Ordinary psychosis

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I thank Leonardo Gorostiza for his presentation, which takes us up to the point of Jacques-Alain Miller's invention in naming the work of the Clinical Sections for the year of 1998 as 'Ordinary Psychosis'. This invention, calling it ordinary psychosis, comes to punctuate work that began long before the three conversations of Angers, Arcachon and Antibes. It began prior to the dissolution of the *École freudienne de Paris.* It began in the Clinical Sections where, on the basis of the orientation laid down following Caracas - where the other Lacan, the Lacan of the object *a*, was presented - we initiated a work programme within the Clinical Sections of reading psychosis, the clinic of the psychoses, not only on the basis of the signifier but on the basis of the ordered pair *S1-a*. The first attempt to rethink the clinic was the reading of Schreber, of *On a Question Prior to Any Possible Treatment of Psychosis,* with the object *a*.

This initiated a work programme that was based on a consideration of the signifier in its effect of disjunction. With the signifier we get regimes of disjunctions, series of disjunctions. The differential functioning of the signifier of the Name-of-the-Father, whether it is there or not, whether we are operating under the regime of repression or of foreclosure, implies clearly separated categories, almost like a tree of disjunctions. Whereas if one were to take into account the ordered pair *S1-a*, one could first obtain, in the place of the Name-of-the-Father, the pluralisation of the functioning of the master signifiers that allow a subject to function without the support of the established discourses, and then, with the object *a,* a regime not of disjunction but rather of supplementation.

On the basis of this reorganisation we first considered the grand psychoses - effectively the extraordinary psychoses, the established categories of paranoia, schizophrenia, melancholia and mania - and this produced a series of studies. But then we had to confront the context of psychoanalysis in the 1990s, which was the epoch, in the analytic movement more generally, of the success of the 'borderline states'. The essential promoter of the 'borderline states' across a whole zone was Otto Kernberg, who developed a clinic based not on the discontinuities produced by the distribution of the symptom but rather on a reinterpretation of the ego's mechanisms of defence in the fashion of Anna Freud, considered instead as 'disorders of the personality'. With this tool of personality

disorders, Kernberg began to constitute a clinic based not so much on symptomatology but rather on a dynamic equilibrium between neurotic and psychotic processes, looking for this equilibrium in the borderline states, separating borderline personalities from psychosis as such.

This was Kernberg's attempt to renew the clinic at the same time as he was negotiating, in the 1990s, with the rise of the clinic of the DSM, the clinic of syndromes, the clinic of the deconstruction of the classical categories. He negotiated the maintenance of an axis within the new system, Axis II, centred on the personality disorders. It was thus a quite considerable project, that of negotiating a place for psychoanalysis with the biological clinic and constructing a new conception of psychoanalysis. This constituted quite a robust research programme.

We thus ourselves had to consider whether this project was valid or not. For us, the error of this whole project was to centre itself, once again, on the ego's procedures of defence - renewed, reinterpreted, but ultimately the same axis that Lacan had opposed in the 1960s. Here we had a new version of what Lacan had been faced with, a new version of a phenomenon from which we had to differentiate ourselves. We had to propose an orientation in regard to this clinic that had a certain effectiveness. This was the reading that Jacques-Alain Miller proposed by considering the ordered pair *S1-a*, which is to say that there is no signifier without its aspect of jouissance. In the same way that in quantum mechanics there are always two aspects of a phenomenon, in our 'mechanics' the aspect of the signifier and the aspect of jouissance are always in play.

This is how the interest in the functioning of the S1 all-alone was first constituted, not so much as ordered pair, but rather the S1 all-alone, cut off from its relation with the S2. This produced an effect that allowed the clinic of psychosis in general to be approached in a way that allowed us to confront those phenomena that presented themselves as psychosis, which from the point of view of the clinics in general were considered as attenuated psychoses, or psychoses with neurotic mechanisms of defence, or neuroses with psychotic phenomena included, etc. All the confusion that appeared in this approach, this presentation of the new clinic outside the ordered categories, the clear perspectives, represented a zone of difficulty.

