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Shared Empathy and Self-Testimony in Psychiatric Therapy and in Philosophical Practice – a Case Study

Abstract

I address the problem of how shared empathy and group therapy are a required condition for any successful work with patients in medical and clients in philosophical practice. Moreover, a theory of shared empathy must also account for the arguably more intricate issue of how group members might properly share their own mental domain with its distinctive phenomenology, and their distinctive attitudes toward one another, so that the necessary self-testimonies of clients do not rest on the previous pathological state. Furthermore, I aim to offer some steps towards solving this problem. I will do so by outlining what methodology lies behind the theory of shared empathy, and showing how, based on the results of a case study, it can be understood in such a way that it still accommodates all requirements for what counts as valid coherence of self-testimony and successful client's healing.

Keywords

shared empathy, self-testimony, counselling, therapy, philosophical practice, collective intentionality, group attitudes, Edith Stein

"... keep good civil order. Immediately afterwards
Oedipus speaks priestly: By what catharsis..."

Johann Christian Friedrich Hölderlin

1. Introduction

The philosophical notion of testimony is primarily an epistemological problem.[1] By comparison, the problem of self-testimony is closely related to philosophical practice and is one of the key parts of both medical and philosophical therapy. However, the notion of self-testimony is not as unproblematic as it might seem at first glance. Self-testimony is a *way of approaching oneself*; the way people view themselves, finally, the way clients view the history of their

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Jonathan Adler begins his first version of *Stanford Encyclopedia of Philosophy* article on "Epistemological problems of testimony" with the following statement: "Testimony is the assertion of a declarative sentence by a speaker to a hearer or to an audience." Cf. Jonathan Adler, "Epistemological Problems of Testimony", *Stanford Encyclopedia of Philosophy* (2008). Available at: http://plato.stanford.edu/archives/fall2008/entries/testimony-episprob/ (accessed on 14 February 2020). For a general historical background on the problem of testimony cf. Cecil Anthony John Coady, *Testimony: A Philosophical Study*, Part II, Oxford University Press, Oxford 1992; Rick Kennedy, *A History of Reasonableness: Testimony and Authority in the Art of Thinking*, University of Rochester Press, Rochester 2004. Cf. also some influential works on testimony: Martin Kusch, Peter Lipton, "Testimony: A Primer", *Studies in History and Philosophy of Science* 33 (2002) 2, pp. 209–217, doi: https://doi.org/10.1016/s0039-3681(02)00003-1; Alvin

illness and its social, professional, or health manifestations. Self-testimony is a *narrative*, full of holes and fictions, especially by clients who have gone through an intensely traumatic experience.

In this text, I will defend the thesis that client self-testimony is unsolvable within the individual, i.e. dyadic philosophical practical therapy. Self-testimony requires *group therapy* and *shared empathy* among group members. For philosophical practitioners, this in short means that they need to include other individuals close to the client (spouses, long-time friends or co-workers) in their therapy. Since not everyone approaches their "history of life" (*die Lebensgeschichte*) in the same way, the empathy of other group members – which is (as we will see later) based on collective intentionality – is indispensable to minimise fallibility and incoherence of self-testimony. Shared empathy is required so that client could present with greater epistemological credibility a narrative history of their problem. This is precisely the problem: self-testimony is always a *narrative* and represents the "writing of history" of one's life that has led to a problem that needs to be solved. The truth about oneself is hard to come by, but the client is more likely to open up and bear with what is hidden within them in front of a group characterised by shared empathy, than in a dyadic front with the therapist.

Self-testimony should bring to light the immediate life experience of a particular client and their interaction with other close people, which is often *pre-reflective* and *pre-theoretical*.[2] This means that the client's immediate life experience is not self-aware of the background in which their life occurs. That is why self-testimony is important – it has to bring the pre-reflexive and non-thetic to the surface and make it a narrative history as a substantive and significant event in one's life. Precisely this Robert D. Walsh emphasise when he writes that "contrary to scientific 'objectivity' as the means to truth-speaking, this view of philosophy [i.e. as "counselling practice"] calls for a consciously articulated autobiographical expression or personal admission on the part of the philosophical practitioner".[3] As a mode of inner truth and attestation of oneself, the client in self-testimony is often confronted with the phenomenon of unrepresentable events, since self-testimony is structurally defined as a *transition* between memory and history and, therefore, faces the danger of *constructing* historical facts.

To at least reduce the space for the construction of historical facts in the therapeutic process of self-testimony, I will show in this paper that the solution is to include group therapy in philosophical practice. Such therapy is directly phenomenologically inspired, based on the concept of collective intentionality and shared emotions, which traces its roots back to Max Scheler and Edith Stein's early phenomenology. After a short chapter on the essential relationship between philosophical practice and therapy, I will focus more on the methodological problems of the phenomenological analysis of shared empathy within a group and its foundation on the *phenomenon* of collective intentionality.

