Ethics and the Increasingly English-Speaking Psychiatric Tower of Babel

Jean-Pierre Cléro

ANNALS of the University of Bucharest
Philosophy Series

Vol. LXVII, no. 2, 2018
CONTEMPORARY PERSPECTIVES ON MORAL PHILOSOPHY AND APPLIED ETHICS

ETHICS AND THE INCREASINGLY ENGLISH-SPEAKING PSYCHIATRIC TOWER OF BABEL

JEAN-PIERRE CLÉRO¹

Abstract

Frenchmen dealing with ethics have only recently focused their attention on questions regarding its relation to language, whereas the British and the Americans who share the same interest have been interested in this problem for decades. The most surprising fact regarding this relative neglect, that is only about to be corrected, is that it would have been noticed and dealt with much sooner, was it not for a blinding reason: namely that international medical bodies, psychiatric in particular, have become Anglophone bodies. The aim of this paper is to consider whether it would not be dangerous to confuse universalism, which is desirable, and translation which is equally desirable, with the choice of one language as axial for the other languages and supposed to define the structures of all situations – something which imposes on the other languages a strange reduction that they would probably not have suffered without this constraint about translation.

Keywords: translation, universalism, Anglophony, axial language.

Frenchmen dealing with ethics have only recently focused their attention on questions regarding its relation to language, whereas the British and the Americans who share the same interest have been interested in this problem for decades. Notably in the 20th century through philosophers such as R.M. Hare or J. Harsanyi, but for an even longer time if we, furthermore, consider the works of Hobbes, Locke, Berkeley, Bentham

¹ University of Rouen (France). Email: <jp.clero@orange.fr>
and Stuart Mill. The most surprising fact regarding this relative neglect, that is only about to be corrected, is that it would have been noticed and dealt with much sooner, was it not for a blinding reason: namely that international medical bodies, psychiatric in particular, have become Anglophone bodies. Psychoanalytic bodies have followed the same way very much about the same time. Since the 1950’s, the World Health Organization publishes booklets in English under the abbreviation CIM, followed by a number\(^2\) and the acronym ICD, again followed by the same number\(^3\), wherein the “diagnostic search criteria” are listed offering a lexicon with a view to discovering symptoms and syndromes, to refer to them collectively, to prescribe treatments, to present types of development according to these treatments, to historicize illnesses that have been detected and which emerge, develop, disappear and change. These booklets are translated into all the languages of the countries agreeing to contribute to this great international enterprise\(^4\). Learning lessons from failed experiments of adaptation, the authors of the prefaces assure us that these booklets have been translated by experts, which is right but which, in their eyes, seems also to remove all ambiguities\(^5\). When

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\(^2\) If the DSM (Diagnostic and Statistical Manual of Mental Disorders) is an American classification (that begins in 1952 and that is penned by the American Psychiatric Association) – translated into French under the title Manuel diagnostique et statistique des troubles mentaux –, during the same period is settled an international classification, the ICD, the International Statistical Classification of Diseases and Related Health Problems; in French, the CIM (Classification internationale des maladies).

\(^3\) ICD System: International Classification of Diseases, Injuries and Causes of Death.

\(^4\) They were already 35 in 1976, as a note of the Introduction points it out, p. 13 of the Glossary and Guide for classifying mental disorders published at Genova by the WHO (World Health Organization). I don’t know how many they are now, forty years later; they are probably more numerous.

