Chapter 10: Phenomenology - A Philosophical Perspective

Danielle Winch

Specialty of Psychiatry, The University of Sydney, Australia.

"It has often been emphasised that psychiatry is still an 'expertise' and has not yet reached the status of a science . . . there is no sharp line of demarcation between the art and science of psychiatry. Science is continually extending into the field of clinical art but the latter always remains indispensable in its own right"

Jaspers (1963)

Introduction

It has been more than a century since Jaspers lamented psychiatry's thwarted attempt to reach the scientific empiricism that governs the rest of medicine. In that time, scientific methods of inquiry have failed to yield robust disease models for most mental disorders. A model of disease requires that aetiology and mechanism be established, and it is from that foundation that we develop diagnostic tests and disease-modifying treatments. Psychiatry has almost no models of disease or diagnostic tests, making diagnosis a more challenging and subjective process. Nevertheless, psychiatrists must still assist those with mental disorder and find ways to ease distress.

When no disease model exists, medicine relies on syndromes to make a diagnosis. Diagnosis in psychiatry is therefore almost exclusively syndromic. A syndrome is defined as "a constellation of symptoms that are unique as a group" (Casey and Kelly, 2007: 1). When the aetiology of a syndrome is discovered it can be called a disease (Casey and Kelly, 2007). Diseases can be reproduced and proven in accordance with the laws of science, which seek to explain by establishing causal connections. Once explained, diseases can be classified within medicine (nosology). Without casual connections, it is not possible for us to explain psychiatric syndromes. When explanation is not possible, the goal of inquiry must be to *understand* by establishing meaning (Jaspers, 1963). If the goal is different, so must

the methodology, and so psychiatry has different methods of inquiry to elicit signs and symptoms and make meaning from them. Phenomenology is one such method of inquiry. It is a method adapted from a branch of philosophy. In trying to understand the nature of the human mind, psychiatry has historically drawn on philosophy as often as science as a way of constructing meaning. Phenomenology seeks to explore and describe the lived experience of patients, in order to understand what may not be readily explainable. In this chapter we will look carefully at phenomenology as a key method of inquiry in psychiatry and how it relates to the study of psychopathology.

Phenomenology as a Philosophy

Put simply, phenomenology is the philosophy of experience. It values lived experience as a tool for interrogating the nature and meaning of existence. It rejects the notion that theories or beliefs are required for the construction of meaning. Instead, it positions itself as a process; a way of doing philosophy (Broome et al., 2013: 1). The summary provided in this chapter is an intentional oversimplification of complex ideas, designed to ensure ease of accessibility for those unfamiliar with the concepts and branches of philosophy.

The structures of experience in phenomenology are called phenomena and can exist in the external environment or the inner world. The modern founder of phenomenology, Edmund Husserl, sought to describe these structures in a way that avoids prejudice and sets aside ("brackets") prior knowledge/beliefs, focusing on the things themselves (de Monticelli, 2019). The goal of engaging with phenomena experientially, rather than analytically, is to access the essential qualities or "essence" of the phenomenon (*eidos*) (Broome et al., 2013). This is a form of knowledge referred to as *a priori,* meaning that prior knowledge of the phenomenon is not required for its essence to be intuited. For example, to experience the essence of the colour green – to know what "green-ness" is - one does not need to know that it is a blend of blue and yellow. One needs only to have had the experience of seeing the colour green. Through that experience one can both recognise greenness and imagine an infinite "horizon" of variations in the colour green by extrapolating its greenness (Broome et al., 2013).

