JOURNAL OF PSYCHOPATHOLOGY, 20 (4), 345-479, 2014

PACINI EDITORE MEDICINA

Periodico trimestrale POSTE ITALIANE SPA - Spedizione in Abbonamento Postale - D.L. 353/2003 conv.in L.27/02/2004 n°46 art.1, comma 1, DCB PISA - Aut. Trib. di Pisa n. 9 del 03/06/95 - I.R.

ISSN 1592-1107

Official Journal of the Italian Society of Psychopathology
Organo Ufficiale della Società Italiana di Psicopatologia

JOURNAL OF PSYCHOPATHOLOGY

GIORNALE DI PSICOPATOLOGIA

Special Issue
Phenomenological psychopathology and clinical practice: resources for early career psychiatrists
Guest Editors: Giovanni Stanghellini, Valentina Ramella Cravaro

WWW.GIPSICOPATOL.IT

Volume 20 • December 2014 • Number 4

Founders: Giovanni B. Cassano, Paolo Pancheri

Cited in: EMBASE - Excerpta Medica Database • Index Copernicus • PsycINFO • SCOPUS • Google Scholar

PACINI EDITORE MEDICINA

Official Journal of the Italian Society of Psychopathology
Organo Ufficiale della Società Italiana di Psicopatologia

JOURNAL OF PSYCHOPATHOLOGY

GIORNALE DI PSICOPATOLOGIA

Managing Editor
Patrizia Alma Pacini

Editorial Assistant
Patrick Moore

Editing
Lucia Castelli
Pacini Editore S.p.A.
Via Gherardesca 1, 56121 Pisa
Tel. 050 3130224
Fax 050 3130300
lcastelli@pacinieditore.it
gipsicopatol@pacinieditore.it

Scientific Secretariat
Valentina Barberi
Pacini Editore S.p.A.
Via Gherardesca 1, 56121 Pisa
Tel. 050 3130243
Fax 050 3130300
journal@jpsychopathol.net
gipsicopatol@pacinieditore.it

Publisher
Pacini Editore S.p.A.
Via Gherardesca 1, 56121 Pisa
www.pacinimedicina.it

WWW.GIPSICOPATOL.IT

Volume 20 • December 2014 • Number 4

Founders: Giovanni B. Cassano, Paolo Pancheri

Cited in: EMBASE - Excerpta Medica Database • Index Copernicus • PsycINFO • SCOPUS • Google Scholar

PACINI EDITORE MEDICINA

Information for Authors including editorial standards for the preparation of manuscripts

The Journal of Psychopathology publishes contributions in the form of monographic articles, news, update articles in clinical psychopharmacology, forums in the field of psychiatry.
The material submitted should not have been previously published, and should not be under consideration (in whole or in part) elsewhere; it must conform with the regulations currently in force regarding research ethics. If an experiment on humans is described, a statement must be included that the work was performed in accordance with the principles of the 1983 Declaration of Helsinki. The Authors are solely responsible for the statements made in their paper, and must specify that consent has been obtained from patients taking part in the investigations and for the reproduction of any photographs. For studies performed on laboratory animals, the authors must state that the relevant national laws or institutional guidelines have been adhered to. Only papers that have been prepared in strict conformity with the editorial norms outlined herein will be considered for publication. Eventual acceptance is conditional upon a critical assessment by experts in the field, the implementation of any changes requested, and the final decision of the Editor. Conflict of Interests. In the letter accompanying the article, Authors must declare whether they obtained funds, or other forms of personal or institutional financing – or if they are under contract – from Companies whose products are mentioned in the article. This declaration will be treated by the Editor as confidential, and will not be sent to the referees. Accepted articles will be published accompanied by a suitable declaration, stating the source and nature of the financing.

General instructions
– *Online submission*: authors are requested to submit their manuscripts to: **www.jpsychopathol.net/journal**
Manuscripts should be accompanied by the "Permission form" downloadable from the website, signed by all authors to transfer the copyright.
– *Software and text*: please saving files in.DOC or in.RTF format.
– *Illustrations*: a) send pictures in separate files from text and tables; b) software and format: preferably send images in.TIFF or.JPEG or.PDF format, resolution at least 300 dpi (100 x 150 mm).

The text must be written in English. The paper must include:
1. **Title** (both in English and Italian);
2. **Summary (in English)** (Summary should be about 3000 typewritten characters (including spaces). It should be divided into 4 sections: Objectives, Methods, Results, Conclusions);
3. **A set of key words** (in English);
4. **Legends for tables and figures** (each figure and/or each table on separate pages, both in English and Italian);
5. **Authors are invited to suggest 3 national or international** referees for their article.

The *first page* of the manuscript must also contain the names of the Authors and the Institute or organisation to which each Author is affiliated; the category under which the Authors wish the work to be published (although the final decision rests with the Editor); the name, mailing address, and telephone and fax numbers of the Author to whom correspondence and the galley proofs should be sent.

Tables (in 3 copies) must be limited in number (the same data should not be presented twice, in both the text and tables), typewritten one to a page, and numbered consecutively with Roman numerals. In the text and legend to the tables, Authors must use, in the exact order, the following symbols:, †, ‡, ¶,, ††, ‡‡ …

Figures, please strictly follow the above-mentioned instructions.

The *references* must be limited to the most essential and relevant references, identified in the text by Arabic numbers in upper script and listed at the end of the manuscript in the order of mention. The first 3 Authors must be indicated, followed by et al. Journals should be cited according to the abbreviations set out by *Index Medicus*.
Examples of the correct format for bibliographic citations:
Journal articles:
Schatzberg AF, Samson JA, Bloomingdale KL, et al. *Toward a biochemical classification of depressive disorders, X: urinary catecholamines, their metabolites, and D-type scores in subgroups of depressive disorders.* Arch Gen Psychiatry 1989;46:260-8.
Books:
Kaplan HI, Sadock BJ. *Comprehensive textbook of Psychiatry.* Baltimore: Williams & Wilkins 1985.
Chapters from books or material from conference proceedings:
Cloninger CR. *Establishment of diagnostic validity in psychiatric illness: Robins and Guze's method revisited.* In: Robins LN, Barret JE, editors. *The validity of psychiatric diagnosis.* New York: Raven Press 1989, p.74-85.

Acknowledgements and the citation of any grants or other forms of financial support should be provided at the end of the paper, after the list of references.

Notes to the text, indicated by asterisks or similar symbols, should appear at the bottom of the relevant page.

Mathematical terms and formulae, abbreviations, and units of measure should conform to the standards set out in *Science* 1954;120:1078.

Drugs should be referred to by their chemical name; the commercial name should be used only when absolutely unavoidable (capitalizing the first letter of the product name and giving the name of the pharmaceutical firm manufacturing the drug, town and country).

Authors are required to correct and return galley proofs of their paper within 4 days of receipt.

Specific instructions for the various categories of papers:

1. Editorials: only upon invitation by the Editor-in-chief or the Editorial Board are brief discussions on general and practical aspects of topics of current interest. The text must not exceed 10 typewritten pages (2000 typewritten characters).

2. Original articles (which may also include invited articles). The text should be subdivided into the following sections: Introduction, Materials and methods, Results, and Discussion and Conclusions. The manuscript should not exceed 40.000 typewritten characters, including the summary, tables, figures and references (max 35). Summary should be no more than 3000/3500 typewritten characters (please strictly follow the above-mentioned instructions). In the Objective(s) section, the aim (or the aims) of the work must be clearly summarised (i.e., the hypothesis the Authors aim to verify); in the Method(s) section, the Authors must report the context of the study (i.e., general paediatrics, Hospital, Specialist Centre …), the number and the kind of subjects under analysis, the kind of treatment and of statistical analysis used. The Results section should refer to the results of the study and of the statistical analysis. In the Conclusion(s) section should report the significance of the results as related to clinical implications.

3. Brief articles: this space is dedicated to brief communications of clinical and experimental data and to preliminary data of ongoing research of particular interest. The manuscript should not exceed 20.000 typewritten characters, including the summary, tables, figures and references (max 10).

4. Case reports: brief articles (maximum 4000/4500 typewritten characters) in which clinical original experiences from medical practice are described.

5. Assessment and instruments in psychopathology. This section hosts articles on psychological and psychopathological assessment instruments aiming at improving knowledge of psychological functioning of those subjects with mental and behavior disorders in different reference models. The use of such instruments is not limited to clinical population but also includes non-clinical and general population. This section also accepts studies on validation and translation into Italian of instruments, new assessment instruments and competing studies of new assessment instruments with other procedures of assessment than psychopathological constructs. The manuscript should not exceed 40.000 typewritten characters, including the summary, tables, figures and references (max 35).

6. Clinical psychopharmacotherapy: articles reporting the latest developments in the area of drug therapy should be subdivided into the following sections: Introduction, Materials and Methods, Results, and Discussion and Conclusions. The text must not exceed 30.000 typewritten characters including the references, tables, figures, and summary (3000/3500 typewritten characters, excluding figure legends and table captions).

Subscriptions
The Journal of Psychopathology is published quarterly. Annual subscription: € 70,00 for Italy; € 85,00 for all other countries; € 30,00 for single issues (when available). All correspondence concerning subscriptions (including payments) should be addressed to:
Journal of Psychopathology, Pacini Editore S.p.A., Via Gherardesca 1, 56121 Pisa (Italy) – Tel. + 39 050 313011 – Fax + 39 050 3130300
abbonamenti@pacinieditore.it - www.pacinieditore.it

Printed by Pacini Editore - December 2014
Journal printed with total chlorine free paper and water varnishing

Informazioni per gli autori comprese le norme per la preparazione dei dattiloscritti

Il Giornale di Psicopatologia pubblica contributi redatti in forma di articoli di argomento monografico, news, articoli di aggiornamento in Psicofarmacologia clinica, forum, relativi a problemi di natura psichiatrica. I contributi devono essere inediti, non sottoposti contemporaneamente ad altra rivista, ed il loro contenuto conforme alla legislazione vigente in materia di etica della ricerca.
Etica della ricerca. In caso di sperimentazioni sull'uomo, gli Autori devono attestare che tali sperimentazioni sono state eseguite previa approvazione del Comitato Etico locale ed in accordo ai principi riportati nella Dichiarazione di Helsinki (1983); gli Autori sono gli unici responsabili delle affermazioni contenute nell'articolo e sono tenuti a dichiarare di aver ottenuto il consenso informato per la sperimentazione e per l'eventuale riproduzione di immagini. Per studi su cavie animali, gli Autori sono invitati a dichiarare che sono state rispettate le relative leggi nazionali e le linee guida istituzionali.
La Redazione accoglie solo i testi conformi alle norme editoriali generali e specifiche per le singole rubriche. La loro accettazione è subordinata alla revisione critica di esperti, all'esecuzione di eventuali modifiche richieste ed al parere conclusivo del Direttore.
Conflitto di interessi. Gli Autori devono dichiarare se hanno ricevuto finanziamenti o se hanno in atto contratti o altre forme di finanziamento, personali o istituzionali, con Aziende i cui prodotti sono citati nel testo. Questa dichiarazione verrà trattata dal Direttore come una informazione riservata e non verrà inoltrata ai revisori. I lavori accettati verranno pubblicati con l'accompagnamento di una dichiarazione *ad hoc*, allo scopo di rendere nota la fonte e la natura del finanziamento.

Norme generali per gli Autori
– *Registrazione degli articoli online*: gli autori sono invitati a registrarsi sul sito **www.jpsychopathol.net/journal** per la sottomissione dei lavori.
I manoscritti devono essere accompagnati dal modulo "Permission form" scaricabile dal sito, firmato da tutti gli autori per trasferire i diritti d'autore.
– *Software*: testo in formato.DOC o.RTF.
– *Illustrazioni:* a) inviare le immagini in file separati dal testo e dalle tabelle; b) software e formato: inviare immagini preferibilmente in formato TIFF o JPG o PDF, con risoluzione minima di 300 dpi e formato di 100 x 150 mm.

Il testo deve essere in lingua inglese e deve contenere:
1. **titolo del lavoro** (in inglese e in italiano);
2. **summary** (in inglese) (il summary deve essere costituito da circa 3000 battute (spazi inclusi). È richiesta la suddivisione nelle seguenti 4 sezioni: Objectives, Methods, Results, Conclusions);
3. **key words** (in inglese);
4. **didascalie delle tabelle e delle figure** (in inglese e in italiano);
5. **indicare l'indirizzo di 3 potenziali referee nazionali o internazionali** per gli articoli.

Nella *prima pagina* del file devono comparire anche i nomi degli Autori e l'Istituto o Ente di appartenenza; la rubrica cui si intende destinare il lavoro (decisione che è comunque subordinata al giudizio del Direttore); il nome, l'indirizzo, il recapito telefonico e l'indirizzo e-mail dell'Autore cui sono destinate la corrispondenza e le bozze.

Tabelle: devono essere contenute nel numero (evitando di presentare lo stesso dato in più forme), dattiloscritte una per pagina e numerate progressivamente con numerazione romana. Nel testo della tabella e nella legenda utilizzare, nell'ordine di seguito riportato, i seguenti simboli:, †, ‡, §, ¶,, ††, ‡‡...

Figure: per l'invio delle figure attenersi strettamente alle indicazioni sopra elencate.

Bibliografia: va limitata alle voci essenziali identificate nel testo con numeri arabi ed elencate al termine del manoscritto nell'ordine in cui sono state citate. Devono essere riportati i primi 3 Autori, eventualmente seguiti da et al. Le riviste devono essere citate secondo le abbreviazioni riportate su *Index Medicus*.
Esempi di corretta citazione bibliografica per:
articoli e riviste:
Schatzberg AF, Samson JA, Bloomingdale KL, et al. *Toward a biochemical classification of depressive disorders, X: urinary catecholamines, their metabolites, and D-type scores in subgroups of depressive disorders.* Arch Gen Psychiatry 1989;46:260-8.
libri:
Kaplan HI, Sadock BJ. *Comprehensive textbook of Psychiatry*. Baltimore: Williams & Wilkins 1985.
capitoli di libri o atti di Congressi:
Cloninger CR. *Establishment of diagnostic validity in psychiatric illness: Robins and Guze's method revisited*. In: Robins LN, Barret JE, editors. *The validity of psychiatric diagnosis*. New York: Raven Press 1989, pp. 74-85.

Ringraziamenti, indicazioni di grant o borse di studio, vanno citati al termine della bibliografia.

Le *note*, contraddistinte da asterischi o simboli equivalenti, compariranno nel testo, a piè di pagina.

Termini matematici, formule, abbreviazioni, unità e misure devono conformarsi agli standard riportati in Science 1954;120:1078.

I *farmaci* vanno indicati col nome chimico. Solo se inevitabile potranno essere citati col nome commerciale (scrivendo in maiuscolo la lettera iniziale del prodotto e inserendo il nome della relativa casa farmaceutica, la città e il paese di appartenenza).

Agli Autori è riservata la correzione ed il rinvio (entro e non oltre 4 gg. dal ricevimento) delle sole prime bozze del lavoro.

Norme specifiche per le singole rubriche

1. Editoriali: sono intesi come considerazioni generali e pratiche su temi d'attualità, su invito del Direttore o dei componenti il Comitato. Per il testo sono previste massimo 10 cartelle da 2000 battute.

2. Articoli originali: possono anche essere commissionati dal Direttore. Devono essere suddivisi nelle seguenti parti: Introduction, Materials and methods, Results, and Discussion and Conclusions. Di regola non devono superare i 40.000 caratteri spazi inclusi, compresi summary, tabelle, figure e voci bibliografiche (massimo 35 voci). Legenda di tabelle e figure sono a parte. Il summary deve essere costituito da almeno 3000/3500 battute (spazi inclusi; attenersi strettamente alle indicazioni sopra elencate). Nella sezione Objectives va sintetizzato con chiarezza l'obiettivo (o gli obiettivi) del lavoro, vale a dire l'ipotesi che si è inteso verificare; nei Methods va riportato il contesto in cui si è svolto lo studio (struttura ospedaliera, centro specialistico …), il numero e il tipo di soggetti analizzati, il disegno dello studio (randomizzato, in doppio cieco …), il tipo di trattamento e il tipo di analisi statistica impiegata. Nella sezione Results vanno riportati i risultati dello studio e dell'analisi statistica. Nella sezione Conclusions va riportato il significato dei risultati soprattutto in funzione delle implicazioni cliniche.

3. Articoli brevi: questo spazio è riservato a brevi comunicazioni relative a dati clinico-sperimentali e a dati preliminari di ricerche in corso di particolare interesse. Il testo non dovrà superare i 20.000 caratteri spazi inclusi comprese tabelle e/o figure e una decina di voci bibliografiche.

4. Casi clinici: comprendono lavori brevi (massimo due cartelle) nei quali vengono descritte esperienze cliniche originali tratte dalla propria pratica medica.

5. Valutazione e strumenti in psicopatologia: la rubrica ospita articoli relativi all'impiego di strumenti di valutazione psicologica e psicopatologica che abbiano un impatto sul miglioramento delle conoscenze del funzionamento psicologico delle persone affette da disturbi mentali ed alterazione del comportamento all'interno di differenti modelli di riferimento. L'impiego degli strumenti non si limita alle popolazioni cliniche ma comprende anche le popolazioni non cliniche e la popolazione generale. La rubrica accetta studi relativi a traduzioni e validazioni di strumenti in lingua italiana, nuovi strumenti di valutazione e studi concorrenti di nuovi strumenti di valutazione con altre modalità di valutazione di costrutti psicopatologici. Di regola non devono superare i 40.000 caratteri spazi inclusi, compresi summary, tabelle, figure e voci bibliografiche (massimo 35 voci).

6. Psicofarmacoterapia clinica: comprendono lavori che trattano delle ultime novità in tema di terapia. Devono essere suddivisi nelle seguenti parti: introduzione, materiale e metodi, risultati, discussione e conclusioni. Il testo non dovrebbe superare i 30.000 caratteri spazi inclusi comprese iconografia, bibliografia e summary (max 3000-3500 caratteri spazi inclusi). Legenda di tabelle e figure a parte.

Abbonamenti
Il Giornale di Psicopatologia è trimestrale. I prezzi dell'abbonamento annuale sono i seguenti: Italia: personale e istituzionale € 70,00; estero € 85,00. Singolo fascicolo € 30,00.
Le richieste di abbonamento e ogni altra corrispondenza relativa agli abbonamenti vanno indirizzate a:
Giornale di Psicopatologia, Pacini Editore S.p.A., Via Gherardesca 1, 56121 Pisa – Tel. 050 313011 – Fax 050 3130300
abbonamenti@pacinieditore.it – www.pacinimedicina.it

Finito di stampare presso le Industrie Grafiche della Pacini Editore SpA, Pisa - Dicembre 2014
Rivista stampata su carta TCF (Total Chlorine Free) e verniciata idro

Special Issue

Phenomenological psychopathology and clinical practice: resources for early career psychiatrists

Guest Editors: *Giovanni Stanghellini, Valentina Ramella Cravaro*

Introduction

1. Phenomenological psychopathology as a core science for psychiatry

2. Psycopathology of mood disorders

3. Psychopathology of schizophrenias

4. Psychopathology of the present

The phenomenological dissection in psychopathology

Phenomenological psychopathology and the identity of the psychiatrist

Who is a psychiatrist? What is the objective and purpose of psychiatry? What formation process and body of knowledge is needed to become a good clinician of the psyche? What is the role of psychopathology in psychiatry and what can young psychiatrists learn from it today? The purpose of this Special Issue is to try to answer these questions by analysing the theoretical, empirical, clinical and therapeutic aspects of psychopathology.

The nosographic revolution, triggered by the development of DSMs and ICDs, led to significant changes with the aim of organising the chaotic world of mental illness diagnoses and providing a scientific point of view to psychiatry within the medical field, which until then was considered a fringe medical specialty. The two main operational changes were the introduction of a simple, descriptive and "atheoretical" approach with homogeneous diagnostic criteria, and the development of assessment instruments that could simplify the diagnostic process. The objectivism and physicalism of this revolution were also fostered by the expanding perspectives of neurobiological research and treatment. What could not be foreseen at that time was that progresses in neurobiology have not improved purely clinical-descriptive diagnostic systems. Moreover, the hope for easy-to-use, reliable categorical diagnostic systems gradually replaced psychopathological manuals, and diagnostic criteria became the simplistic picture of the mental illnesses. The entire body of psychopathological knowledge was shelved as if it could hinder the newly-born operational revolution.

The early career psychiatrists of today, as sons of the "DSM-ICD generation", are training in this milieu where psychiatry is more morbus-oriented than person-oriented [1]. This was an ideological shift that affected both the What (ontology) and How (epistemology) related to mental illnesses [2]. The ontological level has been affected since the psychiatric object is supposed to be more subordinate to symptomatic, physical and biological parameters than to subjectivity and singular human experience. In this sense, symptomatological phenotypes have become the main object of psychiatric study thanks to their reliable, measurable and easy-to-assess nature. Moreover, in order to explain narrower symptomatological phenotypes of a mental disorder, the concept of endophenotype has been introduced – namely the upstream manifestation (neurophysiological, biochemical, endocrinological, neuroanatomical, cognitive or behavioural measures) of a smaller genotype than the whole disease-related genotype [3]. However, a simply symptomatic evaluation cannot explain or grasp the psychopathological phenotype [4]. Indeed, from a psychopathological viewpoint, mental illnesses are experiential anomalies of one's own self/body, of time/space and of otherness that produce abnormal, dysfunctional cognitions and/or behaviours [5]. Hence, symptoms are not accidental to the patient, but rather the manifestation of some implicit subjective dimension; the patient is not a passive casualty of the illness, and on the contrary he has an active role as a self-interpreting agent or goal-directed being in dealing with his abnormal experiences. Cognitions or behaviours are not pathological per se, but in the light of personal history, social situation and cultural context - and this is particularly true in the increasingly multicultural society where we live. What the patient manifests is not a series of mutually independent symptoms, but certain meaning-structures permeated by biographical details [6]. Moreover, the concept of comorbidity brought about by the DSM and ICD discourages seeing the manifold of symptoms displayed by a patient as a meaningful and coherent whole leading to the disaggregation of the structural unity of the patient's personal existence. The mushrooming of comorbid multiple diagnoses undermines the conceptual basis and the credibility of current classification systems.

Furthermore, as already mentioned, the epistemological level has been affected in several ways. Structured interviews were built in order to explore those symptoms that are relevant to establish a specific diagnosis. 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. This approach makes use of a stimulus-response pattern of questions designed to elicit "relevant" answers with the risk of getting not the whole picture, but a "tunnel vision" of the

patient's manifold of abnormal phenomena. This type of interview weakens the intimacy of the relationship, presumes shared meanings between the interviewer and interviewee and gives the interviewer an excessive dominant role over the patient. Furthermore, because of the polysemous nature of psychiatric vocabulary, the technical approach to psychiatric diagnosis underestimates the need to clarify the subjective meaning of the terms with which patients and clinicians refer to abnormal mental phenomena (how can a word aptly express the proper meaning of a mental state?). In the psychopathological perspective, the context of the clinical encounter should be one of co-presence with the aim of understanding and not labelling [7]. This approach is also relevant to rescue abnormal marginal phenomena, not usually covered by standard assessment procedures, which nonetheless are part and piece of a mental picture, not to mention a disturbed form of existence.

The aim of good psychopathological assessment is to reconstruct the subjective experience of a patient and the lived world in which it is embedded. Its underlying tools are empathy and narratization. Empathy is the internal actualization of the other's experience, a special kind of immediate resonance (feeling with) between one person and another [8]. The empathic approach makes the interviewer a participant observer and implies a balanced relationship with the interviewed. Narratization, rather than stimulus-response interviews, allow the patient to communicate and explain their own experiences in their own terms, to posit them in the context of their personal world and history, and to try to make sense of them [9 10].

This is not to speak out against the neurosciences or to praise psychopathology, but only to give psychopathology its proper place [11]. Controversies between radical advocates of the biomedical status of psychiatry and strong supporters of its belonging to the humanities is abstract and sterile. A pathology of the psyche can have clear biological causes, but this does not make it a simple natural entity. The question is that in psychiatry, more than in any other specialty, both scientific and humanistic contributions are necessary, and psychopathology can be seen as the bridge between these two approaches [12 13]. This concept was already hoped for in the early 20th century by Karl Jaspers, the founder of psychopathology as the basic science for psychiatry. His masterpiece – General Psychopathology – first published 100 years ago, was the first systematic attempt to classify abnormal mental phenomena and became the most secure basis to establish valid and reliable diagnosis [14]. As the science of abnormal subjectivity, psychopathology relies both on explanation that allows the formulation of general rules by observing events, experimenting and collecting numerous examples, and on understanding the achievable only by sinking oneself into a singular situation. From the psychopathological perspective, mental illness is conceptualized as the outcome of mediation between a vulnerable self and the person that tries to cope with and make sense of the disturbances that arise from it. Symptoms are not only the direct outcomes of anomalous brain events, but are generated by the interplay between abnormal basic phenomena that have a neurobiological background and the patient's coping and meaning strategies. In this sense, as neurophysiological, biochemical, endocrinological, neuroanatomical, cognitive, or behavioural measures (endophenotypes) could improve the understanding of mental disorders [3], phenomenal (i.e., experiential) traits and constructs (pheno-phenotypes) could also occupy the terrain between symptoms and genetics, leaving room to subjectivity as the primary object of inquiry [4]. The method of 'phenomenological dissection' may prove useful on both theoretical and clinical grounds. The pheno-phenomenological level could be helpful to establish clear-cut syndromic categories that can be studied in neuroscientific terms (e.g. delusion is a very heterogeneous category that must be split into more specific sub-categories in order to successfully look for its neurobiological correlates). In addition, the use of the 'phenomenological razor' is of great help in sorting out "psychopathological receptors" since for successful therapeutic decision-making phenomenological fine-grained characterization of abnormal phenomena as targets of pharmacological treatment is needed [15 16] (e.g. so-called "social phobia" cannot be a valid category for drug prescription as it may arise from a suspicious attitude, or from a melancholic self-blame, or in the context of an anxiety disorder).

Phenomenological psychopathology as the core science for psychiatry

All these questions are developed in the first part of this Issue on *Phenomenological psychopathology as a core science for psychiatry*.

This sections opens with a paper on the phenomenology of atmospheres [17]. The technical approach to the psychiatric interview is blind to essential aspects of the clinical encounter. It is this same objectifying intention that compromises the attention needed to notice the aesthetic properties of the clinical encounter and restricts linguistic contexts risking tautology. Atmospheres are examples of such phenomena that should be salvaged to allow in-depth psychopathological assessment. The authors of this paper clinical also explicate the relevance of tact in sensing atmospheres and the role of metaphors in articulating them. They argue that by bringing aesthetics into the clinical encounter

we may achieve an understanding of the meaning of a clinical situation as felt, rather than simply assessing objective signs and symptoms.

The following paper touches on the relationship between phenomenological psychopathology and the neurosciences [18]. It starts with a discussion of Jaspers' idea of unity and strong interdependence between soma and psyche, and then passes to subsequent and recent suggestions to naturalize phenomenology relating the subjective experience of the world to brain functions, and to phenomenologize neurosciences driving scientific research of the human mind with basic philosophical principles.

The third paper is about phenomenological psychopathology and causal explanation [19]. The author argues that a commonly held view – namely, that psychopathological phenomenology is relevant only to description and not to explanation – is inaccurate. The phenomenological approach (focusing on the subjective life of the patient) is relevant to empirical science, and this relevance includes causal explanation of mental disorders. It develops a deep analysis of ambiguities and controversies pertaining to the notions of description, explanation, understanding and causality (with the particular example of schizophrenia). Phenomenology can help to "explain" in several senses of that term, by showing how prima facie distinct symptoms may actually be mutually interdependent (sometimes called 'implicative' relationship), or can help one to grasp how one phenomenon might lead into another, or motivate it, etc.

The last paper of this Section overviews the current European situation of psychopathologic training based on an online interview addressed to 41 early career psychiatrists' who are representatives of their national associations. Young psychiatrists recognize that psychopathology is a core part of the psychiatric curriculum, although the quality and quantity of the training they received was not satisfying, and emphasize the capacity of psychopathological education to re-humanize psychiatric practice [20].

Phenomenological psychopathology of mood disorders

Section Two starts with the explanation of what emotions are and why they are so relevant in psychiatry [21]. Emotions disclose an inescapable fragility at the heart of our identity and our vulnerability to mental illness. This paper proposes and discusses the definition of 'emotion' as feeling motivation to move, the distinction between "affect" and "mood" according to their intentional structure, and the dialectics between affects and moods. The authors propose a model constructed upon the theoretical assumption that the fragility characterizing human personhood stems from the dialectics of selfhood and otherness at the core of being a person, and that moods are one of the most conspicuous epiphanies of otherness in human life. These dialectics become particularly evident in the way our moods challenge our sense of personal identity due to the way it complicates our relation to the norms and values.

The second paper of this Section illustrates an exemplary phenomenological prototype of vulnerable structure to mood disorders, and specifically to melancholia (a particular type of major depressive disorder characterized by lack of vital drive, guilt and affective depersonalisation) [22]. The melancholic type of personality is a clear example of the tight interrelation between personality and mood disorder. This is a personality structure characterised by tight interpersonal commitments, that is, the need for order in interpersonal relationships and the avoidance of guilt feelings achieved through extreme norm adaptation and identification with one's own social role. The author also discusses the metamorphosis of this personality structure in late modern society, in which the personal ethos is more guided by "I can's" than by "I have's".

The following two papers investigate in great detail the phenomenology of mood disorders. The first describes, next to depressive symptoms per se, the life-world of persons affected by depression and mania [23]. The parameters of this phenomenological dissection of mood disorders – which the reader will find in the majority of clinical papers in this Issue – are the existential structures of the life-worlds. The utility is to produce a systematic description of subtle and often elusive changes in the person's subjective experience and to reconstruct the ontological framework within which they are generated. The experience of time, space, body, self and others, and their modifications, are the guidelines to this dissection whose aim is to enlarge our awareness of the life-world people affected by mental disorders, understand their behaviour and experiences, refine diagnostic criteria and establish homogenous categories for treatment and aetiological research.

The next paper examines recent phenomenological research on both depressive and manic episodes [24]. The author argues that depression and mania cannot be characterised by any particular mood (e.g. sadness, hopelessness, guilt or euphoria, grandiosity or irritability), but instead as a change in the way we "have" moods. Thus, if we conceive of the affective dimension as a decrease or an increase in the degree to which one is situated in and attuned to the world through moods, then the particular mood one finds oneself in is simply irrelevant to a diagnosis of either depression or mania. This analysis is applied to so-called "mixed states", showing how phenomenologically oriented studies can

help overcome the apparently paradoxical nature of this psychopathological condition.

Phenomenological psychopathology of schizophrenia

The first contribution in this Section contains a detailed account of the schizophrenic life-world [25]. It gives a panoramic view of the way schizophrenic patients live their life as embodied persons and how they understand the existence of other people. To this end, lived time, space, body, selfhood and otherness are used as the principal descriptors of the transformation these patients undergo. The authors propose that the phenomenon of fragmentation, which is the loss of a coherent Gestalt of experience, is the best candidate as the core feature of schizophrenia spectrum disorders that runs through the manifold of schizophrenic abnormal phenomena, also affecting self-world related and inter esse. Fragmentation appears to be a basic feature of lived time, as well as space, body and selfhood. This suggests the crisis of the synthetic function of consciousness, that is, of the temporal unity of consciousness, may be at the basis of characteristics of "disarticulation", distinctive of the schizophrenic world.

The second paper in this Section widely discusses the self-disorder hypothesis of schizophrenia, a cutting-edge model of the psychopathology and pathogenesis of schizophrenia [26]. Schizophrenia is interpreted as a disorder of the pre-reflexive self, i.e. a pervasive perturbation of the core sense of self that is normally implicit in each act of awareness. Such a core sense of self refers to a crucial sense of self-sameness, of existing as a unified, unique and embodied subject of experience that is at one with oneself at any given moment. When this basic sense of self is disturbed, the person is inclined to experience both a kind of exaggerated self-consciousness and a concomitant fading in the tacit, pre-verbal feeling of existing as a living and unified subject of awareness (diminished self-affection). This paper gives special attention to the notion of anomalous self-experience and disordered-self with rich clinical descriptions, stressing how the instability of the first-person perspective threatens the most basic experience of being a subject of awareness and action.

The third paper focuses on the pathogenesis and early detection of schizophrenia [27]. Although the developmental nature of the disease and the subclinical prodromal phase have always been recognized, clinical management conventionally begins only at the time of the first frank psychotic episode. Nevertheless, during the last 20 years, the early phases of psychotic disorders have become one of the major clinical and research issues in psychiatric settings because of their importance in defining markers of risk for progression to psychotic illness and in investigating new biological and psychological treatments to prevent a transition to psychosis with the ultimate purpose of improving long term outcomes by reducing the duration of untreated illness. The "at-risk mental state" concept as well as the two main approaches to the early psychosis question are analysed: the ultra high risk approach (UHR) and the basic symptoms (BS) approach, each with its assessing instruments. Besides these, the "anomalous self-experience" (ASE) concept is also analysed and a tentative integration between the UHR, BS and ASE approaches is developed. In closing, the authors describe the clinical staging model and the advantages that it may bring in early psychosis from both clinic and research standpoints.

Phenomenological psychopathology of the present

The fourth and last part is about three psychopathological conditions that, until now, have received relatively little attention by clinical phenomenologists compared to the areas of mood disorders and schizophrenia: borderline personality disorder, eating disorders and addictions.

As is well-known, borderline personality disorder is a highly variegated clinical area in which we encounter particularly difficult patients who, subject to "emotional dysregulation" and tendency to impulsive action, cause much distress to clinicians and health workers committed to their treatment. The contribution of psychopathology becomes essential whenever it allows the clinician to move from the level of the symptoms to that of lived experience [28]. When this shift is not attempted, the clinician remains trapped by the triad of stigmatisation, intractability and chronicity. To ask "What is like to be a person with borderline personality disorder" means, for example, to identify the characteristics of a perpetually dysphoric mood condition that forces the subject to look for ways to quickly reduce such an uncomfortable state. Psychopathology allows us to shed some light on the dynamics of dysphoric mood and the transformation of dysphoria into anger: such knowledge can also help reduce the risk of an emotional mirror-involvement in the clinician.

Eating disorders represent another example of widespread contemporary conditions [29]. There is general agreement on considering behavioural anomalies as secondary epiphenomena to a more profound psychopathological core, defined by excessive concerns about body shape and weight. Body image disturbances have been associated with a more profound subjective alteration consisting in disorders of the way patients experience their own body and shape their personal identity. In a phenomenological perspective, the core dimension

of eating disorders also encompasses the subjective perception of space and time. Several behaviours and cognitive distortion can be derived from the metamorphosis in lived body, space and time. As an example, the subjective perception of time in eating disorder patients appears to be connected with the temporal discontinuity of the representation of one's own body, and the need of predictability of one's own life, which is achieved/failed according with the control of eating and weight. The psychopathological core, rather than behavioural abnormalities, plays a crucial role in the onset and persistence of the disorders (some authors pointed out that the threshold to define the full recovery process might be body shame, appearance schemas and thin-ideal internalisation). Therefore, these may be fruitful targets of intervention among those on a recovery trajectory.

The last paper examines the "being-in-the-world" of addicted patients [30]. First of all, there is the need to distinguish different forms of addictions as each is characterised by typical symptoms and a characteristic form of life-world. As an example, persons with polyabuse of novel psychoactive substances develop radically different forms of psychoses compared with 'old' heroin addicts. Novel psychoactive substances lead to "synthetic psychoses" – a very rich psychotic state comparable to paraphrenia with mental automatism, chronic hallucinations and secondary (interpretative) delusions. As each drug may produce a distinct psychopathological syndrome and life-world, a consequence of polyabuse is that patients, after have "travelled" so many abnormal and uncanny "landscapes", may become unable to stay in a "space-with-others" and to project themselves in a stable identity time. The result of this time/space cleavage is emptiness, an existential condition that is very difficult to treat and characterised by high drop-out rates. The author describes a potential resource to treat these patients called Dasein's group analysis, an original interpretation of Binswanger's Daseinanalysis aimed to "reanimate" these emotionally "frozen" patients.

G. Stanghellini[1], V. Ramella Cravaro[2]

[1] "G. d'Annunzio" University, Chieti, Italy; "D. Portales" University, Santiago, Chile; [2] Department of Neuroscience, Psychology, Drug Research and Child Health. University of Florence, Italy

References

1 Stanghellini G. *The portrait of the psychiatrist as a globally minded citizen*. Curr Opin Psychiatry 2013;26:498-501.

2 Parnas J, Sass LA, Zahavi D. *Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object*. Schizophr Bull 2013;39:270-7.

3 Klosterkotter J. *The clinical staging and the endophenotype approach as an integrative future perspective for psychiatry*. World Psychiatry 2008;7:159-60.

4 Stanghellini G, Rossi R. *Pheno-phenotypes: a holistic approach to the psychopathology of schizophrenia*. Current opinion in psychiatry. Curr Opin Psychiatry 2014;27:236-41.

5 Parnas J, Sass LA, et al. *Phenomenology and psychopathology*. Philos Psychiatr Psychol 2011;18:37-9.

6 Stanghellini G, Bolton D, et al. *Person-centered psychopathology of schizophrenia: building on Karl Jaspers' understanding of patient's attitude toward his illness*. Schizophr Bull 2013;39:287-94.

7 Stanghellini G. *The grammar of the psychiatric interview. A plea for the second-person mode of understanding*. Psychopathology 2007;40:69-74.

8 Stanghellini G. *De-stigmatising manipulation: an exercise in second-order empathic understanding*. SAJP-S Afr J Psychi 2014;20:11-4.

9 Stanghellini G. *Philosophical resources for the psychiatric interview*. In: Fulford KWM, Davies M, Gipps R, et al., editors. *The Oxford Handbook of Philosophy and Psychiatry*. Oxford University Press 2013, pp. 321-55.

10 Stanghellini G. *The puzzle of the psychiatric interview*. J Phenomenol Psychol 2004;35:173-95.

11 Stanghellini G. *Psychopathology: re-humanizing psychiatry*. Acta Psychiatr Scand 2013;127:436-7.

12 Ratcliffe M. *Phenomenology is not a servant of science*. Philos Psychiatr Psychol 2011;18:33-6.

13 Stanghellini G. *Psychopathology: an agenda for psychiatry*. Acta Psychiatr Scand 2013: 1-2 DOI: 10.1111/acps.12180.

14 Jaspers K. *Allgemeine psychopathologie* Berlin: Springer 1946.

15 Stanghellini G, Fusar-Poli P. *The vulnerability to schizophrenia mainstream research paradigms and phenomenological directions*. Curr Pharm Des 2012;18:338-45.

16 Stanghellini G, Raballo A. *Differential typology of delusions in major depression and schizophrenia. A critique to the unitary concept of "psychosis"*. J Affect Disord 2015;171C:171-8.

17 Costa C, Carmenates S, Madeira L, et al. *Phenomenology of atmospheres: the felt meanings of clinical encounters*. Journal of Psychopathology 2014;20;351-7.

18 Catone G, Lindau JF, Broome M. *Phenomenological psychopathology and the neurosciences*. Journal of Psychopathology 2014;20;358-65.

19 Sass LA. *Explanation and description in phenomenological psychopatology*. Journal of Psychopathology 2014;20;366-76.

20 Sampogna G, Del Vecchio V, Luciano M, et al. *Training in psychopathology in Europe: are we doing well? A survey among early career psychiatrists*. Journal of Psychopathology 2014;20;377-80.

21 Rosfort R, Stanghellini G. *How do you feel? Why emotions matter in psychiatry*. Journal of Psychopathology 2014;20;381-92.

22 Ambrosini A, Raballo A, Stanghellini G. *Temperament, per-*

sonality and the vulnerability to mood disorders. The case of the melancholic type of personality. Journal of Psychopathology 2014;20;393-403.

23 Fuchs T. *Psychopathology of depression and mania: symptoms, phenomena and syndromes*. Journal of Psychopathology 2014;20;404-13.

24 Fernandez AV. *Reconsidering the affective dimension of depression and mania: towards a phenomenological dissolution of the paradox of mixed states*. Journal of Psychopathology 2014;20;414-22.

25 Mancini M, Presenza S, Di Bernardo L, et al. *The life world of persons with schizophrenia. A panoramic view*. Journal of Psychopathology 2014;20;424-34.

26 Henriksen MG, Nordgaard J, Parnas J. *Schizophrenia as a disorder of the self*. Journal of Psychopathology 2014;20;435-41.

27 Ramella Cravaro V, Raballo A. *Early detection of schizophrenia: a clinical-psychopathological revision of the ultra-high risk approach*. Journal of Psychopathology 2014;20;442-50.

28 Rossi Monti M, D'Agostino A. *Borderline personality disorder from a psychopathological-dynamic perspective*. Journal of Psychopathology 2014;20;451-60.

29 Castellini G, Trisolini F, Ricca V. *Psychopathology of eating disorders*". Journal of Psychopathology 2014;20;461-70.

30 Di Petta G. *Psychopathology of addictions*. Journal of Psychopathology 2014;20;471-84.

Phenomenology of atmospheres. The felt meanings of clinical encounters

C. Costa[1], S. Carmenates[2], L. Madeira[2,3], G. Stanghellini[4,5]

[1] Centro Hospitalar Psiquiátrico de Lisboa, Portugal; [2] Department of Psychiatry, Hospital de Santa Maria, Centro Hospitalar Lisboa Norte, EPE, Portugal; [3] College of Medicine University of Lisbon, Portugal; [4] "G. d'Annunzio" University of Chieti, Italy; [5] "D. Portales" University of Santiago, Chile

Summary

Operational criteria and structured interviews had a positive impact on psychiatry as they contributed to cleanse the profoundly unscientific and irrational attitude towards systematic assessment and diagnosis. The technical approach to the psychiatric interview focuses on the search for specific symptoms. Yet, it is blind to the essential aspects of the clinical encounter. Subjective and intersubjective features are dismissed even if they have psychopathological meaning. It is this same objectifying intention that compromises the attention needed to notice the aesthetic properties of the clinical encounter and restricts linguistic contexts risking tautology. Atmospheres are examples of such phenomena that should be salvaged to allow in-depth psychopathological assessment. In this paper, we focus on a phenomenological definition of '"atmospheres". First, we review the ontological polarities that make this phenomenon so difficult to be grasped conceptually. Next, we describe the clinical encounter as an aesthetic experience and explicate the relevance of the role of tact in sensing atmospheres and the role of metaphors in articulating them. Herein resides the need to bring aesthetics into the clinical encounter: one must dodge scientific rationalism in order to preserve the phenomenological understanding and achieve an understanding of the meaning of a clinical situation as felt, rather than simply assessing objective signs and symptoms.

Key words

Aesthetics • Atmosphere • Diagnosis • Interview • Phenomenology • Understanding

"What was it – I paused to think – what was it that so unnerved me in the contemplation of the House of Usher? It was a mystery all insoluble; nor could I grapple with the shadowy fancies that crowded upon me as I pondered. I was forced to fall back upon the unsatisfactory conclusion that while, beyond doubt, there are combinations of very simple natural objects which have the power of thus affecting us, still the analysis of this power lies among considerations beyond our depth. It was possible, I reflected, that a mere different arrangement of the particulars of the scene, of the details of the picture, would be sufficient to modify, or perhaps to annihilate its capacity for sorrowful impression".

Edgar Poe, The Fall Of The House Of Usher

Introduction

The concept of atmosphere has been extensively addressed in philosophy, particularly in the field of aesthetics. Until recently, its use in psychiatry has been restricted to some heretic contributions that have few implications in today's diagnostic systems and interview methods. These only assess psychopathological elements in the third person perspective, which has been shown to be insufficient in clarifying the personal meaning of being mentally ill. Subjective and intersubjective features are dismissed in standard psychiatric interviewing even if they seem to have psychopathological meaning. Atmospheres are examples of such phenomena that should be salvaged to allow in-depth psychopathological assessment. The technical approach to psychiatric interviewing is based on a rationalistic paradigm that is classificatory and explanative in nature as its main aims are to establish diagnosis and look for the causes of a given disordered mental state. The conceptual haziness that clouds the idea of atmosphere is claimed as good enough reason for its exclusion from scientific paradigms and clinical diagnosis. Yet, the power to appreciate atmospheres may disclose territories of psychopathological understanding that would otherwise remain off-limits. This power, as we will show herein, is based on the capacity to achieve an understanding of the *meaning* of a clinical situation as *felt*, that is, on *knowing through feelings*, rather than simply assessing objective signs and symptoms.

Correspondence
Cristina Costa, Centro Hospitalar Psiquiátrico de Lisboa, Portugal • E-mail: crismdcosta@hotmail.com.

Towards the definition of atmosphere: ontological polarities of atmospheres

We begin by reviewing some etymological precepts that are the foundations of the word atmosphere. Next, we will expose its ontology by going through the same polarities that make us doubt its true existence. These include subjective *vs*. objective, permanent *vs*. transitory, pre-reflexive *vs*. reflexive and passivity *vs*. activity.

The etymology of the word atmosphere can be traced to the Greek *atmos* "vapour, steam" and *spharia*, "sphere". The Greek *atmos* derives from the proto Indo-European *awet-mo-*, from base *wet* – "to blow, inspire, spiritually arouse". In everyday language, the word atmosphere is used interchangeably with mood, feeling, ambience, tone and other ways of naming collective affects. Tellenbach introduced this concept in the field of psychiatry to account for "a sphere of familiarity which is perceptible in a bodily-sensuous way" [1]. Atmospheres are more easily felt than talked about, as features of an atmosphere cannot be readily described in terms of any particular domain of experience. Boehme suggests that atmospheres are "difficult to express, even if it is only in order to hide the speaker's own speechlessness" [2]. Furthermore, the haziness of the definition of atmosphere stems from its "veiled existence" as it dwells in the cracks of the dichotomies we use to organise our concepts. For understanding purposes, the word atmosphere is used here as the elusive and almost indefinable "air" that imbues and envelops a given situation and participates in the global awareness of that situation.

Objective vs. subjective

The experience of atmospheres informs the subject about himself (subjectively) and about the world (objectively). The subjective appraisal of atmospheres suggests that they are similar to the experience of emotions. However, much like the conception of feelings in the Homeric Greeks, which were described as existing out of one's body, pressing upon it, and invading it, atmospheres are felt as affects originating from outside the subject's boundaries. Considering their objective appraisal, atmospheres are not experienced as concrete qualities belonging to objects, environments or other subjects; nonetheless, they are felt in an object-like, quasi-concrete way. With that in mind, Boehme introduced the term *ekstases* to describe affective qualities that radiate from things persons or places dyeing the in-between or the intermediate space between them and the experiencing subject [2]. Both subjective and objective appraisals seem short in the understanding of the ontological status of atmospheres. They are therefore to be regarded as intermediate phenomena that resist the subjective-objective dichotomy.

Interior vs. exterior

The polarities subjective *vs*. objective can also be discussed in terms of interior *vs*. exterior. These concepts refer to the spatial properties of atmospheres. To assess the spatiality of atmospheres one must question the idea of interiorising feelings. Atmospheres resemble Stern's "vitality affects" and their dynamic qualities of feeling that convey a basic emotional tone [3]. This includes, for instance, a "calming", "relaxing", "comforting", "tense", "heavy", or "light" tone that animates or dampens the background sense of life. These are "spatially diffuse" feelings [4] that are not experienced as enclosed inside the subject's body. For Schmitz, for instance, atmospheres are not exactly feelings, rather they are the condition of the possibility of having feelings. He considers them "spatial bearers of moods (…) which visit (haunt) the body which receives them" [2]. In the sentence "the ambience in the room was tense", one is referring to both an interior private phenomenon and to an exterior collective one. One has the experience of a vibration that pervades space and is therefore exterior, but is also bodily experienced and therefore interior. It is this loosened line between interiority and exteriority that characterizes the spatiality of atmospheres.

To portray the complexities of the spatiality of atmospheres, we draw on the concept of "aura", not because of their resemblances but to shed light on their differences that clarify some of the polarities we are referring to in this section. In common language, the concept of "aura" portrays an objective property that belongs to a person, thing, or place and emanates from them (e.g. the aureole of a saint). Historically, this idea is included in its coining by Benjamin epitomised in his well-known description: "[r]esting on a summer evening and following a mountain chain on the horizon or a branch which throws its shadow on a person at rest - i.e. to breathe the aura of these mountains or this branch" [2]. Whereas the mountains' aura radiates from them, the atmosphere arises elsewhere, in the space between a person (or a sentient being) and a setting (person, thing, or situation) and cannot be traced back to any of them.

Permanent vs. transitory

Another difference between auras and atmospheres refers to their temporality. Auras are not transitory while belonging to the object and are lessened by repetition – e.g. reproductions as in serigraphy diminish the aura of a work of art. The atmosphere, on the other hand, can also rely on such changes to increase or decrease – as if atmospheres included the phenomenological properties of auras but outrun them into a more inclusive concept.

A striking example of the temporality (transitory nature *vs*. permanence) of atmospheres is ballet. In ballet it is

the atmosphere that emerges as a result of the affective movements at different speeds and directions hitting the stage, the other dancers and the experiencing subject. The spectator is not expected to experience the aura of the dancers, instead it is the atmosphere itself that arises as the object of contemplation while the dancers perform. Such transience was described by Dufrenne in his idea of atmospheres "perpetually forming and deforming, appearing and disappearing, as bodies enter into relation with one another" [4]. Following this statement, one could say that the fragility of atmospheres is permanent due to their ever-unattainable stability of form. The atmosphere of a cave, for instance, is vulnerable to the presence of visitors. Chauvet, the recently discovered cave from the Palaeolithic, will never be opened to the public as a means to preserve its atmosphere. A replica is nevertheless being built for visitors aiming to stir the emotions generated by the original. This example serves the purpose of illustrating the double temporality of atmospheres. Atmospheres are ever-changing "constantly seek(ing) renewed completion" [5] and yet some of their features are intransient as they can be repeated or recreated. In Werner Herzog's film *Cave of forgotten dreams* the French Perfumer, entrusted with the task of recreating Chauvet as it was when our ancestors inhabited it, embodies the ability of the sense of smell to bring forth the singularity of an atmosphere, while allowing its recreation and re-experience.

Deleuze's concept of *haecceity* provides further insight on the nature of this in-between that constitutes atmospheres. Haecceities "consist entirely of relations of movement and rest between molecules or particles, capacities to affect and be affected", but are nonetheless "concrete individuations that have a status of their own and direct the metamorphosis of things and subjects" [11]. Atmospheres resemble haecceities in the sense that they are different from entities (for instance persons, bodies, things or substances) that have an actuality on their own. They rather exist fleetingly as a nomadic crisscross or network of qualities. They fill the space, changing the intervenient, while having no concrete origin or destination.

Pre-reflexive vs. reflexive meaning

The understanding of reality was long considered through an "estranged epistemology" as if the subject cognitively delved into his experience. Recently, Gibbs discusses an "engaged epistemology" which portrays two types of meaning in any given situation – a pre-reflexive (which is already imbued in experience) and a reflexive meaning (much like the cognitive interpretation of raw experience) [6]. Through this epistemology, experience itself is not "raw", that is meaningless and in need of being understood, but already imbued with meanings. *Felt* meanings are already present while experiencing a given object or situation, earlier than the appearance of cognitively appreciated meanings. This type of tacit meaningfulness has clear links with the idea of atmospheres. Minkowski uses the verb *aspirer* (breath in) to portray this distinct mode of being in the world, i.e. the mode of experiencing an atmosphere [7], which is close to what Tellenbach calls the "atmospheric mode of being human" [8]. When a subject is assessing an atmosphere he is apprehending an emotional significance in an immediate and self-evident way. Atmospheres are readily meaningful. The relation between pre-reflexive and reflexive meaning is not straightforward as reflexive effort cannot replace pre-reflexive meaning and yet a subject can reflexively elaborate on his pre-reflexive meaning. Yet the latter is only accessible through active effort as in our everyday performance it is embedded in such a way that it remains hidden (psychiatrists must actively undertake such effort). The pre-reflexive meaning is a pre-conceptual assemblage of the assortment of all sensorial inputs available to the subject. Two consequences arise from the nature of this type of meaning. First, there is a threshold before which sensorial inputs from the body and from world are merged as if they were one and the same. As Merleau-Ponty points out, it is as if there was a continuum between the objects being sensed in the sensing body: "[t]here is an objective sound which reverberates outside me in the instrument, an atmospheric sound which is between the object and my body, a sound which vibrates in me as if I had become the flute or the clock" [9]. The atmosphere is indeed immediately perceived as an affective tonality that pervades space and simultaneously permeates the subject's body. "I felt that I breathed an atmosphere of sorrow. An air of stern, deep, and irredeemable gloom hung over and pervaded all" – Edgar Poe writes in *The fall of the house of Usher*. Hence atmospheres inhabit what Strauss named the "pathic" moment of perception [10], where subject-object distinction is fuzzy and so the sensorial domains are inchoate. The merged and pre-conceptual meaning is the integration of different sense modalities, where one sense mode automatically elicits other sensorial modalities. In this moment there are no mono-sensorial experiences, only a synesthetic experiential waltz. As an example: understanding pre-reflexively Marcel Duchamp's "musical sculpture" or some of Stockhausen's pieces entails more than an acoustic experience – a kind of visual-tactile experience is at play, where sounds are felt as sculpting silence.

The second consequence of this pre-reflexive and pre-conceptual appraisal of the meaning of an atmosphere is that the pre-reflexive meaning ultimately accounts for the global awareness of reality as the subject is moved by this bodily felt transformation. For instance, the scent of a perfume assaults us with images and forces us to

experience the ineffable tonalities of the place or situation exceeding the accessible meaning and guiding us to an overall understanding. Tellenbach stresses this in the remark that "in nearly all sensory experiences there is a surplus which remains inexplicit" [8].

Passivity vs. activity

The importance of a passive impression is expressed in Tellenbach's idea of atmospheres where taste and smell are the most "atmospheric" senses as they are more passive than the others (the subject cannot easily divert from what he is sensing) [8]. Yet, the subject is not only passively impressed (and changed) by atmospheres. His active participation in the creation and propagation of atmospheres is imprinted in: (1) the permanently incomplete status of atmospheres (see 3.2. concerning the temporality of atmospheres), which invites participation and (2) the idea that though he is always potentially embedded in an atmosphere, he must first welcome it so that it can emerge to his awareness. The subject's intention is expressed in the necessary predisposition as an *aesthetic attitude*, i.e. the ability to locate oneself at the right distance to allow the emergence of an atmosphere. The agency of the subject is key to understanding what it is like to experience an atmosphere as the subject has to actively predispose himself to the aesthetic experience (hinting that it is voluntary) to then passively surrender to the event that will take place. The feeling of an atmosphere is therefore a paradoxical experience as the subject feels he is an active intervenient and yet also passively impressed.

The clinical encounter as an aesthetic experience

In order to grasp atmospheres in the clinical practice, one must predispose to receive them. According to Schmitz, this predisposition is what allows the distanced influence of atmospheres [2] and atmospheres are themselves the aesthetic objects to be phenomenologically experienced. The idea of predisposing oneself to aesthetically experience the clinical encounter is not farfetched. In 1907, Husserl wrote a letter to Hofmannsthal, comparing Hofmannsthal's theory of aesthetics to the phenomenological method, which as he wrote "requires us to take a stance that is essentially deviating from the 'natural' stance towards all objectivity, which is closely related to that stance in which your art puts us as a purely aesthetical one with respect to the represented objects and the whole environment" [12]. Husserl appears to be referring to the suspension of the natural attitude that would come to sustain the phenomenological method. The potential inclusiveness of an *aesthetic attitude* in the phenomenological method resides in two features that portray the aesthetic object and are also identifiable in the phenomenological object, which are: (1) the aesthetic properties of an object can only appear if one allows the object's detachment from one's intention; (2) the aesthetic properties only arise when the object is stripped of its ordinary meaning. The former resembles the "disinterestedness" that Kant, and more recently Stolnitz, found essential for the "aesthetic judgment" and the *aesthetic attitude*, respectively [13]. The latter implies that in order to experience any object aesthetically one must first adopt a stance that presupposes the predisposition of the subject and the displacement of the aesthetic object from its everyday setting. Duchamp's ready-mades like *The fountain* or the *In advance of the broken arm* are examples of this, for they appear to us aesthetically as soon as they are exposed in a gallery and consequently stripped out of their utilitarian everyday meaning. Even Dickie, who rejects the need of the concept of "aesthetic attitude", admits there is an essential feature of the aesthetic experience, which is *attention* [14]. Although the art critic or collector might have a professional intention or a purpose that risk to undermine the experience of aesthetic objects, in the moment of aesthetically experiencing an object his intentions must be put aside, otherwise his attention would simply be dislocated from the aesthetic properties of an object and the aesthetic experience would not take place. Neuroscientific research also supports this observation. Having found that aesthetic experiences are qualitatively different from everyday experiences, it seems that at the upmost of aesthetic experiences attention is fully focused on a particular object and the object is stripped of its usual purpose, so that "the person is self-transcending, self-forgetful, and disoriented in time and space" [15]. Likewise, in the phenomenological method, the clinician has to learn how to dodge his intention of finding symptoms in order to allow the appearance of atmospheres.

The relevance of aesthetically experiencing the clinical encounter

The atmosphere's significance in clinical diagnosis has long been recognized. Tellenbach considered that during the interaction with a patient, the clinician is led to feel certain atmospheric qualities that exceed the factual, but nevertheless permeate the process of diagnosing. This led him to develop the concept of *diagnostic atmosphere* [8]. Minkowsky used a similar term *diagnostique par penetration* [16] to refer to the importance of intuition (the non-cognitive grasping of the meaning of an object) in the process of diagnosing, particularly referring to diagnosis of schizophrenia. These concepts are evidence to the fact that the two authors acknowledged the partaking of atmospheres in the understanding of phenomena. In the arts, particularly in the art of the stage, atmospheres are present from

the beginning and are essential to the global understanding of the work "the first scenes directly instil in us a certain emotion, which orients our entire comprehension. It is not sufficient that a problem be posed or an intrigue outlined, for it is also necessary that there be communicated to us a certain world-quality within which the problem or intrigue takes on meaning" [17]. No different than in theatre, in the encounter with a patient it is also through the atmosphere into which the clinician is initially thrown that he apprehends the "world quality" that will guide his comprehension. While the quest for objectivity might serve as an excuse to perform the over-detached positivistic act of collecting symptoms, this purpose compromises the entire understanding. The objectivity of atmospheres depends on the possibilities of feeling of the participants in the encounter. The clinician's "being-in-the-world" is not cancelled in the event, neither is his participation in the global awareness of the situation.

Heidegger's concept of *Befindlichkeit* [18] seems useful to further clarify the idea of understanding through atmospheres. Befindlichkeit comes from the irregular and reflexive verb *sich befinden* (to find oneself). In his *Commentary on Being and Time*, Dreyfus relates the concept of *Befindlichkeit* to mood, rather than a state of mind, that is neither subjective nor objective and is itself a source of attunement to the world, constituting "the way we find ourselves" in situations [19]. Accordingly, while accounting for the global awareness of a situation, atmospheres have the ability to place us in that same situation through a sense of proportion and distance that takes into account the position of the other. This sense allows us to find ourselves while attuning to the other is tact.

Sensing atmospheres – the role of tact

Tact is what Gadamer depicts as "a special sensitivity and sensitiveness to situations and how to behave in them for which knowledge from the general principles does not suffice (…) One can say something tactfully, but that always means that one passes over something tactfully and leaves it unsaid (…) and it is tactless to express what one can only pass over" [20]. The relation between understanding and tact can be traced to Aristotle. For Aristotle *phronein*, which means understanding the environment, comes from the senses, particularly from the sense of tact [21]. Unlike other senses, tact needs tangibility, the medium is (in) our body. Thus, through a sense of tact one simultaneously senses an object (a thing or another sentient being) and one's sensing body. Accordingly, tact embodies both ipseity and alterity, and it is only through the dialectics of the two that sensing is possible [21].

Phenomenologically, tact is the sense that is present in the moment of apperception when limits between body and world arise just before the differentiation of all other senses. When Merleau-Ponty tells us "through vision, we touch the stars and the sun" he is showing us how the sensuous quality of the exterior captured through a single sense mode travels through a synesthetic continuum eliciting other sense modes [22]. The relevance of atmospheres in the clinical encounter is ascribed to their ability to dislocate the limits between body and space while traveling through this sensorial continuum eventually meeting its haptic foundation as the statement by Merleau-Ponty suggests. In this sense, the space of atmospheres is experienced as a tactile space. Meanwhile, the changes in bodily feelings of the receiver are felt as a shared awareness of the situation placing him at the right distance, a tactful distance that is tacitly agreed. Like the sense of touch, atmospheres exist in a dialectic space of resonance between self and other, allow for the tacit/inexplicit understanding of a situation and are also a prelude to knowledge. If on the one hand the whole that is experienced through atmospheres is perpetually irreducible to the concepts we use to understand a situation, the ineffability of the experience shelters a latent relevance, which invites the creation of metaphors that may bring about the disclosure of a new understanding.

Understanding atmospheres – the role of metaphors

The leading role of metaphors in the process of understanding atmospheres reflects the pre-reflexive nature of the experience. The embodied transformations impressed by atmospheres are not directly accessible by existing concepts, which means that they can only be indirectly made sense of by a process that is metaphoric in nature. This process brings experience to the reflexive realm, but will perpetually remain unfinished, as metaphors do not pin down atmospheres. On the contrary, they enhance atmospheres, amplifying them and enchaining other metaphors. In the attempt of getting closer to the truth of the experience, they enable a self-sustaining process of "understanding and experiencing one kind of thing in terms of another", which has been considered by Lakoff and Johnson as the basis of our everyday conceptual system [23].

In addition to the main role of metaphors in the process of understanding and experiencing atmospheres, they are also essential to the constant process of understanding phenomena and the corresponding psychopathological concepts used to refer to them. One could say that psychopathologists also make use of metaphorical concepts to refer to abnormal phenomena that exceed common understanding. For instance, flight of ideas or derailment of thought are metaphorical in nature in the fact that two conflicting ideas collide – thoughts don't flight or derail, because they are not beings or things, yet the union of the two brings us closer to the understanding of the original experience.

Despite the frenzied concern for reliability that has expanded into the privacy of the clinical encounter declaring the third person paradigm and its outlined preconceived interviews as the representatives of objectivity, mental symptoms have not been and cannot be fixed in time. They are neither strictly objective nor subjective, and rely on a constant negotiation of meaning that forcibly takes place during the clinical encounter [24]. It is through the clinician's engagement in the process of understanding that the accuracy of psychopathology is preserved. This is due to the fact that the basic process by which meaning is constructed is linguistic and prior to any *Denkstill*, including the scientific *episteme*.
Interview techniques designed according to the third person paradigm, focus the clinician's attention on the search for specific symptoms. It is this same intention that compromises the attention needed to notice the aesthetic properties of the clinical encounter and restricts linguistic contexts risking tautology. If one learns how to experience atmospheres one could dodge the bias of this intention. Here resides the need to bring aesthetics to the clinical encounter: one must dodge the scientific dogmatism through Kant's "desinterested pleasure" in order to preserve the phenomenological understanding.

Conclusions

Gadamer reminds us that the Greeks had a word for "that which brings understanding to a standstill". This word was *atopon*, which in reality means "that which cannot be fitted into the categories of expectation in our understanding and which therefore causes us to be suspicious of it" [25]. In this article, we have tried to unveil the complexities of the concept of atmospheres that have led us to neglect their clinical relevance. Atmospheres are difficult to grasp because they exceed the dichotomies that usually serve the purpose of understanding. Atmospheres arise through the actively endorsed aesthetic attitude adopted in aesthetic experiences, which shares the detachment from common sense and any preconceptions (including scientific preconceptions) with Husserl's *epoché*. Phenomenologically, they belong to the pathic moment of perception, the moment when self and world/other are merged. Yet their presence is felt to interpose a tacitly agreed distance, between self and other. This apparent paradox is peacefully embodied by the sense of tact. Tact is the sense that is present when self finds his limits in the limits of the other, the moment of apperception. Hence, atmospheres are haptically experienced, driving the senses to a past, where the limits between self and other are constantly being defined and redefined according to the present situation, while hinting on the global awareness of that situation and anchoring the process of understanding. Although the experience of atmospheres belongs primarily to the pre-reflexive realm, it can be brought to the realm of the reflexive through the creation of metaphors. Metaphoric thinking generates and regenerates meaning in a permanently unfinished task of describing and redescribing that which is truthful to the unfinished nature of atmospheres, bringing us closer to the original phenomena. The acceptance of atmospheres as clinically relevant phenomena is ultimately related to the acknowledgement of the ambiguous nature of the clinical encounter. The clinical encounter is an event suspended between the pathic and the linguistic domains of experience, an open event that invites participation, and must remain so in order to preserve the phenomenological precision. Operational criteria and structured interviews brought some benefit to psychiatry as they contributed to cleanse the profoundly unscientific and irrational attitude towards systematic assessment and diagnosing. Yet, they are blind to essential aspects of the clinical encounter. The inclusion of aesthetics to the clinical encounter might be the means to preserve its nature.

Conflict of interest

None.

References

1 Böhme G. *The art of the stage set as a paradigm for an aesthetics of atmospheres*. Ambiances [En ligne], Redécouvertes, mis en ligne le 10 février 2013, consulté le 09 décembre 2014. http://ambiances.revues.org/315

2 Böhme G. *Atmosphere as the fundamental concept of a new aesthetics*. Thesis Eleven 1993;36:113-26.

3 Stern DN. *Forms of vitality: exploring dynamic experience in psychology, the arts, psychotherapy, and development*. New York: Oxford University Press 2010.

4 Anderson B. *Affective atmospheres*. Emot Space Soc 2009;2:77-81.

5 Grant S. *Performing an aesthetics of atmospheres*. Literature & Aesthetics 2013;23:12-32.

6 Gibbs RWJr. *Embodiment and cognitive science*. New York: Cambridge University Press 2005.

7 Drobnick J. *Aural cultures*. Toronto: YYZ Books 2004.

8 Tellenbach H: *Geschmack und atmosphäre*. Salzburg: Müller 1968.

9 Merleau-Ponty M. *Phenomenology of perception*. New York: Humanities Press 1996.

10 Straus EW. *The primary world of senses, a vindication of sensory experience*. New York: Free Press of Glencoe 1963.

11 Deleuze G, Guattari F: *Thousand Plateaus*. London: A&C Black, 2001.

12 Huemer W, Schuster MO. *Phenomenological reduction and aesthetic experience: husserl meets hofmannsthal*. In: *Writing the Austrian traditions: relations between philosophy*

and literature. Edmonton: Wirth-Centre for Canadian and Central European Studies 2003, pp. 121-30.

13 Fenner D. *Art in context: understanding aesthetic value*. Chicago: Swallow Press 2008.

14 Dickie G. *The myth of the aesthetic attitude*. Am Philos Quart 1964;1:26-65.

15 Marković S. *Components of aesthetic experience: aesthetic fascination, aesthetic appraisal, and aesthetic emotion*. Iperception 2012;3:1-17.

16 Minkowski E. *La schizophrénie*. Paris: Editions Payot & Rivages 1927.

17 Dufrenne M. *The phenomenology of aesthetic experience*. Evanston: Northwestern University Press 1973.

18 Heidegger M. *Being and Time*. Albany, NY: SUNY Press 2010.

19 Dreyfus HL. *Being-in-the-world: a commentary on Heidegger's being and time*, Division I. Cambridge, MA: MIT Press 1991.

20 Gadamer HG. *Truth and method*. London: A&C Black 2013.

21 Massie P. *Touching, thinking, being: the sense of touch in Aristotle's de anima and its implications*. Minerva – An Internet Journal of Philosophy 2013;17:74-101.

22 Pallasmaa J. *The eyes of the skin: Architecture and the senses*. New York: Wiley 2013.

23 Lakoff G, Johnson M. *Metaphors we live by*. Chicago: University of Chicago Press 2008.

24 Stanghellini G. *The grammar of the psychiatric interview. A plea for the second-person mode of understanding*. Psychopathology 2007;40:69-74.

25 Gadamer HG. *The gadamer reader: a bouquet of the later writings*. Evanston: Northwestern University Press 2007.

Phenomenological Psychopathology and the Neurosciences

G. Catone[1,2], J.F. Lindau[2,3], M.R. Broome[2]

[1] Department of Mental and Physical Health and Preventive Medicine, Second University of Naples, Naples, Italy; [2] Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, UK; [3] NESMOS Department (Neurosciences, Mental Health and Sensory Functions), Sapienza University, Rome, Italy

Summary

Phenomenology and neuroscience share an explicit interest in the "mind", with interest growing as to the inter-relationship between the two disciplines and their object of study. In fact, both aim to explain characteristics of mental life and mental illness. For phenomenology there is often a prioritisation of subjective experience, whereas the neurosciences are primarily interested in brain structure and functioning, but aspire to give a bottom-up account of conscious experience. However, for some authors in the two fields, these disciplines show elements of complementarity. This complex union between the biological and philosophical was already evident in the work of Jaspers and his General Psychopathology, Brentano, and the debate on psychologism that inaugurates Husserl's work. Jaspers conveys a pluralistic vision of science, and contrasted this complementary approach with one of biological exclusivity in explaining mental phenomena. His thought contains elements of topical relevance such as the difficulty of proving the biological substrate of psychic events and the spatial location of mental events in network systems rather than discrete areas. Phenomenologically-speaking, he constantly re-oriented the focus of the discussion to subjective experience as a means to understand mental illness, alongside somatic accounts. In recent years, the scientific community has experienced a long period in which biological psychiatry has possessed major rhetorical force in disseminating scientific progress in psychiatry, but as has already happened in other historical periods, the interest for phenomenology returns when biology needs philosophy to explain the data and progress obtained. The debate is still ongoing and the aim of this paper is to offer an overview of the main contributions on the relationship between phenomenology, neurosciences and psychopathology. Phenomenology and neuroscience have been trying to find a point of agreement and interconnection, and several authors offer the suggestion of naturalising phenomenology, relating the way we experience the world in time, as embodied agents, to brain function, whereas other authors try to phenomenologise the neurosciences, where the basic principles of philosophy applied to human mind should drive scientific research. Both methods seem to be able to increase the possibility of understanding of psychiatric illnesses. Accordingly, the relationship between phenomenology and psychopathology has an impact on classification systems, and more generally on the science of psychiatry. Herein, the points where neuroscience may benefit from phenomenology are discussed.