\(^5\) “The French translation of the present work and of diagnostic devices that comes with it was realized by a team of linguistic experts from sundry French-speaking countries. So, this text is a translation; not an adaptation into French of the Chapter V (F) of the CIM-10” (CMI-10/ICD-10, Classifications internationales des troubles mentaux et des troubles du comportement, Masson, Organisation Mondiale de la Santé, Paris, Milan, Barcelone, 1994, p. XIII). We ought to be plainly relieved; but the matter is less the quality of the translation as “good” or “bad” than the need for translation itself. Romanian psychiatrists use an equivalent work titled “Lista de coduri CID-10”.\n
translations was impossible and produced remainders, an appendix issued in 1994 was published to collect them and list them in a vocabulary that leaves the free designation of the troubles to the language of the (more or less extended) social group wherein they appeared, with the expectation that, with time, these troubles or disorders will join the standardized denominations that English is supposed to realize the best, as the language supposed to be the most appropriate for the sciences and spoken by most learned people in the world. How could patients and their doctors refuse to contribute to such a great cause that promises to and, in a great measure, succeeds in reducing to a common denominator symptoms that otherwise would have been scattered, indexed according to local contingent criteria, and taken into account in a disparate way? How insincere would it not be to reject the advantages coming from the opening of national and linguistic frontiers so that efficient statistics relying on large numbers may contribute to enhancing the prospect of curing every patient, whatever his language, and such that these patients are not disadvantaged – or as little as possible – by living far from a center of efficient medical research? How could a human being whose mind is imbued with Enlightenment not ignoring that the rationale of any discourse or practice is measured by its “precise universality” fail to admire and

Such is the constantly displayed aim. For instance, we read, right from the beginning of the Glossaire et guide de classification des troubles mentaux à utiliser en liaison avec la Classification internationale des maladies (Glossary and Guide for classifying mental disorders, published at Genova by the WHO), 8e révision, (Organisation Mondiale de la Santé, Genève, 1976), the introductory note of Dr. Raymond Sadoun: “The present French edition of the Glossaire et guide de classification des troubles mentaux, published by the OMS (WHO) comes just at the right moment to convince French and French-speaking psychiatrists to use the sort of classification needed for standardization of diagnostic data. The need to use, in psychiatry, standardized diagnostic data is connected with the development of epidemiology, the applying of statistical methods to the study of the efficiency of modern ways of treatment, the multiplication and diffusion of scientific publications, the use of automatic treatment of information” (p. 6). The author of the introductory note highlights that the research program on the standardization of diagnostics, of classification and statistics in psychiatry has been conducted since 1965 by the WHO.
recommend the description of treatments in definite words, acceptable by everybody, without the regionalisms, localisms, turns and procedures which are questionable for all minds permeated by universalism?

However, if it is not possible to be wholly unsympathetic towards a movement that goes beyond national, state-controlled and linguistic frontiers, and that turns upside down the ordinary deep rootedness, when we only consider the benefits of this “idea” and provided it is presented in this way, one can be more cautious about the way we are obliged to implement it and which has proved to be dangerous for many decades. It would be regrettable that pretexting the elaboration of a universal rationality and in particular a universal classification of diseases and their treatments, one should take as the central axis the conceptualizations of some states, with their ordinary deep rootedness in one single language, namely English, which enjoys the privilege of being the principle of the other languages and consequently they have to be translated except for some remainders published elsewhere. You could say much about the way French astronomers, physicians, mathematicians have forced their colleagues in the other European states and – why not – the whole world to toe the line. Would there not be more to say about conforming to medical practices expressed in one language, even if it is possible to translate them into all other languages at will? Perhaps fifteen years ago, I heard Michel Serres say7 that there is no more painful situation than being ill in a foreign country, without being able to speak its language and so unable to tell one’s evil in one’s mother tongue, and begging for care in such conditions. Would the overridingness of one language, be it a wonderful cultural language as the English language is, leave us in circumstances similar to those described by Serres, since the illness I try to describe for the doctor and which he starts to treat is thought and expressed in another language which it will be necessary to translate in order to know what happens to me? In no way, our purpose is to mount a fresh attack against English; as any language, English has its strong points and its weak points, its advantages and disadvantages for structuring the events and give them

