



ORIGINAL ARTICLE

Psychosis and Intersubjective Epistemology

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Delusions and hallucinations present a challenge to traditional epistemology by allowing two people's experiences of the world to be vastly different to each other. Traditional objective realism assumes that there is a mind-independent objective world of which people gain knowledge through experience. However, each person only has direct access to his or her own subjective experience of the world, and so neither can be certain that his or her experience represents an objective world more accurately than the other's. This essay proposes an intersubjective account of psychosis, which avoids this sceptical attack on objective certainty by considering reality not at the level of an objective mind-independent world, but at the level of peoples' shared experiences. This intersubjective hypothesis is developed further, with reference to Husserl's concept of multiple lifeworlds, into a relativistic account. The implication on the social role of psychiatry is also explored.

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INTRODUCTION

The only general characteristic of insanity is the loss of a sense of ideas that are common to all (*sensus communis*), and its replacement with a sense of ideas peculiar to ourselves (*sensus privatus*). (Kant 1798, Ed.1978, p.177)

Psychiatrists frequently encounter people whose experiences and beliefs are dramatically incongruent with their own. Perhaps the most vivid example is that of the patient with florid psychosis. In the usual state of affairs, it is the patient who is considered by the psychiatrist to have incorrectly represented reality. The patient's experiences are judged as being hallucinations, and his or her beliefs are judged as being delusions. However, this begs the question: How can the psychiatrist be sure that it is the patient, and not he or she, who has misrepresented reality?

This question may sound extravagant, but it is a serious one. The psychiatrist and the patient have different experiences. However, as subjective beings, each has access only to his or her own subjective world. Neither therefore appears to have access to an external criterion to judge which one of their representations of reality, if either, is accurate. This frightening scenario is portrayed in the 1920 Robert Wiene film, *The Cabinet of Dr Caligari*. Set in a psychiatric

asylum, the film depicts the experiences of the protagonist, Francis, and a doctor in the asylum. In Francis' world, the doctor is deemed insane and is committed to his own asylum by the other doctors. However, in the doctor's world, it is Francis who is insane and is being treated in the asylum by the doctors. Although viewers may have an inclination to side with the doctor, they will struggle to find justification for why they do so, and the film remains chillingly ambiguous about whose world is being endorsed.

This highlights a problem with assuming objective realism in psychiatry. By objective realism, I am referring the view that there is a mind-independent objective reality, which we come to know through sense experience. The psychiatrist and the patient each assume that his or her experience is the correct representation of this objective reality, and that the other's is incorrect. However, as noted above, each has direct access only to his or her own subjective world. Neither have the privilege of appealing to *noumena* outside of his or her experience to falsify the other's experience. The psychiatrist therefore cannot exclude the possibility that he or she is being deceived by Descartes' demon, and that the patient's representation of reality is actually correct

(Descartes, 1647).

The best the psychiatrist can do is to appeal to the experiences of others. By this, I am referring not only to reports that are immediately relevant to the patient's case, but also to the psychiatrist's broader framework of testimonial beliefs, such as beliefs about history, scientific possibility, and social acceptability. The psychiatrist can then feel reassured that it is his or her own experiences, and not the patient's, that are congruent with those of others. However, as long as the psychiatrist assumes objective realism, not even this appeal to the experiences of others can guarantee him or her complete ontological security. Firstly, this is no more than an elaborate *argumentum ad populum*, and still allows for the possibility that the patient's subjective experience correctly represents the world, while everyone else is suffering from a highly sophisticated *folie à plusieurs*. Secondly, the testimonial reports of others may be different in the experiences of the psychiatrist and the patient. Agreement with others therefore does not confer objective certainty.