Martin Heidegger disputed Husserl's idea that all knowledge can be suspended during (or "bracketed" out of) encounters with phenomena because sometimes the essence of a phenomenon is socially constructed. Such phenomena are experienced as a codified pattern in which the interpretation forms part of the experiential encounter (Broome et al., 2013). For example, when I walk into my clinic room I immediately take in the image of the desk and know it to be the place designated for me to sit and complete my work. I cannot put that interpretation to

the side and return to a pure experience of a wooden surface with four legs and some draws. This is also the case when one encounters phenomena that are intended to convey meaning by their very existence, for example the orange light that blinks on the side of a car that is about to turn (Broome et al., 2013). Heidegger called such signalling phenomena "signs". Noting this process of reflexive interpretation of phenomena as an essential part of a human being's experience in the world, Heidegger began to think of human beings as inherently interpretive creatures, driven to make sense of their worlds through meaning. He felt that part of the inescapable drive of interpretation was the fundamentally affective nature of human experience. We give meaning to experience because we are affected by it (Rosfort, 2019). Heidegger's work moved away from Husserl's epistemological phenomenology (to understand the nature of knowledge) towards a more ontological phenomenology (to understand the nature of being in the world).

Several years before Heidegger, Max Scheler, wrote extensively about human beings as "signs" or signalling phenomena. For Scheler, the human being is a quintessentially emotional entity with the capability to imagine or imbibe the mental lives of others. Scheler also identified emotion as core to the nature of human beings as phenomena, such that they cannot be reduced to bland concrete parts without their essence being lost (Broome et al., 2013). For example, it is not possible for me to see my companion's eyes without seeing that they are looking at me and without seeing the emotion conveyed in the gaze. The sense-data in the human body allow perception of emotional states. A sudden blush in the cheeks conveys shame, a frown on the face, sadness (Frings and Scheler, 2012; Broome et al., 2013). These stigmata are part of the emotions they express and are the medium that allows communication of feelings between people (Dillard-Wright, 2007).

Scheler also delineated types of feeling experienced by human beings (Broome et al., 2013), including revisions of the hierarchy of feelings posited by Aristotle (Frings, 1974):

- Sensible feeling-states that related to an object: pain, smelling a scent
- Intentional feelings that relate to those feeling-states: suffer, endure, enjoy
- Vital feelings that relate to the life force of the being: weakness, vigour
- Spiritual-type feelings: despair, conscience, peace
- Feeling of the emotional characteristics of the atmosphere: serenity of a lake
- Feeling of values: agreeable, good

Given such detailed attention to emotions as constituent parts of human being and their communications with others, Scheler's work is perhaps the most relevant to phenomenology as it exists within psychiatry.

Phenomenology in Psychiatry

The Object of Study in Psychiatry (Psychopathology)

Abnormal mental phenomena are the essential objects of study in psychiatry (Parnas et al., 2013). We are interested in how and why experiences might deviate from normal psychic experience. Our disorders, those of experience and expression, are organised under an umbrella of psychopathology. Psychopathology is the systematic study of abnormal experience, cognition and behaviour. A basic understanding of psychopathology is important because:

- It underpins our understanding of assessment and diagnosis in psychiatry.
- It forms the basis of our professional lexicon (how clinicians communicate).
- It is how we monitor treatment and progress.
- It underpins how we conduct research and construct diagnostic syndromes.

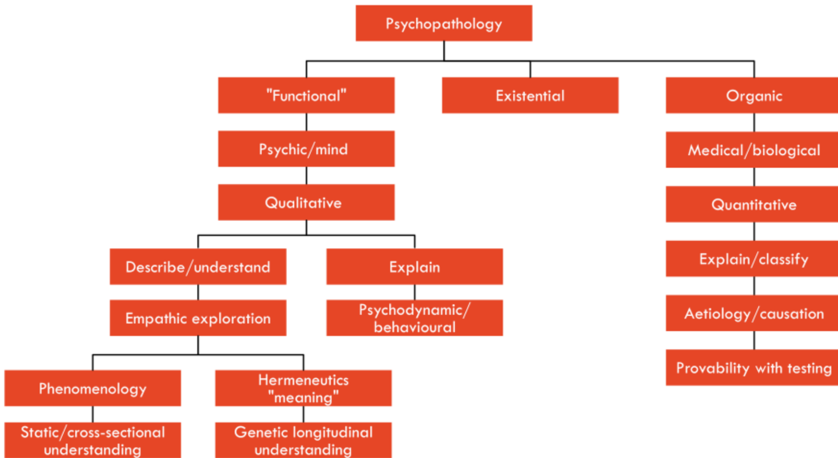


Figure 10.1. Organisation of psychopathology.

