Phenomenology and the interpretation of psychopathological experience

Josef Parnas and Shaun Gallagher

What do psychiatrists encounter when they encounter psychopathological experience in their patients? How should we interpret such experiences? In this chapter we contrast a standard checklist approach to diagnosing and treating psychopathology, based on psychological operationalizing, and a non-standard phenomenological approach that emphasizes the importance of a specific kind of interpretive interview.

Operationalism and phenomenology

A prominent American psychopathologist and influential early advocate of operationalism and biological reductionism describes, in hindsight, the results of the DSM-III+ project in the following way:

Because DSM is often used as a primary textbook or the major diagnostic resource in many clinical and research settings, students typically do not know about other potentially important or interesting signs and symptoms that are not included in DSM. Second, 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 (...). Third, validity has been sacrificed to achieve reliability. DSM diagnoses have given researchers a common nomenclature — but probably the wrong one. (Andreasen 2007).

In Andreasen’s (2007) bleak assessment of psychopathology there is an important omission of the fact that the consequences of the DSM-project are not independent of an adopted epistemology and metaphysics. The DSM reform—a response to a lack of reliability in psychiatry, and a reaction to psychoanalysis -- adopted two assumptions: the first one, epistemological, namely, an explicit neo-positivist form of behaviorism-operationalism; the second one, an implicit metaphysical position, namely physicalism.

According to these assumptions, psychiatric “symptoms and signs” should be considered from the third-person perspective, namely as reified (thing-like), mutually independent (atomic) entities, devoid of meaning in themselves, and open to context-independent definitions, unproblematic objectifications, and useful quantifications. Preference is given to “external behavior,” while subjective experience is for the most part dismissed, mainly because the latter is not accessible to third-person observation and description. A physicalist, neo-Kraepelinian, nosological trend amplified this tendency of reification and atomization of psychopathological phenomena, in the hope of their ultimate reduction to modular defects in the neural substrate that would “carve nature at its joints.”
On this model, the symptom/sign and its causal substrate are both located on the same ontological plane: both are spatio-temporally delimited objects, i.e., things. According to this paradigm—which originates from the medical model—the symptoms and signs have no intrinsic sense or meaning. They are indicators or referents that point to the abnormalities of an anatomic-physiological substrate. This background framework or scheme of “symptoms-as-causal-referents” is thought to make sense, and is automatically activated in the awareness of a physician dealing with a medical condition (e.g. jaundice-> liver/gallbladder disease, coughing-> lung disease).

Yet, it is even questionable whether this concept is perfectly adequate to the model of somatic medicine. Indeed, this view of symptom has long been questioned. For example, in 1937 John Dewey addressed the College of Physicians in St. Louis, advising them not to treat just the body: “we must observe and understand internal processes and their interactions from the standpoint of their interactions with what is going on outside the skin…. ” That is, we cannot understand processes inside the body in isolation from the environment – an environment that is both physical and social. Rather, in the practice of medicine, “we need to recover from the impression, now widespread, that the essential problem is solved when chemical, immunological, physiological, and anatomical knowledge is sufficiently obtained. We cannot understand and employ this knowledge until it is placed integrally in the context of what human beings do to one another in the vast variety of their contacts and associations…. A sound human being is a sound human environment” (Dewey 1937, 54).

If we think of our human form of existence as embodied, and environmentally embedded – and if we think that illness is experientially a complete form of existence as Merleau-Ponty (1963, 107) suggests – it means that we can’t think of illness simply as something that happens to our objective body – a purely physiological condition (Gallagher 2005). More positively, we need a framework that will help to characterize the more complete picture (the positives as well as the negatives) of how the patient’s life is different – a rich diagnosis. The kind of practice needed to get the rich diagnosis, the attempt to gain a full understanding of the complete form of existence, is one that looks at the human system – the embodied and embedded life system – as a gestalt. This is the unit we should think of for the sake of analyzing illness.

Even more so, however, we should think that the scheme of symptom-as-causal-referent is questionable in psychiatry. Yet the psychiatrist, who confronts a “psychiatric object”, finds himself in a situation without analogue in somatic medicine (Jaspers 1913). First, he confronts a person, and not a leg, an abdomen, or a skin surface; not a thing, or an organism, but broadly speaking, another phenomenally conscious person in all its dimensions. What the patient manifests are not isolated symptom-referents but rather certain wholes of interpenetrating experiences, feelings, beliefs, expressions, and actions, all of them permeated by the patient’s dispositions and by biographical (and not just biological) detail.

These contents and forms combine into certain meaning-wholes out of which our psychiatric typifications start. These typifications are not constituted by a referential
function of the symptom (which is not to say that they are totally deprived of referential function). Moreover, we usually have no knowledge of potential referents in any pragmatically useful sense.