Nevertheless, this does not necessarily commit one to scepticism *in extremis*. Rather, it exposes the inherent difficulties with defending a position which sets the bar for facts at a mind-independent objective level. The other extreme is to assume subjective idealism and set this bar at the level of subjective experience. This is hardly more satisfactory, for it suggests that each person is isolated in his or her own subjective reality with no possibility of interacting with others. According to this position, it is only mere coincidence that people have experiences which are congruent with each other, and so genuinely shared knowledge is not possible. In this essay, I endorse a more modest position which considers reality at an intersubjective level. The psychiatrist may not be able to appeal to the nature of *noumena* outside of his or her own subjective experience, but he or she can, as noted earlier, appeal to the reported experiences of others. While this does not give the psychiatrist justification for assuming that his or her own experience represents an objective reality any more accurately than the patient's, it does allow him or her to show that his or her own experience is more in line with the experiences of others in the

community than is the patient's. My main thesis is that psychotic experiences are not pathological in virtue of their objective truth value, but in virtue of their departure from the intersubjective norms of the home community.

The position I endorse draws on the work of Edmund Husserl, who placed intersubjectivity at the centre of transcendental philosophy. After giving a brief historical overview of Husserl's intersubjective philosophy and its later application by others to psychopathology, I shall argue further for an intersubjective account of psychotic experiences by exploring the nature of delusional beliefs. I then refer to Husserl's idea of home and foreign lifeworlds to deviate from prevailing intersubjective accounts of psychotic experience and to develop a more relativistic account. Finally, I propose that an intersubjective account of psychosis emphasises the social dimension of psychiatry, and supports a recovery-based ideology with the primary focus not on the silencing of symptoms, but on the person's ability to function safely and meaningfully in an intersubjective world.

INTERSUBJECTIVITY AND TRANSCENDENTAL PHILOSOPHY

Western philosophy in the 17th and 18th centuries was concerned largely with sources of knowledge. Rationalists such as Descartes and Leibniz argued that one acquires knowledge through reason, whereas empiricists such as Locke, Berkeley, and Hume argued that one acquires it through experience. This culminated in the work of Kant, whose transcendental idealism can be considered to be a powerful synthesis of rationalism and empiricism. A major problem with these philosophical programs was that they all focused on the experiencing subject as a single point of view looking out on the world, and so they had difficulty accounting for the subject as part of a social world or community of subjects. While much was said about the internal workings of the Cartesian *res cogitans* or the Kantian transcendental ego, little was said about the subject's experience of and relation to other subjects.

Husserl's response to this problem was to emphasise the inherent intersubjective nature of

experience. In the fifth of his *Cartesian Meditations*, he observes that he not only experiences others as objects in the world, but also as subjects experiencing the world:

Thus peculiarly involved with animate organisms, as “psychophysical” Objects, they are “in” the world. On the other hand, I experience them at the same time as subjects for this world, as experiencing it (this same world that I experience) and, in so doing, experiencing me too, even as I experience the world and others in it. (Husserl, 1931, Ed. 1960, p.91)

Furthermore, he notes that objects in the world are not experienced as being private, but as being public:

In any case then, within myself, within the limits of my transcendently reduced pure conscious life, I experience the world (including others) and, according to its experiential sense, not as (so to speak) my private synthetic formation but as other than mine alone [*mir fremde*], as an intersubjective world, actually there for everyone, accessible in respect of its Objects to everyone. (Husserl, 1931, Ed. 1960, p.91)

In essence, Husserl is providing a refutation of solipsism by acknowledging the existence of other experiencing subjects and the ability of objects to be experienced by others. However, he goes even further than this, and proposes that it is the intersubjective experienceability of objects that constitute their transcendence. Therefore, what we consider to be objective reality is in fact an intersubjectively valid world. It is by acknowledging reality as being fundamentally intersubjective that Husserl achieved what has been described as the “intersubjective transformation of transcendental philosophy” (Zahavi, 1996).

Other philosophers after Husserl recognised the importance of intersubjectivity. For example, in the field of analytic philosophy, the later Wittgenstein suggested that a person’s activity can only be understood in the context of his or her background of social practices and norms (Wittgenstein, 1953). In the field of phenomenology, among the most influential philosophers who reframed intersubjectivity was Martin Heidegger, whose concept of *Dasein*, in contrast to the isolated ego of Descartes, emphasised the fundamentality of others to one’s being (Heidegger, 1927). While Husserl looks outward from his own self to the selves of others, Heidegger ac-

knowledged the intrinsic social nature of reality from the outset. Because one’s coexistence with others is so primordial, Husserl’s question about how one can make contact with others becomes unnecessary (Thompson, 2005).