Key words

Phenomenology • Neuroscience • Psychopathology • Jaspers • Neurophenomenology

Introduction

In the complex topic that we are addressing, we should start by defining phenomenology before any attempts to go into its contribution to psychiatry and its relationship to neurosciences. The question of "what phenomenology is or what relationship it had with psychiatry" [1 2] might be a good starting point, even if there is no easy answer. The term *phenomenon* originates from the Greek word "phainomenon" which means "that which appears". Hence, phenomenology is the study of what appears, and in psychiatry the subjects of inquiry are not only abnormal mental events but also the science of psychiatry and other themes. First of all, phenomenology is not akin with just the concept of "subjective understanding" and is not simply a detailed description of mental events or states [3]. Secondly, phenomenology is not a school but rather a method of inquiry, an agreement on the precise method does not exist. Several ideas about the relationship between phenomenology and philosophy and the method of phenomenological inquiry have been developed by Simon Glendinning. He affirmed that phenomenology has a critical role against "the natural attitude"; it does not seek to advance theses or defending positions excluding a theoretical work. Furthermore, phenomenology highlights features of our experience that are not explicit, emphasising descriptions rather than explanations, and avoiding theoretical assumptions and distortions. Finally, phenomenology is a manner to understand the world in different way, through its method of enquiry [4]. After this

Correspondence
Matthew R Broome, Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX • Tel. +44(0)1865738772 • Fax +44(0)1865738779 • E-mail: matthew.broome@psych.ox.ac.uk

brief introduction about the definition of phenomenology, we can try to understand how to deal with this important framework about the relationship between phenomenology and neuroscience, in the light of both historical concerns and ongoing debate. It is sometimes supposed that phenomenology is "anti-scientific", or that biological and phenomenological psychiatry are in opposition. It is helpful to recall that phenomenology was conceived of as being the method that would underpin all of science. For Husserl, phenomenology is an a priori science of essences. However, such essentialism may not itself be a defining feature of phenomenology [5] and some commentators suggest that Husserl never developed a critical understanding of the notion of essence [6]. This concept of essence highlights how contemporary phenomenological psychiatry and psychopathology, at least conceptually, share strong similarities with the realism of biological psychiatry. The two disciplines share several similarities: both methods of investigation seek to find the defining characteristic of a mental illness. For phenomenology, this characteristic is some essential feature of subjective experience, whereas for biological psychiatry it may be a particular activation of neural circuitry or a discrete genetic polymorphism. Furthermore, the investigations of both fields may be complementary, and for some contemporary writers there is the suggestion that further advances in biological psychiatry will depend on phenomenology [7]. One of the recent surprises in the history of ideas is that the rebirth of interest in the philosophy of psychiatry closely followed advances in neurosciences. As has been pointed out [8], perhaps this shouldn't come as such as a surprise: with empirical scientific advances comes the pressure to think deeply about their significance, their place within existing knowledge, and how prior discourse and practice stands in relation to the new findings [9]. The contribution of phenomenological approaches in contemporary science, if viewed widely, can include a primarily empirical method of inquiry such as patient's vignettes, phenomenological descriptive experience sample or retrospective introspection, also called (*p)*henomenology or small *p*, and also by a more technical notion of phenomenology that concerns the formal structures than specific content of experiences (Husserl), called *(P)*henomenology or big *p*. (*p)*henomenology could be enriched by (P)henomenology because the former works at a distinct but nevertheless complementary level of analysis to the latter. Data from *p*henomenological reports can lend important clues to how and where these basic structures become compromised or disrupted within anomalous experience. However, *P*henomenology can further contextualise these often fragmentary or isolated reports within a broader transcendental context, and working within the reductions of Husserl, reminds us to bracket off causal accounts of the phenomena we are studying. In fact, while phenomenology asks about the specific contents of experiences (*what* a subject is experiencing), Phenomenology takes into account the formal structures of experience (*How* the subject is experiencing the "what"), and the meaning of those experiences for the individual [10].

The historical background to Jaspers and his response

A pioneering contribution to medical science by a phenomenological physician was made by Jaspers; this is not surprising since Jaspers was first and foremost a psychiatrist and troubled by the state of the discipline. His thought about the relationship between Phenomenology and natural sciences is found in several of his works, but especially in *General Psychopathology*.

Jasper was confronted with an environment dominated by strong scientific positivism, the twilight of the "first biological psychiatry" [11]. He describes much of the psychiatric literature as "unfounded chatter" [12] and criticises the obscurity, jargon and lack of common theoretical language in discourse. Jaspers makes a diagnosis of this difficulty of psychiatric thinking: psychiatry had forgotten that its subject was man, rather than his body. As such, Jaspers describes how he turned to philosophy, philology, social and cultural science, and psychology and utilised the thought of Husserl, Dilthey and Weber [12 13], emphasising the importance of methodological reflection and pluralism regarding theories. Hence, from a more widespread theoretical disaffection, Jaspers launched his attempts to diagnose the crisis in psychiatry and to reground its practice. Jasper pointed out the mind-body unity. His first point is that psyche and soma are an "inseparable unity" and stand in a reciprocal relationship to one another. This seems to suggest that both can affect one another and are in turn constrained by one another. Moving on from this statement of unity, Jaspers makes trenchant approval of what may be called neuro-scientific method. Jaspers then introduces the idea of an epistemological void or abyss, "an impenetrable country", which separates our knowledge of how precisely to link up our comprehension of psychic events with somatic events. Hence, we have both some positive views of Jaspers regarding the unity of psyche and soma, and the importance of neuroscience, but some pessimistic views as to how precise physical changes are mapped onto discrete mental states. Furthermore, there is a seeming worry: with the progress of neurology, the psyche recedes and as such the soma and somatic models of illness have explanatory and ontological dominance. Jaspers here remains not anti-science, or anti-neuroscience specifically, but coherent with his later views on science more generally, ecumenical and pluralistic. His reason for emphasising

the "somatic prejudice", as he refers to this dominance, is not to limit biological research or criticise it, but rather to challenge its hegemony and dominance, As such, Jaspers maintains his view of the unity and inter-dependence of the psyche and soma, a unity where emphasising one element of investigation ('neurology') over another ("psychopathology") is not warranted. Jaspers then moves on to discuss findings in neuropathology and psychiatric illness. As mentioned earlier, here he reiterates that the specificity and lack of tight relationships imply that we cannot presume that brain changes are direct causes of psychic events. This is not, to repeat, to argue that Jaspers believes that brain changes do not cause mental illness, but rather, based upon his understanding of direct cause, they are not close enough on the causal pathway to the event and hence a given brain change that is not specifically linked to a given psychic change cannot serve as a direct cause. For Jaspers, "we postulate that all psychic events, normal and abnormal, have a somatic base, this has never been demonstrated" [14] (p. 458). Jaspers then comments on the clarion call of Griesinger's psychiatry "mental illness is cerebral illness". Echoing contemporary discussions in philosophy around connectionism and in cognitive neuroscience around functional connectivity, Jaspers suggests that function may be dependent not on discrete areas, but on relationships between many different parts of the brain. In addition, we have to remember that in principle cerebral changes may also be the result of primary psychic phenomena, though such an effect has not been empirically demonstrated. In no sense is Jaspers anti-science or opposed to biological psychiatry. Indeed, reading him on cerebral localisation and on extra-conscious causal factors he is likely to have been impressed by the advances that have been made to understand psychopathology through neuroscience. However, what he is clear on is that such work can never be the sole means to understand the psyche and mental illness. These assumptions about the difficulty of proving the biological substrate of psychic events and the spatial collocation of mental events in network systems instead of a discrete area are astonishing elements of novelty and actuality in Jasperian thought. Jaspers constantly warns throughout *General Psychopathology* of one mode of study being dominant and blocking out others, and this theme, of scientific pluralism, is one that Jaspers continues in his later philosophy.

Phenomenology and neuroscience

In the last decades, we have gone through a period of increasing scientific knowledge in the field of neurosciences. Cognitive neuroscience has drastically improved our understanding of mental functioning and this understanding has begun to yield rewards in theories of aetiology and mechanisms of major mental diseases. These scientific advances correspond to an renewed interest in the field of phenomenology for several reasons: the need for cognitive neurosciences to pay attention to the phenomena of human life, the subjectivity of experience; phenomenology allows us to investigate the meaning of the aspects that characterise the results of research; the method of the phenomenological enquiry leads the investigator to broaden the scope of discussion, promoting in this way a continuous investment in the field of ideas and hypotheses, and remaining open to phenomena, rather than only considering data which fits into a prior theory. At this point, a question arises: how concretely can the neurosciences and phenomenology inform one another and how are the disciplines related?

Natural science has the aim of understanding the physical world. When it extends its field of observation to man and his physical and psychical world, a problem arises on how to relate these two aspects. The human is part of nature, but his capacity of reflection and self-reflection distinguish him from other subjects of investigation. The "quiddity" is properly consciousness, and phenomenology has identified this as its object of research[15]. In the attempt to connect these two disciplines, two paths have been followed: on one hand we have those who believed to naturalise phenomenology by attempting *"to integrate into an explanatory framework where every acceptable property is made continuous with properties admitted by the natural sciences"* [16] (pp. 1-2); on the other hand, there are those who tried to phenomenologise the neurosciences. The first route is further divided in three approaches, the first lead by Marbach who proposed a logical formalisation of phenomenology, whereas the second, namely neurophenomenology attempted to mathematise phenomenology in such a way that it has further validity. The third methodology is called "front-loading phenomenology", and was influenced by Merleau-Ponty, who suggested that phenomenology and scientific disciplines could link themselves with dialogue [17]. Essentially the three approaches, although they do share a common aim, differ mainly because of the gateway through which the phenomenology makes contact with the natural sciences: while the first approach looks at the empirical data and the second is concerned with the training of subjects from the study (phenomenologically oriented), the latter starts from the whole experimental design of the research [18] (p. 38).

Marbach postulated to formalise the descriptions of lived experience and to put them into a scientific context. This allowed the management of problems of scientific communication and word meaning, by using a formalised language typically akin to logic or mathematics [19]. A step forward was made by the second approach by Roy, Petitot, Pachoud and Varela. A common concern

is that the mathematics formalisation cannot cover data derived from the first-person experience. Indeed, as Roy et al. proposed, the first step of the translation to mathematics involves eidetic variation. They highlighted the need to understand what the embodied and dynamic experience is [20]. Neurophenomenology may contribute directly to put phenomenology into scientific research through the integration of phenomenological analysis of the experience, dynamical system theory and empirical experimentation on biological systems [20]. In the last years, Varela noted that some studies, although anchored to the tradition of cognitive neuroscience, demonstrated a greater importance to the *lived experience*. He argued this saying that each cognitive science had to take into account the fundamental condition of the understandability of the *mental* outside our experience of it. Varela, in naturalising phenomenology, proposed to make the method of phenomenological enquiry very rigorous, in order to build a broad program of research, called *Neurophenomenology*. This method was constituted by an attitude to Husserl's reductions, intimacy with the phenomenon and subsequent intuition, description of it in terms that are clearly communicable, and thorough training to confer stability and reliability to the method [20]. An example arises when we discuss about time and its relationship with consciousness. Phenomenology, following Husserl's thought, has always emphasised the temporal extension of the act of consciousness. Therefore, the temporal structure of consciousness has been described as being formed by a "primal impression" that indicates the momentary and current perception of the object, and "retention" and a "protention", which means an impression of the object perceived in the "past" and in the "future". According to Husserl, retention does not have a real content but is only an intuition of the past sense of the object whereas protention is fundamental for the experience because it provides a sense of anticipation. In detail, "retention and protention" (a priori conditions) unfold the temporal flow of consciousness [18 21 22]. Varela, in his program of neurophenomenology, explains the protentional-retentional model as a self-organising dynamical system [18]. For the author, each mental act constitutes an integration of functionally and topographically distinct regions of the brain; these require a frame of simultaneity (the lived present), but are included in a more general framework that has extensive dynamic quality. This introduced a *temporal horizon* that Varela completes with the description of three scale of duration of the basic neuro-endogenous event: *basic or elementary events (the "I/I0" scale); (2) relaxation time for large-scale integration (the "I" scale); and (3) descriptive-narrative assessments (the "I0" scale)*. The first corresponds to the minimum time needed for two stimuli to be perceived as non-simultaneous. Neurophysiologially, this corresponds to 10 msec (the intrinsic cellular rhythms of neuronal discharges) to 100 msec (the duration of an excitatory postsynaptic potential (EPSP)/inhibitory postsynaptic potential (IPSP) sequence in a cortical pyramidal neuron), whereas the second is the neurophysiological timeframe of the emergence, operation and subside of a cell assembly (0.5-3 sec). The integration of the basic *neural* events at the 1 scale is correlated with the lived present and describes a potential neurophysiological retentional-protentional structure of the time consciousness [23].

The third approach concerns uppermost with the research design, attempting a dialectical movement between the knowledge acquired in phenomenology and the insights produced by empirical investigation [18] (p. 28-40). Parnas and Zahavi endorse the strategy of phenomenology guiding biological research and, it seems, endorse the possibility of reduction of psychiatric disorder, defined by subjective experiences, to neuroscience. Thus, they believe that phenomenology is a method to define more clearly that which we seek to reduce, namely, the subjective essence of the given experience. They appear to suggest that either ontological identity reduction is possible, or efforts to bridge explanations of subjectivity and biology require phenomenology. They helpfully review the scope of phenomenology, including Jaspers' interpretation of the method [24].

On the contrary, Gallese's point of view was to phenomenologise the cognitive neurosciences using the insights that come from phenomenology reflection, and in particular from the analysis of the body (*leib*) and the role that it has in the constitution of our experience of things of the word and others. For this, Gallese uses the concept of embodied simulation that fits into the broader concept of intersubjectivity, which could be a good example of how the two disciplines might dialogue with each other [25]. In detail, he echoes an epistemological model of the brain that underscores its relational and interactional connotations. To better clarify this point of view, mirror neurons are activated both in the observation of, and the fulfillment of, bodily movements, communicative acts and in the subjective or objective (perceived in the other) experience of the emotions. They represent the neural correlate of the relationship between the subject and the object and therefore perceive and understand the meaning of an action is equivalent to internally simulate the experience of such action, activating a pre-existing brain heritage of the observer. Gallese, through a review of a number of neuro-scientific studies underlying of somatosensory sensations, language and consciousness of the action, sets the stage for a fruitful exchange between phenomenological insights and neuroscientific data. He proposes a theory of social cognition in which the *embodied simulation* and the *shared manifold system* (report for the identity across

all the forms of interpersonal relationships) are some of the mechanisms, although not the only, at the basis of intersubjectivity. The convergence of these interpretations and speculations of phenomenological philosophy are evident, and mirror neurons explain how the observer may utilise his/her neural systems *to penetrate the world of the other from the inside*. Thee recovering the thought of Husserl that the perception of the other presupposes the awareness of own body *acting*, and that the understanding of the others' behaviour implies an experience of their body vital (*Leib*) and not material (*Korper*); that of Merlau-Ponty states that the meaning of the gestures of others is not given, but understood, by the action of the observer, finally concluded: "The man conception that arise from Husserl's thought, still more if reread in the light of findings in the neuroscientific field …, becomes convincing topical today" [26].

Phenomenology and psychopathology

Phenomenology and psychopathology have always had a close relationship since the birth and the growth of the two disciplines. Jaspers, in his *General Psychopathology,* discussed systematically how mental disorders, and its symptoms, are studied from both a theoretical and empirical perspective [14]. The understanding of anomalous mental states, with the aim of description, taxonomy and classification. The narrative structure of Jaspers' work reflected his thought because in his book (*General Psychopathology*), the description of abnormal mental state followed an exhaustive report of the correspondent normal experience, where the opposition facilitated comprehension for readers [27]. Such a vision implies the investigator's effort is to catch the patient's subjective experience and his particular point of view, and to bring his knowledge of the normal and abnormal functioning in his enquiry during the interaction with the patient. The role of the interviewer as described by Jaspers cannot be passive: it must be in active and empathic participation to the relationship with the patient, trying to understand and testing narrative hypotheses together; phenomenologically speaking the psychiatrist assumes his identity only within this relationship. Over the years the term phenomenology has been changed, and in contemporary psychiatry it has acquired the narrower meaning of the study of psychopathology through the signs and symptoms of mental disorder. This conduced psychiatry to nosology and classifications systems, and while the birth of the Diagnostic Statistic Manual (DSM) was initially considered a "revolutionary operation", it was not without disagreements and concerns. In fact, if on the one hand, there was an attempt to create a more reliable and comprehensive system to improve communication between clinicians and to provide reliable diagnoses that would be useful in research and be more consistent with an international approach (i.e. International Classification of Diseases, Ninth Revision), on the other hand, many forms of disease were rejected from the set of diagnostic criteria for their lack of reliability. The psychopathological features of mental illnesses were compressed in lay-language descriptions of symptoms and signs and all those not objectifiable, clearly visible aspects of mental illness were, ignored and discarded as not scientific. The impact of this process was that psychiatry is at risk of returning to the concern that first prompted Jaspers' work: that its object of study is man, and not a disorder defined by the presence of atomistic symptoms, despite the scientific gains made in terms reliability of diagnosis. This has led to a use of common nomenclature and to large advances in scientific research, but possible problems in the validity of constructs [28]. Therefore, the relationship between phenomenology and the DSM is controversial, giving rise to an ongoing debate, and the recent views of the NIMH that the traditional categories of mental disorder may not be amenable to scientific investigation. In fact, a project regarding the development of The Research Domain Criteria has been launched by NIMH to favour a system of classification based on pathophysiological mechanisms and discoveries in neuroscience and genetics. This could improve treatments and communication between clinical data and neuroscience research [29]. Parnas and Zahavi (2002) offer some suggestions as to how phenomenology can aid classification. First, they suggest that single case histories are very important. Most clinicians will be fortunate to remember a handful of patients who have been willing to discuss in detail their experiences and, from this, interviewers can feel as if they have learned what schizophrenia or any other mental disorder "is". Thus, epidemiologically speaking, one would be left with a selection bias in one's data, because some patients are more able than others in expressing their feelings, and otherwise there is a problem of lack of generalisability. Second, Parnas and Zahavi (2002, p. 156-7) suggest that during an assessment, psychiatrists cannot but "typify" and think in terms of prototypes. For Broome, in a recent publication that aimed to review the latest contributions in terms of classification systems, this approach (Parnas and Zahvi) might be considered as part of the broad theme that he defined "realists" or "essentialists" which contrast with other two groups that he called "anti-essentialists" and "eliminativist mindless psychiatry" [7], and shares a view in common with some biological research paradigms that there is a discrete essence that marks out different disorders, for example, for the phenomenologists a particular way of experiencing the world, for the biologist, a genetic polymorphism.

Conclusion

The Maudsley Reader in Phenomenological Psychiatry [13] concluded that the relationship between phenomenology and neurosciences was based on three key points:

1) phenomenology seems to provide opportunities to build new research hypotheses;
2) phenomenology offers a guide to reconsidering nosological boundaries;
3) understanding mental disease requires a whole person approach.

In conclusion, we attempt to address individually each point to inform how phenomenology could deal with cognitive neurosciences.

1) Today it seems the time has come that research in psychiatry has finally agreed to hear the contribution of phenomenological psychopathology. This re-discovery seems to be witnessed by numerous recent papers and books that evaluate this topic, and the empirical interest in subtle changes in mental state as precursors of mental illness (e.g., anomalous self-experiences and basic symptoms in the prodromal of psychosis) [30-33]. Integration between neuroscience and psychopathology is required because psychiatric research is experiencing difficulties due to a decline in clinical psychopathology [34], and a primacy, as with the 'first biological psychiatry' of prioritising somatic accounts of illness [35]. Maj, in his editorial in *World Psychiatry*, explicitly states that two worlds coexist between them: a world of biological and physical entities that in this context, are investigated by neuroscience, genetics etc., and another world of *meanings, symbols, discursive contexts and interpersonal relationships*, equally important for psychiatry, that are studied by the social sciences and phenomenology. The author firmly asserts that: "*That the above two worlds do exist, that they can be studied separately, and that they cannot be reduced to each other, or fully explained each through the concepts that are specific to the other, there seems to be no doubt. But that they are independent from each other appears today implausible*" [36]. This conclusion endorses Jaspers own view of the unity of the psyche and soma. Hence, for theoretical, clinical and scientific approaches to psychiatry, both need to be studied rigorously and in balance. The next horizon of research is not only to answer the questions that arise from the dimension ruled by physical and biological laws, but also to formulate new hypotheses based on the pillars of classical psychopathology, which are phenomenologically oriented. As previously explained, various methods have been proposed. Neurophenomenology constitutes a multi-disciplinary approach to the study of consciousness. It is able to combine the empirical methodologies of neurosciences with the first-person analysis of the phenomenological approach. In this way, following Varela, the dualism mind-body may be exceeded, focusing on the empirical analysis of the "*Leib*" (the body in lived experience). This strategy may allow both a transcendental analysis and an empirical study of the underlying nervous process. Conversely, multiple levels of scientific enquiry and data interpretation, involving psychiatrist, philosophers and scientists, may help forward our knowledge about mental illness [37].

2) As Lewis stated, classification systems are influenced by somatic paradigms [38], while Cooper added that classifications systems are too heterogeneous [39], and that the limits of current classification systems are generated because they are governed exclusively by biological paradigms. These may be able to uncover useful generalisations in assessing and treating our patients, but inevitability fail to highlight strict psychophysical laws [7]. Life and consciousness are phenomena embedded in, but not specified by, the environment [40]. For Andreasen, the study of psychopathology, which was important for those who created the DSM, is now rarely recognized [28]. Indeed, the field of psychiatry inevitably forces practitioners to philosophical reflection; psychiatrists are interested in psychiatric illness, what they are, what we can know and how we can conceptualise them [7]. Therefore, phenomenology may increase the benefit of classification systems; first of all, we have to remember that *second nature* (an adjunctive concept to the first nature, characterised by human rationality and conceptual capacities) is theorized in an attempt to include phenomena that cannot be explained solely by the physical sciences. It is an alternative space that includes issues related to the conceptual nature of psychopathology [41]. Parnas, Sass and Zahavi suggested that phenomenological psychopathology, unlike current classification systems, provides the clinician with the tools to make a differential diagnosis through various prototypical options (i.e. affective spectrum condition vs. schizophrenia spectrum conditions), but it also provides the tools to question the structure that underpins such prototypes. This is not taken into account by the DSM (a problem that has generated the concept of "multiple comorbidities vs. differential diagnosis). As an example, the deep knowledge of schizophrenia is more closer to the concept of its "fundamental" prototypical core than to operational diagnostic criteria provided by classificatory systems [42], and defining the clinical boundaries of schizophrenia requires reinforcement of classical psychopathology [43]. On this matter, Maj criticises the DSM IV definition of schizophrenia affirming that it does not consider what schizophrenia is but rather what it is not; furthermore the operational criteria help only psychiatrists who are familiar with the narrow concept of schizophrenia [44]. Obviously, phenomenology does not resolve all problems linked to the nosology of psychiatry, but a more pluralistic vision of science should be required in future attempts [45].

3) Jaspers in his introduction to the paper "The Phenomenological approach in Psychopathology" explores the dichotomy between the subjective and objective symptoms in psychiatry, describing the features and methods of gathering information for each of the two categories. The objective symptoms were described as follows: "*Objective symptoms include all concrete events that can be perceived by the senses, e.g. reflexes, registrable movements, an individual's physiognomy, his motor activity, verbal expression, written productions, actions and general conduct, etc.; all measureable performances, such as the patient's capacity to work, his ability to learn, the extent of his memory, and so forth, also belong here. It is also usual to include under objective symptoms such features as delusional ideas, falsifications of memory, etc., in other words the rational contents of what the patient tells us. These, it is true, are not perceived by the senses, but only understood; nevertheless, this understanding achieved through rational thought, without the help of any empathy into the patient's psyche*". Conversely, he defined subjective symptoms and distinguished them from the objective ones: "*Objective symptoms can all be directly and convincingly demonstrated to anyone capable of sense-perception and logical thought; but subjective symptoms, if they are to be understood, must be referred to some process which, in contrast to sense-perception and logical thought, is usually described by the same term, subjective. Subjective symptoms cannot be perceived by the sense-organs, but have to be grasped by transferring oneself, so to say, into the other individual's psyche; that is, by empathy*". Jasper continued, raising the question of the primacy of objectivity, which determined in his opinion an inevitable psychiatric science without psyche: "*It is usual to connect with this classification into objective and subjective symptoms a very definite contrast of values. According to this, only the objective symptoms offer certainty; they alone form a basis for scientific study, whereas subjective symptoms, though we cannot easily do without them for our preliminary assessments, are considered to be quite unreliable for making final judgments and unfruitful for the purpose of any further scientific investigation. There is a widespread desire to base our study of mental disorder on objective symptoms alone and ideally to disregard subjective symptoms altogether… An objective psychology is set up in opposition to subjective psychology. The former claims to concern itself with objective data only; its natural consequence is psychology without a psyche*". In view of the approach to the whole person and understanding mental illness, it is necessary to include subjective experiences, which are typically the field of study of phenomenology, and whose instruments are empathy and the Husserlian reductions, isolation and classification of phenomena [46].

Contemporary works are underlying the importance of such methods, emerging from daily clinical and psychiatric activity. Pallagrosi et al., in a diagnostic perspective using the concept of "person centred assessment" [47], stated that the "lifeworld can only be reached through the medium of interpersonal relationship" [48]. Fava, in his editorial, criticised the overconfidence on diagnostic criteria that have emptied clinical processes and their complexity. He stressed the need to recover the science of psychopathology and clinical judgment, even if already used every day by the psychiatrist to make clinical decisions, but not taken into account and considered non-scientific [34]. Therefore, psychiatry needs to regain a feeling of "humanity", that for Engel is based on observation (outer-viewing), introspection (inner-viewing) and dialogue (interviewing) [49]. This vision is not anti-scientific, but together with the progresses of neuroscience allows an approach based on the whole person.

Acknowledgments

Juliana Fortes Lindau and Gennaro Catone contributed equally to the paper.

Conflict of interest

None.

References

1 Berrios GE. *What is phenomenology – a review*. J Roy Soc Med 1989;82:425-8.

2 Wiggins O, Schwartz M, Spitzer M. *Phenomenological/descriptive psychiatry: the methods of Edmund Husserl and Karl Jaspers*. In: Spitzer M, Uehlein F, Schwartz M, et al. editors. *Phenomenology, language & schizophrenia*. New York: Springer 1992, pp. 46-69.

3 Ratcliffe M. *Understanding existential changes in psychiatric illness: the indispensability of phenomenology*. In: Broome M, Bortolotti L, editors. *Psychiatry as cognitive neuroscience: philosophical perspectives*. Oxford University Press 2009.

4 Glendinning S. *What is phenomenology?* Philosophy Compass 2007;3:30-50.

5 Zahavi D. *Husserl's phenomenology*. Stanford, California: Stanford University Press 2003.

6 Moran D. *Introduction to phenomenology*. London, New York: Routledge 2000.

7 Broome MR. *Taxonomy and ontology in psychiatry: a survey of recent literature*. Philos Psychiatr Psychol 2006;13:303-19.

8 Fulford KWM, Morris KJ, Sadler JZ, et al. *Past improbable, future possible: the renaissance in philosophy and psychiatry. Nature and narrative: an introduction to the new philosophy of psychiatry*. New York: Oxford University Press 2003.

9 Stanghellini G, Fuchs T. *One century of Karl Jaspers' general psychopathology*. Oxford University Press 2013.

10 McCarthy-Jones S, Krueger J, Laroi F, et al. *Stop, look, lis-*

ten: the need for philosophical phenomenological perspectives on auditory verbal hallucinations. Front Hum Neurosci 2013;7:127.

11 Shorter E. *A history of psychiatry: from the era of the asylum to the age of prozac*. New York: John Wiley & Sons 1997.

12 Jaspers K, Schilpp PA. *The philosophy of Karl Jaspers*. La Salle: Open Court Pub. Co. 1981.

13 Broome MR. *The Maudsley reader in phenomenological psychiatry*. Cambridge, New York: Cambridge University Press 2012.

14 Jaspers K. *General psychopathology*. Chicago: University of Chicago Press 1968.

15 Ales Bello A, Manganaro P. … *e la coscienza? Fenomenologia, psico-patologia, neuroscienze*. Bari: Giuseppe Laterza 2012.

16 Petitot J. *Naturalizing phenomenology: issues in contemporary phenomenology and cognitive science*. Stanford, CA: Stanford University Press 1999.

17 Merleau-Ponty M, Séglard D. *Nature: course notes from the Collège de France*. Evanston: Northwestern University Press 2003.

18 Gallagher S, Zahavi D. *The phenomenological mind*. London, New York: Routledge 2012.

19 Marbach E. *Towards a phenomenological analysis of fictional intentionality and reference*. Intern Journ Philos St 2013;21:428-47.

20 Petitot J, Varela FJ, Pachoud B, et al. *Naturalizing phenomenology: issues in contemporary phenomenology and cognitive science. Writing science. 1999. Naturalizing phenomenology: issues in contemporary phenomenology and cognitive science*. Stanford, CA: Stanford University Press 1999.

21 Evans JC. *On the phenomenology of the consciousness of internal time* (1893-1917). Husserl Studies 1992;9:237-8.

22 Husserl E, Bernet R. *Zur Phänomenologie des inneren zeitbewusstseins: mit den texten aus der erstausgabe und dem nachlass*. Hamburg: Meiner 2013.

23 Varela FJ. *The specious present: a neurophenomenology of time consciousness*. In: Petitot J, Varela FJ, Pachoud B, et al. editors. *Naturalizing phenomenology: issues in contemporary phenomenology and cognitive science*. Stanford: Stanford University Press 1999, pp. 266-314.

24 Parnas J, Zahavi D. *The role of phenomenology in psychiatric diagnosis and classification. Psychiatric diagnosis and classification*. Hoboken, NJ: John Wiley & Sons Inc 2002, pp. 137-62.

25 Gallese V. *From mirror neurons to embodied simulation: a new neuroscientific perspective on intersubjectivity*. Eur Psychiat 2011;26(Suppl 1):2127.

26 Gallese V. *Neuroscienze e fenomenologia*., Treccani Terzo Millennio 2010.

27 Parnas J, Sass LA, Zahavi D. *Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object*. Schizophr Bull 2013;39:270-7.

28 Andreasen NC. *DSM and the death of phenomenology in America: an example of unintended consequences*. Schizophr Bull 2007;33:108-12.

29 Insel TR. *The NIMH Research Domain Criteria (RDoC) Project: precision medicine for psychiatry*. Am J Psychiatry 2014;171:395-7.

30 Parnas J, Moller P, Kircher T, et al. *EASE: examination of anomalous self-experience*. Psychopathology 2005;38:236-58.

31 Parnas J, Moller P, Kircher T, et al. EASE: *examination of anomalous self-experience*. L'Encephale 2012;38(Suppl 3):121-45.

32 Klosterkotter J, Ebel H, Schultze-Lutter F, et al. *Diagnostic validity of basic symptoms*. Eur Arch Psychiatry Clin Neurosci 1996;246:147-54.

33 Schultze-Lutter F, Ruhrmann S, Berning J, et al. *Basic symptoms and ultrahigh risk criteria: symptom development in the initial prodromal state*. Schizophr Bull 2010;36:182-91.

34 Fava GA. *Road to nowhere*. World Psychiatry 2014;13:49-50.

35 Fava GA. *The intellectual crisis of psychiatric research*. Psychother Psychosom 2006;75:202-8.

36 Maj M. *Social neuroscience as an ideal basic science for psychiatry*. World Psychiatry 2014;13:105-6.

37 Cacioppo JT, Cacioppo S, Dulawa S, et al. *Social neuroscience and its potential contribution to psychiatry*. World Psychiatry 2014;13:131-9.

38 Lewis A. *The later papers of Sir Aubrey Lewis*. Oxford: Oxford University Press 1979.

39 Cooper R. *What is wrong with the DSM?* Hist Psychiatr 2004;15:5-25.

40 Thompson E. *Mind in life: biology, phenomenology, and the sciences of mind*. Cambridge, MA: Belknap Press of Harvard University Press 2007.

41 McDowell JH. *Mind, value, and reality*. Cambridge, MA: Harvard University Press 1998.

42 Parnas J. *A disappearing heritage: the clinical core of schizophrenia*. Schizophr Bull 2011;37:1121-30.

43 Hojaij CR. *Reappraisal of Dementia Praecox: focus on clinical psychopathology*. World J Biol Psychiatry 2000;1:43-54.

44 Maj M. *Critique of the DSM-IV operational diagnostic criteria for schizophrenia*. Br J Psychiatry 1998;172:458-60.

45 Parnas J, Sass LA, Zahavi D. *Recent developments in philosophy of psychopathology*. Curr Opin Psychiatr 2008;21:578-84.

46 Jaspers K. *The phenomenological approach in psychopathology*. Br J Psychiatry 1968;114:1313-23.

47 Pallagrosi M, Fonzi L, Picardi A, et al. *Assessing clinician's subjective experience during interaction with patients*. Psychopathology 2014;47:111-8.

48 Fuchs T. *Subjectivity and intersubjectivity in psychiatric diagnosis*. Psychopathology 2010;43:268-74.

49 Engel GL. *How much longer must medicine's science be bound by a seventeenth century world view?* Psychother Psychosom 1992;57:3-16.

Explanation and description in phenomenological psychopathology

L.A. Sass

Dept of Clinical Psychology, GSAPP-Rutgers University

Summary

The aim of this article is to lay out a number of ways in which the phenomenological approach to psychopathology can be not merely "descriptive", but contribute as well to the project of "explanation". After considering some ambiguities and controversies pertaining to the notions of description, explanation, understanding and causality, the article turns to a particular example of psychopathology: schizophrenia. The "ipseity-disturbance" model of Sass & Parnas is presented as a way of illustrating the various explanatory possibilities.

The ipseity-disturbance model postulates a two-faceted disorder of minimal or basic self-experience, involving hyperreflexivity (exaggerated self-consciousness, initially of an automatic kind) and diminished "self-affection" or self-presence (decline in the sense of existing as a vital and self-identical subject of experience), together with concomitant disturbances in one's "grip" or "hold" on the external world (the clarity and stability of one's experience of external reality).

Six kinds of explanatory relationships are described and discussed. Three are synchronic relationships, involving phenomenological implication: equiprimordial, constitutive and expressive. Three pertain to diachronic relationships, involving causal or quasi-causal changes over time: basic, consequential and compensatory processes. Whereas the first or synchronic relationships concern forms of mutual implication that clarify the structure of the experiences at issue, the second or diachronic type concerns the development or genesis, over time, of abnormal forms of experience, and related forms of action and expression, in light of the causal or quasi-causal patterns they may demonstrate.

These relationships are considered in relation to several philosophical concepts, including Aristotle's notion of the four causes or explanatory factors (material, efficient, formal, final), Husserl's notion of "motivational causality", and the concepts of downward causation, system (or formal) causation, and epiphenomenalism. A final section takes up the self-critical and eminently phenomenological question of the degree to which phenomenological concepts regarding subjectivity can be considered to have an "objective" status, as opposed to being useful ways for us to distinguish aspects or processes of what is in fact a kind of underlying unity. All this helps to clarify the nature of phenomenology's potentially explanatory role.

Key words

Explanation • Description • Causality • Phenomenological-psychopathology • Schizophrenia • Phenomenology • Ipseity • Basic-self • Hyperreflexivity • Aristotle's causes

Introduction

The purpose of this article is to lay out some of the ways in which the phenomenological approach to psychopathology can be not merely "descriptive", but contribute as well to the project of "explanation". This may seem a surprising claim, given how frequently phenomenology – which focuses on experience, subjectivity, or the first-person perspective – has, in fact, been characterised as a purely *descriptive* enterprise, and indeed as deriving its essential value and rigor from such a purified focus. In *Phenomenology of Perception*, a classic text, the philosopher Merleau-Ponty [1] characterises phenomenology as a matter of "describing, not of explaining or analysing … [as an attempt] to give a direct description of experience as it is without taking account of its psychological origin and the causal explanations which the scientist, the historian, or the sociologist may be able to provide". "Phenomenology", writes Moran, "may be characterized broadly as the descriptive science of consciously lived experiences and the objects of these experiences, described precisely in the manner in which they are experienced" [2]. The general idea seems to be that explanation necessarily involves the provision of causal accounts, whereas phenomenology does not traffic in causal explanations. As noted, phenomenology considers the first-person perspective; supposedly, it is concerned only with the "what" and the "how" of subjective life and its abnormalities ("how" in the sense of describing not only the manifest content of experience, but also the form or style of its appearing) rather than with the efficacious factors or processes that brought it about.

This is often associated with the aspiration toward clarity

Correspondence
Louis A. Sass, Department of Clinical Psychology, GSAPP-Rutgers University, 152 Frelinghuysen Road; Piscataway, New Jersey 08854, USA • Tel. +848 445 2000 • Fax 732 445-4888 • E-mail: lsass@rci.rutgers.edu

and certitude of traditional phenomenology, which seeks to set aside anything as speculative as a causal hypothesis in favour of a pure and reliable description of what is directly manifest in experience (using the "phenomenological reductions" advocated by Edmund Husserl, the creator of phenomenology; these include a bracketing of all theories *about* experience in favour of direct description *of* experience) [3]. More "hermeneutic" or interpretive forms of phenomenology (largely post-Heideggerian) aspire to provide "understanding" as well as description, but "understanding," too, is often contrasted with "explanation" [4 5] and with "understanding" sometimes understood as involving the elucidation of reasons or motives, and providing a coherent picture, in contrast with the causal approach of true "explanation", which aspires toward correspondence with objective reality and/or the ability to alter it.

It can seem, then, that phenomenology is irrelevant to explanation in psychiatry and psychopathology. This is likely to diminish phenomenology's importance in the eyes of many researchers and practitioners, given the widespread view that science is essentially explanatory. According to the philosophers of science Hempel and Oppenheim [6]: "to explain the phenomena in the world of our experience, to answer the question "Why?" rather than only the question "What?", is one of the foremost objectives of all rational inquiry; and especially scientific research, in its various branches strives to go beyond a mere description of its subject matter by providing an explanation of the phenomena it investigates (p. 8)".

One's vision of phenomenology and phenomenological psychopathology will immediately be complicated, however, if one considers notions such as that of the "*trouble générateur*" (generating disorder) as formulated by one of the first and greatest of phenomenological psychopathologists, Eugene Minkowski. Minkowski's [7 8] use of the adjective "generative" is somewhat ambiguous: it can refer either to the way in which some underlying orientation or theme *brings together* (into a kind of thematic unity) a variety of different symptoms or other aspects of a person or patient, but also to the way in which some central or originating factor may *bring about* a series of other symptoms that it engenders[a]. Both would seem to involve more than the "mere description" to which Hempel and Oppenheim refer [6].

Phenomenology is, on one level, a profoundly *descriptive* enterprise, and it can be justified on this basis alone – in light of what philosopher Franz Brentano called the inherent "dignity of the psychical domain" [9]. Yet phenomenology's *descriptive* focus does not render it irrelevant for the allied enterprise of explanation. Phenomenology can help us to articulate and to grasp both the *structure* and the *genesis* of human experience and also of the forms of expression and action that go together with it.

Here I shall discuss the explanatory relevance of phenomenology for the science and practice of psychopathology. It is appropriate to take, as our prime example, the syndrome or illness that has been, historically speaking, the most prominent object of study both in psychiatry in general and in phenomenological psychopathology in particular, namely schizophrenia. But first we must acknowledge some significant ambiguities in the philosophical as well as common sense concepts at issue. There is, for example, no clear consensus on what it means to "explain" a phenomenon.

Explanation, as already noted, is often associated with the providing of a *causal* account. Others broaden the notion to include an analysis of the underlying *structure* of a phenomenon, or even any account that answers a "why?" question or, still more broadly, that increases our "*understanding*" of a phenomenon [10 11] (which raises the equally thorny issue of what "understanding" involves – but I will resist falling down that rabbit hole here). Even the notion of "cause" is itself the subject of debate, however, with some philosophers insisting (along with common sense) that a cause must be *independent* of the effect and must have some *actual impact* that brings about the effect (as when one billiard ball hits another, making it move), while other philosophers require only that the occurrence of the purported cause "make a difference" in the likelihood of the effect-event [12]. Still another issue concerning causality pertains to subjectivism versus objectivism: for a causal account to be valid, must the entities or processes it posits correspond to an *actual* or literally existing state of affairs, or is the account rather to be judged on more human or pragmatic grounds – in its ability to organise our experience, help us make predictions, or guide our actions [13 14]?

For some thinkers, "description" and "explanation" are radically distinct, since the former captures only surface appearances whereas the latter grasps deeper or broader factors or patterns that play a role in producing these appearances. Others, however, view description itself as typically "thick", in the sense of going beyond the obvious, and thus as being, in some sense, *continuous* with at least some forms of explanation [15-17]. The latter may seem particularly true in the realm of phenomenological psychopathology, given that what we hope to grasp – the patient's experience – is only indirectly available

[a] Minkowski describes "loss of vital contact" (the *trouble générateur*) as "not a consequence of other psychical disturbances, but an essential point [or state] from which spring, or at least from which it is possible to view in a uniform way all the cardinal symptoms" (1927, p. 87 my translation) [1].

to us, mostly through verbal report; and this typically requires considerable interpretation on our part before it can stand even as a description of what we take to be the patient's actual subjective life. According to Simon [15], the "line between description and explanatory laws is not a sharp one, for we may find all kinds of intermediate cases – especially for qualitative explanations."

Some of the complexities as well as ambiguities at issue are apparent in what is the first, and perhaps still the foremost, account of explanation: Aristotle's notion of the so-called "four causes": material, formal, efficient and final. Although the Greek word used by Aristotle – *aition,* plural *aitia* – has usually been translated as "cause" (as in "Aristotle's four causes"), it can be argued that only one, "*efficient*" – that which makes something happen – corresponds to many modern notions of cause, and that we should speak, therefore, of Aristotle's four explanatory "*factors*". Be that as it may, it has been argued that all such factors can be relevant, and may even be required, for a truly explanatory account (the *material* cause or factor refers to that from which something comes to be or out of which it is made – e.g. the bronze of a sword. The *formal* cause is something's form, pattern, or essence: that which defines it as what it is. The *final* cause refers to purpose or goal, to what something is for, its *telos* [18 19]).

It would, I think, be fruitless to dwell much longer with these philosophical issues – issues that seem, in any case, to be becoming only *more* rather than less controversial in recent philosophical discussion [12]. Without attempting precise definitions, let us take the term "description" to refer to a fairly superficial reporting of what seems to be experienced by a patient, while "explanation" refers to an account that claims to elucidate either the underlying processes or mechanisms, *causal or otherwise*, that produce certain phenomena, or else the unifying structure of an event, state of affairs, or phenomenon that allows us to appreciate its essential unity [16]. Here I would like to lay out some of the major ways in which, contrary to widespread opinion, a typical phenomenological account of abnormal experience can go well beyond mere description and may even offer forms of explanation that, in fact, not only increase our understanding but are ultimately relevant for causal and even neurobiological explanations.

Here I will focus on what seems the most prominent contemporary phenomenological account of schizophrenia, the "ipseity-disturbance" hypothesis put forward by a number of contemporary psychologists and psychiatrists including Josef Parnas and myself [20 21]. The point here will not be to defend the hypothesis, which postulates as the *trouble générateur* a disturbance of basic or minimal self (ipseity), but simply to *use* it as an example of the potentially *explanatory relevance* that a typical phenomenological account may have. It should be noted that the hypothesis has important precedents in early 20th century psychiatry as well as links with neurobiological and psychotherapeutic hypotheses (for overviews of evidence and argument, see Nelson et al., 2014 [22]; Sass, 2014 [21]; Sass et al., 2011 [23]. On relevance for explanation, see Parnas & Sass, 2008 [24], Sass, 2010 [25] and Sass & Parnas, 2007 [26]; for psychotherapy see Skodlar et al., 2013 [27]).

Schizophrenia

According to the ipseity-disturbance hypothesis, the fundamental disturbance or "*trouble générateur*" of schizophrenia is best understood as a two-sided disturbance of "core" or "minimal" self – also known as "ipseity"[20-23 28]. Ipseity refers to the crucial sense of self-sameness, of existing as a subject of experience *or subject pole* that is alive and at one with itself at any given moment, *serving as a vital centre point of subjective life*. The writer Antonin Artaud (who suffered from schizophrenia) was referring to this when he spoke of "the essential illumination" and this "phosphorescent point", equating this vital and illuminating centre-point with the "very substance of what is called the soul", and describing it as a prerequisite for avoiding "constant leakage of the normal level of reality" [29].

The first aspect of ipseity-disturbance is *hyperreflexivity* – which refers to a kind of exaggerated self-consciousness, that is, a tendency, non-volitional at its core (termed *operative* hyperreflexivity), for focal, objectifying attention to be directed toward processes and phenomena that would normally be "inhabited" in the sense of being experienced implicitly as a part of oneself [30]. The second aspect is diminished self-affection or self-presence – a phrase that has nothing to do with diminished liking or fondness, but with a decline in the (passively or automatically) experienced sense of existing as a living and unified subject of awareness. Together, these mutations in the act of awareness are accompanied by alterations in the object or field of awareness, that is by disruption of the focus, salience, or sense-of-reality with which objects and meanings emerge from a background context – what we refer to as disturbed "hold" or "grip" on the experiential world [20]. Though fundamentally automatic or passive in nature, this basic "*operative* hyperreflexivity" may also give rise to processes of a more intentional, volitional, or intellectual sort, such as the "*reflective* hyperreflexivity" to be described below [25].

Shortly I will consider two kinds of relationship, synchronic and diachronic, that can obtain between aspects or processes of experience (They correspond to the two senses of "generative" in Minkowski). Whereas the first concerns forms of mutual implication that clarify the

TABLE I.
Subtypes of Synchronic and Diachronic Relationships

Synchronic relationships (phenomenological implication)	Diachronic dimension (phenomenological causality)
Equiprimordial	Primary/Basic
Constitutive	Consequential
Expressive relationships	Compensatory processes

structure of the experiences at issue, the second concerns the development, over time, of abnormal forms of experience in light of the causal or quasi-causal ("motivational," in Husserl's sense; see below) patterns they may demonstrate[b]. Each domain contains three subtypes (see Table I). I am, by the way, sceptical regarding the prospect of finding a mapping of these explanatory possibilities that is wholly satisfying – in the sense of being all-encompassing, non-overlapping and precisely defined. The present classification is perhaps only a provisional sketch. It should nevertheless serve to clarify, for clinicians and researchers, some of the most important ways in which phenomenology can offer considerably more than *mere* description.

The first or equiprimordial type of synchronic connection is exemplified by the mutually implicatory relationship that seems to exist between the two sides of the foundational ipseity-disturbance: hyperreflexivity and diminished self-affection. Hyperreflexivity refers to the (largely automatic, at least in its origins) coming-to-focal-awareness of aspects of oneself that would normally remain in the background of awareness, where they normally have an implicit rather than explicit form of presence (e.g. kinaesthetic and proprioceptive bodily sensations; the verbalizations inherent in our inner speech or thought)[c]. Diminished self-affection or self-presence refers to the sheer diminishment of a sense of existing as a subject of experience, that is, a diminishment of the sense of being what Artaud termed the "phosphorescent point" or "essential illumination" – as exemplified by a patient who says, "I was simply there, only in that place, but without being present" [31].

On superficial consideration, these two phenomena might seem mutually contradictory, perhaps even psychologically incompatible; for whereas one can be described as involving *heightened* self-consciousness, the other implies *diminished* self-awareness. More careful phenomenological consideration suggests, however, that they can better be understood as not only compatible but even mutually complementary[d]. Whereas the notion of hyperreflexivity emphasises the way in which something normally tacit becomes focal and explicit, that of diminished self-affection emphasises a complementary or equiprimordial aspect of the *very same process*: the fact that what once was tacitly lived is no longer being inhabited as a medium of taken-for-granted ipseity or basic-selfhood.

A second form of implicatory or synchronic interdependence is exemplified by the relationship between altered ipseity and concomitant mutations in the experience of the external world. Here we might speak of a certain sort of world (characterised, for example, by qualities of perceptual fragmentation, static-ness, perplexing disorganization, or fading) as being *constituted* by certain forms of basic subjecthood, given that the latter provides the enabling condition for the former. One might speak of a "world-shaping relation" between a certain kind of lived-body or corporeally grounded subjectivity, and the experiential world that it constitutes [32]. Forms of ipseity characterised by hyperreflexivity and diminished self-presence would imply, and in a sense *constitute*, a certain disorganisation and fading in the field of awareness: distracting and normally irrelevant forms of self-experience (think, again, of kinaesthetic sensations and inner speech), together with a diminished sense of being a witnessing presence, would undermine the coherence, equilibrium, or sheer presence of one's experience of outer reality – thereby accounting for the "constant leakage of the normal level of reality" to which Artaud referred.

"Constitution" is not easily characterised. It should not be confused with a literal creation nor conceived as a temporal succession. There is not *first* the fact or process of subjectivity and only *then* the associated world. Indeed, the former has no existence except in relation to the latter, and in this sense they co-occur – each lacks the kind

[b] The synchronic/diachronic distinction largely corresponds with Husserl's distinction between static and genetic phenomenology (the latter including what he termed "motivational" issues) (Husserl in Welton 1999, pp. 144, 319) [3].

[c] The kind of awareness we normally have of our bodies is, writes Gurwitsch (1964, p. 302, describing Merleau-Ponty's views) [45], "not … knowledge in thematized form. [Rather] an inarticulate and indistinct familiarity completely devoid of positional and disclosing consciousness".

[d] This complementarity is confirmed by two recent studies, which show that, like schizophrenia, both intense introspection (an obvious manifestation of hyperreflexivity of the reflective type) and depersonalisation disorder (by definition a manifestation of a kind of diminished self-affection) actually show prominent manifestation of *both* aspects of abnormal ipseity. See Sass et al. (2013) [46]; Sass et al. (2013) [47].

of independence of the other that is required for most notions of *efficient* causality [33] [e]. Still, in line with Kant's and Husserl's analyses of "transcendental subjectivity" as the grounding of world-experience, it makes sense to think of self-aware subjectivity (ipseity) as "constituting" its world.

A third type of synchronic relationship might be termed "expressive". Here we are thinking of instances in which some quite specific experience, such as a particular delusional claim, with its specific content, seems to reflect or manifest some more general, perhaps formal, structure of experience. The classic influencing-machine delusion experienced by a patient named Natalija illustrates the point [34]. Natalija's claim (I am not sure it should be called a "belief", at least in any straightforward sense [35]) that all her actions and experiences were but reflections of the movements and experiences undergone by a machine-like partial replica of herself existing somewhere in a distant room, seems to express her general alteration of ipseity or minimal selfhood, in which she lacked the usual sense of agency and self-possession. It is often possible to trace a sequential progression from early, vague feelings of self-alienation to this sort of "bizarre" delusion (see below). What I am pointing out now, however, is a *synchronic* relationship, namely, the concordance between levels that might be termed specific and general or concrete and abstract. We see how the partial replica of herself seems to *express* her general ipseity mutation – an abnormality that clearly differs from, say, that of a psychotically depressed individual, whose delusions might rather concern, e.g. having committed some irredeemable crime against humanity [36].

Here, then, are three forms of the "intentional intertwining" or "mutual implication by meanings" that Husserl identified as the "essence of conscious life" [3]. In their "form and principle", Husserl writes, such relationships have "no analogue at all in the physical" world. The "synthesis of consciousness", he states, is completely unlike "spatial mutual exteriority": it involves not efficient causality between separate events but a kind of mutual implication, albeit of an experiential rather than a strictly logical sort. Merleau-Ponty was making the same point when he spoke of "internal links" between aspects of experience that "display one typical structure … standing in a relationship to each other of reciprocal expression" [1] [f]. To articulate such relationships of implication provides an integrating vision, an understanding not of causal interaction but "of style, of logical implication, of meaning and value" [17]; and this does serve an explanatory function. Minkowski characterised phenomenological psychopathology as an attempt to understand symptoms not in isolation or as products of modular defects but as "expression of a profound and characteristic modification of the human personality in its entirety" [1].

Next we turn to three other forms of phenomenological relationship or interaction: these, however, concern relationships over time and suggest something closer to what is usually associated with the (admittedly ambiguous) notion of causality.

I will dwell more briefly on these diachronic and quasi-causal notions since they are, in a sense, but phenomenological variants (emphasising subjectivity) of familiar medical notions regarding forms of physical pathology and their *sequelae*. Thus, we may think of a pathological state or form of subjectivity as being more basic or primary than are certain subsequent or *sequelae* conditions that it somehow engenders as after effects or secondary results. These latter, in turn, may be conceived in at least two ways: as causal *consequences* directly brought about or determined by the more primary condition, or as defensive responses – *compensations* – whereby the organism seeks to protect itself against, or otherwise compensate for, the primary condition. Whereas the former is typically understood in largely causal/deterministic fashion, the latter does assume some kind of teleological or goal-directed factor.

We might think, for example, of a form of operative hyperreflexivity that, from a psychological standpoint, has a primary status – existing as a kind of "basal irritation" [37]. There might be an abnormal tendency for kinaesthetic

[e] Eugen Fink (1995) [33], Husserl's closest associate, warns against "seduction by mundane meanings": for example, talk of "constituting subjectivity" is misleading as long as one is guided by mundane representations of substantial and accidental being and construes the adjective "constituting" as an *accident* in a transcendental subjectivity understood as substance. … Subjectivity is not something that first is and then constitutes, but… it is in the constitutive process in which the world comes about [*Weltwerdungsprozess*] that it constitutes *itself* for the first time. Indeed, even this conception is encumbered with possible misunderstandings and is in a certain sense *false*. … The transcendental constitution of the world is not conceptualised by taking one's lead from either a static-substance or a dynamic-process relationship in being. It is just that the "process" conception is more appropriate for an *analogical* presentation; it has a certain *affinity* to the special transcendental "mode of existence" [*Existenzweise*] (pp. 97f). In Fink's view, "every attempt to speak of the transcendental" necessarily encounters conflict and contradiction. This is due to the gap between the intended, transcendental sense of words as used in phenomenology (which aims at subjectivity itself) and the mundane or natural sense, grounded in the "natural attitude", whence they derive their original sense.

[f] Merleau-Ponty's use of "expression" in this sentence is broader than mine; it encompasses all three synchronic relationships.

sensations in one's limbs, sensations that would normally be unnoticed (because habitual), to emerge into focal awareness – due, perhaps, to some hitch in the neurophysiological process whereby extremely habitual sensations are normally suppressed (due to salience dysregulation involving abnormal dopamine regulation by a hyperactive hippocampus) [38]. On the experiential plane, this would be manifest as an abnormal awareness of, say, the muscle innervations or joint linkages in one's arm or wrist, which might now come to seem overly loose, overly tight, or otherwise awry. One can imagine a similar process affecting the inner speech that normally serves as the tacit medium of our thinking.

Emerging saliencies of this type are likely to draw more attention, thereby encouraging a natural or "consequential" exacerbation whereby the lived-body (or inner speech) emerges as a target rather than a medium of awareness. There are likely to be affective or mood-like consequences as well, given the disconcerting sense of estrangement all this is likely to invoke. And this, in turn, may engender a range of defensive responses, one of which might be a form of withdrawal and/or directed self-scrutiny – the latter a form of *reflective* hyperreflexivity whereby one hopes to understand and perhaps to pacify or control these disturbing developments. Thus we may think of more *basic* or *basal* forms of hyperreflexivity (*operative* hyperreflexivity) as leading to *consequential* exacerbations as well as to *compensatory* reactions of various kinds. Although compensatory reactions may sometimes help, they may also have a paradoxical effect: the defensive focusing may not interrupt (as intended) but rather *exacerbate* the pathological progression whereby the corporeal ipseity of the lived-body, or the more linguistically grounded ipseity of the thinking/speaking self, is undermined or fragmented. This, in any case, is a very plausible scenario, and one that corresponds closely to the findings of longitudinal research as well as to many patient accounts [34]. All these processes will, in all likelihood, have their own neural correlates, warranting study. The crucial (and perhaps obvious) point here, however, is that the consequential and compensatory *sequelae* are, at least to a significant extent, responses to *subjective experiences*, to the *what-it-is-like* of subjective life – something that is not reducible to physical events in the brain and nervous system. Experience is not *epiphenomenal* here; it is not a mere by-product or secondary effect without causal influence[g], given that the *way* in which things are experienced (not neural events *per se* but the emergence of certain kinaesthetic sensations into focal *awareness*) has clear impact on behaviour and thus on the world. It is the "Object [that] stimulates me in virtue of its *experienced properties* and not its physicalistic ones", wrote Husserl [3]. "The world [that motivates my action and mental activity] is *my surrounding world*. That is to say, it is not the physicalistic world but the thematic world of my, and our intentional life". Husserl goes on to clarify that the "surrounding world" of our experience includes not merely the ostensible objects of our awareness, but also the general form or structure of a given *way* or mood-like *mode* of experiencing: it includes "what is given to consciousness as extra-thematic … my thematic horizon". The latter incorporates such formal or structural features as time, space, causal relationships, as well as the overall feel or quality of reality or the lack thereof – all of which provide a field of possibility for progressive experiential developments such as the gradual evolution from mild operative hyperreflexivity toward Natalija's full-blown influencing-machine delusion.

Husserl, in his later work, speaks of all this as involving forms of what he terms "motivational causality", which he considers the "fundamental lawfulness of spiritual life" and which Merleau-Ponty describes as a "fluid concept" indispensable to the study of phenomena. This is the process (Husserl distinguished it from "natural causality") [3], whereby subjective meanings and horizons involve, engender, and inspire various forms of reaction: "One phenomenon releases another, not by means of some objective efficient cause… but by the meaning [*sens*] which it holds out" [1]. The latter would include forms of attentional response and of behavioural comportment, e.g. staring intently, or withdrawal from action into, say, grandiose fantasies and a solipsistic mood-all of which have actual effects, both experiential and behavioural, and thereby participate in the causal nexus of the world.

Philosophical reflections

The synchronic and diachronic factors I have been discussing correspond to the two possible ways of understanding Minkowski's classic notion of a *trouble généra-*

[g] The *Stanford Encyclopedia of Philosophy* describes epiphenomenalism as follows: the view that mental events are caused by physical events in the brain, but have no effects upon any physical events. Behaviour is caused by muscles that contract upon receiving neural impulses, and neural impulses are generated by input from other neurons or from sense organs. On the epiphenomenalist view, mental events play no causal role in this process. Huxley (1874), who held the view, compared mental events to a steam whistle that contributes nothing to the work of a locomotive. James (1879), who rejected the view, characterized epiphenomenalists' mental events as not affecting the brain activity that produces them "any more than a shadow reacts upon the steps of the traveller whom it accompanies" [41].

teur: whereas the synchronic factor helps us understand the essential unity, something like the defining form or overarching theme of the condition, the diachronic factor helps us to grasp how a core disturbance (e.g. of ipseity) can develop over time, giving rise to a full panoply of symptoms.

We might think, as well, of the most classic of all accounts of explanation, that of Aristotle, and recall that whereas his formal and material "causes" are often assumed to refer to synchronic aspects, the "efficient" and "final" factors may pertain to the diachronic dimension of explanation. The synchronic relationships I have delineated (equiprimordial, constitutive, expressive) seem to concern the "formal" cause or factor, for they purport to capture the essence of the phenomenon, the core defining features of schizophrenia, those that (one may claim) make it what it is. A description of the *normal* form of human experience, with its world-directed and implicit/explicit structure, might be understood as capturing the "material" cause (though not material in the sense of "physical"), given that it is this which provides the medium, that out of which, schizophrenia is carved via distinctive transformations of ipseity (e.g. whereby the implicit is rendered explicit [30]). The diachronic factors I have described also seem to fall into place, with the consequential relationships involving something close to Aristotle's efficient cause while compensatory ones seem to involve something more akin to the final cause, in the sense of being teleologically directed.

As I have argued above, the diachronic transitions that I labelled "consequential" and "compensatory" both involve responses to the "what it is like" of the subjective domain. It is the *lived* experience of hyperreflexive processes that elicits a sense of strangeness that, in turn, has effects on both experience and behaviour. Exactly how to conceive the relationship between these experiential changes and the neurophysiological plane is by no means clear, however. This should not be surprising, given that to answer this question with confidence would be tantamount to having solved the mind/body problem. And the reality of contemporary neuroscience and philosophy of mind is that, in fact, *we simply have no idea regarding how to solve the infamous mind/body problem*, nor is there even any prospect of doing so. This is a point that is widely, indeed almost universally acknowledged in the philosophy of mind[h].

One possibility would be to speak of "downward causation", a process whereby experiential processes entrain or otherwise have an impact on the neurophysiological plane. Evan Thompson [39], a philosopher largely in the phenomenological tradition, has argued that we might conceive downward causation as a sort of metaphor for the way in which larger systemic features or global processes, involving experiential states, can impose "organisational constraints" on the operation of their component parts. He quotes analytic philosopher John Searle on the notion of "system causation": "The system, as a system, has causal effects on each element, even though the system is made up of the elements". Thompson himself speaks of "dynamic co-emergence [whereby] part and whole co-emerge and mutually specify each other". And this, he says, allows for a "recuperation" of something like Aristotle's notion of formal causation", a form of causation in which cause and effect are not "external to one another" since part and whole are complementary or intertwined (pp. 423, 427, 431, 433). This, in effect, implies a linking of the two senses of "generate" in Minkowski's notion of the *trouble générateur*, and perhaps, as well, a bridging of the gap between the synchronic and the diachronic.

Husserl (1977, p. 39) [3] does seem, in any case, to have been very justified when he spoke, in his lectures on phenomenological psychology of 1925, of "ultimate unclarities concerning the mutual relation of nature and mind and of all the sciences which belong to these two titles. … What seems at first obviously separated, upon closer inspection turns out to be obscurely intertwined, permeating each other in a manner very difficult to understand". It should hardly be controversial to say that greater understanding of the nature and structure of a phenomenon is likely to contribute to our scientific grasp of it. Indeed, this would be true even if we imagined the phenomenon at issue to be itself an epiphenomenon – a pure by-product or consequence, without causal impact of its own [40]. Suppose that the hypereflexive and diminished-self-affection of schizophrenia were *entirely and only* the result of some biological abnormality in the brain of certain individuals. It would *still* be relevant to have recognised their possible complementarity as two sides of a single experiential mutation. For, at the very least, this would save us from thinking we should be looking for the neurobiological bases of two *distinct* abnormalities, when, in fact, they may well be two sides of a single coin. Phenomenology gives us essential conceptual tools with which to consider such possibilities. This is one way in which it can contribute to cognitive neuroscience: by helping us to re-conceive the field of play regarding what, in fact, may need to be explained, even reductionistically.

But a second point would involve questioning the very

[h] According to Fodor, we have not "even a glimmer [of understanding] of how anything physical could be a locus of conscious experience" (1998, p. 83) [51]. Most philosophers-of-mind would agree; see e.g. Chalmers 1995 [40].

idea of the causal inertness or irrelevance of a supposed epiphenomenon (i.e. "the view that mental events are caused by physical events in the brain, but have no effects upon any physical events" [41]). Consider the classic example of an epiphenomenon, which is a shadow[i]. A shadow may well be entirely the product of a light source and a light-blocking object; this does not mean, however, that it is *itself* causally inert: it may, after all, cool the pavement, or – more to the point, since subjectivity plays a role – may contribute to the occurrence of a significant event, such as an automobile accident. But, in fact, there is little reason to consider the experiential change in schizophrenia as being purely epiphenomenal. We must remember that each and every metaphysical account of the mind/body or mind/brain relationship is deeply problematic, indeed seemingly impossible when given careful consideration [40]. There is simply no compelling reason to prefer an eliminativist, epiphenomenal, or other purely reductive account – especially since all such accounts fly in the face of what seems the experiential undeniability of subjective life and of the possibility of acting on its basis.

Finally, it should be obvious that both synchronic and diachronic understanding might be helpful in the psychotherapy of schizophrenia – so long as one accepts that, other things being equal, it is better to have, and to convey, an empathic grasp of the patient than not to do so. Modular approaches are popular now (e.g. the NIMH "Research Domain Criteria"), and there is a general inclination to reject the more holistic accounts that were inherent in some traditional forms of diagnostic practice. No human being is, however, likely to experience him or herself in a purely additive or fragmentary way, but as constituting, subjectively, some kind of consistent mode or way of being, an "organized and living unity"(Minkowski 1927, p. 12) [3] even if, as in schizophrenia, this mode can *itself* be experienced, from within, as having qualities of fragmentation and alienation. He or she is likely, as well, to have some sense of continuity over time, and perhaps also some sense of progressive change. He or she is likely, in turn, to prefer interacting with mental-health professionals who appreciate all this, rather than being viewed as a meaningless conglomeration of symptoms that can only be captured in the mechanistic vocabulary of deficit and the irredeemably bizarre.

Self-critical reflections

Before concluding, I would like to raise an issue that is perhaps ill advised in an introductory article: namely, the question of the objective reality of all the distinctions I have just been making. I have done my best to clarify phenomenology's potential contribution to explanation and the scientific enterprise. I wish now to ask to what extent the distinctions I have been laying out should be understood to correspond to *objective* reality – which in this case refers to the objective reality of something subjective, the experiential flow – as opposed to being imposed by *us*, the phenomenological investigators. Eugen Minkowski once stated, "I attempt a subjective study here, but one that strives, with all its force, toward objectivity" [42]. But to what extent is this ambition realistic? Indeed what *is*, in fact, the nature of objectivity within the realm of subjective life?

The issue concerning objectivity is not unique to the study of experience, for as I noted at the outset, it is a prime controversy concerning the nature of explanation in the natural or physical sciences as well. The prominent philosopher of science Bas van Fraassen [43], thinking mainly of the natural sciences, stresses that what we may legitimately call the "*causes*" of an event always depend crucially on the particular context and interests of we who seek to understand and explain; and that it is on this always-somewhat-subjective basis that we select, from a multiplicity of interdependent factors (or *seemingly* independent factors) to create a kind of causal account that not only makes sense for us in a given context but helps us to make predictions and to cope.

Consider in this light our own parsing of the diachronic factors in schizophrenia. I have already noted the fact – well-known in medical pathology – that both consequential and compensatory reactions may serve, in turn, to instigate later developments. We may certainly speak of basic, fundamental, or primordial factors, but this is only a kind of relative truth, valid within a certain context. For it is obvious that the factor in question must *itself* have come into being in some fashion, and that it too could therefore also be considered an effect rather than origin or cause; and further, that *its sequelae* can also play an instigating role in later developments. Even the distinction *between* consequential/determined and compensatory/defensive reactions should not be understood too strictly, as if the latter were wholly intentional or entirely goal-directed; for its seems likely that defensive reactions typically call upon and exploit what comes most easily or naturally, indeed quasi-deterministically, to a given individual. (The latter point is discussed by David Shapiro in his indispensable book, *Neurotic Styles*).

Similar points apply in the synchronic domain. It may well be that what we conceptualise as "expressive" relationships between a symbolising dimension and a more fundamental

[i] See William James, quoted in Robinson (2012) [41] in a previous endnote.

structural level could, in many instances, be seen simply as *our* way of describing, in more concrete/specific versus more abstract/general terms, what is really but one indivisible reality. It is not, after all, as if there were *first* the general mode and only *then* the specific manifestations; often, at least, they are probably simultaneous and inseparable.

And what of the "equiprimordial" aspects, hyperreflexivity and diminished-self-affection? I have described them above as complementary *aspects* of a single process rather than as two distinct but co-dependent processes. But perhaps even to call them "aspects" risks projecting, onto a certain kind of lived experience, a duality that stems mostly from ourselves, from our *own* attempts to parse and come to grips conceptually with a phenomenon that, so to speak, is perfectly unitary in itself[l]. The final kind of synchronic relationship – "constitution" – is perhaps the most problematic of all. I have already criticised any tendency to view the constituting factor as existing *prior* to or *independently* of that which is constituted. But perhaps, at the limit, this brings the distinction itself into question, for it implies that the "constituting" process or factor is itself only constituted within the act of constituting itself. Does this not suggest that constituting subjectivity is, in a sense, constituted by world-making itself?

There is a certain risk in recognising the subjective dimension of our concepts or the looseness of their correspondence to what they are presumed to describe. The risk is that of a discouraging scepticism, or perhaps even nihilism regarding knowledge of the realm of subjectivity. The slide into scepticism should be quickly arrested, however, when one recalls that many such questions apply no more to phenomenology than to physics, a field whose validity we are less likely to doubt[m]. One of phenomenology's strengths as an approach to psychology is, in fact, precisely its willingness to question the adequacy of the concepts it uses to characterise the psychological domain (see Merleau-Ponty 1962, Introduction[1]; Carman 2008, p. 44f [44]). This is part of phenomenology's project of auto-reflection, indeed of attempting to provide something like a cautionary phenomenology of phenomenology itself [33]. It contrasts with the tendency, in much of analytic philosophy-of-mind as well as cognitive-behavioural psychology, simply to accept the standard, common-sense or folk-psychological vocabulary for describing mental life; and to justify this tendency, if at all, either by fiat or by a rather facile and un-self-critical form of pragmatism[n]. It is, by contrast, very much in the spirit of phenomenology, especially *hermeneutic* phenomenology, to recognise that our vocabulary and conceptual capacities are derived from, and most naturally suited to, mundane physical reality (the realm of middle-sized everyday objects), rather than to the plane of consciousness or subjective life; and that we are, as a result, always in danger of missing our target precisely because we take it (subjectivity itself) too much as being some kind of targetable entity.