Our tool for reordering the clinic and taking a Lacanian perspective on all this was the S1 all-alone, as a tool for interrogating the elementary phenomenon and the relation of the subject with its supplementary devices. We also studied phenomena that appeared in the negative, such as un-triggered psychosis. The change of perspective was precisely not to consider that it was neurosis until the moment of triggering, as though we would pass to another subjective space once there had been a triggering. Rather, we had to consider that already, beforehand, we were not in the register of neurosis. This programme culminated in 1998 with the idea of ordinary psychosis, which came to name in a striking way what in reality

was a research programme and which continues to be a programme more than a diagnostic or a symptomatic category – as we would say from the perspective of 'Linnean' classification, after Linnaeus the naturalist.

This is especially interesting because today we have to pursue our research programme in a more extensive way as we expect the category of 'personality disorders' to disappear within the next five years with the publication of the DSM-5. Biological psychiatry considers that this remainder, which was negotiated at the end of the 1980s with the universities inspired by the IPA and those of the biological tendency, is already outdated. This is what is contained in a book called *A Research Agenda for DSM-5* – brought to my attention by our colleague Juan Pablo Luchelli, a professor in Switzerland – which implies the decision to do away with this dimension. Our colleagues from the IPA are thus going to have to approach this clinic without the support of the established discourse on 'personality disorders'. It will be interesting to see how they go about it. We will have to keep track of the effort they are going to make, the effort of poetry they will have to produce.

On the other hand we nowadays have to confront the massive prescription of medication which now means that when a subject presents with a symptomatology that is not very clear he is prescribed five essential medications: an antipsychotic, an antidepressant, a stimulant, a mood regulator and a hypnotic. I have the figures, I am not going to bore you with them, but the latest research shows that prescribing is massive. This research involves patients, with the difficulty of obtaining those impeccable cases that allow the dream of an ideal affection and a medication with direct effect to be maintained. This is how it would work ideally, but as the cases do not respond to the ideal there is in certain universities a conflict between the faculties which means that patients go from floor to floor according to the distribution of power and who has the agalma at any given moment, whoever currently appears to hold the future in their hands. But the point is that as the cases do not fit exactly into the little boxes there is massive prescribing.

We now have to orient ourselves in these perspectives using our own research programme which is not centred on these categories, whether categories of 'personality disorder' or those of biology, where a biological disturbance is supposed to account for pathology. We have to use our programme as a form of empirical and clinical research to keep up to date with these displacements of the clinical atmosphere, or the clinical discourse, in order to keep ourselves inserted in this clinical conversation that is being displaced.

In the first place there is the idea of a programme of research into a clinical space defined on the basis of the idea of a distinction between the two great configurations, neurosis and psychosis - if indeed we think that these two poles do in fact exist – or the idea of a distortion between these

great configurations that can be inscribed in structural coordinates or with a topological configuration of knots. This arrangement allows us to think in terms of topological distortions from one state to another, or ruptures that mean that the knot is not inscribed in the same way, which permits phenomena such as inhibitions, symptoms and anxieties to be distributed. But it also produces deformations; for example in the way in which the symbolic and the symptom are joined, since they can be joined in various ways. And this produces clinical consequences.

The fact, for example, that subjects have appropriated a master signifier of our epoch, such as the signifier 'depression', which can involve a whole pathological spectrum, but which provides a signifier under which the subject can recognise himself, could assist us in arriving at a point where, with the signifier 'ordinary psychosis', a subject would not so much recognise himself as come to the psychoanalyst saying: "I have an ordinary psychosis. I am going through a difficult patch. My ordinary psychosis is bothering me."

There is something in this term 'ordinary psychosis' that at the same time maintains the category 'psychosis', which stems from the 19th Century, and with the term 'ordinary' includes something more of the order of the philosophy of 'ordinary language', something, we could say, that is more of the 20th Century. And with this we are trying to produce a signifier for the 21st Century. We will have to see whether with this signifier we manage not only to construct a research programme for ourselves but also to help subjects to make use of it, to make it a tool to define themselves without the support of an established discourse, but with the support of this research programme.

The criticism of the approach to the whole register of the psychoses on the basis of the 'personality disorders' or the perspective of narcissism has to take into account precisely that the success of the notion of depression is based in a narcissistic approach to all pathology. This is why, for example, sociological studies on the consequences of the individualism of the masses consider depressive pathology as something perfectly normal, natural, calling it 'tiredness of oneself'. This was a formula that had a certain success because it caught hold of something. But this leads to the tendency of sociologists, on account of their methodological presuppositions, to overvalue this 'tiredness of oneself' or to think that it is something that can be measured, something that can be isolated in individuals.