In more recent years, intersubjectivity has been applied to the study of psychopathology. R. D. Laing highlighted the powerful ways in which one’s experience can be influenced by others, and suggested that psychosis is one’s reaction to this unhealthy enmeshment (Laing, 1960). In contrast, others have claimed that psychosis involves a breakdown of intersubjectivity, in which the patient suffering from psychosis struggles to maintain normal connections with other people and becomes withdrawn into his or her own isolated world (Parnas, 2011; Rulf, 2003; Sass, 1994; Stanghellini, 2001).

However, despite this influence of intersubjectivity, objective realism has continued to be assumed as the dominant metaphysical paradigm in psychiatry, and the psychotic experiences of the patient with schizophrenia are considered to involve abnormal representations of objective reality. This is particularly evident in diagnostic manuals and assessment tools. For example, the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, considers a delusion to be a “false belief based on incorrect inference about external reality” (American Psychiatric Association, 1994, p.821). Similarly, the *Schedules for Clinical Assessment in Neuropsychiatry* refers to hallucinations as “false perceptions” (World Health Organisation, 1998). Even authors whose phenomenological accounts of psychosis have been inspired by intersubjective philosophy appear to assume an underlying metaphysical framework of objective realism. Louis Sass, for example, refers to the patient with schizophrenia losing contact with the real world (Sass, 1994). In the following paragraphs, I argue against the objective realist assumption that delusions are false beliefs about objective reality, and instead support an account based on intersubjective acceptability.

DELUSIONS AND TRUTH

The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, suggests the

following definition of a delusion:

A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. (American Psychiatric Association, 1994, p.821)

Although the above characteristics have been criticised, the attitude that delusions are fixed false beliefs remains popular in psychiatry. With the help of the following series of cases, I argue that falsity is neither a necessary nor sufficient criterion for a belief to be delusional, and propose that an account based on intersubjective values is required. My hypothesis is that the delusionality of a belief does not depend on its validity with respect to the nature of an objective reality, but on its concordance with intersubjective norms.

CASE 1

A 33-year-old man with a diagnosis of paranoid schizophrenia is admitted to hospital under Section 3 of the Mental Health Act. He claims that he is Stephen Hawking. He refuses to believe that I am a doctor, and instead claims that I am a police officer. He announces that the world will be destroyed by a fire on the following day.

Of course, many delusions are false, as this case illustrates. The patient's beliefs are beliefs about the world shared by others, and can be refuted with reference to facts in this shared world: I know, and others know, that the patient is not Stephen Hawking, but that Stephen Hawking is a famous cosmologist from Cambridge; I know, and others know, that I am not a police officer and have never undergone police training; I know, and others know, that the world was not destroyed by a fire on the day announced by the patient. The patient's beliefs in this case are false, but note that their falsity is not judged with respect to an extrasensory objective world, but with respect to the intersubjective world as shared by others.

CASE 2

A 70-year-old man with a history of vascular dementia and heavy alcohol use is admitted to hospital under Section 2 of the Mental Health Act after having been aggressive towards his wife. Four months ago, he developed the belief that his wife is being unfaithful, and since then has been going to extremes to monitor her activities. Although he is entirely convinced of his wife's infidelity, he has failed to provide

any evidence to support this conviction. However, despite his lack of evidence, it turns out that in the past month, his wife has become exasperated with her husband's behaviour, and has commenced an affair with a man from her swimming class.

This classic case of the Othello syndrome is commonly cited as an example of a delusional belief which is true (Jaspers, 1913; Sims, 2010). The example is used to show that a belief's delusionality does not depend on its truth value, but on the patient's grounds for holding the belief: "The delusion does not cease to be a delusion although the spouse of the patient is in fact unfaithful—sometimes only as the result of the delusion" (Jaspers, 1913, Ed.1963, p.106). In this case, the patient's belief in his wife's infidelity is true, but he has no justificatory evidence for this belief.

