

Rediscovering Psychopathology: The Epistemology and Phenomenology of the Psychiatric Object

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Questions concerning both the ontology and epistemology of the “psychiatric object” (symptoms and signs) should be at the forefront of current concerns of psychiatry as a clinical neuroscience. We argue that neglect of these issues is a crucial source of the stagnation of psychiatric research. In honor of the centenary of Karl Jaspers’ book, *General Psychopathology*, we offer a critique of the contemporary “operationalist” epistemology, a critique that is consistent with Jaspers’ views. Symptoms and signs cannot be properly understood or identified apart from an appreciation of the nature of consciousness or subjectivity, which in turn cannot be treated as a collection of thing-like, mutually independent objects, accessible to context-free, “atheoretical” definitions or unproblematic forms of measurement (as is often assumed in structured interviewing). Adequate and faithful distinctions in the phenomenal or experiential realm are therefore a fundamental prerequisite for classification, treatment, and research. This requires a multi-disciplinary approach, incorporating (among other things) insights provided by psychology, phenomenological philosophy, and the philosophy of mind.

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Introduction

Abnormal mental phenomena, ie, disorders of experience and expression, are “the object” of psychiatry as a science and as a pragmatic medical discipline.¹ This phenotypic level, directly given in experience is, therefore, often termed *phenomenal*. It is at this level that we delineate the phenotypes used for classification or as variables in empirical research. A psychopathological description involves converting the patient’s experiences (lived in the first-person perspective), or translating certain aspects of his/her expression and behavior, into specific categories

of symptoms and signs that are defined in third-person terms, thus providing “objective,” sharable information for diagnosis, treatment, and research.² Obviously, the nature of the being of the “mental domain” (its ontology, form of existence) and the questions of how adequately to address and describe it (its epistemology) are fundamental issues for psychiatry.¹ Yet, despite the fact that consciousness is today at the very forefront of scientific and philosophical debate, such debate, strangely enough, is taking place almost completely outside the mainstream of psychiatric discourse. The ontology and epistemology of the psychiatric object are virtually never discussed in contemporary psychiatric literature (not even in the quite recent reflections on the stagnation of psychiatric science and the related problems of psychiatric classification^{3,4}).

The present article, honoring the centenary of Jaspers’ *General Psychopathology (GP)*,⁵ critically takes up these neglected questions. Our argument proceeds through 3 interconnected stages. First, we will articulate some of the main insights of Jaspers on these crucial theoretical issues. Then, we will examine what could be called the “accepted view” of the ontology and epistemology of the psychiatric object, which is implicit in current operational psychiatry and the developments of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) and the International Classification of Disease, Eleventh Revision (ICD-11). We will question this accepted view of the psychiatric object and the methods used to assess it. Finally, extending the exposition of Jaspers, we will present our own epistemological perspective, outlining certain basic tenets of contemporary phenomenology and philosophy of mind.^{2,6}

There are some timely reasons for such a critical appraisal. The most important is the fact that despite more than 30 years of intensive research, with a bewildering accumulation of detailed empirical data, our actionable knowledge of the boundaries, etiology, and

therapy of major psychiatric disorders has not advanced correspondingly.^{4,7} Second, we believe that psychiatry, in order to match the emerging possibilities for progress now offered by the rapidly advancing neurosciences, must develop an epistemologically adequate approach to the phenomenal realm.

“General Psychopathology”

Psychopathology refers, in a general sense, to the empirical and theoretical study of anomalous experience, expression, and action. Its goal is to offer a description, typology, and general comprehension of anomalous mental states and associated forms of behavior. By virtue of its medical nature and roots, psychopathology borders on an array of natural sciences, including genetics, epidemiology, neurobiology, neuroscience, and neuropsychology, as well as experimental and developmental psychology. Its history is, however, also marked by affinities to the humanities and social sciences, including philosophy and sociology.

In one sense then, psychopathology is an umbrella term that covers a multitude of empirical and theoretical approaches. In his 900-page *GP*, Jaspers⁵ passionately defended the need for methodological pluralism, emphasizing the extent to which methods and viewpoints from philosophy and other fields in the human sciences had a special value for psychiatry. Philosophical erudition, says Jaspers, fosters a curious and sophisticated attitude of mind, one allergic to “platitudinous speculation, dogmatic theorizing, and absolutism in every form.”