But it is much more difficult for them to think about the effects of the inconsistency of the Other, the big Other. Not the inconsistencies of the opinions of the little other, but rather the fundamental inconsistency of the barred A. And the consequences that this has for the functioning of a civilisation in which the support of the established discourses – and there are not many of them that still have any consistency - depends on the manner in which each subject makes a norm of his inventions, is able to

inscribe his inventions of knotting, of quilting, is able to inscribe that which functions as a master signifier for each one of them, within the system of norms that is the normal register of knotting in the epoch in which the Other does not exist.

The research programme that approaches the clinic on the basis of ordinary psychosis consists in trying to establish a certain pragmatics, case by case, of how a subject comes to knot the consistencies of the real, the symbolic and the imaginary. How does the subject come to interpret the body events that he encounters? How does he situate the flight of meaning? How does he cope with the dispersion of the imaginary in the fundamental dismemberment? How does he try to resort to more or less established norms to support himself in the construction of something? Discussing all of this is crucial for the orientation of the treatment.

In the Convention of Antibes we worked with the following three categories: neo-conversion, neo-triggering, and neo-transference. Neo-conversion involved going from what used to be the opposition between hysterical conversion and hypochondria to an idea, a more general conception, of the body event, in order to account for what happens in the clinical zone that interests us. How does a subject relate to a body that is not equipped with a symptom centred on the love of the father?

With neo-triggering it was a question of seeing how to maintain at the same time phenomena of triggering that were clear and those that were less clearly defined, as well as a certain continuity in which the triggering appeared more difficult to establish, giving the appearance that it had always been like that. How is one to consider these two perspectives at the same time? Here it was the notion of unplugging [*desenganche* (Sp.), *débranchement* (Fr.)] that allowed us to consider phenomena that could not exactly be called triggering, but were more like changes, where we are not dealing with phenomena of collapse followed almost immediately by a delusion, as in the acute psychoses where from a clear blue sky, from one day to the next, we can have a rupture and the construction of something utterly unexpected. Whereas phenomena of unplugging can at the same time maintain and make compatible a perspective of discontinuity and a certain perspective of continuity.

And with neo-transference what was crucial was precisely how to interpret this very particular bond that allows us to organise a direction of the treatment, because in the final instance this is what is at stake. With a subject who comes to us with a grand delusion the direction of the treatment involves trying to avoid the delusion as such. The model was Schreber. At the beginning we have millions of 'examined souls', and with the evolution of the delusion these are reduced to a limited number, to a reasonably clear structure that comes to repeat itself and to situate the subject in a relation we can call asymptotic with the encounter with his Other. Fine, this gives a

direction. But when we do not have a production as important as this, what then? This was what I effectively tried to reconsider in my paper on interpretation in psychosis. The idea was rather to focus on the body event as the moment of knotting, the point at which the consistencies RSI could be knotted together for a subject. We have to consider the phenomenon and the pragmatic way in which the subject deals with this emergence of something unprecedented, of something which emerges in his body and which cannot be interpreted with the constituted discourse, and to take this rather as a possibility for the construction not so much of a delusion, but of a knotting.

In this sense the orientation of the treatment consists rather in privileging the quilting, the scansion, the ruptures, in order to avoid the construction of a delusion, so that the subject can maintain himself at the level of these phenomena that appear as fragments of the real, without there being any need to eject him from the common discourse, common language, without any need for the constitution of an enormous delusional construction that separates the subject from common discourse and which would only allow him to recover after a long trajectory. As Freud says, the delusion is a cure in the extraordinary psychoses, where there are these impressive constructions which require the subject to elaborate a trajectory that can take him years, or even decades. While if we can avoid this same construction by punctuating these moments, these erratic irruptions of the real, we can save the subject an enormous amount of work. It is this orientation on the basis of ordinary psychosis that leads us to consider and to investigate how in the practice itself we can obtain these effects and how to maintain them.