To reject phenomenology because of the inherent difficulty of capturing the subtleties of subjective life makes little sense. It would be as if a cosmologist were to refuse to consider the existence of black holes on the grounds that they are just too difficult to observe or conceptualise. Phenomenology is, in this respect, both less and more difficult than physics: less because it does not address scales of reality (micro or macro) that are so utterly beyond the human; more because it turns, even more decisively, back upon itself in attempting to know the ground of all knowing, which is the nature of experience itself – the ultimate instance of what eludes us by being, in a sense, both everywhere and nowhere. Phenomenology is committed to recognising subjectivity as an objective fact of the universe. There is simply no alternative for a sophisticated and truly ambitious psychopathology than to accept this recognition and the consequences it brings. One such consequence is the need to seek concepts and methods adequate for describing subjectivity while at the same time recognising the limits of this necessary enterprise.

Conflict of interest

None.

References

1 Merleau-Ponty M. *The phenomenology of perception* (trans: Smith C). New York: Routledge & Kegan Paul 1962.

2 Moran, D. *Husserl's crisis of the European sciences and transcendental phenomenology*. Cambridge: Cambridge University Press 2012.

[l] A similar point may apply to the notions of ipseity disturbance and basic temporality – which, as various phenomenologists have argued, may amount to the same thing [21 48].

[m] Contemporary physics and cosmology also challenge our intuitive understandings grounded in mundane experience of the object world. Consider, for example, the challenge to standard notion of physical causality inherent in the notion of "quantum entanglement", a.k.a. "spooky action at a distance".

[n] Analytic philosopher-of-mind Jerry Fodor is known for calling common sense psychology or common sense belief-desire psychology, joined with computational model of mind, "the only game in town" (for critiques see Hutto & Ratcliffe 2007 [49]). Cognitive Behaviour Therapy tends to advertise its efficacy without much consideration of the prospects of more subtle forms of psychological understanding; see critiques by Varga (2014) [50] and Skodlar et al. (2013) [27].

3 Husserl E. *Phenomenological Psychology* (lectures, summer semester, 1925) (trans: Scanlon J). The Hague, Martinus Nijhoff 1977.

4 Jaspers K. *General Psychopathology*. Chicago: University of Chicago Press 1963.

5 Von Wright GH. *Explanation and understanding*. Ithaca, NY: Cornell University Press 1971.

6 Hempel CG, Oppenheim, P. *Studies in the logic of explanation* (1948). In: Brody BA, editor. *Readings in the philosophy of science*. Englewood Cliffs, NJ: Prentice Hall 1970, pp. 8-38 (quoted in Mayes 2005).

7 Sass L. *Self and world in schizophrenia: three classic approaches in phenomenological psychiatry*. Philos Psychiat Psychol 2001;8:251-70.

8 Minkowski E. *La schizophrénie*. Paris: Payot 1927.

9 Brentano F. *The concept of descriptive psychology (1888-89)*. In: Broome MR, Harland R, Owen GS, et al., editors. *Maudsley Reader in Phenomenological Psychiatry*. Cambridge: Cambridge University Press 2012, pp. 3-4.

10 Lawson-Tancred H. *Ancient Greek philosophy II: Aristotle*. In: Grayling AC, editor. *Philosophy: a Guide through the Subject*. Oxford: Oxford University Press 1995, pp 398-439.

11 Wilson RA, Keil FC. *The shadows and shallows of explanation*. In: Keil FC, Wilson RA, editors. *Explanation and Cognition*. Cambridge: MIT Press 2000, pp 87-114.

12 Woodward J. *Making things happen: a theory of causal explanation*. NY & Oxford, UK: Oxford University Press 2003.

13 Mayes GR. *Theories of explanation.* Internet Encyclopedia of Philosophy 2005.

14 Monton B, Mohler C. *Constructive empiricism*. In: Zalta EN, editor. *The Stanford Encyclopedia of Philosophy*. The Metaphysics Research Lab, Center for the Study of Language and Information (CSLI), Stanford 2014.

15 Simon HA. *Discovering explanations*. In: Keil FC, Wilson RA, editors. *Explanation and Cognition*. Cambridge: MIT Press 2000, pp. 21-60.

16 Salmon W. *Four decades of scientific explanation*. Minneapolis: University Minnesota Press 1989.

17 Geertz C. *The interpretation of cultures*. New York: Basic Books 1973.

18 Cohen SM. *"Aristotle's metaphysics"*. In: Zalta EN, editor. *The Stanford Encyclopedia of Philosophy*. The Metaphysics Research Lab, Center for the Study of Language and Information (CSLI), Stanford 2014.

19 Pérez-Álvarez M, Sass L, García-Montes JM. *More Aristotle, less DSM: the ontology of mental disorders in constuctivist perspective*. Philos Psychiatr Psychol 2008;15:211-25.

20 Sass L, Parnas J. *Schizophrenia, consciousness, and the self*. Schizophr Bull 2003;29:427-44.

21 Sass L. *Self-disturbance and schizophrenia: Structure, specificity, pathogenesis* (Current issues, new directions). Schizophr Res 2014;152:5-11.

22 Nelson B, Parnas J, Sass L. *Disturbance of minimal self (ipseity) in schizophrenia: clarification and current status*. Schizophr Bull 2014;40:479-82.

23 Sass L, Parnas J, Zahavi D. *Phenomenological psychopathology and schizophrenia: Contemporary approaches and misunderstandings*. Philos Psychiatr Psychol 2011;18:1-23.

24 Parnas J, Sass L. *Varieties of "phenomenology": on description, understanding, and explanation in psychiatry*. In: Kendler K, Parnas J, editors. *Philosophical issues in psychiatry: explanation, phenomenology, and nosology*. Baltimore: Johns Hopkins University Press 2008, pp. 239-78.

25 Sass L. *Phenomenology as description and as explanation: the case of schizophrenia*. In: Gallagher S, Schmicking D, editors. *Handbook of Phenomenology and the Cognitive Sciences*. Berlin: Springer Verlag 2010, pp. 635-54.

26 Sass L, Parnas J. *Explaining schizophrenia: The relevance of phenomenology*. In: Chung MC, Fulford KWM, Graham G, editors. *Reconceiving schizophrenia*. Oxford: Oxford University Press 2007, pp. 63-95.

27 Skodlar B, Henriksen MG, Sass LA, et al. *Cognitive-behavioral therapy for schizophrenia: a critical evaluation of its theoretical framework from a clinical-phenomenological perspective*. Psychopathology 2013;46:249-65.

28 Sass L. *Schizophrenia and the self: hyperreflexivity and diminished self-affection*. In: Kircher T, David A, editors. *The self in schizophrenia: neuropsychological perspectives*. Cambridge: Cambridge University Press 2003, pp. 242-71.

29 Sontag S. *Antonin Artaud: selected writings* (trans: Weaver, H). New York: Farrar, Straus, & Giroux 1976.

30 Sass L. *Madness and modernism: insanity in the light of modern art, literature, and thought*. New York: Basic Books 1992.

31 Blankenburg W. *Der verlust der natürlichen selbstverstandlichkeit: ein beitrag zur psychopathologie symptomarmer schizophrenien*. Stuttgart: Ferdinand Enke Verlag 1971.

32 Taylor C. *Engaged agency and background in Heidegger*. In: Guignon C, editor. *The Cambridge companion to Heidegger*. Cambridge: Cambridge University Press 1993, pp. 317-36.

33 Fink E. *Sixth cartesian meditation* (transl by Burzina R). Bloomington: Indiana University Press 1995.

34 Tausk V. *On the origin of the "influencing machine" in Schizophrenia*. Psychoanal Q 1933;2:529-30.

35 Sass L. *Delusion and double bookkeeping*. In: Fuchs T, Breyer T, Mundt C, editors. *Karl Jaspers' philosophy and psychopathology*. New York: Springer 2014, pp. 125-47.

36 Sass L, Pienkos E. *Varieties of self experience: a comparative phenomenology of melancholia, mania, and schizophrenia, Part I*. J Consciousness Stud 2013;20:103-30.

37 Klosterkötter J, Schultze-Lutter F, Gross G, et al. *Early self-experienced neuropsychological deficits and subsequent schizophrenic diseases: an 8-year average follow-up prospective study*. Acta Psychiatr Scand 1997;95:396-404.

38 Grace AA. *Dopamine system dysregulation by the hip-*

pocampus: Implications for the pathophysiology and treatment of schizophrenia. Neuropharmacology 2012;62:1342-8.

39 Thompson E. *Mind in life: biology, phenomenology, and the sciences of mind*. Cambridge, MA: Harvard University Press 2007.

40 Chalmers D. *Facing up to the problem of consciousness*. J Consc Stud 1995;2:200-19.

41 Robinson W. *Epiphenomenalism*. In: Zalta EN, editor. *The Stanford Encyclopedia of Philosophy* (summer 2012 edition). http://plato.stanford.edu/archives/sum2012/entries/epiphenomenalism.

42 Laing RD. *The Divided Self*. London: Tavistock 1959.

43 Van Fraassen BC. *The scientific image*. Oxford: Clarendon Press 1980.

44 Carman T. *Merleau-ponty*. London: Routledge 2008.

45 Gurwitsch A. *The field of consciousness*. Pittsburgh: Duquesne University Press 1964.

46 Sass L, Pienkos E, Nelson B. *Introspection and schizophrenia: a comparative investigation of anomalous self experiences*. Conscious Cogn 2013;22:853-67.

47 Sass L, Pienkos E, Nelson B, et al. *Anomalous self-experience in depersonalization and schizophrenia: a comparative investigatio*n. Conscious Cogn 2013;22:430-1.

48 Fuchs T. *Temporality and psychopathology*. Phenomenol Cogn Sci 2013;12:75-104.

49 Hutto D, Ratcliffe M. *Folk psychology reassessed*. Dordrecht, Holland: Springer 2007.

50 Varga S. *Cognition, representations and embodied emotions: investigating cognitive theory*. Erkenntnis 2014;79:165-90.

51 Fodor J. *In Critical condition: polemical essays on cognitive science and the philosophy of mind*. Cambridge, MA: MIT Press 1998.

Training in psychopathology in Europe: are we doing well? A survey among early career psychiatrists

G. Sampogna, V. Del Vecchio, M. Luciano, C. De Rosa, A. Fiorillo

Department of Psychiatry, University of Naples SUN, Italy

Summary

Objectives

a) to describe the current status of training on psychopathology; b) to identify the unmet needs of European residents in psychiatry; c) to suggest future perspectives of training in psychopathology.

Methods

In the period July-December 2013, the early career psychiatrists' representatives of national associations recruited from the early career psychiatrists' council of the World Psychiatric Association (WPA) were invited to participate to an online survey. Each respondent was asked to provide the collective feedback of his/her association rather than that of any individual officer or member of their association.

Results

Thirty-two associations returned the questionnaire out of the 41 contacted, for a response rate of 78%. According to respondents, psychopathology should aim to assess psychiatric symptoms, to understand patients' abnormal experiences and to make nosographical [1] diagnoses. Karl Jaspers, Emil Kraepelin and Kurt Schneider are the most cited psychopathologists. A formal training course in psychopathology is available in 29 countries. The main teaching modalities include theoretical lessons, while workshops and role play are needed. The vast majority of residents do not receive training in psychopathological rating scales, although they tend to use them in clinical practice. Half of the sample is not satisfied with received training in psychopathology. As main problems, lack of tutor and practical training were identified. All respondents agreed that psychopathology is the core part of psychiatric curricula and that strategies should be identified to make training in psychopathology more adherent with their needs.

Conclusions

Psychopathology has been recognised as a core component of training curricula for psychiatrists, confirming the recent need to re-discovery psychopathology, according to the agenda proposed by international associations of young psychiatrists. Initiatives to improve training and practice of psychopathology should be addressed by national and international psychiatric organisations.

Key words

Psychopathology • Quality of training • Unmet needs • Early career psychiatrists

Introduction

Psychiatry is a medical discipline with traditional strong links to the humanities, such as philosophy, psychology and social sciences [1]. The context within which psychiatry is practiced is changing rapidly from social, cultural and scientific standpoints [2,3]. The growing social problems, the occurrence of natural disasters [4], the on-going economic crisis [5], globalisation [6] and changes in family organisation and structure [7,8] are only some changes that have taken place in society during the last 20 years, which have had an impact on psychiatric practice. Other major changes are due to the development of new technologies, with a profound change in communication between people with the development of web-based social interactions, such as blogs, tweets, and social networks [9-11].

As society changes, psychiatry needs to adjust its target accordingly, since mental health problems are the result of different biological, social and psychological factors [1]. Consequently, the target of psychiatrists has also changed, from the treatment of mental disorders to the management of mental health problems [12].

Another aspect that has had an impact on psychiatric practice is the widespread use of manuals and assessment instruments to make reliable diagnoses of mental disorders [2,13]. In fact, modern early career psychiatrists tend to base their clinical practice on rating scales rather than on in-depth psychopathological analyses of the patient [14,15].

Until 20 years ago, no doctor would have started a career in psychiatry without studying the bases of philosophy

Correspondence
Gaia Sampogna, Department of Psychiatry, University of Naples SUN, Italy • E-mail: gaia.sampogna@alice.it

and psychopathology. This is very rare today, with early career psychiatrists mostly focusing on reliable diagnostic criteria and assessment instruments [16 17]. This is probably why there has been recently a call to "rediscover psychopathology" and to go "back to fundamentals" by eminent scientists and mentors [18-20]. Moreover, the attention of psychiatrists in general is more on a clinical level and on the pharmacological treatment of mental disorders, rather than on the exploration of the phenomenological background of psychopathology [21].

More recently, the importance for psychiatrists to have strong psychopathological bases has been repeatedly affirmed [22]. In fact, psychopathology represents the common language for psychiatrists worldwide, it makes a unique contribution to understanding patients' personal experiences, it gives a holistic view to the patient and allows to validly apply operational criteria to support psychiatric diagnoses [23 24].

In this paper, we will describe the current status on training and practice of psychopathology in Europe, report the unmet needs of training and suggest future perspectives for training in psychopathology.

Methods

An ad-hoc questionnaire was developed using the same methodology adopted for other surveys recently carried out by the early career psychiatrists networks of the World Psychiatric Association (WPA) and the European Psychiatric Association (EPA) [25-27]. The questionnaire consisted of 29 items, subdivided into 3 sections: a) knowledge of psychopathology; b) training in psychopathology; c) unmet needs and future perspectives for training in psychopathology.

In the period July-December 2013, 41 early career psychiatrists, representatives of the early career psychiatrists of their national associations and recruited from the early career psychiatrists' council of the EPA, were invited to participate in an online survey through email invitation. Each respondent was asked to provide the collective feedback of his/her association rather than that of any individual officer or member. Thirty-two associations returned the questionnaire (response rate 78%). The list of participating countries is reported in Table I.

TABLE I.
Participating countries.

Azerbaijan	Lithuania
Albania	Macedonia
Austria	Malta
Belarus	Montenegro
Belgium	Poland
Bosnia and Herzegovina	Portugal
Bulgaria	Romania
Croatia	Russia
Cyprus	Serbia
Czech Republic	Slovenia
Denmark	Spain
Estonia	Sweden
France	Switzerland
Germany	Turkey
Italy	Ukraine
Latvia	United Kingdom

Results

Knowledge in psychopathology

Before starting the psychiatric residency course, almost all trainees have at least some basic knowledge in psychopathology, i.e. they know what psychopathology is and what is about. In fact, the primary aims of psychopathology are: 1) to assess psychiatric symptoms, 2) to understand abnormal experiences, and 3) to make nosographic diagnoses.

The most well-known psychopathologists are Karl Jaspers, Emil Kraepelin and Kurt Schneider, followed by Eugen Bleuler and Sigmund Freud (Table II).

Training in psychopathology

A formal training course in psychopathology is available in 29 countries (90%). Considering the characteristics of training, in half of the countries the number of hours dedicated to psychopathology is not defined. Teaching modalities include theoretical lessons, role plays, workshops and discussions of clinical records, although theoretical lectures are the most widespread. Although the vast majority of residents use psychopathological rating scales in clinical practice, training in their use is very rarely offered.

At the end of residency, the majority of early career psychiatrists are not satisfied with the training they received in psychopathology.

Unmet needs of training in psychopathology

The three most important unmet needs for residents in psychiatry are: 1) lack of supervision from expert psychiatrists (which is available in only a few countries); 2) number of hours dedicated to psychopathology (which is far from being satisfactory in most countries); 3) time spent with patients. Moreover, most trainees believe that training in psychopathological rating scales should be-

TABLE II.
Most influential psychopathologists.

Most influential psychopathologists	Frequency, N
Karl Jaspers	19
Emil Kraepelin	13
Kurt Schneider	10
Eugene Bleuer	9
Sigmund Freud	9
Philippe Pinel	2
Nancy Andreasen	1
Silvano Arieti	1
Arnaldo Ballerini	1
Simon Baron-Cohen	1
Bruno Callieri	1
Lorenzo Calvi	1
Ernst Kreschmer	1
Victor Kandisky	1
Melanie Klein	1
Jacques Lacan	1
Michael Rutter	1

come a compulsory part of residency courses.
Although European early career psychiatrists think that psychiatry is based, and will continue to be, on psychopathology, the following misconceptions were identified: "psychopathology is not useful in clinical practice"; "psychopathology is old-fashioned"; "psychopathology is not interesting for psychiatric practice"; "we have no time to dedicate to the study of psychopathology".

Discussion

This is the first survey specifically developed to explore the characteristics of training in psychopathology and the unmet needs in psychopathological training of early career psychiatrists from several European countries.
The main findings of the survey were: 1) the level of satisfaction with training received is not very high; 2) psychopathological rating scales are used without appropriate training; 3) psychopathology represents the core part of psychiatric curricula.
Residents in psychiatry are not globally satisfied with their training in psychopathology. Comparing these results with those from other surveys regarding the status of training in other areas, such as psychotherapy [27] and early intervention [26], the level of satisfaction with training in psychopathology is much lower, indicating that some actions should be taken. This dissatisfaction is probably due to the lack of a structured training course in psychopathology, which is – in turn – a consequence of the current approach to psychiatric practice. Nowadays, psychiatric practice is more based on the management of symptoms without really considering the complexity of patients psychopathology [28]. Moreover, the number of hours dedicated to training in psychopathology is very far from being considered adequate by trainees. Recently, early career psychiatrists launched the need to "rediscover psychopathology" [2], considering that the use of operational criteria of the international diagnostic manuals are not fully satisfying for formulating psychiatric diagnoses [13]. The results of this survey highlight the importance of improving psychopathological skills for young psychiatrists and to regain an holistic view of psychiatric patients, considering the complex interplay of biological, psychological and social factors of psychiatric symptoms [28].
The fact that psychopathology has been recognised as the core component of training curricula confirms the need to "re-discovery psychopathology", in line with the agenda of international associations of young psychiatrists, such as the WPA Council of Early Career Psychiatrists and the EPA Early Career Psychiatrists Committee [2, 29]. On these grounds, since 2013 the EPA section on philosophy and psychiatry runs a highly successful annual educational course on psychopathology that brings together many early career psychiatrists from Europe. Further educational activities include the organisation of scientific events and the production of books and educational modules for young psychiatrists [30]. Other initiatives to improve training and practice of psychopathology would be highly welcome.

Conclusions

Although psychopathology still represents the core part of psychiatric curricula, there are no clear indications regarding training in psychopathology across Europe. This can be one of the reasons for the low level of satisfaction reported by residents in psychiatry. International associations, funding bodies, institutional agencies and other stakeholders involved in the mental health enterprise should work together to improve knowledge of psychopathology for the future generations of psychiatrists.

Acknowledgments

We are grateful to the following early career psychiatrists who compiled the questionnaire and made this survey possible: Fidan Mammadova (Azerbaijan), Marinela Kulla (Albania), Nursen Yalcin (Austria), Olga Paravaya (Belarus), Nele De Vriendt (Belgium), Vjsna Vanjac (Bosnia and Herzegovina), Petra Marinova (Bulgaria), Nikolina Jovanovic (Croatia), Neophytos Theodorides (Cyprus), Alexander

Nawka (Czech Republic), Andreas Hoff (Denmark), Marina Cojocaru (Estonia), Olivier Andlauer (France), Sonja Gerber (Germany), Giovanni Martinotti (Italy), Laura Shtane (Latvia), Juditha Augenhaite (Lithuania), Angelina Ilievska (Macedonia), Hector Cutajar (Malta), Aleksandar Tomcuk (Montenegro), Agnieszka Butwicka (Poland), Mariana Pinto da Costa (Portugal), Adriana Mihai (Romania), Maria Orlova (Russia), Maja Pantovic (Serbia), Sonja Virag (Slovenia), Guillermo Lahera (Spain), Hanna Edberg (Sweden), Florian Riiese (Switzerland), Sinan Guloksuz (Turkey), Stanislava Matiukha (Ukraine), Gregory Lydall (United Kingdom).

Conflict of interest

None.

References

1 Fiorillo A, Maj M. *Il ruolo della psichiatria nella medicina moderna*. In: Siracusano et al., editors. *Manuale di psichiatria*. Roma: Il Pensiero Scientifico Editore 2014.

2 Fiorillo A, Malik A, Luciano M, et al. *Challenges for trainees in psychiatry and early career psychiatrists*. Int Rev Psychiatry 2013;25:431-7.

3 Sartorius N. *La psichiatria nel ventunesimo secolo*. In: Fiorillo A, editor. *Lezioni di psichiatria per il nuovo millennio*. Roma: Il Pensiero Scientifico Editore 2010.

4 Ekanayake S, Prince M, Sumathipala A, et al. *"We lost all we had in a second": coping with grief and loss after a natural disaster*. World Psychiatry 2013;12:69-75.

5 Economou M, Madianos M, Evangelia Peppou L, et al. *Suicidal ideation and reported suicide attempts in Greece during the economic crisis*. World Psychiatry 2013;12:53-9.

6 Heinz A, Deserno L, Reininghaus U. *Urbanicity, social adversity and psychosis*. World Psychiatry 2013;12:187-97.

7 Luciano M, Sampogna G, Del Vecchio V, et al. *The family in Italy: cultural changes and implications for treatment*. Int Rev Psychiatry 2012;24:149-56.

8 Bhugra D, Fiorillo A. *Families, functioning and therapies*. Int Rev Psychiatry 2012;24:79-80.

9 Moock J. *Support from the internet for individuals with mental disorders: advantages and disadvantages of e-mental health service delivery*. Front Public Health 2014;11:65.

10 Swendsen J, Salamon R. *Mobile technologies in psychiatry: providing new perspectives from biology to culture*. World Psychiatry 2012;11:196-8.

11 Grady B. *Promises and limitations of telepsychiatry in rural adult mental health care*. World Psychiatry 2012;11:199-201.

12 Maj M. *From "madness" to "mental health problems": reflections on the evolving target of psychiatry*. World Psychiatry 2012;11:137-8 .

13 Frances A. *The past, present and future of psychiatric diagnosis*. World Psychiatry 2013;12:111-2.

14 Volpe U and Sass H. *Why, what and how should early career psychiatrists learn about phenomenological psychopathology*? In: Fiorillo A, Calliess IT, Sass H, editors. *How to succeed in psychiatry: a guide to training and practice*. Chichester: Wiley-Blackwell 2012.

15 Nordgaard J, Revsebech R, Sæbye J, et al. *The validity of structured psychiatric diagnostic interview*. World Psychiatry 2012;11:181-5.

16 Regier DA, Kuhl EA, Kupfer DJ. *The DSM-5: classification and criteria changes*. World Psychiatry 2013;12:92-8.

17 Maj M. *"Clinical judgement" and the DSM-5 diagnosis of major depression*. World Psychiatry 2012;12:89-91.

18 Jablensky A. *Psychiatry in crisis? Back to fundamentals*. World Psychiatry 2010;9:29.

19 Maj M. *Prefazione*. In: Ballerini A, editor. *Psicopatologia fenomenologica: percorsi di lettura*. Roma: CIC Edizioni Internazionali 2002.

20 Parnas J, Sass LA, Zahavi D. *Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object*. Schizophr Bull 2013;39:270-7.

21 Stanghellini G. *The meanings of psychopathology*. Curr Opin Psychiatry 2009;22:559-64.

22 Fusar-Poli P. *One Century of Allgemeine Psychopathologie (1913 to 2013) by Karl Jaspers*. Schizophr Bull 2013;39:268-9.

23 Maj M. *Psychiatric diagnosis: pros and cons of prototypes vs. operational criteria*. World Psychiatry 2011;10:81-2.

24 Parnas J, Sass L, Zahavi D. *Phenomenology and psychopathology*. Philos Psychiatr Psychol 2011;18:1-23.

25 Riese F, Oakley C, Bendix M, et al. *Transition from psychiatric training to independent practice: a survey on the situation of early career psychiatrists in 35 countries*. World Psychiatry 2013;12:82-3.

26 Fiorillo A, Sampogna G, Del Vecchio V, et al. *What is the current status of training and practice of early intervention in psychiatry? Results from a survey in 35 countries*. Early Interv Psychiatry 2013 Aug 22.

27 Fiorillo A, Luciano M, Giacco D et al. *Training and practice of psychotherapy in Europe: results of a survey*. World Psychiatry 2011;10:238.

28 Stanghellini G. *The portrait of the psychiatrist as a globally minded citizen*. Curr Opin Psychiatry 2013;26:498-501.

29 Fiorillo A, Brambhatt P, Elkholy H, et al. *Activities of the wpa early career psychiatrists council: the action plan is in progress*. World Psychiatry 2011;10:159.

30 Fiorillo A, Del Vecchio V, Luciano M, et al. *This is why there is hope for psychiatry*. World Psychiatry 2014;13:1.

How do you feel? Why emotions matter in psychiatry

R. Rosfort[1], G. Stanghellini[2,3]

[1] Søren Kierkegaard Research Centre, University of Copenhagen, Denmark; [2] University "G. d'Annunzio", Chieti, Italy; [3] "Diego Portales" University, Santiago, Chile

Summary

This article argues for the importance of investigating emotions in psychiatry. In a time dominated by striding naturalistic explanations of mental illness, phenomenological psychopathology provides a crucial investigation into the subjective aspect of the disordered mind. Emotional phenomena are Janus-faced in the sense that they bring out the complex interplay of impersonal, biological and personal features of mental illness. We propose a framework for understanding emotional experience that is grounded in four key points: a general concept of "affectivity", the definition of "emotion" as felt motivation to move, the distinction between "affect" and "mood" according to their intentional structure and the dialectics between affects and moods. The reason why emotions matter in psychiatry is that mental suffering brings out an emotional fragility that we argue is constitutive of personal identity. Emotional experience reveals an intimate alienation at the heart of our mental life. What we feel is our own experience, but in this experience we may feel that we are not ourselves. To be a person is to live with this affective experience of selfhood and otherness. Emotions disclose an inescapable fragility at the heart of our identity that plays a significant role in our vulnerability to mental illness. We propose a model constructed upon the theoretical assumption that the fragility characterising human personhood stems from the dialectics of selfhood and otherness at the core of being a person. These dialectics become particularly evident in the way our moods challenge our sense of personal identity by complicating our relation to norms and values. In fact, we argue that moods are the most conspicuous epiphany of otherness in human life, in that they, more than other experiences, complicate our sense of being who we are. By way of conclusion, we illustrate our model with a phenomenological and hermeneutical analysis of the experience and meaning of shame.

Key words

Philosophy • Personhood • Emotions • Moods • Naturalism • Shame

Emotions, identity and vulnerability

Mental suffering challenges our understanding of what it means to be a person more urgently than does the suffering we experience when we, for instance, hurt our forehead against the kitchen cupboard or struggle with a kidney disease. What we consider to be easily localised physical pain is, of course, not as simple a phenomenon as it is often conceived to be[2-4]. Nevertheless, the complexity of mental suffering is even more daunting due to the fact that it, among other things, brings out the fragility constitutive of personal identity.

In this paper, we will focus on the emotional dimension of this fragility. To exist as human persons is to live with the emotional fragility that makes us the persons that each and every one of us is. The reason why emotions matter in psychiatry is, we shall argue, because this emotional fragility plays a major role in the constitution of our personal identity as well as in our vulnerability to mental illness. To assess, explore, care for and cope with the suffering involved in mental illness, we need to make sense of our emotional fragility.

The emotional aspect of mental illness is often characterised by diffuse and impalpable constellations of fleeting sensations, long-lasting dispositions, bodily fluctuations and pressures, nebulous atmospheres, hazy intimations and other affective colourings that are difficult to describe, communicate and make sense of. This broad and encompassing aspect of our emotional life is commonly described with the concept "mood". Unlike most of our emotions, moods normally do not direct a person towards anything in particular. But that does not mean that moods do not carry any informative value. On the contrary, they are perhaps the most densely informative phenomena of our emotional life. Moods do not inform us about the "what" or the "why" of our feelings, but they disclose "how" something is felt. This, in turn, tends to problematise and transform into open questions the "what" and "why" of our moods. In other words, my questioning about myself is often elicited by my mood before my identity becomes an explicit problem. Moods

Correspondence
R. Rosfort. Søren Kierkegaard Research Centre, University of Copenhagen, Farvergade 27D, 1463 Copenhagen, Denmark • Tel. +4533766910 • E-mail: rer@teol.ku.dk

are connected to self-understanding. Moods situate me with respect to a given situation. I understand who I am in the context of a given situation, of my practical engagement, as embedded in a certain world (private as social), and this engagement is primordially enveloped in a certain mood. Moods may disclose to me what words and deeds do not. They are no hindrance to "cognitive" knowledge, as rationalistic theories argue, but the *via regia* to understanding myself as embedded in the world.

This informative overload disclosed by our moods is one of the reasons why philosophy of emotion tends to refrain from questions about moods. Literature, poetry, and not least phenomenological psychopathology, on the other hand, are all concerned with deciphering this overload of information. A novel or a piece of poetry can be about almost nothing, and yet make us understand what seems to be everything. For example, the famous opening of *Moby Dick*, Herman Melville's monumental allegoric exploration of the fragility of human identity, may be read as a poignant description of dysphoric mood: "Call me Ishmael. Some years ago – never mind how long precisely – having little or no money in my purse, and nothing particular to interest me on shore, I thought I would sail about a little and see the watery part of the world. It is a way I have of driving off the spleen, and regulating the circulation. Whenever I find myself growing grim about the mouth; whenever it is a damp, drizzly November in my soul; whenever I find myself involuntarily pausing before coffin warehouses, and bringing up the rear of every funeral I meet; and especially whenever my hypos get such an upper hand of me, that it requires a strong moral principle to prevent me from deliberately stepping into the street, and methodically knocking people's hats off – then, I account it high time to get to sea as soon as I can" [5] [p. 1]. Like skilled novelists, phenomenological psychopathologists know that our attempts at understanding the "what" and "why" of moods, especially bad moods, depend on the accuracy of our description of the "how" the person actually feels.

Our moods are, arguably, the clearest expression of the ambiguity of rationality (subjectivity) and a-rationality (biology) constitutive of being a person. Personhood is ambiguous because of the fact that we are biological organisms who experience and understand ourselves as being more than our biology. We call this the ontological ambiguity of being human. A human person is both a *what* (impersonal organism) and a *who* (personal self), and this ambiguous ontology affects our experience and understanding of the world, other people and ourselves. The fact that the fluctuation of moods involved in mental illness cannot be explained by (or with) our peculiar rational engagement with the world makes it evident that a-rational, biological factors sometimes gum up or even destroy our cognitive endeavours. Thus, to make sense of the emotional fragility at the core of this ambiguity we do best to follow the advice of the philosopher of George Graham: "Seek for explanations of a mental disorder that combine references to brute, a-rational neural mechanisms and to the rationality of persons. Examinations of the immediate forces behind a mental disorder reveal that they carry two distinct inscriptions". "Made by unreason" and "Made by reason" [6] [p. 7]. That I am "made by unreason" means that I cannot choose my moods. And yet, I am not just a passive and helpless vessel for my moods. I can actively relate myself to them. In fact, my personal identity is constituted by my *active relation to the embodied and situated self that I am, including my moods*. Thus, "made by reason" means that through reflection and narratives, moods can be incorporated actively, reflectively and thematically into a person's identity.

Hermeneutical phenomenology of emotions

This complexity of rational and a-rational factors at work in mental suffering remains a major challenge to the current naturalistic atmosphere in psychiatry. On the one hand, human beings are biological organisms on a par with other biological organisms in nature [7 8]. This means that human suffering is caused by, and subjected to, the same anonymous mechanisms as other biological functions in nature. On the other hand, human beings are strange creatures [9 10]. Human suffering is not anonymous, but painfully personal in the sense that our experience of suffering is structured by, and permeated with, the subjective features that make us human. It is *our* experience of suffering, and *our* rational endeavour to make sense of our experience, that makes us suffer.

Phenomenological psychopathology presents a strong corrective to the naturalistic negligence of serious investigations of subjectivity in contemporary psychiatry. It is difficult, if not to say impossible, to dismiss the subjective dimension of human experience and action as irrelevant or illusory when dealing with mental illness. Or, to put it differently, subjectivity is a kind of "objectivity" that psychiatry has to deal with.

However, the fragile ambiguity involved in mental suffering demonstrates that clarifying subjectivity is not enough. Whereas phenomenology as a philosophical position may be allowed to focus its investigations exclusively on the experiential structure and dynamics of subjectivity, leaving out (or merely adding on at a later stage) the subpersonal biological (evolutionary, genetic and neuroscientific) factors of human experience [11 12], this is not the case for phenomenological psychopathology.

The overwhelming evidence for the crucial role that biological factors play in mental illnesses compels phenomenological psychopathology to acknowledge the brute, a-rational workings of human nature, which mark a blind

spot in our phenomenological explanations. Sometimes feelings are simply a-rational bodily feelings. This, of course, should not overshadow the fact that phenomenology is perhaps the best tool we have for articulating and distinguishing the multifarious feelings involved in our emotional life. This phenomenological work must be done, though, with the humble awareness that even though, most of the time, phenomenological analysis and narrative articulations are the best way to understand and cope with our feelings and emotions, sometimes causal explanations are the ones that do the job. In order to deal with this complexity of biology and subjectivity involved in mental suffering, we have developed a theoretical framework for psychopathology inspired by the hermeneutical phenomenology of the French philosopher Paul Ricoeur [13]. This particular hermeneutical version of phenomenological psychopathology is constructed upon the emotional fragility involved in mental illness, and argues that human personhood is constituted by the fragile dialectics of selfhood and otherness. Before going into our explanations of what emotions are and why they matter to psychiatry, we will (very) briefly introduce this theoretical framework.

Phenomenology is a vast and highly diverse tradition in philosophy that continues the patient systematic investigation of human experience inaugurated by Edmund Husserl at the beginning of the twentieth century. Contemporary phenomenology persists in examining basic philosophical questions about subjectivity, intersubjectivity, selfhood, otherness, perception, agency, etc., in order to clarify and make sense of the first-person perspective involved in pre-reflective experience [14 15]. Hermeneutical phenomenology goes back to the severe critique of Husserl delivered by his own reckless student Martin Heidegger. It differs from more traditional Husserlian phenomenology by arguing that we cannot understand subjective experience if we do not pay close attention to the *interpretative* character of subjective experience. Our pre-reflective experience of the world, ourselves and other people is not simply given, but always saturated by our emotional and reflective engagement with the world, other people and ourselves. This critique of "pure" phenomenology is not so much a break with the phenomenological insistence on the need for a thorough investigation of subjectivity as it is a shift of exploratory emphasis. Traditional Husserlian phenomenology focuses on the structures and dynamics pre-reflective of subjective experience. To hermeneutical phenomenology, a human being is not merely a *self* who *experiences* the world, but a *person* who *exists* in the world. Human existence is more than experience in the sense that what we experience as human beings is constantly shaped and influenced by *what* (ontology) and *who* (normativity) we are. That is to say, our experience is ineluctably influenced by the peculiar beings that we are and by the norms and values that orient our understanding of who we are.

Our version of hermeneutical phenomenology revolves around the notions of personhood and emotion [13]. Our sense of selfhood is troubled in the sense that our experience of ourselves is characterised by a basic emotional fragility that makes us question who and what we are. Ricoeur describes this existential condition by saying that human thinking is always "wounded thinking [*cogito blessé*]" [16] [p. 425]. Our model for exploring this fragility, and making sense of the ensuing vulnerability, is constructed upon a rather simple explanatory anvil that, however, has immensely complex consequences. We argue that the fragile character of human experience stems from a basic dialectical interplay of selfhood and otherness at the heart of our identity as human persons. To be a person is to live with the intimate alienation that we experience in our emotional life. Our emotions are intimate in the sense that they are *our* emotions, and they are alienating in the sense that at work in those self-same emotions is an otherness that constantly disturbs our sense of being an autonomous self. We are *what* and *who* we are, but our identity is fragile because the *what* and the *who* we are is constantly challenged in our existing as persons. We do not ourselves decide the persons that we are, and our experience of being the unique self that we are is thus constantly challenged. Our self-understanding is complicated by the fact that we are not merely (our)selves, but persons with a particular biological constitution living in a world shared with other persons (un)like us. Examining this particular emotional fragility at the heart of our identity, we shall argue, helps us to make sense of, and cope with, our vulnerability to mental illness.

Feeling theories and cognitive theories of emotions

What emotions actually are is intensely debated. Yet, few contemporary researchers in the interdisciplinary field of emotion studies would disagree with the one of its leading philosopher, Ronald de Sousa, when he characterises emotions as the most profoundly embodied phenomena of human experiences [17] [p. 47]. The real issue at stake, however, is just how to understand the peculiar combination of body and thinking at work in human emotions. In fact, in the last century or so emotion studies have been shaped by prolonged exchanges between two seemingly irreconcilable conceptions of what emotions are: *feeling theories* and *cognitive theories* [18]. As mentioned above, the emotional experiences most pertinent to psychiatry are the hazy, impalpable phenomena that we describe as moods (e.g. anxiety, dysphoria, depression, euphoria), so in what follows we will present the two dominant theories of what emotions

are through an examination of how they deal with the explanatory challenge posed by moods.

(1) *Feeling theories* pick up the thread from the revolutionary biological theories of emotions introduced by Charles Darwin (1872) [19] and William James (1884) [20] in the last quarter of the nineteenth century. Emotions, these theories argue, are feelings of bodily changes occurring independently of any voluntary or cognitive interference. Our fear is the felt perception of the bioregulatory changes of our body in interacting with the environment. In a sense, our bodies tell us when to be afraid, when to be sad, pleased, surprised, in panic, and so on, because these emotions are feelings of physiological reactions to our coping with the external world. In recent years, the exceptional advance in neuroscience has substituted the generic term "body" with more specified limbic brain systems, but, all in all, the idea remains the same [21-26]. The phenomenologically rich variety of emotional experiences is reduced to a minimal number of emotions, varying from six to nine so-called "basic emotions" (e.g. fear, anger, enjoyment, sadness, disgust, surprise) that are a decisive part of our evolutionary heritage [27]. These emotions vary only slightly among higher primates and are expressions of our shared mammalian affect-systems that are developed to ensure survival, well-being and reproduction. According to this approach, there are different ways of coping with moods. One can reject their relevance for our lives altogether, as does, for example, the hugely influential psychologist Paul Ekman: "Earlier I argued that emotions are necessary for our lives, and we wouldn't want to be rid of them. I am far less convinced that moods are of any use to us. Moods may be an unintended consequence of our emotion structure, not selected by evolution because they are adaptive […] If I could, I would forego ever having any mood again and just live with my emotions. I would gladly give up euphoric moods to be rid of irritable and blue moods" [28] [pp. 50-51]. Or they can be considered as the impersonal workings of our genes, as is the case with the philosopher Dylan Evans: "[W]e saw that the emotions of joy and distress evolved to act as motivators, like an internal carrot and stick. The moods of happiness and sadness may work in a similar way. Natural selection did not design our minds to think directly about how best to pass on our genes. Instead, it gave us the capacity to feel happy, and it made the experience of happiness contingent on doing things that help our genes to get into the next generation" [29] [p. 74].

Although the two statements disagree on the relevance of moods (annoyingly irrelevant vs. very relevant), they concur in establishing the impersonal functioning of the body as the basic framework for the understanding of moods. Emotional experience is shaped, influenced and sometimes even determined by the genetic makeup of our brain. The feelings involved in our emotional life are to be understood in the explanatory context that the evolutionary psychologists Tooby and Cosmides have epitomised as "the past explains the present", where "past" means the remote past of our phylogenetic development [30].

(2) *Cognitive theories* reject such a framework. Our emotional life, these theories argue, cannot be reduced to a few basic emotions determined by the evolutionary development of our bodies. There is something more to human emotions than shared mammalian affect-systems processed by our particularly developed cognitive skills. This was already noticed by the physiologist Walter B. Cannon in 1927. He criticised feeling theories for not being able to explain the phenomenological difference between rage and anger, because on a purely physiological level these emotions have the same visceral reactions, and yet they result in clearly distinguishable emotions [31] [p. 110]. Recent efforts to argue for a reductive explanation of the phenomenological and conceptual distinctions of various feelings in terms of a few universal emotions still have difficulty accounting for the experiential variety of human emotions [23 25 32]. Therefore, the cognitive theories establish a different framework for explaining human emotions. Our emotions are drastically different from those of other animals due to our highly developed cognitive skills. Our merely physiological feelings are secondary to the logical or cognitive structure of our emotions. Emotions tell us something about what it means to be human. They reveal what we value and care for as human persons existing in a world shared with other persons. Responsibility, judgment and volition are key concepts in the cognitive approach. The cognitive framework is the one predominantly advocated by philosophers working in the tradition of, among others, Aristotle, the Stoics, Sartre and it has found its most recent advocates in the late Richard C. Solomon [33 34] and Martha Nussbaum [35]. The cognitive framework revolves around the intentional structure of human experience and the cognitive structures of human understanding. An emotion is always constituted by the object(s) of the emotion. When I am angry, I am angry *with* someone *because* of something that this person has said or done; when I love, I always love someone or something, and the same goes for fear, joy, irritation, shame, etc. As Solomon writes: "What is oddly ignored in the discussion of feelings is the whole dimension of *intentionality*, our many ways of being engaged in the world […] I prefer to talk about *emotional experience* rather than simply "feelings", which carries the implication of something simple and unstructured" [34] [pp. 140-141].

The problem with the cognitive approach is that it leaves very little room for cognitively impenetrable feelings that do not seem to involve any clear-cut intentionality or cog-

nitive structure, such as moods and bodily feelings [36] [pp. 18-42] [37] [pp. 24-40] [38] [pp. 50-83]. By foregrounding the rational or intentional aspect of human emotions, these theories explicitly downplay the a-rational and functional character of our interaction with the environment. Obviously, cognition is the hallmark of the human species, but many aspects of our emotional experience seem to lack the rational structure of intentionality. Conceptual analyses of, for example, beliefs and desires do not clarify all of what we characterise as emotions, because emotions are not always the expression of what we believe or desire [39] [pp. 28-51]. Although intimately related with desires and beliefs, some emotions do not reflect what we want, think, desire, or hope for – or, more exactly, they do not reflect what we explicitly – that is, consciously and voluntarily – want, think, desire and hope for. My emotions can have a grip on me, overcome me and make me do what I never thought I would do. In other words, sometimes, my emotions appear to be stronger than my will, my desires, and my beliefs [40] [pp. 119-121].

Where does this leave us? We have seen that whereas feeling theories operate within an evolutionary framework, cognitive theories refer to an intentionally and rationally structured framework, and that neither is able to articulate and make sense of moods in any substantial way. However, the fact that we continuously experience moods suggests that there must be more to our emotional experience than what is explained in either the evolutionary or the rationally structured framework. We cannot, as Ekman does in the passage cited above, just wish that we did not have moods. We do have them. And they do not disappear simply because they are not analysed in our theories.

Emotions, affects and moods

How, then, do we include moods in the analysis of emotional experience? The first thing to do is to get a hold on the terminology. Contemporary research on emotions suffers from a serious conceptual confusion. To feel something is a very multifarious phenomenon, which means that it is not particularly clear what is meant when we say that an experience is emotional. Two concepts, however, seem to dominate the current debate, namely feelings and emotions. Before the end of the nineteenth century, emotional experience was expressed by a variety of different concepts such as sentiments, passions, feelings, affections, appetites, agitations and emotions. The scientific spring-cleaning of the academic vocabulary together with the writings of Darwin and James on emotions put an end to this novel-like variety. Thus, in the twentieth century, any investigation that wanted to be taken seriously focused on the concepts of (structured) emotions and (bodily) feelings.

As we have seen, *feelings* are generally understood as perceptions of bodily changes and affective states such as, for example, discomfort, pleasure, pain, exaltedness, tiredness and sadness. *Emotions*, on the contrary, are mostly considered as intentionally or rationally structured experiences such as anger (with), surprise (at), love (of), pride (in), shame (at), guilt (about) and so on. In addition to these two concepts, *mood* is often indicated as a third kind of emotional experience, but is seldom given much attention.

There is something impoverishing, even unhealthy, about the conceptual dominance of feeling and emotion [41] [pp. 24-25]. This narrowing of focus has certainly produced an analytically strong understanding of emotional experience, but it has also left out many aspects of the analysis. We believe that it is possible to retain the benefits of the twentieth century's focus on emotions and feelings while enlarging the framework to include the more impalpable aspects of emotional experience that were left out for the sake of clarity. Our version of hermeneutical phenomenology proposes a framework for understanding emotional experience that is grounded in four key points: (1) a general concept of "affectivity", (2) the definition of "emotion" as felt motivation to move, (3) the distinction between "affect" and "mood" according to their intentional structure, (4) the dialectics between affects and moods.

(1) Human consciousness is *affective* besides being cognitive. Our cognitive skills are always embodied in some kind of affectivity. When we experience something, this something *affects* us in a certain way, and the same goes for our perceptions, thoughts and actions. As Michael Strocker writes: "without affectivity it is impossible to live a good human life and it may well be impossible to live a human life, to be a person, at all" [39 [p. 17]]. The affective nature of human experience is basically expressed by the fact that our experiences *affect* or *touch* us. We feel our existence in the world as well as we (partially) understand it. Everything touches us in some way or another. We register this being affected by means of more or less distinctive and more or less conscious feeling-states. There is, in other words, no getting behind or beyond the complexity of our affective lives.

(2) The word "emotion" derives from the Latin *ex movere*. Emotions are the *lived motivation for movement*. Emotions are kinetic, dynamic forces that drive us in our ongoing interactions with the environment [42] [43]. They are *functional* states which motivate and may produce movements [13] [44] and *protentional* states that project the person into the future providing a felt readiness for action [45]. An emotion situates a person, allows her to see the things that surround her as disclosing certain (and not other) possibilities, that is, a given set of affordable actions. Thus, emotions are the core of the person's life-world.

They are, in the words of the phenomenologist Merleau-Ponty, "spatialising and temporalising vortex" [46] (p. 297) that organises the life-world, i.e. the lived time, space, self, otherness and materiality of objects of the world a person lives in. These existential dimensions are the scaffoldings of a person's life-world and, as we shall see, will provide the guidelines for a systematic definition of an emotion.

A necessary first step in understanding an emotion is to describe it in terms of the kinds of movements implied in it, that is, of its specific choreography: the coherent combination of the design of the movements of the person who is experiencing a given emotion, and of the design of the environment (the scenario) in which these movements are situated [47] [pp. 41-62]. For instance, in sadness I flow downwards in a slow, sinking manner as things appear to be forlornly sinking and sagging downwards. In joy I flow upwards in a radiated manner as things around me have an uplifted momentum. In retaliatory anger I feel driven forwards, violently attacking as the "object" of anger grows larger and occupies the foreground. In love I flow forwards in a gently binding way as the loved person flows forwards, towards me. In pride I go upwards in an inflated rising as things grow smaller compared to me. In humiliation I flow downwards in a plummeting, quick and violent drop as persons around me grow larger and look at me. In repugnance I flow backwards creating a centripetal vortex as things flow forward towards me, as if attracted by the vortex. In awe I flow backwards and downwards in a shuddering manner as things flow forwards and upwards, towering above me. In fear I move backwards in a shrinking and cringing manner as things flow forwards, towards me in a looming and menacing manner. In anxiety I feel suspended in a quavering manner over an inner bottomlessness, as an atmosphere, not things themselves, is felt as a menace.

(3) "Emotion" is an umbrella term denoting the multifarious affective phenomena that make up our emotional experience. Our emotional experience can be conceived of as a constantly altering continuum of affective phenomena at the opposite ends of which we find two very different kinds of experiences: affects and moods. The basic difference lies in the fact that affects are focused, and possess a clear-cut intentionality, that is, a specific directedness. Also, they are felt as motivated. In general, they are more determinate than moods and more articulated. Affects do not open up a horizontal awareness, but occupy all my attentional space (e.g., in fear I am completely absorbed by the phenomenon that terrifies me) and usually convey an explicit significance. Moods, on the contrary, are characterised by a lack of a clear, if any, intentional structure. They are unfocused, and thus do not possess a specific directedness and aboutness. They are felt as unmotivated, and there are no "felt causes" for them. They are more indefinite and indeterminate than affects and are often inarticulate. Moods usually manifest themselves as prolonged constellations of feelings. Also, moods have a horizontal absorption in the sense that they attend to the world as a whole, not focusing on any particular object or situation. Moods convey a constellation of vague feelings that permeate my whole field of awareness. Examples of affects are fear, grief, joy, anger and boredom. Examples of moods are anxiety, depression, euphoria, dysphoria and tedium.

Although we said that affects convey an explicit significance, for instance, fear is fear *of* something, it happens that the significance of an affect cannot be characterised at face value. This is the case with phobias, where the fear of the phobic object as such is just one aspect, the explicit one, of the constellation of felt meanings encapsulated in this emotion. For instance, in the emotional experience of cynophobia, the dog-ness of a dog may condense several felt meanings as, e.g. dirt, animality, fidelity, dependence, etc. Each of these meanings may evoke in the phobic person a specific emotion that complements fear as, e.g. repugnance (dirt), shame (animality), envy (fidelity), contempt (dependence), and so on.

Also, each emotion, including moods and affects, next to its explicit and particular significance, conveys an implicit and universal one. This will be explained in the last section, which discusses the case with the emotion of shame.

Furthermore, whereas affects are characterised by their direct relation to action (e.g. fear usually implies flight or avoidance), moods appear to have a more complicated relation. A mood does not prompt me to a specific action, and some (often bad) moods may impede or at least severely complicate action. This is closely related to the lack of object(s). When I am angry, I am normally angry with someone because of something. I have a clear focus for my feelings in the sense that I know where I shall direct my attention and vent my anger or at least deal with it in some way or other. I may be uncertain as to how I should best cope with my affects, but I have a pretty clear idea of what I am feeling and why. Or to put it differently, I have a more or less uncomplicated grasp of the intentional structure of my affects as, e.g. fear, love, surprise, shame, resentment, disappointment, guilt, etc. Moods, however, are different, and bad moods in particular. Moods affect our experience as a whole. We are not able to clearly identify an object for our mood, although we may notice that when we are in a certain mood our otherwise heterogeneous feelings are affected by some general attunement or colouring. Moods take a hold of the entire person and affect how this person feels about the world, other people and him or herself. Contrary to affects, moods attune or colour our emotional experience as a whole. We explain our own disparate feelings and

emotional reactions and those of others by referring to the generality of moods: "Normally, he would not react so aggressively, but he has been in a nervous mood for several days now"; or "I am sorry that I yelled at you, but I am just in a bad mood today". Thus, moods have often been referred to as background feelings, attunement, atmosphere, or emotional climate. Such characterisations are accurate and to the point, but they do not say much about what moods are or anything about their informative value. This is where hermeneutical phenomenology can help to make sense of our moods by articulating their function in our emotional experience and, in particular, their relation to personhood. This approach is not new. Phenomenological philosophers other than Paul Ricoeur such as Max Scheler [48], Martin Heidegger [49], Stephan Strasser [50] and the psychiatrist Thomas Fuchs [51] have emphasised this relation. However, our development of Ricoeur's hermeneutical phenomenology offers a theoretical model that allows us to explore the fragility involved in the phenomenology of moods, while showing how to make sense of the vulnerability to mental illness that fragility inevitably exposes us to.

(4) There exists a dialectics between affects and moods. An affect may transform itself into a mood that imposes itself on me for days (grief => depression; anger => dysphoria; boredom => tedium). Affects may transform themselves into moods and finally become a permanent part of our temperament (grief => sadness => dysthymia). Moods may determine affects because they alter the way we are affected by objects and thoughts (dysphoria => anger). Perhaps the most relevant aspect of this dialectics is that a given mood may become an affect when by reflection I can articulate it and find its motivations and "felt causes", that is, the way it roots me in a given situation (anxiety => fear for x) [52]. This issue will be discussed in the next two paragraphs.

I feel therefore I think

It is generally agreed that there is an intimate relation between emotions, ontology and values [53-56]. Experience becomes qualified by means of feelings. My emotions reveal my concerns and the fact that things matter to me. One way to illustrate the normative and ontological complexity involved in my emotional experience is to take a brief look at how a leading feeling theorist, the philosopher Jesse J. Prinz, explains (away) this complexity in terms of an evolutionary framework. Prinz has proposed a theory about how biological properties control our emotional life in the form of an "embodied appraisal theory" where "emotions are gut reactions: they use our bodies to tell us how we are faring in the world" [26] [p. 69]. Emotions are bodily appraisals of our conduct in the world and express the values that guide our life and well-being.

We fully agree with this conception of emotions as being intimately connected with values, but strongly disagree with Prinz's understanding of the values that shape and determine our life. He writes: "To qualify as an appraisal, a state must represent an organism-environment relation that bears on well-being. On the view I have been defending, emotions qualify as appraisals in this strict sense. They represent core relational themes" [26] [p. 77]. This kind of framework accepts two forms of influences on human emotional experience: on the one hand, somatic core relational themes concerning survival, reproduction and well-being; on the other hand, the variegated ways culture nurtures these basic themes in different sociocultural contexts. In other words, our emotions disclose biological and cultural values, and our well-being is a matter of how we accept and live by these values. Thus, the notion of well-being becomes reductive (to survive is better than not surviving) and relativistic (just do like the others are doing or isolate yourself and do what you like to do) at the same time. Our well-being is constituted by how we relate ourselves to our "organism" and our "environment". Although Prinz strongly emphasises that he is contrary to evolutionary reductionism and pleads for what he calls integrative compatibilism between biology and culture [26] [pp. 117-130, 158], his notion of well-being still remains problematic. And this is due to his simplistic conception of what it means to be a person. In fact, in his theory (as in most evolutionarily inspired theories) the question of personhood is not discussed at all.

A person is not simply the product of biology and culture, and well-being is not merely a matter of accepting biological needs or following cultural norms. This is not to say that biology and culture do not play important roles in the constitution of human values. Our emotions reveal that biological needs (I may be irritated because of lack of sleep or food) and cultural norms (I may be ashamed of myself if I display bad taste or manners) are important to our well-being. Nonetheless, human well-being is more fragile than such an account makes it out to be. A reference to the biological or cultural constitution of our values does not explain the fragile character of personhood. The life of a human person is significantly different from the lives of other highly developed primates. The hypertrophy and spectacularly complex development of our brains [57] is just one of the major differences that make the wisdom of our bodies an extremely "fragile wisdom", as convincingly demonstrated by the recent studies of the biological anthropologist, Grazyna Jasienska [58]. We are not what we are simply by being born, growing up, blossoming in our prime years, becoming old and eventually dying. There is more to the human animal than its organism and environment. An important part of human vulnerability lies in the fragility involved in the fact that a person *can want to be different from who she actually is*.

Every human being is a person, and yet to be the person that I am is always *a task of becoming* the person that I want to be. In this task, emotions play a determinant role as I *feel* who I want to be before I *know* it.

The normative dimension in which I as a person orient myself is permeated by emotions. I have certain character traits, dispositions, desires, ideas, dreams and habits that furnish and shape my values, which are expressed in my *felt* concerns and by what I *care* about [59]. Or, to put it differently, what I acknowledge as my values derive from my "felt meanings" of the world [47], that is, from my emotional experience. Before I cognitively know that a given person or thing means something and is valuable to me, I *feel* it.

This is not to say that my values are merely passively felt. I am able, by thinking about how I feel, to appropriate my feelings and thus to make an explicit meaning and value out of my emotional experience. However, in spite of my cognitive endeavour to circumscribe and explain my values, there always remains an emotional non-transparency in my values that may challenge my self-understanding. I may be a self-confident person, convinced of my values and firm in my actions, and yet question and doubt are still there, intimately lurking in my understanding of the person that I am. I may be inclined to something that I am not all that clear about. I may honestly believe that I am satisfied with my life, and even try to convince others that I am. And still, there is something that seems to disturb the glossy surface of my self-proclaimed stability. Of course, I can ignore this and go on living without paying attention to the supposedly insignificant whims played by my feelings. But I cannot control my moods when they are elicited in a given life situation. They do not abide at my command. Human well-being is fragile due to this unrelenting nature of our emotions and their relation to our understanding the person who we are. Moods are not superficial whims. If we let them be an integral part of our understanding of our emotional life, they may be able to shed some light on the particular relation between the emotions that we feel and the person that we are.

Moods as the epiphany of otherness

It is a common experience for a clinician that a patient asks to help him get rid of a bad mood. Patients, and persons in general, experience their bad moods as hindrances to go on being the persons that they used to be. Anxiety, a panic attack, or a state of dysphoria are first and foremost experienced as a source of useless disappointment devoid of meaning, a burden or brute suffering, and not as phenomena questioning one's habits and selfhood. However, moods, and particularly bad moods, are an epiphany of otherness and otherness that is a constitutive – not accidental – part of oneself. One's own bad moods are the epiphany of otherness in oneself and, as such, an opportunity to challenge the lifestyle and the sense of identity one has previously taken for granted.

Contrary to the ontological pre-conceptions at work in the feeling theories and the cognitive theories, our model operates, as mentioned, with the notion of an ontological ambiguity. This ambiguity stems from the dialectics between selfhood and otherness at work in our personal identity. *Who* and *what* I feel I am is constantly challenged by a sense of otherness, that is, of something that is not me. This challenge of otherness comes from the anonymous biological workings of my own body and the sociocultural world in which I live my life. My sense of being an autonomous self is constantly challenged by this otherness (my body, the world and other people), and the full complexity of the dialectics between selfhood and otherness is experienced in my moods. The model is constructed upon the theoretical assumption that the fragility characterising human personhood stems from these dialectics. In other words, we need to understand the close relation between our emotional life and the dialectics of selfhood and otherness responsible for our fragile sense of personhood. This dialectics becomes particularly evident in the way our moods challenge our sense of personal identity due to the way they complicate our relation to the norms and values involved in our more readily identifiable feelings and emotions. This fragile dialectic is first and foremost affective. As Ricoeur writes, "fragility is the human duality of feeling" [60] [p. 142] because of the complexity of anonymous biology and personal rationality at work in our emotional life.

The ethical, and therapeutic, implications of this are enormous. To become capable of seeing one's own bad moods not as hindrances to one's identity, but as the epiphany of otherness and, as such, as the opportunity to challenge one's previously taken for granted lifestyle and identity, requires an ethical *conversion*. This conversion amounts to considering the never-ending task of interpreting one's own moods as part and parcel of a good life, that is, as part of the care of the self and the otherness that constitute a person's fragile sense of identity.

This ethical principle, which is not imposed on our model from the outside, but is articulated through our hermeneutic method, is the reason why we used a quote from the Nestor episode of James Joyce's *Ulysses* as the motto for this article. The book's significance for our understanding of mental suffering was already noticed by one of the first reviewers, the medical doctor Joseph Collins. Towards the end of his long review he writes: "I have learned more psychology and psychiatry from it than I did in ten years at the Neurological Institute" [61] [p. 226]. In the quotation at the beginning of this article, Stephen Dedalus (Joyce's literary alter ego) states that he fears "big words" (e.g. love, courage, sorrow, sex, anger, pleasure, ambition,

shame, happiness, grief) because of the unhappiness they cause us. In fact, among many other things, Joyce's book is one long exploration of a day in the emotional lives of a few persons who struggle with their fragile sense of identity, and consequently with their emotional relation to the norms and values involved in the "big words" that shape and orient their lives.

The phenomenology of shame

By way of conclusion, we will use shame as an example of the importance of a methodical characterisation of emotions in psychopathology. This analysis first relies on the description of this emotion as felt motivation for movement. This level of description is mainly about the *how* of an emotion. If we want to understand a given emotional experience we must begin with a description of the emotional experience in itself, that is, provide a choreography of the feeling of the emotion in question:
Shame is an emotion (an affect) whereby the person has a flowing sensation of suddenly and sharply falling downwards. It is an unpleasant and unwelcome experience that disposes me unfavourably towards the source of humiliation. The source of humiliation (the other) is in a dominant position, growing larger as I sink downwards.
A second, more detailed characterisation of an emotion requires an existential analysis of the life-world that stems from it. This level of description goes a step further than the *how* an emotion is experienced by delving into the *what* of that emotion. This level is articulated in various dimensions of existing as an embodied and situated self: *Lived space*: shame entails an experience of centrality as space in this emotional state has a centripetal structure: its directedness is characterised by someone who looks at what I am. *Lived corporeality*: I feel naked, deprived of any protection; dirtied, soiled. *Self*: my main feelings as exposed to the other's look are of two kinds: first, I feel unprotected and that I have lost all my power; I wish to hide or disappear. At a later stage, I may feel the drive to reconstruct/improve myself. *Identity*: my identity is constantly threatened by the instability brought about by the feeling of humiliation. My whole identity is confined to the stain that is mercilessly revealed by the other who looks at me. And yet, shame can be a source of self-understanding, in that it provides a sense of what one is. *Other*: the person who makes me feel ashamed is in a dominant position, a watcher or a witness who looks at me with contempt, derision, or avoidance. The main sense implied is sight (being seen). *Lived time*: temporality consists in the fixation in an instant that grows to infinity. *Cause*: the felt cause of shame is my own omission, failing, defect.
A comparison with cognate emotions may help understand the importance of a phenomenological assessment of emotions to appreciate nuances and differences:
Humility, as compared to shame, is a rather gentle and welcomed feeling of lowering myself beneath a reality that I intuitively feel to be absolutely above me. Whereas *reverence* flows downwards and backwards in a deferential and respectful manner, humility does not flow backwards but only downwards. In humility I gaze down at myself. I feel the height, the loftiness of the other indirectly by experiencing the extent of my lowliness. While shame is painful, humility has a pleasurable quality as I want and deserve to put myself beneath this highest reality. I want to be in its intuitive presence.
Modesty is a self-protecting feeling by means of which I conceal myself. Modesty is the natural veil of the soul. As Nietzsche writes, "The most chaste utterance I have heard: 'Dans le véritable amour c'est l'âme qui enveloppe le corps'" [62] [p. 635]. Our feeling of modesty is a flowing backwards, while opening up to the world. It is a feeling of concealment that reveals my fragility without imposing my lingering insecurity upon the other. By flowing backwards it allows the gaze of the other to see me without letting my intimacy intrude upon the other. The essence of modesty is, as Scheler once wrote [63] [p. 28], a revelation of beauty in the manner of concealing itself.

Hermeneutics of shame

We will conclude with an outline of the felt meanings disclosed by the experience of shame. This level of description extends to the *why* of an emotion and more generally to its *importance*. In virtue of its felt significance, a phenomenon acquires a universal (not merely contingent or particular) meaning and embodies a universal theme or problem. It reveals the way an emotion belongs to human existence as a whole, to the human condition. To grasp the importance of a phenomenon is, as Ricoeur argues, to unfold "the revelatory power implicit in his discourse, beyond the limited horizon of his own existential situation" [64].
The feeling of shame, as argued by Scheler [65], belongs to the chiaroscuro of human nature due to the restlessly unique place of human beings within the structure of the world and its entities. Humans are strange creatures who live their life between the divine (thinking) and animality (biology). This duality of the human position in the cosmos expresses itself nowhere so clearly and immediately as in the feeling of shame. Shame arises originally by way of the contiguity between higher levels of consciousness and lower drive-awareness. "Guiltless guilt" is the oxymoron with which Scheler tries to grasp the specific form of this experience of opposites that appears to be at the root of the gloomy and peculiar feeling of shame [66].

It is always conjoined with an element of astonishment and confusion, and with an experience of being between what ideally "ought to be" and what, in fact, is. It is in this peculiar experience that we find the foundation of the myriad ideas of the "fall" of the human being that is central to religious myth [67].

To the origin of the feeling of shame there belongs something like an imbalance and disharmony in man between the senses and thinking, between the claim of spiritual personhood and embodied needs. It is only because the core of the human being is tied up with a "lived body" that we can get in the position where we must feel shame. And only because spiritual personhood is experienced as essentially independent of the "lived body" and of everything that comes from it, is it possible to get into the position where we can feel shame.

Shame also reveals the position of the human being as a transition, as, in shame, spirit and flesh, eternity and time, essence and existence touch one another in a peculiar and obscure manner. In shame one has the opportunity to know oneself to be a transition between two orders of being in which one has such equally strong roots that one cannot sever them without losing one's very humanity. A human being must feel shame – not because of this or that reason and not because we can be ashamed of this or that. We feel shame inevitably because of our being a continuous movement, and a restless transition.

Conclusions

Mental suffering brings out an emotional fragility that we argue is constitutive of personal identity. Our emotional experience reveals an intimate alienation at the heart of mental life. What we feel is our own experience, but in this experience we may feel that we are not ourselves. To be a person is to live with this affective experience of selfhood and otherness. In a time dominated by striding naturalistic explanations of mental illness, phenomenological psychopathology provides a crucial investigation into the subjective aspect of the disordered mind. Emotional phenomena are Janus-faced in the sense that they bring out, more urgently than other phenomena, the complex interplay of impersonal-biological and personal features of mental illness. We proposed a framework for understanding emotional experience that is grounded in four key points: a general concept of "affectivity", the definition of "emotion" as felt motivation to move, the distinction between "affect" and "mood" according to their intentional structure and the dialectics between affects and moods.

The reason why emotions are central in human existence and vulnerability is twofold: first, emotions play a determinant role in the construction of my own identity as I *feel* who I want to be before I *know* it. The normative dimension in which I as a person orient myself is permeated by emotions. What I acknowledge as my values derive from my "felt meanings'. Before I cognitively know what something means and how it is valuable for me, I *feel* it. I can, then, by reflection, appropriate this feeling and make of it an explicit meaning and value. Second, the fragility characterising human personhood stems from the dialectics of selfhood and otherness at the core of being a person. Emotions, and moods in particular, are the most conspicuous epiphany of otherness in human life. This dialectic becomes particularly evident in the way our moods challenge our sense of personal identity due to the way they complicate our relation to norms and values. In other words, emotions disclose an inescapable fragility at the heart of our identity that is a principal factor in our vulnerability to mental illness.

We usually see our own bad moods as hindrances to remaining the same, and hence to our personal identity. Yet, moods are the epiphany of otherness in our life and, as such, they provide a unique opportunity to challenge one's previously taken for granted lifestyle and identity. The awareness of this entails an essential ethical and therapeutic move: from considering emotions as passions of the soul that gum up our capacity to behave appropriately and rationally, to considering the task of interpreting one's own moods as part and parcel of a good life, that is, of self-knowledge and self-acquaintance and, more in general, in the practice of the care of the self and the otherness (the body, world, and other people) that constitute a person's fragile sense of identity.

Conflict of interest

None.

References

1 Joyce J. *Ulysses*. New York: Random House 1986, p. 26.

2 Bourke J. *The story of pain: from prayer to painkillers*. Oxford: Oxford University Press 2014.

3 Wyller T. *The place of pain in life*. Philosophy 2005;80:385-93.

4 Parsman HRW, Rurup ML, Willems DL, et al. *Concept of unbearable suffering in context of ungranted requests for euthanasia: qualitative interviews with patients and physicians*. BMJ 2009;339:1235-41.

5 Melville H. *Moby Dick or, the whale*. New York: Modern Library 1950.

6 Graham G. *The disordered mind: an introduction to philosophy of mind and mental illness*. London: Routledge 2010.

7 Thagard P. *the brain and the meaning of life*. Princeton: Princeton University Press 2010.

8 Churchland P. *Touching a nerve: the self as brain*. New York: W.W. Norton Company 2013.

9 Preuss TM. *What it is like to be a human*. In: Gazzaniga MS,

editor. *The cognitive neurosciences III*. Cambridge, MA: The MIT Press 2004, pp. 5-19.

10 Nagel, T. *Mind and cosmos: why the materialist neo-darwinian conception of nature is almost certainly false*. Oxford: Oxford University Press 2012.

11 Gallagher S Zahavi D. *The phenomenological mind*. London: Routledge 2012.

12 Ratcliffe M. *Feelings of being: phenomenology, psychiatry and the sense of reality*. Oxford: Oxford University Press 2008.

13 Stanghellini G, Rosfort R. *Emotions and personhood: exploring fragility – making sense of vulnerability*. Oxford: Oxford University Press 2013.

14 Zahavi D. *The Oxford handbook of contemporary phenomenology*. Oxford: Oxford University Press 2012.

15 Lund S, Overgaard S. *The Routledge companion to phenomenology*. London: Routledge 2012.

16 Ricoeur P. *De l'interprétation. Essai sur Freud*. Paris: Éditions du Seuil 1965.

17 de Sousa R. *The rationality of emotions*. Cambridge, MA: MIT Press 1987.