2. Relation between Philosophical Practice and Medical Therapy

The account that philosophy also has the therapeutic dimension of thought as such (philosophy as θεραπεία) follows the history of philosophy from its beginnings in ancient Greek philosophy. However, it has also been present from the very beginnings of eastern Buddhist thought.[4] Thus, the philosopher

is originally a practitioner, a kind of therapist, and the philosophical practice is inseparable from its original therapeutic orientation and its healing mission. Philosophy as therapeutics is not just professionals' activity – a trend currently present within the worldwide academic scene – or the conversation between experts in the so-called *Fachchinesisch* (i.e. conversation through technical terminology), it spans from Socrates, and all other ancient schools of philosophy, through the underestimated medieval scholasticism (especially in the *Summa Theologiae* of Thomas Aquinas), and to philosophical theories of Spinoza, Hegel[5] and Nietzsche, not to mention a multitude of works on Wittgenstein's philosophy as therapeutic in its original intention.[6] Even the emergence of religious belief can be viewed therapeutically: the gods served humans as therapists and psychiatrists. Testimony before gods in polytheism or confession and prayers in monotheism can be seen as having a revealing nature: people turned to gods for advice on how to act, how to heal or improve their physical and/or spiritual life.

Thus, philosophy is originally a *praxis of interacting between individuals seeking the truth* of the problems that 'gather' them *together*. But "[t]herapeutic interacting" is not only, as R. D. Walsh claims, "inevitably a local, personal affair (...) that happens between me and you who are in some way close to me".[7] Philosophical counselling practice should always occur within a group of people. And this is, I will show at the end of the paper, precisely because of the stated problem of self-testimony, which requires group interaction.

However, it was not until the early 19th century that the world saw a more concrete closer touch of philosophical theories and medicine as modern emerg-

I. Goldman, *Knowledge in a Social World*, Oxford University Press, Oxford 1999; Elizabeth Fricker, "Testimony: Knowing through Being Told", in: Ilkka Niiniluoto, Matti Sintonen, Jan Wolenski (eds.), *Handbook of Epistemology*, Kluwer Academic Publishers, Dordrecht 2004, pp. 109–130, doi: https://doi.org/10.1007/978-1-4020-1986-9_3; Peter Lipton, "The Epistemology of Testimony", *Studies in the History and Philosophy of Science* 29 (1998) 1, pp. 1–31, doi: https://doi.org/10.1016/s0039-3681(97)00022-8.

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Cf. Hans Bernhard Schmid, "Plural Self-Awareness", *Phenomenology and the Cognitive Sciences* 13 (2014) 1, pp. 7–24, doi: https://doi.org/10.1007/s11097-013-9317-z; Hans Bernhard Schmid, "The Feeling of Being a Group: Corporate Emotions and Collective Consciousness", in: Christian von Scheve, Mikko Salmela (eds.), *Collective Emotions: Perspectives from Psychology, Philosophy, and Sociology*, Oxford University Press, Oxford 2014, pp. 3–16.

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Robert D. Walsh, "Philosophical Counseling Practice", *Janus Head* 8 (2005) 2, pp. 497–508, p. 497.

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Cf. Clare Carlisle, Jonardon Ganeri (eds.), *Philosophy as Therapeia*, Royal Institute of Philosophy Supplement 66, Cambridge University Press, Cambridge 2010.

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On Hegel's therapeutic dimension of philosophy, cf. Rastko Jovanov, "What does Sublation of Moral Consciousness Mean for the Philosophical Practice? On Institutional Dimension of Therapy in Hegel's Philosophy", in: Lydia Amir, Aleksandar Fatić (eds.), *Practicing Philosophy*, Cambridge Scholars Publishing 2015, pp. 262–276.

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Cf. Daniel Hutto, *Wittgenstein and the End of Philosophy. Neither Theory nor Therapy*, Palgrave Macmillan, London 2003; James Peterman, *Philosophy as Therapy. An Interpretation and Defense of Wittgenstein's Later Philosophical Project*, SUNY Press, New York 1992; Christoffer Gefwert, *Wittgenstein on Thought, Language and Philosophy. From Theory to Therapy*, Routledge, London 2017.