GP provided a first systematic description of anomalous mental phenomena, presented against a corresponding, descriptive background of normal experience (eg, discussion of depersonalization follows an exposition of the normal sense of self). In the core sections of his book, Jaspers offered phenomenological expositions of anomalous subjective experiences and disorders of expression and performance. *GP* also contained a thorough presentation of basic philosophical concepts deemed relevant for psychiatry, as well as a critical review of pertinent biological, psychological, and sociological theories and state of knowledge.

GP is, of course, not free of shortcomings, even when judged within its own historical context. Some of its concepts were uncritically carried over from 19th-century psychiatry. Despite these shortcomings, however, the book is full of valuable insights, most of which, unfortunately, have never been applied on an international psychiatric scale. Not only are Jaspers’ highly sophisticated descriptions of pathological experience largely unknown in Anglophone psychiatry, his primary methodological declaration—the need for a faithful description of anomalous experience, “from within”—is dogmatically ignored in the mainstream scientific psychiatry.

Jaspers’ vision of psychopathology places a decisive emphasis on phenomenology, in the sense of a systematic

exploration of the patient’s subjective experience and point of view. The object of psychopathology is the “conscious psychic event,” and psychopathology consequently involves and requires an in-depth study of experience and subjectivity. Jaspers certainly acknowledges that “psychological phenomena” or “psychic events” must also be studied using methods of behavioral description and measures of performance, and in causal relationship with neural structures and processes. Yet, as he points out, what is of interest to us *qua* psychiatrists are never the brain events in themselves, but only these events in relations of correlation or possible causation with what occurs on the conscious level. After all, the only reason brain states can assume the importance they do is through their relationship with mental states identified on experiential grounds. Conscious experience is “an explanandum in its own right,”⁸ as recent philosophers of mind have emphasized. Indeed, “without some idea . . . of what the subjective character of experience is, we cannot know what is required of physicalistic [reductive] theory.”⁹

Jaspers argues that consciousness is neither static nor atomic in nature; it exists rather as a kind of ever-changing streaming or flow, manifest not in separable fragments but as a mutually interdependent or interpenetrating unity: “phenomena do not originate in discrete fashion . . . There is always a total state of consciousness which makes it possible for individual phenomena to arise.” Recognition of this crucial holism is bound up with phenomenology’s distinctive emphasis on the form (structure) rather than the contents of our awareness—ie, on how things appear or on how they show up against a particular framework involving intentional mode, time, or space; or a pervasive mood—and sense of self and reality.

Jaspers further highlights a 3-fold significance of the term “consciousness.” To be conscious can refer to (a) being awake and undergoing experiences; (b) being conscious of an object, ie, implying the “aboutness” or intentional directedness of consciousness (such as the perception of this text); or (c) our capacity for reflective self-consciousness, a connotation bringing in perspective or point of view in an especially salient way. Here, Jaspers notes the distinctive nature of “human psychic illness,” which, he says, “introduces a completely new dimension” in which “the incompleteness and vulnerability of human beings and their freedom and infinite possibilities are themselves a cause of illness.”

How are we to proceed as psychopathologists, according to Jaspers? In his view, it is vital to obtain as correct and detailed an understanding of the patients’ experiential life as possible. Here, Jaspers urges us to elicit and attend to the patients’ self-descriptions, while also paying close attention to their expressive behavior and whatever results various psychological tests can deliver. This combination of methods can be difficult to carry out and is fraught with possibilities of error. There is, however, *no alternative*, short

of giving up entirely on the very project of psychopathology and hence on psychiatry itself—given that, as Jaspers put it, “a psychopathology which simply confines itself to what can be directly perceived through the senses becomes inevitably a psychopathology without a psyche.”

In Jaspers’ phenomenological view, the psychiatrist should, at least for a time, set aside any explanatory or even therapeutic ambition and instead focus on the observational and descriptive task. Only in this way will it be possible to get a proper grasp of what it is that has to be explained or treated. Importantly, however, he by no means entertains the operationalist idea of a purely atheoretical approach. Indeed, he explicitly emphasizes the need to apply “well-differentiated concepts” or “presuppositions,” which form “a necessary part of understanding.” In short, he specifically recognizes that “observation is not enough” and that in order “to take the full range of psychic reality,” the sensitive phenomenological interviewer must bring to bear his/her considerable knowledge of both normal and abnormal psychology (a knowledge of “what people experience and how they experience it”). Thus although Jaspers warns against the barrenness of a purely deductive approach, one that would force the subject matter into a straitjacket of systematic theory, he also rejects an all-too-common inference from this concern: namely, that it is “better to amass data blindly than to sit down and think.”