Phenomenology was appropriated by psychiatry to be deployed as a tool for studying psychopathology, particularly in the area of descriptive psychopathology, which seeks to describe and understand mental phenomena

(Oyebode, 2023: 3). Mental phenomena could be any type of internal experience, including but not limited to, thoughts, affects, reactions, associations, perceptions.

Key Thinkers

Karl Jaspers

It is Karl Jaspers (1883-1969) who is credited with bringing the phenomenological method to the practice of psychiatry. Jaspers first described the dichotomy of understanding versus explaining as a way of conceptualising the divergence of psychiatry from the epistemology (knowledge) of the natural sciences. His introduction of the phenomenological method was his attempt to devise a mechanism for achieving understanding in psychiatric practice.

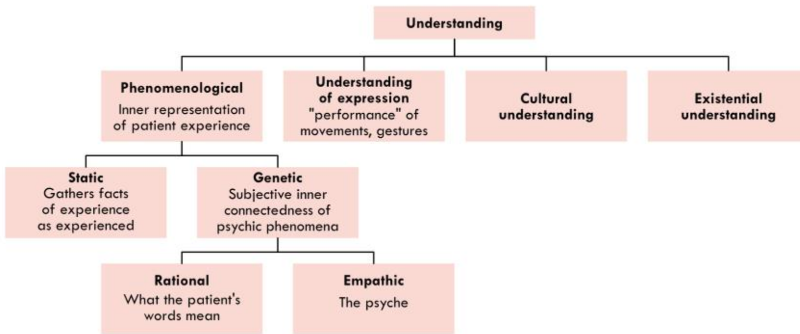
Jaspers was unapologetic about psychiatry's epistemological uniqueness within medicine. He believed there was human value in the subjective truth of lived experience. He rejected the idea that objective truths were more valid or worthy and saw the difference between objective and subjective knowledge as qualitative, not quantitative. It was therefore valuable to have a rigorous methodology for building subjective knowledge and developing shared understanding between psychiatrists and patients. Jaspers adapted Husserl's method to the practice of psychiatry and produced the first comprehensive description of mental disorders according to their essential qualities as phenomena (Jaspers, 1963). He identified three groups of phenomena accessible to the psychiatrist (Jaspers, 1968):

- Those known to us from our own lived experience.
- Those understood as exaggerations or diminutions of our lived experience.
- Those inaccessible by empathic understanding to which we can only get close through metaphor/analogy. Jaspers believed our perception of such phenomena arose through the "shock … of the incomprehensible" (Jaspers, 1968: 1318)

Jaspers posited that up to four modes of understanding could be applied to the exploration of psychic phenomena (Figure 10.2). Cultural and existential types of understanding are outside the scope of this chapter. Neither will we discuss the understanding of expression in detail, as this will be discussed in sections on the mental state examination. Jaspers acknowledged the need for objective observation and description of the mechanical elements of behaviour - because behaviour expresses aspects of internal phenomena - but he prioritized direct exploration of the patient's inner world over the inferences made through behavioural observation

(Parnas et al., 2013). We will therefore turn our attention to the phenomenological modes of understanding that directly explore the psyche: static and genetic understanding.

Figure 10.2. Japsers' organisation of understanding as described in General



Psychopathology Volume One, parts 1 & 2.