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7 In a broadcast or in a conference; perhaps the sentence was written somewhere.
some shape; it lets us see many things and glosses over others, as all the idioms do. My aim is rather to consider whether it would not be dangerous to confuse universalism, which is desirable, and translation which is equally desirable, with the choice of one language as axial for the other languages and supposed to define the structures of all situations – something which imposes on the other languages a strange reduction that they would probably not have suffered without this constraint about translation. One would object that, in order to realize efficiently rational universalism, one has to agree upon a language, even if it means that another language could have been retained for the same use; but that such an arbitrary choice cannot be avoided and only be adapted or improved. I would like to consider here the price you have to pay for this concession in psychiatry; the canting and ambiguity that comes with this concession. For good and bad reasons, Lacan, who was also a psychiatrist, was one of the very few people who rebelled against the dominance of the Anglophones within psychoanalytic international bodies. He lost the fight fifty years ago, during the sixties. The question is neither to imagine that what is problematic in psychoanalysis is likewise problematic in psychiatry nor to incite a chimerical revenge on Anglophony who imposes its criteria. It is rather to become aware of some disadvantages associated with the overridingness of English and of the necessity to be inventive in the struggle against its drawbacks and to adopt an ethical standpoint.

I. Let us begin by pinpointing a very strange thing that happens in psychiatry, but probably not in any other field of medicine.

Psychiatry expresses itself in the categories of ethics. Leaving aside the notion of “personne” in French and that of “person” in English, I will restrict myself to the interplay between the notion of “trouble” in French and that of “disorder” in English and by which the French “trouble” is conveyed.

First, we must agree that a psychiatric disorder often begins by a behaviour that, if it is not always antisocial or aggressive, is nevertheless the fact of a minority and would put the society at risk if it were generalized. The subject that has them seems either not to understand social norms or, if he knows them, he does not care about them or he is
in the impossibility to respect them and thus cannot take his normal place in the ordinary life around him. Even if what is called health – mental health in particular – is a normative power that cannot be confused nor totally identified with social norms, the detection of anomalies or abnormalities in this power depends on the pinpointing of competences which is brought to play in social rules, in order to submit to them, of course, but not only since it is also about playing with them.

The point that we have just raised has often been highlighted, but is also associated with a cutting commentary denouncing psychiatry as having no other aim than to rehabilitate, by all possible means and with the highest degree of therapeutic imagination, the patient into the social fabric of habits and customs, in such a way that this integration might be harmless for society and such that it would be impossible to expect from him any injury of the others. Even if the psychiatrist, would claim that health can be distinguished from the good functioning of social norms, his aim as a psychiatrist is to handle the patient in the right way so that he finds his place in the social structure in which he is bound to live. Unto this point, and at this level of generality, the difference between languages does not change anything.

Things begin to change when we notice that the notions we have just put at stake – like that of trouble, of disorder, and it would have been possible to choose others like person, self, I, intimacy – have a very different meaning and value in each language, even when those languages appear to be very similar, as French and English. We intend to highlight that these differences remain beyond the so-called good translations that are promised by optimistic preface writers of the booklets of CIM/ICD; not because these translations are bad, but only because they are translations, i.e. transfers or displacements, that are now less avowed than they were at the time when the writers of glossaries and classifications were still speaking of “adaptation”.

To confine ourselves to the difference between the “disorder” of the Anglophones and the “trouble” by which the French has expressed it, though English also knows the term, “trouble”, but the Anglophones are careful not to use it in such a psychiatric context, we wonder whether there are not between these two words, whatever the semantic intersection that allows to translate the one into the other, a huge gap in
terms of imaginary? Sartre has analysed the phenomenology of the French term “trouble” remarkably, whose image refers to the chemistry of a vaguely stagnant water\(^8\), whereas the English “disorder” directly refers to dynamics of the perturbation of an order or of a system. The matrix of care, whether we follow the direction opened by one word or by the other is, of course, very different. One reduces or resorbs a disorder; with a trouble it is only possible to separate what is mixed and to restore, through a filter, the transparence of one of the components. The fact that the translation cannot express this difference is evidently gross with equivocations: trouble does not refer as neatly as disorder to a disturbed structure and in which the I plays nothing but a function or a set of functions. The chemical or biological substantialism of the trouble calls for a transformation from purity to impurity (or the reverse when the matter is to filter it) and it associates with the sort of ethical categories that Ricoeur had dissociated from those of sin and guilt, for instance those of the person and other neighbouring types of rationalization. From the structuration that follows disorder can be expected a redistribution of roles and quite a different dynamic. The translation only feigns an agreement between speakers of different languages and about what we don’t know. We are not saying that one language has more value than another in order to explain psychiatry; we merely pinpoint that languages – whether in a scientific context or in a care context – throw us into disjunct universes, even though the same phonemes or the same signifiers are criss-crossing, whereas the aim of