Current Operational Psychopathology

The “operational revolution” in psychiatry was triggered by the US-UK diagnostic project, which demonstrated markedly different diagnostic habits of British and American clinicians.¹⁰ Adding to the sense of urgency were the expanding tools of biological research and the emerging possibilities of biological treatments, both of which pushed issues of nosology to the forefront. A science of psychiatry was simply not compatible with such a degree of unreliability in psychiatric assessment. The “operational revolution,” a conceptual revision of psychopathology, involved the development of criteria-based diagnoses, “operational” definitions of such criteria, and a strong emphasis on interrater reliability, considered to be best assured by the use of fully structured psychiatric interviews. The theoretical foundations of this remaking were, to our knowledge, not explicitly debated. The debate pertained mainly to the technicalities of improving reliability, and it is widely acknowledged that issues of validity took a back seat to reliability concerns.⁴ This operational revolution did, however, involve various implicit assumptions, influenced by the then-dominant philosophical *Zeitgeist*: a positivist and behaviorist epistemology, based on the philosophical positions of logical empiricism or logical positivism and jointly called “operationalism.” Logical empiricism or logical positivism (the terms are essentially synonymous) is a philosophical position claiming that empirical observation, together with

the rules of logic, is the only valid source of knowledge about reality. Originally, it was a strongly antimetaphysical position, refraining from claims about the essence of reality; in some versions, it even bordered on phenomenism (the view that statements about material objects are reducible to statements about sense data or appearances). However, in the psychiatric DSM-III context, it gradually evolved into a stance that may be designated as objectivism and physicalism: namely, the epistemological view that reality is as it is, independently of any human perspective on it; and that the ontology of reality is exhaustively physical.^{6,11} Physicalism, in this common version of neurobiological reductionism, pictures reality as graspable in a certain substantive mechanical sense, akin to the movements of objects in Newtonian mechanics (not, in other words, in accord with the most contemporary models of reality provided by quantum mechanics). This classic type of physicalism still has a tremendous impact on contemporary mainstream research views regarding the nature of consciousness, and, a fortiori, on the psychiatric object. Consciousness and experience are typically treated as if they were somehow on a par with other spatial-temporal, substantive objects of the natural world (ie, things)—ie, as if conscious events (such as delusions or auditory hallucinations) were well-delimited, atomic entities that could be easily captured and quantified without much concern for more contextually based or Gestalt-like features.

Consciousness is frequently assumed to be epiphenomenal—ie, to be a mere product of neurophysiological events that lacks any causally relevant meaning structures of its own. Successful reduction in psychiatry was first envisaged as a match between a given phenotype and a given specific brain dysfunction. The so-called “symptom-based approach,” with an ensuing, strong reductionist research program of simple phenotype-focal substrate correlations, is emblematic of these metaphysical assumptions. The nature and extent of the putative substrate dysfunctions have progressively expanded, however, in response to accumulating failures of the strictly focal or monofactorial (neo-Kraepelinian) research approach (with talk of “networks” replacing talk of “modules” in recent years).

Logical positivism was strongly preoccupied with the issue of how theories and concepts, stated in language, might correspond to extralinguistic reality.¹² This preoccupation came to mark decisively the DSM-III descriptive psychiatric approach. In the early years of logical empiricism, it was even believed that reality might be faithfully described by means of very simple, atomistic, theory-free “observational” statements. Mounting criticism made it clear, however, that language is never theory free.¹³ An important response to these early criticisms was the development, originally in physics, of the notion of “operational definition,” which was supposed to assure an objective link between a concept and its referent or counterpart in nature.¹⁴ This notion

was presented in an influential address that Carl Hempel¹⁵ delivered to the American Psychiatric Association:

“An operational definition of a term is conceived as a rule to the effect that the term is to apply to a particular case if the performance of a specified operation in that case yields a certain characteristic result.”