CASE 3

A 51-year-old lady is admitted to hospital under Section 2 of the Mental Health Act with a manic episode. She repeatedly expresses the belief that there is an angel who wants her to be a messenger and to rescue the world. She states that only she is able to sense and communicate with the angel.

This case provides examples of delusional beliefs which are unfalsifiable. The existence of this angel is not something which can empirically be disproved by others, and so the belief cannot be said to be false. Many non-delusional spiritual and cultural beliefs also have unfalsifiable content, such as the belief in deities (Alcock, 1992).

CASE 4

A 48-year-old university researcher attends the psychiatry outpatient clinic with a moderate depressive episode. She tells the psychiatrist about recent stress at work. She had been working on a particular scientific hypothesis for a number of years, and until recently her laboratory had gathered a reasonable amount of experimental results which appeared to support the hypothesis. However, researchers from a competing laboratory have recently found results which have discredited the hypothesis. Despite this, she continues to defend her hypothesis, and to design experiments with the hope of finding data to explain the anomalies.

This case illustrates an example of a false belief about external reality that is firmly sustained despite what almost everyone else believes. However, this belief is not necessarily delusional. As noted by Thomas Kuhn in *The Structure of Sci-*

entific Revolutions, a scientist's trust in a theory can be remarkably tenacious in spite of the body of evidence against it, and, furthermore, this tenacity is important for a theory to be adequately developed and tested (Kuhn, 1962).

A belief's delusional quality, then, does not depend on its truth value. As the above examples show, delusional beliefs are not necessarily false, but, like all beliefs, can be false, true, or unfalsifiable. What instead appears to constitute delusional quality is the nature of the patient's justification for the belief. As noted by Andrew Sims: "A delusion is held on *delusional grounds*" (Sims, 2010, p.257). In Case 2, the patient's belief in his wife's infidelity is true, but he has no rational justificatory evidence to support his belief. By contrast, in Case 4, the patient's reluctance to let go of her belief in her discredited hypothesis appears more justified: the hypothesis has the empirical support from years of research and she can design further experiments which attempt to rescue it. It is therefore rationality of justification which is the mark of a non-delusional belief. I argue that this rationality is not necessarily truth-conducive, but is based heavily on intersubjective norms and customs.

According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, a delusion is "based on incorrect inference" (American Psychiatric Association, 1994, p.821). However, it does not make clear what constitutes an "incorrect inference". Indeed, we consider some methods of reasoning to generally be more rational than others. For example, "I believe I am a man, because I am male, adult, and belong to the species *Homo sapiens*" is more acceptable reasoning than "I believe I am a man, because it is a Tuesday".

Common assumptions of the rationality of our inferential practices have frequently come under philosophical attack. For example, Hume's great sceptical argument showed that there can be no justification for induction that is not circular, because all attempts at justification rely on the use of the inductive method itself. Regardless of this, our reliance on induction is ubiquitous, and Hume's explanation for this is that we are simply accustomed to using it, suggesting that it is mere convention that leads us to conclude that our

inductive practices are justified (Hume, 1748). Therefore, the patient in Case 1, who through a failure to use inductive reasoning believes that the world will be destroyed by a fire the following day, could be considered irrational because of a failure to maintain convention.

Another problem of induction and justification was highlighted by Carl Hempel in 1945. He demonstrated the problem by considering the hypothesis: "All ravens are black". Typically, this hypothesis would be supported by observing a specific instance of the general class, which would be a black raven. However, Hempel shrewdly points out that the hypothesis "All ravens are black" is logically equivalent to "Everything that is not black is not a raven". This opens up what is logically permitted to constitute supporting evidence for the hypothesis: a specific instance of the general class can be anything that is not black and not a raven, such as a white piece of paper (Hempel, 1945). If this equivalence condition is applied to the patient's delusional belief in Case 2, the hypothesis "My wife is being unfaithful" is logically equivalent to "What is not being unfaithful is not my wife". The patient's supporting evidence for this hypothesis could then be anyone or anything who is not unfaithful and who is not his wife, such as a member of the nursing staff, his daughter, or even his pet dog. Although this is counter-intuitive, according to Hempel it is as logically sound as supporting the hypothesis "All ravens are black" with an observed instance of a black raven.

