Clinical phenomenology and its psychotherapeutic consequences

Fenomenologia clinica e sue implicazioni psicoterapeutiche

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Summary

Can phenomenology be therapeutic in general and especially in the case of schizophrenia? This question is advanced within the framework of the dialectical model in psychopathology whose central ideas are the following: mental pathology contains "positive" features that cannot be simply reduced to negativity (abnormality or absence of mental health), and persons with mental illnesses are not merely passively thrown in their vulnerability, rather they are actively engaged in trying to cope, solve and make sense of it. The dialectical model is employed in the psychotherapy of persons with schizophrenia by applying two concepts: position-taking and perspectivism.

Key words

Dialectical model • Perspectivism • Phenomenology • Position-taking • Psychopathology • Psychotherapy • Schizophrenia

"The experience is always only half of the experience"
J. W. Goethe

The meaning of "phenomenology"

Phenomenology is a method of analysis of the facts of consciousness that is also applicable to psychopathological facts. Of note, this method has little to do with what standard English language psychiatric literature calls "phenomenology". The latter refers to the simple description of the more visible manifestations of a given disease – strictly speaking, "symptomatology". Häfner defined the "symptom" as the external and visible element of an aetio-pathogenetic context or process (the disease) that, in itself, is not shown [1]. The "phenomenon", on the contrary, is "what shows itself in what it is" [2] and includes both the symptom that indicates its presence and the underlying disorder. Phenomenology is not limited to what can be seen, but it tries to get deep inside its structure, to its core. This procedure, developed by Husserl [3], has its origins in Greek philosophy, which established his *episteme* in going further than the *doxa* (opinion), which is based on the way things are presented to the human being in his daily life. It is the aspiration to penetrate into the internal structure of what is real that distinguishes scientific knowledge from common sense knowledge. Now, the task posed by phenomenology proper is to describe with exactitude the very human capacities that enable us to experience and to know.

In a first approach, Husserl tried to investigate the subject of experience, i.e., our reason (immanent investigation); but he then realized that we can know nothing of the cognizant subject without also unfolding *that* which is to be experienced, whether this is a natural object or a cultural object (transcendent investigation). Thus, he overcame to a certain extent the dualisms subject-object and immanent-transcendent, when he proposed to investigate the subjective processes of experience together with that which is shown to us as object in the act of knowing, i.e., the phenomenon. He called this process "intentional act". Intentionality is not merely a way of relating the subject to the object, but an essential feature of consciousness*: "[i]n the simple acts of perceiving we are directed to the perceived things, in remembering to the remembered, in the thinking to the thoughts, in the evaluating to the values, in the desiring to the objectives and perspectives" (p. 237) [3]. It is due to this characteristic of consciousness that we humans are from the first moment with things and always remain

* With "consciousness" phenomenology does not merely mean what surfaces in explicit awareness – what someone is aware of. Rather, it addresses the multi-layered complexity of psychic life, including the implicit contents and processes that allow explicit experiences and cognition to be constituted.

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next to them. And it is also the intentional character of consciousness that allows us to behave transcendentally with respect to ourselves, that is, with respect to one's contents of consciousness, as well as to one's acts of consciousness. The discovery of intentionality as the fundamental character of consciousness have made it possible to overcome the naivety prevailing both in the natural or pre-reflexive understanding and in a scientific and logical context.

