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INTRODUCTION

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(Intro to the *Oxford Handbook of Phenomenological Psychopathology*)

What is Psychopathology?

This volume brings together cutting-edge research arising from the fertile relationship among phenomenology, psychopathology, clinical practice, and the patient's lived experience of mental disorders. Perhaps unsurprisingly, a rebirth of interest in conceptual and philosophical issues in psychiatry followed closely on the heels of 'the decade of the brain' and advances in neurosciences (Fulford et al. 2003). With empirical scientific advancements comes the obligation to think critically about their broader significance, their impact on advancing knowledge, their place within current conceptual frameworks, and how these new findings can help us better understand mental suffering and improve care for persons living with mental disorders. This historical moment, just over one hundred years after the publication of the first edition of Karl Jaspers' *General Psychopathology*, is similar to the conceptual terrain of the 'first biological psychiatry' in which Jaspers found himself in the early twentieth century (Shorter 1997). We are in the heyday of a new reductionistic wave propelled, in part, by the US National Institute of Mental Health's Research Domain Criteria (RDoC) project, which aims to provide a new research classification founded on the assumption that mental disorders are disorders of brain circuitry (Insel and Cuthbert 2015; Akram and Giordano 2017). However, psychiatry is not only a biological discipline. It must maintain an intense concern with the quality of our patients' experiences (Broome 2009; Ratcliffe and Broome 2011; Stanghellini and Broome 2014; Fernandez and Stanghellini in press). In fact, the primary focus of psychiatry is the "psyche" and not the brain, which is of interest to psychiatry only insofar as it helps us to better understand the relevant psychic phenomena. Thus, we must investigate the relationship between these subjective experiences, the brain, and the way we classify psychiatric disorders. Phenomenological psychopathology is increasingly central to these discussions (Stanghellini and Rossi 2014).

However, it's not enough to simply acknowledge that psychiatry's primary domain of investigation is the psyche. At present, the psychiatric study of psyche and subjectivity is defined mainly by changes in experience and behaviour – not (or, at least, not uncontroversially) in terms of biological abnormalities. In fact, to date, there are no established and validated biomarkers for clinical use in psychiatry (Kapur, Philips and Insel 2012; Fusar Poli and Meyer-Lindenberg 2016). Therefore, psychopathology, the discipline that assesses and makes sense of the suffering psyche, is at the heart of psychiatry (Galderisi and Falkai 2018). In contemporary usage, the term 'psychopathology' is employed in a number of different ways (Stanghellini 2009). It is commonly conflated with *symptomatology* – the study of isolated symptoms in view of their clinical, i.e., diagnostic and aetiological, significance. Assessing symptoms allows for the identification of specific diagnostic categories that, in turn, facilitate clinical care. Psychopathology certainly includes the study of symptoms, but it is not reducible to this kind of study. Whereas symptomatology is strictly disease or illness oriented, psychopathology is also *person* oriented since it attempts

to describe a patient's experience and her relationship to her experiences and to the world. Biomedical science was built on the transformation of a complaint into a symptom. This allowed medical science to see in a complaint – e.g., exhaustion – the effect of a cause situated in the human body – e.g., an anatomical anomaly or biochemical imbalance. This may overshadow the fact that a complaint has not only a *cause*, but also a *meaning*, which expresses a question or desire. A person may seek not only the resolution of her complaint, but also the fulfilment of her aspiration to understand how this complaint fits into her existence. Biomedical science – with all its authority and success – risks excluding the subjectivity of patients and the meaning that their symptoms hold for them. A phenomenological approach to psychopathology does not exclude the possibility or utility of viewing abnormal phenomena as symptoms caused by a dysfunction to be treated or ameliorated. However, the phenomenological approach explores lived experience and personal meaning alongside the hunt for causes. The patient, as a person, should be acknowledged as an active partner in the diagnostic process, capable of interpreting her own complaints. On this approach, symptoms are taken as the outcome of a mediation between a vulnerable self and the sick person trying to cope and make sense of her complaints (Stanghellini 2016).

