Phenomenological Psychopathology: Toward a Person-Centered Hermeneutic Approach in the Clinical Encounter

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This introduction is an overall outlook of the methods used in phenomenological psychopathology. The several meanings of the term 'psychopathology' are differentiated, together with a brief overview of the main ideas in philosophical phenomenology. Then, the principal methodological concepts in use in phenomenological psychopathology are discussed: form and content, explaining and understanding, static and genetic understanding, *epoché* and *eidos*, the existentialia exploring the basic way human beings exist in the world. Finally, the hermeneutic approach in psychopathology is discussed at three levels: the hermeneutics of mental symptoms, the hermeneutic circle in the relationship between symptoms and diagnosis, and the hermeneutics of the deep subjective structure on which the previous levels are grounded.

1.1 Psychopathology as the Basic Science for Mental Health Care

A book of phenomenological psychopathology firstly needs to define exactly how the two key terms ("phenomenology" and "psychopathology") will be intended. This is because scholars use them differently in different contexts. Accordingly,

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some terminological clarification is useful to avoid possible misunderstandings. So the first question is: *What is Psychopathology?*

In many instances, this word is used as a synonym for "mental symptom," "mental syndrome," "mental disorder," and the like. For example, the reader of a paper entitled "Psychopathology in Multiple Sclerosis" can reasonably expect to find there the assessment (usually by means of "rating scales") of a more or less large array of mental symptoms, like depression, anxiety, and so on. This use of the word psychopathology is very general and, although acceptable, adds nothing to the information transmitted by the use of more specific names for individual mental symptoms and/or disorders.

In contrast to this very general use, in which psychopathology is defined by its focus on some "pathological" mental contents and abnormal expressions and behaviors, in all other cases psychopathology is conceived as a method or a discipline. Such a shift from content to method is best illustrated by the focus on methodological awareness in Karl Jaspers' *General Psychopathology* (1963, p. 5): "If we wish to raise our statements and discoveries to firm ground, above the daily flood of psychological notions, we shall almost always be forced to reflect on our methodology." Starting from this common ground, different emphases explain further variation in the use of the same word.

In a second, very common usage, the term "psychopathology" refers to the purely descriptive study of mental symptoms. More specifically, the method employed to study mental symptoms, their formal features allowing a distinction from similar phenomena. Descriptive psychopathology is the common language or *koiné* that allows specialists each speaking their own dialect or jargon to understand each other. Its "breeding ground" is the work of Karl Jaspers and the Heidelberg School (Janzarik 1976). Descriptive psychopathology gives a concrete description of the psychic states which patients actually experience; it delineates and differentiates them as sharply as possible; and it creates a suitable terminology (Jaspers 1963, p. 55). It is quintessential in recognizing and naming the abnormal or pathological phenomena that affect the human mind. The main objects of descriptive psychopathology are the patients' experiences. The form in which these experiences are presented is considered more significant than their contents. Perceptions, ideas, judgments, feelings, drives, and self-awareness are all forms of psychic phenomena, denoting the particular mode of existence in which a content is presented to us.

A third psychopathological approach derives directly from such a descriptive psychopathology, considering the significance of the enucleated phenomena within the psychiatric diagnosis and classification. In this context, the study of isolated symptoms shall allow the *identification of specific diagnostic entities* that, in turn, enable prediction of natural history and response to treatment. This use of psychopathology as the tool for nosographic diagnosis is well illustrated by Kurt Schneider's *Clinical Psychopathology* (1975), where the thorough descriptive characterization of mental symptoms makes possible the differential diagnosis between mental pathologies.

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It should be stressed that although psychopathology is about all that, it is not just about that. In fact, the focus on a purely descriptive psychopathology is *prima facie* in line with the biomedical approach that looks for the formalization of good *explananda*, i.e., symptoms and diagnoses intended as natural entities to be reduced and reconceived as *effects* of some supposed underlying (neuro)biological dysfunction which explains them. A psychopathological approach does not exclude seeing mental symptoms and disorders as caused by possible dysfunctions to be cured (Jaspers himself clearly wrote that the use of the explanatory method is admissible, coherent, and potentially unlimited: Jaspers 1963). However, the psychopathologist is also well aware that by reducing a complaint to a symptom of a dysfunction, we unavoidably overshadow the fact that a complaint has a meaning for the individual sufferer. Moreover, if psychopathology is conflated with nosography, only those symptoms that are supposed to have diagnostic value will be investigated, thus loosing relevant information that is not already classified. Accordingly, the focus on the explanation of mental symptoms and on diagnosis discourages attention to real people's experiences. Whereas symptomatology and nosology are strictly illness oriented, psychopathology is also *person* oriented, since it attempts to describe the patient's experience and his/her relationship to himself/herself and to the world. This leads us to the last two ways to intend the term psychopathology.

The fourth way to use the world psychopathology takes into account the subjective experience of the patient as it can be re-experienced by an empathic listener. This roughly corresponds to Jaspers' use of the word "phenomenology." This is, first and foremost, the meaning of psychopathology that inspires this book—the exploration of the experiential or personal dimension of mental pathology or "what is it like" to suffer for a given mental disorder. Its principal purpose is *understanding*. The patients' subjective experience is the "object" of this practice. Mental disorders are apparent in the realm of human subjectivity as abnormal, skewed, or constrained experiences, expressions, and behaviors. This is how mental disorder is presented to us. Mental disorders are first of all *mental*. A pathology of the psyche constitutes an experienced condition and a family of behaviors, feelings, and conscious contents, the peculiar significance of which emerges within a personal existence and history, and a sociocultural context. Such a kind of pathology is, therefore, completely on view only because of what has been called "the personal level of analysis" (Hornsby 2000; Gabbani & Stanghellini 2008). Only at this level, indeed, the real correlates of a psychopathological condition can be understood in their peculiar feel, meaning, and value for the subjects affected by them (Stanghellini 2007). The comprehension of the pathological significance of a psychic state (i.e., its meaning in a personal life) requires a kind of analysis which exceeds the range of a naturalistic approach. What one sees physically may be changes in receptor function, neurotransmitter metabolism, or whatever. But such changes cannot be diagnosed as "disordered" in and of themselves: they require mental abnormalities to be detected. The norm at play here is first and foremost at the mental level. The point here is that mental disorders appear on the personal level. Subpersonal abnormalities are only picked out as such by the person-level experience of disorder. The altered level of dopamine release would

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not be seen without the person already having been given a diagnosis of schizophrenia. And even if this should happen, an altered level of dopamine release in itself is not a mental disorder.

Finally, in a fifth meaning, psychopathology refers to a more global exploration of the patients' experiences. Here the exploration of the patient's subjective experiences is more hermeneutical than simply descriptive and focused on personal experiences as they appear in the patient's field of consciousness and can be re-experienced by an empathic listener. At play at this level is the search for a deep structure of subjectivity that makes possible the emergence of abnormal experiences and their organization in mental disorders. This level of inquiry builds on and extends the work of Minkowski, von Gebsattel, Straus, Binswanger, Tellenbach, Tatossian, Lanteri Laura, Blankenburg, and many others. Phenomenological investigation of abnormal human experience suggests a shift of attention from mere symptoms (i.e., state-like indexes for nosographical diagnosis) to a broader range of experiential phenomena that are indicative of trait-like features of a subject's experience of itself and its world—the life-world. A life-world is the province of reality inhabited by a given person, having its own *style* of subjective experience. The exploration of patients' experience and their life-worlds involves two distinct steps. The first—called *phenomenal* exploration—is the gathering of qualitative descriptions of a person's lived experiences. For instance, a patient may describe his thoughts as alien ("thoughts are intruding into my head") and the world surrounding him as fragmented ("the world is a series of snapshots"). The result is a rich and detailed collection of the patients' self-descriptions (Stanghellini and Rossi 2014). In this way, we detect the critical points where the constitution of experience is vulnerable and open to derailments reflecting the "phenomenal features" of patients' subjective experiences of specific contents, e.g., objects and events, in themselves and the world. In short, phenomenal exploration as first step focuses on contents; experience is considered here in a content-based way.

The second step aims to shift to phenomenology proper in that it seeks the underlying or basic structures or existential dimensions of the life-worlds patients live in. Abnormal phenomena are here viewed as the outcome of a profound modification of human subjectivity within the world. Phenomenology is committed to attempting to discover the common source that ties the seemingly heterogeneous individual experiences or phenomena related to contents together, thus targeting its underlying constitutive structures. This is done by finding similarities among the manifold phenomena and, possibly, the basic and underlying change in what we describe as *trans-phenomenal*. The term *trans*-phenomenal, rather than merely "phenomenal," refers to the fact that what is investigated at this level is not directly experienced. The concept of "trans-phenomenal" targets those features that underlie and, even more important, *constitute* subjective experience prior to and independent of the contents, e.g., events and objects. This second step of phenomenological analysis, then, aims to recover the underlying structures that usually recede into the background and remain implicit yet operative in our subjective self- and world experience.

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The fourth and fifth meanings of psychopathology best illustrate what we mean by a “phenomenological approach” to psychopathology and will be discussed in detail in the following sections.

Now we shall briefly discuss why, in our view, psychopathology is so important for nowadays psychiatry. According to Stanghellini and Broome (2014), there are at least six reasons for psychopathology to be at the heart of psychiatry.

1. Psychiatry being a heterogeneous discipline, it needs a common ground and a joint language. Patients’ lived experience being prioritized, psychopathology can be understood as a shared language that allows clinicians with different theoretical backgrounds to understand each other when dealing with mental disorders.
2. Psychopathology is useful to establish rigorous diagnoses in fields like psychiatry where the major disorders cannot be neuroscientifically defined as disease entities, but are exclusively syndromes defined according to characterizing symptoms, such as abnormal subjective experiences.
3. Psychopathology functions as a bridge between the human and clinical sciences, providing the basic tools to make sense of mental suffering.
4. Psychiatry addresses abnormal human subjectivity. Psychopathology attempts to define what is abnormal (rather than taking for granted commonsense views) and to grasp which elements of mental life remain normal in the context of illness.
5. Psychopathology connects understanding with caring and makes an effort to establish a methodological as well as ethical framework for this.
6. Psychopathology is about bridging understanding (meaningfulness of first-person subjective experience) and explanation (neurobiological causality) in research and clinical settings. Accordingly, basic psychopathological knowledge is a prerequisite for research addressing subpersonal mechanisms.

In conclusion, psychopathology is not one of numerous approaches aiming at conceptualizing mental disorders or illuminating their pathogenesis from a specific theoretical perspective. With its emphasis on systematic assessment of human subjectivity, it represents the basic study of mental phenomena, which is presupposed to any clinical and research enterprise.

