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ILLNESS, BODY AND RELATIONSHIP: GIOVANNI JERVIS AND THE FIELD OF CLINICAL PSYCHOLOGY

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SUMMARY

ILLNESS, BODY AND RELATIONSHIP

Unlike most of his contemporaries, Jervis felt it was necessary to give new answers to last century's clinical psychology crisis. He managed to show the relevance that psychological knowledge coming from other sectors (such as philosophy, evolutionary biology, cybernetics, ethology and, nowadays, neuroscience) could have for clinical psychology. He realized that the clinical world was at risk of loosing its cultural models of reference and threatened to break up with the scientific tradition with which it had not been able to establish a profitable dialogue. Jervis' views on mental functioning allowed him to delimit the field of action of clinical psychology. The focus on pathology and existential distress suggested that correct clinical evaluation and diagnosis are at the core of the activity of clinical psychologists. The tension between relational expectations, self-deceptive aspects of identity and the bodily sources of mental life show the dynamic field on which clinical psychology can deploy its transformative action.

Introduction

When interviewed, Giovanni Jervis used to define himself as a psychiatrist and a psychologist. He never lost the interest on two important issues: the necessity to give adequate responses to the patient's suffering, and the constant questioning as to the origins and mecha-

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nisms that found our subjectivity. It's through this double focus of elaboration that we should look at Jervis' contribution to clinical psychology. Jervis explicitly devoted to this topic only one article[1] and some brief remarks in a wider publication[2] . However, we should consider that many reflections from other texts, dating back to the Seventies, clarifies with much more continuity Jervis' positions on clinical intervention both in the psychiatric and psychological fields. Furthermore, I shall try to highlight how such positions are very consequential and consistent with the broader aspects of the intellectual research to which Jervis committed himself throughout his career. The indications coming from these broader reflections only rarely consisted of specific operational proposals. On the contrary, his critical perspective often aimed at highlighting the complexity, the risks and the inherent contradictions of clinical work. He posed a series of questions with which the helping professional is daily called to deal with, far beyond any simplistic, ideological and charismatic solution.

The cultural crisis of clinical psychology

Starting with the Eighties, Italian clinical psychology seemed to suffer from a period of profound uncertainty, due to the crisis of scientific and clinical legitimacy encountered by psychoanalysis. This sense of uncertainty was also worsened by the parallel affirmation of other therapeutic orientations and, mainly and foremost, of biological psychiatry. These changes initially appeared to have deprived clinical psychology of a unitary, specific and articulated epistemological and theoretical framework. rendering very difficult to delimit and qualify its field of action. This scenery engendered a sense of confusion and precariousness in both students and clinicians. The professional competences of the clinical psychologist were loosing their connections the background of scientific knowledge coming from various sectors of psychology and other allied disciplines. The status of clinical psychology was then being threatened by two possible outcomes:

> A strong cultural impoverishment, given by the disconnection between the clinical activity and the perspective of scientific and naturalistic study of the mind.

The fragmentation of the world of clinical interventions, due to the absence of a common ground of shared theoretical and methodological models.

Many disordered responses were given to these problems. First, the reaction to the great crisis of psychoanalysis was characterized by a very indulgent interpretation of "cultural pluralism" in psychotherapy. In this post-modernist interpretation of treatment there was a tendency to underline the primacy of hermeneuticism in the clinical work. Some important critical issues highlighted by empirical research[3] such as the so-called "paradox of equivalences" or the existence of a-specific-relational factors of clinical change, were translated into a series of oversimplified solutions to the issues of treatment. The picture emerging from this cultural shuffle was the problematic co-existence of disparate approaches: the conservative reflex of orthodox psychoanalytic views, as well as the indiscriminate proliferation of old and new therapeutic schools. The proliferation of many clinical orientations was further sustained by economic interests residing in the birth of private psychotherapeutic training institutions. In 1977[4] and later[5], Jervis had already denounced the "supermarket philosophy" of clinical interventions. In the paradox stemming from this ill-conceived and yielding climate of pluralism, clinical activity was primarily and essentially identified with the affirmation of self-referential theoretical points of view. The construction of a narrative meaning was put ahead as the first and foremost objective of psychological interventions. Whatever this meaning would be, all that mattered was that it could be shared or "co-constructed" with the patient. The understanding of the patient's clinical nature and its eventual solution was considered as an appendix to the narrative