\(^8\) Sartre J.P. (1943, 437): “Desire is defined as trouble. The notion of ‘trouble’ can help us better to determine the nature of desire. We contrast troubled water with transparent water, a troubled look with a clear look. Troubled water remains water; but its translucency is ‘troubled’ by an apprehensible presence which makes one with it, which is everywhere and nowhere and which is given as a clogging of the water by itself. To be sure, we can explain the troubled quality by the presence of an invisible something (…) which is not itself distinguished and which is manifested as a pure factual resistance. If the desiring consciousness is troubled, it is because it is analogous to the troubled water” (Sartre 1993, 387).
the CIM/ICD booklets is to create the commensurability necessary to the obtention of great numbers\textsuperscript{9}.

I might be objected that it is useless to care about the imaginary of words. All what you are saying about English loses all its sense as soon as you understand that the name of illnesses is of no importance; it is only about pinpointing a symptom or a set of symptoms and to work with what is pinpointed or brought together without worrying any more about the imaginary of the word used for its designation. Since the

\textsuperscript{9} We may do similar commentaries on Global Assessment of Functioning Scale (the GAFscale); in French: “Échelle d’Évaluation Globale de Fonctionnement (EGF)”. See, for example, the \textit{Mini DSM-IV-TR. Critères Diagnostiques}, (Paris: Masson, 2004), p. 48. \textit{Assessment}, in English, does not cover exactly the same things that does Évaluation in French and has not the same connotation. We could say exactly the same of \textit{functioning}, translated by \textit{fonctionnement}; this translation does not fit exactly with \textit{fonctionnement}. One cannot say that “une personne fonctionne” has the same meaning as when one says, in English, “the functioning of an individual”. This is not the place to analyze the difference between \textit{fonctionnement} and \textit{functioning}, as we have proceeded above with the difference between \textit{trouble} and \textit{disorder}, but it is clear that the imaginary of the two words is different, even if the signifiers are nearly the same and have been chosen to be the same, except the English one that may use the “-ing form”. The DSM-IV-TR says something about the “fonctionnement social, familial, professionnel ou scolaire”: it is really spoken of “comportement” (behavior). The will to make a scale furthers “le fonctionnement” rather than “le comportement”, because the latter cannot be reduced to a function, which is one aim of the authors of the DSM-IV-TR. \textit{Comportements} (behaviors) may only be classified; \textit{fonctionnements} may enter in a function with very close degrees. In the definition of \textit{dyspareunia} (dyspareunie, in French), \textit{distress} has been translated by \textit{souffrance} in French; of course, one can hear in English the word \textit{stress} that has disappeared in French. Is it spoken of the same illness in English as in French? The differences are countless. It would be necessary to question them, one by one, to solve their riddle. For the authors of the translation the problem was – which is not bad and probably cannot be better – to make illnesses’ names commensurable in order to be taken into account in the same way.

The foreword of the \textit{Glossaire et Guide de classification} (1976), signed by Sir Aubrey J. Lewis, is perfectly clear on the subject: “As all disorders are somehow abstractions, it is not wondering that the nosological entities of which the psychiatrists are dealing have imprecise limits and overlap each other”. But no matter how much fictitious is the entity of illness, it does not hinder the authors of the Introduction to present, this time, the CIM as “a classification of diseases rather than of patients” (p. 12).
perspective of CIM/ICD is more nominalist than essentialist, the words used in Anglo-Saxon psychiatry are just like the names used in mathematics, as when Hilbert says that the names point, line, area, are those of a set of logical proprieties without worrying about the images that, since Aristotle and Euclid, are carried by the same words. Unfortunately, this remark is erroneous as soon as those who designate these “objects”, though being conscious of the arbitrary sense of their designations, persist in speaking of “point”, “line” and “area”, just as one speaks about “person”, “personality”, “disorder of personality”, etc. in psychiatry, remaining within an imaginary denied in other respects. We will see the reasons why it is impossible to give up the imaginary in medical relations. For the time being, let us try to see what happens when English becomes the overriding language for designating illnesses.