1.2 Phenomenology: A Rigorous Method to Study Phenomena of Consciousness

What is phenomenology? As a concept, i.e., the study of phenomena as they appear to us, its historical roots are very old. On the contrary, the word “phenomenology” is more recent. Apparently it was coined in 1764, when J.H. Lambert combined two Greek stems (*phainomenon*, to appear and *logia*, discourse, science) into the German word *Phänomenologie*. Here the word phenomenology was used in the context of a theory of illusion or appearance in optics. Kant was probably influenced by Lambert’s ideas when, in the *Critique of Pure Reason*, he traced

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the distinction between what appears (the *phenomenon*) and the unknowable "thing in itself" (the *noumenon*). Later, Hegel, Whewell, Hamilton, and Mach made use of the word "phenomenology" to describe views of their own. Thus, at the end of the nineteenth century, the term "phenomenology" was largely used by many writers with different nuances depending on the theoretical context. It is at the turn of the century that the word phenomenology acquires its specific meaning, referring to the philosophical inquiry intended as a rigorous method to study phenomena of consciousness. Drawing on ideas of the empiricists (the importance of experience), Descartes (the methodological doubt bracketing commonsense beliefs), Kant (the foundation of the transcendental Self), Brentano (the intentionality of mental acts), and Bolzano (the characterization of propositions as pure logical entities not implying a subjectivity thinking about them), Edmund Husserl founded *phenomenology* as a philosophical method whose motto was *we must go back to the "things themselves"* (Husserl 2001, p. 168). It is hard to summarize Husserl's work in a brief text, mainly because "Husserl himself found difficult to recognize himself in a finished and printed work because his thought developed as a work in progress during all his life, [. . .] Husserl's focusing on phenomenological themes cannot be reduced to single writings and does not follow a strict chronological order" (Farina 2014, p. 51). However, we can try to summarize at least those basic concepts we need for the discussion:

1. Husserl's phenomenology is mainly an epistemological enterprise, i.e., it focuses on how we do know what we know; however, it is also an ontology, because from the way things are given to our knowledge, we can say something about their nature.
2. Whatever we know, we know it from the vantage point of our own state of consciousness. Only what is given to our consciousness is knowable, so rigorous knowledge must be based on it.
3. We shall suspend our obvious trust in naturalistic beliefs regarding both the certainty of science and the objectivity of the commonsense world (Husserl calls this preliminary act *epochè*). Such active bracketing is necessary because the beliefs in the obvious existence of the objects are prejudices that distort pure knowledge.
4. Consciousness is not a space filled with representations but an active process. Hence, objects of knowledge are not independent, objective facts. They are the result of the intentional act of knowing, i.e., they exist as objects of knowledge only in relation to a subjective pole that knows them.
5. By focusing on our act of knowing, we discover that the object as we see it in its entirety is the result of a complex process of synthesis (often "passive" and unaware of itself) grounded on manifold partial perspectives.
6. We can perform imaginative successive subtraction of all those points of view that can be eliminated without affecting the object (e.g., of a chair we are seeing, we can progressively change the color, the material of which it is made, etc., and we still have a chair). By consistently applying this "imaginative variation," we finally arrive at one point when the subtraction of the last feature lets the object

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itself to disappear. This characteristic that cannot be eliminated, otherwise the object is no more itself, is the "essential" feature, which Husserl calls the *eidos*. 238 239

There are many other concepts that could be remembered here (e.g., the distinction between *noesis* and *noema*, the distinction between physical (Körper) and experienced (*Leib*) body, the characterization of the "life-world," the process of intersubjective reciprocal recognition, etc.). However, here it was important to give the reader at least the basic concepts to understand in which sense Husserl's phenomenology is a rigorous enquiry into the way things present themselves to consciousness. 240 241 242 243 244 245 246

In conclusion, Husserl's phenomenology is the careful study of the manifestation of the things themselves in their full evidence in experience. It aims to explore the way phenomena appear and the relation between what appears and the one to whom something appears, abstracting from already acquired knowledge. We'll see below how this rigorous method solicited psychopathologists to rely on it in order to make possible a rigorous description of the otherwise ineffable abnormal mental phenomena. 247 248 249 250 251 252 253

Starting from Husserl, the history of phenomenology undertook different and unexpected developments which in some cases were far away from Husserl's original thought. There is no space here to describe them in detail; however, at least the main trends and variations shall be outlined. 254 255 256 257

Probably the most important figure is represented by Martin Heidegger, who was Husserl's strict collaborator in Freiburg. The history of the divergence between Husserl and Heidegger's understanding of phenomenology significantly involves personal issues, on the background of the Nazi's raising power in Germany. However, there were also key theoretical differences. In *Being and Time*, Heidegger (1927) denies the importance for phenomenology of the reduction to the essences (the *eidetic* method), discards a significant part of Husserl's approach for having improperly retained the centrality of the transcendental self (in Heidegger's view, Being is already and always a "Being-with-others" [*Mit-Dasein*]), and more heavily than Husserl he emphasizes the ontology of the phenomenon in opposition to its epistemology. Accordingly, in Heidegger the phenomenon is no more the *appearance*, as in the empiricist and Kantian traditions, of which a relic was also to be found in Husserl (although in Husserl there was a positive "ontological" part as well: i.e., the way phenomena were given in knowledge also says something on the *things themselves*). In Heidegger, the phenomenon is, according to its etymology, a positive manifestation of the thing itself, or, better, a manifestation of the *Being*. Here the metaphysical question about the Being, and the metaphysical inquiry in general, returns after being eclipsed for almost one century. This metaphysical turn is probably of minor importance for psychopathology, but in doing so, Heidegger starts his analysis from the being that poses the question of Being and for whom the answer is relevant: that being is the human being (the *Dasein* in Heidegger's terms), and this is why his philosophy can also be read as an anthropology whose key concepts are relevant for psychopathology. The original coexistence of subject and object before any differentiation takes place; the world as a character of the *Dasein* 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281

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and the object as something defined by its use for human beings; the fact that the presence of other human beings doesn't need to be justified, because we are originally together, the *Dasein* being always and already *mit-Dasein*; the "existentialia" (*Existenzialen*) as general categories indicating the fundamental ways of being in the world; all these are fundamental anthropological contributions by Heidegger, strongly inspiring generations of phenomenologically oriented psychopathologists.

We will discuss in detail some of these concepts later. Here it is important to highlight that Heidegger's *Being and Time* also represents a shift of emphasis from phenomenology strictu sensu to hermeneutics and that within hermeneutics itself, it is a move from *understanding* conceived as the interpreter's reliving (*nacherleben*) the author's intention (as it was in the romantic tradition), to *understanding* as the *Dasein* that understands himself in his being situated in his world, i.e., as the progressive clarification of a self-comprehension which is already a pre-comprehension (something which is originally given and awaits to be better articulated in the hermeneutical circle by means of the interpretation). Later, H.G. Gadamer (1960) will further expand this stance by stressing that historical work is important for us because it changes our own horizon, history mainly being the history of the effects (*Wirkungsgeschichte*). With this, the shift of interpretation from the author's mind to the effects the text has on the reader is completed, and such a European hermeneutical position will have as its counterpart American pragmatism.

Returning to the phenomenological/hermeneutical movement, it undertook manifold developments in several countries, deeply influencing several research fields, e.g., historiography, metaphysics, logics, linguistics, philosophical anthropology, psychology, theology, ethics, esthetics, etc.

In France, Sartre's existentialism was profoundly influenced by Jaspers, Husserl, and Heidegger. Among the key concepts he borrowed from phenomenology, there was *intentionality*, "interpreted in a personal way to deconstruct the substantiality of consciousness and to free it from any form of interiority" (Farina 2014, p. 60). In Sartre's (2004, p. 186) own words: "consciousness is always 'in situation' because it is always free, there is always and at every moment the concrete possibility for it to produce the unreal."

A few years later, building on Husserl's distinction between the physical and the living body, Merleau-Ponty was highlighting that perceiving is an active process performed by an embodied consciousness entering in a vital relationship with a lived world. Hence, a dualism between body and psyche was rejected because "Taken concretely, man is not a psyche joined to an organism, but rather this back-and-forth of existence that sometimes allows itself to exist as a body and sometimes carries itself into personal acts. [. . .] It is never a question of the incomprehensible encounter of two causalities, nor a collision between the order of causes and the order of ends" (Merleau-Ponty 2013, p. 90).

This fundamental issue of the relationship between natural causes and human motives (reasons, meanings, values, ends) will find in Ricoeur (1969) one of the

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most interesting hermeneutical efforts, trying to reconcile the naturalistic drives hypothesized by Freud and the teleonomy assumed by Hegel.

For reasons of space, we have to stop here our description of the phenomenological/hermeneutical/existential contributions, assuming that we have succeeded in showing at least the basic ideas useful to understand phenomenological psychopathology.

To conclude this section, we have seen that *phenomenology* is a term used in different contexts with important differences in meaning. Leaving aside its early use in esthetics and metaphysics, sensu strictu "phenomenology" refers to the method elaborated by its recognized father, Edmund Husserl. However, many other important thinkers are credited to be part of the phenomenological movement, irrespective of so many significant differences. Hence, sensu lato, we may consider as phenomenological all those contribution, in Europe as well as in several other countries, dealing with the experiential analysis of the acts of consciousness, with hermeneutics and with existential issues. To sum up, the phenomenological movement is not a close and self-referential school, but the manifold contribution of several thinkers sharing a family resemblance.

1.3 The Birth of Phenomenological Psychopathology: The State of the Art in Jaspers' Time and His Solutions

There is some debate about the real importance of Jaspers' *General Psychopathology* for both psychopathology, in general, and phenomenological psychopathology, in particular. According to Berrios (2013a), the young Jaspers is not particularly original in its foundation of psychopathology, both the name psychopathology and its basic contents (the careful description of mental symptoms) being already established in nineteenth-century alienism, in Germany and especially in France. Moreover, to talk of Jaspers' approach as an instance of phenomenology is misleading because he used the term to apply to the study of mental phenomena in a way that is largely inconsistent with that of Husserl; hence, Jaspers' quotation of Husserl's *Logical investigations* should be considered more as a marriage of convenience than as a real example of phenomenological analysis (Berrios 1993). We may agree, and nevertheless we would like to stress that it is not a case if the centennial of Jaspers' *General Psychopathology* was celebrated so widely in the world (e.g., Stanghellini and Fuchs, 2013), while Emminghaus[1] is known only by a few historically minded psychiatrists. The point is that Jaspers' book can be considered the *veritable foundation* of psychopathology as a specific discipline studying abnormal mental phenomena, a discipline which is practically connected

[1] Hermann Emminghaus (1845–1904) was a German psychiatrist, author of an 1878 book on psychopathology entitled *Allgemeine Psychopathologie zur Einführung in das Studium der Geistesstörungen*. Jaspers was surely aware of this book, as well as the contributions of Störring and Morselli.

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but theoretically clearly distinguishable from both psychiatry and clinical psychology (of which it represents the foundation, a sort of "basic science") and a discipline with its own methodological rules and, above all, self-aware of its own methods and specificities.

So, it is true that the young Jaspers had found in the Heidelberg's clinic a fully developed and already available knowledge about mental symptoms and their connection to psychiatric diagnosis, mainly following the ideas of Kraepelin. And he had also found there significant incentives to consider more in depth the humanistic side of our discipline (particularly under the influence of Grühle). But all this material was largely *not systematized*, and Jaspers was asked to write the *General Psychopathology* expressly in order to *secure* such a psychopathological knowledge in a systematic and (as far as possible) coherent system. This is the main reason for writing that book, and thus it was a sort of methodological foundation of a specific discipline whose knowledge was beforehand unsystematically dispersed in psychiatric textbooks. The young Jaspers was the right man for this job, primarily due to his philosophical/methodological knowledge and critical attitude—and also because his healthy problems were preventing him from a fuller involvement in clinical activities, leaving space for study.

When Jaspers started working on it, some alternative views on mental illness were competing. At one side, there was Kraepelin's system of classification, aimed at enucleating real natural entities (the mental diseases) starting from course and phenomenal presentation and looking for a convergence with anatomical and other neurobiological findings. On the other side, there were neurological constructions starting from the known functioning of the nervous system and trying to derive from this possible mental dysfunctions (at least this is the picture Jaspers gives us of systems like those of Meynert and Wernicke, which following Janet he considers "mythologies of the brain"). Finally, still peripheral respect to the academic environment but in rapid growth, there was the psychoanalytic explanation of mental symptoms as symbolic representation of unconscious causes [Jaspers will dispute this approach more directly in the following years: see on Rossi-Monti (2013)].

In short, Jaspers added to previous "psychopathologies" his relevant contribution on the following.

First, a major enhancement was surely methodological. As seen, Jaspers clearly claims that if we have to avoid to be continuously displaced by the emergence of new and unstable fashions, so common in psychiatry, we have to ground our psychopathological research on clear methodological reflections. On this regard, there are three important consequences (Rosini et al. 2013):

1. Man cannot be fully known through a unique, overarching, and dominant point of view. On the contrary, many points of view, many different approaches, and many methods of inquiry are needed. Every method has its own domain of application and its own results. But every method should be aware of its own limitations, thus avoiding to illicitly transcend them. This is Jaspers' *methodological pluralism*.

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2. We cannot avoid to carry with us our preconceptions when approaching the study of psychopathology. However, we must always try to enhance our insight on our preconceptions, thus transforming our *prejudices* (which operate tacitly, hence being at risk of introducing into the research unnoticed conflicting and contradictory assumptions) into *presuppositions*. The latter are the conscious methodological assumptions that guide and also constrain our empirical research.[2]
3. We must refuse all radical reductionisms, either neurobiological (Jaspers' abovementioned criticism to "the mythologies of the brain") or psychological (the assumption that every psychopathological phenomenon can be understood psychologically). In Jaspers' view, reductionism is not contradictory per se, but it is not satisfying because it excludes from the field of inquiry those features of the phenomena that do not fit into the model. Because many excluded features are relevant to psychopathology, a model that a priori leaves out them is not satisfying.