construction and to a not well-specified mutual empathic resonance. No room seemed to be left for the need to present the patient with a respectful but genuinely critical (and possibly demystifying) view of his identity and problems. The risk of derailment of this post-modernist perspective was well represented by some suggestions that would spread among us students, but also among professors and trainers. Affirmations like "the most important thing in one's clinical activity is to work with a therapeutic model that suits you well, that mirrors your personality" or "you can do anything you feel like with a patient as long as you know what you are doing" were really common.

Undoubtedly, Giovanni Jervis' teaching and writings represented a wholly different opportunity to reflect upon the real foundations of the clinical work.

Like only few people at that time, Jervis felt it necessary to show the usefulness and the relevance that the psychological knowledge coming from different sectors could have for clinical psychology. He realized that the clinical world was at risk of loosing its cultural models of reference and threatened to break up with the scientific tradition with which it had not been able to establish a profitable dialogue. Jervis, thus, emphasized the role "scientific psychology" could play for the clinical approaches, along with the necessary framework for the study of mind provided by allied disciplines such as philosophy, evolutionary biology, cybernetics, ethology and, more recently, neuroscience [6, 7]. He strongly believed that notions such as intentionality, behavioural system, motivation, first and second order knowledge, affects, implicit processes, split-brain should be at the core of the clinical psychologist's cultural background. Even more, he was able to clearly illustrate how such notions could have a real impact on the way the clinician assesses, understands and, when it's possible, intervenes to enhance people's suffering and psychological conditions. By doing so, Jervis proposed an effective and modern way to review some of the intuitions and themes that had characterized psy-

choanalysis and dynamic psychology, while it could seem that these issues were about to be weeded out of the contemporary debate in scientific psychology.

The debate on Clinical Psychology in Italy

At the end of the Eighties and for some part of the Nineties, in Italy a debate took place around the theoretical and methodological foundations of clinical psychology [8].

As we have seen, a more precise and rigorous definition of the limits and potentials of clinical psychology was long overdue. At the same time, this debate often ran the risk to fall into an overly intellectualized and recursive self-analysis of the reasons, motivations and cultural models which lead a psychologist to be a psychologist. As students, we ironically commented that our future work would be to ask ourselves what our profession could actually be. This tendency hid the danger to skirt around the key operative issues, as well the problems connected with the patient's request for change and thus to fully take up our professional responsibility.

In particular, one of the leading positions [9; 10; 11; 12] which had emerged in the debate stressed that clinical psychology would come out of its crisis if:

a. It renounced the medical approach founded on the binomial "psychopathological diagnosis- corrective therapeutic intervention".

b. It discarded an objective approach to evaluation founded upon the nosographic psychiatric classifications (starting with the DSM, but including also some psychoanalytic classifications), the personality assessment and, more in general, more rigorous psychological methods of evaluation (e.g., psychological testing).

c. It got rid of the self-referential theoretical and operative

models of the different psychotherapeutic approaches, thus differentiating its methods from the automatic application of a therapeutic technique.

d. It created a *meta-model*, a general theory of clinical praxis that should constitute the specific area of competences of clinical psychologists. This theory of praxis should precede and orient the application of any sort of psychological technique, including psychotherapies.

e. It founded its meta-model upon the analysis of the affective representations and demands implicitly emerging in the relational context in which the clinical psychologist is called to come into play. A certain degree of ambiguity remained as to the theoretical reference through which one should interpret these affective representations and demands. This ambiguity, once more, paved the way to both a do-it-yourself idiosyncratic interpretations or to the re-proposition in an apparently new guise of the various old psychotherapeutic approaches.