For example, the term “ice” can be operationally defined as a volume of water that changes into a solid state if brought to a specified temperature under a specified barometric pressure. Such a definition stipulates a process or tells us how to act (to operate) in order to make an empirical check on the concept of ice. This way of defining does not, however, seem either theoretically appropriate or practically applicable for the vast majority of psychiatric terms. In psychiatry, we typically do not have, and probably cannot have, concepts that are operationalizable in the above sense. Consider, for instance, the task of recognizing “identity disturbance . . . with unstable self-image or sense of self,” a depressive state, inappropriate affect, or a paranoid style. It is obvious that these cannot readily be associated with any easily identifiable, observable atomic facts or be expressed in any easily applicable action algorithm. If viewed in critical perspective, what operationalism finally and actually amounted to in psychiatry was the idea that descriptions of mental or subjective phenomena should be cast at the “lowest possible level of inference”—ie, ideally in descriptions of external behavior, or else in simple lay language (the DSM is readable to a nonspecialist). It was hoped that clinicians would consistently use first-order, ordinary language to frame nonjudgmental, acontextual, and atheoretical definitions, and thereby improve the reliability of their descriptions. However, these operational hopes invariably seem to confront the fact that what words signify is typically framed by their local context, which (by its very nature) cannot be specified in advance. In other words, there are only few acontextual definitions. Thus, the clinician is able to correctly use the diagnostic “operational criteria” (eg, definitions of delusions, hallucinations, or passivity phenomena) only on the condition of him/her having prior conceptual grasp of, and context-sensitive and experience-based familiarity with, such diagnostic concepts.¹⁶ This problem is clearly reflected in the contemporary culture of data collection. It is widely believed that a fully structured diagnostic interview, approaching the purity of the behavioristic stimulus/response paradigm, with preformed questions asked in a predetermined sequence, is able to cut through the complexities of human communication and provide valid access to the patient’s experiential world, thus eventuating in a valid diagnostic classification.¹⁷ But, as we have recently demonstrated in a study of 100 consecutive, unselected first-admission cases, this is far from being the case. The fully structured interview has a prohibitively low sensitivity in detecting DSM-IV schizophrenia spectrum cases.¹⁸

There is now a significant literature on the pitfalls of psychiatric operationalism, discussion of which is beyond our scope here (see Parnas and Zahavi² and Parnas and Sass⁶). Moreover, recent psychological empirical research and theoretical studies seriously question the view of concepts as being amenable to algorithmic definitions; rather, in the view of many experts, concepts are organized around prototypes and exemplars.^{19,20}

In summary, a classification of the “psychiatric object” requires forms of judgment and complex pattern recognition that challenge or defy Hempel’s conceptions of operationalizing (see the following paragraphs).

Many of our above criticisms are anticipated in *GP*. Jaspers was certainly not opposed to the project of defining variables and carrying out empirical research. His overall position would seem, however, to favor those more difficult forms of definitions (“operationalizations”) that are primarily driven by validity concerns, as opposed to the overemphasis on interrater reliability that has come to dominate. This is well illustrated by the problem of defining delusion.²¹ Here, Jaspers was at pains to point out that delusion is not merely a false belief. The famous descriptive triad of features, comprising falsity, conviction, and incorrigibility, said Jaspers, was merely *suggestive* of the presence of a delusion, but in no way exhaustive, or definitive, of its phenomenological nature.

Jaspers makes 2 additional recommendations that are clearly at odds with most contemporary practice: One is his insistence that psychopathology must be “not only a kind of biology but also one of the Humanities,” which would include, but is by no means restricted to, philosophy. The second is his insistence that a detailed focus on a small number, or even a single, case can be as important for the furthering of knowledge as is the study of larger samples: “It is not so much the number of cases seen that matters in phenomenology but the extent of the inner exploration of the individual case, which needs to be carried to the furthest possible limit.” He further argues that the most illuminating cases may not, in fact, be the most common ones (in the sense of capturing the average), but rather those that are unusual yet somehow prototypical: “It is just the rare case which gives orientation to knowledge, in so far as it is not a freak but the full development of a classical extreme. Exceptional, not ordinary cases are the psychologically illuminating ones and through them we gain a firmer grasp of the great company of more commonplace instances.” This is a point well exemplified by the classic case studies of Luria in neurology, which made a major contribution to our understanding of brain function.²²