The phenomenological approach is a useful one in regard to psychopathology, with few exceptions (e.g., in the case of a delirious patient). It consists of a second-person approach guided by phenomenological distinctions. Phenomenologists, in their analysis of experience, extract and individuate certain repeatable invariants, which, for reasons of tradition, are called “symptoms.” Yet a psychiatric symptom or sign is not constituted by its referential weight; it only emerges as an individuated entity of a certain meaning, in a synchronic and diachronic context of simultaneous, preceding, and succeeding, experiences and expressions.

A symptom/sign is not an entity “in itself”—easily or arbitrarily isolated out of the ongoing flow of consciousness, and objectified independently of its context. This is one reason why truly operational definitions (in the sense of Bridgman [1927], i.e., specifying the rules whose application links the concept to its referent in reality (for example, “‘ice’ is an ‘amount of water’ that converts to solid state at temperatures below 0 Celsius”) do not work for psychiatric terms. None of the DSM/ICD constituent criteria (symptoms or signs) are truly operationally defined.

Gestalt
If a symptom is not a referring object, what is it? We suggest that it may be best to consider the symptom in terms of a gestalt. In the context of psychiatric diagnosis, we can think of the concept of gestalt in a narrow sense and in a wide sense. In a narrow sense, a gestalt is a unity or organization of phenomenal aspects, a unity that emerges from the relations between the features of experience (framed in terms of part-whole relations). The whole cannot be reduced to the simple aggregate of parts (“whole is more than a sum”). In a wider sense, the gestalt in question goes beyond phenomenal aspects of experience. It involves an interplay of factors that, from an objective perspective, extend thoroughout and beyond the organism (Weizsäcker 1986). That is, in a very real sense, one has to consider not just a set of subjective experiences, or a set of beliefs or mental states. Rather one needs to consider the person’s embodied experience in the environment. As the phenomenologists say, the person is intersubjectively in-the-world and must be considered as such.

Gestalt in this wide sense goes beyond the traditional dichotomies of “inner and outer”, “form and content”, “universal and particular” (Merleau-Ponty 1963). The salience of an interpersonal encounter, for example, does not normally emerge or articulate itself as piecemeal or disconnected allusions to the patient’s inner life plus some other, independently salient fragments of his visible expressions and behavior. Rather, persons articulate themselves holistically, jointly constituted not simply by their experience, belief, and expression, but by their actions and interactions in an environment that is both physical and social. Furthermore, this wider gestalt is reflected, and gets iterated, in the narrow gestalt of experience, in ways that can be phenomenologically characterized. There is a circle rather than a line between what is traditionally defined as inner and outer. “What” the patient reports (content) is always molded by a “how” (form) of his way of cognition and his experience of self, others, and the world.
A gestalt instantiates a certain \textit{generality of type}. Yet, this type-generality is always modified or deformed, because it inheres in a particular, concrete and situated individual. The particular token always attenuates the ideal clarity and pregnancy of type. Furthermore, the gestalt’s aspects are \textit{not independent self-sufficient symptoms}. They are inter-dependent in a mutually constitutive and implicative manner (Sass and Parnas 2007) and the whole of the gestalt co-determines the nature and specificity of its particular aspects, while, at the same time, it draws from the single features its concrete clinical rootedness. Imagine a case of “social phobia”, motivated by a disgust and fear of physical/tactile contact with other people, a situation that is experienced as engulfing, fusing, and annihilating. One would not consider such “phobia” as an isolated behavioural dysfunction but rather as indicative of insecure identity and porous self-demarcation, with avoidant coping behaviour ensuing by implication. Another example: mumbling; \textit{per se} it is perhaps something that 5\% of a random sample of people do; yet in the context of other schizophrenia features, it acquires a diagnosis-relevant role.

More detailed conceptual determinations of the gestalt proceed through the steps of phenomenological-psychiatric typifications, excellently described by Schwartz and Wiggins, in two seminal papers (1987a&b). The clinical task is to allow the Gestalt to manifest itself in more detail; to let its latent or unexpected profiles become apparent and to conceptualize and flesh out these originally only dimly apprehended or non-apprehended aspects.

All these processes should be constantly subjected to critical reflection. This necessitates training, teaching of concepts, and acquisition of skill and expertise. Such processes are open to intersubjective judgment, and may be shared with other psychiatrists (Schwartz and Wiggins 1987a&b; Parnas and Zahavi 2002) and assessed with respect to inter-rater reliability. Moreover, a psychopathological emphasis on the Gestaltic nature of “mental object” does not preclude that the final formal diagnosis follows a list of pre-specified (e.g., polythetic) criteria.