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R. D. Walsh, "Philosophical Counseling Practice", p. 507.

ing science (primarily understood as natural science, *die Naturwissenschaft*).[8] Medicine has been seen as the "helper of people in difficult business of living and getting along with their naturalness".[9] This is in line with the prevailing romantic movement of the time and the so-called "return to nature", since "the art of genius" (*die Geniekunst*) failed to turn out to be a saviour from the sublime, but also catastrophic powers of nature as such.[10] This is why philosophy turned to medicine as the "art of healing" (*die Heilkunst*):

"Where reason is forced to gather courage and acknowledge the power of nature and thereby risk its own negation: this is precisely where it needs artists and doctors as the organs of a – respectable – fear of this courage."[11]

Attention was also paid to poetry and literature as adjunctive therapeutic means. Also, artistry is becoming a medical and pathological finding, "aesthetic productivity becomes a therapeutic surrogate".[12] Here we had a certain twist, as "philosophy begins turning to medicine, and medicine begins turning to philosophy".[13] This is especially evident in Schelling's philosophy. He gives a central position to the "theory of disease"[14] in the chapter "Theorie der Krankheit, abgeleitet aus der dynamischen Stufenfolge in der Natur"[15] in his book *First Attempt at a System of the Philosophy of Nature* (*Erster Entwurf eines Systems der Naturphilosophie*, 1799). Three years later in his *Lectures on the Method of Academic Studies* (*Vorlesungen über die Methode des akademischen Studiums*), Schelling brought philosophy and medicine closer together:

"… science of medicine presupposes not only general spiritual education but also the foundations of philosophy."[16]

However, we had to wait for the repeated mutual influence of philosophy and medicine – while ignoring the movement of biological criminology theories in the late 10th century[17] or Nazi "bio-technology" – until the end of the 20th century and the emergence of new philosophical discourses, namely bioethics and philosophical practice.

3. Collective Intentionality and Shared Empathy

The self-testimony is a *speech act* based on a narrative of description and interpretation in its declarative phase. The nature of self-testimony is communicative since any testimony entails an addressee. Therefore, self-testimony is inseparable from intersubjectivity and group therapy, as it contains attitudes such as reliability, trust, and condolence and sympathy from group therapy. Such attitudes need to elicit shared empathy in other group members for the therapeutic process to be successful.

To reiterate: a more credible self-testimony, and therefore a more successful therapeutic outcome, requires the involvement of the group in the practical philosophical counselling. Such a counselling group should be based on the phenomenon of shared empathy. To explain the basics of such group therapy that philosophical practitioners should adopt, I will first present Edith Stein's empathy analysis from 1917. In her dissertation *On the Problem of Empathy* (*Zum Problem der Einfühlung*),[18] Stein expounds shared empathy as the glue that holds a group *together*. I will then outline some influential current research on group emotions and collective intentionality.

From a phenomenological standpoint, the term "intentionality" refers to all mental acts in which we are directed towards something. This means that they characterise all experiences (both intellectual and emotional) in which we are relative to an object of experience. Intentionality is thus a phenomenon that makes up the true nature of mental acts. In the very sense of the word, *intentio* means to be directed towards something or to be about something. Every experience, every mental attitude is governed by something: memory is the memory of something, feeling is feeling about something, etc. Until two decades ago and capital works of Margaret Gilbert *On Social Facts* (1989) and John Searle's *The Construction of Social Reality* (1995) the philosophers' attention was exclusively focused on the analysis of *individual* intentionali-

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Cf. Odo Marquard, *Schwierigkeiten mit der Geschichtsphilosophie. Aufsätze*, Suhrkamp, Frankfurt am Main 1997 (especially the chapter "Über einige Beziehungen zwischen Ästhetik und Therapeutik in der Philosophie des neunzehnten Jahrhunderts", pp. 85–107).

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"… der Helfer des Menschen beim schwierigen Geschäft, mit seiner Natürlichkeit zu leben und auszukommen." – Ibid., p. 97.

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The term *empathy* (*die Einfühlung*) had previously been used only in theories of aesthetics. Cf. Joanna Ganczarek, Thomas Hünefeldt, Marta Olivetti Belardinelli, "From 'Einfühlung' to empathy: exploring the relationship between aesthetic and interpersonal experience", *Cognitive Processing* 19 (2018) 2, pp. 141–145. "The term 'Einfühlung' literally means 'feeling into' and refers to an act of projecting oneself into another body or environment, i.e. (…) terms to an imaginary bodily 'displacement' ('Versetzung') of oneself into another body or environment, which is aimed at understanding how it feels to be *in* that other body or environment. In other words, it refers to some kind of imaginary bodily perspective taking, which is aimed at understanding what it would be like to be living another body or another environment." – Ibid., p. 141. Also cf. Karsten Stueber, "Empathy", *The Stanford Encyclopedia of Philosophy* (2019). Available at: https://plato.stanford.edu/archives/win2017/entries/empathy/ accessed on 12 February 2020 English translation of "die Einfühlung" with "empathy" is quite problematic because the common use of the term refers together to empathy, sympathy (*Mitfühlung*), or being united with someone. *Einfühlung* means both *feeling-into* and *feeling-within*. "It is how you find yourself in your own experiences – you feel yourself within them." – Marianne Sawicki, "Personal Connections: The Phenomenology of Edith Stein", *Yearbook of the Irish Philosophical Society*, pp. 148–169, p. 151.