Static understanding is cross-sectional. It describes and characterises a patient's internal experiences to create a landscape of the inner world at that time. The more precisely this is done and the more experiences that are examined, the more cohesive the representation becomes in the mind of the psychiatrist. Genetic understanding introduces a more analytic exploration of how one psychic experience arises from another. It requires empathic immersion into "the psychic situation" of the patient (Jaspers, 1963: 301) because the genesis and evolution of psychiatric symptoms does not proceed in the linear manner of the physical world (Dörr, 2013). Psychopathological processes can have an intrinsic logic/progression. It is important to understand how the patient makes meaning from connections, rather than impose our own meaning on them.

Eugène Minkowski

Eugène Minkowski's (1885-1972) method of phenomenological psychiatry runs somewhat antithetically to the medical model. He saw patients with mental disorder as "different" rather than "diseased" and believed that psychiatry failed to move from syndrome to disease because there was a whole living entity standing between the two (Broome et al., 2013). Minkowski's psychopathological focus was therefore the basic disturbances affecting human the being as a whole. He sought to examine how the structures of disorders influence the structures of the psyche. His method is often referred to as structural phenomenology for this reason.

In Minkowski's model of psychopathology, an individual is endowed with a "*morbid personality*" that intersects with something he calls the "*generating disorder*"

(Broome et al., 2013; Urfer-Parnas, 2019). This intersection between personality and disorder creates certain conditions from which phenomena (symptoms) materialise. Simply put, he posits that certain personality structures are prone to certain disorders.

Minkowski believed that the study of psychopathology should focus on establishing the underlying generating disorders, rather than on the grouping of symptoms. He did not believe that symptom clusters could ever be definitive in psychiatry because symptoms are only the patient's way of expressing their generating disorder and patients have only a few modes of expression at their disposal for conveying their lived experience. For example, somatic/hypochondriacal preoccupations can occur in schizophrenia and anxious depression but are phenomenologically different in each disorder. The generating disorder should be defined by its essence rather than variable expressions of it. In the case of schizophrenia, for example, the generating disorder is a loss of vital connection with reality (Urfer-Parnas, 2019). This intersects with the autistic manifestations of the patient's morbid personality to produce psychotic symptoms.

In this model, symptoms do not relate to brain functions but indicate modification of the structure of psychic life, which should be interpreted using a "*phenomenopsychopathological attitude*" (Broome et al., 2013). Minkowski believed that a hallucination should not be reduced to a disorder of perception, nor should a delusion be reduced to a disorder of judgement (lest judgement become nothing more than something that stops us having delusions). Instead, one should consider delusions a consequence of aberrant salience arising from a disorder in the "*natural flux of life*" (Broome et al., 2013). Aberrant salience occurs when a patient experiences a neutral environmental stimulus as unduly important. This experience is inexplicable and leads to questions that cannot be answered. The delusion creates an answer to the unanswerable question and removes the anxiety associated with the inexplicable. The role of the delusion in this case is to explain an inconsistency that threatens psychic unity. Psychic unity is essential for a cohesive experience of existence and is protected at all costs.

Ludwig Binswanger

Ludwig Binswanger (1881-1966) developed Heidegger's notion of *being-in-the-world* into a process of existential analysis through which one might appreciate the patient's world. Existential analysis examines the "*forms and configurations of existence*" (Broome et al., 2013: 117), or the nature of one's world, in so far as one exists within the world.

Existential analysis proceeds from the premise that there is a common or shared world, which can contentiously be called reality, and one's own subjective personal world. Its use in psychiatry depends on the assumption that the world of the patient with mental illness differs from the collective experience of the shared world. Binswanger believed that inferences can be drawn about a patient's world-design or world-content from the language expression used to describe their lived experience. If we were to look at spatial and temporal domains of description, a temporal description of urgency and a spatial description of crowdedness might help us to understand the frantic and intrusive nature of patient's anxiety as it relates to perceived threat in their world (Broome et al., 2013).

Binswanger hypothesised that anxiety arose out of threat to the patient's world structure. He identified a relationship in which a patient was conditioned through their life experience to have a world structure with certain vulnerabilities to anxiety. Threats to those points of vulnerability then produce a reliably corresponding anxiety. A lack of food security growing up might cause a patient to hoard food, for example, and then a threat to the hoard activates the same anxiety that caused the hoarding in the first place. The core aspect of the experiential world in each case is a feeling of not having enough or being left empty.