In daily life, we always find ourselves naturally and naively oriented towards the world of objects, but this attitude does not lead us to knowledge, let alone scientific knowledge. Empirical science has approached the latter through the reduction of the objects presented to us in natural experience to one of their aspects. Thus, for example, when chemists consider water, they reduce all its features to its mere molecular composition: H_2O. In essence, the natural scientist projects the chemical-physical theory of reality upon the entire phenomenon, disregarding all other elements constituting the real object "water" as we encounter it in the life-world. Chemists do not consider the capacity of water to quench thirst or to make fields bear fruit, nor do they invoke the symbolism of the depth of the sea, the power of clouds to evoke images, or the sublime beauty of a froze lake. In contrast, when phenomenologists adopt a reflexive attitude, they direct their attention to the totality of the many ways in which an object is perceived and understood. According to Blankenburg, the phenomenological approach strives "to be as open as possible to the object's different ways of being, that is, it tries to be (even) 'more natural' than natural experience itself. But on the other hand, it also tries to be "more scientific" than scientific experience, as it does not limit itself to one particular perspective, but transforms in its subject [the totality of] the ways of being of what faces us and investigates them with respect to its constitution" (p. 413) [4]. In every real experience, we experience more than that which is given by perception of the mere object. This was brilliantly formulated almost 100 years before Husserl by Goethe: "The experience is always only half of the experience". We always live more than what we live, and experience more than we experience. To explore this *other part* is the task of phenomenology. The Goethean principle, itself so parallel to Husserl's, leads us directly to Marcel Proust's novel "Remembrance of Things Past", whose meaning lies in the recovery of everything that he experienced in the past and lived at that time almost without being aware of it. The major features of his work resemble fundamental phases of the phenomenological method: a total openness to reality, a reflexive attitude which perceives reality as being provided to consciousness, and a progressive elimination of all presuppositions, prejudices, and incidental elements as an instrument to achieve insight into the essence of what is experienced.

Clinical phenomenology

The question posed is if phenomenology can be therapeutic in general and especially in the case of schizophrenia. From a historical point of view, it would be sufficient to mention the names of Karl Jaspers and of Ludwig Binswanger. The former, even though he consciously limited the application of the phenomenological method to its first phase, merely descriptive and only in part to the discovery of the implicit structures of subjectivity, declining to advance towards the intuition of essences, was a tremendous revolution for psychiatry, by categorically distinguishing between understanding and explanation [5]. This meant, first, that Jaspers' methodological distinction was able to make considerable room in psychiatry for the method of understanding, before which was considered rather marginal. Although Jaspers' concept of understanding initially enabled non-schizophrenic psychoses like paranoid developments to be separated from schizophrenia proper, in the end it contributed to open, with Kretschmer [6], the way towards the understanding of the psychogenesis of psychoses [7]. Binswanger [8], with his systematic application of existential analysis to the life history of schizophrenic patients, made it possible to broaden the comprehension much further than the average understanding posed by Jaspers. His definition of psychosis as "rupture of the consequence of natural experience", the description of schizophrenic existence previous to the emergence of psychosis as characterized by "splitting into irreconcilable alternatives" or the concept of the formation of an "eccentric ideal" (*verstiegene Idealbildung*) and the consequent hiding (*Deckung*) of the rejected side of the (split) alternative, are all unquestionable progresses in the discovery of the core of the schizophrenic form of existence that without doubt have had repercussions in the therapeutic field.

Clinical phenomenology can be of help in the field of psychotherapy and this occurs in three different ways: one, through the *phenomenological interview*, which more than any other form of diagnostic interview in medicine can be therapeutic by itself. The second is through concrete therapeutic methods, derived from phenomenology, like hermeneutical psychotherapies – the most well known of which may be existential analysis. The third, and perhaps most important way in which phenomenology can be of help to therapy is through specific procedures, which cannot properly be considered psychotherapeutic techniques, but which can be the basis of treatment for more serious pathologies, and especially of schizophrenia. This is the case of two procedures based on the dialectic approach in psychopathology that we will call "perspective-taking" and "position-taking". These have a practical importance perhaps greater than existential analysis itself.

The therapeutic moment of the phenomenological interview

We know that in functional psychoses there is no biological substrate on which to base the diagnosis. The operational diagnoses were created in an attempt to overcome the subjectivity of traditional psychiatric diagnoses, but this is at least in part an illusion, because symptoms in psychiatry are not "things", or "substances", or "entities in themselves", but complex subjective experiences of the patient, expressed in an ambiguous language and that only the work of the interviewer can adequately qualify [9 10]. The patient does not speak of "auditory hallucination" or of "primary delusion". He says he communicates directly with God and for that reason he has the belief of being a prophet. Often, only an experienced psychiatrist will be able to determine if those expressions correspond to psychopathological facts rather than to authentic spiritual experiences. In other words, psychiatric "symptoms" occur in an inter-personal space, in the "between" – and this means that a phenomenon becomes a symptom only if it is designated so by a clinician.