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"Wo die Vernunft sich – notge drungen – couragiert, die Macht der Natur anzuerkennen und dadurch ihre eigene Negation zu riskieren: da bedarf es gerade des Künstlers und des Arztes als der Organe einer – respektablen – Angst vor dieser Courage." – O. Marquard, *Schwierigkeiten mit der Geschichtsphilosophie,* p. 94. Marquard also draws attention to the fact that many books on the philosophy of nature in Romanticism were written by the medics themselves. Cf. ibid., p. 99.

12
Ibid., p. 102.

13
Ibid., p. 98.

14
Cf. Friedrich Wilhelm Joseph Schelling, *Werke*, vol. 7, *Erster Entwurf eines Systems der Naturphilosophie*, Frommann-Holzboog, Stuttgart 1976.

15
Ibid., p. 9.

16
"… daß die Wissenschaft der Medizin (...) nicht nur überhaupt philosophische Bildung des Geistes, sondern auch Grundsätze der Philosophie voraussetze." – Friedrich Wilhelm Joseph Schelling, *Werke*, vol. 5, *Fruhe Theologische Und Philosophische Arbeiten (1793-1795)*, Frommann-Holzboog, Stuttgart 1976, pp. 340–341.

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Cf. Rastko Jovanov, "Das Leben als Dokument. Die Genealogie des registrierten Lebens als biopolitische Institution", in: Jan Müller, Rastko Jovanov, Željko Radinković (eds.), *Politiken des Lebens. Technik, Moral und Recht als institutionelle Gestalten der menschlichen Lebensform*, IFDT, Belgrade 2015, pp. 9–55.

18
Edith Stein, *Zum Problem der Einfühlung*, Buchdruckerei des Waisenhauses, Halle 1917.

ty, especially by extending Margaret Anscombe's influential research on the nature of intentionality.[19] In the wake of the 1990s research on *collective* intentionality by the so-called "big four" (Searle, Gilbert, Raimo Tuomela and Michael Bratman), a number of papers have emerged that clearly show that research into the social dimension of human action and cognition must be extended to *shared* intentional states, i.e. to *shared emotional* or *affective states*.

It is these shared emotional attitudes, primarily the problem of empathy that Stein explores in the aforementioned book.[20] Already in the "Foreword" of the book, Stein announced that the question of empathy will be explored "as the perceiving [*Erfahrung*] of foreign subjects and their experience [*Erleben*]".[21] Thus, according to Stein empathy represents the basis of intersubjective experience,[22] and an empathic act should be seen as the founding act of groups. However, before that, Stein needs to explain the key point of analysis of group's emphatic sharing – namely, the *participation* of the subjects in a phenomenological act of empathy. According to her, empathy implies a *mutual* phenomenological experience:

"The world in which we live is not only a world of physical bodies but also of experiencing subjects external to us, of whose experiences we know. This knowledge is not indubitable. Precisely here we are subject to such diverse deceptions that occasionally we are inclined to doubt the possibility of knowledge in this domain at all. But the phenomenon of foreign psychic life is indubitably there, and we now want to examine this a little further."[23]

To analyse the basic structure of experience, Stein distinguishes the intentionality between the *content* of the intended act from the *object* of the intended act. Further, every intentional act has *temporal dimension*, and thus experience as such has temporal dimension that constitutes a correlation between the object and the content of the experience. That is why we can make an analogy between self-testimony (i.e. narrative history with its components such as memory, fantasy, hidden or unconscious content etc.) and acts of empathy in which other subjects' experiences are given through *knowledge*. According to Stein, empathy – as a *kind of knowledge*[24] – is both, an act and an experience:

"When I inquire into its implied tendencies (try to bring another's mood to clear givenness to myself), the content, having pulled me into it, is no longer really an object. I am now no longer turned to the content but to the object of it, am at the subject of the content in the original subject's place."[25]

Empathy is thus a form of intersubjectivity, and it represents a fundamental part of any group. Dan Zahavi is right when he wrote that:

"… empathy has typically been taken to constitute a unique and irreducible form of intentionality, and one of the classical tasks of phenomenological analysis has been to clarify its precise structure and spell out the difference between it and other forms of intentionality, such as perception, imagination, and recollection. In fact, the empathic approach has occasionally been assumed to constitute the phenomenological approach to intersubjectivity."[26]

For explaining the problem of self-testimony, it is important to note here that empathy is always directed at a concrete situation, which is determined by *earlier* experiences, and "presuppose some *external point of view* from which what is given in experience has to be understood"[27] (my emphasis). That means that my self-testimony experience is moving between the future and the past of my life events. Just like empathy, self-testimony is intrinsic *temporarily*. It is a kind of experienced history which could only be brought out through its narrative structure with its own biases and fallibility (running away from the reality of past events, hiding shameful moments, and memory

holes, etc.). Shared empathy between the group participants is necessary to prevent self-testimony, as an indispensable part of medical therapy or philosophical praxis, from remaining at the disease's pathological level.