Binswanger is quick to say that his method is not itself psychopathology, but a tool for communication between the world of illness and ours, which must then undergo psychopathological translation. One could also argue its value as a tool for experiential empathic understanding.

Kurt Schneider

Kurt Schneider (1887-1967) built on the descriptive classifications of Emil Kraepelin and Eugen Bleuler in their work distinguishing schizophrenia (dementia praecox) and affective psychoses. While Schneider valued the phenomenological attitude as a tool for research and understanding, his focus was establishing psychiatric nosology as a spectrum of "psychosyndromes" that could be classified even if they could not be defined as discrete entities (Jablensky, 2015).

Schneider was the first person to try and operationalise the work of psychopathologists into syndromes of characteristic symptoms. He is best known for creating a nosological classification for schizophrenia based on what he termed "first rank symptoms"(Jansson, 2019; Soares-Weiser et al., 2015). Schneider's first rank symptoms (Figure 10.3) formed the diagnostic criteria for schizophrenia in the International Classification of Diseases (ICD) until their omission in the most recent iteration (ICD-11). While first rank symptoms were thought to be pathognomonic for schizophrenia for decades, the prevailing contemporary

understanding is that these symptoms occur not infrequently in other types of psychosis (Jansson, 2019) and cannot offer diagnostic fidelity.

Table 10. 1 Summary of Schneider's first rank symptoms, adapted from Soares-Weiser et al. (2015).

Schneiderian First Rank Symptoms		
Auditory Hallucinations	Thought echo	Voices speaking thoughts aloud
	Running commentary	Voices commenting on every thought/action
	Third person	Multiple voices discussing the patient
Thought Manipulation	Thought insertion	Outside agent putting thoughts in the head
	Thought withdrawal	Outside agent removing thoughts from the head
	Thought broadcasting	Thoughts leaving the head and becoming common/shared property
Passivity	Motor passivity	Actions controlled by outside agent
	Affective/sensation passivity	Feelings controlled by outside agent
Delusional Perception		Sudden false belief about a true perceived stimulus

Hermeneutics

A phenomenological methodology cannot stand alone in the study of psychopathology without the capacity to interpret the phenomena. Hermeneutics is the philosophy of interpretation or "meaning making". While it originally referred to the interpretation of texts, it is now applied more generally to language and communication. The history of hermeneutics is extensively intertwined with phenomenology given their mutual interest in human experience. Phenomenology deals with *how* we experience things, while hermeneutics deals with *what* we experience and *why* we experience things in the way we do (Rosfort, 2019). Hermeneutic phenomenology is a branch of philosophy that seeks to unite these elements to achieve a more holistic understanding of human experience.

When it comes to psychopathology and the practice of psychiatry, it is difficult to conceive of a phenomenological methodology that does not utilise

hermeneutics. How can we make sense of mental suffering without understanding *what* a person experiences, *how* it manifests and *why* the suffering is occurring? While Heidegger brought hermeneutics to the phenomenological method in philosophy, Jaspers was quick to identify meaning as a vital aspect of understanding in psychopathology, because every understanding is a form of interpretation (Dörr, 2013). In fact, Jaspers' notion of genetic understanding is driven by the meaning that connects internal experiences and ideas. The symptoms that comprise psychiatric syndromes are also linked through meaning, rather than through a demonstrated shared causality, so interpreting them should seek to achieve meaningful, rather than aetiological understanding (Rosfort, 2019). Understanding a delusion from within, as a series of faulty interpretations, has greater empathic value than a causal explanation of neurotransmitter dysfunction (Dörr, 2013).