This research is going to continue in the new context that I have described, which is to say a discourse of the clinic in general without the concept of the 'personality disorders'. This has many consequences. It will have consequences, for example, for the fanatics of evaluation, including those within the IPA who are dedicated to elaborating sophisticated programmes of evaluation according to psychoanalytic criteria. The brightest exponent of this orientation is a certain Drew Weston, who recently sent an e-mail to the people of his orientation saying that he considered that it was now impossible to interest anyone within the NIMH, the National Institute of Mental Health, in financing a programme of evaluation into the efficacy of long-term therapies. He says that as they now do not even have the money to finance research into short-term therapy, financing from government funds is out of the question. He thus considers that the only solution is for psychoanalysis to begin to raise funds to finance this research. He concludes his e-mail saying that the sole task of psychoanalytic associations across the globe should be to raise private funds to finance long-term studies because otherwise, he claims, the psychoanalytic associations will not have a single member by the year 2030.

Well, our programme is exactly the reverse. In this context, it involves rejecting evaluation in a decisive way and explaining why evaluation is a completely erroneous perspective that we should not negotiate with. We have to denounce this perspective for what it is – a form of management of the developed societies invented by the anxiety of the discourse of the master which is at a loss and has been seduced by a false science. But it is a perspective that will not last. In the year 2030, it will not be the analytic societies but the evaluators who will not have any members. We will see, but that is our response. Evaluation will last for a while and then the return of the effects of the real will be such that this perspective will be shown up for what it is: a dream, a scientistic dream that has appeared at the beginning of the 21st Century and which then, with the catastrophes produced, will manifest its clear incapacity to treat the real at stake. We could enumerate various things that arise as symptomatic problems, as symptoms of the incapacity of this scientistic dream to treat these questions.

All this, then, at the level of the Other, of the inconsistency of the Other. But it is also at the level of the clinic, of the one by one, that these dreams of obtaining the distribution of pathologies and an approach elaborated on the basis of the discourse of evaluation, are going to give rise to conflicts, inconsistencies, facts produced by the massive distribution of cocktails of medication, now from a very early age. We should not forget that the youngest bipolar sufferer in the world is a two-and-a-half year old girl from Texas, whose mother managed, by a judgement against her psychiatrist, to have her daughter recognised as bipolar and to obtain medication through the judge. In the name of human rights, of course. This is the type of phenomenon that shows what follows from the enthusiasm for anti-depressants.

I remember a Canadian anthropologist – an Argentinean who emigrated to Canada – who did his internship at the Borda Hospital and carried out a study concluding that Lacanians tended to diagnose patients more as psychotics than as depressives, thus prescribing more anti-psychotics than anti-depressants, producing more paralysis and dyskinesia, that is to say, putting subjects at risk instead of taking an anti-depressant with less secondary effects. But a year later the studies against anti-depressants began to appear, where you can see the list of numbers of suicides that the use of anti-depressants had facilitated, producing an effect of dis-inhibition that led to a passage to the act. So now you have written on the boxes of anti-depressants – 'Warning, this medication can lead to suicide'.

In this way we see how the scientistic fable of finding happiness, or rather, of finding the best way to deal with this real by taking support in the scientistic dream, we see how it bumps into a whole series of things. While our orientation in this new epoch is precisely to continue with the programme of research into how to proceed with this perspective of the functioning of the S1 all-alone and how - without the support of the

interpretation with the S2 that oriented our handling of interpretation prior to this perspective - how we can orient ourselves now in a field that is changing, that renews itself, and that redistributes itself. This is the field of research that we are currently pursuing.

Answers to questions

What are the pragmatic consequences for the direction of the treatment? What I think we have to avoid, the fundamental illness in our circles, is falling into the trap of ourselves elaborating a theoretical delusion that has no grasp on anything pragmatic. We know very well how to do this, to spin out signifiers that appear to describe an ideal world without it being possible, at any given moment, to determine what exactly the consequences might be for the direction of the treatment.

Effectively, what has been said is crucial: the reorganisation of the clinic of the psychoses, oriented by Lacan's late teaching, as Jacques-Alain Miller has said, implies rethinking the perspective of neurosis on the basis of psychosis, and not psychosis on the basis of neurosis. That is, not in one direction but in the other. We thus have neurosis as a particular case of generalised psychosis. A particular case, since there is a functioning Name-of-the-Father within the established discourse. There is a conversation about what the Name-of-the-Father is that has been going on for three and a half thousand years, taking its reference from Moses. We thus have a discourse from which the variations can take support. The difference that follows from this orientation on the basis of psychosis is that in neurosis one cannot save, or try to save, the subject from his Oedipal delusion. The problem is how to extract it. It is true that considering the treatment from the point of view of the neurotic subject consists in how to manage – and this is effectively in complete congruence with what has been said – to obtain the production of the S1s without them being taken up in the inscription of the discourse, or the delusion, on the Name-of-the-Father. Or, according to Lacan's formula in *Seminar XXIII: The Sinthome*, how to free ourselves from eternity.