The second important contribution of Jaspers' *General Psychopathology* is his phenomenology. Above we acknowledged Berrios' critique to Jaspers' use of the term "phenomenology." We agree that there are relevant differences in the way Jaspers uses that term. However, there are also similarities; for example, his claim that we should "bracket" already made theoretical systems in order to go directly to our patients' lived experience clearly echoes Husserl's "bracketing" of theoretical as well as commonsense knowledge in the so-called epochè.[3] Similarly, the importance given to the acts of consciousness, the self-confinement of psychopathology to the study of conscious experiences as the unavoidable starting point of any further sort of inquiry about the mind, and the emphasis on a full description of phenomena as they are given in consciousness bear a resemblance to Husserl's phenomenological approach.

Despite this, Jaspers' phenomenology differs from Husserl's because (a) while Husserl's phenomenology applies to every object of knowledge (his examples being often concrete objects seen from different perspectives), Jaspers' phenomenology applies to a much more restricted domain, i.e., that of subjective symptoms (the lived experiences, or *Erlebnisse*), and (b) Jaspers intends the phenomenological method as a rigorous form of descriptive psychology, rejecting Husserl's eidetic research. As far as we know, at the beginning, Jaspers believed he was strictly

[2] It should be stressed that this distinction between prejudices and presuppositions is not yet clearly expressed in the 1913 first edition of the *General Psychopathology*, although the critique of prejudices is somehow already there. Probably the 1913 edition was more confident on the possibility of an approach free of prejudices (today it would be called atheoretical) than later, philosophically more mature editions.

[3] Of course both Husserl and Jaspers inherit this issue from the antimetaphysical spirit which was quite diffused in the philosophical debate of the last part of the nineteen century; i.e., a post-Kantian legacy arguing against all-comprehensive theoretical systems (like Hegel's) and proposing a return to lived experience.

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following Husserl's method, interpreted as a descriptive psychology; it is only later that he acknowledges the difference, but then, in a footnote added to a later edition of his *General Psychopathology*, he explicitly rejected eidetic phenomenology by stressing that its own phenomenology had to be intended as a descriptive enterprise.

Hence, Jaspers usage of the term "phenomenology" is heterodox respect to Husserl's usage of this word sensu strictu. However, a family resemblance and a general influence of Husserl's stance are apparent, and in any case, there are at least three key positive contributions of Jaspers' phenomenology to psychiatry and clinical psychology (Rosini et al. 2013):

1. First, the main function of Jaspers' phenomenology is to stress the importance of subjective experiences in psychopathological research. It is noteworthy that in the same years many psychologists were rejecting the study of mental phenomena to self-confine their research on the analysis of behaviors. On the contrary, Jaspers claims that subjective experiences are essential and must be studied scientifically. What he calls phenomenology is a rigorous description of the subjective psychopathological phenomena. We think that subjective experiences are an essential part of the psychopathological inquiry today as they were one century ago (Aragona 2012).
2. In order to be scientific, such an assessment of the patient's subjective experiences must be grounded on what is effectively present in his/her communication. Accordingly, in Jaspers' view, both neurobiological and psychoanalytic theories were foreign to phenomenology.

   The neurobiological approaches were responsible of a prejudice in that they pretended to deduce from putative neurobiological mechanisms the consequent mental phenomena; as Jaspers suggests, they failed because they postulated mental phenomena that the patients never reported, while they did not predict mental phenomena effectively complained by the patients.

   Psychoanalysis was responsible of a methodological mistake because it explained mental phenomena by means of a "mythological entity" (the unconscious) that was unsuitable to be studied scientifically. Indeed, only conscious phenomena are open to Jaspers' phenomenological study.
3. Finally, one of the most important contributions of Jaspers' phenomenology is the very insightful and rigorous description of the empathic act that Jaspers calls (following the romantic usage) the act of "understanding" (*Verstehen*). We will return on this in a following section.

1.4 The Need of Phenomenological Psychopathology Nowadays: The Current Crisis of Psychiatry

Psychiatry is periodically said to be in crisis, and during its history, there was always someone proposing a radical reformation based on neurobiology, sociology, etc. Moreover, in some periods, it was argued that psychiatry had to be completely thrown out because mental diagnoses were not pathologies at all but just different

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ways of communication; hence, as a medical discipline, psychiatry was a nonsense. Such a continuous attack and request of radical change is unusual in other scientific disciplines, and it is mainly due to the fact that (in Kuhnian terms) psychiatry is not a mature science but a pre-paradigmatic discipline with many distinct and irreconcilable schools of thought. According to Kuhn (1970), in such a state of the art, it is normal that scholars write books devoted to justify their philosophical/theoretical grounds and to attack other views proposing their own alternative solutions to the problems of the discipline. If this is the general state of psychiatry as a discipline, one of us (Aragona 2009a, b) argued that psychiatric nosology after 1980 had displayed a paradigmatic dynamic (a shared view of the matter, a specialized language and method, the publication of results on specialized journals, focusing on research details without the typical pre-paradigmatic need to rediscuss in any occasion the fundamental tenets of the ideas involved). In particular, it was emphasized that with the birth of the DSM-III, we had assisted to a disappearing of the infinite local nosographies that had characterized earlier psychiatry, to the rise of a shared nosographic language, and to a strong influence on epidemiology, research, education, and clinical activity (e.g., almost all new manuals of psychiatry, almost all clinical research trials, etiological researches, and epidemiological surveys are based on the DSM diagnostic criteria).

A historical study showed that from Kraepelin to the DSM-5 there was a line of continuity that involved all versions of the DSM (Aragona 2014a), and nevertheless something radically new is maybe happening nowadays, suggesting that psychiatric nosology is a paradigm involved in a state of scientific crisis whose most powerful proposal of solution is currently based on neurobiology (Aragona 2014b).

In this section, we will discuss the reasons for the current state of crisis, asking if this is only a superficial problem that can be amended within the nosographic system, or a more radical crisis forcing us to put in question our views on psychiatry in general (its image largely depending on the view on what kind of entities are mental disorders, a view largely conveyed by the implicit theoretical assumptions of the classification systems). If this is the case, the proposed shift to the neurobiological approach is itself problematic. It has been stressed that the "recent growth of neuroscientific paradigms in psychiatry has led to renewed challenges for clinicians and researchers in combining objective knowledge of brain functioning with the subjective experiences [of the patients, and that s]imilar challenges in the early years of the twentieth century, during psychiatry's 'first biological phase', led Karl Jaspers to insist on the importance of meanings as well as causes in psychopathology" (Stanghellini et al. 2013, p. 287).

To sum up, this section discusses the main problems involved in the current crisis of psychiatry and defends the idea that neuroscience alone is not sufficient to solve them, because many psychiatric challenges are rooted in descriptive and hermeneutic issues pertaining to the psychopathological inquiry. Hence, a renewed phenomenological psychopathology is needed in order to put our discipline on a solid ground.

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1.4.1 The Unintended Side Effect: Persons Lost in Diagnostic Criteria and Rating Scales

Current psychiatry is largely dominated by procedures involving the application of operative diagnostic criteria and the "measurement" of mental symptoms by means of rating scales and structured interviews, whose main aim is to increase inter-rater reliability. Such an approach to mental disorders derives from the work started in the 1970s by the so-called "neo-Kraepelinian" school, with the subsequent fundamental aid of the leader of the DSM-III project, R. Spitzer. In short, their main idea was that psychiatry had lost credibility mainly because psychiatrists had radically different views on mental diseases. As a consequence, this was responsible of scarce terminological and procedural precision. Psychoanalysis, which was the leading school of thought in the American psychiatry of the time, was considered largely responsible for this state of affairs, due to its subjectivist stance, its lack of standardized diagnostic procedures, and its use of obscure and unverifiable concepts.

A return to its own medical roots was then proposed as the solution for psychiatry's discredit, and Kraepelin's rigorous classification was seen as the best historical example for what was needed in psychiatry: a meticulous description of mental symptoms and illness course in order to enucleate reliable disease entities that further research could prove to be based on altered neurobiological mechanisms.

Years ago a well-known paper lamented that, after several years of rigorous application of this approach, American psychiatrists had to acknowledge that unintended side effects were emerged (Andreasen 2007). The author was the pupil of one of the leaders of the neo-Kraepelinian school, and for many years, she had followed that model trying to integrate it with new available methods and knowledge. For example, in an editorial celebrating one of the most important publications of the neo-Kraepelinian school, she commented that "25 years after that groundbreaking article, psychiatry is not only founded on diagnoses that are validated by clinical description and epidemiological criteria, but it is challenged by the opportunity to probe more deeply into mechanisms and perhaps to reach very fundamental levels of knowledge about etiology that will have profound implications for treatment and prevention" (Andreasen 1995, p. 161). However, with time the expected results did not come, and Andreasen realized that such a failure was related to unintended consequences deriving from the worldwide application of the neo-Kraepelinian DSM: "the study of phenomenology and nosology that was so treasured by the Mid-Atlantics[4] who created DSM is no longer seen as important or relevant. Research in psychopathology is a dying (or dead) enterprise" (Andreasen 2007, p. 111). Perhaps the most striking limitation of a psychiatric praxis reducing the diagnostic process to the administration of rating scales and the application of diagnostic criteria is its intrinsic

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[4] The universities teaching the neo-Kraepelinian approach in the 1970s.

dehumanization: "DSM has had a dehumanizing impact on the practice of psychiatry. History taking—the central evaluation tool in psychiatry—has frequently been reduced to the use of DSM checklists. DSM discourages clinicians from getting to know the patient as an individual person because of its dryly empirical approach" (Andreasen 2007, p. 111). A resource against such a dehumanizing approach is the acknowledgment that besides impersonal diagnostic criteria and brain mechanisms, psychiatry is and must essentially be focused on people. Hence, it has to be concerned with the patients' subjective experiences and the personal meanings the individuals attribute to their psychopathological experiences, being aware that the personal idioms of distress and the active interplay between the person and his/her abnormal experiences (personal elaboration) significantly mold the clinical picture, the illness course, and the therapeutic trajectory. Accordingly, we support a *person-centered approach* in psychiatry, considering "patients as active and meaning-making entities rather than as passive individuals and their attempts at self-understanding as potentially adaptive. This is important in contemporary practice at a number of levels. Crucially, it helps improve understanding of the unique personal values and beliefs by which each individual's experiences [...] are shaped, thus enhancing insight and improving the quality of the clinician-patient relationship" (Stanghellini et al. 2013, p. 292).

1.4.2 The Scientific Failure: Reliability Without Validity

The DSM-5 (American Psychiatric Association 2013) has been published in the midst of unusual controversy. Criticisms had always been advanced, but in the past, the DSM system was the dominant paradigm and criticisms were mainly the unheard complaints of the looser schools of thought. Today it's different, because it is the credibility of the DSM itself that is in question. For example, Maj commented that since the publication of the DSM-IV: "Only a couple of decades have passed, but those already seem 'good old days'. Much of that enthusiasm and faith has now vanished [...] the questions I am now receiving from journalists [...] focus not so much on 'new developments in the manual' (the most common question when the DSM-IV was launched) as on [...] 'why we produce this classification at all, since we do not have a solid ground on which to base it'" (Maj 2012, p. 161). Why such a dramatic change of view?

The present crisis of the DSM was not unexpected. From the very beginning of the revision process, the editors of the DSM-5 had clearly presented the demoralizing state of the art resulting from research evidences. DSM-IV psychiatric diagnoses were largely:

1. Unspecific, allowing no prediction about prognosis and therapeutic outcomes
2. Heterogeneous, including within the same concept individuals presenting with different clinical pictures
3. Instable, the same patient fulfilling the criteria for different diagnoses at different times

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4. Plagued by excessively high comorbidity
5. Without external validators, laboratory tests and/or neurobiological findings being not available to confirm the phenomenally based diagnosis

Their conclusion was that "research exclusively focused on refining DSM-defined syndromes may never be successful in uncovering their underlying etiologies" (Kupfer et al. 2002, p. xix). In other words, although the DSM-III was credited to have improved the inter-rater reliability (i.e., the agreement between independent clinicians looking at the same psychiatric interview), Spitzer's prediction that with more reliable diagnoses validity research would have consequently advanced was not confirmed.