II. I shall lay great stress upon the fact that, like all other languages, English locates the subject in its folds such that this place, necessitated by the structure of the language, is nevertheless contingent if compared with the different ways in which other languages place the subject in their own folds. In so far as the function of the subject has its sense only in a structure, and if this structure differs from one language to the next, the place of the subject in a language will not coincide with the similar place in another, even in similar circumstances. We are not saying that the subject is situated in a better or in a worse way in English than in other languages; we only highlight that English cannot do otherwise than situating the subject and that its way to locate it is neither less original nor less arbitrary than in any other language. No language ensnares the subject as another does. So it is shocking, particularly in a field like psychiatry where the situation of the subject, its consistency, the play between its functions, are of such great importance that a privilege is unduly granted to one language for being the only one to pinpoint and rightly expressing that place. There is no more rightness in one language than in another in these matters. No language should be the language of languages – except if one is artificially built by fiction and method – and no one can feign to be a sort of metalanguage for the others, though, by the means of the position it holds, it could be in position to institute this phantasm and impose its fancy.
The importance for psychiatry of how languages situate the subject cannot escape our attention, since, even if the expert can rightly introduce in his own language nearly all the situations that he cannot spontaneously adopt, the problem of classification of diseases, especially when they imply, as nearly all these illnesses do, troubles and disorders of personality, could not be posed in English – in the booklets of CIM/ICD, – as in the other languages. Of course, the point is more crucial in psychiatry, in psychology and in any other human science than in all the other sciences. Any language spurring the subject towards positions rather than others, if, in a language, one wants to classify these positions, it is clear that – how conceptual our intention might be in this classification – this play of positions will not resemble the one that could have happened in another language. The problem of classification will not be relevant in the same way, at least, in one language and in another.

As far as it is possible to pinpoint, in English, the failings and flaws whose existence is partaken with all the other languages, and without which it could not be used by any speaker, it is the assumption of a special power or in seeing this power granted by a particular contract, and not by some innate merit that English is indebted for this preferential treatment. To solve our problem there are no measuring devices to be produced, sold, repaired or replaced, while there were such apparatuses when France, at the time of the Revolution and during the Napoleonic era, would export its measures; but there are drugs, services, modes of operation to be sold, made invisible by the mode of schematization of languages; for, as soon as a language has the power to be the only one to be used, it hides to its speakers its uniqueness and conceals to itself its own flaws. Only when a language is confronted with others, its speakers realize its own voids that, at the same time, allow them to speak. It is not impossible that, if a language had no flaws and failings, it would not allow to speak and no more give to its speaker the advantages that it pretends to give him. How could it avoid causing some damage on the others in a position of strengths?

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10 Bentham has tested it in his classifications and he has encountered the obstacle of languages of which no one has the same words to designate the same things or, when it has them, one does not attach to them the same value as another.
Let’s be quite clear, it is not the fact that science proceeds by contract that we are questioning. As soon as one questions that knowledge is to discover “already given objects”, that truth is a sort of aletheia, and the aim of science is to grasp essences hidden behind traces or symbols, then the construction becomes unavoidable and structures must be invented to let many researchers work together at the same enterprise and this cannot be the business of one man, in medicine as well as in other sciences and arts. We challenge that one of the partners dares to derive all the advantages from the contract, to condemn all equality and satellize the other partners.