How to free ourselves from eternity, from the eternity of the love of the father? How to refer the subject to the contingency of the encounters with jouissance that marked, traumatised, his body, and which remain as insurmountable fragments of the real? This can be a horizon, even a most profound instrument for orienting ourselves within the experience of the pass. This is the indication of this year's Course that Jacques-Alain Miller began two weeks ago with a reading of the last text of the *Other Ecrits*, which is the *Introduction to the English Edition of Seminar XI*. This is an important text that Jacques-Alain chose to put at the end of the *Other Ecrits*. Starting his Course with a commentary on this condensed, enigmatic and radical text, he made reference to its importance for what was of interest to Lacan at that moment, the experience of the pass. And I think that the

perspective of the S1 all-alone has effective consequences for the handling of the transference in the neuroses, for the outcome of the treatment, and also for approaching what remain as residues at the end of an analysis with the research tool that we have in the experience of the Pass.

Now, on the question of psychosis, the consequences of the ordinary psychoses, and how not to lose what we already know from the point of view of the extraordinary psychoses. The question was raised of how to articulate the two perspectives. When a delusion is being constructed, when the subject takes recourse to this, do we support him in this work of construction, however minimally? Is this perspective valid or not? This question is linked to the other aspect, the double perspective of triggering or unplugging.

We can take the example of a ten-year-old child who begins to develop a delusion of persecution in which his classmates at school are looking at him. This begins with a supposed 'school phobia'; in fact one discovers that coming out of school he has the idea that all the cameras in the street are watching him, because he knows something about the fate of souls after death, and things begin to spread. We see a delusion being constituted, a paraphrenia or a paranoid schizophrenia in a young boy of ten years. One perspective would be to say well, the subject has begun his delusional construction, let's assist him, let's listen to his constructions and try to orient him in this construction. In this way the outcome could be that by adolescence, at the age of fifteen or sixteen years, the subject has a perfectly constituted delusion, with all the advantages and disadvantages involved. That is, the subject that has produced it separates himself from the established discourses in a radical way. He has to invent a personal signification by means of this whole construction, which could culminate in becoming an artist who produces an installation, in the mode of Joseph Beuys, or not. It is going to be a most singular path.

But if rather than supporting him in this construction, we try to isolate the persecutory phenomena at the level of the gaze, always referring him to this point, and also obtaining the effects of manifestation at the level of the voices, we try to discourage the consistency of the delusion at this stage of its development. That is to say, we try rather to discourage this and to refer him only to the consistency of the body events. I have seen how the construction of a delusion can be avoided in a series of cases like this. The young lad comes, has two years of therapy, and then leaves, and we will probably see him again afterwards, when he has to confront the difficulties of adolescence. We will probably have a new edition, but without the construction of the delusion, which is going to allow the subject to remain more or less included in a type of norm, to insert himself into the group of Goths at the school, the hangout for all the paranoiacs there, and in this panorama no-one is going to take any notice of him, more or less, not even the psychiatrists.

I don't know how it is here, but the tendency in France is to consider that children do not have hallucinations, that these are not the same as hallucinations in an adult, that they change with the dynamic of childhood. Why be too preoccupied about them? They do not take this as an axis of work, because they consider it dangerous to give them consistency. And I understand why, because within their clinical perspective they see how this enormous construction isolates the subject and does not allow his rehabilitation, his reinsertion. The banalisation and the ignorance of psychosis as such allow these clinicians to free themselves from anxiety by not dealing with it as a problem. But at the same time I think that it is also important to have the idea that we have to support and try to convince others beyond our own circles of the interest of recognising the existence of hallucination, which as such does not exist in the DSM.

