it contributes to a mystification of the experienced and felt vulnerability which we know from life. Questions arise making us insecure: If we are vulnerable, if we feel hurt, is that something pathological, possibly dangerous? Can we no longer dare to competently speak of our own wounds? The psychiatric concept of vulnerability takes away our very natural ability to speak of vulnerability in everyday life. And secondly, the concept contributes to a fix idea of mental disease. This is no objection to the common experience that we as a people can become mentally (or emotionally) ill, but rather an objection to the idea of mental disease. If we are attacked by such a disease, we can not understand anymore what we experience. Thus, we can not trust even our own feelings. If others do not understand it at all, we can not tell anyone what it means, not even ourselves. This is disastrous, because we then lose our life-world.

There has been much discussion about what ”life-world” actually means. I think it is the common world we know ”from within”. Opposed to that, the world of diseases is one we know from the ”outside”, guided by theoretical concepts and models we learned. The world we know from the inside is the world we can describe from our experiences and feelings. This is the world to which we are physically connected, in which we are bodily present. We can speak of this world from our experience. It is a common world, because we share our stories and descriptions of it with each other and can assess and judge it on the basis of having a feeling for it. The theoretically acquired world, however, is not the common life-world because we are not present in it bodily. We know it ”only with the head”, as we sometimes say. But worlds constructed with the help of concepts also presuppose and rest upon the life-world, because our ideas become too abstract and therefore incomprehensible if they do not relate in any way to the life-world. I can not deal more thoroughly here with the difficult concept of the life-world which Husserl has presupposed in his phenomenology. On the one hand, the life-world is one we all share, there are no life-worlds of individual human beings, as it is sometimes stated, – only individual life in the common life-world, of course. On the other hand, the life-world is not of such nature that we can find it somewhere. Something like a pure life-world does not exist – in addition to limited worlds, in addition to social and cultural worlds, in addition to the world of the empirical sciences, in addition to constructed worlds, in addition to all sorts of ”head worlds.” Also, the life-world is not the ”ideal world”. As I said, I can not explain here in detail the complexity of the life-world concept, but I wish to emphasize one key point: that the life-world is the world we all share and know ”from within”. And that means not only that we are connected with it by experience and feeling, but also that we can understand what we mean when we describe and talk about it. Based on such understanding we can discuss all kinds of life-world events and communicate them. If we no longer believe that we can understand what someone tells us, we take away from him the common life-world and put him into a special world. That's what happens in psychiatry very easily.

Some years ago a man came into my practice who told me that he did not like to leave his house anymore. He had realized that he spread a weariness infecting others around him. For example, he did not like to go to the supermarket, because customers coming too close to him began to yawn and to show more and more that they feel tired and powerless. At that time I did something that I would not do anymore today. I told him that it was not quite conceivable that he could spread weariness through his mere presence. I remember very well how hard he insisted that he really exercised this malign influence. He could remember exactly how other people reacted to him. So he defended the soundness of his experience. We can say that he had to fight the possibility that others could not understand what he had experienced. Today I think I should not have questioned his place in the common life-world. It was completely unnecessary, also because it is something quite familiar that we have an influence on others by our mere presence. I had every reason to ask what exactly he had experienced. I had every reason to wonder about his experiences – together with him. I am sure that if he felt being taken seriously, it would also be possible to talk about the normal or abnormal, the likely or unlikely aspects of his experiences. Then it would be quite possible to tell him what I myself think. For the fact that we would possibly have different views would not threaten his position in the common life-world.

I would now expect the following reaction from mental health workers: It is easy to say that we should wonder about what the patients say together with them. But should we really agree with them? Should we not say in many cases, for example: I believe you that you experience it like that, but I myself do not!? My answer to this question is that we should neither agree nor disagree with the patient but rather recognize his experience. If we tell him: I believe you that you experience it like that – then we do not really recognize his experience, at best only seemingly. Mostly we imply that we can not understand what he experiences, and not because of our own inadequacy. We might just as well say: I think you're crazy. And this is the message the patient actually receives.