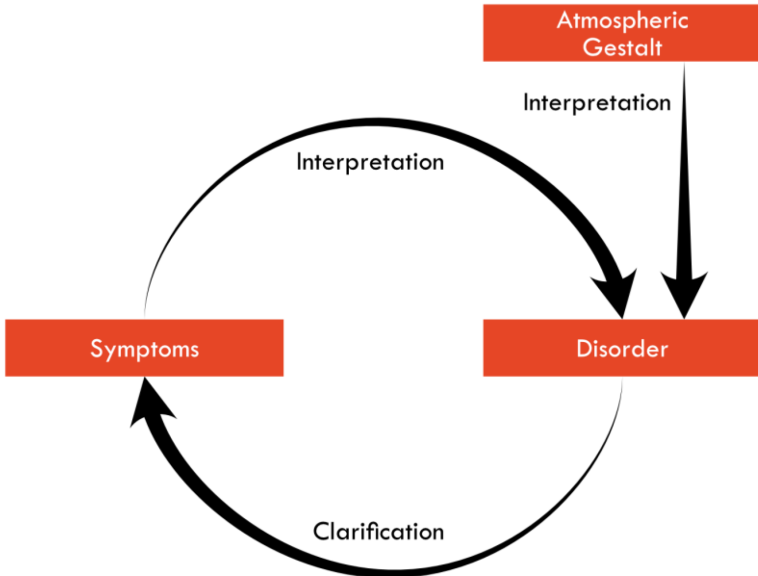


Figure 10.3. Hermeneutic circles in psychiatric assessment.

Phenomenology and hermeneutics work in tandem in all aspects of psychiatric assessment. While signs and symptoms may be observed as phenomena, they are described and discussed using language. The patient's description of their symptoms is an interpretation of their lived experience. The patient questions how best to meaningfully express themself and the psychiatrist clarifies the patient's meaning in order to make their own interpretation of the patient's lived experience. The result is a hermeneutic co-construction of mental symptoms (Stanghellini and Aragona, 2016). Symptoms are interpreted by the psychiatrist with reference to a

diagnostic paradigm, which can then direct further clarifying questions. This is a rough approximation of what is known as a "hermeneutic circle": an expanding cycle of reference between part and whole.

A psychiatrist adopting a phenomenological and hermeneutic attitude may become immediately attuned to an atmospheric gestalt in the patient's embodied presentation, which may invite an intuitive reference to a "whole" diagnosis before any discussion of symptoms ("parts"). For example, a patient presenting with a downcast gaze, a look of dysphoric consternation on the brow and cadaverization of the body invites an immediate interpretation of melancholia. The assessment then proceeds to clarify the truth of that interpretation by exploring its various "parts". While the psychiatrist is attuned to a gestalt in this case, the phenomenological experience of the encounter shares similarities with an eidetic quality (*eidos*).

Phenomenology in Clinical Practice

"Psychology and psychopathology really face a double task: that of knowing the person as the centre of his world and that of knowing the world of which he is the focal centre".

Spiegelberg (1975: 39)

One of the challenges of clinical practice in psychiatry is attempting to understand things that are not directly perceptible or accessible to us. We are trying to imagine phenomena that only the patient experiences directly. In many ways it is a phenomenology of vicarious experience (Spiegelberg, 1975). Accessing, exploring, and describing such phenomena accurately, and understanding lived experience is the true craft skill of the psychiatrist. While the data may be subjective, the experienced psychiatrist can achieve precision in their craft through a variety of tools.

Through repeated application of phenomenology to a multitude of clinical cases, one may hope to arrive at something analogous to the *eidos*, or phenomenological essences of a given disorder (Dörr, 2013). Much like the *eidos* of green can be experienced without the knowledge that it is a blend of blue and yellow, a clinician who is practiced in phenomenology could know the *eidos* of mental disorders, even without the knowledge of the diagnostic criteria. They can intuitively connect to the essence of melancholia, the evolution of delusion or the expansiveness of mania. We will now examine the application of phenomenological tools in the clinical practice of psychiatry.