Jervis envisioned the untoward consequences inherent these proposals and showed a different way of dealing with these problems.
He definitely shared the idea that clinical psychology (and, in part, psychiatry) should be distinguished from the medical *modus operandi*. However, he questioned the possibility to identify clinical psychology with a unique theory of praxis. Even more utterly, he criticized the de-objectifying perspective of this meta-model [13]. He believed that the fundamental activity of clinical psychology was evaluation. The planning of adequate interventions for each clinical case stems from an accurate evaluation of the case. Thus, he agreed that psychotherapy was only one of the possible interventions to be employed, when required by the patient's conditions and allowed by the context and resources available to the clinical

psychologist. He stated that clinical and scientific knowledge coming from psychopathology and psychiatry, developmental psychology, the life-cycle psychology, personality psychology, psychobiology and dynamic psychology was the necessary background for any activity of evaluation [14]. A correct psychopathological diagnosis was central in the evaluation, providing, , according to Jervis, a powerful synthesis of the way the patient experiences both the external world and his inner reality. Furthermore, the patient's psychopathological condition could allow to more accurately foresee the transformative limits and potentials of each specific clinical intervention.

These positions concerning the status and definition of clinical psychology were derived from broader reflections on themes that always attracted Jervis' interest, since the very beginning of his research. It's through the reflections on the nature of mental illness, the relevance of body and relationships in human mental life, the building of individual identity that Jervis fully developed his thought and helped clarifying the field of clinical psychology.

The field of clinical psychology

Psychopathology and mental illness

Although Jervis did not identify clinical psychology with psychotherapy and, even less, with the treatment of mental illness, he undoubtedly believed that the demand for clinical psychology is often motivated by psychopathology and existential suffering. Psychoanalysis and clinical psychology had their roots and gained credit by proposing an explanation of mental suffering and a possible way to transform it. Jervis held that psychoanalysis had encountered its crisis when its aetiological views of neurosis and psychosis had lost credibility on scientific as well as clinical grounds. It's probably less known that he also looked with some wariness at

the idea that psychotherapeutic techniques in themselves could provide more effective remedies for mental disorders [15]. Nonetheless, Jervis stressed that clinical psychology could not avoid giving a proper placement to psychopathology and emotional distress within its area of intervention.

More specifically, I try to summarize Jervis's position on this topic as follows.

First of all, Jervis fully recognized that the evidences from neuroscientific and behavioural genetics leave little room for the psychological interpretations of the basis mental illness. Unconscious conflicts, aberrant patterns of familial communication or maladaptive cognitive beliefs were not the only and not even the determinant factors for the emergence of the majority of psychiatric disorders. In this regard, psychologists struggle to recognize that psychotherapeutic interventions can have only a limited efficacy in the treatment of mental disorders. The causes of mental illnesses should otherwise be sought in the alterations of the neurobiological networks that support the integration of a distinct bodily image, the sense of agency and the affective and temporal continuity of identity. The acknowledgement of the biological origin of mental illness seemed to Jervis to have finally reached the patients, who more and more frequently demand specific and adequate interventions to the psychiatrists, mainly in the form of psychopharmacological treatment. On the other hand, these patients also keep expressing a specific demand of psychological intervention that concerns the possibility to have their experience of mental suffering understood. Clinical psychologists, therefore, have frequently to deal with the relational and subjective distortions caused by mental illness. As Jervis clearly stated, the patient's demand for the clinician (whether she is a psychiatrist or a psychologist) "is about emancipation and primarily and strictly concerns the emancipation from mental suffering" [16, p. 77]. It is also necessary to take into account that "if the patient's de-