18 de Sousa R. *The mind's bermuda triangle: philosophy of emotions and empirical science*. In: Goldie P, editor. *The Oxford handbook of philosophy of emotions*. Oxford: Oxford University Press 2010, pp. 93-117.

19 Darwin C (1872). In: Ekman P, editor. *The expression of emotions in man and animals*. 3rd ed. New York: Oxford University Press 1998.

20 James W. *What is an emotion?* Mind 1884;9:188-205.

21 Damasio A. *Descartes' error. Emotion, reason, and the human brain*. New York: Putnam 1994.

22 Damasio A. *The feeling of what happens. Body and emotion in the making of consciousness*. New York: Harcourt 1999.

23 Damasio A. *Looking for Spinoza. Joy, sorrow, and the feeling brain*. New York: Harcourt 2003.

24 Damasio A. *Self comes to mind: constructing the conscious brain*. London: William Heineman 2010.

25 Ledoux J. *The emotional brain: the mysterious underpinnings of emotional life*. New York: Simon and Schuster 1996.

26 Prinz JJ. *Gut reactions: a perceptual theory of emotion*. New York: Oxford University Press 2004.

27 Ekman P. *An argument for basic emotions*. Cogn Emot 1992;6:169-200.

28 Ekman P. *Emotions revealed: understanding faces and feelings*. London: Weidenfeld & Nicolson 2003.

29 Evans D. *Emotion: the science of sentiment*. Oxford University Press 2001.

30 Tooby J, Cosmides L. *The past explains the present: emotional adaptations and the structure of ancestral environments*. Ethol Sociobiol 1990;11: 375-424.

31 Cannon WB. *The James-Lange theory of emotions: a critical examination and an alternative theory*. Am J Psychol 1927;39:106-24.

32 Prinz JJ. *Are emotions feelings?* J Consciousness Stud 2005;12:9-25.

33 Solomon RC. *The passions*. New York: Anchor Press 1976.

34 Solomon RC. *True to our feelings. What our emotions are really telling us*. New York: Oxford University Press 2007.

35 Nussbaum M. *Upheavals of thought: the intelligence of emotions*. Cambridge: Cambridge University Press 2001.

36 Pugmire D. *Rediscovering emotions*. Edinburgh: Edinburgh University Press 1998.

37 Panksepp J. *Affective neuroscience: the foundation of human and animal emotion*. Oxford: Oxford University Press 1998.

38 Goldie P. *The emotions: a philosophical exploration*. Oxford: Oxford University Press 2000.

39 Stocker M, Hegeman E. *Valuing emotions*. Cambridge: Cambridge University Press 1996.

40 Gordon RM. *The structure of emotions: investigations in cognitive philosophy*. Cambridge: Cambridge University Press 1987.

41 Dixon T. 2003. *From passions to emotions: the creation of a secular psychological category*. Cambridge: Cambridge University Press 2003.

42 Plutchik R. *Emotions. A psychoevolutionary synthesis*. New York: Harper & Row 1980.

43 Sheets-Johnstone M. *The primacy of movement*. Amsterdam: John Benjamins 1999.

44 Rosfort R. Stanghellini G. *The person in between moods and affects*. Philos Psychiatr Psychol 2009;16:251-65.

45 Gallagher S. *How the body shapes the mind*. Oxford: Oxford University Press 2005.

46 Merleau-Ponty M. *Le visible et l'invisible, suivi de notes de travail*. In: Lefort C, editor. Paris: Gallimard 1964.

47 Smith Q. *The felt meanings of the world: a metaphysics of feeling*. West Lafayette, IN: Purdue University Press 1986.

48 Scheler M. *Wesen und formen der sympathie*. Bern: Francke Verlag 1973.

49 Heidegger M. *Sein und Zeit*. Tübingen: Max Niemeyer Verlag 1986.

50 Strasser S. *Das gemüt: grundgedanken zu einer phänomenologischen philosophie und theorie des menschlichen gefühlsleben*. Freiburg: Verlag Herder 1956.

51 Fuchs T. *Leib, raum, person. Entwurf einer phänomenologischen anthropologie*. Stuttgart: Klett-Cotta 2000.

52 Stanghellini G, Rosfort R. *Affective temperament and personal identity*. J Affect Disorders 2010;126:317-20.

53 Tappolet C. *Émotions et valeur*. Paris: Presses Universitaires de France 2000.

54 Pugmire D. *Sound sentiments: integrity in the emotions*. Oxford: Oxford University Press 2005.

55 Panksepp J, Biven L. *The archaeology of mind: neuroevolutionary origins of human emotions*. New York: W.W. Norton & Company 2012.

56 Deigh J. *The emergence of emotion as an object of scientific*

study. In: Deigh J, editor. *On emotions: philosophical essays*. Oxford: Oxford University Press 2013; pp. 215-232.

57 Allen JS. *The lives of the brain: human evolution and the organ of mind*. Cambridge, MA: Harvard University Press 2009.

58 Jasienska G. *The fragile wisdom: an evolutionary view of women's biology and health*. Cambridge, MA: Harvard University Press 2013.

59 Blackburn S. *Ruling passion. A theory of practical reasoning*. Oxford: Oxford University Press 1998.

60 Ricoeur P. *Philosophie de la volonté II. L'homme faillible*. Paris: Aubier 1960.

61 Collins J. *James Joyce's amazing chronicle (New York Times, 28 May 1922)*. In: Deming RH, editor. *James Joyce: the critical heritage, vol. 1: 1902-1927*. London: Routledge, pp. 222-226.

62 Nietzsche F. *Jenseits von gut und böse*. *Werke in drei Bänden, Band 2*. München: Carl Hanser Verlag 1955.

63 Scheler M. *Zur rehabilitierung der tugend*. In: Scheler M. *Vom Umsturz der Werte*, *Gesammelte Werke, Band 3*. Bern: Francke Verlag 1957, pp. 15-31.

64 Ricoeur P. *Appropriation*. In: Ricoeur P. *Hermeneutics and the human sciences*. Cambridge: Cambridge University Press 1981, pp. 182-93.

65 Scheler M. *Über Scham und Schamgefühl*. In: Scheler M. *Schriften aus dem Nachlaß*, *Gesammelte Werke, Band 10*. Bern: Francke Verlag 1957, pp. 65-154.

66 Scheler M. *Zum Phänomen des Tragischen*. In: Scheler M. *Vom Umsturz der Werte*, *Gesammelte Werke, Band* 3. Bern: Francke Verlag 1957, pp. 151-169.

67 Ricoeur P. *Philosophie de la volonté II. La symbolique du mal*. Paris: Aubier 1960.

Temperament, personality and the vulnerability to mood disorders. The case of the melancholic type of personality

A. Ambrosini[1], G. Stanghellini[2], A. Raballo[3]

[1] Department of Psychological, Humanistic and Territorial Sciences, University "G. d'Annunzio", Chieti, Italy;
[2] "D. Portales" University of Santiago, Chile; [3] Department of Mental Health, Reggio Emilia, Italy

Summary

The concept of Typus Melancholicus (TM) was shaped by Tellenbach to describe the premorbid and intermorbid personality vulnerable to endogenous depression. The first part of this paper aims the description of the premorbid features of TM personality-orderliness, conscientiousness, hyper/hetereonomia and intolerance of ambiguity.

After, we present the life world of the TM, i.e. a qualitative descriptions of the lived experiences about the body, self, time, space, and others.

Also, we describe the basic principles of Tellenbach's theory – the method, the concept of endon, rhythmic and situation sensu Tellenbach as a special way of the person of living the relationship with the world per se in an endless reciprocal exchange.

Starting from a clinical case, we show the theoretical evolutions of TM concept and underline the typical way which links the premorbid condition to melancholia.

Finally, we ask if the TM concept can be still considered a valid construct in today's society, helpful in understanding and explaining identity crisis leading to depressive decompositions.

Key words

Major depression • Melancholic type • Personality • Pheno-phenotype • Post partum depression • Psychopathology

The features of the typus melancholicus

The concept of typus melancholicus (TM) was shaped by the German psychiatrist Hubertus Tellenbach (1914–1994) [1] to characterise the premorbid and intermorbid personality structure liable to endogenous depression. Based on the catamnestic recollection of 119 melancholic inpatients hospitalized at the University Hospital of Heidelberg, Tellenbach identified a fundamental set of distinctive features (i.e. orderliness, conscientiousness, hyper/hetereonomia and intolerance of ambiguity) that inform the premorbid personality of the TM, i.e. a certain way of being in the world that revolves around the possibility of developing major depression (melancholia). The work of Tellenbach is essential to clarify the relationship between premorbid personality (broadly understood as an anthropological pre-condition for the development of psychopathological crisis in the spectrum of endogenous depression), existential critical events and developmental pathways towards clinically-relevant psychopathological phenomena. According to the author, indeed, the selective combination of the premorbid characteristics of the TM confers a stable and recognisable imprint through which the vulnerability to major affective disorders is expressed already at the level of a specific personality structure.

By "personality structure", it is here intended a relatively homogeneous set of thoughts, emotions, customs, values and behaviours which, as a whole, constitute the anthropological core of individual subjective being and axiological orientation in the social world. Tellenbach emphasised that TM is a personality structure giving rise to a stable mode of relating to the world and oneself in a way that entails a potential for the development of affective episodes. According to Tellenbach, TM is defined by a set of concomitant, stable characteristics that organise the vulnerability to major depression and transpire across premorbid, intermorbid and morbid phases. Crucially, such characteristic imprint is situated at the ethical-ontological level of value-formation. In fact, values are attitudes that regulate the significant actions of the person, and are organised into concepts that do not arise from rational activity, but rather within the sphere of immediate situative feelings emanating from the type of relationship that the person has with him/herself, with others and with the world. Values are essential in putting the meaning of existence *per se* into order. Thus, values are organised according to the ontological constitution and pre-struc-

Correspondence
A. Ambrosini, Department of Psychological, Humanistic and Territorial Sciences, University "G. d'Annunzio", Chieti, Italy • E-mail: alessandra.ambrosini@tiscali.it

ture a world-view that establishes what is relevant and meaningful. In the case of TM, such a world-view already entails a germ of potential decompensation [2].

Although in the literature the concept of premorbid personality vulnerable to depression is used with several meanings (e.g. as an attenuated expression of an affective disorder, as a personological variable with pathoplastic effect on the development of depressive symptoms or as a result of recurrent depressive episodes), in the case of TM the notion of premorbid is to be intended in a specific pathogenetic sense, i.e. TM personality is a *predisposing* factor to the development of an episode of major depression [3].

According to Tellenbach's phenomenological analysis the core features of the TM are concern with orderliness and conscientiousness (Tables I, II).

Along these lines, originally combining the intuitions of his mentor Tellenbach and Mead's social theory, Alfred Kraus identified two further of the anthropological structure of the TM: hyper/heteronomy and intolerance of ambiguity. According to Mead's social theory, self and identity are an import of the social process. Mead [4] postulated that such identity is dialectically constituted by two poles, the "Me" (i.e. the self as social object) and the "I" (i.e. the self as subject). Whereas the "me" is the organised set of attitudes of others which an individual assumes, the "I" is the individual, subjective response to such accumulated understanding of how one is being perceived by others ("the generalised other"). Inspired by Mead's emphasis on how the mind and the self arise out of social interaction and experience, Kraus focused on the typical way of being social of the TM, extrapolating specific TM features of the dialectic between role identity and self-identity. Briefly, *role identity* is that which each person has to assume on the basis of their own social function; *self-identity* is the self-determination of the personality, that is beyond simple and straightforward identification with the role. The distancing from the role is a necessary operation to preserve one's authenticity as a person over and above that of the mere agent of an impersonal role. This means that a person may maintain a sense of autobiographic continuity recognising him or herself in spite of the transformation of role-identities and not being vexed by self-alienation and estrangement [5]. Such a vital dialectic between role- and self-identity is reduced and suppressed in the TM, which tends to collapse and crystallise self-identity in the simulacrum of the role. Indeed, the TM is unable of going beyond the socially established rules, reinterpreting his relation with himself, the other and the world in a flexible and an autonomous fashion.

Therefore, prominent features of the TM are hyper/heteronomy and intolerance of ambiguity (Tables III, IV).

Besides germanophone psychopathology, Japanese tradition also identified specific features of the TM. Shimoda [6]

TABLE I.
TM's features.

Orderliness
An accentuated seeking for order and harmony in the field of interpersonal relationships. It is manifested, above all, in the domestic and work setting and its function is to maintain the surrounding setting free of possible conflicts that may entail feeling of guilt. TM embodies the prototype of the very high demands by means of the subject's way of being, so that with the other, the TM tries to anticipate and pre-empt any possibility of remaining in debt. E.g.: *"When someone helps me, I feel guilty. If anyone helps me, I need to forget about it afterwards. I cannot think about having to thank them"*.

TABLE II.
TM's features.

Conscientiousness
This is an elevated demand above the mean of one's own possibilities, fuelled by the need to prevent feelings and attributions of guilt. Melancholic persons aim at fulfilling many obligations, always in a consistent, reliable and effective way. The need to cling to one's own controllable and predictable order assures the state of wellbeing and defends it from potential threats from the surrounding world, from the undefined and uncontrollable. Conscientiousness is inspired by a fundamental need to avert any potential feeling of guilt or accusatory attributions. Hence, the TM is constantly seeking acceptance from the other and his behaviour is not based on one's personal criterion, but rather on the perceived social expectation. This is the way in which the subject attempts to keep the conscience scrupulously clean and to protect against any feeling of guilt. It is fundamental to not be blamed by the other. Hence, each interpersonal gesture is a tribute that should be given to existence, a need that protects it from each possibility of loss. The idea that the TM has about his/her order does not foresee exceptions, as they are not open to flexible adaptation in accordance with the circumstances. Given that sooner or later, the unforeseen will outbreak in the *scenario* of existence, the TM radical refractoriness to being subject to the unforeseen in his/her existential field, generates an important exposure to vulnerability. In fact, despite the effort in preserving a controlled and ordered existential eco-system, the desired harmony is never a permanent and guaranteed achievement, especially given that the constriction between such rigid limits prevents the TM from developing the necessary transcendence to reach a higher balance. It is as if the TM had acquired once for all, an impersonal order at the cost of sacrificing the margin of subjective freedom that is required to manage the relationship with the world. E.g.: *"What would be right to do in such a situation?"*.

TABLE III.
TM's features.

Hyper/heteronomy
TM continuously attempts to gain external confirmations of their own identity through the *modus operandi*. The *hypernomia* consists in an excessively rigid adaptation of the standard practice, where the excessive aspect is given by the indiscriminate and stereotyped application of the rule, not linked to the context. The other facet of this incapacity of monitoring the situation in an independent and personal way is made up by the *heteronomy*, an exaggerated reception of the external standard practice by which each action is guided by an impersonal motivation, referring to the socially established criteria.

TABLE IV.
TM's features.

Intolerance to ambiguity
Allows the TM to attune only to those social situations that confirm the pre-established image they have of themselves and of others. This reduces the capacity of TM to maintain true interpersonal relationships as well as the possibility of accommodating situations that presuppose recognition of emotive complexity and ambivalence. Because of the complete attentional absorption in ideal, prototypical role-relations, TMs are not capable of harmonically perceiving the full-scale and the shades of their own and others' individuality *(idioagnosia)*. In this sense, their intersubjectivity is mutilated and sclerotised, being partly blinded to the rich emotional complexities of the interpersonal world. In fact, relating with the other only through their role, the TM does not intercept and relate to the individual needs, desires and feelings of the other, but rather to his/her expected ones as directly derivable from the social identity. On a surface level, the TM is extremely keen on interpersonal relations, anticipating the needs of the others and working intensely to satisfy them, their apparent altruistic availability is not primarily directed at the person in the flesh, but rather is aimed at maintaining social balance. What they have is – de facto – an "impersonal" empathy, based on the effort of synchronising with the other as a social actor, which moves following the predetermined rules and guidelines.

in particular conferred critical importance to "immobilithymia" (i.e. the tendency to cling to a certain mood and therefore to certain ways of being and doing). This characteristic, according to Shimoda, would be typical of those structures with the tendency to the development of manic-depressive conditions, representing a functional strategy to prevent manic or depressive decompensation. Shimoda characterises these persons as diligent, honest, scrupulous and efficient.

The life world of TM

Phenomenological investigations of abnormal human subjectivity suggest a shift of attention from mere symptoms (i.e., state-like indexes for nosographical diagnosis) to a broader range of phenomena that are trait-like features of a given life-world. The phenomenological exploration of patients' life-worlds is the gathering of qualitative descriptions of the lived experiences about the individuals. As lived experiences are always situated within the grounds of body, self, time, space and others, we adopt these basic dimensions of lived experience to organise the data. The result will be a rich and detailed collection of patients' self-descriptions related to each dimension, for example, temporal continuity/discontinuity, space flat/filled with saliences, bodily coherence/fragmentation, self-world demarcation/permeability, self-other attunement/disattunement and so on. In this way, using first-person accounts, we detect the critical points where the constitution of experience and action is vulnerable and open to derailments [7].
In the Table V we summarise the life world of TM.

Phenomenological method and the centrality of temporality

Tellenbach stated that the analysis of his patients was based on an "empirical-phenomenological" method. This method is "empirical" because it is based on the patient's self-description of their experiences and behaviours, and "phenomenological" because these phenomena are investigated as manifestations of the way of relating with the world and oneself. His intention was to understand the "*what*" that characterises the premorbid personality and "*how*", that is, the pathway that leads the TM to endogenous depression. The study of Tellenbach focused on the investigation of the essential properties that belong to the endogenous substrate and how these are added up, forming a stable and recognisable structure.
Tellenbach's theory is indeed framed by an overarching, global view of man in continuous and essential relationship with the world with specific attention to the "*essential forms* of the human condition" (or, more specifically, to the "essential forms of being melancholic"). This comprehensive view of human existence refers to the concept of *endon* as a way of connection between the psychic and somatic and between the person and the world. The endogenous is comparable to the *nature (physis)* of the Greeks and indicates the basic imprint prior to the formation of the personality, i.e. its structure. The endogenous is not considered only in relationship with the somatic or psychic sphere, but also includes a concept of person in his/her relationship with the world. Central in this theory is the role of *temporality* since all this is directly

TABLE V.
TM's life world.

Self/Identity	TM structure does not entail disorders of the pre-reflexive self as is the case with schizophrenia. It implies a different kind of depersonalisation involving the process through which we form the representation of our identity, that is, the narrative self. The narrative self is the concept one constructs of oneself. One's own narrative identity arises from the interplay between I-am's and I-can's. I-can's are what one is not, one's own possibilities. TM persons insist on a finite and un-chosen perspective of stable characteristics that they consider their own, and with which they over-identify and experiences other possibilities merely as a source of alienation or nullification [8-10]. This intolerance to other possibilities and the avoidance of the dialectic between I-am's and I-can's immanent in the constitution of one's narrative self leads to an identification with partial, external and reified identities, such as role-identity, i.e. external/socially appreciated representations of identity [11 12]. They internalise role-identities and through this internalisation they acquire a stable, although inflexible, self-identity [13]. Their identity is based on a reified, sclerotic self-representation. It implies an over-simplified categorisation of oneself and others, who appear in the light of their social roles, rather than in that of their ego-identity [3 11].
Time	The TM strives not to lag behind himself – that is behind his duties and obligation deriving from the social role he has taken up. His entire life can be interpreted as an effort to pay his debts before he contracts them. In order to avoid the danger of remaining behind regarding the subject's own expectations and the emergency of the duty, the time of TM is characterised by a constant need to anticipate the requests of others and timely comply with the duties related to their social roles.
Space	To preserve inner harmony, each thing should occupy a dictated place within a pre-established order. Taking refuge within the limits of one's order is a way or assigning oneself a place, a defined and limited space within which the melancholic person feels able to exercise her own "autonomy".
Other	Its mere existence cannot give satisfaction to anyone. Thus, being loved is an acquired right. TM persons can hardly enjoy the pure and simple fact of being with the other. Their intersubjectivity does not foresee the implicit pleasure of being-together-with another. Occupying a place in the physical or relational space is a right to be conquered and earned with effort and determination in a rigid regime of meritocracy. In fact, spontaneous free exchanges without any obligation of return are not contemplated, the sense of "justice" is reduced to a circle of *do ut des* (I give and you give back) in which the TM is already in a position of disadvantage, one step behind.

related to the rhythmic processes of life, that is, to the normal tendency of man to adjust and synchronise one's own biorhythm (sleep, awakeness, etc.) with the world. This emphasis on temporality is the central feature of all phenomenological theory of the pathogenesis of depression. In normal situations, the *rhythmic* is understood as a fundamental form of the flow of life, which is expressed in some of the characteristics of human behaviour. Tellenbach understands this to be an endo-cosmo-genetic periodicity. This periodicity – yearly, monthly, circadian rhythm cycles – are considered fundamental organisers of the life of a person. Rhythm is not a passive reaction to the environmental influence; on the contrary, it is the indicator of a natural tendency to the synchronisation of the person with the world. Both the slowness and speed of a rhythm contribute to the harmony of movement and are a result of a capacity of control and an inner measure. Both would represent normality and would be the characteristics of movement. In disease, measure and rhythm seem to be absent. Rapidness – understood as swift rhythm – may be replaced by agitation and slowness by delay. Agreement between subjective and objective rhythm defines a state of harmony. Melancholy may be considered an endogenous condition as it breaks such harmonic state. Melancholy is linked to transformation of the movement of life and more specifically inhibition of passing of inner time and loss of ground regarding the flow of the world. This transformation is translated into a modification of the rhythm in all its manifestations: mood, impulses and motivations.

The TM strives not to lag behind himself – that is behind his duties and obligation deriving from the social role he has taken up. His entire life can be interpreted as an effort to pay his debts *before* he contracts them. In the pre-melancholic situation this order goes into pieces. The key-feature of the pre-melancholic situation is despair. To Tellenbach, despair is the emotion characterising the pre-melancholic situation, that is, the prodrome of melancholic breakdown (see below). Tellenbach emphasises the intimate relation between the concept of "despair" (*Verzweiflung*) and the notion of "doubt" (*Zweifel*) as disintegration of something simple and definitive into something ambiguous. He writes:

[T]he crucial emphasis, as also in the concept of *doubt* [*Zweifel*], shifts to the "two", to the doubling. This doubling [zweiheitliche] is also contained in *dubietas* and *dubium*. What we call despair [*Verzweiflung*] is remaining captured in doubt. From the doubling of despair re-

sults all *average* meanings of human states characterized by being shattered [*Zerrissenheit*]. To be precise, despair is *not* just hopelessness and desperation, not an ultimate or an arrival at an endpoint, but rather the movement backward and forward, an alternation, so that a definite decision [*endgültige Entscheidung*] is no longer possible [1](p. 165 [149]; translation modified).

As a consequence of the ambiguity, the person experiences ambivalent feelings in the sense of being simultaneously moved towards two opposite directions. The person is aware of this contradiction, but is not able to resolve it. The core of despair is therefore indecision, and its contrary mental state is not hope, but decision. In despair, this opposition comes to an extreme which results in a *profound alteration of temporality*: "[w]hat previously came about in the mode of *succession*, now appears only in the necessity of *simultaneity*" [1] (p. 167 [151]). The same happens with lived space. Whereas we usually organise our actions in the mode of succession, in despair movements remain stuck in the indecisiveness of juxtaposition, that is, a kind of paralysis of action and thinking, but not a static one, rather a frensied, restless, disconcerting paralysis.

The concept of "situation"

The concept of "situation", and especially "pathogenic situation", has been for decades a focus of psychopathological research. Indeed, the pathogenic situation expresses the intimate relationship between a type of event and a type of personological vulnerability, that is, between the psychological structure of the person and the quality of the event. An event is traumatic if it hits the person in his/her weak point. In this case, the event concept assumes the meaning of personal experience (*Erlebnis*), that is, the very individual way that person lives a particular event. The event turns into a traumatic experience when it acts like a key in its lock (trauma-key-lock). Phenomenological psychopathology makes a distinction between two prototypes: the pathological reactions to the event and the development of personality. Jaspers [14] emphasises the importance that a specific event assumes for a person as a lived experience in relation to the emotional upheaval that it generates in determining pathological reactions. This pathological condition "does not occur because of a single experience, but for the sum of the various effects". In pathological reactions, on the one hand there is a link between the experience and personality, and on the other a link between traumatic experiences and the psychopathological contents (such as emotions, thoughts, etc.). The notion of "personality development" [14] emphasises the personological ground on which an event falls. One of the best known examples of such development of personality is provided by Ernst Kretschemer [15] in his seminal study on "sensitive delusion of reference". This particular persecutory delusion appears to be the prototype of the psychological intelligibility of psychotic manifestations [16]. Kretschmer pointed out the importance of a particular personality (i.e. the sensitive type) structure in the unleashing of a progressive psychopathology under the triggering pressure of a particular type of interhuman event, which has a selective, specific potential to upset that kind of personality.

According to Tellenbach, man is *linked/engaged* in a relationship of special interdependence with the context *per se*. Therefore, a *situation* cannot be either reduced to a way in which a person is passively hit by an event, or to a constellation of events simply induced by the person. The situation transcends the dyad individual-surrounding environment and rather cuts-across the constant modeling of the self-world relation. The notion of *situation* captures both the *active role* (in the sense that the person actively concurs in creating the situation) and the *passive role* (in the sense that there is not an explicit intention or desire to create the situation in itself by the person or that they could not do it in another way). The event and the person are reciprocally reflected in the situation. The TM tends to be located within the typical self-world relationships and being engulfed in characteristic pre-melancholic situations [1]. In other words, the pathogenic situation *mirrors* the person's vulnerability and the person can see vulnerability *reflected* in one's own pathogenic situation.

The concept of *situation* illuminates a hidden aspect of the relationship between the event and the person in the sense that each person may theoretically find any type of event. However, each person tends to co-create the kind of situations that characterise them. The way of being of a person, with his/her anthropological structure, way of understanding life and expressing relationships with the other, the hierarchy of priorities and values, leads to having relationships that are typical for this person. In the case of TMs, this moves from their structure of values characterised by the concern for orderliness and conscientiousness. TMs have high interpersonal sensitivity and do not judge their own behaviour on the basis of personal criteria, but rather on the basis of social standards. Since the main latent existential aim of TMs is social desirability, they intensively strive to comply with the expectations and needs of the others, even before these have been expressed. This double ethical path leads TMs to recursively approach situations characterised by the constellation of *includence* and *remanence* [17 18].

The pre-melancholic phase: includence, remanence and despair

The pre-melancholic situation seems to be the crucial connecting point to understand the link between the

TM personality structure and melancholy. In this phase, there is a critical matching between the existential situation and a certain personality structure, which generates the pathogenic situation. The pre-melancholic situation is characterised by a constant increase of the fixed tasks that overburdens the capacity of TM to preserve predetermined order. In such conditions, the TM is not capable of establishing a hierarchy of priorities, and is unable to discriminate what can be momentarily left aside or postponed. Two key moments characterise the pre-melancholic phase: the situative constellations of *includence* and *remanence*, and, finally, *despair* (i.e. a radical transformation of the self-world relation).

The constellation of *includence* indicates a self-contradiction that sees the TM, at the same time, in the extreme attempt to maintain order and in the need to overcome it, exceeding his own limits. This is the moment in which the undesired is manifested and imposed in the existence, so that the typical meticulous and orderly form of being of the TM is destabilised [1]. In the words of Tellenbach's patient: "*I am very orderly, I need a lot of time, I've always been that way, this is terribly painful for me*". The anxiety related with a possible change in the order of things is clear.

The other constellation is that of *remanence*. This is characterised by the danger of remaining behind regarding the subject's own expectations and the emergency of the duty. The TM is conditioned by the paradoxical tendency of cancelling possible debts in advance. When they are up against the unexpected and chance and unforeseen breaks the schemes, this may precipitate the melancholic episode. Tellenbach described his patient as follows: She had "never shown herself to be guilty of anything" but "*I feel guilty because I haven't been able to carry out my work*".

The two constellations are always manifested in the pre-melancholic situation, but they are not clear until the melancholic phase has begun. The bridge that joins the pre-melancholic phase to the melancholic one is called *despair*. The concept of "despair" cannot be translated, either as hopelessness or helplessness [18]. This concept does not indicate, in fact, either loss of hope or feeling deprived of establishing the possibility of being helped. Rather, with the term despair, "coming and going" towards possibilities for which none are reachable is indicated. In this way, in despair, a cognitive dissonance [19] is manifested and specifically, the lack of capacity to establish priorities. That which previously had an order (one after the other) is now found in the need of the contemporaneity, which becomes inaccessible to the evolution of existence. Tellenbach described the experience of his patient as follows: "*This situation had been partially arduous, on the one hand she had the constant impulse to work as much as possible and as accurately as possible but on the other, the inhibition hindered the way*". Herein, the concept of *despair* should not be understood as a condition without hope, but a situation in which you cannot take any decision. The person who becomes despaired is in suspension in the face of still un-actualised possibilities, having the intention of contemporarily *being* in two places[1]. This is the moment in which melancholy is initiated. Pre-melancholic despair seems to be the pathway through which the TM becomes stagnated, even on a somatic level: the TM person undergoes psychomotor block because of the incapacity to reach a compromise with themselves and with the world.

The evolution of TM concept

Starting with the major contribution of Tellenbach, a series of investigations further explored the TM construct both in the theoretical and empirical directions [1-3 8 11 12 20-65].

Alfred Kraus is possibly the author who has most studied the characteristics of premorbid personality [9 10 22-26] and the psychopathological characteristics of melancholy in the most depth [25 26 66 67]. One of his most important contributions is the definition of the characteristics of the TM construct as opposed to the anancastic behaviour [23]. Whereas in the case of obsessive disorder there is an orientation with the individual standard that is maintained through ego-dystonic thinking that assumes symbolic and magical meanings, the TM bases his/her behaviour on the social expectations and his/her way of reaction is ego-syntonic. Other authors, such as von Zerssen and Mundt, have carried out works that are mainly empirical, attempting to outline and define the specificity of this construct more precisely and to design a test for the diagnosis of the TM personality. A converging research line was developed in Japan where the first self-applied TM test was proposed in 1984 by Kasahara [27], and followed by a series of other studies in nonclinical sample [47-53]. Moreover, several authors have explored the concept of TM with regard to personality disorders [30 36 60] and development of major depression or manic depressive disorder [20 37 40 43 58]. In recent years, the TM construct has been studied as a possible indicator of vulnerability to depressive postpartum disorders [65].

An example of the clinical importance of TM: postpartum depression.

An important focus of research into postpartum pathology is the identification of risk factors for this common and often disabling disorder. Risk factors can be divided into three main categories: psychosocial, clinical and those factors related to pre-morbid personality or temperamental features [68]. Although the most frequently cited are marital conflict [69], lack of a confidant [70], difficult psychosocial conditions [70 71], negative life events during the

year preceding childbirth [72], financial and professional difficulties [73], the personality style of women vulnerable to postpartum depression has been neglected.
Recent studies on the relationship between TM and motherhood [74] highlight two key points: first the pathogenic role of masculine discourse on motherhood in TM women. Indeed, women who blindly accept the standard discourse on motherhood are obliged to exercise their procreative function in an impersonal way. In this way, motherhood ceases to be a personal experience and acquires value only to the extent to which it adheres to social and cultural stereotypes. If women surrender unconditionally to the myths of motherhood, created by men and secularised by culture, they are more likely to feel inadequate, unworthy and incapable. Every attempt made to adhere to an ideal prototype is destined to failure considering that this prototype does not account for women's responses to the birth of a child.
The traditional values that shape the social behavior of TM include *orderliness* and *conscientiousness*. They may have a pathogenic valence in so far as they bring forth a particular kind of mindset and behaviour that reflects the myths of motherhood we described above. TM mothers seem over-identified with social representations of maternal roles that reflect time-honored male expectations. Their system of values, which shapes the inner core of these women's personalities, heightens their psychopathological vulnerability.
Motherhood can assume a pathological valence for women – it is the case of TM mothers – who tend to adhere to the impersonal and masculine discourse on motherhood. This discourse – which has been popular from the times of ancient Greece up to the present, but also informs the technical jargon of psychoanalysis – presents motherhood as the apotheosis of femininity and leads mothers into assuming a role that is functional to the stability of the family and social order. This means giving up many prerogatives of women that are not compatible with motherhood.
In the case of these *hetero/hypernomic* women, who tend to abide by social norms, play the established social roles and hide their inner conflicts and tensions, myths of motherhood contribute to suppress the contradiction which is intrinsic to motherhood itself making this contradiction invisible but still painful and hence uncontrollable and potentially devastating.
Heteronomy, as well as the attitude to subscribe acritically to these myths on motherhood, forcing oneself to live motherhood in keeping with rigid and impersonal schemes that do not take into consideration women's authentic experience of motherhood, signaling a conception of motherhood as the fulfillment of female nature instead of presenting it as a period of existential crisis characterised by the dichotomy between social expectations – "*how I should be*" – and personal experience – "*how do I feel with regard to this new situation*" – may worsen this contradiction and bring the mother on the verge of psychopathological illness.
This urge to meet social expectations that are construed around the idea of motherhood-as-apotheosis of femininity, rather than the idea of motherhood-as-crisis, together with the constant growth of tasks related to motherhood, creates an emotional overload that is hard to deal with and leads to the development of depressive pathology.
The second point highlights the possibility of considering the TM personality structure as a valid model for the early diagnosis of women at risk to develop an episode of postpartum depression, even in those cases in which a clear anamnesis of major depression, as well as other types of mood disorder or symptoms before and during pregnancy, cannot be established. Indeed, motherhood is like a *quid novi* in which a previous existential equilibrium is put at risk [74-76]. TM women are compelled to adapt their own way of being to the new situation and to the changes it involves. Motherhood is a threat to the rigid existential order of TM women, and it is a danger to their *orderliness*. TM women tend to distort the meaning of birth, which is not perceived, at the same time, as a moment of task/duty as well as an opportunity/possibility of self-development and existential self-realisation. The reason for this distortion of the meaning of birth lies in the feature of TM called *intolerance of ambiguity*. The birth is conceived as an obligation characterised by necessity, tasks to fulfill – according to the rules given by *consciousness* and *hyper/heteronomy* – which are typical of TM personality. As a consequence of this, disorganised behaviour and confusion may characterise the prodromal phase of postpartum depression. The pre-melancholic situation is thus characterised by the presence of the situation of *includence*, i.e. the TM encloses herself within the boundaries of her *ordo* – and *remanence* – i.e. she remains encapsulated within these boundaries thus "remaining in self-default" [1].

TM and social change: hyper/heteronomy in the liquid society.

The TM concept was shaped in the mid-1950s in a type of society with its set of values and cultural constraints that have radically changed. Among these changes, the affirmation of individualistic values like the increasing importance attributed to liberty and the decreasing importance of security, the advent of liquid society where nothing is fixed (including social bonds and work careers) and everything changes very quickly, and the triumph of instantaneousness over long-term projectuality. All these have determined radical changes in late modern identities and led to the conceptualisation of personal identity as a con-

tinuous task rather than a heritage to be preserved[78]. In this light, can the TM concept be still considered a valid construct in today's society that is helpful in understanding and explaining identity crises leading to depressive decompositions?

In an unpublished general population study in which 500 university students underwent a protocol for the validation of a self-report TM questionnaire, the dimension "hyper-heteronomy" did not feature among the characteristics of students who could be typified as TM. Of 500 interviewees, 49 (about 10%) were positive for the TM profile. Yet, among these, hyper-heteronomy was absent in 90% and difficult to diagnose in the remaining 10%.

Hyper-heteronomy consists in the rigid adaptation to stereotypical social norms, an unconditional adherence to established socially-shared roles. It is not surprising that in our flexible society (so different from the post World War II rigid German society in which the TM concept was established) hyper-heteronomy may have become non-characteristic in TMs, that is, in people who share all the other features of socially adapted individuals, and chiefly conscientiousness and orderliness. The question is *which* of societal values are (or are not) interiorised.

In a previous paper [65], we found that hyper-heteronomy is a key feature in TM women who developed a melancholic depression in the postpartum. Our interpretation is that the development of postpartum depression may be a consequence of these women's adherence to old-fashioned, if not atavistic, myths of motherhood, including the centrality of the maternal function in defining a woman's identity leading to an idealisation of motherhood. We argued that in hyper-heteromic mothers, who tend to abide by social norms, play the established social roles and hide their inner conflicts and tensions, myths of motherhood contribute to suppress the contradiction which is intrinsic to motherhood itself making this contradiction invisible but still painful, and hence uncontrollable and potentially devastating. The conception of motherhood as the fulfillment of female nature, rather than a period of existential crisis characterised by the dichotomy between social expectations – "how I should be" – and personal experience – "how do I feel with regard to this new situation" – is at the heart of this contradiction.

These two examples may suggest that the adherence to old-fashioned values that are in conflict with the mainstream mind-frame, rather than the presence of hyper-heteronomy, may be the crucial risk factor for the development of major depression.

In fact, social norms have changed and heteronomy may have remained the *form* of a given personality structure whose *content* has changed with the transformation of societal standards. Conformism is no more than compliance to the values of modern sociality, but adherence to the liquid instantaneity of the contemporary late-modern mediatic-social world. The historical prototype of the TM template on the European social codes of the previous century is plausibly rather changed in several apparent social features. The relative eclipsing of the no longer functional faithfulness to cultural standards of the past (in which adherence to tradition and dedication to it were to be considered functional to the task envisaged within the roles imposed by society) has unveiled the TM of the third millennium as a neurotic-like, conflictual structure which seeks a continuous adaptation between the need for order and an "atmosphere" characterised by social instability and disorder.

Next to this "neuroticised" heteronomic structure, there grows other forms of heteronomy that are totally syntonic to the *Zeitgeist*. It is the case of what can be called the "I can" value structure and its psychopathological decomposition that can be named "manager depression". Whereas for the TM the moral imperative can be summed up with the "I must" formula, that circumscribed a limited set of goals to be achieved by restricting one's sense of freedom, "I can" personalities are characterised by an interminable escalation of goals to be achieved that goes together with an exalted sense of freedom. This anthropological structure is endlessly projected towards new objectives and unable to be satisfied with goals once they are achieved. "I can" is the modal verb that reflects late modern *Leistungsgesellschaft* or the society of performance [79]. In this type of culture, the must is being performing and personal identity is conceived as a task to be achieved via being the manager of one's own life. Of course, "I can" personalities are totally egosyntonic with respect to the value of performance. Depressive forms stemming from this anthropological make-up are radically different from melancholic depressions and characterised by exhaustion, burn-out and insolvency and are accompanied by a feeling of shame. This is just another example of the metamorphosis of depression and its mirroring of the transformations of society.

Conflict of interest

None.

References

1 Tellenbach H. *Melancholy*. Pittsburgh: Duquesne University Press 1980.

2 Stanghellini G. *Antropologia della vulnerabilità*, Milano: Feltrinelli Editore Milano 1997.

3 Stanghellini G, Mundt C. *Personality and endogenous/major depression: an empirical approach to typus melancholicus. Theoretical Issues*. Psychopathology 1997;30:119-29.

4 Mead GH (1934). *Mind, Self, and Society*. Chicago: University of Chicago Press 1934. Trad.it. *Mente, sé e società*. Firenze: Editrice Universitaria 1965.

5 Kraus A. *Dynamique de rôle des maniaque-dépressifs*. Psychologie Medicale 1987;19:401-5.

6 Shimoda M. *On manic-depressive illness* (in Japanese). Yonago-Igakushi 1950;2/1:62f.

7 Stanghellini G, Rossi R. *Pheno-phenotypes: a holistic approach to the psychopathology of schizophrenia*. Current Opinion 2014;27:236-41.

8 Kraus A. *Sozialverhalten und psychosen manisch-depressiver*. Enke: Stuttgart 1977.

9 Kraus A. *Modes d'existence des hystériques et des mélancolique*. In: Fédida P, Schotte J, editors. *Psychiatrie et existence*. Grenoble: Millon 1991a.

10 Kraus A. *Role performance, identity structure and psychosis in melancholic and manic-depressive patients*. In: Mundt CH, ed. *Interpersonal factors in the origin and course of affective disorders*. London: Gaskell 1996, pp.31-47.

11 Stanghellini, G, Bertelli M. *Assessing the social behaviour of unipolar depressives: the criteria for typus melancholicus*. Psychopathology 2006;39:179-96.

12 Mundt C, Goldstein MJ, Halweg K, et al. *Interpersonal factors in the origin and course of Affective Disorders*. London: Gaskell, 1996.

13 Mundt C, Backenstrass M, Kronmueller KT, et al. *Personality and endogenous/major depression: an empirical approach to typus melancholicus. Validation of typus melancholicus core properties by personality inventory scales*. *Psychopathology* 1997;30:130-9.

14 Jaspers K. *Psicopatologia generale*. Roma: Il Pensiero Scientifico 1964.

15 Kretschemer E. *Der sensitive beziehungsswahn. Ein beitrag zur paranoidefrage und zur psychiatrischen charakterlehre*. Berlin: Springer 1919.

16 Ballerini A, Rossi Monti M. *La vergogna e il delirio*. Torino: Bollati Boringhieri 1990.

17 Stanghellini G, Rossi Monti M. *Psicologia del patologico*. Milano: Raffaello Cortina Editore 2009.

18 Stanghellini G. *Psicopatologia del senso comune*. Milano: Raffaello Cortina Editore 2008.

19 Festinger A. *Theory of cognitive dissonance*. Stanford, CA: Standford University 1957.

20 Stanghellini G, Bertelli M, Raballo A. *Typus melancholicus: structur and the characteristics of the major unipolar depressive episode*. J Affect Disord 2006;93:159-67.

21 Stanghellini G, Raballo A. *Exploring the margins of the bipolar spectrum: temperamental features of the typus melancholicus*. J Affect Disord 2007;100:13-21.

22 Kraus A. *Identity and psychosis of the manic-depressive*. In: De Koning AJJ, Fenner FA, editors. *Phenomenology and psychiatry*. London Academic Press 1982, pp. 201-216.

23 Kraus A. *Dinamique de rôle des maniaque-dépressifs*. Psychologie Medicale 1987;19:401-5.

24 Kraus A. *Methodological problem whit the classification of personality disorders: the significant of existential type*. J Pers Disord 1991;5:82-92.

25 Kraus A. *Phenomenological and criteriological diagnosis. Different or complementary?* In: Sandler JZ, Wiggins OP, Schwartz MA, editors. *Philosophical perspective on Psychiatric diagnostic classication*. Baltimor: Hopkins University 1994, pp.148-160.

26 Kraus A. *Le motif du mensonge et la depersonalization dans la mélancholie*. L'Evolution Psychiatrique 1994;54:649-57.

27 Kasahara Y. *Depressed patients in the general practice* (in Japanese). J Psychosom Med 1984;24:6-14.

28 Von Zerssen D, Pfister H, Koeller DM. *The Munich Personality Test (MPT): a short questionnaire for selfrating and relatives' rating personality traits: formal properties and clinical potential*. Eur Arch Psychiatr Neurosci 1988;238:73-93.

29 Von Zerssen D. *Melancholic and manic types of personality as premorbid structures in affective disorders*. In: Mundt C, Goldstein MJ, Halweg K, et al. editors. *Interpersonal factors in the origin and course of affective disorders*. London: Gaskell 1996.

30 Von Zerssen D. *Development of an integrated model of personality, personalitydisorders and severe axis I disorders, with special reference to major affective disorders*. J Affect Disord 2002;68:143-58.

31 Schäfer ML. *Typus melancholicus as a personality characteristic of migraine patients*. Eur Arch Psychiatry Clin Neurosci 1994;243:328-39.

32 Schäfer ML, Lautenbacher S, Postberg-Flesch C. *New investigations on the melancholic type personality structure in migraine patients*. Nervenarzt 200;71:573-9.

33 Meszaros K, Fischer-Danzinger D. *Extended suicide attempt: psychopathology, personality and risk factors*. Psychopathology 2000;33:5-10.

34 Schwartz MA, Wiggins OP. *Philosophical anthropology and psychiatry: typus melancholicus as a human disposition*. Seishin Shinkeigaku Zasshi 2003;105:522-32.

35 Fukunishi I, Hattori M, Hattori H, et al. *Japanese type A behavior patterns is associated with "typus melancholicus". A study from the socialcultural viewpoint*. Int J Soc Psychiatry 1992;38:251-6.

36 Sato T, Sakado K, Sato S. *Differences between two questionnaires for the assessment of typus melancholicus, von zerssen's f-list and kasahara's scale: the validity and the relationship to DSM-III-R personality disorders*. Jpn J Psychiatry Neurol 1992;46:603-8.

37 Sato T, Sakado K, Sato S. *Typusmelancholicus measured by a questionnaire in unipolar depressive patients: age and sex-distribution, and relationship to clinical characteristics of depression*. Jpn J Psychiatry Neurol 1993;47:1-11.

38 Sato T, Sakado K, Nishioka K, et al. *Relationship between the melancholic type of personality (Typusmelancholicus) and DSM-III-R personality disorders in patients with major depression*. Psychiatry Clin Neurosci 1995;49:13-8.

39 Heerlein A, Santander J, Richter P. *Premorbid personality aspects in mood and schizophrenic disorders*. Compr Psychiatry 1996;37:430-4.

40 Nakanishi T, Isobe F, Ogawa Y. *Chronic depression of mo-*

nopolar type: with special reference to the premorbid personality. Jpn J Psychiatr Neurol 1993;47:495-504.

41 Mundt Ch, Schroeder A, Backenstrass M. *Altruism versus self-centredness in the personality of depressive in the 1950s and 1990s*. J Affect Disord 2009;113:157-64.

42 Hecht H, Van Calker D, Spraul G, et al. *Premorbid personality in patients with uni- and bipolar affective disorders and control: assessment by the Biographical Personality Interview (BPI)*. Eur Arch Psychiatry Clin Neurosci 1997;247:23-30.

43 Hecht H, Van Calker D, Berger M, et al. *Personality in patients with affective disorders and their relatives*. J Affect Disord 1998;51:33-43.

44 Ueki H, Holzapfel C, Washino K, et al. *Reliability and validity of Kasahara's scale of melancholic type of personality (typusmelancholicus) in a german sample population*. Psychiatry Clin Neurosci 2001;55:31-5.

45 Ueki H, Holzapfel C, Washino K, et al. *Concordance between self and observer-ratings on Kasahara's Inventory for the melancholic type personality*. Psychiatry Clin Neurosci 2002;56:569-74.

46 Ueki H, Holzapfel C, Sakado K, et al. *Dimension of typus-melancholicus on kasahara's inventory for the melancholic type personality*. Psychopathology 2004;37:53-8.

47 Ueki H, Holzapfel C, Sakado K, et al. *Prevalence of typus melancholicus in healthy germans*. Psychopathology 2006;39:113-9.

48 Furukawa T, Nakanishi M, Hamanaka T. *Typus Melancholicus is not a premorbid personality trait of unipolar (endogenous) depression*. Psychiat Clin Neuros 1997;51:197-202.

49 Furukawa T, Yamada A, Tabuse H, et al. *Typus melancholicus in light of the five-factor model of personality*. Eur Arch Psychiatry Clin Neurosci 1998;248:64-9.

50 Lauer CJ, Von Zerssen D, Schreiber W, et al. *The premorbid psychometric profile is steble over time in subjects at high familial risk for affective disorders*. J Affect Disord 1998;51:45-53.

51 Kimura S, Sato T, Takahashi T, et al. *Typus melancholicus and the temperament and character inventory personality dimensions in patients with major depression*. Psychiatr Clinical Neurosci 2000;54:181-9.

52 Kronmuller K-T, Backenstrass M, Kocherscheidt K. *Dimensions of the tipus Melancholicus personality type*. Eur Arch Psychiatry Clin Neurosci 2005;255:341-9.

53 Sakai Y, Akiyama T, Kawamura Y, et al. *Temperament and melancholic type: path analysis of a prospective study of depressive mood change in a nonclinical population*. Psychopathology 2009;42:249-56.

54 Akiyama T, Tsuda H, Matsumoto S, et al. *Cyclothymia and typus Melancholicus: empirical study on personality character of mood disorder*. Seishin Shinkeigaku Zasshi 2003;105:533-43.

55 Meyer TD. *The Hypomanic Personality Scale, the big five and their relationship to depression and mania*. Pers Indiv Differ 2002;32:649-60.

56 Blechert J, Meyer TD. *Are measures of hypomanic personality, impulsive nonconformity and rigidity predictors of bipolar symptoms?* Br J Clin Psychol 2005;44:15-27.

57 Ogawa T, Koide H. *Cultural variations in premorbid personality of endogenous depression: a transcultural study*. Jpn J Psychiatry Neurol 1992;46:831-9.

58 Abe T. *Increased incidence of depression and its sociocultural background in Japan*. Seishin Shinkeigaku Zasshi 2003;105:36-42.

59 Tsuda H, Hori A. *"Shuuchaku" in various types of manic-depressive patients*. Seishin Shinkeigaku Zasshi 2003;105:544-51.

60 Tsuda H. *Depression and personality*. Seishin Shinkeigaku Zasshi 2005;107:1268-85.

61 Sakamoto K. *Premorbide personality*. Nihon Rinsho 2005;65:1591-8.

62 Rubino IA, Zanasi M, Robone C, et al. *Personality differences between depressed melancholic and non-melancholic inpatients*. Aust N Z J Psychiatry 2009;43:145-8.

63 Yamada Y, Hirosawa M. *Does Typus Melancholicus determine characteristics of athlete burnout symptom and its process among Japanese university athletes?* J Hum Ergol 2009;38:67-79.

64 Ambrosini A, Stanghellini G, Langer A. *El typus melancholicus de Tellenbach en la actualidad: una revisión sobre la personalidad premórbida vulnerable a la melancolía*. Actas Españolas de Psiquiatría 2011;39:302-11.

65 Ambrosini A. *Postpartum depression and melancholic type of personality: a pilot study*. Italian Journal of Psychopathology 2013;19:3-13.

66 Kraus A. *How can the phenomenological-anthropological approach contribute to diagnosis and classification in psychiatry?* In: Fulford KWM, Morris K, Sadler J, et al. editors. *Nature and narrative. An introduction to the new philosophy of psychiatry*. New York: Oxford University Press 2003.

67 Kraus A. *Melancholic depersonalisation*. Comprendre 2008;16-17-18; 243-8.

68 Bloch M, Schmidt PJ, Danaceau M, et al. *The role of gonadal steroid in postpartum depression*. Am J Psychiat 2000;157:924-30.

69 Gotlib IH, Whiffen VE, Wallace PM, et al. *Prospective investigation of postpartum depression: factors involved in onset and recovery*. J Abnorm Psychol 1991;100:122-32.

70 Romans SE, Walton VA, McNoe B, et al. *Otago women's health survey 30-month follow-up. I: onset patterns of non-psychotic disorder. II: remission patterns of non-psychotic psychiatric disorder*. Br J Psychiatry 1993;163:733-46.

71 Campbell SB, Cohn JF. *Prevalence and correlates of postpartum depression in first- time mothers*. J Abnorm Psychol 1991;100:594-9.

72 Paykel ES, Emms EM, Fletcher J, et al. *Life events and social support in puerperal depression*. Br J Psychiatry 1980;136:339-46.

73 O'Hara MW, Neunaber DJ, Zekoski EM. *A prospective study of postpartum depression: prevalence, course, and predictive factors*. J Abnorm Psychol 1984;93:158-71.

74 Stanghellini G, Ambrosini A. *Depressione postpartum e typus Melancholicus. Uno studio pilota*. Giornale Italiano di Psicopatologia 2011;17:22-30.

75 Pazzagli A, Benvenuti P, Rossi Monti M. *Maternità come crisi*. Roma: Il Pensiero Scientifico Editore 1981.

76 Stern DN, Bruschweiler-Stern N, Freeland A. *Birth of a mother: how the motherhood experience changes you forever*. New York: Perseus Books 1999.

77 Bondas T, Eriksson K. *Women's lived experiences of pregnancy: a tapestry of joy and suffering*. Qual Health Res 2001;11:824-40.

78 Muscelli C, Stanghellini G. *Istantaneità: cultura e psicopatologia della temporalità contemporanea*. Milano: Franco Angeli Editore 2012.

79 Byung-Chul H. *Agonie des eros*. Berlin: Matthes & Seitz Berlin 2012.

Psychopathology of depression and mania: symptoms, phenomena and syndromes

T. Fuchs

Karl Jaspers Professor of Philosophy and Psychiatry, Head of the Section Phenomenological Psychopathology, Psychiatric Department, University of Heidelberg

Summary

The paper gives a phenomenological account of depression and mania in terms of body, space, temporality and intersubjectivity. While the lived body is normally embedded into the world and mediates our relations to others, depression interrupts this embodied contact to the world. Local or general oppression condenses the fluid lived body to a solid, heavy "corporeal body". Instead of expressing the self, the body is now turned into a barrier to all impulses directed to the environment. This impairs the patient's interaction and affective attunement with others, resulting in a general sense of detachment, separation or even segregation. Depression is then further interpreted as the result of a desynchronisation, i.e. an uncoupling in the temporal relation between the patient and his social environment. This concept leads to some suggestions regarding a "resynchronisation therapy" for affective disorders. Conversely, mania is phenomenologically described as a centrifugal dispersion of the lived body, characterised by a general lightness, expansion and disinhibition. In the temporal dimension, the manic desynchronisation from the environment manifests itself in a lack of rhythmicity and constant acceleration of lived time.

Key words

Depression • Mania • Body • Space • Temporality • Intersubjectivity • Desynchronization • Phenomenology

Introduction

Phenomenological psychopathology has a long tradition of describing and analysing the subjective experience of affective disorders, and in particular, melancholic depression. These analyses have mostly focused on dimensions such temporality, spatiality, personality or identity [1-7]. A basic assumption of the phenomenological approach is that the psychopathologist should methodically suspend any assumptions about causal explanations of a disorder, be it psychological or biological, and instead try to grasp the patient's experience as best as possible. The aim of this approach is not just a thorough description, however, but an analysis of the basic structures of experience that are altered in mental illness. This alteration often takes place on a prereflective level and thus may not be immediately accessible to, and verbalised by, the patients themselves.

The following description tries to link these basic structures of experience, i.e. body, space and time with intersubjective aspects in order to give an integrated picture of the depressive and manic condition. To begin with, a few remarks on the general phenomenology of affectivity and the lived body are necessary in order to prepare the ground for the description of affective disorders.

Moods, emotions and the lived body

In contrast to the common cognitivist picture in which mental states and emotions are located within our head, phenomenology regards emotions as embodied relations to the world, and in particular, as residing in-between individuals [8]. Human beings do not have moods or emotions independent of their relations and interactions with others. First, *moods* are not inner states, but permeate and tinge the whole field of experience. Being atmospheric in nature, they radiate through the environment like warmth or cold, and confer corresponding affective qualities on the whole situation [9]. On the other hand, moods also include certain background feelings of the body, such as lightness and freshness in elation or mania, or weariness and heaviness in boredom, sadness, or depression. This background may also consist of what Ratcliffe has termed *existential feelings*: feelings of wideness or restriction, freedom or imprisonment, vulnerability or protection, familiarity or estrangement, feeling alive or feeling dead [10]. Similarly, *emotions* are ways of being in the world; they emerge on the basis of a prereflective attunement with others, indicating the current state of our relations, interests and conflicts, and manifest themselves as attitudes and expressions of the body. There is no emotion without bodily sensations, bodily resonance and affectability.

Correspondence
Thomas Fuchs, Karl Jaspers Professor of Philosophy and Psychiatry, Head of the Section Phenomenological Psychopathology, Psychiatric Department, University of Heidelberg, Voss-Str. 4, D-69115 Heidelberg, Germany • Tel. +49 6221 564422 • E-mail: thomas.fuchs@med.uni-heidelberg.de

Of course, when I am moved by an emotion, I may not even be aware of my body; yet being afraid, for instance, is not possible without feeling a bodily tension or trembling, a beating of the heart or a shortness of breath, and a tendency to withdraw. In short, the body is a "resonance body", a most sensitive sounding board in which interpersonal and other "vibrations" constantly reverberate [8 11 12].

Kinaesthesia is an important component of this resonance. Emotions are dynamic forces that motivate and move us in our ongoing interactions with the environment, inducing us to move towards or away from something or someone, or to behave in more specific ways. In this view, emotions are first and foremost embodied motivations to action [13]. As such, they are not only felt from the inside, but also displayed and visible in expression and behavior, often as bodily tokens or rudiments of action. The facial, gestural and postural expression of a feeling is part of the bodily resonance that feeds back into the feeling itself, but also induces processes of *interbodily resonance* [14]. Our body is affected by the other's expression, and we experience the kinetics, intensity and timing of his emotions through our own bodily kinaesthesia and sensation. This results in a continuous interplay of both partners' expression and impression, mediating a pre-reflective reciprocal understanding which Merleau-Ponty termed "intercorporeality" [15]; it may be regarded as the bodily basis of affective attunement with others or empathy.

In this context, it is important to note the distinction of the *subjective* and the *objective body* (also termed "lived" vs. "corporeal" body, or *Leib* vs. *Körper*) as conceptualised by the phenomenologic tradition [16 17]. The lived body means the body as the medium of all our experience, or in other words, our embodied being-in-the-world: in everyday life, I perceive, act and exist through my body, without explicitly reflecting on it. The body withdraws from my awareness to the same degree as it mediates my relation to the world. The *corporeal body*, on the other hand, is the material, anatomical object of physiology and medicine that can be observed and grasped. It appears in my own experience whenever the lived-body loses its "taken for granted", mediating role and becomes obstinate or fragile, as for example in the experience of heaviness, fatigue, clumsiness, injury, or illness. The lived-body turns into the objective body whenever I become aware of it in an impeding or embarrassing way. Having been a bodily being without taking notice before, I now realise that I have a material (clumsy, vulnerable, finite, etc.) body. In the tradition of phenomenology, we can say that the lived body is the body that *I am*, whereas the corporeal body is the body that *I have* [16].

The phenomenology of depression: body, space, time and intersubjectivity

On this background, we may now start to describe the phenomenology of depressive and manic experience. In short, the *depressive state* may be characterised by a general constriction or "congealment" of the lived body, leading to a numbing of emotional resonance and loss of attunement. This alters the patient's existential feelings of being-with-others, resulting in a general sense of detachment, segregation, or even expulsion. In this way, the lived body also expresses the experiences of loss and separation which usually trigger depressive episodes on a psychosocial level.

Corporealisation

In severe depression, the lived body loses the lightness, fluidity and mobility of a medium and turns into a heavy, solid body which puts up resistance to all intentions and impulses directed towards the world. The depressive patient experiences an oppression and constriction that may focus on single areas of the body (e.g. feeling of an armour or tyre around the chest, of a lump in the throat, pressure in the head) or also manifest itself in a diffuse anxiety, an overall bodily rigidity ("anxiety" is derived from the latin "*angustiae*" which means "narrows", "constriction"). The materiality, density and weight of the body, otherwise suspended and unnoticed in everyday performance, now come to the forefront and are felt painfully. In this respect, depression closely resembles somatic illnesses such as infections that affect one's overall bodily state. Corresponding reports from patients may well be elicited provided that the interviewer takes their bodily experience serious: they will complain about feelings of fatigue, exhaustion, paralysis, aches, sickness, nausea, numbness, etc. [18]. Moreover, in depression the exchange of body and environment is blocked, and drive and impulse are exhausted. In summary, depression may be described as a reification or corporealisation of the lived body [7 a]: "My body became inert, heavy and burdensome. Every gesture was hard" – "I couldn't escape the awful confines of my leaden body and downcast eye. I didn't want to live, but I couldn't bear to die" [19].

[a] This description refers to the most frequent type of severe depression that is characterised by psychomotor inhibition. There is another type with prevailing agitation and anxiety ("agitated depression") in which the patients experience the same constriction but the loss of drive is less marked, so that they try in vain to escape from their tormenting bodily state by aimless activity.

The constriction and encapsulation of the body corresponds to the psychosocial experiences that typically lead to depression. These are experiences of a disruption of relations and bonds, including the loss of relevant others or of important social roles, further situations of a backlog in one's duties, falling short of one's aspirations, or social defeat [3 20]. These situations of social separation or defeat are perceived as particularly threatening since the patients feel they do not have the necessary resources for coping ("learned helplessness") [21]. Depression is the consequent psychophysiological reaction: on the biological level, it involves a pattern of neurobiological, metabolic, immunological, biorhythmic and other organismic dysfunctions which are equivalent to a partial decoupling or separation between organism and environment[b]. These dysfunctions are subjectively experienced as a loss of drive and interest (anhedonia), psychomotor inhibition, bodily constriction and depressive mood.

Constriction of sensorimotor space

The constriction thus described continues in sensorimotor space. Sense perception and movement are weakened and finally walled in by the general rigidity which is also visible in the patient's gaze, face, or gestures.

Perception is characterised by a loss of alertness and sympathetic sensation: patients may describe a loss of taste, a dullness of colours, or muffled sounds as if heard from afar. Their senses are not able to vividly participate in the environment, their gaze gets tired and empty, their interest and attention weakens. They can only passively receive what comes from outside.

Movement, on the other hand, is marked by psychomotor inhibition: gestures, speech and actions are reduced, only mechanically produced, and lack normal energy. A bowed posture, lowered head and leaden heaviness show the dominance of forces pressing downwards. In order to act, patients have to overcome the inhibition and to push themselves to even minor tasks, compensating by a high effort of will which the body does not have of its own accord any more. Consequently, the external aims and objects withdraw from the patient; using Heidegger's terms, they are not "ready-to-hand" any more, but only "there" (*zuhanden* vs. *vorhanden*).

All this means that the body's space shrinks to the nearest environment, culminating in depressive stupor. The patient cannot *transcend* the body's boundaries any longer – which is what we normally do when we are looking at and desiring things, reaching for them, walking towards our goals, and thus anticipating the immediate future. As we can see, subjective space and time are interconnected: the extension of space around me and the anticipation of what is possible or what is to come are one and the same thing. For the depressive person, however, space is not embodied any longer; there is a gap between the body and its surroundings. This in turn reinforces the bodily constriction and enclosure mentioned above.

Intercorporality and interaffectivity

The bodily constriction results not only in felt oppression, anxiety, or heaviness, but more subtly, in a loss of the inter-bodily resonance which mediates the empathic understanding in social encounters. The depressive body lacks emotional expression and offers no clue for the other's empathic perception. The continuous synchronisation of bodily gestures and gazes that normally accompanies interaction breaks down. The patients themselves realise this congealment of their expression; moreover, their own empathic perception and resonance with the other's body is lacking [22-24]. Thus, they feel unable to emotionally communicate their experience and try in vain to compensate for the loss of attunement by stereotyped repetition of their complaints.

The loss of bodily resonance or affectability concerns, more generally, the experience of affective valences and atmospheres in the surroundings. In milder forms this becomes manifest in a loss of interest, pleasure and desire. But the deeper the depression, the more the attractive qualities of the environment faint. Patients are no longer capable of being moved and affected by things, situations, or other persons. This leads to an inability to feel emotions or atmospheres at all, which is all the more painful as it is not caused by mere apathy or indifference (as for example in frontal brain injury), but by the tormenting bodily constriction and rigidity. Kurt Schneider wrote that the "vital disturbances" of bodily feelings in severe depression – anxiety, oppression, heaviness, exhaustion – are so intense that psychic or "higher" feelings can no longer arise [25]. Patients then complain of a "feeling of not feeling" and of not being able to sympathise with their relatives any more. In his autobiographical account, Solomon describes his depression as "… a loss of feeling, a numbness, [which] had infected all my human relations. I didn't care about love; about my work; about family; about friends …" [26]. Hence, patients lose participation in the shared space of affective attunement.

[b] This comes about through a prolonged organismic stress reaction, affecting, above all, the CRH-ACTH-cortisol system, the sympathetic nervous system as well as the serotonin-transmitter regulation in the limbic system, and resulting in a desynchronisation of diurnal hormone and sleep-wake cycles (Wehr & Goodwin 1983, Berger et al. 2003).

Of course, there are emotions that remain despite the loss of affectability, in particular feelings of guilt, anxiety, or despair. However, these emotions show some characteristic features: (1) they do not connect, but rather separate the subject from the world and from the others; (2) their felt bodily quality is characterised by constriction and rigidity, thus corresponding to the overall depressive state of corporealisation; (3) they are embedded in the prevailing depressed mood rather than arising as independent feelings; therefore, their intentional objects are just as ubiquitous as arbitrary. A depressive patient describes what may be called an elementary, bodily experience of guilt:

"It comes from below, from the gut, like a terrible oppression rising to the chest; then a pressure arises, like a crime that I have committed. I feel it like a wound on my chest, that is my tortured conscience … then this attracts my memories, and I have to think again of all that I have missed or done wrong in my life…" [6].

This shows that an elementary feeling of being guilty can be rooted in bodily experience itself and only secondarily materialises in corresponding, yet arbitrary memories of omissions or failures [1]. Similarly, the bodily state of diffuse, vital anxiety finds its concrete objects in all kinds of imagined disaster (financial ruin, lethal disease, etc.), which the patient anticipates as inevitable. The simultaneity of a loss of affectability and the presence of anxiety or guilt feelings, contradictory at first sight, can thus be explained by their mood-congruent, bodily character. In severe or psychotic stages of depression, such constricting emotions turn into continuous states of agony, and it may be doubted whether they could still be called emotions at all.

Derealisation and depersonalisation

Since the affective contact to the environment is also essential for our basic sense of reality and belonging to the world, a loss of body resonance always results in a certain degree of derealisation and depersonalisation. Therefore, affective depersonalisation is a core-feature of severe depressive episodes [5 27]. Patients do not experience sadness, mourning or grief; they rather feel empty, blunt, dull, or rigid. However, there is a special kind of melancholic depression in which depersonalisation is the prominent symptom; in German psychopathology it is called "Entfremdungsdepression" (depersonalised depression) [28]. Here the emotional quality of perception is lost completely, objects look blunt or dead, and space seems emptied, as in the following reports:

"Everything around me seems far away, shady and somehow unreal – like in a strange dream" (*own clinic, T.F.*).

"I feel detached from all people, like an outcast in a gloomy world. I am unable to participate in life any more" (*own clinic, T.F.*).

"There is only emptiness around me; it fills the space between me and my husband; instead of conducting it keeps me away"[c].

Patients feel like isolated objects in a world without relationships; there is only an abstract space around them, not a lived, embodied space any more. Perception only shows the naked framework of objects, not their connectedness or their "flesh". The depersonalisation in severe depression culminates in so-called nihilistic delusion or *Cotard's* syndrome, formerly called "*melancholia anaesthetica*" [29]. Patients no longer sense their own body; taste, smell, even the sense of warmth or pain are missing, everything seems dead. Having lost the background feeling of the body that conveys a sense of connectedness and realness to our experience, patients may contend that the whole world is empty or does not exist anymore. This lets them conclude that they have already died and ought to be buried: a 61-year-old patient felt that her inner body, her stomach and bowels had been contracted so that there was no hollow space left. The whole body, she said, was dried out and decayed, nothing inside moved any more. The body felt numb, she sensed neither heat nor cold, meals had lost their taste. The environment seemed strangely altered, too, as if everything had gone dead. Finally, she was convinced that all her relatives had died, that she was alone in the world and had to live in a dead body forever [6].

Granted, Cotard's syndrome is a rare phenomenon, yet it illustrates by the extreme how the feeling of reality is dependent on our participation in a shared emotional space. Once the affectability of the body and thus the affective basis of co-experiencing the world is lost, the sense of reality dissolves and gives way to a virtualisation of one's being-in-the-world.

Delusions of guilt

With Cotard's syndrome, we have already entered the domain of psychotic depression. In the next section, I want to look at a more typical example of depressive delusions from an intersubjective point of view, namely at delusions of guilt.

As we have already seen above, the depressed patient's bodily constriction, vital anxiety and loss of interaffective

[c] In general, memories are facilitated by the bodily and emotional state that corresponds to the condition in which they were acquired; cf. the research on state-dependent learning and mood-congruent memories (e.g. Bower 1981, Blaney 1986). This is particularly valid for depression (e.g. Barry et al. 2004).

attunement imply a separation from others and thus are particularly suited to reactivate primary feelings of guilt[d]. This holds true even more for the "typus melancholicus", the personality that is particularly prone to fall ill from depression [3 30 31]. This personality type is characterised by excessive conscientiousness, orderliness, hypernomic adherence to social norms and dependency on stable interpersonal relationships. For these patients, the affective ties to others are essential, even vital, and becoming guilty means to be excluded from the indispensable community with others. In depression, patients experience the bodily constriction as an existential feeling of separation and rejection that activates an archaic, punishing and annihilating conscience [32].

The crucial presupposition for depressive delusions, however, concerns the intersubjective constitution of reality. Precisely the social reality of guilt normally does not mean a fixed state or quantity but is negotiated through a shared process of attribution and justification that defines the omissions or faults as well as their degree of severity. Similarly, dealing with guilt (through responsibility, regret, compensation, forgiveness, rehabilitation, etc.) involves an intersubjective agreement and mutual alignment of perspectives. This in turn requires a deeper fundament that is generated by our prereflective affective connectedness with others, and in particular by a basic sense of *mutual trust*. The depressive patient, however, loses this prereflective connection and becomes locked in his bodily constriction and corporealisation. Thus, he is literally deprived of the free scope that is necessary for taking the other's perspective and relativising his own point of view. The others are separated by an abyss and can no longer be reached. Guilt, instead of being an intersubjective *relation* that can be dealt with, becomes *a thing* or *an object* the patient is identified with, as shown by the following case example:

Soon after his retirement, a 64 year-old patient fell ill with severe depression. Coming from a poor background, he had become staff executive of a large company by hard work. He reported that he had only been on sick leave for 10 days in 45 years of work. In contrast, his depression was characterised by a feeling of decay. All his power had vanished, the patient complained, he had no longer command of his arms and legs. He had burnt the candle at both ends, had not taken care of his family, and now he deserved to get his punishment. He accused himself of being responsible for the failure of an important deal of his company two years ago that would inevitably lead to its bankruptcy. He would never be able to cancel this debt again. Moreover, he complained that he had no more feelings for others. "I am only a burden for them, a millstone around my family's neck … for me, life is over". He finally thought that the death sweat already appeared on his forehead, one could even see the cadaveric lividity on his face. He should be driven in the mortuary in the basement and be abandoned there (*own clinic, T.F.*).