The third critique of our inferential practices I shall consider relates to the process of scientific theory selection. In *The Scientific Image*, Bas van Fraassen observes that scientists frequently appeal to superempirical virtues, such as simplicity, to select one theory over another (van Fraassen, 1980). Because such virtues are not entailed by the empirical data, there is no evidence that they are truth-conducive. In fact, to assume that they are truth-conducive would make the process of theory selection circular: a theory is selected to explain what the world is like, but our reasons for selecting the theory assume that we already know what the world is like. Rather, such empirical virtues are virtuous

because of their pragmatic and aesthetic qualities: simple theories may not be more truthful, but are more convenient and more elegant. Let us reconsider the patient in Case 3, who believes there is an angel with whom only she can communicate. Such a belief is empirically unfalsifiable, and so one cannot dispute its truth by appealing to disconfirmatory evidence. Rather, the belief can be considered extravagant because it does not adhere to the pragmatic considerations of Ockham's razor.

These considerations suggest that the inferential practices which we consider to be rational are not grounded in objective truth-conduciveness, but are rely heavily on intersubjective customs. This is not to suggest that all of our inferences are fundamentally irrational: I concede that some inferences are more rational than others, and that irrationality is a useful criterion for recognizing delusions. Rather, it is to suggest, in line with Husserl, that intersubjective conventions determine what is normal or rational. Therefore, the norms acknowledged by the intersubjective community are the best criteria of rationality we have. This does not call for the revision of our inferential practices, but acknowledgment of the pragmatic nature of knowledge. Rational inferences may not provide one with access to a mind-independent objective world, but do help one to find one's way around a world which is constituted by the conceptual activities of others.

TOWARDS AN INTERSUBJECTIVE ACCOUNT OF PSYCHOSIS

I have argued in the preceding paragraphs that the delusionality of a belief does not depend on its truth value but on whether it is based on an irrational inference, and furthermore that the irrationality of an inference does not depend on truth-conduciveness but on its deviation from intersubjective convention. This supports an intersubjective account of psychosis, which considers the psychotic experiences of the patient with schizophrenia not to involve misrepresentations of objective reality, but to involve a departure from the intersubjective norms of the community. The pathologicality of experiences and beliefs can therefore be determined without making assumptions about the nature of a mind-

independent objective reality.

An advantage of this intersubjective account is that it evades the Cartesian sceptical dilemma presented at the beginning of this essay. Because the pathologicality of an experience can be determined without making metaphysical assumptions about objective reality, the psychiatrist need not worry about the possibility that he or she is deluded and that it is actually the patient who has correctly represented reality. Instead, the psychiatrist can determine the irregularity of the patient's experiences in relation to the shared experiences of the intersubjective community, and judge the experiences as pathological on the basis of this irregularity.

My discussion so far has laid emphasis on delusions, but the same principles can be applied to hallucinations. Traditionally, it has been suggested that a hallucination is a perception without an object (Esquirol, 1838). However, I argue that this is backward epistemology as long as objective realism is assumed: one does not begin with knowledge of a mind-independent reality outside experience and then use this extrasensory knowledge to justify or disconfirm experience, but begins with experience and then builds a conception of reality from this. Under the intersubjective framework being advocated, one's perception is hallucinatory if it is not also perceived by others in the intersubjective community, and if it is incongruent with intersubjectively conceived notions of what constitutes normal experience. For example, a patient's vivid experience of alien abduction is likely to be judged as hallucinatory in an intersubjective community who do not consider such a phenomenon to be normal. Therefore, as with delusional beliefs, the psychiatrist can judge a patient's perception as hallucinatory in virtue of its deviation from intersubjective norms, without reference to metaphysical assumptions about the nature of objective reality.

