# The phenomenological dissection in psychopathology

## Phenomenological psychopathology and the identity of the psychiatrist

Who is a psychiatrist? What is the objective and purpose of psychiatry? What formation process and body of knowledge is needed to become a good clinician of the psyche? What is the role of psychopathology in psychiatry and what can young psychiatrists learn from it today? The purpose of this Special Issue is to try to answer these questions by analysing the theoretical, empirical, clinical and therapeutic aspects of psychopathology.

The nosographic revolution, triggered by the development of DSMs and ICDs, led to significant changes with the aim of organising the chaotic world of mental illness diagnoses and providing a scientific point of view to psychiatry within the medical field, which until then was considered a fringe medical specialty. The two main operational changes were the introduction of a simple, descriptive and "atheoretical" approach with homogeneous diagnostic criteria, and the development of assessment instruments that could simplify the diagnostic process. The objectivism and physicalism of this revolution were also fostered by the expanding perspectives of neurobiological research and treatment. What could not be foreseen at that time was that progresses in neurobiology have not improved purely clinical-descriptive diagnostic systems. Moreover, the hope for easy-to-use, reliable categorical diagnostic systems gradually replaced psychopathological manuals, and diagnostic criteria became the simplistic picture of the mental illnesses. The entire body of psychopathological knowledge was shelved as if it could hinder the newly-born operational revolution.

The early career psychiatrists of today, as sons of the "DSM-ICD generation", are training in this milieu where psychiatry is more morbus-oriented than person-oriented [1]. This was an ideological shift that affected both the What (ontology) and How (epistemology) related to mental illnesses [2]. The ontological level has been affected since the psychiatric object is supposed to be more subordinate to symptomatic, physical and biological parameters than to subjectivity and singular human experience. In this sense, symptomatological phenotypes have become the main object of psychiatric study thanks to their reliable, measurable and easy-to-assess nature. Moreover, in order to explain narrower symptomatological phenotypes of a mental disorder, the concept of endophenotype has been introduced – namely the upstream manifestation (neurophysiological, biochemical, endocrinological, neuroanatomical, cognitive or behavioural measures) of a smaller genotype than the whole disease-related genotype [3]. However, a simply symptomatic evaluation cannot explain or grasp the psychopathological phenotype [4]. Indeed, from a psychopathological viewpoint, mental illnesses are experiential anomalies of one's own self/body, of time/space and of otherness that produce abnormal, dysfunctional cognitions and/or behaviours [5]. Hence, symptoms are not accidental to the patient, but rather the manifestation of some implicit subjective dimension; the patient is not a passive casualty of the illness, and on the contrary he has an active role as a self-interpreting agent or goal-directed being in dealing with his abnormal experiences. Cognitions or behaviours are not pathological per se, but in the light of personal history, social situation and cultural context - and this is particularly true in the increasingly multicultural society where we live. What the patient manifests is not a series of mutually independent symptoms, but certain meaning-structures permeated by biographical details [6]. Moreover, the concept of comorbidity brought about by the DSM and ICD discourages seeing the manifold of symptoms displayed by a patient as a meaningful and coherent whole leading to the disaggregation of the structural unity of the patient's personal existence. The mushrooming of comorbid multiple diagnoses undermines the conceptual basis and the credibility of current classification systems.

Furthermore, as already mentioned, the epistemological level has been affected in several ways. Structured interviews were built in order to explore those symptoms that are relevant to establish a specific diagnosis. Standard assessment procedures are devised in such a way that the patient's symptomatology needs to fit pre-existing diagnostic criteria, overlooking the subtle experiential differences and their meaning for the patient. This approach makes use of a stimulus-response pattern of questions designed to elicit "relevant" answers with the risk of getting not the whole picture, but a "tunnel vision" of the

patient's manifold of abnormal phenomena. This type of interview weakens the intimacy of the relationship, presumes shared meanings between the interviewer and interviewee and gives the interviewer an excessive dominant role over the patient. Furthermore, because of the polysemous nature of psychiatric vocabulary, the technical approach to psychiatric diagnosis underestimates the need to clarify the subjective meaning of the terms with which patients and clinicians refer to abnormal mental phenomena (how can a word aptly express the proper meaning of a mental state?). In the psychopathological perspective, the context of the clinical encounter should be one of co-presence with the aim of understanding and not labelling [7]. This approach is also relevant to rescue abnormal marginal phenomena, not usually covered by standard assessment procedures, which nonetheless are part and piece of a mental picture, not to mention a disturbed form of existence.