The capacity of taking the perspective of others is not only a cognitive feat but depends on a common interaffective sphere that is part of the "bedrock of unquestioned certainties" [33 34]. It provides a foundational, non-representational structure of mutual understanding that underpins our shared view of reality. In delusional depression, however, the loss of the pre-predicative relation to others makes it impossible to take their perspective and to gain distance from oneself, thus forcing the patient *to completely equate his self with his current depressed state*. This present state means being thrown back upon oneself, feeling rejected and expelled. The delusional patient, as shown in the case example, is identified with his existential feeling of guilt to the extent that he is *guilty as such*. There is no remorse, recompensation, or forgiveness, for the guilt is not embedded in a common sphere which would allow for that. Delusions of guilt result from a disruption of intersubjective relations on the basic level of interaffectivity [8].

This is characteristic of depressive delusion in general: corporealisation and loss of attunement to others prevent the patient from taking their perspective. As a result, a state of self beyond the present one becomes unimaginable. It has always been like this, and it will stay like this forever – to remember or hope for anything different is deception. The patient is inevitably identified with his present state of bodily constriction and decay, with his state of feeling guilty as such, or, in nihilistic delusion, with his state of feeling dead. Hypochondriacal or nihilistic delusions, delusions of guilt or impoverishment are all just different manifestations of a complete objectivation or reification of the self that can no longer be transcended. Depressive delusion is therefore rooted in the loss of the shared interaffective space and in the utter isolation of the self that results from it.

Temporality and desynchronisation

As pointed out earlier, there is a narrow connection between the lived body, lived space and temporality. In the last analysis, the possibility of bodily movement, the ac-

[d] This is in line with recent research on the embodiment of emotions, showing that bodily postures, expressions, sensations and interoceptive states influence one's emotional state in various ways, "bottom-up", so to speak (Damasio 1999, Niedenthal 2007, Craig 2008).

cessibility and openness of space, and the movement of life towards the future are one and the same thing. So if the body is isolated from the surroundings by constriction, then space will appear to be inaccessible, unreachable and detached from the potentiality of the body. But what is more, the temporal movement of life will also cease and come to a standstill.

Thus, an inhibition of lived time is the hallmark of depression, as Straus, von Gebsattel and Tellenbach have pointed out [1-3]. Following Straus, in melancholic depression the "ego-time" of the movement of life gets stuck, whereas the "world-time" goes on and passes by. The inhibition of inner time does not allow the patient to progress towards the future, nor is he able to close up and leave behind his past experiences. "The more the inhibition increases and the speed of inner time slows down, the more the determining power of the past is experienced" [1]. What has happened remains conscious as a fault or failure, as ever-growing guilt. Such analyses are still fundamental for a psychopathology of temporality. Modifying this approach, however, I will consider the depressive pathology of time not only as an individual inhibition but as a disturbance of a synchronised relation, or a *desynchronisation*. Depression then means an uncoupling in the temporal relation of organism and environment, as well as with the individual and society [35].

The concept of synchronisation is derived from chronobiology, referring to the order of rhythms such as the sleep-wake-cycle or the diurnal period of hormone levels. There is a continuous attunement between organismic or endogenous with cosmic or exogenous rhythms, such as daily, lunar and solar periods. On the social level, however, we find many forms of synchronisation as well. Since birth, the rhythms of the organism (eating, sleeping, excretion times, etc.) are shaped by socialisation. More subtly, the everyday contact with others implies a continuous fine-tuning of emotional and bodily communication, an intercorporeal resonance. Moreover, social synchronisation is conspicuous in the manifold ways of "timing", of day- and week-time regulation, date scheduling, as well as in all mutual commitments and agreements which are bound to certain time frames. These various temporal coordinations engender a basic feeling of being in accord with the time of the others, and to live with them in the same, intersubjective time.

All these biological and social synchronisations, however, are not constant. The homoeostasis of the organism in relation to its environment is only preserved through recurring deviations or *desynchronisations*. On the social level, too, we periodically experience asynchronies, i.e. situations that require us to re-adapt to external changes, to compensate for disturbances and backlogs. Uncompleted tasks, unresolved conflicts, strain and distress accumulate, thus inhibiting our progress toward the future. Even more in serious experiences of trauma, in guilt, loss, or separation, the person temporarily loses the lived synchrony with others.

A prolonged desynchronisation between the individual and the environment is characteristic of melancholic depression. The typical constellation triggering the illness has already been characterised by Tellenbach as a situation of "*remanence*" which means falling short of one's own rigid demands concerning social duties and orderliness [3]. According to Tellenbach, remanence is the risk inherent in the personality structure of the melancholic type. Patients do not feel equal to the pace of changes or cannot cope with increasing obligations. Often they surrender in the face of painful processes of detachment or grief, or they refrain from necessary role changes.

This corresponds to the premorbid striving of the melancholic type to avoid discrepancies in relation to the environment by all means. The "hypernomia" which Alfred Kraus has characterised as the hallmark of the melancholic person's social identity, is a "hypersynchrony" as well [4]. Down to the microdynamics of everyday behaviour, the melancholic type seeks continuous resonance by social attunement, compliance, friendliness, punctuality and timely completion of tasks. The capitulation before an inescapable task of coping or development now leads exactly to what the melancholic fears most of all: the breakdown of coherence with his social environment in depressive illness.

Depressive psychopathology may then be viewed as the result of a general desynchronisation, as a psychophysical slowdown or *stasis*. On the physiological level, this manifests itself in disturbances of neuroendocrine and temperature periods, of the sleep-wake-rhythm, in a loss of drive, appetite and libido. One may also think of the seasonal depressions as desynchronisations in relation to the annual period. The uncoupling of organism and environment also manifests itself in the experience of *corporealisation* described above. The body loses its embedding in, and resonance with, the environment, and turns into an obstacle that falls short of its tasks.

Let us now consider the desynchronisation concerning intersubjective time. Depressed patients avoid the environment with its social or physical timekeepers. They do not get up in time, withdraw from social obligations, and their tasks are taken over by others. Painfully, the patient experiences his inhibition and rigidity in contrast to the movement of life going on in his environment. The desynchronisation also becomes manifest in a failure to achieve forgetting and elimination of the past. "Everything goes through my head again and again, and I always have to wonder if I did things right", as a patient described it. It is the torture of not being able to forget, of being constantly forced to remember and therefore not arriving at the present any more.

With increasing inhibition the basic movement of life comes to a standstill. The depressive has fallen out of common time, usually expressed in the complaint that time has slowed down or stopped. He literally lives in another, sluggish time, and the external, intersubjective time passes him by [8 36]. This disturbance of temporalisation can be experimentally verified: depressive persons experience a time dilation, i.e. they estimate given time intervals to be longer than the actual, objectively measured time [37].

"My inner clock seems to stand still, while the clocks of the others run on. In everything I do I am unable to get ahead, as if I am paralysed. I lag behind my duties. I am stealing time" (*own clinic, T.F.*).

"I have to keep on thinking that time is continuously passing away. As I speak to you now, I think 'gone, gone, gone' with every word I say to you. This state is unbearable and makes me feel driven. (…) Dripping water is unbearable and infuriates me because I have to keep on thinking: another second has gone, now another second. It is the same when I hear the clock ticking – again and again: gone, gone" [2].

This patient perceives time in fragments because she cannot experience it in the flow of spontaneous becoming but as something remaining outside her. She must subsequently go back to everything that she was not able to live through in perceiving and acting, however, only to notice that the impression or the movement is already "gone".

With uncoupling from external time, the future is blocked, which means that *the past is fixed once and for all*; it may no more be changed or compensated by future living. Now all past guilt and all omissions are actualised: "What has happened can never be undone again. Not only the things go by, but also possibilities pass by unused. If one does not accomplish something in time, it is never done any more … The real essence of time is indelible guilt" [38]. Thus, in melancholic depression, time is continuously transformed, as it were, into guilt which cannot be discharged any more.

Complete desynchronisation is marked by the transition to melancholic delusion. Now the return to a common intersubjective time has become unimaginable, the determination by the past total. A state of self outside the present one seems impossible. The patient is forced to identify with his present state of bodily inhibition and decay, with his state of feeling guilty as such, or, in nihilistic delusion, with his state of not feeling alive any more. He is no longer able to keep his situation in perspective, and to relativise his convictions. It has always been like this, and it will stay the same forever – all reminiscence or hope different from that is deception.

Now if for the patient there is no state of self outside the present one, he loses the capacity to change his perspective and to transcend his present experience towards an intersubjective view. Depressive delusion is therefore rooted in the total constriction of self-experience: Corporealisation and desynchronisation, i.e. bodily and temporal separation from the shared world, prevent the patient from taking the perspective of others. He loses the freedom of self-distancing, of considering other possibilities of self-being. Delusions of guilt or impoverishment, nihilistic and hypochondriacal delusions are all just different expressions of the same state of the self: a state of total objectivation or "reification" that can no longer be transcended.

Resynchronising therapy

I have described depression by two main alterations that are closely interconnected: *corporealisation* and *desynchronisation*. The loss of goal-oriented capacities of the body, of drive, appetite and desire, are equivalent to a slowing-down and finally a standstill of lived time. Thus the past, the guilt, losses and failures gain dominance over the future and its possibilities. Melancholic delusion is the utter manifestation of this uncoupling from common time.

From this point of view, the treatment of depression should have the aim to restore and support the missing processes of synchronisation. Apart from biological approaches, a psychosocial "*resynchronising therapy*" should take into account the following guidelines:

1) The first requirement would be a spatial and temporal frame that creates a legitimate recovery period for the patient, a "time-out" so-to-speak, during which he can gradually readapt to the common social course of time with as little pressure as possible. In this phase of treatment, the aim is to loosen the rigidity of bodily restriction and anxiety, which is mainly achieved by psychotropic medication, but also by the relief of everyday tasks that overburden the patient's capacities.

(2) Secondly, it is important to give rhythm to everyday life, i.e. to emphasise repetition and regularity in the structure of the day and week. This helps the patient to gain a stand against fleeting time and to support the resynchronisation of internal and external rhythms.

(3) Careful activation therapy may support the patient's orientation toward future goals, however modest. This may be stressful at first, since the patient's own, appetitive motivation is still missing and each action is in immediate danger of not satisfying his high demands on achievement. It is therefore important to explain to the patient that the intentional arc alone, which he draws in planning and execution, is enough to extend his sensorimotor space again und to re-establish his directedness towards the future.

(4) From this follows the principle of "optimal resynchro-

nisation": the patient should experience a degree of activation and stimulation appropriate to his present state, so that the empty time is filled again, without however, causing a relapse into uncoupled time by forced rehabilitation. The image of a gear-change suggests itself here, where different levels of synchronisation are chosen according to the present capacity.
(5) After the remission of acute depression, it becomes important to further the psychological and social processes of resynchronisation whose failure has contributed to the onset of illness, above all, processes of grief and role change.

The phenomenology of mania: body, space, time and intersubjectivity

Mania is obviously the antithesis of depression. The depressive heaviness, inhibition and retardation is replaced by lightness, disinhibition and acceleration. The lived body, instead of its constriction in depression, is characterised by a *centrifugal expansion*, connected with a general sense of omnipotence and appropriation. Therefore, the manic mood is not so much a state of happiness and cheerfulness, but rather a state of superficial elation, often experienced with feelings of flying or floating. One may speak of a "vital euphoria", since the manic state of mood is not due to a narcissistic grandiosity, but mainly to an excess of drive, energy and disinhibition. The body seems to have lost all inner resistance that normally hinders us from acting out every impulse immediately.
However, manic euphoria may turn into *dysphoria* and irritability, especially when others question the manic person's omnipotent attitude or confront his expansion. Dysphoria (from the Greek *dysphoros* = hard to bear) denotes a condition of disagreeable, nervous tension, hostile emotional reactivity and propensity for aggressive acting out. It becomes the dominant mood in so-called *mixed states* of bipolar disorders, characterised by rapidly shifting affects, agitation, accelerated thoughts, lack of concentration and memory, and sudden attacks of depression which may even cause suicidal thoughts and actions [39 40]. Dysphoric mood should thus be considered as a particular type of mood that is qualitatively distinct from anger, sadness, anxiety, or euphoria.
As a result of the excess of drive and the expansivity of the body, the *space* of the manic person changes into an unlimited, homogeneous medium of projects and activities. The patient's self is exteriorised and extended in his environment, trespassing on others' territories regardless of barriers of decency or respect. "The world is too small for this being in expansion [...] and distances become smaller" [41]. Space is lived as if it were vast, open and lacking resistance. Attractive qualities or opportunities abound, all objects seem equally close, available and ready-to-hand [42], leading to the notorious excessive consumption. Thus, the relation of person and space is characterised by *centrifugal dispersion* and *dedifferentiation*, overriding the gradations of proximity and distance that normally structure the peripersonal environment. In the symbolic realm of thinking, the "flight of ideas" corresponds to the dispersed mode of existence that is conspicuous in the patient's lived space.
Regarding *temporality*, we find the opposite type of desynchronisation compared to depression, namely an *acceleration* and finally uncoupling of the individual from the world time. Manic action is characterised by restless hustle and agitation. The present is not enough, it is virtually marked by what is still missing or what would be possible. Whereas the depressive patient keeps lamenting over missed opportunities of the past, the manic person is constantly ahead of himself, addicted to the seemingly unlimited scope of possibilites. Interest in the present is always distracted in favour of the next-to-come. The future cannot be awaited and expected, but must be assailed and seized immediately. Impatience leaves no ease for pursuing long-term goals. The past, on the other hand, is forgotten as soon as new alluring options and possibilities emerge; commitments are betrayed in favour of a more enticing future.
All this leads to a momentary life, consisting of isolated "nows", not allowing for a sustained development and conclusion of projects. The manic mode of existence is volatile, playful and provisional; both the past and the future lose their influence on the present [43]. If one project fails, then a dozen of other plans take its place at once, resulting in a spinning round on the spot without actual efficacy. In so doing, the manic person neglects the natural rhythms that oppose his acceleration: he represses the cyclic time of the body in favour of homogeneous, linearly accelerated time. He disregards the needs of his body, denies it the necessary sleep and ignores the signs of beginning exhaustion. The body is exploited recklessly, as a mere vehicle of the expansive drives.
In summary, in mania the movement of life is accelerated and overtakes external, social, or world time. Only in fleeting transition does the patient come in contact with the world and the others, unable to dwell in the present and instead always turning to the next-to-come. Here too, the disturbance of temporality may be experimentally verified: in studies on time estimation, hypomanic and manic patients experience a shortening of time periods [44].
If we finally turn to *intersubjectivity*, we find patients bustling around in dispersed attention, without being able to take a specific interest in others. Though the manic person constantly approaches and seizes them, he soon loses his interest once they do not participate, and no deeper affective connection results. The patient's euphoria feigns

affection, but actually remains a "frozen", fixed state of empty cheerfulness. Since the component of *receptivity* in contact is lacking, encounters cannot establish contentment and fulfillment. Lack of distance and disinhibition, often a sexualised behaviour to the point of promiscuity, may have a destructive effect on personal relationships. Frequently the manic episode leaves behind a mess of job loss, debts, or divorce. Manic patients thus live over their means and exhaust their biological and social resources to the point of depletion and breakdown. Even though they may not realize this immediately for lack of self-criticism, the disillusionment after the manic episode is all the more profound and may often contribute to a sudden fall from mania into depression.

Conclusion

From a phenomenological point of view, depression and mania are not just "inner", psychological, or mental disorders, but disturbances of the bodily, affective and intersubjective space in which the patients live, behave and act. In depression, the corporealised, constricted body loses its affectability and emotional resonance; this undermines the patient's existential feelings of being-with-others, resulting in a general sense of detachment, separation, or even expulsion. The typical cognitive symptoms of depression – negative thoughts about self and future, delusional ideation – are a result of this basic bodily and affective alteration.

The constriction and encapsulation of the lived body also corresponds to the typical triggering situations of depression. These are mostly experiences of a disruption of relations and bonds: a loss of relevant others or of important social roles, experiences of backlog or defeat, resulting in a desynchronisation from others and in a blocked movement of life. To these situations of threatening or actual separation, the depressive patient reacts as a psychophysiological unity. Without doubt, depression is a bodily illness even in the biological sense, implying functional disturbances on different levels and a partial decoupling of organism and environment. But at the same time, the biological dysfunctions that result in the felt bodily constriction are the meaningful expression of a disorder of intercorporality and interaffectivity on the psychosocial level. Our participation in interaffective space is mediated by a fundamental bodily resonance. In depression, this attunement fails, and the lived body, as it were, shrinks to the boundaries of the material body.

In mania, the depressive heaviness, inhibition and retardation find their counterparts in lightness, disinhibition and acceleration. The centrifugal expansion of lived body and lived space is connected with a compression of experienced time and a dispersion of activities rendering the patient incapable of pursuing his goals in a sustainable and productive way. Moreover, the overstimulated and expansive body is inadequate for establishing the fine-tuned and reciprocal interactions with others that are necessary for emotional resonance and interaffectivity. Though the manic person's behaviour may convey a different impression, his rapport with others is no less disturbed than in depression; his contacts remain fleeting and superficial. In summary, both disorders are only fully described as disorders of intersubjectivity, which means, as a failure to participate in the interaffective space that is mediated by bodily resonance.

Conflict of interest

None.

References

1 Straus E. *Das Zeiterlebnis in der endogenen Depression und in der psychopathischen Verstimmung.* Monatsschrift für Psychiatrie und Neurologie 1928;68:640-56.

2 Gebsattel E. von. *Prolegomena einer Medizinischen Anthropologie*. Berlin Goettingen: Springer 1954.

3 Tellenbach H. *Melancholy. History of the problem, endogeneity, typology, pathogenesis, clinical considerations*. Pittsburgh: Duquesne University Press 1980.

4 Kraus A. *Rollendynamische Aspekte bei Manisch-Depressiven*. In: Kisker KP, et al. editors. *Psychiatrie der Gegenwart*. Berlin Heidelberg, New York: Springer 1987;5 403-23.

5 Stanghellini G. *Disembodied spirits and deanimatied bodies: the psychopathology of common sense*. Oxford: Oxford University Press 2004.

6 Fuchs T. *Psychopathologie von Leib und Raum. Phaenomenologisch-empirische Untersuchungen zu depressiven und paranoiden Erkrankungen*. Steinkopff: Darmstadt 2000.

7 Fuchs T. *Corporealized and disembodied minds. A phenomenological view of the body in melancholia and schizophrenia*. Phil Psychiatr Psychol 2005;12: 95-107.

8 Fuchs T. *Depression, intercorporality and interaffectivity*. J Conscious Stud 2013;20:219-38.

9 Anderson B. *Affective atmospheres*. Emotion, Space and Society 2009;2:77-81.

10 Ratcliffe M. *Feelings of being. Phenomenology, psychiatry and the sense of reality*. Oxford: Oxford University Press 2008.

11 James J. *What is an Emotion*? Mind 9 34:188-205.

12 Fuchs T, De Jaegher H. *Enactive intersubjectivity: participatory sense-making and mutual incorporation*. Phenomenol Cogn Sci 2009;8:465-86.

13 Sheets-Johnstone M. *Emotion and movement. A beginning empirical-phenomenological analysis of their relationship*. J Conscious Stud 1999;6:259-77.

14 Froese, T, Fuchs T. *The Extended body: a case study in the neurophenomenology of social interaction*. Phenomenol Cogn Sci 2012;11:205-36.

15 Merleau-Ponty M. *Eye and mind*. Trans. by C. Dallery. In: Edie J, editor. *The primacy of perception*. Evanston: Northwestern University Press 1964, pp.159-190.

16 Plessner H. *Die Stufen des Organischen und der Mensch*. Berlin: de Gruyter 1975.

17 Merleau-Ponty M. *The phenomenology of perception*. New York: Humanities Press 1962.

18 Ratcliffe M. *A bad case of the flu? The comparative phenomenology of depression and somatic illness*. J Conscious Stud 2013;20:198-218.

19 Shaw F. *Composing myself: a journey through postpartum depression*. Hanover, NH: Steerforth Press 1998.

20 Bjorkqvist K. *Social defeat as a stressor in humans*. Physiol Behav 2001;73:435-42.

21 Seligman MEP. *Helplessness. On depression, development and death*. San Francisco: Freeman & Comp. 1975.

22 Persad SM, Polivy J. *Differences between depressed and nondepressed individuals in the recognition of and response to facial emotional cues*. J Abnorm Psychol 1993;102:358-68.

23 Csukly G, Czobor P, Szily E, et al. *Facial expression recognition in depressed subjects: the impact of intensity level and arousal dimension*. J Nerv Ment Dis 2009;197:98-103.

24 Bourke C, Douglas K, Porter R. *Processing of facial emotion expression in major depression: a review*. Aust NZ J Psychiat 2010;44:681-96.

25 Schneider K. *Die Schichtung des emotionalen Lebens und der Aufbau der Depressionszustände*. Zeitschrift für die gesamte Neurologie und Psychiatrie 1920;59:281-86.

26 Solomon A. *The noonday demon: an atlas of depression*. London: Vintage Books 2001.

27 Kraus A. *Melancholie: eine Art von Depersonalisation?* In: Fuchs T, Mundt C, editors. *Affekt und affektive Stoerungen*. Paderborn: Schoeningh 2002; pp. 169-186.

28 Petrilowitsch N. *Zur Psychopathologie und Klinik der Entfremdungsdepression*. Arch Psychiat Z Ges Neurol 1956;194:289-301.

29 Enoch MD, Trethowan WH. *Uncommon psychiatric syndromes*. 3rd ed. Bristol: John Wright 1991.

30 Mundt C, Backenstrass M, Kronmüller KT, et al. *Personality and endogenous/major depression: an empirical approach to typus melancholicus*. Psychopathology 1997;30:130-9.

31 Kronmüller K-T, Backenstrass M, Kocherscheidt K, et al. *Typus melancholicus personality type and the five-factor model of personality*. Psychopathology 2002;35:327-34.

32 Fuchs T. *The phenomenology of shame, guilt and the body in body dysmorphic disorder and depression*. J Phenomenol Psychol 2002;33:223-43.

33 Wittgenstein L. *On certainty*. In: Anscombe GEM, von Wright GH, editors. Oxford: Basil Blackwell 1969.

34 Rhodes J, Gipps RGT. *Delusions, certainty, and the background*. Philos Psychiatr Psychol 2008;15:295-310.

35 Fuchs T. *Melancholia as a desynchronisation. Towards a psychopathology of interpersonal time*. Psychopathology 2001;34:179-86.

36 Ratcliffe M. *Varieties of temporal experience in depression*. J Med Philos 2012;37:114-38.

37 Mundt C, Richter P, van Hees H, et al. *Zeiterleben und Zeitschaetzung depressiver Patienten*. Nervenarzt 1998;69:38-45.

38 Kuiper PC. Seelenfinsternis. *Die Depression eines Psychiaters*. Frankfurt: Fischer 1991.

39 Azorin, JM. *Mixed states with predominant manic or depressive symptoms: baseline characteristics and 24-month outcomes of the EMBLEM cohort*. J Affect Disord 2013;146:369-77.

40 Bertschy G, Gervasoni N, Favre S, et al. *Frequency of dysphoria and mixed states*. Psychopathology 2008;41:187-93.

41 Binswanger L. *On the manic mode of being-in-the-world*. In: Straus E, ed. *Phenomenology, pure and applied*. Pittsburgh, PA: Duquesne University Press 1964, pp. 131-132.

42 Alonso-Fernandez F. *Space and time for the manic person*. In: de Koning F AJJ, Jenner A, editors. *Phenomenology and Psychiatry* New York: Grune & Stratton 1982.

43 Figueira ML, Madeira L. *Time and space in manic episodes*. Dialogues in Philosophy, Mental and Neuro Sciences 2011;4:22-6.

44 Bschor T, Ising M, Bauer M, et al. *Time experience and time judgment in major depression, mania and healthy subjects. A controlled study of 93 subjects*. Acta Psychiatr Scand 2004;109:222-9.

Reconsidering the affective dimension of depression and mania: towards a phenomenological dissolution of the paradox of mixed states

A.V. Fernandez

University of South Florida, Department of Philosophy. Tampa, Florida, USA

Summary

In this paper, I examine recent phenomenological research on both depressive and manic episodes, with the intention of showing how phenomenologically oriented studies can help us overcome the apparently paradoxical nature of mixed states. First, I argue that some of the symptoms included in the diagnostic criteria for depressive and manic episodes in the DSM-5 are not actually essential features of these episodes. Second, I reconsider the category of major depressive disorder (MDD) from the perspective of phenomenological psychopathology, arguing that severe depressive episodes should not be characterized by any particular moods (such as sadness, hopelessness, or guilt), and should instead be characterized by a diminished capacity for finding ourselves situated in and attuned to the world at all. In other words, the affective dimension of depression should be characterized as a change in the way we have moods, not as a change from one kind of mood to another. Third, I turn to mania, arguing that manic episodes, taken as the opposite of depressive episodes, should be characterized not by any particular moods (such as euphoria, grandiosity, or even irritability), but should instead be characterized by an enhanced or heightened capacity for finding ourselves situated in and attuned to the world. In other words, the affective dimension of mania, like the affective dimension of depression, should be understood as a change in the way we have moods, not as a change from one kind of mood to another. Fourth, I return to the phenomenon of mixed states and argue that the affective dimension of depression and mania, when conceived along the phenomenological lines I set forth in the previous sections, dissolves the paradox of mixed states by showing that the essential characteristics of depression and mania cannot and do not coincide. Many cases of mixed states are diagnosed because moods that we take to be essential features of either depression or mania arise within the context of what is considered to be the opposite kind of episode (e.g. dysphoria, typically associated with depression, often arises in what is otherwise considered a manic state). However, if we conceive of the affective dimension of depression as a decrease in the degree to which one is situated in and attune to the world through moods, and the affective dimension of mania as an increase in the degree to which one is situated in and attuned to the world through moods, then the particular mood one finds oneself in is simply irrelevant to the diagnosis of either depression or mania. As a result, the manifestation of any particular moods in what otherwise seems to be a pure manic or depressive episode does not constitute a mixed state.

Key words

Depression • Mania • Mixed state • Phenomenology • Psychopathology

Introduction

Both the general public and professional psychiatrists typically conceive of depression and mania as polar opposites – embodied in the term "bipolar disorder" itself. However, the possibility of mixed states (i.e. states that incorporate symptoms considered essential to both depressive and manic episodes) has a long history. In his book, *Manic Depressive Insanity and Paranoia*, Emil Kraepelin clearly elucidated the possible manifestations of such states [1]. Some authors even point as far back as Hippocrates and Aretaeus of Cappadocia, arguing that these ancient physicians described cases of melancholic symptoms appearing during the course of behaviour that we would today characterise as manic [2-5].

The formal definition of mixed states, given in the DSM-5, consists of either a state meeting full criteria for a manic or hypomanic episode, accompanied by at least three depressive symptoms, or a state meeting full criteria for a depressive episode, accompanied by at least three manic or hypomanic symptoms [6]. This shares some similarities with earlier conceptions of mixed states, but there is one important difference in the DSM. While Kraepelin did not conceive of depression and mania as opposing poles, the DSM conception implies the opposition of the two phenomena, thereby establishing mixed states as a problematic, if not paradoxical, form of human subjectivity. Many of the particular symptoms of each kind of episode are clearly juxtaposed. For example, a major depressive episode is characterised by a depressed mood, while a

Correspondence
Anthony Vincent Fernandez. University of South Florida, Department of Philosophy. Tampa, Florida, USA • Email: avf@mail.usf.edu

manic episode is characterised by an elevated or expansive mood. Another characteristic of a major depressive episode is loss of interest or pleasure in activities, while a manic episode often includes excessive involvement in activities that have potential for painful consequences. As a result of this characterisation of depressive and manic episodes, mixed states of any sort (whether they be predominantly depressive or manic) present us with a kind of paradox. If depression and mania are, in fact, polar opposites, how can it be that essential features of both disorders manifest simultaneously?

Questions of this kind have given rise to a large body of psychological and psychiatric research that attempts to reconceive the essential features of depression and mania with the intention of bestowing some sense on the strange phenomenon of mixed states [7-23]. One account, made popular by Kraepelin, characterises mixed states as the outcome of prolonged periods of transition between depressive and manic episodes, or vice versa. According to this account, the movement from one kind of episode to the other is typically either rapid or includes a transition through a non-episodic state. However, in some cases a person moves from one kind of episode to the other without the typically rapid transition, thereby displaying a mixture of what seem to be two opposing states [1 4]. Another, more radical account claims that depression and mania are not actually two opposing poles. Instead, mania is a severe mental disorder, while depression is a less severe disorder on the same spectrum. According to this conception of depression and mania, the opposing poles, or extremes, are actually mania and a non-episodic state. Because depression stands at a point between these states, it is not unusual to find depressive and manic symptoms arising together [8].

While either of these accounts might explain the possibility of mixed states, in this paper I wish to consider another solution. Rather than *explaining* mixed states, I attempt to *explain them away*. In other words, I argue that mixed states may not actually exist – instead, they are artefacts of inaccurate diagnostic constructs that have been perpetuated in light of misattributions of the essential characteristics of depressive and manic episodes.

This paper is divided into four main sections. First, I argue that some of the symptoms included in the diagnostic criteria for depressive and manic episodes in the DSM-5 are not actually essential features of these episodes. Second, I reconsider the category of major depressive disorder (MDD) from the perspective of phenomenological psychopathology, arguing that severe depressive episodes should not be characterised by any particular moods (such as sadness, hopelessness, or guilt), and should instead be characterised by a diminished capacity for finding ourselves situated in and attuned to the world at all. In other words, the affective dimension of depression should be characterised as a change in the way we have moods, and not as a change from one kind of mood to another. Third, I turn to mania, arguing that manic episodes, taken as the opposite of depressive episodes, should be characterised not by any particular moods (such as euphoria, grandiosity, or even irritability), and should instead be characterised by an enhanced or heightened capacity for finding ourselves situated in and attuned to the world. In other words, the affective dimension of mania, like the affective dimension of depression, should be understood as a change in the way we have moods, and not as a change from one kind of mood to another. Fourth, I return to the phenomenon of mixed states and argue that the affective dimension of depression and mania, when conceived along the phenomenological lines I set forth in the previous sections, dissolves the paradox of mixed states by showing that the essential characteristics of depression and mania *cannot* and *do not* coincide. Many cases of mixed states are diagnosed because moods that we take to be essential features of either depression or mania arise within the context of what is considered to be the opposite kind of episode (e.g. dysphoria, typically associated with depression, often arises in what is otherwise considered a manic state). However, if we conceive of the affective dimension of depression as a decrease in the degree to which one is situated in and attuned to the world through moods, and the affective dimension of mania as an increase in the degree to which one is situated in and attuned to the world through moods, then the particular mood one finds oneself in is simply irrelevant to the diagnosis of either depression or mania. As a result, the manifestation of any particular moods in what otherwise seems to be a pure manic or depressive episode does not constitute a mixed state.

Before I begin, it will help to briefly clarify what I mean by "essential characteristics" and by "phenomenology". Essential characteristics can be defined in a variety of ways. The essence of something can be understood as that which makes something what it is, in the sense that if this characteristic were removed, the being in question would necessarily become something other than what it is. Another way of defining essence is as that essential feature that stands as a ground, or source, of the other features of the phenomenon in question. In philosophical phenomenology, both senses of essence, or essential characteristics, are taken together. Phenomenologists study those characteristics of human subjectivity and existence that must hold for something to count as human subjectivity or existence. And these characteristics are, in turn, conditions for a lived world showing up at all.

This brings us to the issue of the definition of phenomenology. The term has a variety of meanings, being used in psychological [1], sociological [1], anthropological [1], and philosophical research, among other domains. While

this paper is on phenomenological psychopathology, I use the term phenomenology in the philosophical, rather than the psychological or psychiatric, sense. In psychology, phenomenology is typically understood as a method for the qualitative study of subjective experience. Such data is obtained through avenues such as surveys, first-person reports, and interviews. In psychiatry, the term can have an even broader meaning, being used to refer to any observable symptoms of a disorder – in this sense, even the DSM is phenomenological. Philosophical phenomenology, by contrast, while still concerned with human subjectivity and lived experience, has its roots in the Kantian tradition of transcendental philosophy. What this means is that phenomenology, as a discipline within philosophy, is a research program aimed not at describing particular qualitative differences in experience, but instead at describing the form or structure of subjectivity and experience in general.

In this sense, philosophical phenomenology is still descriptive, but its focus is primarily on what we might broadly construe as "form" – although "structure" [*Struktur*] is the more common coinage, at least among the German phenomenologists. In some cases, phenomenologists speak of the structure of consciousness or human existence as a whole, while at other times they speak of structures in the plural, referring to specific characteristics of consciousness or human existence. Some of the specific characteristics, sometimes referred to as "existentials", include temporality; spatiality; intersubjectivity; selfhood; embodiment; and situatedness or affectivity. In this paper, I focus primarily on the way subjects are situated in, attuned to and affected by their world through moods.

Symptomatology in phenomenology and mainstream psychiatry

The DSM-5 organises and distinguishes its categories of disorder by reference to symptom checklists. The kinds of symptoms listed for each disorder are varied, but there is predominance of behavioural criteria or, at the very least, criteria that can be interpreted behaviourally. A diagnosis of major depressive disorder (MDD), for example, is made when a patient presents with five or more of the following symptoms (with at least one of the symptoms being the first or second on the list) over a period of at least two weeks: (1) depressed mood; (2) diminished interest or pleasure; (3) significant weight loss or weight gain; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or excessive guilt; (8) diminished ability to think or concentrate; (9) recurrent thoughts of death, suicidal ideation, or a suicide attempt or plan [6].

Many of these symptoms seem dissimilar and unrelated, especially considering the fact that there does not seem to be any core symptom around which the rest are organised or motivated. In light of this, it is reasonable to ask how such a set of symptoms became *the* symptoms by which MDD is diagnosed.

There are a variety of ways we can formulate such a question, and each formulation will give us a different answer. A historical formulation, for example, would ask about the actual events that led to the selection of the particular criteria in the DSM. A more philosophical formulation, however, might ask why the particular *kinds* of symptoms listed in the DSM have been selected. What is it about these symptoms that made them attractive for use as DSM diagnostic criteria? This is the kind of question I wish to address here.

Many of the symptoms of MDD, including (1), (2), (7), (8) and (9) listed above, seem to be experiential, or subjective. That is to say, they are symptoms that seem to be observable primarily from the perspective of the patient herself. Others, such as (3) and (6), seem physiological, rather than primarily behavioural or experiential. However, nearly all of these symptoms come with some kind of qualification that allows for it to be met, or checked off, as a result of observations made by a clinician, family member, or close acquaintance, rather than the patient herself. For example, depressed mood, diminished interest or pleasure in activities, and diminished ability to think or concentrate are all followed by the qualification that these items can be met by observations made by others. Such a possibility for diagnosis is also implied in the physiological symptom of significant weight loss or weight gain, as this item includes the qualification, "when not dieting", which integrates a behavioural character into the symptom. Out of all the experiential or subjective symptoms that can be used to make a diagnosis, only one – feelings of worthlessness or excessive or inappropriate guilt – does not include the qualification that it can also be confirmed by outside observation, rather than just first-person report.

It follows from this insight into the preponderance of behavioural, or behaviourally qualified, diagnostic criteria that what makes a particular symptom likely to make the list of characteristic features of a psychiatric disorder is the quality of being easily observable. Each symptom listed in the DSM can be quickly and easily observed by a clinician, patient, family member or close acquaintance, or some combination thereof.

The reason for qualifying symptoms in such a way as to allow for observation or confirmation from multiple sources is clear enough. Easily observable symptoms expedite the process of diagnosis and, in turn, reduce the time it takes to implement targeted interventions – whether these be psychopharmaceuticals or psychotherapies. However, the symptomatology of many of the DSM categories of disorder still leaves one wanting. The most easily observ-

able symptoms are not necessarily the most essential, or characteristic, of the disorder in question. The authors of the DSM, however, do not seem to acknowledge this difference. As they say in the preface to the DSM-5, "… the current diagnostic criteria are the *best available description of how mental disorders are expressed* and can be recognized by trained clinicians" (my emphasis) [6]. And, further, they claim that the DSM is used by researchers and clinicians who "…strive for a common language to communicate the *essential characteristics* of mental disorders presented by their patients" (my emphasis) [6].

While the assumption that the easily observable symptoms listed in the DSM are also essential characteristics of these disorders is problematic, the privileging of easily observable symptoms within the context of a diagnostic manual is not problematic in itself. As said above, there are legitimate practical reasons for the privileging of such symptoms. However, there is another issue that, when combined with the privileging of easily observable symptoms over essential characteristics, problematises the situation. This additional issue is that of validity. While the DSM categories are, for the most part, reliable – in the sense that most clinicians, when presented with the same patient or the same symptom cluster, will make the same diagnosis – they are not necessarily valid. Validity does not have a single definition within the context of psychiatric research and practice, but it is often used to refer to a disorder being "real", which many take to mean that it has a distinct neurobiological cause, or biomarker. Proponents of the DSM have promised time and again that the DSM categories of disorder will be neurobiologically validated in the near future, but this promise has been left unfulfilled for the past few decades.

Another kind of validity, and one that is particularly relevant to philosophical phenomenological investigations of psychiatric disorders, is construct validity. Jablensky and Kendell explain that a category of disorder has construct validity when it "is based on a coherent, explicit set of defining features" [24]. Phenomenological psychopathology can assist in the project of offering coherent features by finding essential characteristics of a disorder that help us make sense of other, less foundational characteristics. And, further, it can assist in the project of offering explicit features by supplying careful and robust descriptions of the essential characteristics.

In the following sections, I consider depression, mania and mixed states, in turn, from a phenomenological perspective. In so doing, I illustrate the way in which phenomenology can assist in the project of discovering and accurately describing essential features of disorder. Finally, I argue that this kind of phenomenological research can help us overcome issues inherent in our conceptualisations of disorders and disordered phenomena, such as mixed states.

The phenomenology of depression

The last decade has seen a renewed interest in the phenomenology of depression. Figures such as Kevin Aho [25], Thomas Fuchs [26-29], Matthew Ratcliffe [30-33], and Giovanni Stanghellini [34] and René Rosfort [35-36] have all contributed to this growing body of literature. Each of these phenomenological psychopathologists has developed a focus on a particular aspect of depressive disorders, but there remains substantial overlap in their work. Some have focused on issues of temporality, or shifts in the way time and the temporal flow manifest in cases of depressive episodes [25 29 32]. Some focus on issues of embodiment, or changes in the way people experience their body or have bodily engagements with the world [25-28]. Others focus on the relationships between depressive episodes and other disorders, such as borderline personality disorder [35 36].

In spite of the varied interests of these phenomenological psychopathologists, there is one point of focus that they all share. Every phenomenological psychopathologist who studies depression must, to some extent, consider the affective dimension of depressive episodes. This focus has taken a variety of forms, and a few competing interpretations of the affective dimension of depressive episodes have been offered. However, each phenomenological account of this feature of depression might be understood as an attempt to make sense the central, but rather ambiguous, symptom referred to as "depressed mood". The DSM describes this symptom with the following words: "Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, hopeless) or observation made by others (e.g. appears tearful)" [6]. As is made clear in this brief description, the DSM does not actually include a definition of depressed mood. Instead, it offers the clinician a few examples – sadness, emptiness, and hopelessness – and in so doing leaves open the possibility for other kinds of moods or affective phenomena to fulfil this criterion, while giving very little instruction on how to go about deciding what other affective phenomena or changes in mood actually count as "depressed mood".

This very ambiguity is used by Stanghellini as the starting point for one of his phenomenological investigations of depression and mania. As he says, "In ICD-10, depressed mood is defined quantitatively as 'lowered mood' and it is also assumed that the differentiating criteria between normal and pathological sadness is merely quantitative. Depressed mood is also used as a synonym to 'sadness', assuming that persons affected by major depression feel sad – rather than having no feelings at all" [34]. As he goes on to explain, the ambiguity inherent in the poorly defined symptom of "depressed mood" in both the ICD and DSM create difficulties in drawing boundaries between pathological and non-pathological moods and affective

states. Adequately describing what it is that we are trying to express or point to when we refer to "depressed mood" can, as he says, go a long way towards overcoming controversies over the pathological/non-pathological boundaries, at least in the case of depression.

Much of the recent phenomenological research on describing and defining what exactly we mean by a "depressed mood" has come from the work of Ratcliffe. Two papers in particular – one on deep guilt [31] and one on hopelessness [33] – bring to light the distinct characteristics that these moods take in the context of depressive disorders. In order to adequately characterise these moods, Ratcliffe accounts for them as what he terms "existential feelings". The concept of existential feeling is Ratcliffe's own development, but it is owed in large part to Martin Heidegger's account of moods and ground moods in *Being and Time* [37] and *Fundamental Concepts of Metaphysics* [38]. Existential feelings are understood as all-encompassing, and even world-disclosing, affective phenomena that are pre-intentional (meaning that they are not about, or directed towards, anything in particular), thereby shaping the meaningfulness of our world as a whole. In the case of deep guilt, for example, the person perceives himself as being guilty as such (i.e. not guilty for any distinct reason). Further, this deep guilt, pervading the person's lived world in its entirety, determines the kinds of intentional feelings and emotions (i.e. feelings and emotions that are about, or directed toward, something) that can manifest. Only feelings and emotions that conform to the all-encompassing guiltiness of the person's lived world can arise. Hopelessness, or what Ratcliffe refers to as "radical hopelessness", is a similar phenomenon that is also common in patients diagnosed with MDD. In this case, what is so radical about the hopelessness of depression is that it eliminates the possibility for hoping at all. While most cases of hopelessness are contextual – in the sense that the feeling of hopelessness is linked to the fact that the person finds herself in a hopeless situation – the hopelessness of the person in a depressive episode is not a response to any particular context and a change in context will not cause the hopelessness to subside. This kind of hopelessness can therefore be considered existential. It is the person's very existence, or subjectivity, that has undergone a profound change.

While Ratcliffe's accounts enrich the rather impoverished descriptions of "depressed mood" in the DSM, others have focused on a different feature of the affective dimension of depression that, while historically important, is mostly ignored in the contemporary symptomatology. This is the phenomenon of the loss of feeling, or what is sometimes referred to as the feeling of the loss of feeling. While Ratcliffe's work does touch on this, he characterises it as another kind of existential feeling, arguing that the loss of feeling is, in fact, a *feeling* of the loss of feeling, thereby making it a distinct affective phenomenon in its own right (as opposed to an actual shift in the degree to which we can be affected by the world).

This phenomenon of the loss of feeling is characteristic of the 20th century conception of melancholia, which was further developed by historical phenomenological psychopathologists such as Hubertus Tellenbach [39], but also plays a central role in contemporary works by Stanghellini and Fuchs. Stanghellini refers to a loss of emotional resonance as characteristic of melancholic depression [34], while Fuchs focuses on the ways in which melancholia alters our embodiment, referring instead to a loss of *bodily* resonance that incorporates a diminished capacity for perception (e.g. food tastes bland) [28].

Stanghellini, in investigating the loss of feeling associated with depressive episodes, points out that the DSM does in fact refer to such a phenomenon, but immediately downplays its importance, or even eliminates it as a legitimate expression of "depressed mood", by allowing for the clinician's observations of the patient's behaviour to override the patient's descriptions of his own experience. This comes to light in the DSM-5 in the line, "In some cases, sadness may be denied at first but may subsequently be elicited by interview (e.g. by pointing out that the individual looks as if he or she is about to cry). In some individuals who complain of feeling 'blah', having no feelings, or feeling anxious, the presence of a depressed mood can be inferred from the person's facial expressions and demeanour" [34]. In other words, even if a patient does in fact undergo an existential shift in which his capacity for being affected by his world is diminished, and he subsequently expresses this shift in a psychiatric interview, the clinician's "expert" interpretation of the patient's facial expressions supplies overriding evidence for the fact that the patient is actually sad (thereby having what the DSM considers to be a "depressed mood"). Such lapses into behaviourism undercut the very possibility of alternative interpretations of the existential changes occurring on the side of the patient's subjectivity.

Continuing in the vein of research opened up by Fuchs, Stanghellini and others, I have developed an account of the affective dimension of depressive episodes that is similar to their accounts of the loss of emotional and bodily resonance, but focuses more heavily on the distinction between this kind of change and a change in mood [40]. I argue that one of the essential features of a major depressive episode is – contrary to the popular account of depression as a kind of mood – a degradation or erosion of the capacity for having moods at all. In this sense, the fundamental affective shift in depressive episodes is in what Heidegger refers to as *Befindlichkeit* – commonly translated as "situatedness" or "affectivity" – rather than *Stimmung* – commonly translated as mood, atmosphere, or even tune, in the sense of tuning an instrument. Ac-

cording to Heidegger, *Befindlichkeit*, which refers to the fact that at any time we find ourselves always already situated in and attuned to the world, is a categorial characteristic of human existence. That is to say, it refers to an essential feature of human existence that is itself a category that encompasses a certain group of phenomena. The phenomena that fall into the category of *Befindlichkeit* are *Stimmungen*, or moods. Moods, according to Heidegger, are particular ways of finding ourselves in the world, and determine the ways we can be affected by this world. The relationship between these terms is, then, that *Befindlichkeit* refers to the category of moods as a whole, while a *Stimmung* is a particular mood, and thus a particular way of being situated in and attuned to the world. By following this distinction, we can see that the affective changes expressed in the DSM, as well as in the work of Ratcliffe, are of a fundamentally different kind from the affective changes I have discussed in my own account. If we understand "depressed mood" as a *kind of mood*, then it is a shift in what Heidegger refers to as *Stimmung*. Depression, characterised in this way, should be understood as a distinctive mode of being situated in and attuned to the world. However, if we understand "depressed mood" as a *diminished capacity to have moods*, then it is a shift in what Heidegger refers to as *Befindlichkeit*. Depression, characterised in this way, should be understood as a diminishing of the intensity of moods as a whole. (It should also be noted that the shift I am proposing here is in some ways alien to Heidegger's own account. Heidegger does not seem to allow for the possibility of changes in the degree to which one is situated in and attuned to the world. Rather, he only allows for changes from one mood to another.)

Of course, these two accounts are not mutually exclusive. Moods with diminished intensity are still moods. It is possible for a depressed person to be situated and attuned through a dulled or blunted mood of guilt, hopelessness, or sadness. However, this does not imply that any of these moods should be considered an essential characteristic of depression. Rather, the fact that all moods are, for the depressed person, dulled or blunted, is an essential characteristic. In light of this, if "depressed mood" is to remain an essential characteristic of depression, it should be redefined as a decrease in the intensity of moods as a whole – not as an ambiguous set of moods that includes sadness, hopelessness and guilt.

A similar account of depression has arisen from psychological research on what is referred to as emotion context insensitivity [41 42]. As Jonathan Rottenberg explains, "depression flattens the emotional landscape, greatly constricting the range of emotional reactions to differing emotional contexts" [41]. This account, however, differs from my own in one important respect. According to Rottenberg and colleagues, depression is still a distinctive mood. What makes it distinctive is that, rather than causing the depressed person to be more easily affected by negative events – thereby becoming more susceptible to sadness, despair and related emotions – it instead causes the depressed person to be less emotionally affected by their context in general. In other words, depression, as a mood, reduces the degree to which one is affected by, and has emotional responses to, one's world. My own account, by contrast, appeals to the same phenomenon – low emotional sensitivity to context – but does not explain this reduction in sensitivity by appealing to the distinctiveness of a particular mood. Rather, I argue that it is the capacity to be situated in and attuned to the world through a mood in general that is an essential characteristic of depression, which explains the low emotional sensitivity to context.

To return to the above discussion of the easily observable versus the essential characteristics of depression, the account I offer here portrays a degradation of *Befindlichkeit*, or a diminished capacity for being situated in and attuned through moods, as an essential characteristic of depression. The particular kinds of moods that may often manifest in depression, such as sadness, hopelessness, or guilt, are considered non-essential because their manifestation is not a necessary feature of a depressive episode (this is, of course, in contrast to the DSM characterisation). "Depressed mood", then, should be redefined as a lowering or diminishing of the intensity of moods as a whole, and not as a particular kind of mood.

The phenomenology of mania

Continuing from the account of depression I have sketched here, we can reconsider the phenomenon of mania from a phenomenological perspective. In reviewing the criteria for a manic episode listed in the DSM-5, it seems that particular kinds of moods are considered essential characteristics of a manic episode. While the depressed person is said to feel sad, empty, or guilty, the manic person is described as displaying an elevated, expansive, or irritable mood (although the latter clearly holds a secondary status, as is evidenced by the qualification that the person must present with four, rather than three, additional symptoms if her mood is only irritable, rather than elevated or expansive).

If we reconsider mania in light of the phenomenological account of depression given above, we can bring into question to what an elevated or expansive mood actually refers. Are these *kinds* of moods, in the way that sadness and guilt are kinds of moods? Or is the reference to elevated and expansive moods similar to my reinterpretation of "depressed mood"? If it is the latter, this forces us to rethink our conception of the essential characteristics of mania as portrayed in both popular culture and professional psychiatry.

The further descriptions of a manic episode offered in the DSM-5 refer to the manic mood as "euphoric, excessively cheerful, high, or 'feeling on top of the world'" [6]. However, while these constitute the popular conception of the affective dimension of mania, the DSM-5 also states, "Rapid shifts in mood over brief periods of time may occur and are referred to as lability (i.e. the alternation among euphoria, dysphoria, and irritability)" [6]. In other words, the DSM-5 describes mania as characterised both by a certain kind of mood (e.g. euphoria, or excessive cheerfulness) and by increased lability, or the ease and frequency with which moods change over.

This is again similar to the DSM's characterisation of the affective dimension of depression. Depression, according to the DSM, is characterised by particular moods, but may also be characterised by a loss of feeling. The DSM's characterisation of mania, by comparison, includes references to particular moods, but also to the fact that these moods may change rapidly.

To clarify this characterisation, we can reconceive mania along the same lines as that of depression. If depression is a diminishment of *Befindlichkeit*, or a decrease in the degree to which we find ourselves situated in and attuned to the world, then we might understand mania as an amplification or intensification of *Befindlichkeit*. What would follow from such an existential shift? One thing that would be likely to follow is that a person in the midst of a manic episode will be profoundly affected by the world around them. Persons, events and even objects appear as more meaningful (whether positively or negatively), affecting the person to a greater degree. In the psychological and psychiatric literature, this is referred to as emotional reactivity. At least two psychiatric studies have shown that a fundamental characteristic of both manic and mixed manic states is emotional hyper-reactivity, rather than a distinctive mood tonality [15 17]. This account is similar to the one I am proposing here, although it focuses on a narrower dimension of manic affectivity.

Another feature that would be likely to follow from an intensification of the existential structure of *Befindlichkeit* is the lability of mood, or the ease with which moods change over. This feature of manic states, as mentioned above, is discussed in the DSM-5 (however, it does not actually make it into the diagnostic criteria, so the authors of the DSM-5 may not consider it to be an essential feature). And it is also proposed as an important characteristic of mania in a number of psychiatric and psychological studies [14 17 20 22].

These reformulations of the essential characteristics of both depression and mania, while perhaps of interest in their own right, may be able to be applied in the context of other issues is psychopathology and psychiatric classification. In the following section, I address the paradox of mixed states in light of the phenomenological account of depression and mania offered here.

Dissolving the paradox of mixed states

To reiterate, mixed states are defined as cases in which one meets the full criteria for a depressive episode while exhibiting manic symptoms, or cases in which one meets the full criteria for a manic episode while exhibiting depressive symptoms. The paradox, then, arises in light of the fact that depression and mania are conceived of as polar opposites. The possibility of having symptoms, not to mention essential characteristics, of one kind of episode manifesting in the midst of the other seems, on the face of it, paradoxical. My solution to this apparent contradiction, unlike the solutions discussed at the beginning of this paper, is neither that depression and mania are polar opposites that may nevertheless overlap in cases of prolonged transition, nor that depression and mania are not, in fact, polar opposites. Rather, I argue that depression and mania *should* be understood as polar opposites, and that *they do not, in fact, manifest at the same time*. The belief that mixed states are possible stems from a misunderstanding of the essential features of depression and mania.

As I have argued, the affective dimensions of both depression and mania should not be characterised as particular moods, or even as general kinds of moods, such as dysphoric or euphoric moods. Instead, the affective dimensions of these states should be characterised as changes in what Heidegger refers to as *Befindlichkeit*, which refers to the fact that we always already find ourselves situated in and attuned to the world through a mood. Depression, under this account, is characterised by a diminished or eroded intensity of moods. This results in low emotional reactivity – as evidenced by the fact that people in depressive episodes are largely unaffected by the world around them. Mania, by contrast, is characterised by an intensification of moods. This results in emotional hyper-reactivity – as evidenced by the fact that people in manic episodes can be profoundly affected by the world around them.

It follows from this recharacterisation of the essential features of depression and mania that many of the symptoms we considered constitutive of mixed episodes should not be understood as playing any such role. Because no particular moods, or even kinds of moods, constitute essential features of depression or mania, they cannot be used as evidence of mixed episodes. In other words, sadness, guilt and related moods and emotions should not be considered legitimate symptoms of depression. Euphoria and excessive cheerfulness, in turn, should not be considered legitimate symptoms of mania. It follows from this that these symptoms should not only be abolished from discussions of the classification of mixed states, but should

also be removed from the symptomatology of pure manic and depressive states.

Conclusion

In summary, I have considered the paradox of mixed manic and depressive states from the perspective of contemporary phenomenological psychopathology. I argued that contemporary psychiatric classification in the DSM-5 privileges easily observable symptoms while neglecting essential features of disorders. Furthermore, the authors of the DSM-5 seem to portray their symptomatology as capturing the essential features of disorders, thereby sedimenting the problematic nature of their system of classification. I followed this discussion with an illustration of how philosophical phenomenology can assist in the project of separating essential from non-essential features of a disorder by offering more accurate descriptions of disordered subjectivity that can, in turn, be used to draw more accurate boundaries between categories of disorder. Finally, I argued that the phenomenological accounts of the affective dimensions of depression and mania I offered in this paper help us overcome the apparent paradox of mixed states.

Acknowledgments

I would like to thank Christine Wieseler and William Parkhurst for their extensive and helpful comments on an earlier draft of this paper.

Conflict of interest

None.

References

1 Kraepelin E. *Dementia praecox and paraphrenia, together with manic depressive insanity and paranoia*. The Classics of Medicine Library 1989.

2 Cassidy F, Murry E, Forest K, et al. *Signs and symptoms of mania in pure and mixed episodes*. J Affect Disord 1998;50:187-201.

3 Akiskal H. *The prevalent clinical spectrum of bipolar disorders: beyond DSM-IV*. J Clin Psychopharmacol 1996;16(Suppl 1):4S-14.

4 Swann, AC, Lafer B, Perugi G, et al. *Bipolar mixed states: an international society for bipolar disorders task force report of symptom structure, course of illness, and diagnosis*. Am J Psychiatry 2013;170:31-42.

5 Angst J, Marneros A. *Bipolarity from ancient to modern times: conception, birth and rebirth*. J Affect Disord 2001;67:3-19.

6 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, 5th edition*. American Psychiatric Publishing 2013.

7 Castle DJ. *Bipolar mixed states: still mixed up?* Curr Opin Psychiatry 2014;27:38-42.

8 Court J. *The continuum model as a resolution of paradoxes in manic-depressive psychosis*. Br J Psychiatry 1972;120:133-41.

9 Dilsaver S, Chen YR, Shoaib AM, et al. *Phenomenology of mania: evidence for distinct depressed, dysphoric, and euphoric presentations*. Am J Psychiatry 1999;156:426-30.

10 Ghaemi SN. *Feeling and time: the phenomenology of mood disorders, depressive realism, and existential therapy*. Schizophr Bull 2007;33:122-30.

11 Ghaemi SN. *Understanding mania and depression*. In: Fulford KWM, Davies M, Gipps RGT, et al. editors. *The oxford handbook of philosophy and psychiatry*. Oxford University Press 2013, pp. 803-819.

12 Goldber JF, Garno JL, Portera L, et al. *Qualitative differences in manic symptoms during mixed versus pure mania*. Compr Psychiatry 2000;41:237-41.

13 Gonzalez-Pinto A, Aldama A, Pinto AG, et al. *Dimensions of mania: differences between mixed and pure episodes*. Eur Psychiatry 2004;19:307-10.

14 Henry C, M'Bailara K, Desage A, et al. *Towards a reconceptualization of mixed states, based on an emotional-reactivity dimensional model*. J Affect Disord 2007;101:35-41.

15 Henry C, Swendsen J, Van den Bulke D, et al. *Emotional hyper-reactivity as a fundamental mood characteristic of manic and mixed states*. Eur Psychiatry 2003;18:124-8.

16 Koukopoulos A, Sani G, Ghaemi SN. *Mixed features of depression: why DSM-5 is wrong (and so was DSM-IV)*. Br J Psychiatry 2013;203:3-5.

17 M'Bailara K, Atzeni T, Colom F, et al. *Emotional hyperreactivity as a core dimension of manic and mixed states*. Psychiatry Res 2012;197:227-30.

18 McElroy SL, Stakowski SM, Keck PE, et al. *Differences and similarities in mixed and pure mania*. Compr Psychiatry 1995;36:187-94.

19 Pacchiarotti I, Mazzarini L, Kotzalidis GD, et al. *Mania and depression. Mixed, not stirred*. J Affect Disord 2011;133:105-13.

20 Perugi G, Akiskal HS, Micheli C, et al. *Clinical subtypes of bipolar mixed states: validating a broader European definition in 143 cases*. J Affect Disord 1997;43:169-80.

21 Perugi G, Medda P, Reis J, et al. *Clinical subtypes of severe bipolar mixed states*. J Affect Disord 2013;151:1076-82.

22 Perugi G, Quaranta G, Dell'Osso L. *The significance of mixed states in depression and mania*. Curr Psychiatry Rep 2014;16:486.

23 Swann AC, Secunda SK, Katz MM, et al. *Specificity of mixed affective states: clinical comparison of dysphoric mania and agitated depression*. J Affect Disord 1993;28:81-9.

24 Jablensky A, Kendell RE. *Criteria for assessing a classification in psychiatry*. In: Maj M, Gaebel W, López-Ibor J, et al., editors. *Psychiatric diagnosis and classification*. John Wiley & Sons 2002, pp. 1-24.

[25] Aho KA. *Depression and embodiment: phenomenological reflections on motility, affectivity, and transcendence*. Med Health Care Philos 2013;16:751-9.

[26] Fuchs T. *The phenomenology of shame, guilt and the body in body dysmorphic disorder and depression*. J Phenomenol Psychol 2003;32:223-43.

[27] Fuchs T. *The phenomenology of body, space, and time in depression*. Comprendre 2005;15:108-21.

[28] Fuchs T. *Corporealized and disembodied minds: A phenomenological view of the body in melancholia and schizophrenia*. Philos Psychiatr Psychol 2005;12:95-107.

[29] Fuchs T. *Temporality and psychopathology*. Phenomenol Cogn Sci 2013;12:75-104.

[30] Ratcliffe M. *Feelings of being: phenomenology, psychiatry, and the sense of reality*. Oxford: Oxford University Press 2008.

[31] Ratcliffe M. *Depression, guilt, and emotional depth*. Inquiry 2010;53:602-26.

[32] Ratcliffe M. *Varieties of temporal experience in depression*. J Med Philos 2012;37:114-38.

[33] Ratcliffe M. *What is it to Lose Hope?* Phenomenol Cogn Sci 2013;12:597-614.

[34] Stanghellini G. *Disembodied spirits and deanimated bodies: the psychopathology of common sense*. Oxford: Oxford University Press 2004.

[35] Stanghellini G, Rosfort R. *Emotions and personhood: exploring fragility – making sense of vulnerability*. Oxford: Oxford University Press 2013.

[36] Stanghellini G, Rosfort R. *Borderline depression:a desperate vitality*. J Conscious Stud 2013;20:153-77.

[37] Heidegger M. *Being and time*. New York: Harper & Row Publishers Inc 1927/1962.

[38] Heidegger M. *Fundamental concepts of metaphysics*. Bloomington, IN: Indiana University Press 1929-30/2001.

[39] Tellenbach H. *Melancholy: history of the problem, endogeneity, typology pathogensis, clinical considerations*. Pittsburgh, PA: Duquesne University Press 1980.

[40] Fernandez AV. *Depression as existential feeling or de-situatedness? Distinguishing structure from mode in psychopathology*. Phenomenol Cogn Sci 2014.

[41] Rottenberg J. *Mood and emotion in major depression*. Curr Dir Psychol 2005;14:167-70.

[42] Rottenberg J, Gross JJ, Gotlib IH. *Emotion context insensitivity in depressive disorder*. J Abnorm Psychol 2005;114:627-39.

The life-world of persons with schizophrenia. A panoramic view

M. Mancini[1], S. Presenza[1], L. Di Bernardo[1], P.P. Lardo[1], S. Totaro[1], F. Trisolini[1], L. Vetrugno[1], G. Stanghellini[1,2]

[1] "G. d" Annunzio" University of Chieti, Italy; [2] "Diego Portales" University of Santiago, Chile

Summary

The profound transformation of the life-world of persons with schizophrenia involves changes in the ontological framework of experience and has serious consequences for how such persons live their life as embodied persons and how they understand the existence of other people. Drawing on classical as well as contemporary psychopathological accounts, we systematically and succinctly describe the basic features of these changes. Lived time, space, body, selfhood and otherness are used as the principal descriptors of this transformation. We offer a reconstruction of the life-world of persons with schizophrenia that discloses their primordial in esse, their basic sense of being in the world. We argue that detailed knowledge of these deep ontological changes is fundamental for the understanding of the schizophrenic style of experience and action as well as for making sense of the symptoms of schizophrenia. From our reconstruction, it emerges that the phenomenon of fragmentation is a candidate common denominator of the schizophrenic experience. Fragmentation appears a basic feature of lived time, as well as space, body and selfhood. The loss of a coherent Gestalt of experience seems to run through the manifold of schizophrenic abnormal phenomena, also affecting the related self-world and inter esse. This suggests the crisis of the synthetic function of consciousness, that is, of the temporal unity of consciousness, could be at the basis of characteristic of "disarticulation", distinctive of the schizophrenic world.

Key words

Body • Other • Phenomenology • Schizophrenia • Self • Space • Time

Two strategies were here locked in combat, two integral positions, two sets of logical consistency. But Moosbrugger had the less favourable position; even a much cleverer man could not have expressed the strange, shadowy reasonings of his mind. They rose directly out of the confused isolation of his life, and while all other lives exist in hundreds ways – perceived the same way by those who led them and by all others, who confirm them – his true life existed only for him. It was a vapour, always losing and changing shape. He might, of course, have asked his judges whether their lives were essentially different. But he thought no such things. Standing before the court, everything that had happened so naturally in sequence was now senselessly jumbled inside him.

R. Musil, *The man without qualities*, pp. 76-7.

Introduction

Schizophrenia is a complex condition that defies simple description. In addition to the symptoms identified by the DSM [2], abnormal phenomena that affect people with schizophrenia include other important though more subtle changes in their subjective experiences[1 3-10]. This paper examines these anomalous experiences, addressing changes of schizophrenic subjectivity, and aims to reconstruct the life-world inhabited by people with schizophrenia.

Life-world, in Edmund Husserl's sense [11], is the original domain, the obvious and unquestioned foundation both of all types of everyday acting and thinking and of all scientific theorising and philosophising. In its concrete manifestations, it exists as the "realm of immediate evidence". The variant of life-world phenomenology developed by Alfred Schutz [6] on the basis of ideas derived from Husserl is today without question one of the most important background theories of qualitative research. The main objective of research in this field is to reconstruct the formal structures of the life-world [6-11], that is, to provide a formal description of invariable basic structures of experience, action and the constitution of meaning.

Although the majority of people are situated within a shared life-world, there are several other frameworks of experience – for example, fantasy worlds, dream world and "psychopathological worlds" [6]. Abnormal mental phenomena are the expression of a modification of the ontologi-

Correspondence
Milena Mancini, Department of Psychological, Humanistic and Territorial Sciences, University "G. D" Annunzio", via Dei Vestini 31, Chieti, 66013, Italy • Tel. +39 0871 355 5376 • E-mail: mancinimilena@yahoo.it

cal framework within which experience is generated. The overall change in the ontological framework of experience transpires through the single symptoms, but the specificity of the core is only graspable at a more comprehensive structural level [5 12-14]. The experience of time, space, body, self and others, and their modifications, are indexes of the patient's basic structures of subjectivity within which each single abnormal experience is situated [15].

Recent phenomenological research on schizophrenia has addressed this issue by adopting the concept of pheno-phenotype [14]. This concept is a supportive tool for the phenomenological dissection of psychopathological disorders. It aims to describe phenomena as they are experienced by patients so that the features of a pathological condition emerge, while preserving their peculiar feel, meaning and value for the patient. The utility of the concept of pheno-phenotype is to produce a systematic description of subtle and often undescribed changes in the patient's subjective experience and to reconstruct the ontological framework within which they are generated. The aim is to improve our knowledge about psychopathological phenotypes in order to enlarge our awareness of the life-world people affected with mental disorders live in, understand their behaviour and experiences, refine diagnostic criteria and establish homogenous categories for neurobiological research.

Lived time

The schizophrenic pheno-phenotype is characterised by subjective experiences such as those concerning the way these patients experience time [1 7 9 13 16-31]. Classic phenomenological studies provide several, and sometimes inconsistent, descriptions of time experience in people with schizophrenia. Minkowski [19] suggested that people with schizophrenia experience time as altered in its flow and fluidity, frozen, immobilised, blocked, without "élan vital". Also, their time experience is characterised by the loss of the immediate attunement with the present situation [20 16 18]. People with schizophrenia have also been considered affected by the spatialisation of time experience: time is felt as divided in juxtaposed elements that the schizophrenic person doesn't weld and gather [19]. Persons with schizophrenia were also described as living in an elusive, eternal and pregnant "now", called the *ante festum*, in which what is most important is always about to happen [17 21 22 32]. Especially in early schizophrenia, time is suspended: it is a paradoxical mixture of immobility and protention, a knot of stillness and frenzy, stop and incipient moment [13]. Temporal fragmentation has been considered as a generative disturbance in schizophrenia. Major schizophrenic symptoms such as thought disorder, thought insertion, hallucinations, or passivity experiences have been regarded as manifesting a disturbance of the constitutive synthesis of time consciousness [27]. There is a breakdown of time *Gestalt*: with the fracturing of the time flow, we observe an itemisation of now-moments in consciousness [13]. With the collapse of the temporal continuity, each "moment" in a person's stream of consciousness will be experienced as detached from the previous one and from the following, as well as extraneous to one's sense of selfhood [13 27].

In schizophrenia, compared to mood disorders, the collapse of the very vector-like nature of the present moment (understood as James's "specious present" or the Husserlian "now") can occur; as a result, rather than merely experiencing time flow as slowing (melancholia) or accelerating (mania), life itself can turn into a series of stills as time turns wholly strange and unpredictable. Unlike in melancholia, in which the crisis of life-drive that projects into the future leaves the person dominated by the past, futility and fatigue; in schizophrenia, temporality loses all organisation and meaning [9].

As a way to lend some coherence to these studies, we suggest that abnormal time experience in people with schizophrenia can be characterised as follows (patients' quotes from unpublished database) (Table I):

1. Disarticulation of Time Experience
   Patients live the temporal plot as disarticulated. It includes the following sub-categories:

1.1 Disruption of time flow: patients may experience a collection of disarticulated snapshots rather than as a coherent series of actions and events. Typical sentence: "The world like a series of photographs".

1.2 Déjà vu/Vecu: patients experience places, people, etc. as already lived; this presupposes a disarticulation between past and present. Typical sentence: "When I heard news I felt I had heard it before".

1.3 Premonitions about oneself: patients live the present as the anticipation of their future, as a forewarning of something that concerns them, e.g. they have a feeling that something is going to happen to them or that they or the others are going to do something. Typical sentence: "I have premonition of what is going to happen to myself".

1.4 Premonitions about the external world: patients live the present as the anticipation of their future, as a presentiment about external world, (e.g. they experience that something is going to happen in the external world). Typical sentences: "*Something going on, as if some drama is unfolding*".

2. Disturbed Experience of Time Speed
   Patients live time speed as disturbed. They can live time as decelerated (longer, slower, fixed, frozen), accelerated, or both decelerated and accelerated. Typical sentences are: "*I felt I was moving normally and*

TABLE I.
Lived time in people with schizophrenia.

Subjective experiences	
Category	**Description category/ subcategory**
1. Disarticulation of Time Experience	1.1 Disruption of time flowing: A collection of disarticulated snapshots rather than a coherent series of actions and events ("World like a series of photographs"). 1.2 Déjà vu/Vecu: Places, people, etc. are already lived; this presupposes a disarticulation between past and present ("When I heard news I felt I had heard it before"). 1.3 Premonitions about oneself: Present is the anticipation or forewarning of something in the future concerning the patient ("I have premonition of what is going to happen to myself"). 1.4 Premonitions about the external world: Present as the anticipation or presentiment about external world ("Something going on, as if some drama unfolding).
2. Disturbed Experience of Time Speed	*Time speed is anomalous - decelerated, accelerated, or both decelerated and accelerated ("I felt I was moving normally and everyone was moving slowly"; Time went by very quickly"; "Mouth movement and speech of other out of synchronizing: one faster and the other slower").*
3. Discrepancies about Time Experiences	Time "different" as compared to previous or commonsense experience of time; lost regarding common temporal references ("Time is somewhat changed". "Time isn't supposed to be the way it was. I don't know in what way. I have to think it").

everyone was moving slowly"; Time went by very quickly"; "*Mouth movement and speech of other out of synchronizing: one faster and the other slower*".