Subsequent epistemological research claimed that the abovementioned problems deriving from the application of the DSM diagnostic criteria were not just "empirical" results that could find a resolution by extensive application of evidence-based methods. Rather, it was suggested that they could be better understood if they were reconceived as Kuhnian "anomalies," i.e., apparently empirical outputs largely dependent upon the way the classification system is internally structured (Aragona 2009a, b). A few of such problems, i.e., the DSM scarce phenomenal determination of mental symptoms and the basic belief that they can be objectively described, are relevant for the present discussion and will be discussed below. Here it is sufficient to highlight that we are in a particular historical period coinciding with the end of the neo-Kraepelinian long-lasting dominance in psychiatry, and in the next years, the survivors of such a nosographic overemphasis will need to reorganize the discipline on firmer grounds, paying more attention to the specific qualities of the patients' experiences. In conclusion, according to Zachar and Jablensky (2014, pp. 9–10), "the neo-Kraepelinian paradigm established by Robins and Guze and institutionalized in the DSM has resulted in so many problems and inconsistencies that a crisis of confidence has become widespread [and this drives] a transition from a period of normal science (where the paradigm serves as an integrating framework in which questions are asked and answered) to a period of *extraordinary science*. The defining features of the fragmented periods called extraordinary science include: (a) lack of agreement on what are the most appropriate methodologies, (b) magnification of the problems that define the crisis into the most important problems of the discipline, (c) the generation of speculative new theories, and (d) a dramatic increase of interest in exploring the philosophical assumptions of the discipline."

1.4.3 Lack of Phenomenal Determination

A widely acknowledged problem with current classification systems and the assessment instruments derived from them is their insufficient attention to the qualitative specificities of the assessed mental phenomena. We will see why the definition of symptoms "as oversimplified phenomenal variants" (Stanghellini and Rossi 2014, p. 237) is inappropriate. But firstly, why is it so?

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Two intertwined major aims of the DSM-III significantly influenced the approach on this issue: the diagnosis of any mental disorder had to be based on reliable observation, and clinicians from different schools of psychiatry had to feel comfortable when using the same terms. Because most source of disagreement was thought to depend from the fact that qualitative nuances were more difficult to detect and that different schools tended to highlight different qualitative features of mental phenomena, the architects of the DSM-III chose to use lists of symptoms whose definition was commonsensical and detection was simple as much as possible. Moreover, because in the diagnostic procedure different schools tended to give different weights to this or that symptom, the diagnostic criteria were organized as quantitative lists with diagnostic thresholds, without a hierarchical organization of symptoms depending on their possible importance. Examples of this are the DSM-5 definitions of euthymic mood as "mood in the 'normal' range" (tautology), "bizarre" schizophrenic delusion defined as a delusion involving "a phenomenon that the person's culture would regard as physically impossible" (vagueness), the same weight of antithetical symptoms in the same diagnosis (e.g., weight loss or gain, and decrease or increase in appetite, in major depression), and so on. 646–662

Such a choice to prefer a quantitative and commonsensical approach was responsible (together with other choices) of many current anomalies in the application of the diagnostic criteria to the clinical and research populations. For example: 663–665

1. Lack of distinction between the once called "endogenous" or "vital" depression (typical of melancholics), and the dysphoric "depression" in borderlines reacting to a disillusion can improperly increase the chance to make a diagnosis of major depression and borderline personality disorder in comorbidity. 666–669
2. Lack of distinction between Jaspers' primary and secondary delusions can magnify the impression of continuity of mixed cases between schizophrenia and affective disorders and also increase the internal heterogeneity of samples of patients selected for research. 670–673
3. Lack of distinction between fundamental and accessory symptoms increases the inclusion in the same sample of non-prototypical patients, hence internal diagnostic heterogeneity and consequent poor prognostic and treatment specificities. 674–676

Examples of this kind could be multiplied, but here is sufficient to stress one key point: starting from heterogeneous samples is practically very difficult to point to possible underlying neurobiological dysfunctions. Hence (as stated in Sect. 1.4.2), the failure of the neo-Kraepelinian approach is mainly a problem of lack of validity, and it cannot be solved by simply increasing neurobiological research, because it is the phenomenal characterization of the samples to be studied that is primarily in question. As we will see in this book, European psychopathology has always been concerned with a careful qualitative distinction and delimitation of psychopathological phenomena, in order to grasp their essential features independently from nonspecific or derivative symptoms. For example, several chapters of this book will show that schizophrenic people are not simply carriers of delusions, voices, and other incoherent symptoms in a number sufficient to make diagnosis. 677–688

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Rather, essential self-disorders specifying a general specific *Gestalt* are nuclear disturbances that lie beneath superficial paranoid phenomena. Accordingly, although diagnostic criteria (nosographic organizers) may be useful for simple communication, understanding persons with mental disorders also requires a more fine-grained competence in detecting nuanced but fundamental phenomena representing the core of the phenomenal picture. Independently from strict nosographic usages, at this core level, psychopathological concepts organize a complex array of psychopathological phenomena in unities based on meaningful structures (psychopathological organizers) (Rossi-Monti and Stanghellini 1996). This is the task of the so-called structural psychopathology, which "assumes that the manifold of phenomena of a given mental disorder is a meaningful whole, i.e., a structure. The symptoms of a syndrome are supposed to have a meaningful coherence" (Stanghellini 2010, p. 320); hence, the phenomenal specificities and the internal links between the parts of the structure should be thoroughly investigated.

1.4.4 The Promised Neurocognitive Revolution (The RDoC Project)

It has been argued that psychiatry is in a scientific crisis and that today the most powerful revolutionary proposal comes from the neurocognitive field (Aragona 2014b).

Early proposals (Murphy 2006; Sirgiovanni 2009) had suggested to ground psychiatric diagnoses neither on the microlevel (the genes or other molecular/biochemical features) nor on the macro-level of behavior and personality; rather, cognitive scientists were invited to focus on an intermediate level, that of the cognitive computational modules, mental disorders being conceived as "breakdowns of neurocomputational mechanisms" (Sirgiovanni 2009, p. 47).

More recently, the US National Institute of Mental Health launched an ambitious research plan called "Research Domain Criteria (RDoC) project" (Insel et al. 2010; Cuthbert and Insel 2013). Although the DSM-5 presented itself as a "bridge" between the old model and the RDoC project, the RDoC project proposes a radical change in psychiatric research. In fact, its aim is "to shift researchers away from focusing on the traditional diagnostic categories as an organizing principle for selecting study populations towards a focus on dysregulated neurobiological systems" (First 2012, p. 15). We do not consider here the many criticisms against this model, confining our discussion on the basic features of the RDoC project and on its continuity and differences compared to the usual DSM-based approach. Only then we will raise some critical concerns whose discussion might be useful in this context.

Firstly, the RDoC proposal is not a diagnostic system in its classical sense but a matrix based on basic areas of psychological (cognitive) functioning to be correlated to corresponding brain circuits. That is, it focuses on cognitive domains as the key constructs around which available evidence (from different sources, from genes to self-observation) should be trans-nosographically organized (First 2012; Cuthbert and Insel 2013). As such, it has no immediate concrete effects on

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psychiatric nosography; it is just in a future, when/if the expected research findings will be sufficient, that it will be possible to build on these bases a new, radically different nosography, grounded on a neurocognitive paradigm. Epistemological research suggested that such a model is revolutionary because it radically changes the direction of the validation process: while in the traditional approach researchers are "expected to proceed from phenomenally defined disorders *back* to the discovery of their etiology, in the etiopathogenic approaches the direction is expected to be from "subpersonal" dysfunctions (of genes, brain processes, or cognitive mechanisms) *ahead* to the resulting phenomenal picture" (Aragona 2014a, p. 40). However, despite its recognized revolutionary potential, the RDoC project remains largely continuous with the traditional reductionist ideal of validation intended as the discovery of the neurobiological processes responsible for mental disturbances.

Hence, some basic problems remain: how are the cognitive disturbances to be investigated phenomenally characterized? Why are they limited to those already enlisted? Can other cognitive domains be added in the future or is it a close system? Are they independent or interconnected functions? Are they homogeneous or heterogeneous? It can be predicted that questions like these will be part of the debate on the RDoC system as they were in the case of mental symptoms and disorders.

Here it is sufficient to stress that the RDoC model is interesting but with some possible problems. One of them is that, more or less explicitly, it conveys a reductionist idea assuming that what really matters is neurobiological explanation in terms of neurocircuits, chemistry, and genes, while the space dedicated to the experiential and relational features is at best marginal. Once again, as it was the case with reductionist models of the past, the risk is to transform psychiatry in a neurological activity where the sufferer as a person is lost.

1.5 Toward a Person-Centered, Multidisciplinary, Empathic, Human- and Value-Friendly Psychopathology

In the previous sections, we discussed the limitations of old and new mainstream approaches in psychiatry. We showed that what remains quite the same in different ages is the basic idea that the study of mental illnesses should focus on the underlying neurobiological dysfunction of which they are supposed to be the expressions. In such a context, in order to go further, psychiatry should increase its "objectivity," that is it should look at diseased deanimated bodies whose abnormal cognitions and behaviors should be seen as dysfunctional mechanisms to be normalized. This should be done preferably by means of direct intervention through pharmacological modulation, physical neurostimulation or neuroinhibition (e.g., transcranial magnetic stimulation and electrical devices), and when psychotherapy is considered, its role is admitted only because it is a nonphysical activity that nevertheless changes the brain. As stated above, in such a perspective, the individual sufferer and his/her world made of meaningful connections, significant relationships and values are completely lost. This is not to deny that people have a

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brain and that the brain is the organ to be studied to explain people's perceptions, emotions, cognitions, and actions, including both normal and abnormal ones. Yet, is this satisfying? Somehow ironically, although the model described above pretends to be medically oriented, nowadays medicine is deeply involved in a critical self-evaluation. From such self-criticism arises the idea that disconnecting the whole sufferer and dispersing its body parts under the aegida of different unconnected specialties was responsible of worse treatments, increased costs, and poorer compliance. Accordingly, "as medicine has become more powerfully scientific, it has also become increasingly depersonalised, so that within many areas of clinical practice it has been possible to witness the substitution of scientific medicine for scientistic medicine and to see an accompanying collapse of humanistic values in the principles and practice of medicine. [...] now that we can 'cure', we no longer retain any responsibility to 'care'—thus exacerbating [...] a crisis of knowledge, compassion, care and costs—and which risks a grave outcome for patients and clinicians alike" (Miles and Mezzich 2011, p. 208).

In psychopathology, a person-centered approach draws attention to the patient as a human being who has an active role in interacting with his/her basic disturbances and in the shaping of the psychopathological syndrome. Thus, in this context, the patient is seen as a meaning-making individual, a self-interpreting agent engaged in a world shared with other persons and whose individual values and experiences are key aspects of his/her self-understanding (Stanghellini et al. 2013).

Some key concepts are important here because they are part of a necessary general stance that psychiatrists (above all, those psychiatrists and psychologists who have clinical responsibilities) shall share independently from their respective schools of thought. Being phenomenology a humanistic contribution to the psychopathological science, it has a significant role in promoting such key notions. However, we believe that their importance largely transcends the phenomenological school and shall be part of a more basic common ground for any human being curing and caring for mental sufferers.

1.5.1 A Person-Centered Approach

As seen, the entire medicine is facing a radical challenge: while it is and has to be continuously more scientifically informed, technological, and evidence-based, in doing so it risks (and unfortunately this already happened) to lose the human contact with the sufferer, reduced to a dysfunctional body or part, de-individualized, and transformed in the "carrier" of a disease. We saw that this has negative effects on crucial issues like the therapeutic alliance and compliance, which are important in internal medicine as they are in psychiatry. Moreover, today's biological medicine is also reconsidering the primacy given to the disease with respect to its "carrier": in fact, individual differences promise to be key features for future individualized therapies; e.g., persons with different metabolism may respond differently to the same drug, despite having the same disease. The study of individual genetic differences is another case in point. If this is particularly

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relevant in internal medicine, it is at least equally important in psychopathology, where the patient is never the simple "carrier" of an independent disease. In fact, each individual, with his/her unique strengths and resources as well as needs and difficulties, plays a central role in actively shaping his/her disorder, its course, manifestation, outcome, etc. (Stanghellini et al. 2013). As said by Strauss (1992), the person is never peripheral, merely as a passive victim of a disease; rather, persons are "goal-directed" beings with an active role in shaping their own symptoms and guiding the evolution of the phases of their disorder. Accordingly, any clinical approach to mental sufferers has to be strictly individualized, because different persons have different needs and resources.