The aim of good psychopathological assessment is to reconstruct the subjective experience of a patient and the lived world in which it is embedded. Its underlying tools are empathy and narratization. Empathy is the internal actualization of the other's experience, a special kind of immediate resonance (feeling with) between one person and another [8]. The empathic approach makes the interviewer a participant observer and implies a balanced relationship with the interviewed. Narratization, rather than stimulus-response interviews, allow the patient to communicate and explain their own experiences in their own terms, to posit them in the context of their personal world and history, and to try to make sense of them [9 10].

This is not to speak out against the neurosciences or to praise psychopathology, but only to give psychopathology its proper place [11]. Controversies between radical advocates of the biomedical status of psychiatry and strong supporters of its belonging to the humanities is abstract and sterile. A pathology of the psyche can have clear biological causes, but this does not make it a simple natural entity. The question is that in psychiatry, more than in any other specialty, both scientific and humanistic contributions are necessary, and psychopathology can be seen as the bridge between these two approaches [12 13]. This concept was already hoped for in the early 20th century by Karl Jaspers, the founder of psychopathology as the basic science for psychiatry. His masterpiece – General Psychopathology – first published 100 years ago, was the first systematic attempt to classify abnormal mental phenomena and became the most secure basis to establish valid and reliable diagnosis [14]. As the science of abnormal subjectivity, psychopathology relies both on explanation that allows the formulation of general rules by observing events, experimenting and collecting numerous examples, and on understanding the achievable only by sinking oneself into a singular situation. From the psychopathological perspective, mental illness is conceptualized as the outcome of mediation between a vulnerable self and the person that tries to cope with and make sense of the disturbances that arise from it. Symptoms are not only the direct outcomes of anomalous brain events, but are generated by the interplay between abnormal basic phenomena that have a neurobiological background and the patient's coping and meaning strategies. In this sense, as neurophysiological, biochemical, endocrinological, neuroanatomical, cognitive, or behavioural measures (endophenotypes) could improve the understanding of mental disorders [3], phenomenal (i.e., experiential) traits and constructs (pheno-phenotypes) could also occupy the terrain between symptoms and genetics, leaving room to subjectivity as the primary object of inquiry [4]. The method of 'phenomenological dissection' may prove useful on both theoretical and clinical grounds. The pheno-phenomenological level could be helpful to establish clear-cut syndromic categories that can be studied in neuroscientific terms (e.g. delusion is a very heterogeneous category that must be split into more specific sub-categories in order to successfully look for its neurobiological correlates). In addition, the use of the 'phenomenological razor' is of great help in sorting out "psychopathological receptors" since for successful therapeutic decision-making phenomenological fine-grained characterization of abnormal phenomena as targets of pharmacological treatment is needed [15 16] (e.g. so-called "social phobia" cannot be a valid category for drug prescription as it may arise from a suspicious attitude, or from a melancholic self-blame, or in the context of an anxiety disorder).

## Phenomenological psychopathology as the core science for psychiatry

All these questions are developed in the first part of this Issue on *Phenomenological psychopathology as a core science for psychiatry*.

This sections opens with a paper on the phenomenology of atmospheres [17]. The technical approach to the psychiatric interview is blind to essential aspects of the clinical encounter. It is this same objectifying intention that compromises the attention needed to notice the aesthetic properties of the clinical encounter and restricts linguistic contexts risking tautology. Atmospheres are examples of such phenomena that should be salvaged to allow in-depth psychopathological assessment. The authors of this paper clinical also explicate the relevance of tact in sensing atmospheres and the role of metaphors in articulating them. They argue that by bringing aesthetics into the clinical encounter

we may achieve an understanding of the meaning of a clinical situation as felt, rather than simply assessing objective signs and symptoms.
The following paper touches on the relationship between phenomenological psychopathology and the neurosciences [18]. It starts with a discussion of Jaspers' idea of unity and strong interdependence between soma and psyche, and then passes to subsequent and recent suggestions to naturalize phenomenology relating the subjective experience of the world to brain functions, and to phenomenologize neurosciences driving scientific research of the human mind with basic philosophical principles.
The third paper is about phenomenological psychopathology and causal explanation [19]. The author argues that a commonly held view – namely, that psychopathological phenomenology is relevant only to description and not to explanation – is inaccurate. The phenomenological approach (focusing on the subjective life of the patient) is relevant to empirical science, and this relevance includes causal explanation of mental disorders. It develops a deep analysis of ambiguities and controversies pertaining to the notions of description, explanation, understanding and causality (with the particular example of schizophrenia). Phenomenology can help to "explain" in several senses of that term, by showing how prima facie distinct symptoms may actually be mutually interdependent (sometimes called 'implicative' relationship), or can help one to grasp how one phenomenon might lead into another, or motivate it, etc.
The last paper of this Section overviews the current European situation of psychopathologic training based on an online interview addressed to 41 early career psychiatrists' who are representatives of their national associations. Young psychiatrists recognize that psychopathology is a core part of the psychiatric curriculum, although the quality and quantity of the training they received was not satisfying, and emphasize the capacity of psychopathological education to re-humanize psychiatric practice [20].