Empathy

Empathy is not simply being kind and compassionate. Nor is it feeling the feelings of the patient (sympathy). It is the capacity to genuinely imagine someone else's experience, using your own cognitive and emotional experiences as a point of reference. Empathy requires the psychiatrist to adopt the perspective of the patient and it has been suggested that a truly phenomenological approach to empathy might require transposal of the clinician into the place of the patient at that specific place and time (Spiegelberg, 1975).

Empathic precision requires cycles of clarification in which the psychiatrist's understanding of psychic experience is fed back to the patient to check accuracy and invite further exploration of discrepancy. True empathic exploration and understanding is therefore a cooperative encounter (Spiegelberg, 1975). Jaspers believed that a shared truth discovered through empathic clarification has greater capacity for achieving mutual understanding than simply informing a patient they have a particular illness.

Diagnosis

A lack of aetiological disease models doesn't obviate the need for a diagnostic classification in psychiatry. Psychiatric diagnoses currently exist as "typologies of human experience and behaviour" (Parnas and Zahavi, 2002: 137). For such typologies to have utility for research, treatment and prognosis, their classification would ideally have clearly delineated boundaries between disorders and between each disorder and "normal". Phenomenology attempts this through its pursuit of the essential qualities of a disorder. Jaspers felt this could be achieved through immersion in the behaviour and expression of the patient, questioning by the psychiatrist, and spontaneous accounts of experience by patients (Spiegelberg, 1975). Through our empathic connection with these data, we achieve an understanding of the lived experience of the patient. Elements of this lived experience are meaningfully connected to form a cohesive whole, or, organising Gestalt (Parnas and Zahavi, 2002: 157). The psychiatrist then subjects this Gestalt to a typification process (Parnas and Bovet, 2014: 205; Parnas and Zahavi, 2002: 156) that references the patient's experience against prototypic lived states or essential types. Here the psychiatrist asks to what extent the essential elements of the patient's experience resemble the essential elements of a given disorder. Psychiatry's methods of diagnosis have moved incrementally distant from this phenomenological ideal since their inception in the early Twentieth Century.

Operational Psychiatry

For most of this chapter, we have discussed very specific and technical definitions of phenomenology as it pertains to philosophy and psychiatry in the modern era. Unfortunately, over recent decades, the meaning of phenomenology in clinical practice has been eroded to a reductive and unrigorous definition approximating signs, symptoms, and underlying thoughts and feelings (Parnas and Zahavi, 2002; Andreasen, 2007). Clinical assessment has suffered a similar decline in precision, as psychiatry has been progressively reduced to a set of symptom checklists. This process is referred to as the operationalisation of psychiatry (Parnas and Bovet, 2014; Parnas et al., 2013; Parnas and Zahavi, 2002) and some commentators have suggested that it has heralded the "death of phenomenology" (Andreasen, 2007). Operational diagnosis is now the standard methodology in psychiatry, and it stands in opposition to the phenomenological tradition. The benefits and products of operational psychiatry will be discussed in sections relating to classification. It is the role of this chapter to explain the shift in approach and make the case for phenomenology.

How Did It Happen?

Regional differences in the practice of psychiatry in the Twentieth Century created divergences in ethos between Europe and America. Europe continued its nosological pursuits, while the spread of psychoanalysis in America saw diagnosis largely abandoned as therapeutically insignificant (Andreasen, 2007). Uptake of ICD after its publication in 1956 was low and studies reporting overdiagnosis of schizophrenia in America began to appear (Kendell, 1975; Parnas et al., 2013; Andreasen, 2007). In addition, a controversial study was published in which participants feigned psychotic symptoms to gain psychiatric admission and were discharged (sometimes after weeks) with a diagnosis of schizophrenia, despite behaving in an entirely normal manner after admission (Rosenhan, 1973). Even though questions were raised about the integrity of the latter study decades later (Cahalan, 2020), at the time of its publication the ignominy of haphazard diagnostic practices became inescapable.