1.5.2 A Multidisciplinary Approach

One of the major limitations of current medicine is when different disciplinary approaches do not communicate in the individual case. However, in medicine the opposite case is often available, e.g., when physics, biologists, engineers, nurses, and clinicians with different specialties (internal medicine, radiology, surgery) coordinate themselves in a unique staff for the treatment of complex cases by means of technologically advanced devices. Psychiatry should be constitutively open to a multidisciplinary approach, because the biopsychosocial model of mental illness has significantly shaped its organization in the twentieth century. However, in many instances, it was organized totally independently from internal medicine, and for this reason in the last decade, the World Psychiatric Association increased its efforts to promote the importance of general medicine in the management of mental disorders. On the other side, there are examples of service organization where psychiatrists self-limited their activity to diagnostic assessment (largely using neuroimaging and laboratory analyses, although both provide unspecific results, the diagnosis being phenomenally based) and psychopharmacological intervention, without the necessary integration of the psychological and social level. Today the treatment of complex eating disorders, which so heavily involve the physiopathology of the body, was the occasion for the organization of multidisciplinary and integrated services where psychiatrists, psychologists, nurses, rehabilitators, and physicians expert in nutrition work together and coordinate their activities. However, while efforts were done for the integration of psychiatry and internal medicine, a lot remains to do for an improved dialogue between the schools of psychiatry and psychology. In fact, different schools are often in opposition to each other, showing the above discussed pre-paradigmatic state of the art well described by Kuhn.

A philosophical approach to psychiatry is here particularly important because it shows that most difference between schools is due to their acceptance of different philosophical basic tenets. Being aprioristically accepted, such basic claims often act as Jaspersian prejudices, and their explicit discussion and clarification is often very useful in order to increase collaboration between clinicians holding different views.

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Moreover, a phenomenological approach that focuses on phenomena as they give themselves to consciousness in all of their concrete and distinctive features further increases the possibility of a reliable agreement. In fact, here “the primary object of inquiry is the patient’s subjectivity, focusing on patient’s states of mind as they are experienced and narrated by them [. . .]. Theoretical assumption are minimized and the structures of the patient’s experience are prioritized” (Stanghellini and Rossi 2014, p. 238). This increases the possibility of a shared agreement on the phenomena themselves, independently from (and prior to) causal accounts addressing etiological explanations and subpersonal mechanisms. It should be stressed that although there are apparent similarities between this approach and the DSM-III’s atheoretical claim, one significant difference is that phenomenology brackets theoretical preknowledge by means of a conscious, deliberate, and philosophically informed technical act of judgment suspension (the *epoché*), while the DSM suggests a naïve atheoretical stance based on a covert neopositivist assumption that symptoms are real entities which are directly observable without the need of any inference (Aragona 2013). This last atheoretical implicit belief contrasts the acknowledgement that mental symptoms are observed from the point of view of the observer (theory-ladenness) and are the product of a hermeneutical process taking place within the patient as well as in the dialogical exchange between patient and fellows, the clinician included (Berrios 2013b; Aragona and Marková 2015). Neglecting the intrinsic hermeneutics of mental symptoms leads to ineffectiveness, for clinical practice, of standard interviews molded on research-objectifying procedures, because it overlooks that the assessment of a mental state involves two kinds of reductions. According to one of us (Stanghellini 2013, p. 326), the first “is performed by the speaker who tries to find the propositional correlate of a given mental state, or the ‘right words’ to communicate it. The other reduction is performed by the listener who must sometimes interpret the speaker’s meaning by asking the speaker and himself ‘what does he mean by that?’ This problem, which plagues psychopathological research and clinical practice, becomes even more acute in using standardized assessment, since when interviewees respond to questionnaires, they might have very different understandings of the questions, and this may lead to the inaccurate conclusion that different individuals or groups have similar experiences or beliefs.”

Finally, a value-based sensibility (see below) is also helpful in reducing conflicts between the members of a service, thus promoting the interdisciplinary dialogue (Fulford and Stanghellini 2008).

1.5.3 An Empathic, Human- and Value-Friendly Approach

The phenomenological stance promotes the importance of empathy, humanities, and values in the approach to mental sufferers. Empathy is a complex, multifaceted, and polysemic concept. We will discuss it in detail in the following section, because it is a key concept in phenomenological and hermeneutic psychopathology. Here we briefly concentrate on the basic empathy in the therapeutic relationship, which is

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simply a general stance of "openness" and "attunement" to the other human being and his world of meanings. In this sense, an empathic relationship is defined as "other-oriented feelings of concern, compassion, and tenderness experienced as a result of witnessing another person's suffering" (Batson et al. 1990), and in psychiatry and psychology, it is also seen as a way of "putting the patient and yourself at ease" (Othmer and Othmer 2002), as well as a special technique to elicit trust in order to achieve rapport and relevant information (Turner and Hersen 2003). Of course, an empathic openness to the other human being in the therapeutic relationship is not a specific feature of phenomenological psychopathology, because it is the common basis for the vast majority of psychotherapies and it should be considered fundamental also in biological psychiatry. So, phenomenological psychopathology shares with many other approaches an emphasis on the importance of a general empathic stance in the therapeutic relationship, but it is much more than this. We will see later that in psychopathology empathy is not only a mere precursor to the genuine article of psychopathological understanding. Rather, it is the medium itself where understanding takes place, and psychopathological empathy can be additionally differentiated along the lines of the debate on the concept of "understanding" (*Verstehen*), from Jaspers to post-Heideggerian developments.

To this basic openness, phenomenological psychopathology adds a specific philosophical expertise that brings to psychiatry and clinical psychology a methodologically rigorous defense of complexity and anti-reductionism views. According to Fulford et al. (2004), a philosophical stance gives psychiatry a more complete picture of its structure, promoting a better characterization of the psychiatrist's role in crucial areas including the role of patients (philosophy puts patients first) and research (where philosophy reconnects minds with brains).

Finally, the work in values-based practice (VBP) is based not only in philosophical value theory but also in the contribution of phenomenological psychopathology. The specific contributions of VBP include:

1. Raising awareness of the role of values even in categorical psychiatric diagnostic systems.
2. Providing a clear theoretical explanation for the relative prominence of values in psychiatric diagnostic classifications (derived from the relative complexity of human values in the areas with which psychiatry is concerned).
3. Through the policy frameworks and training methods already established for values-based practice (Fulford and Stanghellini 2008). It is noteworthy that phenomenological psychopathology is interconnected with VBP, at the same time being one of its theoretical sources and a field of application of its principles.

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1.6 The Phenomenological Analysis of Suffering

This section will explore in detail the main concepts, i.e., the categories of thought that inform the experiential encounter in clinical and research activity performed with a phenomenological approach. As we will see, the utilization of such concepts in practice is manifold, paralleling the multiple phenomenological views that influenced psychopathologists in different ways. Hence, the following concepts are not held by all phenomenologically oriented psychopathologists in the same way; some of them put more emphasis on some terms and reject others and vice versa. What is common is a general family resemblance and a deep involvement in human meaningful relationships.

1.6.1 Bracketing Theoretical Preknowledge

One of the key methodological steps in phenomenology is the so-called epoché which is an active and rigorous bracketing of our obvious as well as scientific/ theoretical preknowledge, in order to go directly "to the things themselves" as they appear to consciousness. We stressed above that Husserl's *epoché* differs from more recent naïve atheoretical stances because the latter do not bracket obvious preknowledge but implicitly assume it in the form of a covert neopositivist trust in the description of mental symptoms viewed as mere objects (Aragona 2013). On the contrary, the phenomenological *epoché* assumes that objects of knowledge are not mere facts but are intentionally constituted in consciousness activity. Binswanger (1923) directly refers to Husserl's phenomenology as science of the pure essence of phenomena as they give themselves in the categorical intuition. He stresses that Husserl's essences are beyond the gnoseological distinction between real and ideal, because phenomenology is against *all* theories, gnoseological theories included. Hence, in Binswanger's view, Husserl would leave these problems aside. Although in this 1923 work he does not mention explicitly the word *epoché*, this "atheoretical" claim is Binswanger's way to describe it. However, he also stresses some differences between philosophical and psychological phenomenology, because while in the former the suspension of judgment is radical, in psychology such "bracketing" is only relative because its object (e.g., the perceptive act) is still considered as a real act, really occurring in a real men. A similar position is accurately carried on by Tatossian (1997, p. 10) who stresses the phenomenological "change of attitude, which is abandonment of the natural and «naive» attitude, that is to say [abandonment] of that attitude where, being either psychiatrists or not, we apprehend what we encounter as objective realities existing independently from us, being them psychical or material realities. Phenomenology is not interested in realities as such but in their conditions of possibility, hence it doesn't start before having practiced, in one or the other form, the *phenomenological reduction*, which suspends the natural attitude and its claims, or better its implicit or explicit theses about reality. This reduction or *epoché* is the foundational act of Husserl's

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phenomenology—what poses the problem of the relationships between philosophical phenomenology and psychiatric phenomenology."

Jaspers discussed this issue in a quite different vein. As discussed above, the founder of *General Psychopathology* can be considered a phenomenologist only in a broad sense, because his phenomenology differs from Husserl's eidetic research. However, also in Jaspers there is the need of bracketing preknowledge in order to go to the psychopathological phenomena themselves. The main difference is that Jaspers conceives his position as an empiricist one; he writes unambiguously that his aim is to describe mental pathological phenomena as they *really* are, intending as they effectively present themselves in the clinical encounter. Here the philosophical roots are not in phenomenology (although Jaspers quotes with admiration Husserl as a significant influence in his psychopathology) but in the post-Kantian views characterizing the late nineteenth-century "dispute on methods" in human sciences. There Jaspers finds an anti-metaphysic spirit that rejects a priori theoretical systems in favor of a *new* empiricist approach focused on the direct analysis of the lived experience (*Erlebnis*). The debate between Dilthey and the neo-Kantians is illustrative of this basic issue. It is from this, as well as from a rejection of some neurobiological systems of the time (particularly those of Meynert and Wernicke), that Jaspers moves in suggesting the need to make explicit and scrutinize the prejudices influencing our appraisal of mental phenomena. It is just after bracketing prejudices that we can approach mental phenomena in order to study them as they really present to our consciousness. In different words, "Avoiding all theoretical prejudices is the quintessential methodological as well as ethical (i.e., maximum respect for the person as a subject of experience) prerequisite of descriptive psychopathology. Descriptive psychopathology is not concerned with any subsidiary speculations, psychological constructions, interpretations or evaluations, but solely with the phenomena that are present to the patient's consciousness" (Stanghellini 2013, p. 341).

Finally, a few words are needed on Heidegger's view on the matter, because in general his ideas strongly influenced (and still influence) phenomenological psychopathology. Heidegger is very clear in tracing a sharp distinction between Husserl's and his own concept of the phenomenological reduction as a method to bracket the natural attitude and commonsense assumptions that accompany it. In Heidegger's account, for Husserl "phenomenological reduction [...] is the method of leading phenomenological vision from the natural attitude of the human being whose life is involved in the world of things and persons back to the transcendental life of consciousness and its noetic-noematic experiences, in which objects are constituted as correlates of consciousness. For us phenomenological reduction means leading phenomenological vision back from the apprehension of a being [...] to the understanding of the being of this being" (Heidegger 1982, p. 21). Hence, for Heidegger we always start our analysis from some concrete being, and at this level Husserl's *epoché* applies; but the essence of Heidegger's method is to go beyond that being in order to go back to its being. In his words, "[a]pprehension of being, ontological investigation, always turns, at first and necessarily, to some being; but then, *in a precise way, it is led away from that being and led back to*

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its being. We call this basic component of phenomenological method—the leading back or re-duction of investigative vision from a naively apprehended being to being *phenomenological reduction*" (Heidegger 1982, p. 21).