As brilliant a Francophone as he was an Anglophone, Stuart Mill clearly saw how English could have devastated other Indian languages, and, through this devastation, have reduced to nothing the juridical, economic and political structures of the countries that English speakers had invaded. There are no damages worse than those that can be caused on languages by languages that allow an overridingness. “The first English conquerors of Bengal, for example, carried with them the phrase landed proprietor into a country where the rights of individuals over the soil were extremely different in degree, and even in nature, from those recognized in England. Applying the term with all its English association in such a state of things; to one who had only limited right they gave an absolute right, from another because he had not an absolute right they took away all right, drove whole classes of people to ruin and despair, filled the country with banditti, created a feeling that nothing was secure, and produced, with the best intentions, a disorganization of society which has not been produced in that country by the most ruthless of its barbarian invaders. Yet the usage of persons capable of so gross a misapprehension determines the meaning of language” (Mill 1974, 692-693). The colonization by languages is much more dangerous than the military colonization. The sniper may be placed in ambush: but, in the end, he is traced and hunted out, after he has caused limited damages. Language cannot be traced in its effects and easily detected; it is necessary to have learned much to be able to locate a language and, even when it is located by the scholar, this location has no a great effect on the ordinary speaker: a Herculean strength, guided by a lot of linguistics, is necessary to get rid of the
pregnancy of language upon ourselves, because a language, under the guise of carrying one of its meanings to another language, can subject this other language without the consciousness of its speakers; and it can, by this way, colonize their modes of thinking, feeling and acting.

III. We will be accused of exaggerating the danger: is it not enough to learn English correctly so that we will be no more be led astray by false friends, phrasings which in French has no ordinary use, etc.? We will be told that, in medicine, we are rather in a situation to benefit from concepts created in a language and translated in another without a huge loss of meaning. But is this exactly the case? Is it the same problem we encounter in medicine where a great number of notions and expressions can easily be shared between doctors and patients who were told they have such or such troubles or diseases, as in mathematics or in physics where the greatest number of notions has no common words in the usual life? When we work in the field of the so called “human sciences”, it is not seldom that the scholar is busy working with the notions produced by the subjects that he is studying. I think it fitting to recall here that Lacan, for instance, liked to work, in psychoanalysis, with the language of the other – may that other be a patient; the ethnologist does the same with words of a culture that is not his own, raising thereby a lot of criticisms.

From this point of view, the strange ethnological device introduced in 1994 in the appendix 2 of CIM 10 / ICD 10, and which will be periodically reproduced from this year onwards, should give food for thought. Would its function not be contradictory? On the one hand, the names of diseases or, merely, the names of symptoms that appear in

11 F. Gorog rightly writes: “During the 70’s we saw Lacan give preference to words chosen by the patient in order to designate its disorders” (Cassin and Gorog, 2016, 107).

12 It is well known that in the 50’s some ethnologists would have questioned the possibility of telling about a culture in the very terms of this culture. Florence Weber mentions this in her Presentation of the Essai sur le don (Essay on Gift), when she speaks about the strength of things, the hau, that Mauss leaves untranslated in the original language (Mauss 2012, 26).
non-English-speaking countries, are, even with respect for their inhabitants, introduced as remainders, trims, temporarily impossible to take account of in the general nosographic system supposed to be so well expressed in English, that is considered as the fundamental cultural language in medicine. In this way, we are referred to a Maussian style ethnology in which the research fields already interested in the technics of the corps are extended to illnesses. On the other hand, if we admit that there are diseases that escape an English expression, which are designated in non-Anglophone idioms, then looking for help in the old technique used by Mauss calling some aspects of a studied culture by its own words transferred without any translation into the ethnologist’s language, would make it difficult to understand why the general project of a universal logical construction under the aegis of English would not be jeopardized by the existence of nearly all the non-English languages. Presented as “remainders”, temporarily unmanageable, but soon integrable, the fragments of languages supposed to resist to English are at once too narrow and too large: too narrow, because no language can escape the discrepancy between itself and English in the designation of the diseases; too large, on the other hand, because the “remainder” is a threat for the whole aim of the project. The embarrassment is visible from those who introduce the notions of those “disorders specific to a given culture”: “The position of these disorders is uncertain. From some authors, they would differ only by their degree of harshness from certain disorders actually described in existing classifications, for instance the anxious states and reactions to stress factors, and, by this very fact, they ought to be considered as local variations of disorders known for a long time. The exclusive appearance of these disorders in specific populations or cultural regions has been questioned”\textsuperscript{13}.