mand does not often go any further than adjustment, it's also because the very condition of psychological suffering impoverishes instead of illuminating the patient's, not allowing for broader alternative views [17, p. 77]. Thus, it's difficult to establish common objectives of clinical work with the patient without recognizing the nature of the alterations of subjective experience produced by different forms of psychopathology. At the same time, it is as well fundamental to distinguish mental disorders from the various aspects of existential suffering. Again, this distinction calls into play the necessity of accurate diagnosis for clinical psychologists [18] and the professional responsibility of the clinical psychologist in the activity of evaluation. However superfluous this consideration may appear today, back in those years it was at odds with the spread anti-diagnostic convictions of many clinical psychologists. Even worse, the anti-diagnostic and nearly anti-pathological attitude of many clinical psychologists somehow reinforced the fears and defences of young psychologists who would prefer not to take on the responsibility to deal with the patient's anguish and vulnerabilities.

Notwithstanding a clear recognition of the biological aetiology of psychiatric disorders, Jervis thought that mental suffering is always expressed on the level of a "loss without return of the *presence*" [19; 20] to quote his first mentor Ernesto de Martino. The loss of the sense of being caused by the "brain illness" does not compare with any subjective consequence of any other organic disease. The patient is induced to require a change in the domain of subjective and interpersonal experience. On this level clinical psychology in general (and not only psychotherapy) can contribute, if not to transform these conditions, at least to make them more tolerable. If we take it for granted that many symptoms and psychiatric disorders do not make their appearance because they have a meaning, we should also recognize they end up acquiring a meaning. Moreover, this process of signification becomes part of the pathological organization the

patient requires to deal with. This view of mental illness was initially drawn by Jervis from his psychoanalytic background:

> *"Psychoanalysis with its method proposes an alternative to the essential contradictions with which psychiatry has always been struggling. This contradiction is characterized by the division of the research into the same fields which Freud's doctrine tries to unify. As a matter of facts, psychiatry deals with alterations of human behaviour that, on the one hand, can definitely be derived from the more or less stereotyped repetitions of somatic illnesses, on the other hand, they are also surely placed on the level of historical events in the continuity of existence and its environment, drawing from this environment the stimuli, the evidence, the conditioning, the contradictions and the very motives for their own manifestation (Jervis, 1977, p. 45-4).*

Jervis gradually abandoned the methodological and theoretical framework of psychoanalysis. Still, the contradiction highlighted by psychoanalysis remains open, at least in the clinical practice of both psychiatrists and psychologists. Jervis stressed that unlike psychoanalysis, contemporary clinical psychology and dynamic psychology do not mainly rely on the subjective-introspective method to build their hypotheses on personality development, individual differences, sources of mental suffering and mechanisms of clinical change [21; 22]. For Jervis, it was fundamental that clinical psychology would draw from the clinical insights of psychoanalytic tradition concerning the unconscious dimension of the clinical relationship, moulding its theories and clinical practice on an empirical basis and objective methods of verification at the same time.

In this regard, Jervis did not propose a unique meta-model for clinical psychology but he evidenced the tensions that constantly cross its field. This leaves us with more questions than answers. Once we acknowledge the biological origin of mental suffering, what room is left for a transformative clinical intervention based upon psychological treatments?

A better framing of this question, if not a proper answer, comes from Jervis' view of the themes of relationship, body and identity.