'Psychopathology' has also been used as a synonym of *nosography*. The latter outlines provisional and conventional characteristics of a syndrome (i.e., a combination of symptoms empirically and statistically aggregated) and thereby serves the goal of classification which is essential to formulating a clinical diagnosis. However, psychopathology is not only about diagnosis and is not, therefore, reducible to nosography. To psychopathology, what matters most is that the "chaos of phenomena" should stand out in an evident way and in multiple connections. Psychopathology aims to make sense of, or comprehend, that which at first seems incomprehensible (Fernandez and Stanghellini in press). It promotes explicit attention to the person's whole field of experience, rather than a restricted focus on symptoms selected according to their putative diagnostic *relevance*. The existing classifications of mental illnesses are provisional diagnostic conventions. Since no extraclinical (e.g., biological) indexes of putative nosological discontinuities are available, our current taxonomy is based exclusively on psychopathologically defined syndromes. Hence psychopathology is still the primary method of linking symptoms and diagnosis in psychiatry. Yet, if psychopathology is conflated with nosography, then only those symptoms that are assumed to have diagnostic value will be investigated. We stand in a sort of nosography-focused twilight state where we wear clinical blinkers structured by contemporary classificatory systems (Andreasen 2006). The dominant focus on diagnosis covers over many of the actual experiences of people suffering from mental disorders. As a consequence, clinical utility is confined to *ad hoc* bits of information useful for clinical decision-making. By confining our study to the phenomena that we have already deemed relevant to diagnosis, we neglect the diverse elements of the patients' experience – thus limiting our capacity to understand the worlds they live in and closing us off to the discovery of new psychopathological knowledge (Lawrie et al. 2016, Maj 2018, Reed et al., 2018, First et al., 2018)

Phenomenological Psychopathology as the basic science of Psychiatry

There are at least six reasons for why phenomenological psychopathology is a the heart of psychiatry (Stanghellini and Fiorillo 2015):

1) Psychiatry is interdisciplinary field adopting multiple languages to deconstruct the complexity of the suffering psyche. Practitioners approach their discipline from many

different angles, including neuroscience, sociology, genetics, epidemiology, dynamic or cognitive psychology, etc., each of which has its own language, methodology, and practice. Psychiatrists therefore need a common ground and a shared language if they want to understand each other. Phenomenological psychopathology is not one of numerous approaches aiming to conceptualize mental disorders – such as psychoanalysis or the cognitive sciences. Phenomenological psychopathology develops a framework for approaching mental illness in which theoretical assumptions are minimised and the forms and contents of the patient's subjective experience are prioritised. Although the emphasis on subjectivity looks like a theoretical commitment, that commitment is the product of a stance that seeks to respect the phenomenon rather than impose upon it. Thus, phenomenological psychopathology can be understood as *psychopathologia prima* and the basic science of psychiatry – it is the shared language that allows clinicians with different theoretical backgrounds to understand each other when dealing with mental disorders.

2) Psychiatry aims to establish *rigorous diagnoses*. Phenomenological psychopathology plays a central role in a field where the major disorders cannot be neuroscientifically defined as disease entities, but are exclusively syndromes that can be defined only in terms of symptoms. Neurophysiological, biochemical, endocrinological, neuroanatomical, cognitive, or behavioural measures (i.e., endophenotypes) help to improve the diagnosis of mental disorders. But we also need a phenomenological clarification of experiential traits and constructs (i.e., pheno-phenotypes). Even if we aim for a neuroscientific classification, we must accurately delineate the experiential phenomena that we want to explain or reduce to neuroscientific terms. As an example, 'delusion' is a heterogeneous category that must be split into more specific sub-categories to successfully identify its neurobiological correlates (Stanghellini and Raballo 2015). In addition, the use of the 'phenomenological razor' (Rossi Monti and Stanghellini 1996) is particularly useful in sorting out 'psychopathological receptors'. Even therapeutic decision-making, including accurately targeted pharmacological intervention, requires fine-grained distinctions among the abnormal phenomena that we aim to treat (Stanghellini and Ramella Cravaro 2015). Phenomenology provides tools that can facilitate successful clinical diagnosis as well as the revision of our diagnostic categories (Fernandez 2016; Fernandez forthcoming).

3) Psychiatry is about *understanding* disturbed human experience, in addition to assessing, diagnosing, and classifying it. Phenomenological psychopathology functions as a bridge between human sciences and clinical sciences within psychiatric knowledge, thus providing the basic tools to make sense of mental suffering. The dominant focus on diagnosis and on those symptoms deemed relevant for nosographical diagnosis disregards the complexity and diversity of people's experiences. Moreover, it excludes the scrutiny of what is relevant *from the patients' perspective* – the way in which one's vulnerability and suffering is distinctly personal. In mainstream practice, interviewing is seen as a technique that should conform to the technical-rational paradigm of natural sciences (namely laboratory techniques in biological sciences) in which psychiatry as a branch of biomedicine is positioned. Interview techniques are typically designed to reduce information variance and to elicit only "diagnostic-relevant" answers. Standard assessment procedures are devised in such a way that the patient's symptomatology needs to fit pre-existing diagnostic criteria, overlooking the subtle experiential differences and their meaning for the patient. Phenomenological psychopathology, on the contrary, wants to "give the word" to the patients, instead of merely assessing their abnormalities according to pre-structured interviews. This is the essential precondition to understand their wounded existence, and to open up to the

discovery of new psychopathological knowledge (Nordgaard, Sass, and Parnas. 2013).