## Phenomenological psychopathology of mood disorders

Section Two starts with the explanation of what emotions are and why they are so relevant in psychiatry [21]. Emotions disclose an inescapable fragility at the heart of our identity and our vulnerability to mental illness. This paper proposes and discusses the definition of 'emotion' as feeling motivation to move, the distinction between "affect" and "mood" according to their intentional structure, and the dialectics between affects and moods. The authors propose a model constructed upon the theoretical assumption that the fragility characterizing human personhood stems from the dialectics of selfhood and otherness at the core of being a person, and that moods are one of the most conspicuous epiphanies of otherness in human life. These dialectics become particularly evident in the way our moods challenge our sense of personal identity due to the way it complicates our relation to the norms and values.
The second paper of this Section illustrates an exemplary phenomenological prototype of vulnerable structure to mood disorders, and specifically to melancholia (a particular type of major depressive disorder characterized by lack of vital drive, guilt and affective depersonalisation) [22]. The melancholic type of personality is a clear example of the tight interrelation between personality and mood disorder. This is a personality structure characterised by tight interpersonal commitments, that is, the need for order in interpersonal relationships and the avoidance of guilt feelings achieved through extreme norm adaptation and identification with one's own social role. The author also discusses the metamorphosis of this personality structure in late modern society, in which the personal ethos is more guided by "I can's" than by "I have's".
The following two papers investigate in great detail the phenomenology of mood disorders. The first describes, next to depressive symptoms per se, the life-world of persons affected by depression and mania [23]. The parameters of this phenomenological dissection of mood disorders – which the reader will find in the majority of clinical papers in this Issue – are the existential structures of the life-worlds. The utility is to produce a systematic description of subtle and often elusive changes in the person's subjective experience and to reconstruct the ontological framework within which they are generated. The experience of time, space, body, self and others, and their modifications, are the guidelines to this dissection whose aim is to enlarge our awareness of the life-world people affected by mental disorders, understand their behaviour and experiences, refine diagnostic criteria and establish homogenous categories for treatment and aetiological research.
The next paper examines recent phenomenological research on both depressive and manic episodes [24]. The author argues that depression and mania cannot be characterised by any particular mood (e.g. sadness, hopelessness, guilt or euphoria, grandiosity or irritability), but instead as a change in the way we "have" moods. Thus, if we conceive of the affective dimension as a decrease or an increase in the degree to which one is situated in and attuned to the world through moods, then the particular mood one finds oneself in is simply irrelevant to a diagnosis of either depression or mania. This analysis is applied to so-called "mixed states", showing how phenomenologically oriented studies can

help overcome the apparently paradoxical nature of this psychopathological condition.

## Phenomenological psychopathology of schizophrenia

The first contribution in this Section contains a detailed account of the schizophrenic life-world [25]. It gives a panoramic view of the way schizophrenic patients live their life as embodied persons and how they understand the existence of other people. To this end, lived time, space, body, selfhood and otherness are used as the principal descriptors of the transformation these patients undergo. The authors propose that the phenomenon of fragmentation, which is the loss of a coherent Gestalt of experience, is the best candidate as the core feature of schizophrenia spectrum disorders that runs through the manifold of schizophrenic abnormal phenomena, also affecting self-world related and inter esse. Fragmentation appears to be a basic feature of lived time, as well as space, body and selfhood. This suggests the crisis of the synthetic function of consciousness, that is, of the temporal unity of consciousness, may be at the basis of characteristics of "disarticulation", distinctive of the schizophrenic world.