Risks and opportunities of the notion of relationship in clinical psychology

The notion of *relationship* affirmed itself as a sort of key-word or, better, magic word for most psychologists starting from the Seventies. First of all, the concept of relationship represented for many psychologists a comprehensive framework to understand what happens within the patient's mind. At the same time, the theme of relational mind allowed to overcome the Hobbesian view of the Freudian developmental theory. Finally it constituted a unified ground for many psychological models such as contemporary psychoanalytic trends, attachment theory, family-systems approaches, more recent cognitive orientations. Overall, the emphasis on affective development and therapeutic relationship had introduced a very important shift in clinical work bringing up the importance of the subjective and inter-subjective dimensions in psychiatry [23, 24]. Jervis had always appreciated the clinical contributions of authors such as Harry Stack Sullivan from the interpersonal psychoanalytic school. He explicitly stated that psychiatric orientations exclusively adhering to a medical model, guiltily overlook this basic aspect of clinical work [25; 26]. The observation of relational dynamics occurring in the relationship with the clinician is a basic instrument to let the patient acknowledge her idealized expectations toward parental figures, her omnipotent projections and more immature components and desires. The clinical work can become effective through the analysis and eventual reduction of these idealized and omnipotent expectations. However, Jervis felt that the notion of relationship was too generic and hid many misunderstandings and ambiguity. It needed to be further articulated. Jervis believed that the world of interpersonal relations constitutes the environment in which human mind develops. Mental contents

are always declined in relation to this interpersonal environment. The individual does not encounter the world of relationships at a certain point of development, as Freud had proposed with the notion of primary narcissism. Relationships are the fundamental matrix within which the mind perceives, plans its actions and construct its meanings. Our mental contents take the others as their object and take into account that the others take us as their object [27].
At the same time, we should never forget the active role of the individual in building relationships:

> *"It's surely true that each individual does not exist outside the context of a social environment: but individuals are the agents of their thoughts and actions and not the reverse, they are the real protagonists of the relationships bounding them; and, in this way, also beyond human species, we realize that all living nature is made of individuals committed to survival, and not of abstract relational systems. And finally and foremost, it is the case not to forget that ethics and morals do not concern social sets, but only, eventually, individual responsibilities [28, p. 78].*

This critical remark meant to shed light on the risks of a view emphasising the all-inclusive role of relationships in human development, mental life and clinical work. This relational emphasis is prone to overlook the more objective aspects of the clinical work. More precisely, this relational holism is oblivious of the conditioning imposed by biological processes (including also the traumatic experiences and the early affective imprinting of the past). In conclusion, the relational perspective forgives the basic fact that the roots of mental life are somewhere else.

Body and the sources of human identity

I think that the following quotation splendidly summarizes the themes under discussion:

> *"Our life is not abstract but real, our life is not only a social biography, and construction of culture, and a world of ideas; on the contrary, it is in*

> *the first place and much more strongly, the history of a body, of hates and desires, of dissents and loves, of sex and illnesses, of idiosyncrasy and sufferings, of all that our parents gave us when we were conceived, of how we were moulded by the childhood abandonment and joys, of how we globally bear within us the everyday contradictions – and the richness – of being passionate and carnal individuals. Of course, the experience (both psychological and rationalized) of our body it's something widely cultural: the lived experience of the body in the "civilized" world it's not the lived experience of the body in a pre-literate culture. But the body in itself is not a lived experience: it's an objective reality and it has been substantially the same for thousands years for all human beings. The body determines our sense of being there, it dominates our life, precedes our conscience of being, influences our mental experiences, it imposes itself with its necessities and its limits, resists to all the attempts of sublimation, in synthesis, it maintains its primary character. At times, it is surprising how much efforts of lucubration are spent to obliterate its importance" [29 p. 129].*

The body, therefore, exerts a constitutive conditioning on human existence, on the world of symbols, affective bonds and social relationships. In this regard, it is more understandable Jervis' emphasis on mental illness as a moulding and pervasive influence upon the patients' psychic experience.