The (often accidental) discovery of effective treatments for psychiatric illness, which occurred around the same time, also renewed interest in nosology, especially given the persistent lack of aetiological models of disease. In America, this renewed interest led to the development and publications of a new diagnostic approach in the form of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III). DSM-III was ideologically conceived to create shared syndromic diagnoses that would foster research and clinical consistency.

The Problems of the DSM

Philosophical Problems

DSM intended to operationalise diagnosis in psychiatry. Psychiatry borrowed the term "operational" from physics but appropriated it in a way that arguably nullifies its scientific and epistemological meaning. In physics, an operational definition defines something by the procedures through which it is determined (Parnas and Bovet, 2014). An approximate example within medicine would be the definition of intelligence as what is measured in an IQ-test. When it was proposed for use in psychiatry, it included the explicit assumption that our observation of the psychiatric object was the defining "operation". The problem inherent in this proposal is that we are dealing with the experiential word of a whole person, which cannot be defined only through its observation by a psychiatrist. It takes psychiatry in a decidedly behaviourist direction, suggesting that we can understand psychiatric disorders simply through observation of behaviour, without reference to inner worlds (Parnas and Bovet, 2014: 196). It also removes vast domains of human experience that are not directly observable from diagnostic consideration (self-experience, identity, interpretation of experience). The only applicable definition of "operational" then becomes a rudimentary lay definition: "ready for use" (Parnas and Bovet, 2014: 200). In many ways, this is exactly what DSM has become: a ready-for-use system for counting observable signs and symptoms, using common-sense, lay language, at the lowest order of inference (Parnas and Bovet, 2014: 199). It empowers clinicians, even those with minimal training, to make diagnoses with naïve confidence, based on the presence of absence of symptoms from a designated list. This accessible, common-sensical and "atheoretical" position was intended as a noble endeavour to further research and diagnostic consistency and the problems I have mentioned were an unforeseen consequence (Andreasen, 2007).

Practical Problems

The first issue to mention with DSM is the sacrificing of validity for the sake of reliability (Andreasen, 2007; Parnas et al., 2013; Parnas and Zahavi, 2002; Parnas and Bovet, 2014). Reliability was felt to be paramount for research, training, and clinical communication at the time (Andreasen, 2007). Reliability is based on reproducibility, and this was achieved through the creation of standardised lists of symptoms, from which diagnosis is achieved by reaching a threshold quantity. The problem with this is the symptoms themselves don't confer the essential meaning of the condition (Parnas and Bovet, 2014). If we take depression as our example, the diagnosis requires five symptoms from a list of nine, which can occur in hundreds of combinations. This raised numerous questions. How essential can any of these

features be if they can be omitted from diagnosis? Which combination of five features better reflects what it is to be depressed? What does it mean if you only have four symptoms from the list but have symptoms that are not on the list? How many symptoms could you have from the list but still be experiencing a "normal" form of distress in response to life events? With many symptoms of depression corresponding to physiological features of the human stress response, how does depression separate from normal responses to stress? With so many questions raised, it seems clear that a symptom-based method doesn't get us closer to the essence of what it is to be depressed.

The second issue to highlight is the progressive deskilling of psychiatrists in the study of psychopathology. DSM has become more of a textbook for training than seminal psychopathological texts and training in clinical assessment (Andreasen, 2007) has been largely reduced to a box-ticking exercise. The ability to explore psychic phenomena from within and the capacity to take in an atmospheric gestalt in an analytically attuned manner is diminishing. This leads on to the third problem with DSM: its dehumanizing effect on psychiatry (Andreasen, 2007). It places the disorder at the centre of assessment, rather than the patient. While this may be an unconscious process for the clinician, it is antithetical to the notion of patient-centred care that has become a central tenet of the practice of medicine. It is for all of the above reasons that there has been a resounding call for a return to phenomenology and descriptive psychopathology over the last two decades.

Further Reading

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