Though its formulation is confused, this last position is a full avowal: if there are local disorders, they are contingent variations on more essential diseases, expressible in English. The whole ethnocentric ideology of the booklets is enclosed in these two propositions. Every

\textsuperscript{13} CIM 10/ICD, WHO/Masson, 1994, for a French translation of the text published under the title \textit{The ICD-10 Classification of Mental Health and Behavioural disorders: Diagnostic criteria for research}, by the World Health Organization, 1993, p. 161.
disease has an essence, although the authors deny holding such an essentialism, and it may have, outside the Anglo-Saxon countries, local variations that diversify the principal theme.

The DSM-IV-TR is less an improvement of the situation than a moral hindrance to it. The authors highlight “how far the cultural circumstances are important in taking a patient into care”, but they go on thinking that, following the foreword, “the diagnostic criteria and the classification by the DSM-IV of mental disorders reflect an actual consensus lying on an evolving knowledge in the field of psychiatry”\textsuperscript{14}. Are they not still sticking to the ethnological prejudice that fundamental or fundamentally designed diseases are expressed in English and may only be translated into other languages, whereas the other diseases are particularisms, localisms, provincialisms, even if their phenomena appear in huge areas of the world? This total blindness to the language is surprising.

IV. I would like to conclude with a remark that will clarify a point.

By highlighting the function of language, as if it would give a scheme an access to illness, in order to proceed with its denomination, to announce it and explain its treatment, we have perhaps given the impression that we think that all mental diseases are nothing but imaginary, and that it seems like they through the medium of language and according to sundry ways are produced by dysfunctions in society; in other words, and to reiterate the old slogan, so much heard in the 60’s and so imprudently stressed: \textit{if an individual is ill, it is more fundamentally because he is a member of a society that has become dysfunctional.} So would it be the society that has to be changed in order for the individual to recover his health; so psychiatry would take the wrong road stating as its aim for the patient that he should be reinserted into social relations, when they are the ones that made him ill.

I do not think so: even though societies would need to improve their functioning, I do not think that mental diseases are, in the last instance, mere dysfunctional troubles in families and societies,

\textsuperscript{14} Op. cit., p. XLI.
resonating through the individuals; still less that these dysfunctions are the only causes of pathologic difficulties in the individual and its morbid state. Certainly, an illness is not only cured by words. We only intended to say that the treatments, the ways of shaping our illnesses – that do not exist by themselves and so have no existence unless we take them into account through our acts and all those things we do while pointing in one direction – cannot be separated from language’s schemes, and even from the schemes of all the languages in which the treatment becomes a sort of story, a destiny, for every speaker. The important thing for us is to have shown how languages, divided between them, produce remainders in their reciprocal translations. These “remainders” seemed misused in the appendix of the booklets of CIM/ICD; even if the act of collecting them is not devoid of interest.

To say that illness happens in an inextricable network of sensations and words, mutually intertwined does not mean that they are nothing at all; it is precisely the intersecting of all these perceptual series and even the intersecting of all the events and representations that, being named or not, tells the story by virtue of the very play of these series and our practices in regard to them. Illness has neither identity nor reality apart from these series. In a way, an illness is a sort of tale that incorporates images, sensations, perceptions, emotions, pleasures and displeasures, sufferings, recollections and words; it is nothing beyond this bundle that does not exist as something in itself and whose flow of sensations would only be the dream. Its “real” itself is the flow. Those who say that illness does not exist and that it is inoculated only by society did not err by less “realism” than those which point of view and philosophy they seek to destroy. We do not go from one extreme to another, because, for us, the real does not transcend our representations and sensations, but it is immanent to them. Real is representations themselves, without any below, without the reverse, without anything hidden.