The second paper in this Section widely discusses the self-disorder hypothesis of schizophrenia, a cutting-edge model of the psychopathology and pathogenesis of schizophrenia [26]. Schizophrenia is interpreted as a disorder of the pre-reflexive self, i.e. a pervasive perturbation of the core sense of self that is normally implicit in each act of awareness. Such a core sense of self refers to a crucial sense of self-sameness, of existing as a unified, unique and embodied subject of experience that is at one with oneself at any given moment. When this basic sense of self is disturbed, the person is inclined to experience both a kind of exaggerated self-consciousness and a concomitant fading in the tacit, pre-verbal feeling of existing as a living and unified subject of awareness (diminished self-affection). This paper gives special attention to the notion of anomalous self-experience and disordered-self with rich clinical descriptions, stressing how the instability of the first-person perspective threatens the most basic experience of being a subject of awareness and action.

The third paper focuses on the pathogenesis and early detection of schizophrenia [27]. Although the developmental nature of the disease and the subclinical prodromal phase have always been recognized, clinical management conventionally begins only at the time of the first frank psychotic episode. Nevertheless, during the last 20 years, the early phases of psychotic disorders have become one of the major clinical and research issues in psychiatric settings because of their importance in defining markers of risk for progression to psychotic illness and in investigating new biological and psychological treatments to prevent a transition to psychosis with the ultimate purpose of improving long term outcomes by reducing the duration of untreated illness. The "at-risk mental state" concept as well as the two main approaches to the early psychosis question are analysed: the ultra high risk approach (UHR) and the basic symptoms (BS) approach, each with its assessing instruments. Besides these, the "anomalous self-experience" (ASE) concept is also analysed and a tentative integration between the UHR, BS and ASE approaches is developed. In closing, the authors describe the clinical staging model and the advantages that it may bring in early psychosis from both clinic and research standpoints.

## Phenomenological psychopathology of the present

The fourth and last part is about three psychopathological conditions that, until now, have received relatively little attention by clinical phenomenologists compared to the areas of mood disorders and schizophrenia: borderline personality disorder, eating disorders and addictions.

As is well-known, borderline personality disorder is a highly variegated clinical area in which we encounter particularly difficult patients who, subject to "emotional dysregulation" and tendency to impulsive action, cause much distress to clinicians and health workers committed to their treatment. The contribution of psychopathology becomes essential whenever it allows the clinician to move from the level of the symptoms to that of lived experience [28]. When this shift is not attempted, the clinician remains trapped by the triad of stigmatisation, intractability and chronicity. To ask "What is like to be a person with borderline personality disorder" means, for example, to identify the characteristics of a perpetually dysphoric mood condition that forces the subject to look for ways to quickly reduce such an uncomfortable state. Psychopathology allows us to shed some light on the dynamics of dysphoric mood and the transformation of dysphoria into anger: such knowledge can also help reduce the risk of an emotional mirror-involvement in the clinician.

Eating disorders represent another example of widespread contemporary conditions [29]. There is general agreement on considering behavioural anomalies as secondary epiphenomena to a more profound psychopathological core, defined by excessive concerns about body shape and weight. Body image disturbances have been associated with a more profound subjective alteration consisting in disorders of the way patients experience their own body and shape their personal identity. In a phenomenological perspective, the core dimension

of eating disorders also encompasses the subjective perception of space and time. Several behaviours and cognitive distortion can be derived from the metamorphosis in lived body, space and time. As an example, the subjective perception of time in eating disorder patients appears to be connected with the temporal discontinuity of the representation of one's own body, and the need of predictability of one's own life, which is achieved/failed according with the control of eating and weight. The psychopathological core, rather than behavioural abnormalities, plays a crucial role in the onset and persistence of the disorders (some authors pointed out that the threshold to define the full recovery process might be body shame, appearance schemas and thin-ideal internalisation). Therefore, these may be fruitful targets of intervention among those on a recovery trajectory.
The last paper examines the "being-in-the-world" of addicted patients [30]. First of all, there is the need to distinguish different forms of addictions as each is characterised by typical symptoms and a characteristic form of life-world. As an example, persons with polyabuse of novel psychoactive substances develop radically different forms of psychoses compared with 'old' heroin addicts. Novel psychoactive substances lead to "synthetic psychoses" – a very rich psychotic state comparable to paraphrenia with mental automatism, chronic hallucinations and secondary (interpretative) delusions. As each drug may produce a distinct psychopathological syndrome and life-world, a consequence of polyabuse is that patients, after have "travelled" so many abnormal and uncanny "landscapes", may become unable to stay in a "space-with-others" and to project themselves in a stable identity time. The result of this time/space cleavage is emptiness, an existential condition that is very difficult to treat and characterised by high drop-out rates. The author describes a potential resource to treat these patients called Dasein's group analysis, an original interpretation of Binswanger's Daseinanalysis aimed to "reanimate" these emotionally "frozen" patients.

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