The reflection on the importance of the body is complementary to another theoretical topic that has always been at the core of Jervis interest, which is *identity*. The theme of identity is an elaboration of the notion of *presence* [30] which Jervis drawn from his master Ernesto De Martino. De Martino had stressed the relationship between cultural phenomena and the need to overcome the ontological precariousness of human being. Identity becomes for Jervis the place where the tensions between the socio-cultural definition of human existence and the inherently and primarily universal and biological roots of the mind become apparent. While for De Martino the cultural definition of identity is the solution to existential vulnerability, Jervis points out that identity always reflects the conflict between body and relationships, individual and society, and between subjective and ob-

jective determinants of human experience. Thus, Jervis transforms De Martino's existentialist views in a dialectic and dynamic sense. Since the very beginning of his work with De Martino, Jervis clarified that identity cannot be achieved only by "transcending" the individual subjectivity into the process of cultural signification [31]. Following psychoanalysis but also William James's notion of self [32; 33; 34], Jervis founded his view of identity on the personal process of "self-recognition" and "self-appropriation" of individual experience that is mainly based on the experience of the body. The experience of self-appropriation is given by the constancy of perceptions relative to individual peculiarities as well as from man's universal dispositions. Cultural and social definitions of identity come later and pertain the socialized version of self [35; 36]. Notwithstanding his interest in the cultural and social aspects of identity formation, Jervis relentlessly questioned those positions discarding the individual and biological foundations of subjectivity. In particular, he repeatedly criticized perspectives such as radical social constructivism, deconstructionist philosophical abstractions, post-modernist distortions to end up with some mystical conceptions of some contemporary psychoanalysts [37; 38]. Jervis elaborated his criticism in many regards. First of all, he thought that these social-constructivist perspectives paved the way to a return to idealistic, pre-Darwinian and pre-Freudian views of mental functioning. Jervis thought that the naturalistic study of the mind afforded by the Darwinian perspective necessarily leads to an individualistic view of identity. This individualistic view, of course, does not rule out a critical perspective in which identity formation is also influenced by social processes of development. But he pointed out that the emphasis on social formation of identity could lead to two distortions: A) to posit an unlimited possibility of self-modelling of the mind; B) to neglect the universal mental processes and dispositions that represent the embodied and intimate constituency of the sense of self.

Secondly, Jervis criticized the social constructivist interpretations of identity also from an ethical and political point of view.
One of the unacceptable consequences of a radically anthropological and social view of identity construction is an ideological and pseudo-scientific justification of the alienation of individuals' rights to self-determination by great social and political structures [39]. Jervis saw in this alienation of individual drive toward self-realization a major obstacle to the achievement of modernity and progress. The denial of the biological and individual sources of self-identity, in fact, corresponds to the denial of the essential right to the acquisition of the individual psychological autonomy and the strive to consolidate one's own ontological safety. Unlike Freud and many other individualistic thinkers, Jervis did not consider sociality as inherently alienating. But he believed that the disavowal of the naturalistic roots of identity would hinder both individual and social progress [40]. This argument has an important consequence for the clinical work. The, individualistic view of identity should also mark the limits to the influence of suggestion and charismatic power of the clinician within the therapeutic relationship.
But there is another controversial aspect of Jervis' view of identity bearing many consequences for the clinical approach. He always paid attention to the unavoidable hiatus between the natural foundation of the sense of identity and the subjective illusions produced by man's narcissistic frailty, interpersonal complacence and, last but not least, social scripts and the processes of everyday interpretation of the purposes of human actions, being much influenced by the American sociology of epistemology [41] and Erwin Goffmann [42]. In this sense, he proposed an unresolved and challenging conflict between a realist and sceptical view of identity. These conflicting views of identity meet in a peculiar way on the clinical ground. Jervis saw this tension between self-deceptions and the natural tendency toward self-appropriation of one's personal features as the area of potential clinical change.