Contemporary Phenomenology of the Psychiatric Object

The approach of Jaspers to the issues of consciousness and experience is congruent with the views put forward in recent years by philosophers of both analytic and

phenomenological persuasions—all of whom argue (in their various ways) that any serious study of the mind or “psyche” must involve a consideration of consciousness, subjectivity, or the first-person point of view. Indeed, a study of this dimension would be indispensable even if we accepted that consciousness were exhaustively determined by brain events. The psychiatric object (symptoms, signs, behaviors, suffering, and altered existential patterns) always plays itself out in the phenomenal-experiential realm. Anomalies in the realm of subjectivity (here understood broadly, as conscious experience, expression, and general sense of existence) are therefore largely constitutive of any sensible notion of psychiatric disorder. The distinctions in the phenomenal realm are crucially pertinent to both etiologic and therapeutic approaches of psychiatry. In fact, they are foundational of psychiatry as a clinical neuroscience. It follows that valid, ie, phenomenologically faithful distinctions are a prerequisite of any possibility of a successful project of neuroscientific explanation. The mechanisms of “social phobia” may, eg, be expected to vary, when “avoiding others” occurs in the contexts of a suspicious attitude, a melancholic self-reproach, or a feeling of external access to one’s own thinking. Perhaps adding such considerations may unlock the potential of neuroscientific research and make focusing on so-called “symptom domains” or “psychopathology domains”²³ more fruitful. Otherwise, such a “symptoms domains” approach may risk ignoring the broader and subtler psychopathological context within which these symptoms occur (and which may, in fact, render them less comparable than they may otherwise seem in the “operational approach”).

There are 2 essential psychopathological domains of questioning that stand today largely unresolved and are in need of interdisciplinary assistance. First, central to many psychopathological disorders, are the notions of self, self-identity, ownership, reality, rationality, etc.; in other words, notions that all imply the issue of subjectivity and the first-person perspective. Because philosophy has traditionally been thematically concerned with these issues, it follows that its investigations can help conceptualize the disorders and further refine and supplement the terminology and overall framework of psychiatry. In other words, psychiatry is not simply facing a number of factual and empirical problems; a central part of its undertaking involves conceptual and epistemological issues as well. Similar to other sciences, psychiatry makes a number of assumptions about the nature of reality, the status of consciousness and the process of scientific investigation. The skeptical eye of philosophy might prevent psychiatry from falling prey to unwarranted reifications, scientism, and a too facile reductionism. A second domain concerns how and to what extent is a psychiatrist able to access the patient’s mind and reconstruct his experience?

We will briefly outline a few basic tenets of the contemporary phenomenological position, in continuation with certain ideas of Jaspers, on selected yet interdependent issues, which are highly pertinent to the ontology and epistemology of the psychiatric object.

Consciousness

It is crucial to understand phenomenal consciousness (subjectivity) as the overall field, ground, or horizon within which all “manifestation” or “presencing” of the objects of our awareness occurs. Consciousness, the phenomenal manifestation of thoughts, feelings, and perceptions, is not some kind of complex spatial, 3-dimensional object but a lived reality, a presence to itself and the world: “psyche,” writes Jaspers, is “not [...] an object (..) but ‘being in one’s own world,’ the integrating of an inner and outer world.”⁵ Consciousness manifests itself as a “becoming,” a temporal “streaming” of a unity of intertwined experiences. This streaming is not an amorphous mass of contents but is organized into a field of consciousness, which exhibits certain structures, involving intentionality, temporality, embodiment, self-awareness, and intersubjectivity (for detailed accounts, see Parnas and Zahavi² and Parnas and Sass⁶). Consciousness does not consist of sharply separable, substantial components, exerting mechanical causality on each other. Rather, as Husserl states, it is a “network of interdependent moments (ie, nonindependent parts). . . founded on intentional intertwining, motivation and mutual implication, in a way that has no analogue in the physical.”²⁴

One crucial issue in psychopathology—totally neglected by operationalized approaches but central for phenomenologists—concerns the various ways in which these intentional modes and structures can be transformed. Such transformations may be made more explicit and manifest in the course of a phenomenological investigation (interview). Classic examples are the prodromal “delusional mood” described by Jaspers and also the varied forms of derealization that can introduce heterogeneity into what may, too simplistically, be dismissed simply as “delusion.”²⁵ Other examples concern empirical, phenomenologically oriented studies of the alterations in self-awareness and first-person perspective in patients with schizophrenia spectrum conditions.^{26–29}

Symptom and Sign

The prevailing assumption (clearly evident in the psychometrics of research literature) is that psychiatric “symptoms and signs” should be treated as a form of being close to material objects: publicly accessible, mutually independent, and unproblematically graspable. The symptom/sign and its presumed causal substrate are considered to exhibit a similar ontological and descriptive nature: both are treated as spatiotemporally

delimited thing-like entities. In this paradigm—adequate and fruitful in somatic medicine—symptoms and signs have no intrinsic sense or meaning. Their role is to guide us toward their biological causes. But the psychiatrist confronts not a thing or body part or physiological process, but a person, ie, another embodied consciousness embedded in the realm of meaning. The person does not manifest a series of independent referring symptoms/signs but rather certain unities of interpenetrating experiences, feelings, expressions, beliefs, and actions, all permeated by biographical detail. These wholes and these aspects are not, in their essence, defined by a reference to underlying substrate but by their meaning.