3. Discrepancies about Time Experiences
   Patients live time "differently" compared to their previous or common sense experience of time, or they feel themselves lost regarding the common temporal references. Typical sentences: "*Time is somewhat changed*"; "*Time isn't supposed to be the way it was. I don't know in what way. I have to think about it*".

Lived space

Jaspers already mentioned space (and time) as a primary and omnipresent element in the sense world of human beings [33]. Classic phenomenological studies have explored lived space in people with schizophrenia [9 13 14 32-49]. Lived space represents "the totality of the space that a person pre-reflectively "lives" and experiences". Under normal conditions, lived space is "not homogeneous, but centred on the person and his body, characterised by qualities such as vicinity or distance, wideness or narrowness, connection or separation, attainability or unattainability" [38]. Callieri [39] talked about the *habitability* of space, that is the space where you can stay in and deploy your own activities. The same phenomenon is addressed by Willi's *ecological niche* [40].

In schizophrenia, lived space is no longer a space of possibility whose extension represents the degree that one feels able to "reach" things in the world [9]. , Rather, lived space in schizophrenia is a kind of *espace figé*, defined by Callieri et al. [41] in analogy with the time described by Le Guen. In this kind of space, things may not appear meaningfully related to one's own body [42]. People with schizophrenia may find themselves living in a strange and uncanny space, at times dull, at times as an infinity plane, in the boundlessness, or in a space where objects are fragmented, flat [9]. Patients try to describe these quasi-ineffable experiences using generic terms as "unreal", "inscrutable", "fake", "meaningless", and define their condition as characterised by "disorientation", "bewilderment", "incertitude", "awe" and so on [13].
An attempt to classify disorders of lived space in schizophrenia groups these into three main categories (Table II):

1. Loss of perspectival properties
   One key feature of lived space in schizophrenia is its growing homogeneous, two-dimensional characteristics, losing its perspectival quality [43-47]. Space appears as a rarefied atmosphere, shaded or fuzzy, or an extension with blinding light. It seems that patients lose their sense of having any subjective centre at all, a point of view, or orientation. It may involve an ineffable feeling of being surrounded by unknown territories. Also, the background of lived space can

TABLE II.
Lived space in people with schizophrenia.

Subjective experiences	
Category	**Description category/ subcategory**
1. Loss of perspectival properties	Space is a rarefied atmosphere, or an extension with blinding light. Patients lose their sense of having any subjective point of view, or orientation. Ineffable feeling of being surrounded by unknown territories ("There is only the space between things; things are there in a fashion but not so clear", "I felt spaceless").
2. Itemization	Space is a disarticulated collection of unrelated items, or decontextualized details ("In the silence and immensity, each object was cut off by a knife, detached in the emptiness, in the boundlessness, spaced off from other things", "I am overwhelmed by too much detail - too much detail in objects").
3. Alteration of spatial properties of things	Various types of anomalous experiences: alteration of dimensions and shape of objects, e.g., macropsia, micropsia and dysmegalopsia, objects fragmented, flat, or unrelated. ("For a while it seemed big and open, then too close to me", "My perception of the world seemed to sharpen the sense of the strangeness of things", "The air was between things, but the things themselves were not there").

be experienced as coming into the foreground as lived space loses its perspectival quality and paradoxically becomes an unfathomed flatness [13]. This uncanny experience of flatness is taken by the patient as an intimation and a warning: what appears is mere surface, façade, exteriority – a mask hiding a baffling profundity. Typical sentence: "*There is only the space between things; things are there in a fashion but not so clear*", "*I felt spaceless*".

2. Itemisation
Another typical feature is the fragmentation of space *Gestalt* reducing the ensemble of a living situation to a mere collection of itemised details. Space is reduced to a disarticulated collection of unrelated items, or decontextualized details. Typical sentences: "*In the silence and immensity, each object was cut off by a knife, detached in the emptiness, in the boundlessness, spaced off from other things*"; "*I am overwhelmed by too much detail - too much detail in objects*".

3. Alteration of spatial properties of things
Often anomalies in lived space are described by patients, rather than as anomalies of space itself, as anomalies of the way *things* appear in space. This category includes various types of anomalous experiences, such as alteration of dimensions and shape of objects, e.g. macropsia, micropsia and dysmegalopsia, objects fragmented, flat, or unrelated. Typical sentences: "*For a while it seemed big and open, then too close to me*"; "*My perception of the world seemed to sharpen the sense of the strangeness of things*"; "*The air was between things, but the things themselves were not there*".

Lived body

Phenomenology considers the lived body (i.e. the often implicit experience one has of his own body) as one the most important dimensions of self-experience and the most primitive form of self-awareness [50 51]. Empirical research shows that patients with schizophrenia frequently present many different kinds of abnormal bodily sensations in the course of their illness, including somatic delusions [52], coenaesthesias [53-58], disturbance of pain perception [59-62], out-of-body experiences [63 64], dysmorphophobia [65-71], body disintegration [72] and self-injury or self-mutilation [73-77]. Most characteristic are ongoing bodily feelings of disintegration/ violation and "thingness/mechanisation". These include experiences of instability of bodily boundaries, including externalisation of parts of the body that normally are within the bodily boundaries as well as internalisation of objects that normally occupy the external space. In addition, fragmentation of bodily construction and changes of body appearance seem to be typical of schizophrenia. Other typical phenomena are "morbid objectivisation" and devitalisation [13 48 78-83]. In mainstream clinical scales [34 58 75 84-86], abnormal bodily experiences are often listed in the domain of positive symptoms, including somatic delusion, bodily hallucinations and disorders of ego-boundaries, blurring their specific characteristics and properties. To overcome this problem, ad hoc symptom checklists were designed to assess experiential anomalies in people with schizophrenia that may be considered as subtle and sub- or pre-psychotic disorders (BSABS [34] and EASE [72]). These

TABLE III.
Lived body in people with schizophrenia.

Subjective experiences	
Category	**Description category/ subcategory**
1. Dynamization	1.1 Dynamization of bodily boundaries: Perplexing experience of strange, uncommon forces or objects violating from outside the boundaries of the body ("Areas of body where forces enter"). 1.2 Dynamization of bodily construction: Perplexing phenomena of unusual, strange movements or forces acting inside one's body; bodily components are moving away from their usual position ("Mouth was where hair should be"). 1.3 Externalization: Bodily components, vital energies or biological activities are projected beyond one's somatic boundaries ("Vagina half outside").
2. Morbid Objectivation	Bodily parts or functions that are typically in the tacit background are explicitly experienced. Increased degree of 'thingness' in the body. Parts of oneself are spatialised. The body is experienced as devoid of life or substituted by some kind of mechanism ("I felt programmed like a robot").
3. Dysmorphic-like Phenomena	3.1 Dysmorphic phenomena: Puzzling phenomena of an ongoing change/destructuring in parts of one's body, especially its form/appearance, or in the body as a whole; ("My nose is changing"). 3.2 Dysmorphophobia: Bodily form/appearance experienced as ugly, or having some physical defect although it appears to others within normal limits ("Bust bigger and bones smaller").
4. Pain-like Phenomena	Paroxysms or persistent unpleasant/painful and "strange" bodily feelings not substantiated by any medical evaluation ("Pains and feelings of being cut up in various parts of body").

interviews contain distinct sub-scales for abnormal bodily experiences, but the issue of their sensibility and specificity is still debated.
In a recent study, [82] we identified four categories of abnormal bodily phenomena (see Table III):

1. Dynamisation
   This category refers to the way patients experience their bodily boundaries and construction. Dynamisation includes 3 Subcategories:

1.1 Dynamisation of bodily boundaries. Patients report the perplexing experience of strange, uncommon forces or objects violating from outside the boundaries of the body. A typical sentence is: "*Areas of body where forces enter*".

1.2 Dynamisation of bodily construction. Patients report perplexing phenomena of unusual, strange movements or forces acting inside one's body; bodily components are also experienced as moving away from their usual position, shifting around the usual spatial relationships. A typical sentence is: "*Mouth was where hair should be*".

1.3 Externalisation. Bodily components, vital energies or biological activities are experienced as projected beyond one's somatic boundaries. A typical sentence is: "*Vagina half outside*".

2. Morbid Objectivation
   This category refers to the way persons experience the vitality and workings of their body. Patients explicitly perceive bodily parts or functions that are typically in the tacit background of experience. There is an increased degree of "thingness" in the body. Parts of oneself are spatialised, as if they were not part of the living body. Also, the body is experienced as devoid of life or substituted by some kind of mechanism. A typical sentence is: "*I felt programmed like a robot*".

3. Dysmorphic-like Phenomena
   This category refers to the way patients experience and represent the external form and appearance of their body. This category includes 2 subcategories:

3.1 Dysmorphic Phenomena. This includes puzzling phenomena of an on-going change/destructuring in parts of one's body, especially its form/appearance, or in the body as a whole; the experience may involve the entire organism, or components. A typical sentence is: "*My nose is changing*".

3.2 Dysmorphophobia. Patients are puzzled about the form/appearance of their body because they experience it as ugly, or having some physical defect (especially asymmetry or change in proportion), although they appear to others within normal limits. A typical sentence is: "*Bust bigger and bones smaller*".

4. Pain-like Phenomena
This is a residual category that may also include phenomena that are not specific to schizophrenia. The core phenomenon in this category is that the patients report unpleasant/painful bodily feelings that are not substantiated by any medical evaluation; experiences may present themselves in the form of paroxysms or persistent sensations; they are characterised by feelings of strangeness. A typical sentence is: "*Pains and feelings of being cut up in various parts of the body*".

Self

Classic phenomenological studies reveal that a disruption in the basic sense of being a self is a fundamental feature in schizophrenia [5 9 32 72 87-109]. Jaspers [33] defined self-awareness according to four formal characteristics: *self-activity, self-unity, self-identity* and *self-demarcation*. Scharfetter [104] added a fifth dimension, *self-vitality*. Recently, after several decades of neglect, the concept of "selfhood" assumed again relevance for understanding and diagnosis of schizophrenia spectrum disorders. Drawing on the French phenomenologist Michel Henry's [105] concept of the basic sense of existing and the philosopher Michael Polanyi's[106] notion of the "tacit dimension" – together with various ideas from Husserl [107] and Merleau-Ponty [108] – Parnas and Sass have interpreted schizophrenia as a disorder of the pre-reflexive self, i.e. a pervasive perturbation of the core sense of self that is normally implicit in each act of awareness [5 72 95].

These changes in the basic structures of consciousness are accompanied by an alteration of the very structure of the field of awareness, which leads to an emergent, particular way of experiencing that is infused by: (a) a change in the focus or salience with which objects and meanings emerge from the background context; (b) an altered conceptual "grip" or "hold" on the world; (c) a mutual amplification of the growing dissolution of the sense of existing as a subject with a more pronounced, disturbing and alienating self-scrutiny; (d) an increasing objectification and externalisation of normally tacit inner phenomena, with a morbid objectification of one's own psychic life [109]. At the extreme of such progression the person might lose the naturally pre-given sense of coinciding with his own thoughts, sensations and actions and may feel that he is under the influence of some alien force or entity.

We may distinguish two main domains of self-disorders in schizophrenia (Table IV):

1. Diminished self-affection.
This refers to the breakdown of the crucial sense of self-sameness, of existing as a unified, unique and embodied subject of experience that is at one with oneself at any given moment. When this basic sense of self is disturbed, the person is inclined to experience a concomitant fading in the tacit, pre-verbal feeling of existing as a living and unified subject of awareness and a kind of exaggerated self-consciousness (hyper-reflexivity, see below). Self-affection provides to subjective experience the sense (pre-reflexive) of being the owners (mineness) and initiators (agency) of our own thoughts, behaviours and emotions. Experiences of intra-psychic and somato-psy-

TABLE IV.
Self-experience in people with schizophrenia.

Subjective experiences	
Category	**Description category/ subcategory**
1. Diminished self-affection	Breakdown of the crucial sense of self-sameness, of existing as a unified, unique and embodied subject of experience that is at one with oneself at any given moment. A concomitant fading in the tacit, pre-verbal feeling of existing as a living and unified subject of awareness and a kind of exaggerated self-consciousness (hyper-reflexivity, see below) ("I feel my self dislocated from its normal position", "I do not feel my Self anymore").
2. Hyperreflexivity	*Tendency toward focal awareness of aspects of consciousness and the body that would normally be experienced in a tacit or immediate manner. It may occur in an "operative", automatic, or non-volitional fashion ("I had to think about what to think", "I can feel my thoughts as they come out of my mind").*

chic depersonalisation emerge as the split between parts of one's self. Typical sentences: "*I feel my self dislocated from its normal position*", "*I do not feel my self anymore*".

2. Hyperreflexivity.
   Diminishes self-affection is associated with a complementary tendency toward focal awareness of aspects of consciousness and the body that would normally be experienced in a tacit or immediate manner. Hyperreflexivity may occur in an "operative", automatic, or non-volitional fashion [103]. It emphasises the capacity of the self to split into a subject and an object of experiences and implies, e.g. the perceptualisation of inner speech or thought. Typical sentences: "*I had to think about what to think*", "*I can feel my thoughts as they come out of my mind*".

Other persons

A core feature in schizophrenia is the difficulty to enter into contact with other persons [10 20 32 50 79 83 89 95 98 100 110-122]. Schizophrenic autism reflects the fundamental constitutional fragility of selfhood, that is, its fundamental incompleteness, which results in problematic relations, meetings and confrontations with others [50]. Modern phenomenological accounts of autism mainly draw on Minkowski's [20] and Blankenburg's ideas [110]. Minkowski assumed that schizophrenic autism is a loss of vital contact with reality, including morbid rationalism and the so-called "antithetic attitude". Vital contact with reality provides a latent awareness of reality "making us adjust and modify our behaviour in a contextually relevant manner but without distorting our overall goals, standards and identity" [111]. Over the years, phenomenological psychopathology has never ceased deploying the concept of autism as an organiser of the meaning of the conditions of existence that go under the name of schizophrenia [32 79 112-117]. In brief, from the angle of clinical phenomenology, autism implies a disturbance of attunement, i.e. of the ability to perceive the existence of others and to see their mental structure as similar to one's own; make emotional contact and establish mutual relationships; intuitively understand the manifestations of mental life of other persons, and communicate with others using the shared meaning structures in a context-relevant manner [115 118]. The phenomenon of schizophrenic autism is characterised by the progressive removal of other individuals from the category of living-conscious beings, up to a mechanical objectivisation of the Other and an impersonal and algorithmic conception of social life [83 119]. Autism implies a fracture in social life, which is therefore compromised in the ability to recognise others as individuals endowed with complex and interrelated mental states (emotions, thoughts, feelings of affection which influence one another), and in the possibility to understand other people by means of pre-reflective and non-propositional attunement with the expressions of their mental life and by means of a keyboard of shared symbols and experiences. It is possible to identify five distinctive categories that characterize the world of schizophrenic autism [120] (Table V):

1. Hypo-attunement
   This is the immediate feeling of reduced attunement, i.e. emotional contact and detachment from other persons, and the pervasive feeling of inexplicability incomprehensibility of people's behaviours and social situations. It includes:

1.1 Immediate Feeling of Distance Detachment or Lack of Resonance
   The immediate feeling of distance and detachment, a sense of barrier between oneself and the other. Typical sentence: "*I always felt as if I belonged to another race*".

1.2 Immediate Feeling of Incomprehensibility of Other People and Social Situations
   The lack of intuitive "grip" on social situations. Typical sentence: "*I simply cannot grasp what others do*".

1.3 Ego-Syntonic Feelings of Radical Uniqueness and Exceptionality
   The exaltation of one's feelings of radical uniqueness and exceptionality. It seems to be grounded in anomalous sensations, feelings of disconnectedness from commonly shared reality. Typical sentence: "*I've always thought to be radically different from all other people, perhaps an alien. It depends on all my strange thoughts which surprised me*".

2. Invasiveness
   This is the feeling of being oppressed and invaded by the others, from without. It includes:

2.1 Immediate Feeling of Hostility or Oppression: the experience to be somewhat invaded, flooded by the external world or by the other people, or to be somehow in a passive, dangerously exposed position. Typical statement: "*I feel driven by the human flood. It is a feeling of danger, as if I were invaded*".

2.2 Immediate Feeling of Lack of Self-Other Boundaries: immediate feeling of being somehow "too open or transparent", to be physically invaded or penetrated by other people's gestures, speech, actions, or glances. Typical statement: "*I feel people entering inside me*".

2.3 Hyper-Empathic Experiences: the inability to take distance from other people determined by immediate feelings of merging with other persons, direct mindreading of others, fusional, or mimetic experience. Typical sentence: "*I feel the mental states of others and I can no longer find myself*".

TABLE VI.
Experiences of others in people with schizophrenia.

Subjective experiences	
Category	**Description category/ subcategory**
1. Hypo-attunement	1.1 Immediate Feeling of Distance or Lack of Resonance: A sense of barrier between oneself and the other ("I always felt as if I belonged to another race"). 1.2 Immediate feeling of incomprehensibility of other people and social situations: Lack of intuitive "grip" on social situations ("I simply cannot grasp what the others do"). 1.3 Ego-Syntonic Feelings of Radical Uniqueness and Exceptionality: Exalted feelings of radical distinctiveness grounded on anomalous sensations of disconnectedness ("I've always thought to be radically different from all other people, perhaps an alien. It depended on all my strange thoughts that surprised me").
2. Invasiveness	2.1 Immediate Feeling of Hostility or Oppression: Feeling of being in a passive, dangerously exposed position ("I feel driven by the human flood. It is a feeling of danger, as if I were invaded"). 2.2 Immediate Feeling of Lack of Self-Other Boundaries: Feeling of being physically invaded or penetrated by other people's gestures, speech, actions, or glances ("I feel people entering inside me"). 2.3 Hyper-Empathic Experiences: Feelings of merging with other persons, direct mindreading of others, fusional or mimetic experiences ("I feel the mental states of others and I can no longer find myself").
3. Cenesthopathic/Emotional Flooding	3.1 Emotional Paroxysms: Feeling of being overloaded by distressing emotions when in front of others ("When people get too close to me I feel a tension in my muscles"). 3.2 Coenesthesic paroxysms: Feeling of being oppressed by uncanny bodily sensations evoked by interpersonal contacts ("When I look someone straight in the eyes I feel strange vibrations inside").
4. Algorithmic Conception of Sociality	4.1 Observational (ethological) attitude: Attempt to make sense of the others' mental states through empirical observations in everyday life transactions, or "scientific" analysis of the workings of "intelligent" mechanisms ("I study people. I want to understand how they are inside"). 4.2 Algorythmic conception of sociality: Development of an explicit personal method to take part in social transactions ("I studied a system to intervene at the right moment in conversations").
5. Antithetic Attitude towards Sociality	5.1 Antagonomia: Independence as the most important value. Conventional knowledge and emotional attunement are dangerous sources of loss of individuation ("What I detest more is being persuaded by others"). 5.2 Abstract idealization of sociality: Engagement with 'real' persons is replaced by utopian interest in abstract humanitarian values ("I love Mankind, but I detest humans"). 5.3 Idionomia: Exalted existential standpoint not allowing integration with the other's point of view or with common sense. ("I must test the reality of reality", "Through suffering, from God I will have the power over the planet").

3. Cenesthopathic/Emotional Flooding
   This is the feeling of being oppressed and submerged from within by paroxysms of one's emotions and bodily sensations evoked by interpersonal contacts. It includes:

3.1 Emotional Paroxysms: feeling overloaded by one's distressing emotions in form of paroxysms when in front of others. Typical sentence: "*When people get too close to me I feel tension in my muscles*".

3.2 Coenesthesic Paroxysms: feelings of being oppressed by uncanny and incomprehensible bodily sensations evoked by interpersonal contacts. Typical statement:

"*When I look someone straight in the eyes I feel strange vibrations inside*".

4. Algorithmic Conception of Sociality
This is a conceptual, analytic, hyper-cognitive, hyper-rationalist, hyper-reflective stance toward sociality and the adoption of a "mathematisable" conceptualisation of interpersonal transactions in everyday life. Its main features are:

4.1 Observational (ethological) attitude: the attempt to make sense of the mental states of others that lie behind their behaviour through empirical observations of other people in everyday life transactions, or from the "scientific" analysis of the workings of "intelligent" mechanisms. Typical statement: "*I study people. I am curious. I want to understand how they are inside*".

4.2 Algorithmic Conception of Sociality: the observational attitude provides the basis for developing an explicit personal method or algorithm to take part in social transactions. Typical statement: "*I have studied a system to intervene at the right moment in conversations*".

5. Antithetic Attitude towards Sociality
Antithetic attitude toward sociality is the value-structure or existential orientation of persons with schizophrenia. It is comprehensive of:

5.1 Antagonomia: the feeling to be vulnerable to the influx coming from the external world and claim one's independence as the most important value. Conventional (common sense) assumptions, social-shared knowledge, common ways of thinking and behaving and immediate (empathic) relationships and emotional attunement are evaluated as dangerous sources of loss of individuation. Typical statement: "*What I detest more is being persuaded by others*".

5.2 Abstract Idealisation: replacing the engagement with "real" persons by a marked utopian interest in mankind or abstract humanitarian values. Typical statement: "*I love Mankind, but I detest humans*".

5.3 Idionomia: a kind of exalted existential standpoint that does not allow integration or compromise with the other's point of view or with common sense. Idionomia is comprehensive of metaphysical concerns (they are sceptical about the face value of phenomena) and charismatic concerns (they are convinced that they have a mission to accomplish). Typical statements: "*I must test the reality of reality*", "*Through suffering, from God I will have the power over the planet*".

Conclusions

The profound transformation of the life-world of persons with schizophrenia involves changes in the ontological framework of experience, and has serious consequences for how such persons live their life as embodied persons and how they understand the existence of other people. Drawing on classical as well as contemporary psychopathological accounts, we systematically, although succinctly, described the basic features of these changes. Lived time, space, body and selfhood and otherness are used as the principal descriptors of this transformation. We offer a reconstruction of the life-world of persons with schizophrenia that discloses their primordial *in esse*, their basic sense of being in the world. We argue that a detailed knowledge of these deep ontological changes is fundamental for our understanding of the schizophrenic style of experience and action as well as for making sense of the symptoms of schizophrenia.

A mental disorder is not a simple association of symptoms, but a coherent way of being in the world in which the phenomena intimately interpenetrate each other in a meaningful whole, i.e. a structure. From our reconstruction of the schizophrenic life-world, it emerges that the phenomenon of fragmentation is a candidate common denominator of schizophrenic experience. Fragmentation appears a basic feature of lived time, as well as space (itemisation), body (dynamisation and morbid objectivation) and selfhood (diminished self-affection). The loss of a coherent Gestalt of experience seems to run through the manifold of schizophrenic abnormal phenomena, also affecting self-world relatedness and *inter-esse* (hypo-attunement). This suggests that the crisis of the synthetic function of consciousness, that is, of the temporal unity of consciousness, could be at the basis of the characteristic "disarticulation", distinctive of the schizophrenic world.

Conflict of interest

None.

References

1 Cutting J, Dunne F. *Subjective experience of schizophrenia*. Schizophr Bull 1989;15:217-31.

2 American Psychiatric Association. *DSM-5. Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Press 2013.

3 Parnas J, Handest P, Jansson L, et al. *Anomalous subjective experience among first-admitted schizophrenia spectrum patients: empirical investigations*. Psychopathology 2005;38:259-67.

4 Fuchs T. *The self in schizophrenia: Jaspers, Schneider, and beyond*. In: Stanghellini G, Fuchs T, editors. *One century of Karl Jaspers' general psychopathology*. Oxford: OUP Oxford 2013, p. 245-257.

5 Parnas J. *A disappearing heritage: the clinical core of schizophrenia*. Schizophr Bull 2011;37:1121-30.

6 Schutz A, Luckmann T. *The structures of the life-world*. Evanston III: Northwestern University Press 1989.

7 Fuchs T. *Phenomenology and psychopathology*. In: Schmicking D, Gallagher S, editors. *Handbook of phenomenology and cognitive science*. Dordrecht: Springer Science & Business Media BV 2010, p. 547-573.

8 Stanghellini G, Ballerini M, Fusar Poli P, et al. *Abnormal bodily experiences may be a marker of early schizophrenia?* Curr Pharmac Design 2012;18:392-8.

9 Sass LA, Pienkos E. *Space, time, and atmosphere: a comparative phenomenology of melancholia, mania, and schizophrenia, part II*. J Conscious Stud 2013;20:131-52.

10 Stanghellini G, Ballerini M. *What is it like to be a person with Schizophrenia in the social world? A first-person perspective study on schizophrenic dissociality - part 2: methodological issues and empirical findings.* Psychopathology 2011;44:183-92.

11 Husserl E. *The Crisis of european sciences and transcendental phenomenology: an introduction to phenomenological philosophy*. Northwestern University Press 1970.

12 Parnas J. *Belief and pathology of self-awareness: a phenomenological contribution to the classification of delusions*. In: Zahavi D editor. *Hidden resources. Classical perspectives on subjectivity*. Exeter: Impring Academic 2004, p. 148-161.

13 Stanghellini G, Rosfort R. *Emotions and personhood: exploring fragility-making sense of vulnerability*. Oxford: Oxford University Press 2013.

14 Stanghellini G, Rossi R. *Pheno-phenotypes: a holistic approach to the psychopathology of schizophrenia*. Curr Opin Psychiatry 2014;27:236-41.

15 Stanghellini G, Ballerini M, Cutting J. *Abnormal Bodily Phenomena Questionnaire*. J Psychopathology 2014;20:36-41.

16 Fouks L, Guibert S, Montot M. *Minkowski's concept of lived time*. Ann Med Psychol 1989;147:801-9.

17 Pringuey D. *L'impatience schizophrenique*. L'Èvolution Psichiatrique 1997;62:357-67.

18 Chamond J. *Le temps de l'illégitimité dans la schizophrénie. Approche phénoménologique*. L'Évolution Psychiatrique 1999;64:323-36.

19 Minkowski E. *Le temps vecu*. Paris: d'Arey, 1933.

20 Minkowski E. *La schizophrénie. Psychopathologie des schizoïdes et des schizophrènes*. Paris: Payot 1927.

21 Pringuey D, Kohl FS, Schwartz MA, et al. *Schizophrenia as a temporal mode of being: an existential "ante-festum" impatience*. Seishin Shinkeigaku Zasshi 2003;105:734-43.

22 Kimura B. *Scritti di psicopatologia fenomenologica*. Roma: Giovanni Fioriti Editore 2005.

23 Wyllie M. *Lived time and psychopathology*. Philos Psychiatr Psychol 2005;12:173-85.

24 Broome MR. *Suffering and eternal recurrence of the same: the neuroscience, psychopathology, and philosophy of time*. Philos Psychiatr Psychol 2005;12:187-94.

25 Kupke C. *Lived time and to live time: a critical comment on a paper by Martin Wyllie*. Philos Psychiatr Psychol 2005;12:199-03.

26 Fuchs T. *The temporal structure of intentionality and its disturbance in schizophrenia*. Psychopathology 2007;40:229-35.

27 Fuchs T. *Temporality and psychopathology*. Phenom Cogn Sci 2013;1:75-104.

28 Bilheran A, Barthélémy S, Pedinielli JL. *La temporalité dans la psychose: une temporalité mythique? Rythmicité circulaire et sacralité*. L'évolution psychiatrique 2008;73:629-38.

29 Leiviska, Deland AC, Karlsson G, et al. A *phenomenological analysis of the psychotic experience*. Hum Stud 2011;34:23-42.

30 Arzy S, Mohr C, Molnar-Szakacs I, et al. *Schizotypal perceptual aberrations of time: correlation between score, behavior and brain activity*. PLoS ONE 2011;6:16154-60.

31 Husserl E. *On the phenomenology of the consciousness of internal time*. Dordrecht: Kluwer 1991.

32 Sass LA, Pienkos E. *Space, time, and atmosphere: a comparative phenomenology of melancholia, mania, and schizophrenia, part II*. J Conscious Stud 2013;20:131-52.

33 Jaspers K. *General psychopathology*. 7th ed. Baltimore, MD: Johns Hopkins University Press 1997.

34 Gross G, Huber G, Klosterkotten J, et al. *Bonn scale for the assessment of basic symptom*. Aachen: Shaker Verlag 2008.

35 Ellenberger HF. *A clinical introduction to psychiatric phenomenology and existential analysis*. In: May R, Angel E, Ellenberger HF, editors. *Existence: a new dimension in psychiatry and psychology*. New York: BasicBooks 1958, pp. 92-124.

36 Raballo A, Nelson B. *Unworlding, perplexity and disorders of transpassibility: between the experiential and the existential side of schizophrenic vulnerability*. Psychopathology 2010;43:25-1.

37 Sass L. *Madness and modernism: insanity in the light of modern art, literature, and though*. New York: Basic Books 1992.

38 Fuchs T. *Psychotherapy of the lived space: a phenomenological and ecological concept*. Am J Psychother 2007;61:423-39.

39 Callieri B. *Quando vince l'ombra – problemi di psicopatologia clinica*. Roma: Edizioni Universitarie Romane 2001.

40 Willi J. *Ecological developing by shaping the personal niche*. Cambridge, MA: Toronto, Goettingen; Hogrefe & Huber 1999.

41 Callieri B, Maldonato M, Di Petta G. *Lineamenti di psicopatologia fenomenologica*. Napoli: Alfredo Guida Editore 1999.

42 Stanghellini G. *Schizophrenic consciousness, spiritual experience, and the borders between things, images and words*. Transcul Psychiatry 2006;42:610-29

43 Sechehaye M. *Autobiography of a schizophrenic girl*. New York: Penguin 1962.

44 Conrad K. 1966. *Die beginnende Schizophrenie*, Stuttgart, Thieme, 1966.

45 Matussek P. *Studies in delusional perception*. In: Cutting J, Shepherd M, editors. *The clinical roots of the schizophrenia concept*, Cambridge: Cambridge University Press 1987, pp. 89-103.

46 Sass L, Pienkos E. *Delusions: the phenomenological approach*. In: Fulford W, Davies M, Graham G, et al. editors. *Oxford handbook of philosophy and psychiatry*. Oxford: Oxford University Press 2013, pp. 632-57.

47 Sass L, Pienkos E. *Varieties of self-experience: a comparative phenomenology of melancholia, mania, and schizophrenia, part I*. J Conscious Stud 2013;20:103-30.

48 Cutting J. *Principles of psychopathology: two worlds - two minds - two hemispheres*. Oxford: Oxford University Press 1997.

49 Gozzetti G, Cappellari L, Ballerini A. *Psicopatologia fenomenologica della psicosi – sul senso dell'incontro con l'esperienza psicotica*; Milano: Raffaello Cortina Editore 1999.

50 Stanghellini G. *Embodiment and schizophrenia*. World Psychiatry 2009;8:56-59.

51 Fusar-Poli P, Stanghellini G. *Maurice Merleau-Ponty and the embodied subjectivity*. Med Anthropol Q 2009;23:91-3.

52 McGlichrist I, Cutting J. *Somatic delusions in schizophrenia and the affective psychoses*. Br J Psychiatry 1995; 167:350-61.

53 Huber G. *Die coenaesthetische Schizophrenie*. Fortschr Neurol Psychiatr 1957;25:491-520.

54 Huber G. *Die coenaesthetische schizophrenie als praegnanztyp schizophrener erkrankungen*. Acta Psychiatr Scand 1971;47:349-62.

55 Roehricht F, Priebe S. *Disturbances of body experience in schizophrenic patients. (Stoerungen des Koerpererlebens bei schizophrenen Patienten.)* Fortschr Neurol Psychiatr 1997;65:323-36.

56 Schmoll D, Koch T. *Leib gefuehls stoerungen in der schizophrenen psychose. Eine kasuistik*. Nervenarzt 1989;60:619-27.

57 Schmoll D. *Coenaesthetische schizophrenie*. Fortschr Neurol Psychiatr 1994;62:372-78.

58 Klosterkötter J, Hellmich M, Steinmeyer EM, et al. *Diagnosing schizophrenia in the initial prodromal phase*. Arch Gen Psychiatry 2001;58:158-64.

59 Dworkin RH, Caligor E. *Psychiatric diagnosis and chronic pain: DSM III-R and beyond*. J Pain Symptom Manage 1988;3:87-98.

60 Rosenthal SH, Porter KA, Coffey B. *Pain insensitivity in schizophrenia: case report and review of the literature*. Gen Hosp Psychiatry 1990;12:319-22.

61 Dworkin RH. *Pain insensitivity in schizophrenia: a neglected phenomenon and some implications*. Schizophr Bull 1994;20:235-48.

62 Guieu R, Samuelian JC, Coulouvrat H. *Objective evaluation of pain perception in patients with schizophrenia*. Br J Psychiatry 1994;64:253-5.

63 Blackmore S. *Out-of-body experiences in schizophrenia. A questionnaire survey*. J Nerv Ment Dis 1986;174:615-9.

64 Twemlow SW, Gabbard GO, Jones FC. *The out-of-body experience: a phenomenological typology based on questionnaire responses*. Am J Psychiatry 1982;139:450-5.

65 Connolly F, Gipson M. *Dysmorphophobia. A long term study*. Br J Psychiatry 1978;132:458-70.

66 Hay G. *Paranoia and dysmorphophobia*. Br J Psychiatry 1983; 142:309-10.

67 Birtchnell SA. *Dysmorphophobia – a centenary discussion*. Br J Psychiatry 1988;153:41-3.

68 Snaith P. *Body image disorders*. Psychother Psychosom 1992;58:119-24.

69 Phillips KA, McElroy SL. *Insight, overvalued ideation, and delusional thinking in body dysmorphic disorder: theoretical and treatment implications*. J Nerv Ment Dis 1993;81:699-702.

70 deLeon J, Bott A, Simpson GH. *Dysmorphophobia: body dysmorphic disorder or delusional disorder, somatic type?* Compr Psychiatry 1989;30:457-72.

71 Phillips KA, McElroy SL, Keck PE, et al. *A comparison of delusional and nondelusional body dysmorphic disorder in 100 cases*. Psychopharmacol Bull 1994;30:179-86.

72 Parnas J, Møller P, Kircher T, et al. *EASE: Examination of anomalous self-experience.* Psychopathology 2005;38:236-58.

73 Feldman MD. *The challenge of self-mutilation: a review*. Compr Psychiatry 1988;29:252-69.

74 Martin T, Gattaz WF. *Psychiatric aspects of male genital self-mutilation*. Psychopathology 1991;24:170-8.

75 Sonneburn CK, Vanstraelen PM. *A retrospective study on self-inflicted burns*. Gen Hosp Psychiatry 1992;14:404-7.

76 Weiser M, Levy A, Neuman M. *Ear stuffing: an unusual form of self mutilation*. J Nerv Ment Dis 1993; 181:587-8.

77 Kennedy BL, Feldmann TB. *Self-inflicted eye injuries: case presentations and a literature review*. Hosp Community Psychiatry 1999;45:470-4.

78 De Haan S, Fuchs T. *The Ghost in the machine. Disembodiment in schizophrenia. Two case studies'.* Psychopathology 2010;43:327-33.

79 Stanghellini G. *Psicopatologia del senso comune*. Milano: Raffaello Cortina 2008.

80 Stanghellini G. *Schizophrenic delusions, embodiment, and the background*. Philos Psychiatr Psychol 2008;15:311-4.

81 Stanghellini G, Ballerini M, Fusar Poli P, et al. *Abnormal bodily experiences may be a marker of early schizophrenia?* Curr Pharm Design 2012;18:392-8.

82 Stanghellini G, Ballerini M, Blasi S, et al. *The bodily self: a qualitative study of abnormal bodily phenomena in persons with schizophrenia*. Compr Psychiatry 2014;55:1703-11.

83 Cutting J. *Morbid objectivization in psychopathology*. Acta Psychiatr Scand 1999;99(Suppl):30-3.

84 Bräunig P, Krueger S, Rommel O, et al. *Zönästhetische schizophrenien*. Schweiz Arch Neurol Psychiatry 2000;151:16-21.

85 Röhricht F, Priebe S. *Do cenesthesias and body image aberration characterize a subgroup in schizophrenia?* Acta Psychiatr Scand 2002;105:276-82.

86 Priebe S, Röhricht F. *Specific body image pathology in acute schizophrenia*. Psychiatry Res 2001;101:289-301.

87 Hur JW, Kwon JS, Lee TY, et al. *The crisis of minimal self-*

awareness in schizophrenia: a meta-analytic review. Schizophr Res 2013;152:58-64.

88 Parnas J. *The self and intentionality in the pre-psychotic stages of schizophrenia. A phenomenological study*. In: Zahavi D, editor. *Exploring the self. Philosophical and psychopatological perspective on self-experience*. Amsterdam/Philadelphia: Benjamins 2000, pp. 115-48.

89 Parnas J, Handest P. *Phenomenology of anomalous self-experience in early schizophrenia*. Compr Psychiatry 2003;44:121-34.

90 Parnas J, Handest P, Saebye D, et al. *Anomalies of subjective experience in schizophrenia and psychotic bipolar illness*. Acta Psychiatr Scand 2003;108:126-33.

91 Parnas J, Jansson L, Sass LA, et al. *Self-experience in the prodromal phases of schizophrenia: a pilot study of first admission*. Neurol Psychiatry Brain Res 1998;6:107-16.

92 Sass LA. *Self-disturbance and schizophrenia: structure, specificity, pathogenesis (current issues, new directions)*. Schizophr Res 2014;152:5-11.

93 Sass LA, Pienkos E, Nelson B. *Introspection and schizophrenia: a comparative investigation of anomalous self experiences*. Conscious Cogn 2013;22:853-67.

94 Zahavi D. *Self-awareness and alterity. A phenomenological investigation*. Evanston: Northwestern University Press 1999.

95 Sass LA, Parnas J. *Schizophrenia, consciousness, and the self*. Schizophr Bull 2003;29:427-44.

96 Parnas J. *Self and schizophrenia: a phenomenological perspective*. In: Kircher T, David A, editors. *The Self in Neuroscience and psychiatry*. Cambridge: Cambridge University Press 2003, p. 127-141.

97 Sass L. *Schizophrenia, self-consciousness, and the modern mind*. J Conscious Stud 1998;5:543-65.

98 Sass L. *Self and world in schizophrenia: three classic approaches in phenomenological psychiatry*. Philos Psychiatr Psychol 2001;8:251-70.

99 Stanghellini G. *Vulnerability to schizophrenia and lack of common sense*. Schizophr Bull 2000;26:775-87.

100 Stanghellini G, Ballerini M. *Values in persons with schizophrenia*. Schizophr Bull 2007;33:131-41.

101 Maggini C, Raballo A. *Self-Centrality, basic symptoms model and psychopathology in schizophrenia*. Psychopathology 2004;37:69-75.

102 Raballo A, Parnas J. *Examination of anomalous self-experience: initial study of the structure of self-disorders in schizophrenia spectrum*. J Nerv Ment Dis 2012;200:577-83.

103 Sass L. *Civilized madness: schizophrenia, self-consciousness and the modern mind*. History Hum Sci 1994;7:83-120.

104 Sharfetter C. *General Psychopathology*. Cambridge: Cambridge University Press 1980.

105 Henry M. *Incarnation. Une philosophie de la chair*. Paris: Edition du Seuil 2000.

106 Polanyi M. *The Tacit Dimension*. Garden City, NY: Anchor Books 1967.

107 Husserl E. *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy, second book*. Dordrecht: Kluwer 1989.

108 Merleau-Ponty M. *The phenomenology of perception*. New York: Routledge and Kegan Paul 1962.

109 Stanghellini G, Raballo A. *Differential typology of delusions in major depression and schizophrenia. A critique to the unitary concept of "psychosis"*. J Affect Disord 2015;171C:171-8.

110 Blankenburg W. *Der verlust der natürlichen selbstverständlichkeit*. Stuttgart: Enke 1971.

111 Urfer A. *Phenomenology and psychopathology of schizophrenia: the views of Eugene Minkowski*. Philos Psychiatr Psychol 2001;8:279-89.

112 Stanghellini G, Ballerini M. *Autism: disembodied existence*. Philos Psychiatr Psychol 2004;11:259-68.

113 Binswanger L. *Drei formen missglueckten daseins*. Tuebingen: Max Niemeyer 1956.

114 Mundt C. *Constituting reality: its decline and repair in the long-term course of schizophrenic psychoses: the intentionality model*. In: Marneros A, Andreasen NC, Tsuang MT, editors. *Negative versus positive schizophrenia*. Berlin/Heidelberg: Springer-Verlag 1991, pp. 96-108.

115 Parnas J, Bovet P. *Autism in schizophrenia revisited*. Compr Psychiatry 1991;32:1-15.

116 Tatossian A. *Phénoménologie de la schizophrénie*. Schweiz Archiv Neurol, Neuropsychiatry Psychiatry 1984;135:9-15.

117 Wyrsch J. *Klinik der schizophrenie*. In: Gruhle E, Jung R, Mayer-Gross R, et al. editors. *Psichiatrie der gegenwart*. Berlin: Springer 1949.

118 Stanghellini G, Ballerini M. *What is it like to be a person with schizophrenia in the social world? a first-person perspective study on schizophrenic dissociality – part 1: state of the art*. Psychopathology 2011;44:183-92.

119 Stanghellini G. *Schizophrenia and the sixth sense*. In: Chung MC, Fulford KWM, Graham G, editors. *Reconceiving schizophrenia*. Oxford: Oxford University Press 2007.

120 Stanghellini G, Ballerini M, Lysaker PH. *Autism rating scale ARS*. J Psychopathology, *in press*.

121 Stanghellini G, Ballerini M. *Dis-sociality: the phenomenological approach to social dysfunction in schizophrenia*. World Psychiatry 2002;1:102-6.

122 Parnas J, Bovet P, Zahavi D. *Schizophrenic autism: clinical phenomenology and pathogenetic implications*. World Psychiatry 2002;1:131-6.

Schizophrenia as a disorder of the self

M.G. Henriksen[1,2] , J. Nordgaard[1]

[1] Psychiatric Center Hvidovre, University of Copenhagen, Denmark; [2] Center for Subjectivity Research, University of Copenhagen, Denmark

Summary

This paper offers an overview of a current direction of clinical and empirical research in schizophrenia, viz. the phenomenologically informed approach that regards the generative disturbance of schizophrenia as a specific disorder of the self. Empirical studies have recently documented that anomalous self-experiences (i.e. self-disorders) aggregate in schizophrenia spectrum disorders, but not in other mental disorders. What appears to underlie this aggregation of self-disorders is an instability of the first-person perspective, which threatens the most basic experience of being a subject of awareness and action. In this paper, we elicit the meaning of the phenomenological notion of "disordered self" in schizophrenia spectrum disorders, we offer rich clinical descriptions of self-disorders, and we provide a concise overview of results from contemporary empirical studies. Finally, we provide some suggestions for future research on self-disorders, their nosological and diagnostic implications, and consider their potential value in psychotherapy for schizophrenia.

Key words

Self-disorders • Schizophrenia • Schizotypy • EASE • Phenomenology

Introduction

The neglect of the phenomenology and epistemology of the psychiatric object, which occurred in the wake of the so-called "operational revolution" in psychiatry, has led to a vast oversimplification of psychopathological phenomena (e.g. delusions and hallucinations, but also syndromes), depriving them of their phenomenological validity and any overarching conceptual framework [1]. One possible remedy to this unfortunate development involves a return to the basic science of psychiatry, viz. psychopathology, and systematic explorations of the ways in which psychopathological phenomena manifest themselves in patients' experiences and existence. Here, we must bear in mind that grasping mental phenomena is not similar to grasping physical objects. To place the "disordered self" in schizophrenia into proper perspective, some preliminary considerations on subjectivity and consciousness are required.

For a long time, the issue of subjectivity was nearly forgotten in psychiatry, but currently we are witnessing an almost global increase of interest in this particular topic. Psychiatry, existential psychiatry, phenomenological psychiatry, psychoanalysis, psychosocial rehabilitation and dialogical psychology all seem to agree that schizophrenia involves a "diminished sense of self" – a view also supported by many first-person accounts of schizophrenia [2]. Yet, the meaning of the term "self" and the nature of its "diminishment" vary considerably among these approaches – some considerations on these approaches, similarities and dissimilarities can be found elsewhere [2 3]. Due to the ambiguities associated with the notion of "diminished sense of self", we first illuminate the phenomenological notion of "disordered self" in the schizophrenia spectrum (i.e. schizophrenia and schizotypy). Secondly, we offer a series of typical and quite common clinical complaints of anomalous self-experiences (i.e. self-disorders) from patients diagnosed within the schizophrenia spectrum. Finally, we will summarise the results from contemporary empirical research and discuss their implications for future research and treatment in schizophrenia.

The disordered self

For the purpose of providing the reader with a preliminary sketch of the conclusions we shall draw later, we anticipate here the central result from the empirical studies: collectively, these studies demonstrate that the self in schizophrenia is often fragile and unstable.

Most importantly, the "self" that is found to be disordered in schizophrenia spectrum disorders in empirical studies does not refer to complex aspects of selfhood such as "social identity" or "personality" (although these as-

Correspondence
M.G. Henriksen, Center for Subjectivity Research, University of Copenhagen, Njalsgade 140-142, 25.5.23, DK-2300 Copenhagen S, Denmark • Tel. +45 3533 5597 • E-mail: mgh@hum.ku.dk

pects certainly also may be affected), but to a very basic *experience* of being a self. This experience signifies that we live our (conscious) life in the first-person perspective, as a self-present, single, temporally persistent, bodily and bounded subject of experience and action [4]. In other words, it is the first-personal articulation of experience that implicitly facilitates a sense of "mine-ness" or "ipseity" [5], transpiring through the flux of time and changing modalities of consciousness (e.g. perception, imagination, thinking), which appears to be unstable in schizophrenia. Consequently, the normally tacit, taken-for-granted, and pre-reflective experience of being a self no longer saturates one's experiences in the usual and unproblematic manner. It is quintessential to realise that this experiential notion of "self" is not a hypothetical construct, but a real and phenomenologically accessible structure of consciousness. I am always pre-reflectively aware of being myself and I have no need for self-reflection or self-perception to assure myself of actually being myself. For example, I do not need to reflect upon *who* these trains of thoughts might belongs to or *whose* image I perceive in the mirror in order to know that it is *me*. This intimate, foundational sense of self is not really a sort of knowledge, but rather prior to knowledge; it arises from a structure of consciousness that is operative in all experiential modalities; it is simply there, given and imbuing all my experiences with an elusive, yet absolutely vital feeling of "I-me-myself" (which we also may describe with the concept of self-presence). Following Henry, we can say that this basic sense of self arises from the "auto-affectivity" of subjectivity – a feature of the very givenness of consciousness [6]. Of course, I may still question *what* I think, *why* I have these thoughts or feelings and the possible allurement of my body or the nature of my being (e.g. my moral values, ability to exist in accordance to these values, and the purpose of my existence), but usually the question never arises if these thoughts, feelings or this body actually is *mine*.

In schizophrenia spectrum disorders, by contrast, this structure of consciousness is unstable and oscillating, resulting in certain characteristic anomalies of self-experience (e.g. a markedly diminished sense of mine-ness of one's own thoughts, actions and body), which patients frequently report and which, in empirical studies, have consistently been found to aggregate in schizophrenia spectrum disorders but not in other mental disorders (see summary of results below).

From a phenomenological perspective, this basic experience of being a self is intrinsically bound together with an automatic, pre-reflective immersion in the world. Thus, it should come as no surprise that the disorders at the "self-pole" of experience in the schizophrenia spectrum disorders also frequently entail certain deformations at the "world-pole" of experience. For example, lack of spontaneous immersion in the shared world and diminished sense of being present in it, alienation from the social world (often leading to social isolation and withdrawal), perplexity (questioning what others consider quite obvious or just take for granted, e.g. why do people say "hello" to each other or why is the colour code in traffic signals "red-yellow-green'?) and various forms of derealisation. Against this backdrop, it should be evident that the phenomenological notion of a "disordered self" in the schizophrenia spectrum disorders does not refer to a disturbance solely at the level of the subject, but rather to a disturbance of the tacit and foundational "self-world structure" [7] or, differently put, of "the intentional arc" [8]. This self-world structure appears to be fragile and unstable in disorders in the schizophrenia spectrum, constituting its core vulnerability, and resulting in a variety of specific self-disorders of which we provide clinical examples below.

It also merits attention that this "instability" does not equal something like a *disappearing* or *dissolution* of the self. Of course, patients with schizophrenia spectrum disorders continue to be subjects of awareness and action, and to affirm themselves with the first-personal pronoun (i.e. the "I"). Patients experience self-disorders within an overarching experiential-existential perspective, which constitutes their being-in-the-world, and no matter how many self-disorders they suffer from, their lives remain complete forms of human existence. The notions of "instability" and "dis-order" suggest, however, that the normally tacit and pre-reflective experience of being a subject of awareness and action no longer saturates one's experiences in the usual, unproblematic way.

Clinical descriptions

Many first-admitted patients with schizophrenia spectrum disorders complain of feeling as if they do not truly exist, of lacking an inner core and of being profoundly, though regularly ineffably, different from others (*Anderssein*). The distinctness of the quite frequent feeling of *Anderssein* seems to be a pervasive sense of being ontologically different; it is a feeling of being different in which one's very humanity is at stake. As one of our patients put it, "I looked just like every other child, but inside I was different. It is as if I am another creature that somehow ended up inside a human body". Another patient described this feeling in the following way: "I feel categorically different from others". Occasionally, the feeling of *Anderssein* may evoke a sort of solipsistic grandiosity (e.g. "I often doubt if others have a soul or any feelings"), but no matter what form this underlying feeling may take, it is usually a constant source of solitude, isolation and suffering. Frequently, patients also describe a deficient sense of "mine-ness" of the field of awareness (e.g. "my thoughts

feel strange as if they aren't really coming from me"), which sometimes may be linked to various distortions of the first-person perspective (e.g. "I look out through my eyes from a retracted point, and I see my skull in my visual periphery"). In her autobiography, Prof. Elyn Saks shares a dramatic experience of what seems to be a rare, momentary dissolution of the very first-person perspective:

- And then something odd happens. My awareness (of myself, of him, of the room, of the physical reality around and beyond us) instantly grows fuzzy. Or wobbly. I think I am dissolving. I feel – my mind feels – like a sand castle with all the sand sliding away in the receding surf. (…) Consciousness gradually loses its coherence. One's center gives away. The center cannot hold. The "me" becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal. There is no longer a sturdy vantage point from which to look out, take things in, assess what's happening. No core holds things together, providing the lens through which to see the world, to make judgments and comprehend risks [9].

Often, patients complain of thematically unrelated thoughts breaking into and interfering with their main train of thoughts. Thought pressure is another frequent complaint, i.e. rapid, parallel trains of thoughts, occurring with a clear loss of meaning ("My thoughts are like rockets, shooting in all directions at once. It's one big chaos"). Some patients also describe thought block – one of our patients reported that his thoughts could suddenly "slow down, fade away, or just stop", and this emptiness of thoughts could last a few minutes. Many patients also describe a certain hyper-reflective stance toward their own experiencing, allowing them, so to say, to inspect their own thoughts or imaginations as "objects" of awareness. For example, some patients report that it is as if they can spatially locate certain thoughts to specific parts of the brain, feel certain thoughts move around or physically feel them press on the inside of the skull.

The process of spatialisation or objectification of thoughts is also implicated in incipient *Gedankenlautwerden*, i.e. hearing one's own thoughts spoken aloud internally. A normal sense of "mine-ness" implies a fusion or unity between the experiencing subject and its thinking. In schizophrenia, however, an experiential distance can creep in between the thinking subject and its thoughts, forcing patients to inspect, perceive or listen to their own thoughts in order to know what they are thinking. Similarly, in acts of imagination, the experiential distance can set in between the subject and the imaginary objects, thereby increasingly reifying and spatialising the imaginary objects. This transforms the apparent "obsession" into a pseudo-obsession (sometimes with quasi-hallucinatory qualities), which typically appears fairly ego-syntonic and occurs with only minimal resistance (although its pictorial content may be anxiety-provoking) – e.g. a patient described that he often had pictures "in his head" where he perceived himself behead another and then kick the head around. During the experience, he took some pleasure in it and it never occurred to him to resist it. But when it was over, he felt disgusted by it (note that the subsequent feelings of discomfort and shame should not be mistaken for resistance, which possibly could translate the pseudo-obsession into a true obsession). Pseudo-obsessions have relevance in the context of diagnostically differentiating obsessive-compulsive disorders from the schizophrenia spectrum disorders – see also Rasmussen and Parnas [10].

Many patients complain of a diminished sense of being self-present and present in the world (e.g., "I live in a sort of bubble, where the world does not matter. I lack synchrony with the people around me"). The so-called mirror-phenomena and certain experiences of disembodiment are also frequently found in the schizophrenia spectrum – the following vignette illustrates some of these:

- The patient describes an "uncontrollable inner change" occurring at the age of 12. Ever since, she has not, as she puts it, "been able to find myself". She spends hours studying herself in the mirror and often she cannot recognise her specular image. She knows well that she perceives her own image, but "it is as if the reflected image is not supposed to be me (…) When I pass by a mirror, I must stop and make sure that there have not been too many changes". She reports various feelings of bodily self-alienation, e.g. "the body feels awkward as if it does not really fit. It feels like the body is not really me, as if it is rather a machine controlled by my brain, as if the body is a mere appendage". Regularly, she experiences motor inference (e.g. that her legs suddenly turn and walk in a different direction than she intends) and motor blockage (sometimes she cannot open her eyes or move her limbs). She also describes a myriad of unusual bodily sensations (typically that her body or parts of it feels unusually heavy or stiff), and she has spatialised experiences of her inner organs (e.g., she feels her brain wobbles).

Moreover, patients sometimes describe transitivistic experiences, e.g. persistent feelings of being radically exposed or "too open" (without any barriers) or confusion with others (as if being somehow "mixed up" with another in the sense of entirely losing one's sense of whose thoughts and feelings originate in whom). Finally, quasi-solipsistic experiences are also regularly reported by our patients – e.g. a fleeting sense of being at the centre of the world or as if feelings of having unique insight into more true dimensions of reality that usually remain hidden from others. The vignette below offers descriptions of

various quasi-solipsistic experiences and indicates how these experiences may be fused together with a feeling of *Anderssein*.

- The patient reports that during childhood she felt very different from others and often doubted if they had any feelings or a soul. All the time, she was preoccupied with philosophical questions about the meaning of life and she could not relate to her peers, whose life, values and topics of conversation she found utterly superficial. When walking in the street, she often feels as if people are looking at or talking about her, but she has never seen or heard anything to substantiate her feeling. When watching television, she sometimes has a fleeting feeling as if the commercials contain hidden messages intended for her alone. Frequently, she has the impression that the perceived world is not truly real ("it feels as if I'm in a play, like everything is staged for me"). During the time of hospitalisation, she had a transient feeling as if her visual field was all there existed – "the door at the end of the hall was the end of the world. Behind the door, there was nothing". Occasionally, she feels as if that she has extraordinary insight into others" psyche in the sense that she is, as she puts it, "almost able to permeate others and feel what they feel".

Assessment of self-disorders

Four clinical observations deserve mentioning here. First, the interviewer should not expect patients to simply offer verbal reports of self-disorders that just fit the relevant item definitions or effortlessly gravitate toward them, e.g. the items listed in the *EASE: Examination of Anomalous Self-Experience* scale [11]. On the contrary, patients' initial complaints may frequently have a character of quite vague or trivial clichés, and often it is only when the patient is asked to give a concretely lived example of his vague (non-specific) complaint that a more characteristic (specific) configuration emerges. Blankenburg used the expression of "non-specific specificity" to describe this particular phenomenon in schizophrenia [12]. For example, a patient may mention, *en passant*, that he feels different form others. Seemingly, this is a trivial complaint; we all feel different and, in fact, are different from each other in numerous ways. Upon further questioning, it may, however, turn out that the patient's feeling of being different is not at all specifiable in terms of concrete, *ontic* properties (e.g. feeling too clever or too fat, coming from a different socio-economic background or having other interests than one's peers, etc.), but has to do with a feeling of being *ontologically* different, i.e. somehow not really human (e.g., robot-like, non-existent or alien). If this is this case, then the apparently trivial complaint of feeling different carries, in fact, great typicality for schizophrenia spectrum disorders. In another case, a patient was asked if she sometimes experiences ambivalence with regard to simple, everyday decisions. The patient replied "no". When approaching the issue from a different angle, the patient was asked if she sometimes experiences difficulties in deciding what to eat. Again, the patient replied "no", but she also stated that he never eats breakfast. When asked to explain why she never eats breakfast, she replied that she is unable to decide she wants. When asked what then is different at lunchtime, she replied that she always takes a bit of everything, because she still cannot decide what she wants. In this case, the patient most likely experienced ambivalence, but the ambivalence was concealed behind her coping strategies. We raise here, in some detail, the issue of the "non-specific specificity" in schizophrenia, because important psychopathological phenomena, including self-disorders, may be easily overlooked if the interviewer is not attentive to the possibility that they also might be lurking beneath seemingly trivial complaints. Familiarity with the phenomenon of "non-specific specificity" in schizophrenia is, in our view, quintessential in the context of early diagnostic assessment, especially of patients who present with a quite vague, unelaborated picture of illness.

Second, when assessing self-disorders, it is not sufficient that the patient merely affirms the interviewer's question; an affirmative answer must never simply be taken for granted. By contrast, the patient must always provide a concretely lived example of such an experience, and only upon further questioning, clarifying the nature of this experience, may the interviewer score the item as "present" if the experience fulfils the relevant item definition [13]. It also merits attention that assessment of self-disorders cannot be obtained by a series of structured questions on a checklist or, for that matter, by non-clinicians, selectively trained in the use of a specific structured interview. Instead, assessment of self-disorders requires considerable clinical experience, some level of psychopathological scholarship, reliability-training with experts in the EASE scale and, not least, a phenomenological interview approach that seeks to establish rapport and trust, and in which the psychopathological inquiry is adequately and smoothly integrated into the patient's own narrative [13].

Third, self-disorders appear to have a persisting, trait-like character, i.e. these phenomena tend to articulate themselves as a recurring or sometimes nearly constant infrastructure of the patient's experiential life. Self-disorders are rarely fleeting mental contents similar to an isolated hallucinatory experience or a singular panic attack but reflect typically an enduring instability in the structure of consciousness. Although the temporal stability of self-disorders still needs systematic, longitudinal exploration (such studies are in preparation), our patients most frequently report that their self-disorders date back to child-

hood or early adolescence. At the time of first admission, many of their self-disorders have become almost indistinctly interwoven into their very mode of experiencing, and at least partly for this reason, our patients do often not seem to experience their initial self-disorders as "symptoms" of an illness (parallel to how jaundice is a symptom of liver failure), but rather as intrinsic aspects of their existence ("It is just who I am"). In our view, this particular aspect offers new resources for understanding the nature of poor insight into illness in schizophrenia [4].
Fourth, it is worth stressing that self-disorders are not psychotic phenomena. Self-disorders are typically reported with the "as if" or "it feels like" qualification (e.g. "*It feels like* the body is not really me, *as if* it is rather a machine controlled by my brain"). Thus, the patient's reality judgment remains intact [14].

Summary of empirical results

In 2005, a semi-structured psychometric instrument for a qualitative and quantitative assessment of self-disorders was published, viz. the EASE scale [11]. The EASE scale offers phenomenological exploration of experiential anomalies that is believed to reflect a disorder of the basic experience of being a self. The scale comprises 57 main items, aggregated into five domains: 1) Cognition and stream of consciousness; 2) Self-awareness and presence; 3) Bodily experiences; 4) Demarcation/transitivism; 5) Existential reorientation/solipsism. Today, the scale has been translated into 10 languages (see www.easenet.dk for details). The EASE scale exhibits a very high internal consistency (Cronbach's alpha > 0.900 [15]), a mono-factorial structure [15 16] and good to excellent inter-rater reliability among trained and experienced psychiatrists or clinical psychologists [11 17-19].
The empirical research employing the EASE scale or pre-EASE analogue scales demonstrate the following results:

- Self-disorders aggregate selectively in schizophrenia and schizotypy, but not in disorders outside the schizophrenia spectrum [15 20 21].
- There is no significant difference in the level of self-disorders among patients with schizophrenia and patients with the schizotypy [15 16].
- Self-disorders differentiate between first-admitted patients with bipolar psychosis and schizophrenia [22], and self-disorders occur more frequently in residual schizophrenia than in remitted bipolar psychosis [23].
- Self-disorders occur in individuals who are biologically related to probands with schizophrenia and who themselves suffer from a schizophrenia spectrum disorder [24].
- Prospective studies suggest that that self-disorders predict transition to psychosis in an ultra high-risk for psychosis sample [18]; that high baseline scores of self-disorders in first-admitted non-schizophrenia spectrum patients predict subsequent diagnostic transition to the schizophrenia spectrum at 5-year follow-up [25]; and that self-disorders are identifiable among non-psychotic help-seeking adolescents [26].
- Positive correlations have been found between self-disorders and positive and negative symptoms, formal thought disorders and perceptual disturbances [15].
- Correlations have been found between self-disorders and social dysfunction [27] and suicidality [28 29], respectively.
- No correlations have been found between self-disorders and IQ [15] or neurocognitive measures, except for impaired verbal memory [30].

For an overview of the aggregation of self-disorders, measured with the EASE scale, in schizophrenia, schizotypy, bipolar disorder, other mental disorders and in healthy controls, see Table I. For a comprehensive re-

TABLE I.
Mean total EASE score, standard deviation, and sample size.

Study	Schizophrenia	Schizotypy	Bipolar disorder	Other mental disorders	Healthy controls	p value
Haug et al. (2012) [22]	25,3 (9,6) n = 57	n/a	6,3 (4,8) n = 21	11,5 (8,7) n = 3*	n/a	< 0,001†
Raballo and Parnas (2012) [16]	21,4 (9,6) n = 19	17,0 (7,2) n = 8	n/a	5,7 (5,1) n = 9‡	n/a	< 0,001§
Nelson et al. (2012) [18]	n/a	n/a	n/a	n/a	2,37 (2,45) n = 52	n/a
Nordgaard and Parnas (2014) [15]	19,63 (8,39) n = 46	17,82 (6,82) n = 22	n/a	8,06 (5,89) n = 32**	n/a	0,00††

n/a = not available; * "Other mental disorders" comprises other *psychotic* disorders (i.e. delusional disorder and psychosis NOS); † Schizophrenia *versus* bipolar disorder and other mental disorders; ‡ "Other mental disorders" comprises major depressive disorders and one case of cyclothymic disorder; § Schizophrenia and schizotypy *versus* other mental disorders; ** "Other mental disorders" comprises anxiety disorders, OCD, and non-schizophrenia spectrum personality disorders; †† Schizophrenia and schizotypy *versus* other mental disorders.

view of all empirical pre-EASE and EASE based studies, see Parnas and Henriksen [3].

Implications for research and treatment

In our view, self-disorders constitute essential aspects of the psychopathology of schizophrenia. The results from empirical studies support the phenomenological notion of "disordered self" as an important phenotype of the schizophrenia spectrum. Although the idea that the generative disorder in schizophrenia is a specific disorder of the self was ventilated in most classic texts on schizophrenia [31-33], empirical studies have only emerged in the last decade. More systematic research is needed to further elicit the specificity of self-disorders for the schizophrenia spectrum – e.g. by exploring potential self-disorders in certain non-schizophrenia spectrum disorders, which seem to involve some kind, though *presumably not the same kind*, of disturbance of subjectivity (e.g., anorexia nervosa or borderline personality disorder). Also, the time of onset and temporal stability of self-disorders need empirical corroboration. Self-disorders have potentially considerable implications for early detection and intervention, but today it remains unclear from what age it can make sense to screen help-seeking, young adolescents for self-disorders, since participation in an EASE interview require some linguistic maturity and ability to self-reflect. Clarifying this issue is also an important target of future research.

It is worth stressing that self-disorders are not sharply delimited, independent symptoms but rather interdependent aspects of a more comprehensive psychopathological Gestalt – reflected also in the mono-factorial structure of the EASE scale. This implies that it is not any singular self-disorders *per se* that are specific for schizophrenia but rather the psychopathological Gestalt, which is constituted in part by self-disorders. Moreover, we believe that the notion of self-disorders may help sharpen the diagnostic boundaries between schizophrenia spectrum disorders and affective illness, thus counteracting the recurring and, in our view, quite problematic unitary view of psychosis.

Finally, it is noteworthy that many of our patients, during an EASE interview, express feelings of relief when realising that the interviewer is familiar with the nature of their experiences or that others suffer from similar experiences; this may to some extent counterbalances, though perhaps only temporarily, the patients' feelings of *Anderssein* and existential loneliness. Discussing self-disorders in group-sessions may thus have psychotherapeutic value. In our view, a psychotherapeutic approach that is better informed about the core of the patients' suffering, vulnerability and experiential life is likely to be a more effective treatment [34].

Funding

Carlsberg Foundation (#2012010195 to M.G.H.).

Conflict of interest

None.

References

1 Parnas J, Bovet P. *Psychiatry made easy: operation(al)ism and some of its consequences*. In: Kendler K, Parnas J, editors. *Philosophical issues in psychiatry III: the nature and sources of historical science*. Oxford: Oxford University Press 2014, pp. 190-212.

2 Lysaker PH, Lysaker PT. *Schizophrenia and alterations in self-experience: a comparison of 6 perspectives*. Schizophr Bull 2010;36:331-40.

3 Parnas J, Henriksen MG. *Disordered self in the schizophrenia spectrum: a clinical and research perspective*. Harv Rev Psychiatry 2014;22:251-65.

4 Henriksen MG, Parnas J. *Self-disorders and Schizophrenia: a phenomenological reappraisal of poor insight and non-compliance*. Schizophr Bull 2014;40:542-7.

5 Sass LA, Parnas J. *Schizophrenia, consciousness, and the self*. Schizophr Bull 2003;29:427-44.

6 Henry M. *The essence of manifestation*, trans. Etzkorn G. The Hague: Martinus Nijhoff 1973.

7 Parnas J, Henriksen MG. *Subjectivity and schizophrenia: another look at incomprehensibility and treatment non-adherence*. Psychopathology 2013;46:320-9.

8 Merleau-Ponty M. *The phenomenology of perception*. London: Routledge 2002.

9 Saks ER. *The center cannot hold*. New York: Hyperion 2007.

10 Rasmussen AR, Parnas J. *Pathologies of imagination in schizophrenia spectrum disorders*. Acta Psychiatr Scand 2014 Aug 7 doi: 10.1111/acps.12323.

11 Parnas J, Møller P, Kircher T, et al. *EASE: examination of anomalous self-experiences*. Psychopathology 2005;38:236-58.

12 Blankenburg W. *Der versagenszustand bei latenten schizophrenien*. Deutsche Medizinische Wochenschrift 1968;93:67-71.

13 Nordgaard J, Sass LA, Parnas J. *The psychiatric interview: validity, structure, and subjectivity*. Eur Arch Psychiatry Clin Neurosci 2013;263:353-64.

14 Henriksen MG, Parnas J. *Clinical manifestations of self-disorders and the gestalt of schizophrenia*. Schizophr Bull 2012;38:657-60.

15 Nordgaard J, Parnas J. *Self-disorders and schizophrenia-spectrum: a study of 100 first hospital admissions*. Schizophr Bull 2014;40:1300-7.

16 Raballo A, Parnas J. *Examination of anomalous self-experience: initial study of the structure of self-disorders in schizophrenia spectrum*. J Nerv Ment Dis 2012;200:577-83.

17 Møller P, Haug E, Raballo A, et al. *Examination of anoma-*

lous self-experience in first-episode psychosis: inter-rater reliability. Psychopathology 2011;44:386-90.

18 Nelson B, Thompson A, Yung AR. *Basic self-disturbance predicts psychosis onset in the ultra-high risk for psychosis "prodromal" population*. Schizophr Bull 2012;38:1277-87.

19 Nordgaard J, Parnas J. *A semi-structured, phenomenogically oriented psychiatric interview: Descriptive congruens in assessing anomalous subjective experience and mental status*. Clin Neuropsychiatry 2012;9:123-8.

20 Parnas J, Handest P, Jansson L, et al. *Anomalous subjective experience among first-admitted schizophrenia spectrum patients: empirical investigation*. Psychopathology 2005;38:259-67.

21 Raballo A, Saebye D, Parnas J. *Looking at the schizophrenia spectrum through the prism of self-disorders: an empirical study*. Schizophr Bull 2011;37:344-51.

22 Haug E, Lien L, Raballo A, et al. *Selective aggregation of self-disorders in first-treatment DSM-IV schizophrenia spectrum disorders*. J Nerv Ment Dis 2012;200:632-6.

23 Parnas J, Handest P, Saebye D, et al. *Anomalies of subjective experience in schizophrenia and psychotic bipolar illness*. Acta Psychiatr Scand 2003;108:126-33.

24 Raballo A, Parnas J. *The silent side of the spectrum: schizotypy and the schizotaxic self*. Schizophr Bull 2011;37:1017-26.

25 Parnas J, Raballo A, Handest P, et al. *Self-experience in the early phases of schizophrenia: 5-year follow-up of the Copenhagen prodromal study*. World Psychiatry 2011;10:200-4.

26 Koren D, Reznik N, Adres M, et al. *Disturbances of basic self and prodromal symptoms among nonpsychotic help-seeking adolescents*. Psychol Med 2013;43:1365-76.