Empathy means thus to see together with other persons and to recognise the other persons. But the experience of the other's viewpoint will never be also *mine*. Empathy is an act that provides an original experience of the content of another's experiences; it is not just about perceiving others but grasping their thoughts and feelings. As Alasdair MacIntyre properly suggests, empathy should be seen in the way "how human beings comprehend the psychic life of their fellows".[28] It concerns our *engagement* to be open to the "realities" that people tell us about, to empathise with their self-testimonies.

Stein's analysis of the structure and role of empathy in human cooperation and the sharedness or collectivity of these intentional states and attitudes takes us further to see how it works in practice. In the following chapter, I will present a case study to confirm that group therapy, through shared empathy, leads to the more successful healing of client than dyadic therapy between the client and the psychiatrist or philosophical practitioner.

4. Case Study

In January and February 2020, I spent three weeks at the Institute of Mental Health in Belgrade.[29] I researched how patients were treated for addiction to polydrug use, gambling and alcoholism. The model of group therapy is applied at the Institute. The group consisted of twelve to twenty-two patients. To be admitted to the group for treatment at all, each patient first went through

English translation: Edith Stein, *The Collected Works of Edith Stein*, vol. 3, *On the Problem of Empathy*, translated by Waltraut Stein, ICS Publications, Washington, D. C. 1989. On the life and work of E. Stein, cf. new entry from 20 March 2020 in Stanford Encyclopedia: Thomas Szanto, Dermot Moran, "Edith Stein", *The Stanford Encyclopedia of Philosophy*. Available at: https://plato.stanford.edu/archives/spr2020/entries/stein/ (accessed on 22 March 2020).

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Cf. Gertrude Elizabeth Margaret Anscombe, *Intention*, Basil Blackwell, Oxford 1957.

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For other social ontological topics explored by E. Stein (community, society, state, authority, etc.), cf. Rastko Jovanov, "Solidarität und Gruppenidentität: Mimesis, Gesetz, Kampf", in: Holger Zaborowski, Rastko Jovanov, Željko Radinković (eds.), *Phänomenologische Ontologie des Sozialen*, IFDT, Belgrade 2015, pp. 116–136.

21
E. Stein, *On the Problem of Empathy*, p. 1.

22
Ibid., p. 64.

23
Ibid., p. 5.

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Stein's claim that empathy is also a kind of knowledge represents her departure from Husserl's philosophy.

25
Ibid., p. 10.

26
Dan Zahavi, *Subjectivity and Selfhood. Investigating the First-Person Perspective*, MIT Press, London 2008, p. 155.

27
Alasdair MacIntyre, *Edith Stein. A Philosophical Prologue*, Continuum, London 2006, p. 112.

28
E. Stein, *On the Problem of Empathy*, p. 11.

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On this occasion, I would like to thank the psychiatrists and other medical personnel at the Institute for Mental Health in Belgrade for allowing me to follow the medical therapy processes live, and attend group sessions. I cannot here, for obvious professional reasons, mention their names.

the process of the disease *symptoms identification* by the professional board, which is very similar to the phenomenological method of analysing objects in the world (the patient's appearance and behavior are analysed). But it also contains the patient's brief account of the reason why he agreed to the treatment at all. Psychiatrists then *genealogically* consider the possible course of development for the disease curing. Only then do they decide whether to admit the patient to treatment. The patient is then assigned a psychiatrist, who makes a *prognosis*, i.e. the assessment of further development, and prescriptively determines the treatment protocol.[30] That is where the personal, dyadic relationship between the psychiatrist and the patient ends. Everything else is *left to the group*.

Unlike philosophical practitioners, medical therapy for various forms of addiction has been shifting to group work since the 1970s. The first thing I heard from the director of the Institute at the professional board meeting while admitting a new patient was the precondition that they *had to* express *empathy* for other members of the group in order to be able to expect successful healing at all. What was a kind of surprise to me was that treatment was entirely left to the group and that all members, especially those who have been treated longer, are fully committed to further the development of collective empathy within a group. Each new patient is provided with a guide instructing them to the *rules* that *constitute* the group. The two basic rules are: (a) to never stand out from the group, and (b) to develop healthy social relationships based on empathic identification with other group members.