“Inner and Outer” and the Notion of Gestalt

We can of course artificially separate the expression from the expressed content when scoring a mental status examination (eg, the sign of tearful eyes from the symptom of sadness). Also, certain psychopathological conditions involve dissociations between experience and expression. However, a fundamental separation of symptoms and signs is an epistemological impossibility, because a human being manifests him-/herself through certain meaningful wholes that emerge from a conjunction of the outer and the inner.

Here, the notion of Gestalt helps to express the wholeness of the clinical picture. A Gestalt is a salient unity or organization of phenomenal aspects. As is well known, the Gestalt is not a simple aggregate; the “whole is more than the sum of its parts.” This unity emerges from the relations between component features and is influenced by the whole (part-whole relations). In a nosological context, the Gestalt confers a diagnostic specificity on its component aspects while drawing from these concrete aspects its clinical rootedness. Aspects of a Gestalt (especially those with high cue validity) may be focused on in diagnosis or research; but one must remember that these aspects are interdependent in a mutually constitutive and implicative manner. The salience of, eg, an interpersonal encounter is jointly constituted by the patient’s experience, belief, and expression (“inner and outer”). We always perceive expression (sign) in the context of its temporal unfolding and in conjunction with the expressed contents (symptoms) and vice versa. The very same physical movement may be a wink or a mere blink, depending on context and ascribed expression or intent.^{30,31}

The prevalent view of the psyche as a mere assemblage of the inner and the outer is reliant on the Cartesian dualisms of mind-vs-world and mind-vs-body, which are now almost universally rejected in philosophy and mind science. Contemporary philosophers of mind certainly recognize the experiential asymmetry between the first- and the third-person perspectives (a difference between my access to my own thoughts and sensations from your access to my thoughts and sensations); they also point, however,

to the public or intersubjective dimensions of experience, most clearly manifest in emotion and intentional action.

Individuation of Symptom and Sign

What, then, defines a given individual experience/expression as a specific symptom or sign, given that it is not pre-given as an autonomous, thing-like entity but articulates itself from within an experiential expressive whole? The symptom is individuated (becomes *this* or *that* symptom) along several dimensions, not only through its sheer content but also through its structure or form and through its meaning relations to previous, simultaneous, and succeeding experiences. Often, the symptom does not exist as a fully articulated “mental object” directly accessible to introspection (or to a preformed question) but rather as a prereflective, implicit content or even as an altered framework/structure of consciousness. Frequently, it requires recollection. In all these instances, articulation or individuation of a symptom requires a reflective, conceptualizing process.

Consider the symptom of “audible thoughts” at the prepsychotic and psychotic phases of schizophrenia.³² The phenomenon of audible thoughts is not defined by its presumed acoustic loudness or pitch. It should be suspected rather when there is a structural change in the field of awareness, namely, a disintegration of the unity of inner-speech thinking into its components of meaning (content) and expression (signifier; sign). The patient seems to listen to or attend to his “spoken” thoughts (or to thoughts expressed in writing or other visual form) in order to grasp what he is thinking. This is in contrast with normal experience, in which one simply knows what one thinks while thinking it, without any need to focus directly on verbal signifiers passing through one’s mind and without any temporal or experiential gap between the subject and his thought.

Language and Psychiatric Interviewing

Mental terms are highly polysemic (the same term may have several different meanings). When a patient says “I feel depressed, sad, or down,” such a statement may, if further explored, be found to indicate a bewildering variety of experiences with varying affinities to the concept of depression: not only depressed mood but also, for instance, irritation, anger, loss of meaning, varieties of fatigue, ambivalence, hyperreflectivity, thought pressure, psychic anxiety, and even voices with negative content. It requires a careful interviewing effort to extract the salient profile of the distress behind the statement “I am depressed.” Here, we stumble upon one of the core issues confronting psychiatric interviewing. As we argued already, the symptoms are not ready-for-use objects, ripe for the picking. Their final linguistic designation is an outcome of a conceptualizing process. An example might help us