27 Haug E, Øie M, Andreassen OA, et al. *Anomalous self-experiences contribute independently to social dysfunction in the early phases of schizophrenia and psychotic bipolar disorder*. Compr Psychiatry 2014;55:475-82.

28 Skodlar B, Parnas J. *Self-disorder and subjective dimensions of suicidality in schizophrenia*. Compr Psychiatry 2010;51:363-6.

29 Haug E, Melle I, Andreassen OA, et al. *The association between anomalous self-experience and suicidality in first-episode schizophrenia seems mediated by depression*. Compr Psychiatry 2012;53:456-60.

30 Haug E, Øie M, Melle I, et al. *The association between self-disorders and neurocognitive dysfunction in schizophrenia*. Schizophr Res 2012;135:79-83.

31 Kraepelin E. *Psychiatrie. Ein Lehrbuch für Studierende und Ärzte. Auflage 8, vollständig umgearbeitet*. Leipzig: Johann Ambrosius Barth 1913.

32 Bleuler E. *Dementia praecox or the group of schizophrenias*, trans. Zinkin J. New York: International Universities 1950/1911.

33 Minkowski E. *La schizophrénie. Psychopathologie des schizoïdes et des schizophrènes*. Paris: Payot 1927.

34 Skodlar B, Henriksen MG, Sass LA, et al. *Cognitive-behavioral therapy for schizophrenia: a critical evaluation of its theoretical framework from a clinical-phenomenological perspective*. Psychopathology 2013;46:249-s65.

Early detection of schizophrenia: a clinical-psychopathological revision of the ultra-high risk approach

V. Ramella Cravaro[1], A. Raballo[2]

[1] Department of Neuroscience, Psychology, Drug Research and Child Health. University of Florence, Italy; [2] Department of Mental Health, AUSL, Reggio Emilia, Italy

Summary

During the last 20 years, early phases of psychotic disorders have become one of the major clinical and research issues in psychiatry. It is well known since the last century that schizophrenia and psychotic disorders are characterised by a subclinical prodromal phase that can last weeks, months, or even years before the onset of overt psychotic symptoms. The prodromal phase is important in defining potential risk-markers of progression to psychotic illness and as a target for new biological and psychological treatments to prevent a transition to psychosis. Furthermore, the focus on early phases of psychotic disorders may improve the long term outcomes of patients by reducing the duration of untreated illness [1-3]. For all these reasons, during the last two decades a clinical "At Risk Mental State" syndrome and its operational criteria have been described leading to the development of two main early detection approaches: the ultra high risk approach (UHR) and the basic symptoms (BS) approach, each with its assessing instruments. Beside these, another important research front is that of anomalous self-experiences (ASE). ASE have been already widely detailed in early phenomenological descriptions of the core features of schizophrenia that might surface in the prodromal phases. The integration of these approaches could be of great value to enrich current operational criteria with a deeper, experience-close understanding of the unique, subjective perspective of individuals at risk of developing a psychosis. However, the integration of these approaches is not a mere juxtaposition of terms. Indeed, the field of early detection is vexed by an increasing terminological confusion related to the lack of an international consensus catalogue of terms that facilitate the bibliometric proliferation of new expressions that do not allow facile comparison of results from all the early psychosis research groups worldwide [4]. Likewise, to date, a diagnostic category for prodromal phases has not yet been included in DSM or ICD despite the presence of the "attenuated psychotic syndrome" in the appendix of the new DSM-5 as a condition for further study [5]. From a conceptual point of view, the integration of UHR, BS and ASE approaches awaken the discussion about the existence or not of a psychotic continuum with schizophrenic and affective psychoses at the extremes. Indeed, if the former has been used for the evaluation and monitoring of individuals at high risk of developing a psychotic disorder, the latter describes and assesses a set of symptoms characteristic of schizophrenia spectrum disorders. In closing, we describe the clinical staging model as well as the clinical and research benefits and disadvantages that it could bring for early psychosis.

Key words

Early detection • Prodrome • Ultra-high risk • Basic symptoms • Self-psychosis • Clinical staging

Terminological issue

In the last 20 years, the focus has moved from timely recognition and phase-specific treatment of first-episode psychosis to the pre-onset period (prodromal phase) [6 7]. This shift has revealed a critical "blind spot" in our mainstream classificatory systems that also affect the way to call and define early phases of psychotic disorders. In an interesting and recent paper, Schultze-Lutter and colleagues talk about a "near Babylonian speech confusion" [4]. The term prodromal, introduced for the first time by Mayer Gross in 1932, has been criticised because of its sense of unavoidable transition to a psychotic disorder. In fact, in medicine, the prodromes are the first signs or symptoms of a disease before it becomes clinically manifest [8]. Thus, the retrospective concept of prodrome is unsuitable to capture prospective psychotic conditions [9]. In the 1990s, McGorry and colleagues coined the definition of "at risk mental state" (ARMS) to identify individuals with clinical features suggesting an impending disorder, but without the certainty of onset. Moreover, the concept of "risk state" is borrowed from medicine (e.g. a patient suffering from angina is at risk of developing an acute myocardial infarction). Similar or derived from the ARMS concept are terms such as ultra-high risk (UHR), clinical high risk (CHR) and early/late at risk state. Other

Correspondence
Valentina Ramella Cravaro, Department of Neuroscience, Psychology, Drug Research and Child Health, University of Florence, Largo Brambilla 3, 50134 Firenze, Italy • Tel. +39 0557947487 • Fax +39 0557947531 E-mail: v.ramellacravaro@gmail.com

terms commonly used are: prepsychotic state, subthreshold psychotic symptoms, early psychosis, subpsychosis and hypopsychosis. These terms are more descriptive than operational. Moreover, the so-called x-like experiences (psychotic, delusional, hallucination, schizophrenia – like experiences) refer to the experience of psychotic symptoms in the absence of psychotic disorder. Nowadays, these experiences are assessed by self-rating scales raising doubts about the real psychotic nature of the experience itself [10 61]. As Schultze-Lutter and colleagues hoped for, to resolve the current confusion and to ensure the comparability between studies from different research groups, an international consensus catalogue of terms and their definition shall be developed [4].

Conceptual issue

In the field of early detection of schizophrenia the definitional problem echoes a conceptual one. If there is not a univocal answer to the question "how to define prepsychotic experiences?" the same happens when trying to answer what to look for in individuals at risk for developing a psychotic disorder. There are a variety of symptoms that are assessed and called in different ways, and the principal ones are summarised below:

- attenuated psychotic symptoms (APS): subthreshold attenuated positive symptoms (e.g. unusual ideas, magical thinking, perceptual disturbances, paranoia/suspiciousness);
- brief limited intermittent psychotic episode (BLIPS): transient psychotic symptoms with spontaneous remission;
- basic symptoms (BS): subjective experienced disturbances of different domains including perception, thought processing, language and attention with an intact insight;
- anomalous self-experiences (ASE): non-psychotic disturbances of the person's subjective experience of his own identity or "self".

The focus on the above-mentioned symptoms and subjective experiences in people considered at CHR of developing a psychotic episode/disorder led to the development of three main approaches: UHR approach, BS approach and self-disturbance approach.

UHR approach

To date the UHR approach has been widely applied in different research and clinical settings worldwide [11-18]. Over the years some modifications of UHR criteria have been made both within the same research group and between different ones, but the concomitant presence of state and trait risk factors plus a socio-demographic criterion (young person aged 14-30 years referred for healthcare) has always been maintained. The state risk is defined by the presence of APS or BLIPS, while the trait risk factors include decline of psychosocial functioning or sustained low functioning, genetic risk (first degree relative with a psychotic disorder) or schizotypal personality disorder, and unspecific prodromal symptoms. The focus on help-seekers applies a filter reducing the high number of false positives that could necessitate assessing large asymptomatic community samples. Indeed, before the development of the UHR concept, many studies focused on genetic risk (i.e. called "high risk approach") by longitudinally monitoring individuals with a positive family history for a psychotic disorder. The recruitment of individuals on the basis of familiarity led to not only a high number of false positives, but also the loss of all those patients developing a psychotic disorder without familial risk. In 1992, Bell developed an alternative strategy to identify individuals at high risk of developing a psychotic disorder based on the concepts of "multiple-gate screening", namely the satisfaction of more than a unique criterion to define the risk state in order to obtain a selected sample, and "close-in follow up", namely a shorter time monitoring the onset of sign and symptoms coincident with the period of maximum incidence [19]. These acute intuitions were operationalised for the first time by the Australian group of Yung and McGorry in the mid 1990s. This led to the development of the UHR approach that was widely applied in the subsequent years by many research and clinical groups worldwide [20] (Table I).

Over the years many instruments have been developed for UHR assessment. The main ones are: CAARMS, SIPS/SOPS and ERIraos. The Comprehensive Assessment of At-Risk Mental States (CAARMS) was developed by Yung and colleagues and is now widely used mainly in Australia, Asia and Europe [21]. The two main purposes of this instrument are to identify the imminent development of a psychotic episode and to determine if UHR criteria are satisfied. Indeed, all the three main UHR criteria (APS, BLIPS and supposed vulnerability) are investigated. The CAARMS is a semi-structured interview with many subscales: disorders of thought content, perceptual abnormalities, conceptual disorganisation, motor changes, attention and concentration, emotion and affect, subjectively impairment of energy and impaired tolerance to normal stress. The Structured Interview for Prodromal Symptoms (SIPS) and the Scale of Prodromal Symptoms (SOPS) were both developed by Miller, McGlashan and colleagues at PRIME Research Clinic at Yale University and are mostly used in North America and Europe [22]. These two instruments are conjointly used to provide a systematic measure of the presence/absence of prodromal states, to measure the severity of prodromal symptoms and to define an operational threshold for psychosis. The SIPS consists of several measures: SOPS, Schizotypal Personality Disor-

TABLE I.
Main international early detection research programs (adapted from Dominguez Martinez et al., 2011) [20].

Programme	Aim	Method
Early Psychosis Prevention and Intervention Centre (EPPIC). Melbourne, Australia	To provide both early detection and specialised treatment for early psychosis and treatment-resistant psychosis; to evaluate the effectiveness of the EPPIC program on 12 months outcome in FEP in contrast to the previous model of care	Prospective clinical trial with historical control group. Patients with onset of psychosis between the ages of 16 and 30 using CAARMS criteria
The Personal Assessment and Crisis Evaluation Service (PACE). Melbourne, Australia	To improve understanding of the neurobiological and psychosocial processes during the pre-psychotic phase; to develop psychological and medical interventions and evaluate their safety and efficacy; to establish an accessible and appropriate clinical service for young people ARMS	Prospective longitudinal study. Patients between the ages of 16–30 identified as UHR for developing a psychotic disorder using CAARMS criteria
The North American Prodrome Longitudinal Study (NAPLS), United States	To establish consortium of prodromal psychosis research centres and integrate database	Collaborative multisite investigation, longitudinal database. The NAPLS represents the largest sample of prospectively followed at risk subjects worldwide
The European Prediction of Psychosis Study (EPOS). Germany, Finland, UK, Netherlands and Spain	It is the first European multicentre investigation focusing on early detection of persons at risk for psychosis	Prospective multicenter, naturalistic field study. Persons between 16 and 35 years with UHR criteria. Includes a comprehensive baseline assessment and 2 follow-ups, at 9 and 18 months
The Early Detection and Intervention Programme of the German Research Network on Schizophrenia (GRNS). Cologne, Bonn and Düsseldorf	To promote help-seeking and engagement with early intervention services for individuals at-risk of psychosis	Longitudinal Study. Young people suffering from possible pre-psychotic symptoms using the Early Recognition Inventory (ERIraos)
The Early Detection and Intervention Evaluation (EDIE) trial. United Kingdom (UK)	To indicate an identified high risk group and randomly allocate participants to a psychological intervention or to a monthly monitoring	A randomised controlled trial. People at high risk of psychosis using CAARMS criteria
The Prevention Program for Psychosis (P3). Torrelavega and Oviedo, Spain	To assess the effectiveness of an intervention program for the prevention of psychosis, in the medium and long term	Prospective intervention and longitudinal study. Patients between 16-30 years at UHR using CAARMS criteria
Programma 2000. Milan, Italy	To provide early detection and intervention in subjects at the onset of, at risk of, or showing "prodromal" signs of psychosis	Prospective intervention and longitudinal study. Patients between 17-30 years at ARMS according to UHR criteria
The Detection of Early Psychosis (DEEP). Turku, Finland	To describe psychopathology and deficiencies in neuropsychological, neuroimaging and neurophysiological examination of subjects vulnerable to psychosis	Prospective and longitudinal study. Patients are selected for a screening of prodromal symptoms (SIPS-SOPS criteria)
Early Treatment of Pre-Psychosis Project (TOPP)	To study whether patient to define prodromal states develop psychosis within a 5-year follow-up period	Longitudinal and prospective study. Patients at risk to develop psychosis according to SIPS/SOPS scales
The Prevention Through Risk Identification, Management, and Education (PRIME). New Haven, Connecticut, USA	To test in a double-blind study whether early treatment with an atypical antipsychotic compared to placebo can prevent or delay the onset of psychosis	Double-blind controlled trial. Patients who are judged to be at risk for psychosis according to SIPS/SOPS scales
The Recognition and Prevention of Psychological Problems (RAP). New York, USA	To prevent severe mental illness focusing on patients with possible prodromal symptoms or early symptoms of psychosis	Prospective longitudinal study. Patients between the ages 12 and 25 with prodromal symptoms or early symptoms of psychosis according to RAP prodromal criteria

der checklist (DSM-IV), family history questionnaire and Global Assessment of Functioning Scale (GAF). The SOPS includes different subscales: positive symptoms (unusual thought content/delusional ideas, suspiciousness/persecutory ideas, grandiosity, perceptual abnormalities/hallucinations, disorganised communication); negative symptoms (social anhedonia, avolition, expression of emotion, experience of emotions and self, ideational richness, occupational functioning); disorganisation symptoms (odd behaviour and appearance, bizarre thinking, trouble with focus and attention, personal hygiene); general symptoms (sleep disturbance, dysphoric mood, motor disturbances, impaired tolerance to normal stress). The Early Recognition Inventory (ERIraos) was developed in the Central Institute of Mental Health (CIMH, Mannheim) in association with the University of Heidelberg and is mainly used in Europe. The peculiarity of this instrument is that it permits the investigation of both UHR criteria and basic symptoms. It is a two-step procedure: a 17-item screening instrument is used to identify potential ARMS individuals and is administered by a general practitioner or other professional contact person; if the defined cut-off is reached, the individual should be referred to an early psychosis recognition centre for a more detailed risk assessment with the ERIraos complete symptoms list (110 items). This is divided in 12 sections: introductory questions; changes in mood, interest and drive; disturbance of sleep and appetite; changes in personality; dysfunctional behaviour; anxiety and obsessive-compulsive symptoms; thought disorders; disorders of self and delusions; impaired bodily sensations; abnormal perceptions; motor disorder and observed behaviour [23].

BS approach

Basic symptoms are phenomenally different from APS/PLIPS in the sense that BS are subtle, subjectively experienced subclinical disturbances in drive, affect, thinking, speech, (body) perception, motor action, central vegetative functions and stress tolerance [24]. BS can occur not only in prodromal, but also in the residual phases of psychotic disorder and during psychotic episodes [25 26]. The subjective feature of BS makes these symptoms accessible only to the suffering individual, differentiating BS from negative symptoms that are functional deficits visible from the outside. Indeed, avoidance or social withdrawal can represent BS coping strategies. Another feature of BS is insight: the patient realises that something new, strange and barely understandable and explicable is happening. Chapman [27] and Varsamis [28] firstly studied similar kind of experiences during 1960-1970, yet it was Gerd Huber and his research group to propose their first systematic exploration coining the notion of "Basic Symptoms". The choice of the term "basic" reflects the idea of such symptoms as the first, immediate experiential expression of the presumed neurobiological substrate of vulnerability to schizophrenia. According to the BS approach, in the early phases of psychotic disorders, especially schizophrenia, symptoms occur in three developmental levels: the first consists of uncharacteristic BS (subthreshold alterations in drive, volition, affect, concentration and memory) that could spontaneously remit or gradually increase in number and severity reaching the second level of BS with more typical alterations in thinking, speech, motor action and body perception. In the absence of remission, the second level BS can evolve into third level BS represented by outright psychotic symptoms. The symptomatic rise to real psychotic experiences is often the consequence of a burn-out, an exhaustion of personal resources and coping strategies closely related to external factors such as familiar environments, social relationships, working/studying functioning, coping skills, resilience etc [29]. The first instruments developed for BS assessment were the Bonn Scale for the Assessment of Basic Symptoms (BSABS) [30] and the Frankfurt complaint Questionnaire (FBF) [31]. More recently, the schizophrenia proneness instrument [available in both Adult (SPI-A) [32] and Child-Youth (SPI-CY) [33] version] was developed. To date, SPI-A/-CY are commonly used to assess BS. By analysing data from the Cologne Early Recognition (CER) study, two BS subgroups were identified for the definition of the prodromal phase: the first, known as COPER, includes 10 cognitive-perceptive BS (thought interference, thought perseveration, thought pressure, thought blockages, disturbance of receptive speech, decreased ability to discriminate between ideas/perceptions and fantasy/true memories, unstable ideas of reference, derealisation, visual perception disturbances and acoustic perception disturbances); the second, known as COGDIS, includes 9 cognitive disturbances (inability to divide attention, thought interference, thought pressure, thought blockages, disturbance of receptive speech, disturbance of expressive speech, unstable ideas of reference, disturbances of abstract thinking and captivation of attention by details of the visual field). According to the results of German Research Network of Schizophrenia, the COPER BS group has good predictive accuracy. On the other hand, the COGDIS BS group has been used as a set of high risk criteria as an alternative to UHR [34]. The combination of BS and UHR criteria may identify the highest risk of transition to psychosis in the next 18 months [15]. However, the average period between COGDIS/COPER assessment and onset of psychosis is longer than the one between UHR evaluation and first episode of psychosis, suggesting that BS are more appropriate for early detection of distal prodromal states (compared to more proximal ones indexed by UHR APS and BLIPS criteria).

Self-disturbance approach

From a phenomenological point of view, a core marker of psychotic vulnerability and above all of schizophrenia spectrum disorders is the concept of self-disturbance. Indeed, in early descriptions of schizophrenia the disturbances of the self always had a central role: Bleuler described Ich-Spaltung and Autism, both involving an affliction of the self, as the two basic features of schizophrenia [35]; Kraepelin metaphorically depicted the disunity of consciousness typical of schizophrenia as an "orchestra without a conductor" [36]; Jaspers sustained the possible affliction of the self in different aspects such as activity, unity, vitality, identity and demarcation [37]. Furthermore, he described the "delusional mood", that is the first experiential, qualitative crisis that precedes the delusional manifestation; a similar construct has been labelled "trema" by Conrad [38]; along a convergent line, Minkowsy coined the expression "le trouble generateur"[39] to describe the loss of vital contact with reality and the interrogative attitude typical of the early phases of schizophrenia, whereas Blankenburg talked about the loss of natural self-evidence, the non-specific specificity of being unable to grasp everyday mundane significations [40]. Nowadays, phenomenologically-oriented psychopathology still emphasises the importance of examining subjective experiences rather than focusing on behavioural symptomatic manifestations to grasp the real psychotic vulnerability. This conceptual lacuna in the current behaviouristic and neurobiological psychiatry is also evident in the field of early detection of psychotic disorders. The UHR assessment of state and trait factors surely has substantial pragmatic value in identifying individuals at risk for imminent onset of a psychotic episode, but partly neglects the subjective and unique psychopathological core of self-experienced vulnerability. Thus, it is important not to equate UHR criteria and psychotic vulnerability. The BS, developed by Gerd Huber and largely studied in Germany during the last decades, partly overlap with the self-disturbances described by Parnas and Sass (e.g. disturbances of consciousness and action, alterations in bodily experiences), [41-44] although self-disturbance tend to emphasise a global, gestaltic change of subjecthood. According to the model developed by Parnas and Sass, self-disorders represent psychopathological trait markers of psychotic vulnerability and especially of schizophrenia spectrum disorders. Indeed, the fact that prodromal and psychotic symptomatology is not restricted to any particular modality of consciousness (i.e. it can appear as a cognitive, perception or sensory disturbance) suggests that a more basic and essential feature exists. As Minkowsky said "… it is not this or that function which is disturbed, but much more their cohesion, their harmonious interplay in its globality …" [45]. As the self can be described as the first personal givenness of experience, self-disturbance may be defined as pervasive or frequently recurrent experience in which one's first-person experiential perspective or one's status as a subject of experience or action is somehow distorted[46]. These anomalous experiences are not yet of psychotic intensity and the patient is able to keep a distance from them [47]. The instrument to assess these disturbances is the Examination of Anomalous Self-Experience (EASE) [48]. It is a symptom checklist for semi-structured phenomenological exploration of experiential subjective anomalies that appear to reflect disorders of basic self-awareness. It has been developed on the basis of self-descriptions obtained from patients suffering from schizophrenia spectrum disorders. It consists of five domains: cognition and stream of consciousness, self-awareness and presence, bodily experiences, demarcation and transitivism, and existential reorientation. The exploration of ASE can be complex because of the difficulty for the patient to communicate these uncanny and often ineffable subjective experiences (they often need to draw upon metaphors to describe them). It is also difficult for the interviewer who needs substantial familiarity with the experiences described, as well as the ability to create an intimate but neutral interview climate, since the patient has probably never talked with anyone about his basic self-disturbances. Empirical research on self-disturbance indicates that the ASE specifically captures schizophrenia spectrum vulnerability, rather than a generic psychosis-proneness.

Clinical staging model of psychosis and future directions

Clinical staging differs from conventional diagnostic practice in that "it defines the progression of disease in time and where a person lies along this continuum of the course of illness" [49] and can provide a clinical-decisional framework for person-tailored early intervention [29 50]. Clinical staging not only defines the extent of progression of a disorder at a particular point in time, but also where a person lies along the continuum of the course of an illness [51]. The rationale of such developmental model is that the earlier in the course of illness the treatment is offered, the safer and the more effective it should be in terms of long-term outcomes [52]. The clinical staging model is already widely used in medicine for those disorders that are potentially severe and inclined to progress if untreated. This is the case of the majority of psychiatric disorders, although the clinical staging model is not yet common in the psychiatric practice where disorders are strictly defined by outright symptomatic criteria. The concept of clinical staging related to early psychosis indicates a continuum of increasing risk, in which initially unspecific conditions phenotypically overlapping with the initial stages of other disorders gradually progress to

more crisply defined clinical-diagnostic profiles. A clinical staging model of psychotic and severe mood disorders, composed of four different developmental stages has been developed [49]:

- Stage 0 comprises asymptomatic individuals with an increased risk for psychotic disorders;
- Stage 1 is divided in two subgroups. Stage 1a consists of individuals with mild or non-specific symptoms and with mild functional decline. Stage 1b coincides with UHR individuals. These two subgroups are quite similar to early/late initial prodromal states described by German Research Group;
- Stage 2 includes individuals with a first psychotic/severe mood disorder;
- Stage 3 consists of three subgroups: incomplete remission (3a); remission and relapse (3b) and multiple relapses (3c);
- Stage 4 is characterised by the persistence of the psychotic/severe mood disorder.

For each of these developmental stages of the disorder, target populations, referral sources and potential therapies are proposed (Table II).

The usefulness of this model as a guide to early interventions is rather transparent since contemporary classifications (e.g. DSM, ICD) do not offer a clear framework for describing and managing the widespread subthreshold symptomatology that characterises the early phases of psychosis [53]. Indeed, to date, DSM and ICD criteria al-

TABLE II.
The clinical staging model framework for psychotic and severe mood disorders (adapted from McGorry PD, Hickie IB, Yung AR, et al. *Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier, safer and more effective interventions*. Aust NZ J Psychiat 2006;40:616-22).

Stage	Definition	Target population and referral sources	Potential interventions
0	Increased risk of psychotic/severe mood disorder No symptoms	1st degree teenage Relatives of a proband	Improved mental health literacy Family education Drug education Brief cognitive skills training
1a	Mild/non-specific symptoms Mild functional change/decline	Screening of teenage population Primary care physicians School counsellors	Formal mental health literacy Family psychoeducation Formal CBT Active substance misuse reduction
1b	UHR	Primary care physicians Educational agencies Welfare agencies Emergency services	Family psychoeducation, formal CBT Active substance misuse reduction ω3 fatty acids Atypical antipsychotics Antidepressants, mood stabilizers
2	First episode of psychotic or severe mood disorder	Primary care physicians Welfare agencies Emergency services Specialist care agencies Drug/alcohol services	Family psychoeducation Formal CBT Active substance abuse reduction ω3 fatty acids Atypical antipsychotics Antidepressants, mood stabilizers
3a	Incomplete remission	Primary and specialist care services	As for stage 2 but with additional emphasis on medical and psychosocial strategies to achieve full remission
3b	Recurrence or relapse of psychotic or mood disorder with residual symptoms or decline in neurocognition	Primary and specialist care services	As for stage 3a but with additional emphasis on relapse prevention and strategies to detect early warning signs
3c	Multiple relapses Impact of illness is objectively present	Specialist care services	As for stage 3b but with additional emphasis on long-term stabilisation
4	Severe persistent unremitting illness	Specialised care services	As for stage 3c but with more emphasis on tertiary treatment and social participation

low the diagnosis of stable disorders (e.g. schizophrenia), but not developmental conditions. Although in the new DSM-5 "Attenuated Psychotic Syndrome" has been added in the appendix as a condition of further study, some refinement is necessary. Due to the non-specific nature of prodromal symptoms, there are reasonable concerns about labelling early psychotic phases. First of all, there is the conceptual and practical danger that risk could be seen as disorder [51]. This is why the DSM-5 former proposal "psychosis risk syndrome" has been replaced by "attenuated psychosis syndrome". Moreover, since psychotic experiences can appear even in benign conditions and in the general population, the possibility to expose false positives to unnecessary medication is real [54]. Likewise, the majority of these patients will not develop a psychotic disorder (in a recent meta-analysis the transition rate is 22% at 1 year, 29% at 2 years and 32% at 3 years) calling the safety and utility of treatment in question [55 56]. Another important counterargument is that (at risk) psychotic-spectrum patients, once labelled, might begin to see themselves as defective, unworthy, shameful as well as discriminated and stigmatised by others; it is likely that knowing that one is at risk to develop a disabling psychotic disorder will have an impact on how the person views himself and plans for the future [57]. On the other hand, the clinical staging model and the inclusion of ARMS in traditional diagnostic systems could have potential benefits. The conceptualisation of stigmatising phenomena as existing across a continuum within the general population suggests the possibility that liability to psychosis is simply a human vulnerability depending on the interaction of both genetic and non-genetic risk factors, not differently from other medical fields where gradations of parameters or symptoms confer quantified risk for outright disease. Moreover, the coding of ARMS in traditional diagnostic systems would include a large number of patients that, at present, are not enrolled in psychiatric services, even if they have high levels of suffering. Indeed, according to both ARMS and APS criteria, symptoms must be sufficiently distressing and disabling enough to lead to help-seeking [56 58]. Therefore, early clinical management could not only prevent a possible transition to psychosis and better and early treatment, but it can also ameliorate the impaired quality of life of these patients. Furthermore, clinical staging substitutes a taxonomy of risk to a categorical concept of psychiatric diseases hopefully leading to a rational stratification of treatment according to the different developmental stages of a disease [58]. In this sense, psychosocial counselling and support should be more tailored to the early phases, in which no specific symptoms are detectable, while psychoeducation, family intervention, cognitive behavioural therapy and eventually psychopharmacology would progressively become more pertinent with the emergence of more characteristic prodromal and psychotic states [6 7 17 59 60].

Conclusion

A contemporary early detection approach, while shaping pragmatic-descriptive criteria to conduct rational intervention-based research in help-seekers at high risk of imminent onset of psychosis has overlooked fundamental clinical phenomena associated with the prodromal phases of psychotic disorders. Although some the phenomenological insights have been incorporated in the at risk BS criteria (i.e. COPER/COGDIS), further contributions of phenomenologically-oriented psychopathology are worth emphasising. First, on the clinical-phenotypic level, recent empirical research has shown the relevance of structural disorders of subjectivity (i.e. self-disturbance) as an early phenotypic marker of vulnerability to schizophrenia spectrum conditions (including both psychotic and not psychotic expressions) [62-64]. Thus, integrating the exploration of self-disorders in contemporary ARMS models could further identify (within the pool of subjects at increased risk of transition to psychosis) those who harbour a higher vulnerability to schizophrenia. Second, on a more comprehensive level, a phenomenologically-guided approach can provide a more experience-close explication of the early clinical phenomena that accompany the development of psychosis. This is of value for both early risk stratification and for psychosocial and educational support.

Conflict of interest

None.

References

1 Yung AR, Phillips LJ, et al. *Psychosis prediction: 12-month follow up of a high risk ("prodromal") group"*. Schizophr Res 2003;60:21-32.

2 Yung AR, McGorry PD, et al. *Monitoring and care of young people at incipient risk of psychosis*. Schizophr Bull 1996;22:283-303.

3 Vaglum P. *Earlier detection and intervention in schizophrenia: unsolved questions*. Schizophr Bull 1996;22:347-51.

4 Schultze-Lutter F, Schimmelmann BG, Ruhrmann S. *The near babylonian speech confusion in early detection of psychosis*. Schizophr Bull 2011;37:653-5.

5 Tsuang MT, Van Os J, Tandon R, et al. *Attenuated psychosis syndrome in DSM-5*. Schizophr Res 2013;150:31-5.

6 McGorry PD, Nelson B, Amminger GP, et al. *Intervention in individuals at ultra-high risk for psychosis: a review and future directions*. J Clin Psychiatry 2009;70:1206-12.

7 McGorry PD, Killackey E, Yung A. *Early intervention in psychosis: concepts, evidence and future directions*. World Psychiatry 2009;7:148-56.

[8] Yung AP, Stanley PA. *Fever and maculopapular rash*. In: Kincaid-Smith P, Larkins R, Whelan G, editors. *Problems in clinical medicine*. Sydney, Australia: MacLennan and Petty 1989, pp. 335-40.

[9] Eaton WW, Badawi M, Melton B. *Prodromes and precursors: epidemiologic data for primary prevention of disorders with slow onset*. Am J Psychiatry 1995;152:967-72.

[10] Hanssen MS, Bijl RV, Vollebergh W, van Os J. *Self-reported psychotic experiences in the general population: a valid screening tool for DSM-III-R psychotic disorders?* Acta Psychiatr Scand 2003;107:369-77.

[11] McGlashan TH, Zipursky RB, Perkins D, et al. *A Randomized, double-blind trial of olanzapine versus placebo in patients prodromally symptomatic for psychosis*. Am J Psychiatry 2006;163:790-9.

[12] Yung AR, Stanford C, Cosgrave E, et al. *Testing the Ultra High Risk (prodromal) criteria for the prediction of psychosis in a clinical sample of young people*. Schizophr Res 2006;84:57-66.

[13] Carr V, Halpin S, Lau N, et al. *A risk factor screening and assessment protocol for schizophrenia and related psychosis*. Aust N Z J Psychiatry 2000;34(Suppl):S170-80.

[14] Cornblatt BA, Lencz T, Smith CW, et al. *The schizophrenia prodrome revisited: a neurodevelopmental perspective*. Schizophr Bull 2003;29:633-51.

[15] Ruhrmann S, Schultze-Lutter F, Salokangas RK, et al. *Prediction of psychosis in adolescents and young adults at high risk: results from the prospective european prediction of psychosis study*. Arch Gen Psychiatry 2010;67:241-51.

[16] Broome MR, Woolley JB, Johns LC, et al. *Outreach and support in south London (OASIS): implementation of a clinical service for prodromal psychosis and the at risk mental state*. Eur Psychiatry 2005;20:372-8.

[17] Ruhrmann S, Schultze-Lutter F, Klosterkötter J, et al. *Early detection and intervention in the initial prodromal phase of schizophrenia*. Pharmacopsychiatry 2003;36(Suppl 3):S162-7.

[18] Simon AE, Dvorsky DN, Boesch J. *Defining subjects at risk for psychosis: a comparison of two approaches*. Schizophr Res 2006;81:83-90.

[19] Bell RQ. *Multiple-risk cohorts and segmenting risk as solutions to the problem of false positives in risk for the major psychoses*. Psychiatry 1992;55:370-81.

[20] Dominguez Martinez T, Blanquè JM, Codina J, et al. *Rationale and state of the art in early Rationale and state of the art in early detection and intervention in psychosis*. Salud Mental 2011;34:341-50.

[21] Yung AR, Yuen HP, McGorry PD, et al. *Mapping the onset of psychosis: the comprehensive assessment of at-risk mental states*. Aust N Z J Psychiatry 2005;39:964-71.

[22] Miller TJ, McGlashan TH, Rosen JL, et al. *Prodromal assessment with the structured interview for prodromal syndromes and the scale of prodromal symptoms: predictive validity, interrater reliability and training to reliability*. Schizophr Bull 2003;29:703-15.

[23] Rausch F, Eifler S, Esser A, et al. *The Early recognition inventory eriraos detects at risk mental states of psychosis with high sensitivity*. Compr Psychiatry 2013;54:1068-76.

[24] Schultze-Lutter F, Ruhrmann S, Fusar-Poli P, et al. *Basic symptoms and the prediction of first-episode psychosis*. Curr Pharm Des 2012;18:351-7.

[25] Gross G. *The "basic" symptoms of schizophrenia"*. Br J Psychiatry 1989;7(Suppl):21-5.

[26] Huber G, Gross G. *The concept of basic symptoms in schizophrenia and schizoaffective psychoses*. Recenti Prog Med 1989;80:646-52.

[27] Chapman J. *The early symptoms of schizophrenia*. Br J Psychiatry 1966;112:225-51.

[28] Varsamis J, Adamson JD. *Early schizophrenia*. Can Psychiatr Assoc J 1971;16:487-97.

[29] Schultze-Lutter F. *Subjective symptoms of schizophrenia in research and the clinic: the basic symptom concept*. Schizophr Bull 2009;35:5-8.

[30] Gross G, Huber G, Klosterkotter J, et al. *Bonner skala für die beurteilung von basissymptomen (bsabs: bonn scale for the assessment of basic symptoms)*. Berlin Heidelberg New York: Springer 1987.

[31] Süllwold L. *Manual Zum Frankfurter Beschwerde-Fragebogen (FBF)*. Springer Berlin Heidelberg 1991.

[32] Schultze-Lutter F, Addington J, Klosterkotter J. *J. Schizophrenia proneness instrument, adult version (SPI-A)*. Roma: Giovanni Fioriti Editore 2007.

[33] Schultze-Lutter F, Marshall M, Koch E. *schizophrenia proneness instrument, child and youth version (spi-cy), extended english translation*. Roma: Giovanni Fioriti Editore 2012.

[34] Klosterkötter J, Ruhrmann S, Schultze-Lutter F, et al. *The european prediction of psychosis study (EPOS): integrating early recognition and intervention in Europe*. World Psychiatry 2005;4:161-7.

[35] Bleuler E. *Dementia praecox oder gruppe der schizophrenien*. In: Aschaffenburg G, ed. *Handbuch der psychiatrie*. Leipzig: Franz Deuticke 1911.

[36] Kraepelin E. *Psychiatrie*. Leipzig: Barth 1896.

[37] Jaspers K. *Allgemeine Psychopathologie*. Berlin: Springer 1946.

[38] Conrad K. *Die beginnende schizophrenie.Versuch einer gestaltanalyse des wahns*. Stuttgart: Thieme 1958.

[39] Minkowsky E. *La schizophrènie: Psychopathologie des schizoides et des schizoprènes*. Paris: Payot 1927.

[40] Blankenburg W. *Approach to the psychopathology of common sense*. Confin Psychiatr 1969;12:144-63.

[41] Parnas J. *Clinical detection of schizophrenia-prone individuals: critical appraisal*. Br J Psychiatry Suppl 2005;48:s111-2.

[42] Sass LA, Parnas J. *Schizophrenia, consciousness, and the self*. Schizophr Bull 2003;29:427-44.

[43] Parnas J, Handest P, Jansson L, et al. *Anomalous subjective experience among first-admitted schizophrenia spectrum patients: empirical investigation*. Psychopathology 2005;38:259-67.

44 Raballo A, Maggini C. *Experiential anomalies and self-centrality in schizophrenia*. Psychopathology 2005;38:124-32.

45 Minkowski E. *La notion de perte de contact vital avec la réalité et ses applications en psychopathologie"* Paris: Jouve & Cie 1926.

46 Zahavi D, Parnas J. *Phenomenal consciousness and self-awareness: a phenomenological critique of representational theory"*. Consciousness Stud 1998;5:687-705.

47 Parnas J, Handest P. *Phenomenology of anomalous self-experience in early schizophrenia*. Comprehensive Psychiatry 2003;44,121-34.

48 Parnas J, Møller P, Kircher T, et al. *EASE: Examination of Anomalous Self-Experience*. Psychopathology 2005;38:236-58.

49 McGorry PD. *Issues for DSM-V: clinical staging: a heuristic pathway to valid nosology and safer, more effective treatment in psychiatry*. Am J Psychiatry 2007;164:859-60.

50 Yung AR, Nelson B, Stanford C, et al. *Validation of "prodromal" criteria to detect individuals at ultra-high risk of psychosis: 2 year follow-up*. Schizophr Res 2008;105:10-7.

51 McGorry PD. *Risk syndromes, clinical staging and DSM V: New diagnostic infrastructure for early intervention in psychiatry*. Schizophr Res 2010:120:49-53.

52 Meyer SE, Bearden CE, Lux SR, et al. *The psychosis prodrome in adolescent patients viewed through the lens of DSM-IV*. J Child Adolesc Psychopharmacol 2005;15:434-51.

53 Van Os J, Linscott RJ Myin-Germeys I, et al. *A systematic review and meta-analysis of the psychosis continuum: evidence for a psychosis proneness–persistence–impairment model of psychotic disorder*. Psychological Medicine 2009;39:179-95.

54 Fusar-Poli P, Borgwardt S, Bechdolf A, et al. *The psychosis high-risk state: a comprehensive state-of-the-art review*. JAMA Psychiatr 2013;70:107-20.

55 Fusar-Poli P, Bonoldi I, Yung AR, et al. *Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk*. Arch Gen Psychiatry 2012;69:220-9.

56 Corcoran CM, First MB, Cornblatt B. *The psychosis risk syndrome and its proposed inclusion in the dsm-v: a risk-benefit analysis*. Schizophr Res 2010;120:16-22.

57 American Psychiatric Association. *Attenuated Psychosis Syndrome*. In: *Diagnostic and statistical manual of mental disorders*. 5th ed. Arlington, VA: American Psychiatric Publishing 2013.

58 Raballo A, Larøi F. *Clinical staging: a new scenario for the treatment of psychosis*. Lancet 2009;374:365-7.

59 Svirskis T, Korkeila J, Heinimaa M, et al. *Quality of life and functioning ability in subjects vulnerable to psychosis*. Compr Psychiatry 2007;48:155-60.

60 McGorry PD, Yung AR, Bechdolf A, et al. *Back to the future: predicting and reshaping the course of psychotic disorder*. Arch Gen Psychiatry 2008;65:2-7.

61 Stanghellini G, Langer AI, Ambrosini A, et al. *Quality of hallucinatory experiences: differences between a clinical and a non-clinical sample*. World Psychiatry 2012;11:110-3.

62 Parnas J. *The core gestalt of schizophrenia*. World Psychiatry 2012;11:67-9.

63 Parnas J, Raballo A, Handest P, et al. *Self-experience in the early phases of schizophrenia: 5-year follow-up of the Copenhagen prodromal study*. World Psychiatry 2011;10:200-4.

64 Haug E, Øie M, Andreassen OA, et al. *Anomalous self-experiences contribute independently to social dysfunction in the early phases of schizophrenia and psychotic bipolar disorder*. Compr Psychiatry 2014;55:475-82.

Borderline personality disorder from a psychopathological-dynamic perspective

M. Rossi Monti, A. D'Agostino

Department of Human Sciences, University of Urbino

Summary

As is well-known, borderline personality disorder is a highly variegated clinical constellation, so that it might be better pictured as an area rather than a line. It is in this clinical area that we encounter particularly difficult patients who, subject to emotional dysregulation and tendency to impulsive action, cause much trouble to clinicians and health workers committed to their treatment. The contribution of psychopathology becomes essential whenever it allows the clinician to move from the level of symptoms to that of lived experience. When this shift is not attempted, the clinician's gaze remains dominated by the triad of stigmatisation, intractability and chronicity. To ask "what is it like to be a person with BPD" means, for example, to identify the characteristics of a perpetually dysphoric mood condition that forces the subject to look for ways to quickly reduce such uncomfortable state. Psychopathology allows us to shed light on the dynamics of dysphoric mood and the transformation of dysphoria into anger: this knowledge can also help reduce the risk of emotional mirror-involvement in the clinician.

Key words

Borderline personality • Disorder • Dysphoria • Anger

Introduction

As is well-known, the clinical constellation of borderline personality disorder is highly variegated, so that it might be better pictured as an area rather than a line. This area resembles a kind of condominium (the "borderline condo") whose tenants can display very different characteristics. This should not be seen as a static metaphor. In fact, there is the possibility of changing apartments within the same building or even abandoning it for another building. The latter is indeed the goal of every therapeutic enterprise. According to Clarkin, Hull and Hurt's [1] clinical typification, we can imagine a ground, first and second floors. The ground floor is occupied by borderline patients characterised by an uncontrollable drive to act (impulsivity, acting out). The first floor is dwelled by borderline patients with an affective impairment that can take the form of atypical depression. The second and top floor is inhabited by "quiet borderline" patients [2]: these people live in a condition of identity diffusion and suffer from chronic states of emptiness and despair, but do not display serious self-harming behaviours such as those characterising the borderline patients living on the ground floor.

While those inhabiting the first and second floors are generally able to ask for help, the borderline patients who live on the ground floor are in a far more problematic condition: they are imprisoned in a mechanism that finds a temporary "solution" to their chronic suffering in the impulsive discharge towards the outside world. Unable to formulate a more or less explicit request for help, these patients end up trapped in situations in which the low level of mentalisation and the frequency of acted-out behaviours (impulsive behaviour, acting out, self-harming behaviour, provocative or antisocial behaviour) conspire with each other, causing the endless repetition of traumatic or even catastrophic interpersonal events. This type of borderline patients is usually taken care of by Community Mental Health Services.

Relationship: the stage of the disorder

In the area of personality disorders, borderline personality disorder (BPD) has always enjoyed a privileged position, so that it represents the most diagnosed condition; it is also the main object of study, research and both theoretical and clinical reflection. This attentional bias is certainly related to the complexity of the disorder and its multiple possibilities of expression, but also and foremost to the serious difficulties experienced by clinicians and Community Mental Health Services in dealing with it.

The main obstacle to treatment is represented by the type

Correspondence
Mario Rossi Monti, Department of Human Sciences, University of Urbino, via Bramante 16, 61029 Urbino, Italy • Email: rossimonti53@gmail.com

of relationship that the borderline patient establishes with others, and especially with those who deal with him or her from a clinical point of view (psychiatrists, clinical psychologists, nurses, psychosocial nurses). The therapeutic relationship invariably becomes emotionally turbulent or even fiery because of the intensity of the emotions involved. It also becomes highly addictive, very discontinuous, stormy and constantly on the verge of rupture or interruption. This relationship is highly traumatic for both the patient (who follows a relational pattern with the clinician that repeats itself cyclically in its life story) and the clinician (who needs to maintain his therapeutic attitude under the pressure of events).

In fact, one of the fundamental features of borderline personality disorder is that, on the one hand it has serious effects on the sufferer and severely restricts his lifestyle, and, on the other, it also plagues those who interact with the subject: parents, relatives, friends and partners, as well as clinicians. The symptoms of BPD, in this sense, do not simply belong to the psychopathological disorder, but "flood" the relationship. This explains why, paraphrasing Winnicott, it is possible to argue [3] that there is no such a thing as *an isolated* borderline person: each time there is one, there must be somebody else interacting with him or her. In brief, one cannot be a borderline person all by oneself: those who interact with a borderline personality are inevitably at risk to be dragged into borderland territory. Thus, being a borderline also means *disturbing* someone: that is, it means to force the other to bear and share one's own subjective states (especially when the other is a clinician who adopts a therapeutic point of view).

In other serious disorders, gravely depressed or delusional subjects, for example, withdraw and shut themselves into a private world hardly accessible to the others. Something very different happens to people with BDP. In this case, the relationship with the other becomes the stage on which the disorder unfolds and keeps re-enacting those highly problematic or destructive relational patterns that "burn out" one relationship after the other: one partner after the other, one friend after the other, one employer after the other – and even a psychiatrist, or a clinician, one after the other. Thus, BPD takes the form of what Kurt Schneider [4] would have called a true "disordering disorder". By the middle of the twentieth century, Schneider had come up with this quite acute definition by arguing that the abnormal and psychopathic personalities are those that, because of their abnormity, suffer or cause suffering: today we could say with greater precision that they are those who "suffer *and* cause suffering".

Since the relationship with the other becomes the stage on which the disorder is enacted, it is very difficult to build, develop and maintain a therapeutically-oriented relationship with these patients. In the absence of the clinician's continuous monitoring and rethinking of the status of the relationship, the course of events inevitably leads to the discharging of the patient (*prise en décharge*) rather than the "taking charge" of him or her (*prise en charge*). In addition, it is well known that severe personality disorders have a bad reputation among healthcare workers. According to the title of a 1988 article by Lewis and Appleby [5], borderline patients are "patients psychiatrists dislike". This mere nosographic diagnosis seems to trigger negative emotions and thoughts [6 7] among clinicians, so that it has been regarded as a "diagnosis of exclusion" – which means a diagnosis employed *not* to deal with a problem. In this sense, the old adage that diagnosis of borderline personality psychopathology is a sort of waste basket needs to be rethought. Rather than a container for all those cases that are difficult to match with established nosological models, it is a trash bin in which to throw everything one does not want to deal with: the waste of the clinic. The vague clinical symptoms elicit unpleasant responses in healthcare workers and tend to be dismissed. Many studies [8-12] have emphasised that the negative perception of borderline patients affects healthcare workers' ability to develop a good therapeutic relationship. The negative perception of the patient (starting with diagnosis) often leads to a problematic or negative interaction. Once assigned to a patient, diagnosis of BPD becomes "sticky" and often triggers a chain reaction that leads to a real stigmatisation. This depends on the fact that often these patients unleash a "destructive whirlwind" [13] – an image used by many healthcare workers to describe the effect of their encounter with patients suffering from the most severe cases of BPD.

BPD patients frighten, bewilder and worry healthcare workers; they cause emotional problems and trigger intense emotional reactions that are sometimes uncontrolled and in any case difficult to contain in the context of the therapeutic process. In the absence of any understanding of the true nature of these phenomena and of training that can prepare one to deal with their effects on the therapeutic group, the most likely outcome results in the triad: stigmatisation-misunderstanding-intractability. This situation triggers another vicious circle: due to the tendency to stigmatise, the vindicating, challenging and sometimes violent attitudes of these patients are not seen as partial data to be processed and integrated into a broader clinical context, but rather as symptomatic elements that preclude and compromise any therapeutic process. In essence, faced with the inability to understand the workings of the borderline mind, the healthcare worker quickly develops the tendency to objectify and stigmatise – and the paradigm of chronicity-intractability resurfaces. Eventually, the low level of mentalisation typical of the borderline functioning is reflected in a similarly low level of mentalisation in healthcare workers, leading to impairment of therapeutic function.

These serious difficulties in establishing a therapeutic relationship with the most severe borderline patients (most likely to be encountered in a Community Mental Health Service rather than in private practice) highlight the limits of a diagnostic system which – due to its non-theoretical character – does not provide any help in the planning and implementation of therapeutic intervention. Once a diagnosis of BPD is reached according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the Clinical Manual abandons the clinician to his destiny: how is it possible to convert the identification of symptoms from a categorical-nosographic perspective into a therapeutic intervention that will not be compromised by the emotional-relational disturbances described above?
In the history of borderline psychopathology, the nosographic phase (inaugurated in 1980 by the DSM-III) put an end to a pioneering, pre-nosographic first phase. The third historical phase, still on-going, has seen the attempt to introduce distinctions within such a complex and elusive clinical area: traits that remain stable over time have been distinguished from acute symptoms and the main core dimensions of the disorder have been identified. The most important of such dimensions are: impulsivity, identity diffusion, cognitive impairment and emotional instability [14 15]. In particular, emotional instability plays a fundamental role because it is perhaps the best discriminant between borderline personality psychopathology and normality [16].
In what measure did (and does) psychopathology contribute to the understanding of the borderline condition? Its contribution should go beyond the description of the symptoms or the structural functioning of the disorder (as with Kernberg's model of Borderline Personality Organization) and, instead, should emphasise the lived experience and the lived world of the borderline person. Is it possible to highlight the subjective character of the experience, namely what it feels like to be a borderline person? Is it possible to develop at least a vague and problematic idea of the borderline person's perspective on himself, the others and the world?
What is it like to be a bat? – Thomas Nagel asked in his famous 1974 essay [17]. The point was not to try and imagine what it would feel like *for us* to be a bat, but, rather, what it feels like *for the bat*. Similarly, we could ask what it feels like for a borderline to be a borderline. This question, however, implies a shift from the level of the description of the psychiatric symptom to the dimension of lived experience. The scope of this effort will be represented by the dysphoria and the dysphoria-rage sequence.

From emotional instability as a symptom to dysphoria as lived experience

The psychiatric literature has emphasised how emotional instability, emotional disorder and poor emotional awareness are all aspects of the same pathogenetic core, which has strong and specific ties with the borderline symptomatology [18 19]. The various, if not infinite, facets of the borderline personality psychopathology might well be just the superficial manifestation – in the context of relationships – of an instable and disordered emotional core, which functions as the true *driving force* behind the borderline existence.
Emotional instability, however, is a construct that needs clarification. What does emotional instability mean exactly? Koenisberg [20] has shown that this label hides several different phenomena: sudden and rapid shifts from one emotion to another; high levels of emotional intensity; sudden eruptions of emotions; long recovery time to return to the state *quo ante*; high reactivity to interpersonal stimuli; unpredictability; dramatic display of emotions. The typical patterns of emotional instability are at least two: 1) strong reactivity to psychosocial stimuli; 2) mood fluctuations that develop autonomously. While this last pattern is typical of mood disorders, the first belongs specifically to the borderline area and consists of the three following additional elements:

a) Emotional specificity

Does the emotional instability typical of the borderline personality involve all emotions or is it limited to specific ones? The borderline emotional instability has no generic emotional features, but is emotion-specific, meaning that it generally concerns emotional states that fluctuate between fear and rage. Goodman et al. [21] have identified the core of the borderline emotional instability in the oscillation between dysphoria and rage [22-24] – an oscillation that is particularly sensitive to the variables that pertain to the interpersonal context. What happens here, then, is different from what happens with mood disorders, where the emotional instability, if present, is less dependent on the context and the fluctuations concern the polarities depression/euphoria, euthymia/depression, and euthymia/euphoria [25].

b) Dependence on the context

The borderline emotional instability is strongly dependent on the context (environmental, relational, interpersonal) and is characterised by a distinct reactive component. This resembles what has been called "interpersonal sensitivity": an extraordinary sensitivity to detect flaws and imperfections in the relationship with others and the environment. Such sensitivity can detect even minor atmospheric changes. This reactivity is triggered primarily by negative stimuli (Gratz et al. 2010) and is not confined to occasional mood episodes, but, on the contrary, forms a constant element in the way the borderline personal-

ity functions. Some impulsive conducts develop on this ground as an attempt to "cleanse" – at least momentarily – a state of permanent internal tension.

c) Poor emotional awareness

Emotional instability goes together with a scarce awareness of one's own emotions: confusion, dissociation, denial, avoidance and episodes of emotional cutting off are all typical features. Every process of emotional self-regulation presupposes some form of emotional awareness. An impairment of this function severely interferes with the process of feedback regulation of the intensity of emotions. In this way, in the borderline personality, emotions are experienced as autonomous physical and mental states that cannot be easily modulated, mitigated or oriented in one direction rather than another. In this condition, the person easily loses the sense of being the agent and source of his emotional states: the awareness that a particular emotion originates within the self, belongs to it and has much to do with it and with the vicissitudes of its internal and the external world, is lost. When the borderline patient is not able to see himself as an active agent, such emotional states start fluctuating like vague and menacing entities in search of a place to settle.

Together with poor awareness of his emotional involvement (which tends to be experienced as overwhelming), the borderline person has the ability to capture – with incredible sensitivity – micro-variations of the emotional atmosphere in the context of human relationships. Equipped with this sensitivity, he or she seems to look for objects, individuals or situations to which to "attach" his or her emotions, thereby trying to give such emotions a limited and therefore accessible meaning. This way, however, the objects end up playing the modulating function that the borderline lacks – as if the patient's wellbeing depended on what the object does (an object often charged with an overwhelming amount of responsibility). Every clinician who has dealt with a borderline patient is familiar with this kind of feeling. As one of such clinicians said: "Those patients make you feel worn out, they suck up your energy. They're like leeches: if you keep them on you, they suck your blood. If you take them off, they die".

What is dysphoria?

What do we mean by dysphoria? [22] [26-28] To what extent does dysphoria differ from, on one side, anxiety and depression and, on the other, from rage? In the psychiatric and clinical-psychological literature, the term "dysphoria" appears quite frequently. In the context of mood disorders, the term "dysphoria" is used mostly as synonymous of sadness, to indicate mild forms of depression (subthreshold) or to describe a mixture of negative and unpleasant emotions: a kind of general dissatisfaction or a mixture of experiences of anxiety and depression that lack specificity [29] [30]. In short, dysphoria is a so-called "as if" term: it is often used *as if* one could rely on some implicit shared meaning, so stable and reliable that there is no need to make it explicit. In order to better understand the nature of dysphoric mood, it is essential to describe its fundamental characteristics: one is a general characteristic, while the other three are specific.

From a *general* point of view, dysphoria is a mood condition that is experienced as unpleasant, uncomfortable, negative and oppressive, with all the features of mood states (an enduring state, devoid of an intentional object, unmotivated, rigid, difficult to articulate, encompassing the whole horizon of the subject and affecting his relationship with the world, the others and himself). In this sense, the term "dysphoria" indicates an emotional state that is hard to endure: while euphoria is an emotional state comparable to the feeling of wearing a comfortable dress that fits the body like a glove, dysphoria points to the exact opposite feeling. In this case, the subject experiences a state that, literally, does not suit him. This is the meaning of the term in many psychiatric conditions, where the subject experiences a state of uncomfortableness, distress and discomfort with respect to: 1) the body that it is forced to inhabit (gender dysphoria); 2) a body condition that hinders his life and must be dealt with (premenstrual dysphoria); 3) a feeling of unease and discomfort related to a sense of mental and motor awkwardness, which the patient sees as an effect of the intake of neuroleptics (neuroleptic dysphoria). In short, the mood condition typical of dysphoria has to do with the perception of something that is askew – something that went wrong and hinders one's life. Indeed, in dysphoria, *everything* goes wrong. It is difficult for most of us to imagine a condition in which this emotional state does not represent an isolated experience (whether temporary or transient), but, rather, a stable and enduring one. One of the best examples of dysphoric mood can be found in Herman Melville' *Moby Dick* [31]. Ishmael – the narrating voice – is describing the kind of mood that periodically forces him to get to the sea:

"Call me Ishmael. Some years ago—never mind how long precisely—having little or no money in my purse, and nothing particular to interest me on shore, I thought I would sail about a little and see the watery part of the world. It is a way I have of driving off the spleen and regulating the circulation. Whenever I find myself growing grim about the mouth; whenever it is a damp, drizzly November in my soul; whenever I find myself involuntarily pausing before coffin warehouses, and bringing up the rear of every funeral I meet; and especially whenever my hypos get such an upper hand of me, that it requires

a strong moral principle to prevent me from deliberately stepping into the street, and methodically knocking people's hats off—then, I account it high time to get to sea as soon as I can".

We could consider what Ishmael calls spleen and hypos as parts of the dysphoric mood state typical of the borderline person. However, insofar as he is able to identify his mood condition, to come to terms with it and also to find effective coping strategies, Ishmael has nothing of the borderline personality. In the borderline functioning, the subject, utterly incapable of recognising his discomfort, to make sense of it and to find a way to modulate it, is overwhelmed by what Ishmael is able to describe with such precision and, desperate to find ways to reduce the tension, is dragged into the abyss of impulsive actions, (step into the street and display aggressive behaviours, take drugs, develop self-harming behaviour, etc.). The pervasive mood condition that Ishmael describes as episodic is merely a fraction of the borderline condition, which is durable and devoid of an intentional object (in the sense that the subject cannot ascribe it to a specific situation). This condition dominates the borderline existence, an existence in which dysphoria envelops the subject like a thick fog.

Any attempt to imagine the dysphoric mood condition inevitably leads to a delimitation of it: our instinct is to provide it with some intention, some content and a specific reference, thereby explaining its manifestation by reducing it to a particular set of events. This is how a patient tried to describe the condition with which she had to cope every day: "It's like getting up in the morning and banging your toe against the bed!". Those who are fond of *bricolage* will be reminded of a somehow similar situation: the screw that, under the pressure of the screwdriver, refuses to be driven vertically – or the nail that gets twisted on the first hammering. From then on, everything goes wrong. Not only is it almost impossible to straighten the nail, but any attempt to improve the situation leads to further disasters. The twisted nail becomes an obstacle to implementing the whole project of hanging a picture on the wall. Instead of a picture, there seems to be a bottomless pit on the wall. Each one of these examples, however, allows us to taste only a small portion of dysphoria, and does not portray dysphoria as a *general* mood. In the above examples, in fact, it is tempting to identify a triggering event (the bed, the screw, the nail) and focus all our attention on it. This way, however, the emotion, far from being experienced as something that permeates the world of the patient, is circumscribed, contained and explained.

In order to get an idea of what the dysphoric mood means for a borderline patient, we should think of a condition in which such an emotional state cannot be traced back and confined to the feelings experienced before a twisted screw or a hurt toe. Events such as these, if they ever happened, must have fallen into oblivion: it is as if the toe, once and for all, had banged against the bed in some kind of primeval and forgotten condition, but the emotional experience related to this event had settled deep in the subject and conditioned his emotional barometer irreversibly. In dysphoria, so to speak, the name of the object went lost: what is left is only the background emotion. Detached from its possible objectual referents, this emotion expands in the air like a gas, poisoning the entire emotional life of the patient and overflowing into its relationships with the others.

Once the ties with its original source are lost, dysphoria becomes a pervasive, unintentional and unjustified emotion, thereby resulting as overwhelming, tormenting and inescapable. This condition becomes so unbearable and widespread that one is forced to look for an object (any object) to which to trace back one's mood in order to modulate and circumscribe it in space and time. In this sense, dysphoric mood is in permanent search of a twisted screw – and if the screw doesn't twist by itself, one can always lend a hand. In Florence, we have an expression for this particular condition: "What is it? Did you wake up *twisted*?" To be twisted or askew means to endure this painful condition. In dysphoria, however, it is not the screw that is twisted, but, rather, the mood itself. From this perspective, dysphoric mood is an emotional state close to depersonalisation: here the mood is not just the implicit and unproblematic background on which our experience as human beings rests; this tacit background has turned into a condition in which one's mood has lost its air of familiarity and has given way to a feeling of suspension and estrangement. This is one of the reasons why dysphoria is a state of discomfort.

The condition described by Zanarini et al. [32] as "psychic pain" closely recalls, on the one hand, the general characteristics of the dysphoric mood and, on the other, some aspects of the sense of painful incoherence that Wilkinson-Ryan and Westen [33] identified as the essential component of the borderline personality disorder. This latter perspective, however, involves a shift from the level of emotions to that of personal identity (with respect to the outside world) or to the state of the self. This was one of the key points on which Clarkin et al. [34] based their analysis of the borderline constellation. Such a change in perspective, however, is likely to divert the attention from the level of pain and emotional involvement – a level that (insofar as mood is concerned) is *closer to the experience of both the patient and the clinician,* and is therefore essential to the therapeutic process. The clinician has to deal with a borderline patient and feels invariably affected, if not "flooded", by the dysphoric mood. Such direct, less mediated and almost contagious aspect of dysphoria (conceived as mood) strongly calls for an

analysis of dysphoria as one of the key elements of the borderline condition – something that, clinically speaking, must be dealt with. A better understanding of both dysphoria as mood and the experiences that characterise it would surely prove very useful, whether one is facing a borderline patient or dealing with the mood condition normally triggered by the encounter with a borderline patient.

Alongside these general features, dysphoric mood is characterised by at least three specific elements: *tension*, *irritability* and *urge*.

a) *Tension* refers to a state of great inner tension, underlying bad mood, chronic and nameless unhappiness and widespread and tenacious discontent. It is like being permanently "on edge", together with a tendency to anxiety, apprehension and intensification of reactivity and vigilance in a state of persistent *dysphoric alertness*.

b) *Irritability* refers to a state of constant and annoying underlying irritability, restlessness, worry and insistent anxiety. It is like a chronic and irritating thorn that torments the patient and gives him no respite: a general state characterised by aversion, unfriendliness and tendency to quick temper. The main attitude here is that of aversion towards the entire world: this renders the patient ill-disposed, irritated, distrustful - if not even suspicious – intolerant, resentful and hostile: "Rage – a patient clarified – rests on a cause. Me, I'm left with just rage, without any cause". This dysphoric irritability expands across the board. Such an emotional condition is the mark of the psychopathology of the borderline personality and expresses itself in the form of an extraordinary sensitivity to relational vicissitudes and their atmospheric microdisturbances [35].

c) *Urge* refers to an aspect of dysphoria that is characterised by a kind of impatience and intolerance that develops into an urge to action. This is a condition that precedes the discharge into action, as when, after a certain point, a loaded spring snaps, violently releasing all the stored energy. The action is always "violent", not necessarily in the sense of physical violence, but rather in that of a great intensity of the emotions involved; the idea is that through action one will be able to shatter and break through the sort of shell one feels trapped in. The underlying fantasy is that of getting rid of such a shell through action. Action responds to the need of cleaning up, lowering the tension and the irritability, thereby somehow modulating the dysphoric mood state. This element of dysphoria has strong connections with rage: it is the outcome of the oscillation between dysphoria as mood and rage as an affect. The emotional urge must find a relief valve – it doesn't really matter how: "*I cut myself, I take drugs, I get a fix...I skip a red light, I insult a traffic warden, I punch in the face the first person I bump into…, in other words, I just do something!*". The important thing is to stop, at least for a moment, the dysphoric agony. From this point of view, it is as if at this stage the borderline patient is searching for a twisted screw that can serve as a target for his rage and as an explanation of his suffering – and most of the time the patient does find such screw.

Precisely because dysphoria as a mood cannot be easily modulated, the only possible modulation is sought outside of the mind, on the surface of a body on which to inscribe one's own emotional state. Borderline self-harm is a way to find relief from the torment of inner tension. The self-inflicted lesion of the skin provides a temporary oasis of peace and relaxation. It is a way to take a rest from dysphoria. This relief, however, can also be achieved by targeting the outside world, that is, by acting on the environment and transforming it even with violence. For example, to ruin and destroy things, to create a messy and deteriorated environment around oneself may be a way to try to lower the inner tension and irritation by using the environment as a regulating mechanism: such inner tension and irritation are experienced when one has to acknowledge the difference between the drama that unfolds internally and the indifference, the tranquillity, or (even worse) the beauty of the surrounding environment.

In one of the very few studies that have tried to give a specific connotation to dysphoria, Starcevic [36] has divided the additional secondary features characterising dysphoria as a mood into two groups: the first is a cognitive type and the second a behavioural one. The features included in the first group range from a tendency to suspiciousness and to blame others to feelings of bitter disappointment and injustice, which can easily turn into genuine paranoid ideas. Such a cognitive structure organises itself around a "borderline attributional style" [37] – an idiosyncratic style, made of malevolent expectations towards the world and human relationships and directed primarily to the immediate satisfaction of one's needs.

The behavioural features of dysphoria, on the other hand, concern the dimension of impulsivity and actions: these actions are generally parasuicidal and are aimed mainly at "naming" and "localizing" dysphoria. One example of such behaviour is the attempt to engrave, so to speak, dysphoria on one's own skin by engaging in self-mutilation acts such as incisions, cuts, burns, etc. Precisely because dysphoria as a mood is scarcely flexible, the only chance of modulating it – as we have already noted – can only be sought on the outside. The cutting/burning of the surface of the body, in fact, is systematically described by self-mutilators as a way to alleviate the torment of dysphoria: this appears to be the borderline way to take a rest from dysphoria. The high levels of *harm avoidance* and *novelty seeking* detected by Korner et al. [38] and Cole et al. [39] in their studies of borderline patients strongly challenge the idea that the aim of self- and hetero-destructive behaviours is simply to inflict pain and cause damage to

oneself or others. On the contrary – and paradoxically – even when the behaviour clearly appears harmful to the subject, the goal is to avoid greater damage. In the words of a self-mutilating patient: "It is like staunching one kind of pain with another kind of pain".

Tension, irritability and urge are just *static* characteristics of dysphoric mood. To complete the picture, we should visualise them within a dynamic progression that structures itself as a real sequence. Such a "dysphoric sequence" might progress from an inner psychological condition (*tension*) to a condition that surfaces on the skin, which is perceived as a shell for the self and as a membrane that functions as a contact point with the world (*irritability*); finally, the subject can reach a state of dysphoric aversion towards the world, the environment, the relationships and even the skin (*urge*). The product of the dysphoric sequence, however, can take at least two different forms: a disorganising one and an organising one.

The first form (*disorganising*) coincides with a state of disorganisation and confusion with respect to personal identity. This is the basic condition of borderline psychopathology described by Kernberg as identity diffusion. Tension, irritability and urge cannot break down the dysphoric mood so to structure it and orient it towards a specific object. On the contrary, the mood condition intensifies and leads to a disorganisation of the self by a "centrifugal" effect [40]. Such state of disorganisation does not belong just to the patient, but can also affect the clinician in the therapeutic relationship: this might give the clinician serious trouble or force him or her to try to "organise" the dysphoric sequence. Such an organisational attempt often results in acts that are symmetrical to those of the patient, which in turn leads to the expulsion of the patient and breakdown of the relationship. On the other hand, however, the state of disorganisation can represent a guiding tool in the therapeutic relationship. In the fluctuations of one's *own* sense of identity occurring during sessions, Searles [41] sees an important and unexpected source of data to understand what is happening in the therapeutic relationship, so much as to propose to use this as a sort of clinical organ of perception.

In the second form (*organising*) of the dysphoric sequence, instead, we see – downstream of the dysphoric aversion – a behaviour that possesses a specific content or an emotional condition characterised by a dominant affect: fear or rage. Self-mutilating behaviours [42 43] represent a typical expression of this organising mode. By means of a precise ritualisation, these behaviours position dysphoria into a behavioural circuit that has a constant effect: invariably, the skin lesion leads to a state of lowered tension. It is a momentary oasis of peace. The act of providing dysphoria with a shape by means of an objective, concrete and visible skin lesion allows a kind of "emotional discharge to the ground". In the words of a patient: "There was such tension inside my head – it is so strong that it goes away only if I do something bad, like cutting myself […]. For me, cutting is the only medicine". The cuts are a way to stop a dysphoric state of mind: "The cuts – another patient says – are my air vent". Cutting the flesh represents an attempt to modulate or staunch a dysphoric mood condition, precipitating dysphoria in a place that has a name, is concrete, visible, objectifiable, delimited and also "curable". Another organising sequence takes place when an affect gains a prominent position, imbuing the entire emotional field. The emotional field verticalises itself and takes on an "affective" character, orienting itself toward a specific object. An object is recognised by an affect and becomes the focus of the patient's rage or fear.

From dysphoria to rage

Along this path, the oscillation between dysphoria and rage occupies a privileged position. Kernberg [44 45] has tried to sum up the main functions of rage, from the most primitive to the most evolved:

1. eliminate a source of irritation or pain by means of a violent reaction;
2. remove an obstacle to gratification;
3. restore – by an extreme and desperate attempt – a sense of autonomy in the face of very frustrating situations, trying to recreate a state of narcissistic equilibrium;

The first two functions gravitate around an object that acts as a "source" of pain or as an "obstacle" to gratification. In this sense, rage – unlike dysphoric mood – presupposes the identification and focalisation of an object as a target for one's own arrows. The third function identified by Kernberg, instead, concerns the self and the effect that rage has on the state of the self. Keeping in mind these three different functions, I would like to try to characterise rage as an affect as opposed to dysphoria as a mood by taking into account the following areas:

a) Rage and the object

What is the best way to elicit the characteristic rage of the borderline person? According to Adler [46], this can be achieved by not playing a holding function (or by not playing it at a particular moment with the required intensity). Rage is the way the borderline patient responds to every fracture or even micro-fracture of empathy: rage emerges when the patient feels that the person in front of him or her is not willing to perform the function he or she is in desperate need of. Each affect that – as such – has an object, is intentional and motivated. In a state of rage, the object is clearly visible, strongly characterised and stands out very distinctively. Such an object is certainly far from being vague, blurred and confused, nor are its features

difficult to focalise. To get angry with someone (or with something) means to make the object present, to take it out of ambiguity and to delineate some of its features very clearly: these are negative features that work as "handles" to which rage clings to. In this sense, rage allows one to switch from the state of dispersion and "centrifugal force" typical of dysphoric mood (where the object's outlines and features are blurred, vague and ambiguous), to a condition in which the boundaries and characteristics of the object stand out with great clarity.