4) Phenomenological psychopathology attempts to describe the diversity of experiential alterations and differences and to bracket common sense, socio-political, and scientific views about what is abnormal. Mainstream diagnostic concepts, for example, typically appeal to "social and occupational dysfunction," which is defined strictly in behavioural and quantitative terms (less than *n* social contacts per time unit) rather than being conceived as a consequence of typical and specific motivations, peculiarities of intersubjectivity, and of the values held by persons with a diagnosis of mental disorder. Phenomenological psychopathology is also about grasping what is human in apparently alienating (e.g., irrational or nonsensical) phenomena. We should remember that we, as clinical psychiatrists, do not usually sit in front of a broken brain – we sit in front of a suffering person. Indeed, mental disorders are primarily disorders of the human psyche. If the crucial task of psychiatry is understanding mental suffering, then its project should be to articulate the life-world of each person and identify the *conditions of possibility* for the emergence of pathological phenomena in human existence. This can shed light on the structure, meaning, and importance of the phenomenon at issue. Phenomenological psychopathology can help us re-think the meaning of psychopathological conditions.

5) Psychiatry is also about caring for troubled human existence, rather than judging, marginalising, punishing, or stigmatising it. Phenomenological psychopathology connects understanding with caring, and endeavours to establish an epistemological as well as ethical framework for this. This framework is a *dialogical* one. In some countries, phenomenological approaches have dramatically improved the care of psychiatric patients leading through the development of modern mental health models of care (Barbui et al., 2018). The kind of clinical practice promoted by phenomenological psychopathology is fundamentally a quest for meaning. It encourages the patient to unfold his experiences and his personal horizon of meaning, helping him to reflect upon them and take a position on them. In this framework, the clinician promotes a reciprocal exchange of perspectives with his patient. The clinician and patient cooperate in the co-construction of a meaningful narrative that includes and, if possible, integrates contributions from both original perspectives. And, when it is not possible to establish consensus, the clinician should facilitate coexistence of apparently conflicting values and beliefs, embracing a diversity of perspectives (Stanghellini and Mancini 2017; Broome 2009).

6) Psychiatry looks for a way to connect first-person experience with brain functioning. Phenomenological psychopathology aims to bridge understanding (*Verstehen*) and causal explanation (*Erklären*) in research as well as in clinical settings. As the science of abnormal subjectivity, psychopathology relies both on explanations based on deductive and inductive methods, and on understanding that is achievable only by immersing oneself in a singular situation. Phenomenological psychopathology in itself is prior to any causal accounts of subpersonal mechanisms. At least some of the inconsistent and heterogeneous results in neuroscience research are perhaps the result of insufficient knowledge in descriptive psychopathology. Basic psychopathological knowledge is a prerequisite for research in explanatory psychopathologies and it can help clarify fundamental concepts in biological psychiatry. We must accurately describe the phenomenon before we can arrive at a satisfying explanation. This is not a new agenda. It was principal aim of Karl Jaspers when he founded psychopathology as the basic science for psychiatry in the early 20th century (Broome 2013, Stanghellini and Fuchs 2013).

Section Outlines

The Handbook is divided into seven sections.

Section One – *History* – is edited by Anthony Vincent Fernandez and René Rosfort. This section includes intellectual biographies of leading figures of the phenomenological movement, including philosophers such as Husserl, Stein, Heidegger, Gadamer, Sartre, Beauvoir, Merleau-Ponty, Ricoeur, and Levinas, as well as psychiatrists and psychologists such as Jaspers, Binswanger, Boss, Fanon, Laing, Minkowski, Straus, Kretschmer, Tellenbach, Blankenburg, Kimura, Basaglia. This section provides a broad historical and intellectual background, which highlights two key points. First, it illustrates the variety of research methods and topics that fall under the label of 'phenomenology'. Second, it demonstrates that psychiatric and psychopathological research has had an intimate and fruitful relationship with philosophical phenomenology.