The therapeutic process within the group can be briefly described as follows. On the first day, the patient briefly introduces themselves to the group and discusses why they applied for treatment. After two days, they self-testify about the history of their illness and its social, familiar, professional and health consequences. The group then decides whether or not the patient should be fully admitted for treatment and be treated as a group member. The ultimate decision thus *belongs to the group itself*, not to the psychiatrists. Patient's self-testimony will be repeated at the very end of the therapeutic process, as this first self-testimony is expectedly presented in a pathological state and its credibility is highly questioned due to completely non-objective views of patient's addiction and its consequences.

The patient is first familiarised with their illness through learning from special textbooks and taking exams ahead of expertly trained medical professionals. Emphasis is placed on understanding the traits and character changes of the "addictive personality" as personality character stands – as a set of personality traits, attitudes, and behaviours of the subject – in close connection with the moral and ethical *norms* of existing society. That is why the therapy insists on the *consequences* the addictive personality causes in their social milieu and on the insight into the dissolution of the *Super-Ego* (or moral consciousness) in each addict. More precisely, the addictive personality prevents the *Super-Ego* from controlling the *Id* of the personality (instinctive, impulsive reactions that do not conform to social norms). After the learning phase, the patient takes the exam in front of the group, which evaluates the patient's knowledge of "addictive personality" with their personal examples. Empathy is also shown through the criticism of their poor knowledge or lack of personal details of the disease. However, the group has to be empathetic *before* it can be evaluative: listening should not be only a judgement. Since patient education is a group process, every patient's failure is a crisis of the group itself.

Attending numerous group meetings demonstrated other patients' genuine desire to help someone who is currently in crisis. The patients in crisis are also required to *write down an analysis* of their crisis. The common belief is that they will better cope with the cause of the crisis and overcome it.[31]

After about a month of abstinence from addiction, the patient with their close associates (wife/husband, adult child, friend, etc.) again self-testifies in front of the group about the therapeutic process, the better insight into causes and deleteriously effects of her/his disease and current condition. As the group already met them and established mutual empathic relationships, assessing the patient's validity of self-testimony validity is facilitated. Moreover, the patient is much more open to their illness's narrative history and its manifestations than at the first self-testimony. All this was made possible by shared empathy within the group and open trust among group members.

At the very end of the therapy process, the patient presents a rehabilitation plan they developed with their associates. The plan covers changes in every field: from family context, through professional rehabilitation and health recovery, to resocialisation in the broadest sense.

Thus, what kept this group I was analysing *together* was shared empathy, through which the patient reached a credible self-testimony and richer insights into the history of their life. Only then will they be able to continue their successful abstinence after clinical treatment. A dyadic relationship between therapist or counsellor and client cannot lead to such an intensity of empathy, as there is a certain discrepancy between the pathological (patient) and normal (philosophical practitioner).[32] Shared empathy between the patients themselves gives much better healing results. Therefore, based on this case study, a philosophical practitioner needs to insist on their work with their patients so that there is a necessary presence of at least one person close to

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On medical versus philosophical diagnostics, cf. Hans Sluga, "Von der normativen Theorie zur diagnostischen Praxis", *Deutsche Zeitschrift für Philosophie* 59 (2011) 6, pp. 819–834. "Medical diagnosis not only tries to determine current symptoms of a possible disease, but it also tries to find out the genesis of these symptoms and thus the underlying disease. The doctor asks how long the patient has been uncomfortable, how the symptoms started, how they developed, etc. Genealogy is equally necessary and appropriate in philosophical diagnosis. A dynamic picture of the symptoms and the pathology to be determined is a prerequisite for determining their likely further course and the basis for every practical indication." – Ibid., p. 826.

31

On the beneficial process of writing one own's traumatic experience in the form of self-testimony, cf. Janie A. Van Dijk, Mirjam J. A. Schoutrop, Philip Spinhoven, "Testimony Therapy. Treatment Method for Traumatized Victims of Organized Violence", *American Journal of Psychotherapy* 57 (2003) 3, pp. 361–373. "While composing the testimony, the traumatised person is gradually exposed to the traumatic memories. The person tells about the experiences and then reads the story or it is being read to him/her so he/she can revise it. The painful events are brought back to memory in a controlled way (...) which might help patients to better understand what happened. (...) This effect might be brought about by the patients' active participation that the therapy requires: he/she reads (or listens when it is being read) and revises the document." – Ibid., p. 369.

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There is still a strong stream in philosophical counselling which puts the dyadic over group therapy, and emphasis the process of fostering virtues, wisdom, and prudence within *philosophical* treatment of the client. Cf. Arto Tukiainen, "Philosophical Counselling as a Process of Fostering Wisdom in the Form of Virtues", *Practical Philosophy. The British Journal of Philosophical Practice* 10 (2010) 1, pp. 47–56. The concept of 'virtues' also plays a significant role in the work of Lydia B. Amir and Jess Flemming. On the other hand, many philosophical practitioners have been

the patient, a person aware of their illness or the problem that needs to be addressed.