It's important to further elaborate on this point. Jervis acknowledged that clinical change is characterized by the possible transformations of the existential project with respect to the mature acceptance of one's own limits, being them determined by the individual genetic patrimony, by the mistakes of a past which cannot any longer change and, not in the least, by psychopathological vulnerabilities. Of course, existential projects are also driven by the individual need to realize one's own potentials. But it's never easy for the clinician to help a patient to re-orient her existential project. This difficulty does not only concern the limits posed by the pathological functioning of the mind. An equal difficulty derives from the impossibility of a general definition of the areas of mental health and the horizon of potential change for each individual. According to Jervis' reading of contemporary trends in clinical psychology, many approaches converge in identifying self-fulfilment, as well as the construction of a solid and satisfying personal identity as the final objectives of change. Still, there's no doubt that the acquisition of a satisfying personal identity should not be tied to a predefined ethical or psychological standard: "everyone has the right to chose to survive how she likes: with the only condition not to harm others with her choices" [43, p. 95]. Furthermore, bizarre balances and anti-conformist choices should not be automatically considered as the expression of suffering or, worse, psychopathology, although they may be more manifest in more vulnerable and fragile people [44, p. 95].

At the same time, the *conquest of identity* cannot even be meant as a process of spontaneous and deliberate building and re-building of essential aspects of one's personality, of the most intimate ways of feeling oneself and the world, that is, what makes up the peculiarity of our individual being. It is certainly true that identity is never guaranteed once for all, because it depends on the complexity and multi-layered components of consciousness and awareness. As said before, identity is founded on a process of self-observation and self-

description that is prone to self-deception and to biases that are typical of the way humans interpret behaviours. The self-presentations that constitute identity, furthermore, are influenced by specific developmental vicissitudes and by the basic need to establish and maintain the individual psychic balance. Nonetheless, Jervis once more warned against sliding into a relativist, subjectivist and anti-realistic view of identity and mental functioning. It's duly to abandon the authoritarian and dogmatic stereotypy of certain psychoanalytic ways of interpreting individual dispositions. But this should not mean that we all abdicate a dialectic confrontation and a function of genuine criticism of the patient's false identity that generate suffering and hinder the individual emancipation. From this critical perspective on identity, Jervis stressed that a relativist view of identity would leave few chances for the individual maturation and personal growth: "if, in fact, we take for granted the too generic idea that any psychological identity has necessarily to 'be all right', then any identity, no matter how uncertain and precarious it may be, has no real reason to evolve and can immediately be considered as definitive. The moral goes as follows, and it's a bit too hurried: everybody has his own right and nobody else has the authority to tell what the best way of functioning is" [45, p. 97].

As often in his writings, Jervis does not avert the gaze from inherent conflicts emerging in the context of debate. Here, the problem concerns the possibility to compound a sceptical view of identity with a realistic aspiration to the self-knowledge in the clinical work. The problem is not only that this compound is always provisional and identity always changes and is prone to crisis. In his most recent writings [46], Jervis not only criticized the psychoanalytic idea of getting to know the "unconscious" contents of the mind, but he also proposed that self-representations cannot be but self-deceptions, because they are not really able to introspectively capture the sum of micro-processes that make up the work of the mind. Here a striking paradox is presented by Jervis: though

identity is always a virtual self-presentation, we are driven to believe in ourselves. But how can we reach the sense of a genuine identity and to distinguish it from false self-presentations? Which are the subjective experiences and objective representations that we feel as more "real" and more "personal" so that we tend to trust them as our real identity? According to Jervis, being much influenced by William James' pragmatic view of the self-experience, this existential dilemma can be solved assuming an empirical and naturalistic self-observatory stance. Provided that self-conscious identity does not have any metaphysical foundation, it's all the same true that its construction is based upon the possibility "to read and capture, in a realistic and even tempered manner, the *describable* set of characteristics of our species and of single human beings: our identity [47, p. 141]. Whereas our spontaneous tendency would be too create a self-soothing and self-enhancing vision, it is our nature, the patrimony of genes and experiences, which establishes who we really are. Man struggles with this basic conflict. The field of clinical psychology is thus delimited by the need to overcome the gap between the defensive constructions of self-awareness and the reality of our personality. We are then bound to delude ourselves as to whom we are, but "we are condemned to be always ourselves" [48, p. 99].

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