here: a symptom might be verbalized as, eg, a distressing feeling, “as if there are electric vibrations in my spine.” Here, an anomaly in the field of awareness, an alien feeling or sensation, immediately mobilizes reflective attempts to conceptualize and describe (perhaps to regain a sense of control and intersubjective belonging³³). This process is aided by metaphorical means, preeminently by metaphors involving space and energy, linked to basic bodily sensory-motor modes.³⁴ In our case, the complaint is localized to an anatomical structure (the spine) that is normally experientially mute. The description is therefore strange, yet still accessible to understanding. The phrasing of “electric vibrations” gives us a glimpse into “what it is like” to have this symptom. Perhaps a further concretization of this metaphor, away from its intersubjective anchoring, would bring the statement closer to a delusion. In our example, the conditional “as if there are electric vibrations in my spine” indicates that the patient maintains a reflective distance to his experience, linked to potential intersubjective agreement. He does not say, eg, “I know that there are electric vibrations in my spine,” in which case we might well consider him delusional.

Thus, the phenomenological approach to interviewing is an eminently dialogical (I-thou) approach in which a nonintrusive and accepting interpersonal rapport is crucial, in addition to the interviewer’s training, skill, and knowledge. It emphasizes spontaneity, narration, and self-reflection on the part of the patient, facilitating a maximally authentic articulation of anomalous experience and belief.¹⁷ It is extremely important to convey to the patient that even talking about the most bizarre experiences or fantasies is not beyond the psychiatrist’s professional competence and familiarity. This pertains to what is perhaps the most distinctively phenomenological aspect of the interview: In ordinary interactions with other people, we take for granted that we are all situated in a shared realm—where certain things show up as “out there” or “real” or in various other ways such as “remembered,” “imagined,” and so on—in short, in accord with our socially shared “natural attitude.” What a phenomenological interviewer must attempt to do is to suspend the standard presuppositions of the shared, common-sense world, the unquestioned background with its assumptions about time, space, causality, and self-identity, and about what does and does not exist as “real.” The aim of this suspension is to make these tacit assumptions (usually overlooked) manifest and available to reflective awareness and, thus, to allow for the identification, comprehension, and description of lived worlds and perspectives, in which other ontological dimensions or presuppositions (eg, other forms of space, time, or causality) might prevail.

A phenomenological approach to interviewing in no way precludes exhaustiveness and systematicity: in the semistructured interview, the interviewer is typically obliged to address all the items of a given scheme or checklist, but in an adequate conversational way

and context-sensitive sequence and fashion.^{17,18} Jaspers pointed out that such interviewing expertise requires experience, skill, and theoretical knowledge. In our own experience, such expertise may be achieved during a 2-year residency training, involving weekly psychopathology teachings, which comprise peer-shared discussion of concepts, live patient interviews, followed by discussion of elicited data, technicalities of the interview performance, and theoretical study.

Conclusion

The widely recognized lack of progress in psychiatry research has generated much criticism of the classificatory approach to psychiatric diagnosis, together with proposals to focus elsewhere: either on *domains* of psychopathology (eg, depression, reality distortion)²³ or else on behavioral constructs with known neural bases (eg, in the Research Domain Criteria, or RDoC: negative and positive valence systems, cognitive and social-process systems, and arousal/regulatory systems).³⁵ These programs may well generate important findings; their yield for psychopathology research remains to be explored.

The phenomenological approach to psychopathology may or may not involve a robust defense of diagnostic classification; it is certainly not opposed, on principle, to the study of “symptom domains” or of neurobehavioral factors. It does, however, suggest a somewhat different diagnosis of and a somewhat different cure for psychiatry’s own current malaise. A key problem is that our very conception of our object of study has been vastly oversimplified and that this ontological oversimplification has been accompanied by reliance on methodologies (eg, the structured interview) that are unable to capture the subtle forms of experience and expression that constitute the essential “psychiatric object.” We need clearer, sophisticated, and philosophically informed debate about epistemological and ontological issues, together with an openness to other approaches, both theoretical and methodological, required by an enterprise that includes the study of subjectivity.^{36,37} How a phenomenological approach may be implemented in a neuroscientific and therapeutic enterprise is exemplified by recent proposals for studying delusions^{6,17,25,38} and for developments of person-centered approaches in psychopathology.^{6,17,39}

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