Psychotherapists and mental health workers, and by the way educators as well, are in a paradoxical situation. They are committed to ensuring that the patient, client or student experiences a change for the better. However, this improvement must come from the patient, client or student himself. The therapists or teachers thus want to achieve an improvement which they can not produce themselves in a controlled way. In psychiatry, this paradox is carried to extremes. Treatment shall improve the patient’s health. This health, however, is identical with the normality of the patient. To observe whether the patient’s health is improving becomes the same as to determine whether he (or she) is responding and acting more normally. But how could it be that somebody suddenly becomes more normal after his normality has been denied? For a therapist, such a change might be imaginable. For the patient, however, such a change is initially completely impossible, because normality has been denied to him from the outside and can therefore be given back to him only from the outside. This leads to the situation that patients who are capable of doing so strive to fulfill the expectations – because they want to be good patients, because they want to escape from psychiatry or due to other reasons –, whereas patients who are not capable of doing so remain uncurably ill. And if the patients who had shown improvement feel worse again and they again end up in a mental hospital, you know that they had not really been healed. The disease becomes an entity that the patient not only has, but that he rather is identical with. Psychiatric patients *are* schizophrenic, they *are* bipolar, whereas patients who had a heart attack are not reduced to this heart attack. Thus, the mental disease becomes a disease of this individual’s nature. That triggers a certain fear which affects not only the patient but also the therapist. Becoming mentally ill is a fatal event, a banishment from the life-world, something horrible.

The (already mentioned) Norwegian philosopher Hans Skjervheim has shown how educators can get away from the paradox of education. In his essay ”A fundamental problem of educational philosophy”, he has described how educators, when they realize that they can not methodically shape a student, easily pass on to the opposite view and think they need to let him grow freely. However, letting him grow freely is just as impossible as shaping him systematically. From this paradox, there is only one way out: understanding the educational activity as a dialogue between educator and the one to be educated, a dialogue in which both are shaping and shaped at the same time. Referring to Plato's dialogue *Phaidros*, Skjervheim (2002, p 117) calls this process ”*psychagogy*, guidance of the soul through words.” I think that the only way out of the paradox of psychiatric treatment has to be dialogical as well. We must assume that on the basis of a common understanding both sides, the therapist as well as the patient, can communicate the experiences of mental illness and encounter each other. This will demand a lot from both of them, maybe more than they are really able to cope with. But the enormous fear of being banned from the life-world is taken away from them. However, a requirement for that is that the idea of a mental disease is abandoned or loosened. Diagnoses are either to be avoided, or they must be seen as preliminary descriptions, as snapshots. Someone is then for example tired, now drowsy, now psychotic, paranoid, manic, and so on. A psychosis is not a dangerous disease threatening one’s personality but rather a dream while being awake that can have disastrous consequences if it is not met by adequate means; but for others it is usually not dangerous. If one is not afraid of psychoses, it is not too difficult to encounter somebody psychotic in an appropriate way. The woman who had become psychotic at the airport told me that if she became psychotic again, she would just want to have someone around who was not afraid and who was ready to be together with her until the psychotic attack was over. She also told me that psychoses leave behind memories that do not easily and quickly fade away, like the dreams of the night after waking up, but that rather stay in mind and have to be digested. This digesting would be difficult, however, because as soon as she spoke of the psychotic contents, this would trigger the fear in others that her psychosis could break out again.

A psychiatrist once told me: ”When I meet a psychotic patient, he either leaves the psychotic condition and comes toward me, or he moves away from me deeper into the psychotic state. And the scary thing is”, she added, ”I suspect it has to do with me.” Similar experiences are made by mental health workers working ”systemically”. They might proceed according to the reflecting processes developed by Tom Andersen (see 1991, cf. also Anderson & Jensen, 2007), or they might follow the principles of the Open Dialogue presented by Jaakko Seikkula (see 1996, cf. also Seikkula & Olson, 2003). In these cases, health care workers make the experience that psychotic or mentally ill people find orientation in life again and are able to master their lives as good as possible. If their place in the common life-world is not taken away from them (anymore), they can often be saved from a (further) ”career” in psychiatry. Philosophical Practitioners, who have no intention to treat their guests and therefore avoid the paradox of the helper, can actually play a role in these processes. As philosophers, they are open enough to allow the expression of the other to make an impression on them. The question is whether health care is open for such a practice.

References:

Achenbach, G. B. (1984) *Philosophische Praxis*. (Mit Beiträgen von M. Fischer, T. H. Macho, O. Marquard und E. Martens.) Köln: Verlag für Philosophie Jürgen Dinter. (Schriftenreihe zur Philosophischen Praxis, Band I.)

Andersen, T. (1991) *The Reflecting Team: Dialogues and Dialogues About the Dialogues*. New York: W. W. Norton.

Anderson, H. & Jensen, P. (eds) (2007) *Innovations in the Reflecting Process – The Inspirations of Tom Andersen*. London: Karnac Books.

Falter, R. (2005) "Sinn-Bilder. Warum es sinnvoll ist, Natur-Charaktere mit Götternamen zu benennen, Teil 2", *Hagia Chora*, No. 20, pp. 94-97.

Gadamer, H.-G. (1993) Vom Zirkel des Verstehens. In: *Gesammelte Werke, Band 2* (2. ed.), pp. 57-65. Tübingen: J. C. B. Mohr (Paul Siebeck).