As I had noted earlier, most contemporary intersubjective accounts of the phenomenology of schizophrenia have suggested that psychosis involves a breakdown of intersubjectivity. Rulf, for example, argues that detachment from others is a key feature of schizophrenia (Rulf, 2003), whereas Sass, in his book *The Paradoxes*

of *Delusion*, suggests an interesting hypothesis that the patient with schizophrenia develops an alternative and very private view of reality (Sass, 1994). The common theme of these accounts is that the patient with schizophrenia fails to connect with the shared world of the intersubjective community, and becomes isolated in his or her own private psychotic world.

I put forward two problems with this hypothesis. The first problem is that the idea of the patient with psychosis living in a private world fails to account for the phenomenon of shared psychosis. Since the syndrome was first described by Baillarger in 1860, cases of *folie à deux*, *folie à famille*, and *folie à plusieurs* have been well established in the literature (Enoch and Ball, 2001; Sacks, 1988; Wehmeier et al., 2003). As noted by Christoph Hoerl, Karl Jaspers was aware of the dilemma presented by the phenomenon of shared psychosis (Hoerl, 2001). The fact that two or more people can share the same psychotic experiences suggests that they are not living in private isolated worlds, but in their own intersubjective community, within which they can communicate meaningfully with each other.

The second problem with the idea of psychosis involving a failure of intersubjectivity is that it does not account for the ways in which patients with schizophrenia can interact with their hallucinatory characters. Patients have frequently been observed to respond to their hallucinations as personalities, often holding conversations and laughing with them (Jimenez et al., 1996; Kobayashi et al., 2004). In such a case, it appears that the patient with psychosis is not so much isolated in his or her own private world, but is stuck in an intersubjective world with his or her hallucinatory characters. This may sound like an outlandish idea, but it deserves to be taken seriously. As argued by Husserl and later by his student Edith Stein, the experience of empathy, or *Einfühlung*, is how others are established as being experiencing subjects, and is what leads to the constitution of a shared intersubjective reality (Husserl, 1912; Stein, 1917). Just as one experiences other people as subjects, the patient with schizophrenia experiences his or her hallucinatory characters as subjects experiencing him or her, thus forging intersubjective relationships

with them. The natural reaction to this idea is to claim that other people are real whereas hallucinations are not, but this claim is based on the kind of unjustified assumption that led us to the sceptical scenario presented at the beginning of this essay. Even at a logical level, subjective experience is not logically supervenient on the physical (Chalmers, 1996), and so there is no logical contradiction in the patient's experience that there is a consciousness associated with such a hallucinatory character.

The above considerations suggest that the distortion in intersubjectivity associated with psychosis does not necessarily result in the patient becoming marooned in an isolated world. Rather, the patient becomes part of an intersubjective world different from that shared by the non-psychotic community. This can be better understood by considering Husserl's concept of the lifeworld. Essentially, the term refers to the intersubjective reality that is shared and lived by a community of subjects. It is not only generated and influenced intersubjectively by the experiences and activities of the community, but in turn shapes the way that members of the community structure their experiences and activities. Hence, it is not a static and independent structure, but a dynamic system that is lived (Husserl, 1936).

One of the challenges to Husserl's hypothesis that reality is intersubjectively constituted is the problem of disagreement between experiencing subjects (Zahavi, 1996). Husserl overcomes this firstly by arguing that only the experiences of normal members of the community are considered relevant for the constitution of reality. This concept of normality is itself constituted intersubjectively by the set of cultural and historical norms of the community. Hence, the delusional beliefs of the patient with schizophrenia are unlikely to pose a challenge to the worldview of the non-psychotic community. Secondly, as noted by Zahavi, Husserl acknowledges that there is not only one lifeworld, but many:

"... we speak of normality when it concerns our own homeworld, whereas anormality is attributed to the foreigner, which, however, if certain conditions are fulfilled can be apprehended as a member of a *foreign community*". (Zahavi, 1996)

Therefore, subjects from a community with dif-

ferent experiences and beliefs to those of one's home community can be understood as living and interacting in their own lifeworld, with its own norms and conventions. This lifeworld is considered foreign to those outside it, but home to those within it.