In the DSM, in the clinic of childhood there are only the massive developmental disorders, with the autistic dimension. There is not much more than this, everything is reduced to the disorders of attention, which allow hallucinatory phenomena to be included as phenomena of imaginary dispersion. Someone can't concentrate on one thing, their gaze is distracted, they hear voices, they feel persecuted – all of this is a problem of attention, of concentration. We have to avoid this perspective but it is also a question of trying to maintain someone in the norm, of making use of the fact that in our world the norms are sufficiently elastic for someone a bit strange to also fit into the panorama. We have to be a bit flexible here. It is not simply a question of complaining that there are more psychotic phenomena because subjects are abandoned to their own devices. It's true, but the other side of the coin is that these subjects can also be included in these fluctuating norms of the epoch of the Other that does not exist in such a way that they can feel themselves within a zone of the common discourse.

In the epoch when the Other did exist, Lacan said – at the end of his Thesis – that the treatment of a paranoiac was to get them to enter the Church or the military. It was the epoch of Bunuel, of his film *El*, where we see exactly this, the treatment of a paranoia, of a monk in a Catholic order. Bunuel's idea was taken directly from Lacan's Thesis. I suppose that monks still exist today, that they reinvent themselves, and so they probably make room for a certain number of paranoiacs who function there. But with the more relaxed norms we can also insert a subject into the common discourse on the basis of more eccentric norms, making use of all this.

[...]

It is not a question of elaborating a discourse in our own Lacanian circles, where it would be: "Have you read about the latest orientation, S1 all-alone? If you understand the S1 all-alone, everything will be clarified." No, nothing is clarified. This is only a tool for entering into the common discussion, for

thinking about the phenomena that present themselves, and thinking about the distribution of the real, which is pressing. We have to enter into a common conversation on all these questions.

I think we have to take up the question of bipolarity in the same way. Bipolarity is like depression, it is an excellent signifier. It was probably invented by some marketing genius. You know that the big pharmaceutical laboratories now have enormous marketing departments where they try out the effects of signifiers. That's what marketing is – trying to gauge whether one signifier or another is to the taste of the epoch: polarity, bipolarity, a bipolar world. Since the fall of the Berlin Wall in 1989, the end of the bipolar world has become fashionable. We thus now have bipolarity, multi-polarity, everywhere at the level of the big Other. So of course people feel bipolar. It is something that is in the air, and it is fine, it's true.

In France, a great journalist, Franz-Olivier Gisbert, who invited Jacques-Alain Miller onto his television show, wrote a book about President Chirac, who is due to retire, in which he describes, in a slightly cynical way, Chirac's political career. And he gives the opinion that the candidates that we now have for the Presidency, Nicolas Sarkozy and Dominique Villepin, are both bipolar. So that whatever the results of the election are, we are going to be governed by a bipolar. It's the state of the world. Even Winston Churchill was medicated with the resources of the times. When he was down, he was down. And when he got excited, everyone ran around trying to prevent him from producing a catastrophe in his interviews. And this is the guy who was in charge of the war!

There are profound reasons why this happens. We have to know how to manage with the signifiers that have a certain success: depression, bipolar: "You are bipolar, but with the RSI consistency, the particular knot, that you have, you are a very particular bipolar." Let's say that it's not a battle at the level of the categories, there you can only lose. It is not a question of convincing. When I said in jest earlier that subjects could say: "I'm an ordinary psychotic", this is something that has already happened. I know of subjects who come to an analyst saying: "I'm an ordinary psychotic." But beyond this, it is not a question of convincing the contemporary pharmaceutical industry to use our signifiers. They produce their own signifiers, they have a whole industry for this. It is we who have to make use of these signifiers in order to get to the level of the particular, the singular. And this is a most potent resource.

Our resources, then. When someone arrives in an acute state, it is not that we lack resources. We listen to the subject, we see that they are in an acute state, that they have to be admitted, and they are admitted. How long does this last, a couple of months, two weeks? Afterwards we have fifty years. When the subject has been hospitalised, they take the medication for a while. They come to see their analyst, taking the medication at first, and then we wait for a moment where it is possible to construct, as they say, a

window of opportunity, where it is possible to come off the medication. This continues for a while and you see whether the subject can manage without it. In private practice we can receive various kinds of pathology, but with the idea that you have to make use of all the available resources, including medication and hospitalisation. And you have to keep up a conversation with the doctors and the psychiatrists so that they can understand aspects of the subjective trajectory of each patient.

In this way I believe that our research programme is a powerful resource not only for us but also for the community in general. This is the public utility of our programme of research. It seems to me that in the discursive atmosphere in which we live we can maintain that our programme really is of public utility.

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