Every psychiatrist learns from his teacher, next to descriptive and clinical psychopathology as the indispensable bases for reliable and valid diagnosis [11], to recognize psychopathological syndromes through their respective "atmospheres". This is why the hermeneutic approach and the phenomenological method are fundamental for determining with some precision the diagnosis of these diseases. A classical case of atmospheric diagnosis is the *"praecox feeling"* described by Rümke [12] in schizophrenia or the *"melancholy-feeling"* described by one of us [13 14] in melancholy. Both correspond more or less exactly to Gadamer's concept of prejudice, "that judgment that is formed before the definitive verification of all the relevant objective facts" (p. 255) [15]. One of the most difficult tasks of the teacher in the formation of the disciple consists in training him/her to separate the good "prejudices" from the false – or in other words, to grasp the true atmosphere emanating from the patient in which the symptom is embedded. This atmospheric moment of the encounter with the patient acquires special importance in the field of psychoses. What has been called "loss of contact", "lack of attunement" or "distance" in the schizophrenic patient is something difficult to define (let alone operationally define) since it corresponds to an original pre-verbal phenomenon. This predominance of the atmospheric dimension over reliable diagnostic criteria is even more relevant in prodromal psychosis. Patients may communicate elusive changes in their existential feelings, a quasi-ineffable altered relationship with the world, the failure to express what is "really going on", vague complaints of being stripped from the surrounding ambient. These phenomena cannot easily be "pinned down", either by the patient or by the clinician. In an encounter with a prodromal schizophrenic patient, what is missing is a certain primordial community, which the Japanese call *"ki"* [16]. Trying to reduce these uncanny sensations to symptoms of an illness may not only be epistemologically unjustified (if the clinician does not have enough clinical data to establish or to exclude a valid and reliable evidence-based diagnosis), but also clinically disadvantageous. Suspending clinical judgement, constructing a space of dialogue to facilitate expression and communication to enhance reciprocal approximation between the clinician and her interlocutor seem to be the best clinical choice and the principal resource for the psychiatrist [17].

In summary, in the diagnostic interview, both in its pre-verbal and in its verbal moment, the phenomenological method is unavoidable. To base the first encounter with the patient in a series of questions oriented to identifying symptoms, or applying questionnaires means to betray the complex nature of the object of our science. If we cannot recognize the richness of the pre-verbal moment, perhaps we will miss the more specific facts, at least in the case of psychoses. Not to adopt a phenomenological attitude during the verbal phase of the encounter will necessarily imply surrender to a previous theory, which will translate into verifying in the patient exactly what we have projected onto him, with all richness of the patient's field of experience and of the therapeutic potentialities of the encounter itself being lost.

The basis for phenomenological-hermeneutic psychotherapy: the dialectical model in psychopathology

Phenomenology seeks to unfold the subjectivity of a given person, i.e. it strives to let fully manifest the patient's field of experience, values and beliefs. The hermeneutic method does not seek to "explain" what phenomenology has unfolded, but to "understand it" – to make sense of it. The starting point of clinical hermeneutics is to place oneself beyond the sane-mad, normal-abnormal, as well as positive-negative and active-passive dichotomies. By means of the phenomenological *epoché*, we must suspend the ingenuous realism affecting both everyday natural attitude and the scientific-naturalistic attitude that sees madness as a mere abnormality, negativity and passivity. It is necessary to understand the patient's mode of being simply as an unequivocal sign of something new, of a new type or form of relationship with the world.

This can be achieved by embracing the *dialectical model* in psychopathology. The central ideas underpinning the dialectical model are the following: (1) abnormality or mental illness (the negative) must contain certain positivity, and (2) the patient is engaged in trying to cope, solve