Grimm, J. & W. (1952) *Deutsches Wörterbuch*, elfter Band, I. Abteilung, II. Teil (TREIB-TZ). (Ed. by Deutsche Akademie der Wissenschaften zu Berlin.) Leipzig: Verlag S. Hirzel.

Holen, A. (ed.) (1981) *Stillhetens psykologi – en bok om Acem-meditasjon*. (4. ed.) Oslo: Dyade Forlag.

Juul Jensen, U. (1986) *Sygdomsbegreber i praksis. Det kliniske arbejdes filosofi og videnskabsteori* (2. ed.) København: Munksgaard.

Kompa, N, Nimtz C. & Suhm, C. (eds.) (2009) *The A Priori and its Role in Philosophy*. Paderborn: mentis Verlag.

Kübler-Ross, E. (1997) *On Death and Dying. What the dying have to teach doctors, nurses, clergy, and their own families*. New York: Touchstone. (First ed. 1969.)

Lindseth, A. (2005) *Zur Sache der Philosophischen Praxis. Philosophieren in Gesprächen mit ratsuchenden Menschen*. Freiburg/München: Verlag Karl Alber.

Lindseth, A. (2008a) Wirken Philosophischer Praxis. *Jahrbuch der Internationalen Gesellschaft für Philosophische Praxis (IGPP)*, Band 3, [T. Gutknecht, B. Himmelmann, T. Polednitschek (eds.), *Philosophische Praxis und Psychotherapie. Gegenseitige und gemeinsame Herausforderungen*], pp. 10-24. Berlin: Lit Verlag.

Lindseth, A. (2008b) Ort und Gespräch. *Aufgang. Jahrbuch für Denken, Dichten, Musik*, *5*, pp. 110-116.

Lindseth, A. (2010) Von der Methode der Philosophischen Praxis als dialogischer Beratung. In: D. Staude (ed.), *Methoden Philosophischer Praxis. Ein Handbuch*, pp. 67-100. Bielefeld: transcript Verlag.

Lindseth, A. (2011) Når vi bliver syge på livets vej – en udfordring for filosofisk praksis. In: J. Bresson Ladegaard Knox & M. Sørensen (eds.), *Filosofisk praksis i sundhedsarbejde*, pp. 139-167. Frederiksberg: Frydenlund.

Løgstrup, K. E. (1956) *Den etiske fordring*. København: Gyldendal.

Løgstrup, K. E. (1968) *Opgør med Kierkegaard*. København: Gyldendal.

Løgstrup, K. E. (1982) *System og symbol. Essays*. København: Gyldendal.

Løgstrup, K. E. (1987) *Solidaritet og kærlighed og andre essays*. København: Gyldendal.

Løgstrup, K. E. (1995) *Metaphysics, Vol. II* (transl. with an introduction by R. L. Dees). Milwaukee: Marquette University Press. (Translation of K. E. Løgstrup, *Ophav og omgivelse. Betragtninger over historie og natur. Metafysikk III*. København: Gyldendal, 1984.)

Løgstrup, K. E. (1997) *The Ethical Demand* (ed. with an introduction by H. Fink & A. MacIntyre). Notre Dame and London: University of Notre Dame Press.

Martinsen, K. & Eriksson, K. (2009) *Å se og å innse. Om ulike former for evidens*. Oslo: Akribe.

Nietzsche, F. (2007) *On the Genealogy of Morality*. (Ed. by K. Ansell-Pearson, transl. by C. Diethe, revised student edition.) Cambridge: Cambridge University Press. (Title of the German original: *Zur Genealogie der Moral*, first published 1887.)

Norberg, A., Bergsten, M. & Lundmann, B. (2001) A model of consolation. *Nursing Ethics*, *8*, pp. 544-553.

Ritter, J. (1980) Methode I. In: J. Ritter & K. Gründer (eds.), *Historisches Wörterbuch der Philosophie*, Band 5, pp. 1304f. Darmstadt: Wissenschaftliche Buchgesellschaft.

Seikkula, J. (1996) *Öppna samtal: Från monolog till levande dialog I sociala nätverk*. Stockholm: Mareld.

Seikkula, J. & Olson, M. (2003) The open dialogue approach to acute psycosis. *Family Process*, *42*, pp. 403-418.

Skjervheim, H. (1996) *Deltakar og tilskodar – og andre essays*. Oslo: Aschehoug.

Skjervheim, H. (2002) Eit grunnproblem i pedagogisk filosofi. In: H. Skjervheim, *Mennesket*, (ed. by J. Hellesnes & G. Skirbekk), pp. 103-117. Oslo: Universitetsforlaget. (Paper first published 1965.)

Svare, H. (2002) Samtalens plass i et menneskeliv. Anders Lindseth i samtale med Helge Svare. *Samtiden*, nr. 3, s. 114-123.