This relativistic reading of Husserl has been popular among transcultural philosophers. For example, Zhang Rulun analyzes the difficulty of intercultural exchange in terms of the incommensurability of different lifeworlds:

However, the lifeworld is not merely a sensible world, but a full-fledged cultural-historical world. It contains all the sedimentation of past cultural-historical and ideal activities, and hence varies more or less dramatically from one culture and period to another. For this reason, there cannot be a common lifeworld, but plural and different lifeworlds, each intentionally referenced ("relativized") to a special intersubjective community as the group for which this world is "there". (Rulun, 1999, p.328)

Like Kuhn's scientific paradigms, Rulun proposes that the lifeworlds of different cultures have different histories, concepts, and standards of normality, thus resulting in a likely incongruity between the core beliefs of a person from one culture and those of a person from another.

I suggest that the same principle can be applied to the incongruity between the experiences of patients with psychosis and those of the non-psychotic community. As discussed above, the psychosis involves a change in intersubjectivity in which the patient withdraws from a home community and becomes part of a community constituted by his or her hallucinatory characters or by other people who share the psychosis. The experiences and beliefs of the patient are so unfamiliar to those without psychosis, that they are effectively "un-understandable" (Jaspers, 1913, Ed. 1963, p.581). The patient with psychosis can therefore be considered to be living in a foreign lifeworld which is incommensurable with the home lifeworld of the non-psychotic community.

In his *Textbook of Psychiatry*, Eugen Bleuler warns that "To argue with the patient about his delusions is nearly always useless or harmful (Bleuler, 1924, Ed. 1951, p.219). This is not surprising given that the experiences of the psychiatrist and the patient are not merely incongruent but incommensurable. While the patient's experiences and beliefs are judged to be abnormal in

the psychiatrist's lifeworld, they may be considered normal in the patient's lifeworld. Both are correct relative to the very different *a priori* assumptions of their respective lifeworlds, with little room for argument. As suggested by Rulun:

"At best consensus would consist in acknowledgment of the incommensurability of lifeworlds: these beings belong to our lifeworld, and those to others, without a demand or need for a resolution of the difference" (Rulun, 1999, p.331).

However, although complete synthesis of incommensurable lifeworlds is difficult, Husserl does propose that meaningful exchange between lifeworlds is possible with reference to common structures shared by the different lifeworlds (Soffer, 1991). This attitude has been reflected in the field of psychopathology by the criticism of Jaspers' claim that primary delusions are "un-understandable". Laing, for example, argues that the psychiatrist should attempt to aim gain insight into the patient's world and understand the meaning of his or her experiences (Laing, 1967). Similarly, Schwartz, Wiggins, and Spitzer propose that the one can relate to the experience of the patient with schizophrenia as a meaningful experience, regardless of how bizarre it may seem (Schwartz et al., 1997). This therefore emphasises the importance of empathy between the psychiatrist and the patient, in spite of the incongruity of their experiences.

THE SOCIAL ROLE OF PSYCHIATRY

A final implication of this intersubjective philosophy I would like to discuss is the emphasis on the social dimension of psychiatry. A person does not live in an isolated vacuum, but in a communal world shared with others. As mentioned earlier, rational inferences and beliefs may not necessarily be objectively truth-conducive, but they do help one to orientate oneself around this communal world constituted by the social practices and norms of others. This becomes a struggle for the patient with psychosis, whose world is so radically different to the worlds of non-psychotic persons that he or she becomes alienated from them. Furthermore, while this essay has focused predominantly on the positive symptoms of hallucinations and delusions, the negative symptoms which I have not had the opportunity to discuss have a profound disabling

effect on the patient, thus perpetuating his or her alienation.