In conclusion, phenomenological psychopathology shares a common view on the importance of the *epoché* and phenomenological reduction for the sake of its analysis of psychopathological phenomena. However, under this commonality, there are interesting nuances: Jaspers appears at least partially independent from Husserl's account, while Binswanger and the majority of those following a Daseins-analytic perspective, although in general clearly indebted to Heidegger's ideas, on this particular point (phenomenological reduction) follow Husserl's view and (at least to our knowledge) substantially neglect Heidegger's alternative account.

1.6.2 The Distinction Between Form and Content

According to Berrios (2013c), "[i]t is customary to talk about the 'form' and the 'content' of mental symptoms: indeed, this distinction is central to the so-called 'phenomenological' approach. In spite of this, both concepts are not very well defined in the specific context of psychopathology." The history of the form/content distinction (Berrios 2013c) and the Kantian influence on Jaspers' usage of it (Walker 2013) are beyond the purposes of this introduction. Here we will focus on Jaspers' distinction for the aims of his *General Psychopathology* and on subsequent developments.

Jaspers describes three different ways to trace the distinction between form and content. The first is the most important for him, and we will discuss it in detail later. The other two are the following: one (the second case he describes) is the divide between the form as the general syndrome as a whole ("periodic phases of dysphoria" in Jaspers' example) and contents as the particular symptoms that may be part of the syndrome (in this example, dipsomania, wandering, suicide). As far as we know, Jaspers did not further elaborate on this, implicitly suggesting that this second meaning was not very important in his conception. The other distinction (the third case) is between the form as a very general, global change of the entire personality, as in the schizophrenic or hysteric experience (Jaspers' examples), and the content as every "variety of human drive and desire, every variety of thought and fantasy, [which] can appear as content in such forms and find a mode of realisation (schizophrenic, for instance, or hysteric) in them" (Jaspers 1963, p. 59). On this, interpretations slightly diverge: Berrios (2013c) suggests that according to this definition, "the psychological modality itself becomes the 'content' and is subordinated to the higher concept of diagnosis that becomes the 'form'." On the contrary, Aragona (2009c) does not emphasize the diagnosis (which is the focus of the second case) but the global change of the person's existence (of the way of Being in the World, we may say phenomenologically) and interprets it as part of Jaspers' confrontation with Binswanger's *Daseinsanalyse*.

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In any case, it is the first distinction between form and content that is central in Jaspers' *General Psychopathology*, because the main objects of descriptive psychopathology are the patients' experiences and particularly the form in which these experiences is presented (Stanghellini 2010). In Jaspers' words, "form must be kept distinct from content which may change from time to time, e.g. the fact of a hallucination is to be distinguished from its content, whether this is a man or a tree, threatening figures or peaceful landscapes. Perceptions, ideas, judgments, feelings, drive, self-awareness, are all forms of psychic phenomena; they denote a particular mode of existence in which content is presented to us" (Jaspers 1963, pp. 58–59). It is noteworthy that here there is a minor but interesting ambiguity in Jaspers sentence, because it swings between form as formal characteristics of a given psychopathological phenomenon (e.g., hallucination) and form as type of intentional act (to use Brentano's terminology): in the example, perceptions, ideas, judgments, etc. Considering that a major aim of Jaspers' psychopathology is to scientifically describe and differentiate psychopathological phenomena, the emphasis should be on specific formal features of single phenomena, and this also explains why Jaspers adds that "from the phenomenological point of view it is only the form of the phenomenon which interests us" (Jaspers 1963, p. 59). This is because it is only through the form that we can give enough stability to the phenomenal description, in order to generalize our observation to any phenomenon of the same type (e.g., all hallucinations should share the same basic formal characteristics), while content is idiosyncratic, strongly depending on the life history of the patient. In other words, contents may be idiosyncratic, whereas forms reflect transpersonal generalizable aspects of the acts of consciousness (Stanghellini 2010, p. 323). But of course our patients' life history is fundamental in the psychotherapeutic relationship, and this is why Jaspers adds that although form is the most important for phenomenology, "the psychologist who looks for meaning will find content essential" (Jaspers 1963, p. 59).

Subsequent developments focused on the global way of being of the patient in his/her world. According to Stanghellini (2010, p. 321), a good case in point is Minkowski's structural psychopathology: in order to reconstruct the patient's life-world (which in his view is far more important than simply counting his symptoms), Minkowski "methodically brackets or suspends all the 'ideo-affective' (cognitive and affective) contents of experience, and focuses on formal aspects or the spatio-temporal configurations that are implicit in the patient's experiences. The main guidelines for this are lived space and time, but the way the patient experiences his own body, self and other persons are also included in Minkowski's inquiries. The depressive patient's experiences, examined from this angle, manifest profound anomalies as compared to the common-sense world we all live in. Following this path, to a certain extent it is possible to feel or imagine what it is like to live in that world. However, at this stage of reconstruction the lived world still lacks a core that keeps its parts meaningfully interconnected." So the next step is to look for grasping "the structural nexus that lend coherence and continuity to them, because each phenomenon in a psychopathological structure carries the traces of the underlying formal alterations of subjectivity" (Stanghellini 2013, p. 344). Accordingly, it is

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through the import of Heidegger's *existentialia* in phenomenological psychopathology that this is systematically addressed. We will discuss this in a section below. In the meanwhile it is enough to stress that this is important for the present discussion of the form/content distinction, because the aim of such a systematic analysis is the reconstruction of the other's lived world by grasping the *form* in which his experience is set in time and space, the *mode* in which he experiences his own body and others, and the *way* the physiognomy of material things appears to his senses (Stanghellini 2013, p. 339).

1.6.3 The Distinction Between Explaining and Understanding

The late nineteenth century saw the emergence of an epistemological dispute concerning the most appropriate methods for the emerging human sciences (sociology, history, jurisprudence, economy, and the like), as well as the proper place of psychology (is it a natural or a human science?). Comte's positivism had proposed to extend the methods of natural sciences to human sciences (e.g., the newborn sociology), while those disciplines that did not fit those methods had to be considered nonscientific at all (in Comte's view, psychology was a case in point). Despite disagreements on the place of psychology in their classification, both neo-Kantians and Dilthey agreed that human sciences (their name for them was *Geisteswissenschaften*: sciences of the spirit) were scientific but that their methods were different from those applied in natural sciences. There was additional disagreement regarding the defining features of human sciences, but this is beyond our present aim.

One important contribution was Dilthey's rejection of experimental psychology in order to support a "descriptive and analytic psychology" which should start from the phenomenal wholeness as it presents itself in the stream of consciousness (Dilthey 1977). There Dilthey pronounce his famous aphorism "We explain nature, we understand the spirit." There is some debate on the real importance of Dilthey's dichotomy for psychopathology, and in later occasions, Dilthey himself seemed to suggest that psychology could use and integrate both experimental and comprehensive methods. In any case, the distinction between causal explanation and empathic understanding is the distinctive feature of Jaspers' contribution to the birth of psychopathology as a scientific discipline.

In Jaspers' view, psychopathology uses both methods in order to find relationships between subsequent phenomena. At one side, we can causally explain any psychopathological phenomenon as the effect of an (known or hypothesized) underlying cause. Here the epistemological model is that of a chain of causes and effects explaining the functioning of a mechanism. Transposed into medicine, this is the chain from etiology to final symptoms via pathophysiological changes. In Jaspers' words, "the appreciation of objective causal connections [. . .] seen 'from without'" (Jaspers 1963, p. 28). It is noteworthy that Jaspers adds that we can *always* hypothesize causal brain mechanisms underlying psychopathological phenomena; hence, in psychopathology this approach finds *no limits*. But Jaspers adds

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that, although possible, causal explanation is not always satisfying for the needs of psychopathology. Psychopathology is not only a science of nature, but it is also a human science (see above Jaspers' methodological pluralism). In many instances, we are not satisfied to know that somebody acted as he did because some parts of his brain were activated, while others were inhibited. If we want to know why he did so, we need to understand his reasons, his motivations, and his purposes. This is a different level that can be grasped only by means of a totally different method. This method is *understanding* (Jaspers' *Verstehen*); it consists in reproducing (*nachbilden*) in ourselves a representation of what is actually taking place in the mind of that person. In Jaspers' psychopathology, such understanding was mainly an empathic understanding, an emotional reliving (*Nacherleben*, *Nachgefühl*). We will discuss it in the next section. Now it needs to be stressed that Jaspers clearly admitted that by means of this method we can understand those phenomena which are similar to what we might have experienced in similar circumstances. However, there are many phenomena that, despite our efforts, we are unable to understand empathically. Among the examples given, it is typical the case of primary delusions, which in Jaspers' terms are underivable and un-understandable phenomena. Hence, in Jaspers' view, the act of understanding is fundamental for psychopathology, but unfortunately it is a *limited* method: it can apply well in some circumstances, allowing for a humanistic study of mental phenomena, but it cannot apply in other cases, where it must be substituted by other methods.

We will see later that many psychopathologists returned on this problem trying to find a different method in order to understand our patients' way of being in the world. Here is enough to stress that despite relevant differences, psychopathologists agree at least on the need to find a method in order to grasp the patients' existential world, thus preserving a humanistic access to their own way to conceive, feel, and value their experiences.

Before concluding this section, we would like to emphasize that the parallel questions explaining/understanding and causes/reasons have been and still are extensively debated in epistemology. However, even a summary of this debate would be too long to find space in this introduction.

1.6.4 Characteristics and Limitations of Jaspers' Empathic Understanding

The literature on this issue is huge; here we limit our discussion to the main features of Jaspers' concept of understanding (*Verstehen*), to those points that although only implicit in his text need to be openly discussed, and the main epistemological limitations of such an approach.

In the first part of his *General Psychopathology*, Jaspers starts describing as much rigorously as possible the pathological mental phenomena. There he sharply distinguishes between those phenomena which are objectively given to our observation (e.g., behaviors) and subjective experiences (*Erlebnisse*) that, being part of the private world, are not directly observable from the exterior. Here the question is:

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how is it possible to scientifically grasp, describe, differentiate, and univocally denominate such phenomena if they are not directly observable? Jaspers proposes his "phenomenological" method called "static understanding." Although we do not observe directly the subjective experiences of our patients, we can make them present in our consciousness by means of a sort of transposition, of reliving in ourselves what the other is actually living. This is an empathic act which gives us the material for the appraisal of such subjective, private experiences, in order to use them scientifically. Technically, such an empathic understanding requires a preliminary bracketing of our prejudices in order to grasp the phenomenon as it presents itself in our consciousness: "The first step, then, is to make some representation of what is really happening in our patients, what they are actually going through, how it strikes them, how they feel. We are not concerned at this stage [. . .] with any subsidiary speculations, fundamental theory or basic postulates. [. . .] Conventional theories, psychological constructions, interpretations and evaluations must be left aside. [. . .] We refuse to prejudge when studying our phenomena, and this openmindedness, so characteristic of phenomenology, [. . .] must be acquired painfully through much critical effort and frequent failure. [. . .] Phenomenological orientation is something we have to attain to again and again and involves a continual onslaught on our prejudices" (Jaspers 1963, p. 56).

Once this basic material is grasped by means of such an act of static understanding, the next question is how mental phenomena are interrelated. This is the second part of Jaspers' *General Psychopathology*, where he traces the abovementioned distinction between explaining and understanding. While, at least in principle, all phenomena can be part of an explanatory chain of mechanistic causes and effects, some psychopathological phenomena need to be viewed as typically human in order to preserve their specificity. In Jaspers' own words: "Phenomenology presents us with a series of isolated fragments broken out from a person's total psychic *experience*. [. . .] How are all these various data to be related? In some cases the meaning is clear and we understand directly *how one psychic event emerges from another*. This mode of understanding is only possible with psychic events. In this way we can be said to understand the anger of someone attacked, the jealousy of a man made cuckold, the acts and decisions that spring from motive. In phenomenology we scrutinize a number of qualities or states and the understanding that accompanies this has a *static* quality. But in this question of connectedness, we grasp a psychic perturbation, a psyche in motion, a psychic connection, the actual emergence of one thing from another. Here our understanding has a *genetic* quality" (Jaspers 1963, p. 27).