Section Two – *Foundations and Methods* – is edited by Anthony Vincent Fernandez and René Rosfort. Phenomenology is often characterized by its method or approach, rather than by its subject matter. However, whereas most phenomenologists agree that method is key to the identity of phenomenology, they rarely agree on what, exactly, phenomenology's methods are and should be. This situation is made even more complex when phenomenology is applied to interdisciplinary contexts, such as psychopathology. Once phenomenology enters into conversation with the needs of clinical practice and scientific, empirical approaches to psychiatric research, its methodological identity needs to be clarified and adapted. This section addresses these issues. First, it provides accounts of phenomenology's broad approach – including descriptive, transcendental, and hermeneutic methods – its subject matter, and its focus on the temporal and intersubjective aspects of experience, such as phenomenological notions of normality and abnormality. Second, it provides accounts of phenomenology's relationship with naturalism, the cognitive sciences, and introspective methods.

Section Three – *Key Concepts* – is edited by Matthew Broome and Giovanni Stanghellini. This Section includes the definition of key theoretical concepts, e.g. self, emotion, consciousness, unconscious, intentionality, personhood, values, embodiment, autonomy, alterity, *Beflindlichkeit*, time, moral conscience and explanation and understanding. The contributors show how the meanings of these terms came about through phenomenological work, and how they can be used in clinical and research settings. Each term is briefly defined in light of its use in the standard psychiatric, psychological, and neuroscience literature. Then each chapter offers some accounts of the ways phenomenologists have reconceived these notions. This section's main aim is to show how phenomenological reconceptualization of notions used in psychiatry, psychology and the sciences offers clarification and insight into what sometimes were previously ambiguous concepts.

Section Four – *Descriptive Psychopathology* – is edited by Andrea Raballo and Matthew Broome. This section includes an account of basic abnormal psychic phenomena Each chapter provides descriptions, definitions, and vignettes of a type of abnormal phenomenon. These areas of psychopathology include consciousness and its disorders, the experience of time and its disorders, disorders of attention, concentration, and memory, thought, speech, and language and associated disorders, affectivity and its disorders, selfhood and associated disorders, vital anxiety, phenomenal consciousness and hallucinations, disorders of bodily experience, catatonia, eating disorders, grief, gender dysphoria, the

psychopathology of hysteria, dissociation, conversion and somatisation, obsessions and phobias, and thought passivity.

Section Five – *Life-Worlds* – is edited by Giovanni Stanghellini and Anthony Vincent Fernandez. Whereas Section 3 deals with particular abnormal phenomena, this section takes a more holistic approach. With 'life-world' we mean the reality as it appears and is self-evident from the perspective of a given person. This approach provides accounts of how psychopathological phenomena are organized into a coherent gestalt, with core disturbances in one aspect of subjectivity motivating disturbances and alterations across the full scope of one's experience. As lived experience is always situated within the grounds of body, time, space and others, each kind of psychopathological life-world can be described through an investigation of each of these features of lived experience. This section includes the description of the life-worlds of persons affected by hysteria, phobias, and obsessions, borderline personality disorder, feeding and eating disorders, melancholia, mania, schizophrenia, and addictions.

Section Six – *Clinical Psychopathology* – is edited by Matthew Broome and Paolo Fusar-Poli. This Section includes chapters discussing the connection between symptoms and current categorical diagnosis in mainstream diagnostic manuals, and how phenomenological psychopathology may be able to improve this. The "phenomenological razor" is used to sharpen the clinician's capacity to establish a valid and reliable classification through symptom assessment. The associations between particular abnormal phenomena and particular kinds of life-worlds are also discussed, figuring out what kinds of life-worlds the patients inhabit when particular abnormal phenomena are expressed. Topics discussed in this section include first rank symptoms, schizophrenic delusions, paranoiac delusions, delusional mood, auditory-verbal hallucinations, affective temperaments, schizophrenic autism, dysphoria and borderline condition, psychosis high-risk, psychopathology and the law, the clinical significance of atmospheres, psychopathy, and trauma.

Section Seven – *Phenomenological Psychopathology: Present and Future* – is edited by Paolo Fusar-Poli and Matthew Broome. This Section demonstrates how phenomenological psychopathology can contribute to a variety of disciplines that are partially embedded in psychiatric knowledge and that deal with abnormal human subjectivity. And, reciprocally, it demonstrates how these disciplines can and should inform phenomenological investigations. The disciplines covered include neuroscience, the bodily self in phenomenology and neuroscience, qualitative research, quantitative research, psychotherapy, ethics, politics and society, clinician training, classification, clinical decision-making, psychoanalysis, autobiography, and neurodiversity.

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