I add as a final remark that if speaking about the discourse of the other is essential in psychiatry and this disqualifies the existence of one principal language for psychiatry such that all the other languages ought to be translated in this single language – with all the drawbacks we saw –, it is also a great principle of rationality to do so. Pascal noticed the point perfectly in his Provinciales, when he said that we must not fight about
definitions, but left them to the interlocutor when he does not agree with ours. Under the guise of rationalizing, the choice of one particular language defies rationality.

Epilogue

It was objected to what I said above that, if it is desirable that psychiatrists all over the world exchange their knowledge between them, then we really must have one common language; and because there is no language of languages or some super-language or metalanguage that may override all the others, why should we not choose English? I agree and I do not defend the cause of any other language – Romanian or French – that could be substituted for English and could play the same role. I only highlight that this arbitrary though unavoidable overridingness of English is not without consequences and does not remain neutral in psychiatry and in the way the patient tells and lives his/her illness. Besides the expression of diseases in English, it is not seldom that the diseases are cured with drugs nominated in English, and sold, for many important of them, by American or English firms.

To cure illnesses other than psychiatric disorders, may require tools and equipment made in an English-speaking country; we will be told, once more, that this fact has no consequences because it is always possible to translate, from English into any other language, the units of measure and other expressions. But how a translation could be neutral? Is it possible to base an argument in favor of neutrality of languages on the fact, always forwarded against our position, that the English-speaker, when he receives it in English, can adjust the meaning of an expression in his own mother tongue, without paying it attention? We mean here by neutrality of language the pretended indifference to live and think one’s disorder or disease in a way or in another. As if being unconscious of a process and paying no attention to it would be equal to inexistence of that process. On the contrary, is it not true that when one is not able anymore to perceive a phenomenon, it becomes more “real”, more insistent? It is undoubtedly true that the Anglophone does not think anymore to the imaginary of the words he uses; but first of all the
patient is not necessarily an English-speaker, and secondly, the imaginary of patient is bound to his unconsciousness. Unconsciousness labours thought through the imaginary. Would it not be rough to neglect unconsciousness in health business, particularly when the diseases are mental disorder?

I admit that the preceding remarks may be felt as a bar to the international consensus sought for convenience in medicine, because we do not know which is the appropriate equilibrium between a language that has won a primacy in trade, scientific exchanges, diplomatic relations, and the other languages in which the patients tell their illness and are answered by their doctor for the suitable treatment. A double linguistic system would not be embarrassing; but it is perfectly clear that the expected issue is well and truly an uniformization of the disorders’ names; however, such an uniformization requires an entire philosophy or a all new way of thinking, that nobody is obliged to hold: the conception of a neutrality of languages in the genesis and in issue of illnesses, as if illnesses do exist by themselves while languages do permit only to describe them, without any performation nor any contribution to their genesis. Or, at least, as if we could feel entitled to put them aside. It makes you wonder whether the method is right; particularly since, through a strange contradiction, the authors of the CIM-10/ICD-10 reserve the right to write a short chapter on ethnography in order to deal with cases when English has no names for referring certain disorders and to take them into account.

Then one will be ironic with the lack of universality that would characterize the clinging to a Romanian, French,… psychiatry. We retort that there is no Romanian, French … psychiatry, but that the patients are Romanian, French, etc. and express their disorders in their respective languages: why ought we call their illnesses in English? Why ought the ethnological concessions to stop to the frontiers of some linguistic items of which the authors of CMI-10/ICD-10 would be unable to give the rules? The attitude of Lacan, who spoke as a psychoanalyst rather than as a psychiatrist, though he were both one and the other, was, on the one hand, doubtful and untenable, when he discredited English psychoanalysis and questioned whether the English language be a receivable tongue to deal with the unconsciousness; on the other hand,
the idea that languages do not only represent disorders but also penetrate right through them, particularly when these disorders are mental, seems essential to be promoted and furthered. The will to reduce medicine to one language, maybe in order to obtain a common denominator, seems a fallacious conception of universality and an unacceptable reduction, as would have been any other reduction, to whatever other language.

REFERENCES

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