Jaspers' concept of "understanding" has distinctive features that shall be briefly considered.

First of all, it is an empathic, emotional understanding (*ein fühlendes*). He clearly stresses that rational understanding of the meaning of a sentence is not his concept of understanding, because what he has in mind is understanding the person through his phrase, not simply the sentence in itself: "where we understand how certain thoughts rise from moods, wishes or fears, we are understanding the connections in the true psychological sense, that is by empathy (we understand

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the speaker). Rational understanding always leads to the statement that the psychic content was simply a rational connection, understandable without the help of any psychology. Empathic understanding, on the other hand, always leads directly into the psychic connection itself. Rational understanding is merely an aid to psychology, empathic understanding brings us to psychology itself" (Jaspers 1963, p. 304).

The second feature is what has been called "the problem of the right distance" (Villareal and Aragona 2014). Empathic understanding is neither emotional fusion nor cold distance; it is something in between, where the "sympathetic tremulation of one psyche with the experiences of another" coexists with scientific objectification of "such experience critically" (Jaspers 1963, p. 22). According to Ballerini (2003), an important issue for the psychopathologist is his need to modulate the distance between himself and the patient. In his view, the therapist and patient continuously change their interpersonal distance, with a continuous oscillation between the extremes of a fusional and a sidereal distance, i.e., between general objective categorization and individual existential subjectivity.

Third, genetic understanding is asymmetric (Villareal and Aragona 2014). In the case of causal explanation, we move from the phenomenon to be explained to the causes that produced him. Once the causal chain is known, and we realize it conforms causal laws, we can invert the direction of the inferential process and assert that, if the cause is present and all other circumstances are the same, the effect is produced by necessity. Hence, causal explanation is symmetric and allows law-like predictions as well as post hoc reconstructions. On the contrary, genetic understanding allows us, by empathy, to grasp the motivations that led the person to perceive, feel, or act as he did, but this knowledge cannot be subsumed under a law. Hence, while in that occasion he did something, he could also have done something else (here the concept of *freedom* applies), so we can at best realize that a general tendency occurred, but we can never be sure that in similar circumstances the person in question will do the same again.

Fourth, the possibility of understanding is limited. We cannot always relive in ourselves what is happening in our interlocutor. We can understand phenomena that at least in principle we can or could reexperience ourselves, and this means that understanding is based on a common ground between human beings, a shared world of meanings that make it possible. Thus, we can understand phenomena that we already know in a first-person perspective (e.g., we can understand the other's sadness because we know how is it like to be sad), or that we can know in principle (e.g., I can project myself into the other's life and circumstances and feel that if I was at his place, I would have felt as he did), or that we can feel as meaningful although exaggerated (e.g., we may say that at his place we would have not reacted as he did, but also feel that although such a reaction is quantitatively exaggerated, nevertheless it is qualitatively congruent with circumstances and personal features of the person in question). Famously, Jaspers' claim that schizophrenic primary delusions are un-understandable raised several critiques and was used by Binswanger and many others as a starting point to explore different ways to "understand" psychotic experiences (we will discuss this later). Here it shall be briefly remarked that some critiques were unfair to Jaspers, because what he really

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asserted was not that schizophrenic primary delusions had to be necessarily explained looking for neurobiological causes but simply that his method was limited and that psychopathologists had to be aware of such an intrinsic limitation. Jaspers himself mentions philosophical clarification as well as other forms of interpretation (not necessarily psychoanalytic) as other possible ways to transcend the limits of understanding.

Fifth, the limits of understanding are not fixed once for all. Interestingly, Ballerini (2003, p. 40) stressed that the limits of our ability to understand depend on "consistency, deepness, and duration" of the therapeutic relationship. Drawing on this concept, it was emphasized (Villareal and Aragona 2014) that there are at least four basic features influencing the possibility of understanding:

1. The characteristics of the clinical setting, which may be more or less favorable to self-disclosure
2. The duration of the therapeutic relationship
3. The personal characteristics of the patient
4. The personal characteristics of the clinician

Accordingly, the limits of understanding are not fixed but movable and changeable, and understandability itself shall not be conceived as an intrinsic characteristic of psychopathological phenomena but as an *emerging relational property* within the clinical encounter.

As seen, the analysis of the main features of Jaspers' concept of understanding raises several problems, the most important being epistemological: empathic understanding entails an implicit twofold movement, i.e., I must have a direct access to my own emotions, and I shall recognize that what I'm feeling is how the person in front of me actually feels. Here two epistemological problems are involved, the first being the more general problem of introspection (do we have any direct access to our own mental states?) and the second being the more specific problem of empathy ("how do I know that I am not projecting my own experiences onto the other?" Stanghellini 2013, p. 338). An analysis of these questions is far beyond the possibilities of this introduction, but the reader shall be aware of them as well as of other epistemological shortcomings (Oulis 2014) that make Jaspers' understanding an approach to psychopathology which is still useful and important, but also in need of revision.

1.6.5 Looking for the Essence (Eidetic Research)

We already introduced words like "eidos" and "eidetic research," which are the technical terms used by Husserl to describe the aim of phenomenological analysis after bracketing pre-given ordinary and theoretical knowledge. In the intentional act of exploring phenomena as they give themselves to consciousness, the aim is to progressively remove unessential properties and perspective views in order to grasp the essence of the thing itself. Roughly, if the thing remains itself after

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progressively removing several features (e.g., color, shape, and so on) but finally vanishes when a feature is eliminated, then that feature is its essence. Farina (2014, p. 55) stresses the intuitive nature of Husserl's essences: "This knowledge of the essence of things is what Husserl calls "eidetic intuition", which takes place not by abstraction or comparison of similar things, as erroneously believed the empiricists, but by a direct intuition of what is universal". This emphasizes a possible contrast between an intuitional and an empirical understanding of Husserl, which maybe explains similar interpretative fluctuations in the reception of Husserl's "rigorous method" (as Husserl himself was used to call it) by clinicians.

Binswanger imported Husserl's essences in the psychopathological debate. In an early methodological paper (Binswanger 1923), he claims that psychopathologists should advance, step by step, from the particular empirical and individual facts toward the meta-empirical, general pure essences described by Husserl. Binswanger appears well aware of the meaning Husserl had given to the word "essence" and to his eidetic research. In fact, he clearly writes that when we consider perceptive acts, we acknowledge that we can perceive the same object (a key, in his example) from an endless series of possible points of view, but we see a unique object (this description conforming to Husserl's concept of "synthesis"). Moreover, he rightly defines Husserl's phenomenology as a discipline describing the essence of the immanent products of consciousness. Hence, it is sure that in 1923 Binswanger has a good knowledge not only of Husserl's *logical researches* but also of his further eidetic development in the *ideas*. Despite this fact, there are some significant differences in Binswanger's own way to conceive essences. In fact, his essences are more akin to immediate artistic intuitions than Husserl's rigorous derivation from subsequent and systematic acts of eidetic variation. For example, Binswanger writes that when we see Marc's colored horses, the painter clearly forces nature by representing a blue or a red horse, and nevertheless he has seen and expressed the proper "essence" of the horse. This seeing is not through the eyes, but it is an immediate awareness that looks inside, which has nothing to envy to sensorial knowledge and yet it is maybe more reliable. In the same article, Binswanger returns on this point and specifies that such an intuitive vision of essences in scientific phenomenology should not be confused with the artistic intuition, but also that the two forms of intuition have "undoubtful and strict relationships" which are beyond the contraposition between science and art. Therefore, a significant space for interpretation remains here, so that in psychopathology phenomenological reduction and eidetic appraisal tend to fluctuate between scientific dissection of phenomenal appearances at one side and a more global and intuitive vision of essential themes on the other side. Binswanger's famous clinical cases may be read as examples of the second type.

Finally, in a recent article, Stanghellini and Rossi (2014) contrast both superficial mental symptoms (like those described in diagnostic manuals) and endophenotypes to a new level of analysis that they call the "pheno-phenotypes paradigm." In this view, mental symptoms are not accidental meaningless disturbances occurring to a patient. Rather they are the manifestation of some

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implicit quintessential "core" change in the fundamental structures of the patient's subjectivity.

It is this fundamental global "core" of human subjectivity which transpires through the single symptoms and gives to the whole syndrome a specific and characteristic *Gestalt* that many psychopathologists call "phenomenological essence."

1.6.6 A Hermeneutic Framework for Psychopathology

The primary "object" of inquiry of phenomenological psychopathology "is the patient's subjectivity, focusing on patients' states of mind as they are experienced and narrated by them" (Stanghellini and Rossi 2014, p. 238). At this level, it aims at "a systematic knowledge of patients' experiences, so that the features of a pathological condition emerge in their peculiar feel, meaning, and value for a patient" (Stanghellini and Rossi 2014, p. 238). It is noteworthy that here is already at play a hermeneutic approach, because subjective experiences are not simply "given"; they are not objects that can be simply itemized in operative diagnostic criteria. Mental symptoms are the product of a complex hermeneutic process involving a recursive interpretation between two poles: the patient's self-interpretation of what he/she is feeling and the clinician's interpretation of what the patient is trying to communicate. Due to different personal, familial, and sociocultural conceptual categories and idioms of distress, the patient may perceive, interpret, and express differently what he/she is experiencing (cp. Berrios 2013b; Aragona and Marková 2015). Similarly, another interpretative act "is performed by the listener who must sometimes interpret the speaker's meaning by asking the speaker and himself "what does he mean by that?" This problem, which plagues psychopathological research and clinical practice, becomes even more acute in using standardized assessment, since when interviewees respond to questionnaires, they might have very different understandings of the questions, and this may lead to the inaccurate conclusion that different individuals or groups have similar experiences or beliefs. An interview is a linguistic event. It is not a behavioral-verbal interchange simply *mediated by* language. Rather, it happens *in* language" (Stanghellini 2013, p. 326). Accordingly, subjective mental states may be opaque to its owner and *errors in translation* may always occur; nevertheless, this hermeneutic status of mental symptoms is constitutive, and for this reason a hermeneutic approach to psychopathology is not a philosophical surplus but a necessary requirement in psychiatric and psychological trainings. In fact, the acknowledgment of the hermeneutic co-construction of mental symptoms "implies, in practice, that the coding of each item of an interview always requires an (often laborious) process of interpretation—rather than a pseudo-objective simple 'ticking'" (Stanghellini 2013, p. 326).

If this applies to the hermeneutics of any individual symptom, it should also be stressed that phenomenological psychopathology considers the assessment of symptoms as part of a more general diagnostic "hermeneutic circle" where symptoms are recognized because they are part of a whole picture, the latter

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being more than a mere sum of items in a list (Aragona 2013). In other words, it "goes beyond the description of isolated symptoms and the use of some of those symptoms to establish a diagnosis. It aims to understand the meaning of a given world of experiences and actions grasping the underlying characteristic modification that keeps the symptoms meaningfully interconnected" (Stanghellini 2010, p. 320). Hence, the manifold of (abnormal) phenomena in a syndrome is interconnected, and the internal links between them are not etiological (i.e., based on causal relationships) but phenomenological (based on meaningful relationships). Stanghellini (2010) proposed the concept of structure to enlighten such a meaningful interconnection of apparently manifold phenomena. Meaningfulness shall be found in the structure itself, without involving elements that do not belong to the structure. Hence, meaningfulness emerges from the internal links between the elements of the structure, which are not juxtaposed but interrelated. Let's consider the following examples: Bleuler's acknowledgment of a meaningful interplay between the experience of primary symptoms and the reaction of the personality leading to secondary symptoms, Minkowski's *trouble générateur*, the phenomenological *eidos* which in a single phenomenon summarizes what is characteristic of the entire picture, the search of a common *Gestalt* characterizing the entire syndrome, and Huber and Klosterkoetter's description of a meaningful development from basic symptoms to full-blown mental disturbances. Even though they are the fruit of partly different perspectives, they exemplify the common view, in phenomenological psychopathology, that mental phenomena pertaining to a given syndrome are neither the result of a merely statistical association nor the product of a purely biological common pathophysiology. Rather, they are part of a meaningful whole where possible outputs of neurocognitive basic disturbances may trigger the person's "top-down" reaction seeking to make sense of such basic changes. This highlights the patient's active role in interacting with his/her distressing experiences and in the shaping of his/her symptoms, course, and outcome (Stanghellini et al. 2013). It is this self-hermeneutic process that makes understandable the meaningful link between apparently manifold symptoms in a given patient, i.e., the common structure of the whole clinical picture.