\textbf{Structured versus phenomenological interviews}

In the structured interview the clinical situation is represented as a transaction between equals and the patient is portrayed as a rational consumer and a motivated informant. The theoretical framework behind the development of highly structured, pre-formed psychiatric interviews for use by non-clinicians is consistent with the behaviorist methodology of opinion-polls. This form of interviewing presupposes (as its theoretical foundation) that the answers, which the patient emits, are considered as a set of third person (“objective”) \textit{propositional signals} that can be spatiotemporally delimited in the same way as physical object. The entire issue of \textit{information and information variance} is seen only as a matter of reliability, a driving force behind the increasing standardization of questions (stimuli) and permissible responses.

\footnote{This is, of course, of paramount epistemological importance and makes the operationalist project of counting the number of symptoms for a diagnostic purpose highly problematic.}
So, the very issue of the individuation of a symptom (e.g. whether something is identified as a “delusion” or a “social phobia”) is entirely left to the patient (many have “diagnosed” themselves through the web-available DSM IV criteria), and the symptoms are supposed to exist in the patient’s awareness (that is, in access consciousness), each time he is addressed by a preformed question. The symptom is a delimited mental-behavioral object. The preformed question acts as a stimulus, evoking the presence or absence of a symptom. Not only is the symptom considered as a self-delimited, naturally existing object (thing), with a referent function; it is also taken for granted that the patient has no motivation to respond negatively, if he indeed harbors the symptom.

In contrast, from the phenomenological perspective, the notions of prototype and gestalt provide psychiatrists with conceptual tools necessary for the clinical encounter with the “other mind.” This is an approach that can be taught with high levels of reliability (Parnas and Zahavi 2002). The cardinal epistemological point is that clinicians always do perceive their patients in a gestaltic manner, because a prototypical lens happens to be built into the nature of human cognition (Rosch 1973). Omitting prototypes from teaching and training of psychiatry is a non-project, because it disarms the clinician, placing him or her in a chaotic situation of having to confront a myriad of non-connected equivalent data, where each individual signal is a priori worthy of attention, as a potential fulcrum for a nascent diagnostic class.

If not taught the prototypes systematically, clinicians acquire their own private prototypes in a way that is not subjected to disciplined, critical and peer-shared reflection. Such “private” prototypes cannot resist becoming anchored in single, contingently towering, clinical features that happen to hit a protuberant diagnostic category. Here, a decisive role is occasionally played by the first verbalizations of the complaint. Someone, who says, “I feel depressed” will be likely diagnosed with “depression”; someone who says, “I have a habit of cutting myself” will be diagnosed as “borderline”. If a 30-years old habitually dysfunctional bachelor says that he has been suffering from OCD since the age of 17 when he was so diagnosed, the likelihood of a thorough assessment of his inner life is small (e.g., what does the word “obsession” mean to him; is this particular obsession given as a thought, fantasy, urge, image or picture; is his obsession experienced from a mental distance? Etc.).

Subjective experience cannot be faithfully assessed by structured interrogation with affirmative or negative responses, i.e., in the manner of a pre-formed structured interview. The assessment of the patient’s experience can only be psychiatrically assessed with sufficient validity in the course of a conversation, which conveys a friendly-neutral, non-judgmental atmosphere, is supportive of the patient’s spontaneity and provides a space for verbalizations of experiential examples and their contexts. It requires an active informed attention in order to hear/see and assess/typify experiences/symptoms. Such listening and seeing is apperceptively supported, as Jaspers pointed out, by the psychiatrist’s basic conceptual distinctions. To explicitly and faithfully assess and to typify another person’s anomalies of

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2 Even the western police forces have abandoned such techniques of witness interrogation in favor of eliciting a more open, spontaneous narrative from the witness, yielding better and more valid results. (Fisher et al. 1987)
experience, belief, expression and behavior from a second person perspective, requires specific demands on our interpersonal, empathic, and perceptual skills, as well as the analytic-conceptual (reflective) skills and knowledge that constitute psychiatry and psychopathology which are also academic and scholarly endeavors.

All such aspects of interviewing are open for assessment, for intersubjective evaluation, and hence for the examination of the “objectivity” or reliability and reproducibility of psychiatric assessment (Jansson et al, 2002; Vollmer-Larsen et al, 2007; Møller et al, 2011). It is likely that nosological and therapeutic progress cannot happen unless these epistemological root problems in psychopathology are addressed, discussed, and re-dressed. Improving the talking with and listening to psychiatric patients is the first step needed in re-humanizing the métier of clinical psychiatry as well as an indispensable methodological prerequisite of scientific development.

References