5. Conclusion: The Role of Philosophical Practitioner

To sum up the results of the case study. Medical professional help in appropriate institutions is needed at the first place (prescribing therapeutic measures in the form of taking tranquilisers, establishing abstinence with alcoholism, drug addiction, gambling), and only then it becomes possible for philosophical practitioners to successfully implement their therapeutic measures (also within group therapy).[33] This means that the client always comes to therapy with people with whom they have close relationships and who are essential to their health, social, professional or family life. The problem of therapeutic self-testimony is not only the epistemological problem of knowledge as such. Client's self-testimony should be primarily evaluated and justified through special kind of *social* knowledge, i.e. through the emphatic act of group counselling. I have argued that this could be only achieved through group therapy, that is, confronting the client's self-testimony with the claims (affirmative or renouncing) of their close relatives (husband/wife, friends, etc.) and/or other group members.

Group therapy requires *catharsis* seen in the client's second self-testimony, their insight into their own delusion (*der Irrtum*) about their addictive existence.[34] Only then does their healing begin, and only then is it possible for the philosophical practice to raise to a higher level, bring round, and strengthen the client's healing. A philosophical practitioner is previously powerless, and their counselling can be ineffective and lead to a greater degree of client's pathology.

It seems that it needs to be particularly emphasised that the *normativity* of philosophical notions and concepts should play no role in philosophical counselling: listening should not be judging. Because understanding another person does not come from judgment, but through empathic acts and identifying with the other. Effective philosophical therapy requires emotional and thoughtful participation on the part of the client, as well as empathetic and, therefore, emotional and rational participation on the part of the practitioner. The epistemic quest of aiming to understand the coherence of another person's self-testimony is not a normative process because it is not a process of rating, but of a process of *relating*. A philosophical practitioner should phenomenologically focus their analysis on the client's observations and less on their opinions. Havi Carel, therefore, argues for a reconfiguration of client-therapist relationship:

"I found phenomenology – the description of lived experience – to be the most helpful approach to augmenting the naturalistic account of illness. Phenomenology privileges the first-person experience, thus challenging the medical world's objective, third-person account of disease. The importance phenomenology places on a person's own experience, on the thoroughly human environment of everyday life, presents a novel view of illness. On the phenomenological account, illness is no longer seen merely as biological dysfunction to be corrected by medical experts. Because of phenomenology's focus on the subjective experience of the ill person, it sees illness as a way of living, experiencing the world and interacting with other people. Instead of viewing illness as a local disruption of a particular function, phenomenology turns to the lived experience of this dysfunction. It attends to the global disruption of the habits, capacities and actions of the ill person."[35]

But against H. Carel I have argued previously that philosophical practitioners should consider not only phenomenology's notion of the *first-person singular* but also *first-person plural*, i.e. a group with its distinctive shared emphatic relations and collective attitudes between group members, of which philosophical practitioner is one of them.

After successfully leaving clinical treatment, the client signs the document that they were discharged from the treatment after (a) *writing down* a second self-testimony, (b) oral presenting it in front of the group, and finally (c) after the group accepts the testimony. This *signing of the document* can be seen as a beneficial aspect of self-testimony therapy, as *the ritualistic closure of therapy*. This is why writing down one's own experiences – in addition to shared empathy and oral self-testimonies – is also one of the necessary step clients need to experience to overcome their illness or life problems of any kind. The question is if there could be a successful therapy without written self-testimony about the client's mental or social problems, I have to leave for a future research.

influenced by Socrates and 'critical thinking', by treating world *beliefs* as the basis of philosophical counselling, for example, Pierre Grimmes, Eckart Ruschmann and, most influentially, Ran Lahav. Regarding classical individual therapy, cf. Gerd B. Achenbach, "On Wisdom in Philosophical Practice", *Inquiry: Critical Thinking Across the Disciplines* 17 (1998) 3, pp. 5–20, doi: https://doi.org/10.5840/inquiryctnews199817322; Gerd B. Achenbach, *Lebenskönnerschaft*, Verlag Herder, Freiburg 2001; John Kekes, "Wisdom", *American Philosophical Quarterly* 20 (1983) 3, pp. 271–286.

33

It needs to be noted that some traditions of philosophical counselling have explicitly acted as anti-psychiatric, and an important part of this movement that separates itself from psychotherapy is the tendency to avoid medicalisation and the use of drugs in therapy. However, Sam Brown justly claims in the journal published by Society for Philosophy in Practice that if "philosophical therapy is ever to claim a place alongside other forms of mental health care provision, practitioners must adduce convincing evidence of its therapeutic merits and demonstrate rigorous professional safeguards. Unfortunately, the strong anti-psychiatric rhetoric employed by some of its proponents is unlikely to garner the endorsement of statutory regulators – particularly when their advisory boards are drawn from the health sector". – Sam Brown, "The therapeutic status of philosophical counselling", *Practical Philosophy. The British Journal of Philosophical Practice* 10 (2010) 1, pp. 111–120, p. 115.