and make sense (activity) of the basic abnormal experiences into which he/she is passively thrown.
The question of the positivity of the negative goes back to Hegel. The first who tried to systematically apply dialectics to psychiatry was Wolfgang Blankenburg [18 19]. His starting point is the hypothesis that mental pathology contains "positive" features that cannot be simply reduced to negativity (abnormality or absence of mental health). Within this perspective, Blankenburg developed in detail the positive aspects of hysteria, showing how all its features could be interpreted not as mere deviated behaviour, but as a movement of existence *against* an opposite structure, characterized by excess of authenticity, of identification with the role, of rigidity, etc. [18].
Following the line begun by Blankenburg, we have tried [20-22] to apply this model to psychopathological syndromes. This perspective has two advantages: (i) it is closer to the clinical fact of the multiple transitions between the different psychopathological syndromes; (ii) and it helps in establishing a therapeutic alliance with the patient since it is very different to approach a patient focusing on the negative or deficient aspects than doing it with the opposite attitude, of considering how it can be positive to view things or behave as a patient does. This perspective could hold for obsession, depression, mania and schizophrenia itself. The schizophrenic shows a level of authenticity, of radicalism in his search for truth, a certain ability to reach the transcendent dimension and originality in his appreciations of reality that far exceed that attainable by the so-called normal individual [23].
An in-depth awareness of the patient's values is fundamental in order to not conflate them with abnormal or delusional beliefs. Beliefs that depart from common sense are not *ipso facto* delusions. To confuse idiosyncratic values with delusions is not only conceptually wrong and ethically inadmissible, it is also therapeutically ineffective. Values are not symptoms to be "killed". They need modulation and therapeutic accommodation with the requirements of reality, not eradication [24].
The therapeutic consequences are evident. Besides what is gained in the contact with the patient when adopting this perspective, therapeutic methods have been developed in the last decades for schizophrenics that can be considered dialectic as, e.g. the "positivation" by Benedetti [25], the paradoxical intention by Mara Selvini Palazzoli [26], the "projective acknowledgement" by Wulff [27] or the "dialectic strategies" developed by Stierlin [28] in psychotherapies with families of schizophrenics. All these are methods inspired by dialectic thought and as such, close to phenomenology and hermeneutics.
The other basic tenet of the dialectical model is that the person, as a self-interpreting agent or "goal directed being" engaged in a world shared with other persons, plays an active role in interacting with his/her basic vulnerability [9 10]. According to the dialectical model, therefore, the individual person, with unique strengths and resources as well as needs and difficulties, plays a central role not only in outcomes but also in the course and manifestations of the psychotic vulnerability itself. The main difference between an exclusively neurobiological and the dialectical model is that in the former the patient is conceived as a passive victim of symptoms, whereas the latter attributes to the patient an active role in shaping symptoms, course and outcome. Each person stamps his own autograph onto the raw material of basic abnormal experiences, driven by the painful tension that derives from "the drive for the intelligible unity of life-construction" (p. 171) [29].
Wyrsch [30] has probably provided the most detailed account of the dialectical model of schizophrenia. Describing the relationship between the person and the onset of acute schizophrenia, he distinguished four groups of patients: patients who try to objectify their own sufferings and conceive them as symptoms of a somatic illness; patients who are passive and incapable of any reaction; patients who engage in a fight against their pathological experiences, displaying a stubborn and often desperate attempt to fit such experiences into the meaning context of their life-story; and a last group who are exalted by the novelty of the psychotic experience, which acquires for them a cosmic meaning: "it is significant in the world order and not just for him" (p. 104) [30].

Position-taking

If we assume that a given set of abnormal experiences are the *core Gestalt* of schizophrenia, then we can assume that the manifold, fluctuating and state-like schizophrenic phenotypes are the consequence of the schizophrenic person's individual position-taking in response to this state-like, structural core anomaly. The dialectical model is consistent with the self-disorder hypothesis of schizophrenia which considers that it originated from structural changes of subjectivity. Self-disorders are subjectively experienced subclinical disturbances in stream of consciousness (e.g. perceptualization of inner speech or disorders of time experience), of self-awareness and presence (e.g. distorted first person perspective or myness of experience), anomalies in bodily experience, in self-demarcation, etc. [31]. These self-disorders can be seen as psychopathological trait markers of the vulnerability to schizophrenia.
The self-disorder hypothesis of schizophrenia has two major advantages: (1) it focuses on trait-like, supposedly more specific vulnerability phenomena rather than on state-like, unspecific "psychotic" (e.g. delusions) or "negative" (e.g. withdrawal) symptoms; (2) it helps disentangling basic vulnerability from personal "reactions" leading to full-blown symptoms.
This contributes to a better positioning of the person with

respect to his/her disorders by shifting the focus of therapy from full-blown symptoms (delusions and hallucinations) to more basic manifestations of vulnerability. Full-blown symptoms are experienced by patients as ego-proximal, i.e. as part of their own identity and as such not as abnormal phenomena to be diagnosed and treated. Anomalous experiences, like self-disorders, are experienced as ego-distal, and not as part of one's own identity, rather as disturbing one's sense of selfhood, i.e. unity, continuity, demarcation and myness. They are almost spontaneously recognized as something wrong with one's self-, bodily-, and world-experience that reduces their quality of life. As such, they can become instrumental symptoms for prevention and treatment, whereas full-blown symptoms may not manifest [24].