For many years, treatment of schizophrenia has been targeted at the control of symptoms and the prevention of relapse. However, attention has recently shifted to helping patients with schizophrenia function in society with minimal distress. The treatment of symptoms becomes one of the interventions that help to attain this purpose, rather than being the principal goal itself. This supports the value-based model of psychiatric practice promoted by Bill Fulford. Fulford and his colleagues observe that even diagnostic criteria in manuals such as the *Diagnostic and Statistical Manual of Mental Disorders*, which are supposed to be atheoretical, are in fact heavily value-laden:

The DSM, we should say straight away, makes clear that its definition of mental disorder requires that there be “*clinically significant* distress or impairment”. (Fulford et al., 2005)

Symptoms are therefore pathological because they are negatively evaluated by the patient and his or her broader community, and they are negatively evaluated because of their effects on the patient’s ability to function safely in this community.

A consequence of this social approach is that the attitudes towards a symptom can differ depending on its effects on the patient’s social functioning. Consider the following two cases.

CASE 7

While recovering from a moderate depressive episode complicated by harmful use of alcohol, a 46-year-old man has a mystical experience and believes that Christ has instructed him to live a clean life. He decides to abstain from alcohol and to serve as a hospital chaplaincy volunteer. He maintains his previous social and occupational functioning.

Mystical experiences are common, and do not in themselves warrant the diagnosis of a pathological state (Dein, 2004). The above case is such an example. Here, the patient’s experience is an integrating one. The following case, although it involves a similar mystical experience, is quite different.

CASE 8

A 52-year-old man is admitted to hospital under Section 2 of the Mental Health Act. Following a mystical experience and believes that Christ has instructed him to live a clean life, he abandons his job, refuses

to leave his flat, and stops eating. He continues to fast despite experiencing symptoms of severe malnutrition.

In contrast to the patient in Case 7, this patient’s experience is an isolating and harmful one, which is negatively evaluated by the psychiatric community as a symptom of a psychotic illness.

These two cases therefore highlight the importance of evaluative judgments about social functioning in psychiatric decision making. For example, consider Criterion B for schizophrenia in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition:

For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement). (American Psychiatric Association, 1994, p.312)

An experience, therefore, may not necessarily be considered pathological unless its effects impair the ability of the patient to function in his or her social environment. Again, this judgment relies on reference to values and standards established by the intersubjective community about expected levels of achievement.

CONCLUSIONS

Delusions and hallucinations present difficulties for objective realism by presenting a Cartesian sceptical scenario about the validity of one’s beliefs and experiences. In this essay, I have proposed a move away from objective realism and towards Husserlian intersubjectivism. After giving a brief historical overview of intersubjective philosophy, I demonstrated with examples that the delusional nature of a belief does not depend on its truth value, but on the rationality of its justification. I also argued that the rationality of an inference does not necessarily depend on its truth-conduciveness, but on its intersubjective acceptability, thus moving towards an intersubjective account of psychosis.

The account I have advocated suggests that a patient’s experiences are psychotic in virtue of their deviation from the intersubjectively constituted norms of the home community. Because no reference is made to a mind-independent objec-

tive world, this account avoids the sceptical dilemma presented at the beginning of this essay. Indeed, neither the psychiatrist nor the patient has grounds to assume that his or her subjective reality is any more objectively real than the other's, but the psychiatrist can appeal to the experiences of others, and view the patient's phenomenal world in the context of its relation to the shared intersubjective world or others.

I then further developed this intersubjective account of psychosis by applying Husserl's concept of multiple lifeworlds. In contrast to other contemporary intersubjective accounts which view the patient with psychosis to be isolated in his or her own private world, I proposed the idea that the patient with psychosis becomes part of a different lifeworld from that of the non-psychotic community. The resultant approach is a relativistic one, which considers the norms of different lifeworlds to be incommensurable.

Finally, I explored how an intersubjective philosophy emphasises the centrality of social values in psychiatric judgments. Psychotic symptoms are pathological because they impair the patient's ability to find their way around a social world. This moves the principal focus of treatment away from the mere silencing of symptoms, and towards the patient's ability to attain inclusion and meaning in a world governed by social norms and constructs. Under this model, the purpose of psychiatry avoids being reduced to thought policing, but remains, as with all medical professions, to reduce suffering, prevent harm, and help patients to live meaningfully in their social environment.

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