34

It is no surprise that the title of one of the first medical journals in Germany was *Jahrbücher für Anthropologie und zur Pathologie und Therapie des Irreseins* (*Journal for Anthropology, Pathology and Therapy of Insanity*), for *Irresein* has the same root as delusion *Irrtum*.

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Havi Carel, *Illness*, Routledge, New York 2013, p. 10.

Rastko Jovanov

Dijeljena empatija i samosvjedočanstvo u psihijatrijskoj terapiji i filozofijskoj praksi – studija jednog slučaja

Sažetak

Bavim se problem toga kako su dijeljena empatija i grupna terapija obvezni uvjeti za uspješan rad s pacijentima u medicinskoj i klijentima u filozofijskoj praksi. Nadalje, teorija dijeljene empatije mora se baviti i nedvojbeno zamršenijim problemom toga kako članovi grupe mogu ispravno dijeliti svoju mentalnu domenu s njenom posebnom fenomenologijom, te svoja osebujna držanja jednih prema drugima, tako da nužna samosvjedočanstva klijenata ne počivaju na prethodnom patološkom stanju. U nastavku nudim neke korake prema razrješenju toga problema. Učinit ću to ocrtavajući metodologiju koja se nalazi iza teorije dijeljene empatije te pokazujući, na primjeru jedne studije slučaja, kako to može biti razumljeno na taj način da se prilagođava svim preduvjetima za valjanu koherenciju samosvjedočanstva i uspješnog klijentova liječenja.

Ključne riječi

dijeljena empatija, samosvjedočanstvo, savjetovanje, terapija, filozofijska praksa, kolektivna intencionalnost, grupno držanje, Edith Stein

Rastko Jovanov

Geteilte Empathie und Selbstzeugnis in der psychiatrischen Therapie und der philosophischen Praxis – eine Fallstudie

Zusammenfassung

Ich beschäftige mich mit dem Problem, wie geteilte Empathie und Gruppentherapie Pflichtvoraussetzungen für eine erfolggekrönte Arbeit mit Patienten in der medizinischen und Kunden in der philosophischen Praxis sind. Fernerhin muss sich die Theorie der geteilten Empathie ebenso mit einem zweifellos verwickelteren Problem befassen, nämlich wie Gruppenmitglieder die mentale Domäne mit ihrer besonderen Phänomenologie sowie ihre eigenartigen Haltungen zueinander richtig teilen und besitzen können, sodass die notwendigen Selbstzeugnisse der Kunden nicht auf einem vorausgehenden pathologischen Zustand beruhen. Darauffolgend biete ich einige Schritte zur Lösung dieses Problems. Ich tue dies, indem ich die hinter der Theorie der geteilten Empathie liegende Methodologie skizziere und am Beispiel einer Fallstudie darlege, wie sich dies in einer solchen Weise begreifen lässt, dass es sich an alle Vorbedingungen für eine gültige Kohärenz von Selbstzeugnis und gelungener Kundenbehandlung anpasst.

Schlüsselwörter

geteilte Empathie, Selbstzeugnis, Beratung, Therapie, philosophische Praxis, kollektive Intentionalität, Gruppenhaltung, Edith Stein

Rastko Jovanov

Empathie partagée et témoignage dans la thérapie psychiatrique et la philosophie pratique – étude d'un cas

Résumé

Je traite du problème de savoir comment l'empathie partagée et la thérapie de groupe sont des conditions nécessaires pour un travail réussi avec les patients dans la pratique en médecine, et avec les clients dans la pratique philosophique. En outre, la théorie de l'empathie partagée doit indubitablement faire face à un problème plus complexe : comment les membres d'un groupe peuvent partager et posséder de manière juste le champ mental avec sa phénoménologie particulière qui lui est propre, mais également les attitudes particulières des uns envers les autres ? Ainsi, les témoignages nécessaires des clients ne reposent pas sur leur état pathologique antérieur. Dans la suite du travail je propose quelques éléments visant à résoudre ce problème. Pour cela, je décrirai dans les grandes lignes la méthodologie qui se situe en arrière-fond de la théorie de l'empathie partagée en montrant, sur l'exemple d'une étude d'un cas, que cela peut être compris de manière à s'adapter à toutes les préconditions afin d'obtenir une cohérence valide du témoignage et un traitement efficace pour le client.

Mots-clés

empathie partagée, témoignage, conseil, thérapie, pratique philosophique, intentionnalité collective, attitude de groupe, Edith Stein