An in-depth, tactful exploration of the patient's subtle and pervasive changes in self- and world-experience may help him/her to take a reflexive stance with respect to vulnerability [32], to acknowledge vulnerability, to articulate it in a better expressive and communicative format and to construe it as situated in a personal-historical as well as relational-interpersonal context. This opens up two therapeutic strategies. The first, and more ambitious, is helping the patient to retrace the psychological/existential contexts in which his/her abnormal experiences were generated (remote life-history) and/or are aggravated (recent pathogenic situations). To final aim is to set one's vulnerability into one's sense of identity and integrate it into an narrative identity. The second, less ambitious therapeutic perspective is, after carefully mapping these disturbances, positing them as ego-distal (substrate-close, "anonymously" caused) and to help the patient to establish a better coping towards them.

Perspective-taking

With perspectivism, it is meant that the human being is necessarily bound to a given point of view from the moment it is an embodied self that is always located in and views the world and others from this perspective. This fixation can be overcome by changing the position or the point of view. In the physiology of senses, this occurs through the circle of perception and movement (*Gestaltkreis*), described by von Weizsäcker [33], which allows a perfect interaction with the world. But this is not valid for judgments. A healthy "reality judgment" requires a special kind of movement, that of placing oneself in the perspective of the other, of trying to see reality "with the eyes of the other". To place oneself in the perspective of the other necessarily means to take a step away from one's own point of view and this would seem to be a *conditio sine qua non* of a healthy relationship with the world. As in turn the others have to try to see it with my eyes, a natural exchange of perspectives arises. This dialectic is the basis for every non-delusional relation with oneself and the world [34]. Just as the man can relativize his necessary fixation on a point in space by freely moving about, so in other realms he will be able to overcome his dependence on his own subjective stance only to the extent that he is able to relativize his perspective. Being relativized by the intentionality of the other does not pose a threat to the healthy, but rather something positive which at the same time implies both adjustment and enrichment of the own perspective.

Persons with schizophrenia, in contrast, lack the spontaneity to actively put themselves in the place of the other. They cannot detach themselves from their perspective, and feel threatened by the eventuality of taking the other's perspective [23 35]. Thus, they remain trapped within themselves.

The therapeutic consequences of the above are immediate [36], and we will briefly sketch them. Strategies that facilitate the development of the "exchange of perspectives" can be developed. Blankenburg speaks in this context of "promoting personal interaction by means of training in the mobility of perspectives" (p. 73) [37]. The patient is stimulated to view the objects of his environment from different sides and thus become aware of how different a thing looks depending on from where it is seen from. The exercise can be made more complex, switching from objects to persons and in this case, not so much referred to the physical aspect, but rather to the *world* of the other, that is, to his social role, values and interests [38 39].

Accordingly, the psychotherapy of persons with schizophrenia may be conceptualized as a "dialogical prosthesis" that helps patients kindle internal and external dialogue [40]. The therapeutic process consists of providing patients an intersubjective space where they can evolve the "reciprocity of perspectives" [41]. This means to acknowledge the other's perspectives, as well as to develop a second-person perspective, or reflexive stance, on oneself, through seeing oneself from the other's (especially, the clinician's) perspective. The clinician can offer an example through efforts to reconstruct the patient's life-world and try to understand how and from what perspective he sees the world as he is seeing it. In general, the need to rescue the patient's perspective holds true for the therapist, even if this means accepting a delusion by suspending one's (clinical or moral) judgment or tolerating the inadequacy of the patient's behaviour.

This attitude has particular value in treatment with the patient's family. This can be achieved by empowering the patient's relatives with a fine-grained knowledge of the world that the patient live in. This will help them to put themselves in the position of the patient and, by taking up their perspective, make sense of his otherwise irrational, illogical and incomprehensible behaviours, since the patient's behaviour becomes meaningful if seen in the perspective from which the patient himself experiences, makes sense and acts in the world.

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