The process described above introduces a third point which is fundamental in phenomenological psychopathology: the central "active role that the person, as a self-interpreting agent or "goal-directed being" engaged in a world shared with other persons, has in interacting with his/her basic disorder and in the shaping of psychopathological syndromes" (Stanghellini et al. 2013, p. 289). This entails a shift of attention from apparent symptoms to the deeper level of the person's life-world or, as it is often said, the way the human presence (*Dasein*) is in the world and with others (*in-der-Welt mit-Dasein*). Here the single symptoms as well as their meaningful interconnection in the syndrome's structure are seen as the phenomena through which the hidden dimension of existence is made manifest. Accordingly, it was proposed that in psychopathology a phenomenological motto should be "making the invisible visible" (Stanghellini 2013, p. 333), meaning that through the *text* produced in the clinical encounter between patient and clinician, the deep architecture of the life-world inhabited by the person shall emerge.

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Such a deep structure is particularly emphasized by Cargnello (2010), who remarks that the primary "object" of the phenomenological inquiry is neither the mental phenomenon as natural object nor the mere subjectivity of the sufferer or the examiner. On the contrary, it is a non-derivable primum, i.e., how the human presence projects himself/herself in the world and at the same time reveals himself/herself in expressing it in his/her original *exsistere*.

The phenomenological search for a deep structure of subjectivity, which makes possible the emergence of abnormal experiences and their organization in mental disorders, builds on and extends the work of Minkowski, von Gebsattel, Straus, Binswanger, Tellenbach, Tatossian, Lanteri Laura, Blankenburg, and many others. The way they approach the matter is interrelated but also different on some points. Here we will focus on a representative example, i.e., Binswanger's *Daseinsanalyse*. According to Needleman (1963), it can be generally considered as a transposition of Heidegger's *Daseinsanalytik* to the problems of psychiatry, although we shall stress that Binswanger does not simply import Heidegger's concepts but actively reinterprets them. We have already introduced some key concepts of Heidegger's philosophy, so we can focus only on those notions which play a major role in the analysis of the way the human being projects his existence in the world and with the other human fellows. We just remember that Heidegger's *Sein und Zeit* was conceived as a metaphysical inquiry on the Being and an anthropological use of it is possible only because the human being (*Dasein*) is the being that poses the question of the Being. Binswanger's anthropological analysis of the human presence is clearly a misinterpretation of Heidegger's ontological intentions, and nevertheless it has been heuristically fruitful, not only in psychopathology.

The image of man which is suggested by this "implicit" Heideggerian anthropology is that while natural objects are mere presence (*Vorhandenheit*), i.e., objects that can be observed from outside and subdivided in their properties, human beings are open projects displaying their potentialities.

They are already and constitutively in the world, and for the human beings the objects of the world are originally known not as mere objects but as possible tools to be used, as something "at-hand"; accordingly, the pragmatic context is primary, and cognitive objectification (what we now call representationalism) is a secondary and derived modality.

Humans are already together, in mutual relationship with their human fellows (*mit-Dasein*); accordingly, we are originally part of a human community and the problem of solipsism can only arise in a secondary reflective stance, having already severed the knowing subject and the objects of knowledge.

Humans are intrinsically hermeneutic entities, implicitly self-interpreting their position in the world, in their own context, and attuning to it; accordingly, self-interpretation before being a reflective introspectionism is a pre-reflective accordance within the situation, which usually appears obvious because of such pre-reflective attunement.

Humans are also in a given emotional basic attitude, in a given time and space, and so on.

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All these concepts can be heuristically imported in psychopathology, opening the possibility to study the basic structure of our patients through the analysis of the so-called existentials, and in effect this is Binswanger's project: "The intention governing Binswanger's *Daseinsanalyse* was to understand psychiatric symptoms as the expression of an alteration of the structural components of one's basic being-in-the-world. To do this, he had to take the ontologically determined existentials[5] of Heidegger and bring them into the frame of concrete human existence (that is, applying the ontological a prioris to the concrete individual)" (Kraus 2010, p. 3).[6]

According to Needleman (1963), the existential a prioris function in a manner analogous to the Kantian categories, in that they are the forms through which ontic reality can manifest itself to the *Dasein*. And Kraus (2010) adds that because Heidegger's *Existentialien* are the fundamental structures of *Dasein*, and because the openness of *Dasein* makes the being-in-the-world of the person possible, the existentials can be conceived as different kinds of possible-being (*Sein-können*). In other words, they are basic possible ways to be, allowing a study and a comparison of the different ways of being-in-the-world characterizing psychopathological conditions.

According to Stanghellini (2013, p. 344), "The guidelines for reconstructing the life-world a person lives in are the so called *existentialia*, namely, lived time, space, body, otherness, materiality, and so on. [. . .] In this way we can trace back this transformation of the life-world to a specific configuration of the embodied self as the origin of a given mode of inhabiting the world, perceiving, manipulating, and making sense of it." In this way, the phenomenological analysis of the basic existential dimensions of human existence aims at disclosing and grasping the conditions that make possible the emergence of surface symptoms. In this vein, Heidegger's *existentialia* are the implicit, tacit, and pre-reflexive core structures of experience or, using different words, the way subjectivity must be structured to make phenomena appear as they appear to the experiencing human subject.

1.7 Conclusions

This book is structured in two parts. The individual chapters represent the second part and are organized with a progressively abstracting structure that should lead the reader from the living material of concrete case histories to the theoretical

[5] Existentials, existentialia, and existential a prioris are different translations of the same term, i.e., Heidegger's *Existenzialien*.

[6] This last sentence introduces another fundamental distinction between the ontological level, which is the study of the Being, pertaining to the metaphysics (the level of analysis in Heidegger's Being and Time), and the ontic level, which is the level of concrete existence of this or that being. Needleman labels Binswanger's approach as "meta-ontic," as something lying in between the ontological and the ontic level. To avoid unnecessary complications, it is enough to consider that the ontic level is the level of concrete existence and that psychopathological analyses, dealing with the way of being in the world of real persons, can be conceived as ontic analyses.

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implications for clinical practice and research in psychiatry, clinical psychology, and psychotherapy. Written by leading phenomenologists, these chapters are concrete examples of the importance and usefulness of a phenomenological approach to persons experiencing mental sufferance. This introduction represents the first part of the book and should provide the reader with an overall picture of the methods used in phenomenological psychopathology. In doing so, we tried to be sensitive to historical development of the ideas and philosophical influences, although the main focus was to draw a comprehensive (and hopefully understandable) schema of the main methods and concepts used in phenomenological psychopathology. Focusing on theoretical issues, this *Introduction* is abstract compared to the living relationships between patients and healers that were at the basis of these theoretical concepts. We consider this as the necessary price to be paid in order to give the reader a general idea of the matter in a synthetic text. We are confident that the concrete examples flourishing in the following chapters will provide the reader of the necessary exemplars to concretely visualize the issue in its full complexity and comprehensiveness.

A few final remarks are needed in order to stress the main points discussed in this Introduction.

First, we argued that phenomenological psychopathology is important per se in order to give clinicians the needed skills to understand and appropriately take care of persons experiencing mental sufferance. However, we also stressed that this is even more important in this particular period of scientific crisis of psychiatry, when the general *Zeitgeist* and the consonant proposals to solve the crisis are strongly oriented toward reductionist neurocognitive models, with the concrete risk to see patients as deanimated bodies. At the opposite, phenomenological psychopathology focuses on persons. It is a person-centered, empathic, and value-friendly approach to mental sufferers which are seen more as companions of a common experience aimed at the empowerment than as mere carriers of broken mechanisms. Hence, phenomenological psychopathology stresses the importance of taking care of persons as a whole, not just of some dysfunctional parts of their bodies.

Second, we tried to show the main methods and theoretical commitments underlying the phenomenological approach. We stressed that phenomenological psychopathology is not a monolith but a method partly shared by original thinkers holding a family resemblance. Accordingly, not all distinctions and concepts are assumed by all thinkers, and free thinking and possibility to dissent are values that phenomenological psychopathology endorse. On this respect, its approach is very far from some "parochial" approaches pervading many schools of thought in psychiatry and psychology. In phenomenological psychopathology, there is not an orthodox knowledge to be strictly followed and defended. In general, positive knowledge on single issues is important but not as much as the ability to cultivate doubts and methodological self-criticism, in line with the Kantian epistemology where reason criticizes itself in order to respect its own limits. Phenomenological psychopathology respects other points of view, suggesting that many different perspectives can contribute to knowledge, provided that they do not pretend to have a total and absolute knowledge (see on this Jaspers' critique of prejudices).

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Hence, phenomenological psychopathology is not to be intended as a humanistic view against scientific and neurocognitive programs, but as a methodological stance rejecting absolutist thinking in general.

Third, we discussed the different meanings of the term "psychopathology," suggesting that we conceive it (with Jaspers) as a scientific discipline studying the phenomena presented by psychiatric patients with the aid of several methods of inquiry. We further subdivided psychopathology according to its "object" of study: definition and distinction of individual phenomena, their diagnostic relevance, the empathic method to grasp subjective experiences and their meaningful connection, and the art of unfolding the underlying structure of subjectivity that makes possible the emergence of mental symptoms.

Fourth, we described the main tenets of some representative philosophers who are part of the European tradition generally called phenomenology, including existential and hermeneutic approaches. In doing so, we stressed similarities but also differences, acknowledging that such a tradition is a fruitful exchange of ideas in the discussion of such differences.

Fifth, we described the main methodological concepts that psychopathologists use in order to properly assess the qualitative specificities of mental phenomena and subjective structure: the distinction between form and content, that between explaining and understanding, the different forms of empathic understanding (static and genetic understanding), the phenomenological *epoché* and the resulting *eidos*, and the analysis of the way the human being projects (or encounters difficulties in doing it) his/her existence in the world with others.

Finally, a section was specifically dedicated to the hermeneutic approach in psychopathology, discussing the hermeneutic stance at three levels: the hermeneutics of mental symptoms, the hermeneutic circle in the relationship between symptoms and diagnosis, and finally the hermeneutics of the deep subjective structure on which the previous levels are grounded.

In conclusion, we argued for a philosophically informed approach in the clinical encounter in psychiatry, clinical psychology, and psychotherapy, especially for the task of exploring the patient's subjectivity. The main reason for this is that the assessment and the comprehension of a psychic state require a kind of analysis which largely exceeds the range of a naturalistic approach. Accordingly, a *personal level* of analysis is required to assess and confer meaning to psychopathological experiences. Indeed, it is within a personal history and a sociocultural context that their peculiar significance can emerge and be understood in their *peculiar feel, meaning, and value* for the subjects affected by them.

In endorsing the legacy of phenomenological psychopathology and its emphasis on the analysis of subjectivity, we have sketched a framework for the psychiatric and psychological encounter aimed to a wide-range, fine-grained assessment of the patient's morbid subjectivity, which can be useful not only in the clinical but also in the research setting (Stanghellini 2013).

In the clinic, this approach can provide the background for unfolding the phenomena of the life-world inhabited by the patient, moving toward the

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illumination of the structures of subjectivity that allegedly *generate and structure* the phenomenal world.

In research, the reconstruction of the complexities of the patients' subjectivity and life-worlds may prove helpful to rescue fringe abnormal phenomena that are not covered by standard assessment procedures. Thus, it provides the basis for exploratory studies, for the assessment of real-world, first-personal experiences of subpersonal impairments since this approach is concerned with bringing forth the typical feature(s) of personal experiences in a given individual to establish objective, transpersonal constructs helpful for empirical research (Stanghellini and Ballerini 2008).

Finally, reflection on the philosophical resources for the psychiatric interview may help to combat the hegemony of de-narratization in the mainstream psychiatric biomedical model with its emphasis on matters of fact rather than on intelligible relations. Hermeneutics looks for significance in our actions, experiences, and beliefs, aimed at a co-construction of meaning combining personal experiences into a coherent story related to the personal level of experience. In doing so, it can be an antidote to the dehumanization of psychiatry and of psychiatric patients.

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