The rage-affect has a "centripetal" role: it coagulates emotional dispersion by identifying, in each occasion, an object/interlocutor. All those vague emotions that floated around in dysphoric mood converge and plunge on such an object. Now those emotions have an interlocutor – somebody (or something) who can be held accountable for what happens at that particular moment, but also for *everything* else that happened in the past – and the list of the unpaid debts is huge. This explains the violence with which the object is invested with rage and the feeling that, in each occasion, everything is at stake, as if it were a matter of life or death. Dysphoria turns into rage each time it can be directed towards a specific object that has been identified as the source and cause of one's suffering. In this sense, dysphoria resembles a widespread and unsaturated magmatic state in search of an object on which to converge. Instead of getting lost inside a dysphoric cloud, rage hunts out the object, forces it out of a state of vagueness, inconsistency and anonymity and turns it into the target of a sniper rifle. This is also how the clinicians and healthcare workers feel when they become the target of borderline rage: they feel loaded with an amount of responsibility that often exceeds their understanding and ability to endure.

b) Rage and hope

At some level, the expression of rage implies the existence of a dimension of hope. In other words, it implies the belief that under the blows of rage, the object, the environment, or reality itself can react and respond to the violence of the stimulus, thereby gaining the role it had never played or had lost. Rage, therefore, is not resignation or annihilating despair; rather, it is a desperate vital reaction that presupposes both an interlocutor to be held accountable and the possibility of a response. At the same time, rage also plays a defensive role with respect to the pain caused by the separation and the irreparability of the loss: a mind kept busy by angry fantasies somehow is still clinging to what it has lost.

c) Rage and the self

Rage makes the object present and allows a clear focalisation of it, but, at the same time, it consolidates and gives consistency to the self. As the rage-affect gains ground, the object of rage stands out as the true cause of pain, while the subject adopts a clear and consistent accusatory role towards such an object and focuses on what it perceives as its faults. At the same time, this unambiguous focalisation of the object gives the subject the chance to perceive his own self as cohesive and, to some extent, as powerful. From this point of view, rage clarifies things and gives them consistency: in this state, the person presumes to see things clearly and to know the reasons of his suffering. These reasons are identified in a precise object that is held responsible for his condition. The transition from dysphoria to rage contributes to preserving or recovering a precarious cohesion of the self. Edward Bunker [47], who spent most of his life in jail, describes how, when a man has no other identity left, the ability to arouse fear in the others succeeds at least in fulfilling his need for one. The chance to observe the effect of one's own rage on another person can contribute to the development of this sense of increased vitality and cohesion too. To the extent that I am able to scare others, I am and exist as an acting and powerful subject.

d) Rage and authenticity

Rage does not only clarify the outlines of the object and gives the illusion of having identified it as the source of all evil: it also reaches for the object, shakes it and subjects it to a great stress. This way, rage verifies the true nature of the object – it is a bit like when a child, smashing a new toy on the ground, tries to see how it is really made and what its true inner nature is. In a very similar way, borderline rage brings the object out of the shadow, opens it like a can opener would do and forcibly extracts its true nature. This is a sort of load test whose aim is to see how the object reacts under pressure and stress: it is a bit like what happens in those stress-tests made to test the soundness of banks. The intention here is to test the soundness of the other person, but also to lay bare the true features of him or her. As if only by putting people in a traumatic situation can one see how they really are. In order to see what the other person is made of and "bring the soul out of him" [48], the borderline patient needs to see the other bleeding. Touching on this issue, Stone [49] writes: "Borderline patients reduce us to our final human common denominator". They force us to go beyond our defensive asset in order to see what we are really made of, what we are as people. In a way, they peel us like onions.

Conclusions

In conclusion, we can say that while dysphoria is characterised by a mood condition where the subject falls prey

to the mists of an all-pervasive and all-assimilating mood (a mood that absorbs both the subject and the other), rage as an affect leads to a clarification of the situation: the object emerges as what is responsible for one's suffering and the self gains cohesion by facing such object. In this sense, rage helps to dispel the fog and allows to better focalise both oneself and the other.

Borderline emotional functioning seems to be rooted in the need to modulate the vagueness of dysphoric mood (a mood that envelops the person like a *crust*, influencing his vision of the world, his perception of the self, the others and his relationships), and to avoid this condition by focusing its emotions on an affect (rage) that identifies, from time to time, an object to be held responsible. The borderline existence, therefore, is in constant search, in the context of its relationships, for an object to be held accountable – which means accountable *for everything*. In a temporality dominated by the absorption in the immediacy [50 51], where only the present moment counts, the transformation of dysphoria into rage always gives the patient the illusion that the tangle of relationships which the borderline subject has always inhabited (perhaps starting with a traumatic childhood) has been unravelled. Years ago, Akiskal argued – a bit cynically – that "borderline" was an adjective in search of a name. A few decades later, we can rather say that to be a borderline means to experience a condition of "being obliged to be", tormented by a *mood in constant search for an affect*, in the vain attempt to get rid of a bad mood that comes from far away.

Conflict of interest

None.

References

1 Clarkin JF, Hull JW, Hurt SW. *Factor structure of borderline personality disorder criteria.* J Pers Disord 1993;7:137-43.

2 Sherwood V, Cohen CP. *Psychotherapy of the Quiet Borderline Patient: The as-if Personality Revisited*. New York: Aronson, 1994.

3 Fonagy P, Target M, editors. *Attaccamento e funzione riflessiva*. Milano: Raffaello Cortina 2000.

4 Schneider K. *Klinische psychopathologie*. Stuttgart: Georg Thieme 1950.

5 Lewis G, Appleby L *Personality disorder: the patients psychiatrists dislike.* Br J Psychiatry 1988;153:44-9.

6 Markham D. *Attitudes towards patients with a diagnosis of "borderline personality disorder": Social rejection and dangerousness*. J Ment Health 2003;12:595-612.

7 Bodner E, Cohen-Fridel S, Iancu I. *Staff attitudes toward patients with borderline personality disorder.* Comprehensive Psychiatry 2011;52:548-55.

8 James PD and Cowman S. *Psychiatric nurses' knowledge, experience and attitudes toward clients with borderline personality disorder*. J Psychiatr Ment Health Nurs 2007;14:670-8.

9 Koehne K,Sands N. *Borderline personality disorder an overview for emergency clinician*s. Australasian Emergency Nursing Journal 2008;11:173-7.

10 Woollaston K, Hixenbaugh P. *"Destructive Whirlwind": nurses' perceptions of patients diagnosed with borderline personality disorder*. J Psychiatr Menta Health Nurs 2008;15:703-9.

11 Giannouli H, Perogamvros L, Berk A, et al. *Attitudes, knowledge and experience of nurses working in psychiatric hospitals in Grece, regarding borderline personality disorder: a comparative study*. J Psychiatr Ment Health Nurs 2009;16:481-487.

12 Rizq R. *There's always this sense of failure': an interpretative phenomenological analysis of primary care counsellors' experiences of working with the borderline client.* Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community 2012; 26,1: 31-54.

13 Woollaston K, Hixenbaugh P. *"Destructive Whirlwind": nurses' perceptions of patients diagnosed with borderline personality disorder.* J Psychiatr Ment Health Nurs 2008;15:703-9.

14 Fertuck EA, Jekal A, Song I, et al. *Enhanced "reading the mind in eyes" in borderline personality disorder compared to healthy controls*. Psychol Med 2009;39:1979-88.

15 Goodman M, Hazlett EA, New AS ,et al. *Quieting the affective storm of borderline personality disorder*. Am J Psychiatry 2009;166:522-8.

16 Clifton A, Pilkonis PA. *Evidence for a single latent class of diagnostic and statistical manual of mental disorders borderline personality pathology.* Compr Psychiat 2007;48:70-8.

17 Nagel T. *What Is It Like to Be a Bat?* The Philosophical Review 1974; 83, 4:435-450.

18 Glenn CR, Klonsky ED. *Emotion dysregulation as a core feature of borderline personality disorder*. J Pers Disord 2009;23:20-8.

19 Cole PM, llera SJ, Pemberton CK. *Emotional instability, poor emotional awareness, and the development of borderline personality*. Dev Psychopathol 2009;21:1293-1310.

20 Koenisberg HW *Affective instability: toward an integration of neuroscience and psychological perspectives*. J Pers Disord 2010;24:60-82.

21 Goodman M, Hazlett EA, New AS , et al. *Quieting the affective storm of borderline personality disorder*. Am J Psychiatry 2009;166:522-8.

22 Pazzagli A, Rossi Monti M. *Dysphoria and aloneness in borderline personality disorder*. Psychopathology 2000;33:220-6.

23 Stanghellini G, Rosfort R. *Emotions and personhood. Exploring fragility, making sense of vulnerability*. Oxford: Oxford University Press 2013a.

24 Stanghellini G, Rosfort R. *Borderline depression: a desperate vitality*. J Conscious Stud 2013;20:153-77.

[25] Henry C, Mitropoulou V, New A, et al. *Affective instability in BPDP and bipolar II disorders: similarities and differences*. J Psychiatric Research 2001;35:307-12.

[26] Berner P, Musalek M, Walter H. *Psychopathological concepts of dysphoria*. Psychopathology 1987;20:93-100.

[27] Stanghellini G. *The doublets of anger*. Psychopathology 2000;33:155-8.

[28] Stanghellini G. *Dysphoria, vulnerability and identity*. Psychopathology 2000;33:198-20.

[29] Voruganti L, Awad AG. *Neurolpetic dysphoria: towards a new synthesis*. Psychopharmacology 2004;171:121-32.

[30] Cella M, Cooper A, Dymond S, et al. *The relationship between dysphoria and proneness to hallucination and delusions among young adults*. Compr Psychiatry 2008;49:544-50.

[31] Melville H. *The whale*. London: Richard Bentley 1851.

[32] Zanarini MC, Frankenburg FR, Hennen J, et al. *The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder*. Am J Psychiatry 2003;160:274-83.

[33] Wilkinson-Ryan T, Westen D. *Identity disturbance in borderline personality disorder: an empirical investigation*. Am J Psychiatry 2000;157:528-41.

[34] Clarkin JF, Hull JW, Hurt SW. *Factor structure of borderline personality disorder criteria*. J Pers Disord 1993;7:137-43.

[35] Goodman M, Hazlett EA, New AS , et al. *Quieting the affective storm of borderline personality disorder*. Am J Psychiatry 2009;166:522-8.

[36] Starcevic V. *Dysphoric about dysphoria: towards a greater conceptual clarity of the term*. Australasian Psychiatry 2007;1:9-13.

[37] Westen D. *Cognitive-behavioral interventions in the psychoanalytic psychotherapy of borderline personality*. Clin Psychol Rev 1991;11:211-30.

[38] Korner A, Gerull F, Meares R, et al. *The nothing that is something: core dysphoria as the central feature of borderline personality disorder implication for treatment*. Am J Psychotherapy 2008;4:377-94.

[39] Cole PM, llera SJ, Pemberton CK. *Emotional instability, poor emotional awareness, and the development of borderline personality*. Dev Psychopathol 2009;21:1293-1310.

[40] Fusilli A. Personal communication 2008.

[41] Searles H. *My Work With Borderline Patients*. New York: Aronson 1994.

[42] Rossi Monti M, D'Agostino A. *Autolesionismo*. Roma: Carocci 2009.

[43] Lemma A. *Under the skin. A psychoanalytic study of body modification*. London: Routledge 2010.

[44] Kernberg O. *Aggression in personality disorders and perversion*. New Haven, London: Yale University Press 1992.

[45] Kernberg O. *Aggression, trauma and hatred in the treatment of borderline patients*. In: *Borderline personality disorder*. Psychiatr Clin North Am 1994;17:701-14.

[46] Adler G. *Borderline psychopathology and its treatment*. New York: Aronson 1994.

[47] Bunker E. (1973) *No beast so fierce*. Harpenden: No exit, 2004.

[48] Correale A. *Borderline: il mondo capovolto*. Convegno SIP - Regione Marche, *Quale modello regionale nelle politiche di salute mentale,* Urbino, 4 febbraio 2011.

[49] Stone MH. *Treatment of borderline patients: a pragmatic approach*. Psychiatr Clin North Am 1990;13:265-85.

[50] Kimura B. *Ecrits de Psychopathologie Phénoménologique*. Paris: PUF 1992.

[51] Fuchs T. *Fragmented selves: temporality and identity in borderline personality disorder*. Psychopathology 2007;40:379-87.

Psychopathology of eating disorders

G. Castellini[1,2], F.Trisolini[3]; V. Ricca[1]

1 Department of Neuroscience, Psychology, Drug Research and Child Health. University of Florence, Italy; 2 Sexual Medicine and Andrology Unit, Department of Experimental, Clinical and Biomedical Sciences, University of Florence, Italy; 3 DiSPUTer – "G. d'Annunzio" University of Chieti, Italy

Summary

Eating disorders are severe psychiatric syndromes that most likely result from, and sustained by, sociocultural, psychological and biological factors. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Feeding and Eating Disorders encompass three main diagnoses, namely anorexia nervosa, bulimia nervosa, and binge eating disorder. However, the collection of disturbances of eating attitudes and behaviours includes several other conditions such as pica, rumination disorder, purging disorder, atypical anorexia and bulimia nervosa, subthreshold binge eating disorder and night eating syndrome.

In a trans-diagnostic perspective, all these conditions underscore key similarities across the eating disorders, including dietary restraint, binge eating, compensatory purging, body checking and weight preoccupation. There is a general agreement on considering behavioural anomalies – which are required for DSM diagnosis – as secondary epiphenomena to a more profound psychopathological core, defined by excessive concerns about body shape and weight. In particular, patients with eating disorders overvalue their body shape and weight. Furthermore, the body image disturbance has been associated with a more profound disturbance consisting in disorders of the way persons experience their own body and shape their personal identity. In other words, whereas most people evaluate and define themselves on the basis of the way they perceive their performance in various domains, patients with eating disorders judge their self-worth largely, or even exclusively, in terms of their shape and weight and their ability to control them.

According with a phenomenological perspective, the core dimension of the disease of subjects with proneness to eating disorder behaviours also encompasses the perception of space, as well as the subjective experience of time. Several behaviours and cognitive distortion can be derived from a basic sense of spatial metamorphosis that is deeply associated with the disorder of corporeality. In the same way, the subjective perception of time in eating disorder patients appears to be connected with the temporal discontinuity of the representation of one's own body, and the need of predictability of one's own life, which is achieved/failed according to control of eating and weight.

The psychopathological core, rather than behavioural abnormalities, plays a crucial role in the onset and persistence of these disorders. Indeed, it has been associated with different responses to psychological treatment in several reports, and some authors have pointed out that the threshold to define the full recovery process might be body shame, appearance schemas and thin-ideal internalisation. Therefore, these may be fruitful targets of intervention among those on a recovery trajectory.

In line with this perspective, a comprehensive assessment of a person with EDs should include: the way of perceiving once own body and the lived corporeality, the significance of the illness and the body in the inter-subjective interactions as well as the identity definition, the space perception and the way of experiencing time associated with several EDs features (such as binge eating, weight control).

Key words

Eating disorders • Lived corporeality • Identity • Lived-body-for-others • Spatial metamorphosis • Perceived temporality

Introduction

Eating disorders (EDs) are severe psychiatric syndromes characterised by a persistent disturbance of eating or eating-related behaviours that result in the altered consumption or absorption of food and that significantly impair physical health or psychosocial functioning. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the Feeding and Eating Disorders category encompasses pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa and binge-eating disorder. However, the *constellation* of the disturbances of eating attitudes and behaviours includes several other conditions such as purging disorder, atypical anorexia and bulimia nervosa, sub-threshold binge eating disorder and night eating syndrome. According to a trans-diagnostic perspective, all these conditions underscore the same distinctive psychopathology, and patients move between these diagnostic states over time (diagnostic crossover) [1 2].

Correspondence
G. Castellini, Department of Neuroscience, Psychology, Drug Research and Child Health, Sexual Medicine and Andrology Unit, Department of Experimental, Clinical and Biomedical Sciences, University of Florence, Italy • E-mail: giovannicastellini78@hotmail.com

Furthermore, empirical studies have demonstrated that both typical and subthreshold EDs share the same clinical features, including dietary restraint, binge eating, compensatory purging, body checking and weight preoccupation. Taken together, these observations suggest that common mechanisms are involved in the persistence of all EDs [3].

In line with this position, there is general agreement on considering behavioural anomalies – which are required for DSM diagnosis – as secondary epiphenomena to a more profound psychopathological core. For example, according to the cognitive behavioural theory the overevaluation of eating, shape and weight and their control is considered the primary psychopathological phenomenon, and most of other clinical features can be understood as stemming directly from it, including the extreme weight-control behaviours,persistent attempts to restrict food intake, self-induced vomiting, misuse of laxatives and diuretics, over-exercising, various forms of body checking and avoidance, and preoccupation with thoughts about eating, shape and weight [3 4].

According to a phenomenological position, the core psychopathological features represented by shape and weight concerns are the result of a more profound disturbance of the way persons with EDs experience their own body (embodiment) and shape their personal identity, assuming that the various kinds of anomalous eating behaviour are a consequence thereof. In line with this perspective, a comprehensive assessment of a person with EDs should overcome the merely behavioural assessment required for a DSM diagnosis, and it should include the general way of perceiving one's own body and the lived corporeality. Moreover, clinicians should evaluate the consequences of this core dimension on other domains of the patient's life, such as the significance of the illness and the body in the inter-subjective interactions as well as identity definition, space perception and the way of experiencing time associated with several features of EDs (such as binge eating, weight control). Indeed, several behaviours and cognitive distortion often taken into account by the psychiatric and cognitive literature can be derived from a basic sense of spatial metamorphosis that is deeply associated with the disorder of corporeality. In the same way, the subjective perception of time in ED patients appears to be connected with the temporal discontinuity of the representation of one's own body, and the need of predictability of one's own life, which is achieved/failed according to control of eating and weight.

An accurate psychopathological assessment in EDs is crucial from a clinical point of view for several reasons. At first, psychopathology allows definition of a qualitative threshold along a continuum of severity, discriminating healthy subjects from high risk persons with abnormal eating behaviours in the general population, and non-clinical persons with abnormal eating behaviours from EDs in a clinical setting. Furthermore, the core features of EDs have been associated with different responses to psychological treatments and a different course of illness [5-8]. In other words, while diagnoses do not seem to represent adequate outcome predictors, psychopathological dimensions identify subpopulations of persons with EDs with different trajectories across time, and therefore different maintaining factors and pathogenic mechanisms.

The present chapter is aimed at providing a comprehensive description of the main psychopathological dimensions that can be affected in subjects with proneness to EDs. Our attempt is to overcome the simplistic behavioural assessment suggested by the DSM, and some of the constructs of the cognitive literature, and to focus on the subjective perception of body, space and time, as well as on the sensation of control/loss of control which underlies several pathological eating behaviours.

Body

Several studies have demonstrated the importance of concerns related to the body (e.g. shape, weight) in determining a different course of patients with EDs, in terms of response to treatment and long-term outcome. Patients with EDs typically overvalue their body shape and weight, and body image disturbances may be the key to distinguish between partially and fully recovered individuals and a healthier relationship with one's body may be the final hurdle in recovery [9].

In particular, it has been suggested that *body image distortion* – defined as "a disturbance in the way in which one's body weight or shape is experienced" [10] – represents a specific trait of EDs , which allows distinguishing between affected EDs patients and normal subjects across a continuum of severity of several psychopathological domains, including the influence of body weight or shape on self-evaluation, and the tendency to control body weight. It is considered as a multidimensional pattern, which includes cognitive and affective components (concerns and feelings about the body), perception (estimation of body size) and behaviours related to the own body perception [11].

In many cases, the term *body image* has been adopted in a rather unspecific manner, including different psychological and neurocognitive domains. For a more accurate psychopathological definition, it is important to distinguish between different dimensions of embodiment, such as *body schema*, *body image* and *lived body*, although no consensus concerning terminology has yet emerged [12]. The concept of *body image* should be clearly differentiated from *body schema*, which is "a system of sensory-motor capacities that function without awareness or the necessity of perceptual monitoring" [12]. Ac-

cording to Head [13], the *body schema* is a model/representation of one's own body that constitutes a standard along which postures and body movements are judged. This representation can be considered the result of comparisons and integration at the cortical level of past sensory experiences (postural, tactile, visual, kinaesthetic and vestibular) with current sensations. This gives rise to an almost completely unconscious "plastic" reference model that makes it possible to move easily in space and to recognise the parts of one's own body in all situations. According to Schilder [14], the body image can be defined as "the picture of our own body which we form in our mind, that is to say, the way in which the body appears to ourselves". Allamani and Allegranzi [15] refer to *body image* as "a complex psychological organization which develops through the bodily experience of an individual and affects both the schema of behaviour and a fundamental nucleus of self-image". A third concept, namely *lived body*, is taken from phenomenology and addresses the body experienced from within, my own direct experience of my body in the first-person perspective, myself as a spatiotemporal embodied agent in the world [16-20]. In a phenomenological perspective, the layer of cenesthetic sensations is the prerogative of the lived body as the immediate experience of one's body, and not a representation of it (as the case with "body image") [21].

Since the beginning of the 20th century, phenomenology has developed a distinction between lived body (*Leib*) and physical body (*Koerper*), or between body-subject and body-object. The first is the body experienced from within, my own direct experience of my body in the first-person perspective, myself as a spatiotemporal embodied agent in the world; the second is the body thematically investigated from without, as for example by natural sciences as anatomy and physiology, a third-person perspective [16 17]. One's own body can be apprehended by a person in the first-person perspective as the body-I-am. This is the cenesthetic apprehension of one's own body, the primitive experience of oneself, the basic form of self-awareness, or the direct, unmediated experience of one's own "facticity", including oneself as "this" body, its form, height, weight and colour, as well as one's past and what is actually happening. First and foremost, we have an implicit acquaintance with our own body from the first-person perspective. The lived body turns into a physical, objective body whenever we become aware of it in a disturbing way. Whenever our movement is somehow impeded or disrupted, then the lived body is thrown back on itself, materialised or "corporealised". It becomes an object for me. Having been a living bodily being before, I now realise that I have a material (impeding, clumsy, vulnerable, finite, etc.) body [22].

Anomalies with embodiment have already been posited as central domains of several mental disorders, including schizophrenia [19 23], manic-depressive disorders [22] and body dysmorphic disorder [24]. Abnormal attitudes toward one's own corporeality, and difficulties in the definition of one's own identity, have been proposed as the core features of these disorders. EDs are affected by disturbances of the way people experience their own body (embodiment). In subjects with a proneness to pathological eating behaviours, the body is no longer the essential experience of the being-in-the-world, but the world becomes the field to play the game to define their own identity. The body becomes the means to get in touch with their own emotions. Accordingly, these are sentences often reported by EDs patients: "*Having my weight under control makes me feel in control of my emotional states*"; "*If my measurements remain the same over time I feel that I am myself, if not I feel I am getting lost*".

From a neurobiological perspective, brain activation in response to the view of one's own body involves extensive circuitry including dorsolateral prefrontal, supplementary motor, insular, inferior parietal (representation of one's own body schema), fusiform (human face recognition process), occipito-temporal (the so called "extrastriate body area") and cingulate regions. Moreover, body image distortion has been associated with a specific activation pattern that includes the inferior parietal lobule and the dorsolateral prefrontal cortex (DLPFC) [25]. The DLPFC represents an intriguing neurobiological correlate for psychopathological domains, given the functions associated with this brain region. It is part of cortico-striatal loops, which contribute not only to executive functions but also to the regulation of emotional impulses mediated by limbic and paralimbic structures [26], by means of enhancing the tendency of individuals to suppress aversive emotional states [27]. Furthermore, it may represent the biological underpinning of the link between body image and identity disturbance in EDs. Indeed, the DLPFC has long been considered a key component of a network subserving awareness of self and metacognitive evaluation of the self [28 29]. Therefore, in EDs specific activation of DLPFC in response to body image distortion tasks could suggest that the oversized body stimuli can be considered highly relevant for self-evaluation [30].

Identity

There is a general agreement to consider the maintenance EDs as based on a dysfunctional system for evaluating self-worth. Whereas most people evaluate themselves on the basis of their perceived performance in a variety of domains of life (e.g. the quality of their relationships, work, parenting, sporting ability, etc.), people with EDs judge themselves largely, or even exclusively, in terms of their eating habits, shape or weight and their ability to control them [3].

From a cognitive point of view, the self-concept is de-

fined as a set of knowledge structures about the self that originates from the cognitive products of the person's interaction with the social world. These aspects are important for development of self-schemas that shape the individual's social interactions [31 32]. The literature in this field has provided two main constructs pertaining one's own identity, which have been proposed as maintaining factors of EDs: severe clinical perfectionism, and core low self-esteem [33]. Clinical perfectionism is a system for self-evaluation in which self-worth is judged largely on the basis of striving to achieve demanding goals and success at meeting them [34]. Perfectionism is well-known to be frequently observed in patients with ED [34 35]. There is often an interaction between the two forms of psychopathology with the patient's perfectionist standards being applied to the attempts to control eating, shape and weight, as well as other aspects of life (e.g. performance at work or sport) [3]. Regarding the core of low self-esteem, most of patients with ED have an unconditional and pervasive negative view of themselves that is seen as part of their permanent identity. These patients show particularly pronounced negative cognitive processing biases, coupled with over-generalisation, with the result that any perceived "failure" is interpreted as confirmation that they are failures as people thereby reaffirming their overall negative view of themselves [36].

Moreover, in a psychodynamic perspective, impairments in overall identity development and the failure to establish multiple and diverse domains of self-definition have been considered the core pathoplastic mechanism of EDs [37-41]. In particular, Bruch [37] suggested that the dissatisfaction and preoccupation with body image that characterises persons with EDs reflect a maladaptive "search for selfhood and a self-respecting identity". Accordingly, the basis for the development of the sense of a core subjective self is represented for Stern [42] by the interaction between mother and infant in sharing affective states and experiences. Feeding represents a vital activity for the construction of the self since it serves as a framing environment and allows face-to-face contact with the caregiver via the phenomenon of *affective attunement* [42], an essential step toward the development of a narrative self and a sense of identity.

Stanghellini et al. [43] provided a phenomenological interpretation of the core psychopathology of EDs based on a disturbance of self-identity. According to this hypothesis, in persons with EDs the disturbance of the experience of one's own body is interconnected with the process of shaping their personal identity. As stated, the cenesthetic apprehension of one's own body is the more primitive and basic form of self-awareness, and patients with EDs often report – with different extents of insight – their difficulties in perceiving their emotions and that do not "feel" themselves [38-41]. Indeed, *feeling oneself* is a basic requirement to achieve an identity and a stable sense of one's self [21]. Therefore, for persons prone to symptomatology of EDs, the identity is no longer a real psychic structure that persists beyond the flow of time and circumstances. The experience of not feeling own body and emotions involves the whole sense of identity. This causes us to deprive ourselves of our existence as a being-for-itself and instead learn to falsely self-identify as a being-in-itself [44]. Therefore, there is the need to resort to one's own body weight as a viable source of definition of the self, as patients often report: "*Sometimes, the emotions I feel are extraneous to me and scare me*"; "*I see myself out of focus, I don't feel myself*".

From an empirical point of view, the relationships between abnormal eating behaviour and self-construct or identity in EDs has already been investigated [45]. For example, Nordbø documented that anorectic persons may explain their behaviour as a tool for achieving a new identity. Skarderud [46 47] showed that for some persons with ED, changing one's body is a tool to become another. They want to change, and changing one's body serves as both a concrete and a symbolic tool for such ambitions. Thus, shaping oneself is a "concretised metaphor", establishing equivalence between a psychic reality (identity) and a physical one (one's body shape). As suggested by Surgenor et al. [48], looking into the different ways persons with ED construe their own self, especially in relation to their disorder and therapy, has strategic implications for the therapeutic endeavour.

Recently, based on theoretical background, a questionnaire named IDEA (IDentity and EAting disorders) assessing abnormalities in lived corporeality, and of personal identity has been validated [43]. The questionnaire was developed based on the following conceptual areas: feeling oneself through the gaze of the other, defining oneself through the evaluation of the other, feeling oneself through objective measures, feeling extraneous from one's own body, feeling oneself through starvation, defining one's identity through one's own body, feeling oneself through physical activity and fatigue. Theoretically, the questionnaire assumed that most pathological eating behaviours and features are a consequence of the severity of abnormal bodily experiences and identity disorders. The questionnaire was administered to a sample of women with EDs. The validation process considered four subscales, namely *feeling oneself through the gaze of the other* and *defining oneself through the evaluation of the other*, *feeling oneself through objective measures*, *feeling extraneous from one's own body* and *feeling oneself through starvation*. The authors demonstrated that the questionnaire is able to identify important psychopathological phenomena that are closely related to the specific anomalies of patients with EDs measured with commonly-adopted psychometric instruments. In par-

ticular, the subscales showed a different pattern of association with the features of EDs. *Feeling oneself through the gaze of the other and defining oneself through the evaluation of the other* was associated with overvalued thoughts regarding body shape. A measure of alienation from one's own body and emotions, and *feeling extraneous from one's own body* significantly correlated with concerns about weight and body shape. Finally, *feeling oneself through objective measures* and *feeling oneself through starvation* were associated with overvalued thoughts regarding weight and eating concerns and with dietary restriction, respectively. In line with these results and with the phenomenological perspective, some characteristic ED behaviours, such as starvation and the fixated checking of objective measures, might be interpreted as an alternative coping strategy aimed to feel oneself for those patients who are unable to feel themselves cenesthetically.

These results were confirmed for patients reporting anorexia nervosa, bulimia nervosa and binge eating disorder [43]. Moreover, it was also applied beyond the boundaries of the DSM diagnostic categories, and abnormal bodily experiences were observed not just for "over-threshold" ED patients. First of all, it was tested in a large population of university students who did not suffer from EDs [21]. IDEA appeared to be able to identify vulnerability in subjects without full-blown EDs but with abnormal eating patterns. Moreover, the questionnaire provides a numerical threshold to discriminate clinical vs. non-clinical populations. Indeed, in people who develop clinically relevant EDs, extraneousness from one' own body is a phenomenon that is significantly more manifest and penetrant than in people who display over-threshold, but non full-blown abnormal eating patterns. This could represent the first step to demonstrate that IDEA is able to identify candidate experiential intermediate phenotypes that express a gradient of vulnerability from healthy to clinical persons with EDs.

Finally, the questionnaire was applied to morbidly obese patients, which is a population at high risk of developing EDs behaviours [49]. The vulnerability to EDs behaviours such as binge eating appeared to be associated with abnormal bodily experiences in a dimensional pattern. Moreover, abnormal bodily experiences measured by IDEA represent the psychological underpinning of the relationship between binge eating behaviours and impulsivity, which has been frequently associated with such behaviours. A mediation model clarified that not impulsivity in itself, but the presence of impulsivity in persons affected by abnormal bodily experiences, may lead to ED psychopathology and abnormal eating behaviours. Authors concluded that the disturbance in the lived corporeality may represent the core vulnerability trait that is one of the psychological characteristics underlying the association between personality traits such as impulsivity and the development of eating disorders features.

The other

Clinicians often report that EDs patients define themselves by the gaze of other persons: "*For me it's very important to see myself through the eyes of the others*"; "*The way I feel depends on the way I feel looked at by the others*"; "*Sometimes I focalize myself through the gaze of the others*".

As previously stated, a specific alteration of lived corporeality can be detected in patients with EDs, and represents the psychopathological dimension underpinning the commonly observed body image disturbance. More specifically, persons with proneness to the symptoms of EDs showed a predominance of one dimension of embodiment, namely *the lived-body-for-others,* which is a concept proposed by Sartre [44]. In addition to the body-subject and body-object dimensions of corporeality, Sartre emphasised that one can apprehend one's own body even from another point of view, as one's own body when it is looked at by another person. This further step of self-representation happens when people realise that their own body can be observed by other persons, and therefore it can be an object for the others. When persons become aware that they, or their own body, is looked at by another person, they realise that their body can be an object for that person. "With the appearance of the Other's look", writes Sartre, "I experience the revelation of my being-as-object". The upshot of this is a feeling of "having my being outside (…) [the feeling] of being an object". Thus, one's identity becomes reified by the gaze of the other, and reduced to the external appearance of one's own body. Therefore, the lived body is no longer direct, first-personal experiential evidence, but it is an entity that exists as viewed from an external perspective [43]. This means that the other becomes the mirror in which one can perceive oneself.

Persons with EDs experience their own body first and foremost as an object being looked at by another, rather than cenesthetically, or from a first-person perspective. Therefore, the comprehension of the profound uneasiness of lived corporeality of EDs – leading to the sense of alienation from one's own body and from one's own emotions - should be integrated with an exaggerated concern to take responsibility for the way one appears to the others, as well as the possibility to feel oneself only through the gaze of the others, through objective measures and through self-starvation [21]. This interpretation overcomes the general position of the *alloplastic personality* frequently observed in subjects with EDs. According to this perspective, for persons with EDs the other is no longer an interlocutor with which to engage an in-

tersubjective co-creativity relationship, but it is the one who confirms my existence, my being-in-the-world. The gaze of the other becomes the unique way through which we are aware of our own presence. It is as the mirror in which to see themselves and to feel themselves [21].

Space

Patients with EDs with a severe clinical condition often have been reported to say: "*I cannot step through the door*". "*I take a lot of space when I'm in a room*", "*My body does not enter into my clothes*". These kinds of sentences are often generically attributed to *body image distortion* phenomenon. Furthermore, clinicians generally attribute to *body image distortion* most of the *checking* behaviours of those with EDs. Indeed, individuals with EDs perform repetitive, often time-consuming, and compulsive behaviours such as long hours of lifting weights, excessive mirror checking or avoidance, comparing one's appearance with that of others, seeking reassurance about the perceived weight fluctuation, skin picking, camouflaging the perceived changes of the space they feel to occupy (e.g. with hair, makeup, body position, or clothing), frequent clothes changing and frequent body measuring. Although the goal of such behaviours is to diminish the anxiety provoked by the body image concerns, these behaviours often increase and maintain anxiety.

The mentioned behaviours and cognitive distortions can be interpreted in the light of the disorder of the lived body which leads to a kind of *spatial metamorphosis*. This position might overcome the neurocognitive literature on the complex relationship between the *body schema* and the *body image*. From the cognitive perspective, it has been extensively noticed that changes in *body schema* affect spatial perception and perception of objects. Exercise, dance and other practices that affect motility and postural schema have an effect on the emotive evaluation of one's own *body image*. Furthermore, subjects who improve in neuromuscular coordination, strength and endurance by means of exercise, or experience increased coordination, balance, agility and improved posture, gain a perception of body competence and achieve a higher degree of satisfaction with their own bodies. Thus, changes in *body schema* associated with exercise alter the way that subjects emotionally relate to and perceive their bodies. On the basis of these observations, Gallagher [12] argued that performances of the *body schema* may place constraints on intentional consciousness, and suggested that changes in various aspects of *body schema* have an effect on the way subjects perceive their own bodies, that is, changes in *body schema* lead to changes in *body images*. The neurobiological substrate of disorder associated alterations in body schema are essentially localised in the parietal-occipital region [50], which, besides EDs, have been proposed for body dysmorphic disorder and neurological disorders, including interparietal syndrome, Gertsmanís syndrome, inferoparietal syndrome, phantom limb syndrome, genital retraction syndrome, panencephalitis, cerebrovascular syndromes and pharyngeal streptococcia affecting the basal ganglia. An interdependence between cerebral regions through integrated neural networks enables efficient processing of information. Disturbances in these association pathways can lead to an imbalance in the extensive cerebral loops.

However, as previously reported, it is clear that the disturbance of of body image in EDs cannot simply be ascertained from a somato-sensorial alteration, or a failing of the integration of somatic sensations at different levels. Since 1893, Bonnier [51] rejected the idea that the meaning of one's body is simply the sum of somatic sensations arising from it. He proposed that the space is the unifying element to define the various somatic and visceral sensations. Therefore, the mental representation of one's body is firstly a spatial representation. In this model, the *body schema* is the mental representation of topography that allows us to first know the space we occupy and that allows us the orientation with respect to the external environment and the various parts of our body. For Lhermitte, [52] body image exists upstream as a necessary condition for every sensation, perception and even action. The representation of one's own body is for the author simultaneously a current image, subject to continuous modifications by sensory afferents and a memory image linked to past experiences.

Fisher and Cleveland [53] address the issue of body image primarily in terms of *bodily boundaries*, and the body helps to create a sense of individuality in each of us, especially in terms of space. Generally speaking, body image boundaries coincide with those of the physical surface of the body. In the first months of life, body boundaries are confined within it, because the life experiences in this period relate mainly to the mouth and digestive tract. With growth, they move closer to the body surface and only in adulthood is an acceptable match reached between the boundaries of body image and physical surface of the body.

According with the identity disturbance of EDs, we can expand the disorder of lived corporeality in terms of *space occupied by the body*. Therefore, persons with EDs report an extreme polarisation of the continuum represented by the sentence: "*I am the space that my body occupies*". A psychological assessment should take into consideration the meaning for the perceived spatial metamorphosis often reported by persons with EDs, in the light of the disorder of their lived corporeality. For all of us, our body represents the boundary from the rest of the word. The body forms the dividing line with the outside,

the limit that encloses its *ipseity* distinguishing it from the external environment. A healthy person would perceive this limit, represented mainly by body surface area, as extremely impervious to the inside (towards what is most intimate inner-body) and how patent towards the outside (like a door that opens onto the world) [54].

For persons with EDs, spatiality loses the anthropological feature with whom "*I'm in the skin of my body*". Being in this sense does not means being "here" or "there" (the basic form of self-experience - sense of existing as a subject of awareness – rooted in one bodily experience), but just being "here" where I occupy a place, a space. Thus, the space become smaller, and becomes too tight to contain my body.

Time

Merleau-Ponty [17] dedicates one of the most important parts of his lecture about the lived body (*leib*) to be considered as "*belonging to the world, being in the world temporality committed*". He focuses on the temporal dimension since the structure of the world is the temporality, following the approach of Husserl's consciousness of inner time. In this sense, the primary contact with the world is the so-called field of presence, the *leib* with its own temporality, in which all our actions take place.

Every human experience is configured on experience of time. Indeed, the stream of consciousness comprises an ensemble of experiences that is unified both at any given time and over time. The temporal continuity of the representation of the body is altered in patients with EDs. Time is no longer intentionality, and therefore it cannot be a way for being with the other in a simultaneity or in a succession temporality.

First of all, patients with EDs always report the feeling that the body can change continuously. Time is reduced to a mere control function, and in particular to be employed in control and/or loss of control of weight and eating – in other words to monitoring one's own body over time. For example, EDs patients have been observed to report: "*I spend most of the time before the mirror to control my body*", or "*the perception of time depends on body control. My body is under control all the times. I fail, at times, miserably and at times I am successful, but I would like to be successful all the time*", "*One morning I feel my thighs fit perfectly in my pants, another morning instead they have become huge*".

Clinicians should always take into consideration the situational and temporal variations of body image experiences within individuals with EDs. Specific situations or events activate patients' thoughts and emotions, while at other times these body image experiences are either absent or much more benign. Cash and Pruzinsky [55] highlighted that *body image* must be considered as a fluid and dynamic person–situation interaction (or transaction), and it is of note that this fluid versus static issue has long permeated much of psychology, especially the domain of personality theory. In contrast to centralist (intrapersonal) and peripheralist (situational) perspectives, an interactionist view maintains that we must consider both the person and the situation if we are to understand the complexities of human behaviour. Understanding the dynamic interplay of *body image* and contextual events is crucial for the appreciation of body image fluidity in everyday life.

For example, there can be activating contexts such as a public party. Persons' beliefs entail self-evaluative social comparisons in which they look extremely fat, and they infer that others at the party notice how fat they are. Emotional consequences include feelings of socially based self-conscious anxiety and shame. The behavioural consequences include attempts to conceal their "offending" body shape by covering it or with restriction of social interactions. Diaries often used as a self-monitoring strategy of treatment can describe activators of body image dysphoria, and capture such prototypical and troublesome body image states. For the therapist and client alike, this is clinically useful in the process of beginning to understand the essentially scripted nature of the client's experiences, which are often replete with common themes (e.g. contextual similarities, underlying cognitive distortions and schemas, specific emotions and coping strategies) [55].

According to a qualitative analyses of the reports of patients, time appears to be subjectively perceived in a different way by persons with EDs. For example, considering some patients with bulimia nervosa, binge eating episode occur in a very short period of time as a breakdown in a context of continuous control of eating habits. The purging behaviour occurs as a way to regain the control. Binge eating episode patients report either binge eating occurring in a short period of time either binge eating days, during which they spend all the time eating sweet things or *craving* or *nibbing*. For both bulimia nervosa and binge eating episode patients, it is clear that the subjective perception of time during binge eating episodes is completely different compared with a normal time course. Patients often do not remember what they were doing, how long the episode lasted or even what they have eaten.

An approach that overcomes merely behavioural assessment is necessary in EDs as demonstrated by the difficulties of researchers in their attempt to operationalise the definition of *binge eating* with objective variables. The consumption of a large amount of food (an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances) or the temporal boundary to the episode (eating, in a discrete period of time; e.g. within any 2-h period),

have been deeply challenged from an empirical point of view [56]. Indeed, a binge eating episode is an experience that is both variable and subjective, and the proposed 'objective' criteria do not appear to be adequate to describe its complex phenomenology. Neither do they seem to have a real clinical utility as, for example, *subjective binge eating* (involving the same sense of loss of control but the consumption of a small to moderate amount of food) has been found to better predict the outcome of psychological treatments compared with objective episodes [2 57 58]. The persistence of subjective loss of control over eating – an effect that is probably underestimated by clinicians – may contribute to relapse, by decreasing self-efficacy and confidence in maintaining the changes achieved during treatment.

This kind of observations highlights the importance of using the *subjectiveness* of the experience to understand the phenomenology of pathological eating behaviours. A person's definition of a "large amount" of food as well as a "discrete period of time" is highly subjective and can be influenced by personal beliefs and rules, which can vary from day to day. From a qualitative point of view, the main dimension of a binge, for all clinical ED conditions (including binge/purging anorexia, bulimia nervosa and binge eating disorder), is based on a subjective experience of lack of control. This means that the episode exits on the basis of what a person thinks is *being under control*.

The subjective perception of time in persons with EDs appears to be interconnected with the construct of *control*. Time is perceived in different ways on the basis of the interchange of control/loss of control phases. From a cognitive perspective, *control* is mostly related to anxiety, and it has been conceptualised as anxious perception of low control over external threats and emotional reactions. Feeling control over a threat involves predicting the threat and also being able to respond to the threat in a way that reduces it and enhances the sense of personal competence and self-efficacy [59 61]. The dimension of control in EDs has also been sustained in the psychodynamic literature, especially for anorexia nervosa patients [62 63], who maintain a sense of control by continuous monitoring of eating and body weight and shape, and dietary restrictions. However, it has been observed that the perception of control does not pertain only to the domains of eating, body weight and image, and control is an ample and complex construct, linked not only to eating and body aspect but also to life in general [64-67]. Williams et al. [68] showed that individuals with any ED perceive a low degree of internal control and high external control exerted by family and society. Sassaroli et al. [61] showed that the construct of perceived low control is not involved only with dietary restriction, but that it is also is a core belief of the whole domain of ED. Accordingly, individuals with ED feel a pervasive perception of lack of control most of the time, which results as a continuous and strength resistance against an imminent threat. Thus, they commonly restrict their experience and focus on eating and body size to regain a feeling of control and achieve some degree of predictability in their life [61 68].

Conclusion

The phenomenological point of view on EDs considers the pathological eating behaviours as epiphenomena of a more profound disorder of lived corporeality and self-identity. In the same way, some of the cognitive distortions often associated with these disorders can also be derived from the main psychopathological dimensions, involving a sense of metamorphosis of space and a sense of time interconnected with the need of predictability. In line with this position, it has been suggested that the term "eating disorders" is referred to a merely behavioural definition. However, it is important to note that the behavioural characteristics defining diagnoses change across time, and provide scarce information on prognosis. Moreover, some cognitive constructs – frequently reported as maintaining factors of pathological eating behaviours - have been found to show a non-specific association with the pathology of EDs. Therefore, the search for core psychological dimensions could provide more specific and stable phenotypes, which would result more suitable both for clinicians and researchers.

Conflict of interest

None.

References

1 Tozzi F, Thornton LM, Klump KL, et al. *Symptom fluctuation in eating disorders: correlates of diagnostic crossover.* Am J Psychiatry 2005;162:732-40.

2 Castellini G, Lo Sauro C, Mannucci E, et al. *Diagnostic crossover and outcome predictors in eating disorders according to DSM-IV and DSM-V proposed criteria: a 6-year follow-up study.* Psychosom Med 2011;73:270-9.

3 Fairburn CG, Cooper Z, Shafran R. *Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment.* Behav Res Ther 2003;41:509-28.

4 Fairburn CG, Harrison PJ. *Eating disorders.* Lancet. 2003;361(9355):407-16.

5 Carter JC, Blackmore E, Sutandar-Pinnock K, et al. *Relapse in anorexia nervosa: a survival analysis.* Psychol Med 2004;34:671-9.

6 Loeb KL, Walsh BT, Lock J, et al. *Open trial of family-based treatment for full and partial anorexia nervosa in adolescence: evidence of successful dissemination.* J Am Acad Child Adolesc Psychiatry 2007;46:792-800.

7 Bardone-Cone AM, Joiner TE Jr, Crosby RD, et al. *Exam-*

ining a psychosocial interactive model of binge eating and vomiting in women with bulimia nervosa and subthreshold bulimia nervosa. Behav Res Ther 2008;46:887-94.

8 Ricca V, Castellini G, Lo Sauro C, et al. *Cognitive-behavioral therapy for threshold and subthreshold anorexia nervosa: a three-year follow-up study*. Psychother Psychosom 2010;79:238-48.

9 Bardone-Cone AM, Harney MB, Maldonado CR, et al. *Defining recovery from an eating disorder: Conceptualization, validation, and examination of psychosocial functioning and psychiatric comorbidity*. Behav Res Ther 2010;48:194-202.

10 American Psychiatric Association. *Diagnostic and statistical manual for mental disorders*. 4th ed. Washington, DC: American Psychiatric Press 1994.

11 Thompson JK, Heinberg LJ, Altabe M, et al. *Exacting beauty*. Washington, DC: American Psychological Association 1999.

12 Gallagher S. *How the body shapes the mind*. Oxford: Oxford University Press 2006.

13 Head, H. *Aphasia and kindred disorders of speech*. London: Cambridge University Press 1926.

14 Schilder P. *The image and appearance of the human body: studies in the constructive energies of the psyche*. New York: International Universities Press 1950.

15 Allamani A, Allegranzi P. *Immagine corporea: dimensioni e misure. Una ricerca clinica*. Archivio di Psicologia Neurologia Psichiatria 1990;2:171-95.

16 Husserl E. *Ideen zu einer reinen phaenomenologie und phaenomenologische philosophie. ii. phaenomenologische untersuchungen zur konstitution*. Den Haag: Nijhoff 1912-1915.

17 Merleau-Ponty M. *Phenomenology of perception*. 1940. Engl. Transl. by Colin Smith. New York: Humanities Press 1996.

18 Dillon MC. *Merleau-Ponty's ontology*. Evanston: Northwestern University Press 1997.

19 Stanghellini G. *Embodiment and schizophrenia*. World Psychiatry 2009;8:1-4.

20 Stanghellini G, Rosfort R. *Emotions and personhood. Exploring fragility. Making sense of vulnerability*. Oxford: Oxford University Press 2013.

21 Stanghellini G, Trisolini F, Castellini G, et al. *Is feeling extraneous from one's own body a core vulnerability feature in eating disorders?* Psychopathology 2014 Oct 22 [Epub ahead of print].

22 Fuchs T. *The phenomenology of shame, guilt and the body in body dysmorphic disorder and depression*. J Phenomenol Psychol 2002;33:223-43.

23 Stanghellini G. *Psicopatologia del senso comune*, Milano: Raffaello Cortina Editore 2008.

24 Morris KJ. *The phenomenology of body dysmorphic disorder: a Sartrean analysis*. In: Fulford KWM, Morris KJ, Sadler JZ, et al. editors. *Nature and narrative. An introduction to the new philosophy of psychiatry*. Oxford University Press 2003, pp. 171-85.

25 Pietrini F, Castellini G, Ricca V, et al. *Functional neuroimaging in anorexia nervosa: a clinical approach*. Eur Psychiatry 2011;26:176-82.

26 Lévesque J, Eugène F, Joannette Y, et al. *Neural Circuitry underlying voluntary suppression of sadness*. Biol Psychiatry 2003;53:502-10.

27 Miller EK, Cohen JD. *An integrative theory of prefrontal cortex function*. Annu Rev Neurosci 2001;24:167-202.

28 Johnson S, Baxter L, Wilder L, et al. *Neural correlates of self reflection*. Brain 2002;125:1808-14.

29 Schmitz TW, Kawahara-Baccus TN, Johnson SC. *Metacognitive evaluation, self-relevance, and the right prefrontal cortex*. Neuroimage 2004;22:941-7.

30 Castellini G, Polito C, Bolognesi E, et al. *Looking at my body. Similarities and differences between anorexia nervosa patients and controls in body image visual processing*. Eur Psychiatry 2013;28:427-35.

31 Markus H. *Self-schemata and processing information about the self*. J Pers Soc Psychol 1977;35:63-78.

32 Markus H, Smith J, Moreland R. *Role of the self-concept in the perception of others*. J Pers Soc Psychol 1985;49:1494-1512.

33 Fairburn CG. *Cognitive behavior therapy and eating disorders*. Psychiatr Clin North Am 2010; 33:611-27.

34 Shafran R, Cooper Z, Fairburn CG. *Clinical perfectionism: a cognitive-behavioural analysis*. Behav Res Ther 2002;40:773-91.

35 Sassaroli S, Apparigliato M, Bertelli S, et al. *Perfectionism as a mediator between perceived criticism and eating disorders*. Eat Weight Disord 2011;16:37-44.

36 Fairburn CG, Peveler RC, Jones R, et al. *Predictors of twelvemonth outcome in bulimia nervosa and the influence of attitudes to shape and weight*. J Consult Clin Psychol 1993;61:696-8.

37 Bruch H. *Anorexia Nervosa: therapy and theory*. Am J Psychiatry 1982;139:1531-8.

38 Goodsitt A. *Eating disorders: a self-psychological perspective*. In: Garner D, Garfinkel P, editors. *Handbook of treatment for eating disorders*. New York: Guilford Press 1997, pp. 205-28.

39 Sands S. *Bulimia, dissociation, and empathy: a self-psychological view*; In: Johnson C, editor. *Psychodynamic treatment of anorexia nervosa and bulimia nervosa*. New York: Guilford Press 1991, pp. 34-50.

40 Malson H. *Women under erasure: anorexia bodies in postmodern context*. J Community Appl Soc 1999;9:137-53.

41 Piran N. *Reinhabiting the body*. Fem Psychol 2001;11:172-6.

42 Stern D. *The interpersonal world of the infant: a view from psychoanalysis and developmental psychology*. New York: Basic Books 1985.

43 Stanghellini G, Castellini G, Brogna P, et al. *Identity and eating disorders (IDEA): a questionnaire evaluating identity and embodiment in eating disorder patients*. Psychopathology 2012;45:147-58.

44 Sartre JP. *L'etre et le neant*, 1943. English translation: *Be-*

ing and Nothingness. New York: Washington Square Press 1992.

45 Nordbø RH, Espeset EM, Gulliksen KS, et al. *The meaning of selfstarvation: qualitative study of patients' perception of anorexia nervosa*. Int J Eat Disord 2006;39:556-64.

46 Skarderud F. *Eating one's words, Part I. "Concretised metaphors" and reflective function in anorexia nervosa – an interview study*. Eur Eat Disord Rev 2007;15:163-74.

47 Skarderud F. *Eating one's words, Part II. The embodied mind and reflective function in anorexia nervosa - theory*. Eur Eat Disord Rev 2007;15:243-52.

48 Surgenor LJ, Plumridge EW, Horn J. "*Knowing One's Self" anorexic: implications for therapeutic practice*. Int J Eat Disord 2003;33:22-32.

49 Castellini G, Stanghellini G, Godini L, et al. *Abnormal bodily experiences mediate the relationship between impulsivity and binge eating in overweight subjects seeking for bariatric surgery*. Psychother Psychosom 2014 (in press).

50 Yaryura-Tobias J, Neziroglu F, Torres-Gallegos M. *Neuroanatomical correlates and somatosensorial disturbances in body dysmorphic disorder*. CNS Spectrums 2002;7:432-4.

51 Bonnier P. *Vertige*. Paris: Masson 1893.

52 Lhermitte J. *De l'image corporelle*. Rev Neurol 1942;74:20-38.

53 Fisher S, Cleveland SE. *The Body image boundary construct: a study of the self-steering behavior syndrome*. J Proj Tech Pers Assess 1969;33:318-21.

54 Marcel G. *Being and Having*. New York: Harper & Row 1965.

55 Cash TF, Pruzinsky T. *Body images: Development, deviance, and change*. New York: Guilford Press 1990.

56 Wolfe BE, Baker CW, Smith AT, et al. *Validity and utility of the current definition of binge eating*. Int J Eat Disord 2009;42:674-86.

57 Mond JM, Latner JD, Hay PH, et al. *Objective and subjective bulimic episodes in the classification of bulimic-type eating disorders: another nail in the coffin of a problematic distinction*. Behav Res Ther 2010;48:661-9.

58 Ricca V, Castellini G, Mannucci E, et al. *Comparison of individual and group cognitive behavioral therapy for binge eating disorder. A randomized, three-year follow-up study*. Appetite 2010;55:656-65.

59 Barlow DH. *Anxiety and its disorders: the nature and treatment of anxiety and panic*. New York: Guilford Press 2002.

60 Hoyer J, Becker ES, Roth WT. *Characteristics of worry in GAD patients, social phobics, and controls*. Depress Anxiety 2001;13:89-96.

61 Sassaroli S, Gallucci M, Ruggiero GM. *Low perception of control as a cognitive factor of eating disorders. Its independent effects on measures of eating disorders and its interactive effects with perfectionism and self-esteem*. J Behav Ther Exp Psychiatry 2008;39:467-88.

62 Bruch H. *Eating disorders: Obesity, anorexia nervosa and the person within*. New York: Basic Books 1973.

63 Button E. *Eating disorders: a quest for control?* In: Button E, editor. *Personal construct theory and mental health*. London, Sidney: Croom Helm 1985, pp. 153-168.

64 Orbach S. *Hunger strike: the anorectic's struggle as a metaphor for our age*. London: Faber & Faber 1986.

65 Rotter J. *Internal versus external control of reinforcement*. Am Psychol 1990;45:489-93.

66 Shapiro DH, Astin JA. *Control therapy: an integrated approach to psychotherapy, health, and healing*. New York: John Wiley 1998.

67 Surgenor L J, Horn J, Plumridge EW, et al. *Anorexia nervosa and psychological control: a reexamination of selected theoretical accounts*. Eur Eat Disord Rev 2002;10:85-101.

68 Williams GJ, Chamove AS, Millar HR. *Eating disorders, perceived control, assertiveness and hostility*. Br J Clin Psychol 1990;29:327-35.

Psychopathology of addictions

G. Di Petta

S. Maria delle Grazie Hospital, Female Prison, Addiction Centre Consultant, Mental Health Department, ASL Naples 2 North, Italy

Summary

This paper intends to examine, both from a psychopathological and a phenomenological perspective, the state of "being-at-the-world", which is common in individuals with drug addiction. Past abuse, as well as present abuse, are crucial in the modification of the psychiatric impact in the history of drug abuse. The former drug lifestyle characterised by the use of heroin led to a form of psychosis which is known with the symptomatological expression as basic psychosis. On the other hand, the contemporary poly-abuse of novel psychoactive substances leads to what is called a synthetic psychosis: a very rich paraphrenic state with continuous hallucinations caused by a mental automatism syndrome and secondary (interpretative) delusions. From a phenomenological point of view, all addictions lead to the final collapse of the Dasein structure (the constitution of the being-in-the-world-with-others). Subsequent to having travelled down many different psychopathological pathways, many addicts remain without the spatial-temporal "here and now" dimension. This makes it impossible for them to stay in a space-with-others and to project themselves in time. The result of this time/space cleavage is emptiness. It is very difficult to treat this existential situation, which is characterised by patients frequently dropping out of conventional treatment, the loss of the being-in-the-world structure, boredom, emptiness, dread, anger, lack of meaning, loneliness and isolation. In this paper, Dasein Group-Analysis (an original interpretation and application of Binswanger's Dasein-Analysis) is proposed and discussed. Unlike Dasein-Analysis, this approach applies phenomenology beyond the classic pair of analyst and patient, to a group of people composed of doctors and patients, in which everyone is simply a human being in the world. If the psychopathological and therapeutic approaches prove to be ineffective, the frequent consequences are: the patient's admission into a psychiatric hospital; his/her arrest for crimes related to antisocial behaviour; a worsening of their psychopathology and addiction; a diffusion of infective diseases commonly found in addicts; more frequent overdoses; aggressive behaviour; legal problems; an increase in the costs of public health system; and, finally, even suicide of the patient.

Key words

Polyabuser • Novel psychoactive substances • Paraphrenia • Endogenic psychosis • Exogenic psychosis • Phenomenological approach • Psychopathology of consciousness • Phenomenological group

Take me on a trip upon your magic swirlin' ship
/ My senses have been stripped
my hands can't feel to grip / My toes too numb to step
wait only for my boot heels to be wanderin.
Then take me disappearin' through the smoke rings
of my mind
down the foggy ruins of time
far past the frozen leaves…
Let me forget today until tomorrow.
Bob Dylan

The field of battle

Psychopathological syndromes are ever more frequently characterised by psychiatric symptoms and substance abuse in clinical practice. However, the connection between use, misuse, abuse and polyabuse of substances and psychiatric symptomatology is unclear. The same substances, in fact, can both reveal and cover an underlying or contemporary mental disorder. Recently, the change in abuse, for example polyabuse of mixed and often synthetic exciting substances, has reduced the traditional "covering effect" of opiates. In addicts substances strongly influence the clinical form of psychiatric disorder, connecting it to addiction. On the other hand, there are many psychiatric outpatients who take substances on the road and become addicts after that. In this case, even the primitive psychiatric syndrome in addicts changes its clinical form. It is very important to clearly identify the *cluster* of symptoms that indicates the presence of psychiatric alteration in addicts, in order to treat patients with opiate agonists, along with psycho-pharmacotherapy, psychotherapy and rehabilitation. However, in order to do this it is crucial to try to understand – through Jaspers [1], Schneider [2], Bonhoeffer and de Clerambault's [3]

Correspondence
G. Di Petta, Psychiatrist and Neurologist, S. Maria delle Grazie Hospital, Female Prison, Addiction Centre Consultant, Mental Health Department, ASL Naples 2 North, Italy • Vice-president of Italian Society of Phenomenological Psychopathology • E-mail: gilbertodipetta@alice.it

psychopathology – how the developing psychosis bases itself on the addiction background. The crucial question of this discussion is about the switch/crossing point between the toxicomanic experience and the psychotic experience, identified in a particular state of consciousness, the *twilight state*. In poly-abusers of novel psychoactive substances (NPS)[a], however, it is important to identify and to define a specific mental automatism as a primary elementary phenomenon, and to consider the consequent thought disorder a secondary phenomenon.

The "addicted" consciousness

For psychiatry, the psychopathology of consciousness has always represented a sort of final frontier. From Janet's studies on the splitting of consciousness to Ey's studies on the de-structuring of the field of consciousness, there is no psychiatric disorder that cannot be collocated on the ground of consciousness. According to Jaspers, the ego-consciousness can be understood in four ways: 1) sense of activity; 2) sense of uniqueness; 3) sense of identity; 4) sense of oneself [1]. It is very clear how subjective consciousness here limits the field of experience of one's *being-in-the-world-with-others*, the dramatic change of which indicates the beginning of psychosis. The assessment of a state of consciousness is fundamental when the psychopathologist is face to face with addicts under the effect of substances. In this type of encounter, the clinician perceives the boundaries between the areas of consciousness where there is attunement and the areas of consciousness where there is no attunement. For example, if we assume that depersonalisation, de-realisation and dissociation are global experiences of the formal destructuring of the field of consciousness and not simple symptoms, we can also find them in a broad spectrum of psychiatric disorders, from schizophrenia to panic attacks, from phobia to dissociation, from post-traumatic-stress disorder to somatic disorder, from addiction to withdrawal. At this point, we come to the following conclusions:

1. consciousness is a field with formal and fundamental characteristics and there is no psychiatric disorder that does not have its background in modification and de-structuring of consciousness;
2. the causes of disease that produce modification of the ordinary state of consciousness, especially substances, strongly influence the development of psychiatric disorder, touching many aspects of psychopathological vulnerability.

The crossing-point of the "twilight state"

What do the addicts mean when they say: "I am high?" What is the psychopathological meaning of this state of consciousness (*highness*) which for them represents a sort of steady-state of daily living existence? Probably the experience of *highness* is an equivalent of a *twilight state* of consciousness (*Zwielicht-Daemmerungzustand*). This modification of the state of consciousness is well represented by many current expressions: numbness, clouding, drowsiness. In the classic description of Jaspers [1] and Schneider [2], a *twilight state* of consciousness is a restriction of the field of consciousness. In the *twilight state* of consciousness, there is no dramatic alteration of arousal. The field of consciousness, furthermore, can still spread itself (Fig. 1). The *twilight state* of consciousness is a sort of threshold between the light of reality and the shadow of dream and psychosis. The *twilight state* of consciousness promotes illusions, delusions, visual or auditory hallucinations: the patient may respond to them with irrational behaviour. The person may be unaware of the surroundings at the time of the experience and have no memory of it later, except perhaps to recall a related dream. De-personalisation and de-realisation are normal experiences in the *twilight state* of consciousness, in which it is easier that Klosterkötter's transitional phenomena take place, from basic symptoms toward final phenomena [4]. Heroin addicts experience this vulnerable condition every day, every month, every year, over a prolonged period of time. The perception of reality in addicts is discontinuous and incomplete, and this *twilight state* becomes a sort of normal way of life. Their state of consciousness is like a display that is continuously turned on and off, short flashes appear and disappear. Being instable, the *twilight state* becomes a transitional state, like a *funnel*. When the *funnel* is upside down, addicts lose touch with reality and fall into delusions.

The "basic" psychosis in heroin addicts

When psychosis begins to manifest itself in heroin addicts it is very difficult to differentiate typical schizophrenia from bipolar psychosis. This "twilight psychosis" remains a sort of cluster of basic symptoms, in which mood, cognition, thought and perceptions are all affected. In this *twilight state*, a particular form of psychosis eventually develops: "basic psychosis". In this "basic psychosis", cognitive and thinking symptoms are confused with perceptive and mood symptoms. The recognition and the

[a] An increasing number of unregulated websites are dedicated to the dissemination of novel psychoactive substances (NPS), which include plant-based compounds, synthetic derivatives of well-established drugs, as well as "designer medicines".

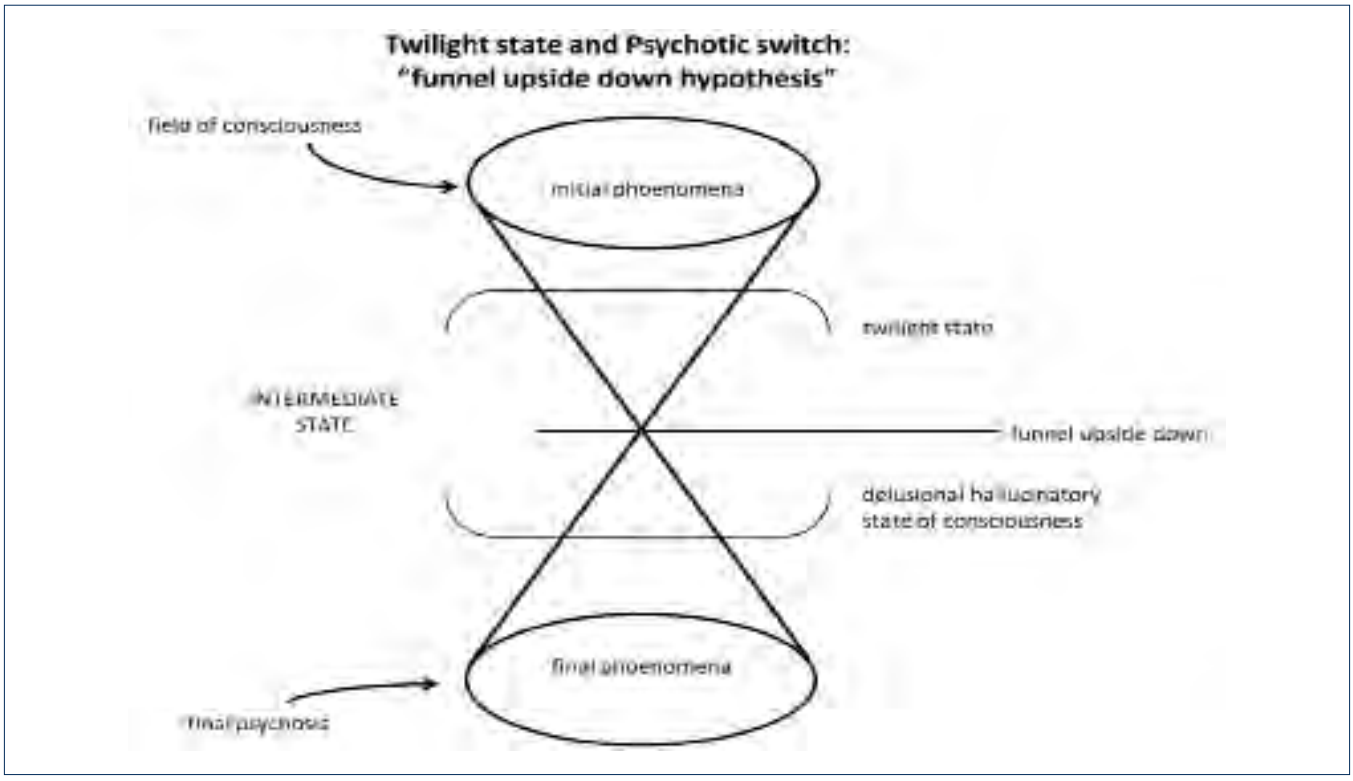

FIGURE 1.
This figure shows how the initial field of consciousness reduces itself until the crossing point, after which the field of consciousness is inside-out and instead of looking out is polarised on psychotic phenomena.

assessment of this "basic psychosis" can be done by basic symptoms interview (FBF, BSABS) [5 b].
"Basic psychosis" is characterised by one or more "basic stages". It is very difficult to classify this "basic psychosis" in heroin addicts. Psychiatrists do not often recognise it and as a consequence fail to treat it. This "basic disorder" causes severe discomfort in addicts and induces them to self-administration of substances. Mental functioning is disturbed by this basic symptomatology. Many addicts don't give up substances because they feel acute discomfort of "basic psychosis" when they are drug free. Substances cover and aggravate the "basic psychosis". Very often, basic irritation doesn't proceed towards externalisation and concretisation of the final psychosis. This is a germinal psychosis, a mixture not differentiated by affective and cognitive elements, which often remains at the initial stage, and then freezes with no further progression. Without progression and without differentiation, there is neither personality deterioration nor stabilisation or residual psychosis (the patient remains constantly unstable). When these traditional addicts suffer from psychotic symptoms, i.e. *revelatory* delusion, they have the experience of the pleasure of aberrant meaning, and show a different sensitivity to substance abuse. The "meaningful delusion" represents a milestone ("before and after") in the life of these patients. This "before and after" is in competition with substance abuse and determines a new *imprinting* connected to successive substance relapse. In some of these patients, delusional relapse completely substitutes relapse of substance abuse. In these cases, delusion seems to become a sort of "endogenic drug", having the same effect as an exogenic drug on the life of patients. The experience of "salience", the underlying dopamine and relapse are crossover concepts between drug addiction and psychosis. The aim of good treatment with opioid agonists is global mental stabilisation and not just oriented to the morphinuria negativisation. Decreasing the dosage of opioid agonists is dangerous, especially when mental disorder is concurring. The risk of transforming a heroin addict into a mentally ill patient with-

[b] Basic symptoms are described by Huber, Gross (1986-1996) and Klosterkötter (1992) as alterations of subjective experience that indicate the beginning of psychosis. The sequences of transition by Klosterkötter lead the transformation from basic symptoms to final phenomena. Several basic symptoms together constitute a psychopathological condition defined as "basic stage".

out opioid treatment is high. Often the heroin addict is a "masked" psychotic, or a "basic" psychotic. On the other hand, heroin addiction undermines the patient's sense of reality and the patient's coherence of self. The area of drug vulnerability is the self concerning experience[c].

The "chemical madness" induced by NPS: the "Alice in Wonderland" syndrome

Seeing something out of the ordinary visual field, seeing an unreal (inexistent) landscape, a bizarre environment, geometric forms; seeing bi-dimensional and flat images added to the ordinary visual field: all these are common visual perceptions induced by hallucinogenic drugs. It is not easy even for a general psychiatrist, even one well versed in all things medical and psychopathological, to deal with these emerging (chemical) hallucinatory-delusional patterns. The diffusion of NPS in young people is responsible for a new pattern of mental disorders induced by substances: chemical psychosis, which can also be called "synthetic psychosis", is a sort of "Alice in Wonderland syndrome"[d]. This is the paradigmatic speech of Stefano – "I have to say that I have been hearing voices ever since I was a young child though I only started to have visions after the breakdown I had when I was 20. I remember the first time I heard voices. I was two or three years old and I was sitting in my high-chair and I could hear them talking to each other but I couldn't understand what they were saying. Then the voices noticed that someone was listening to them. Now I can say that those voices already knew the meaning of everything that has happened to me since then. When I was four years old I was in the front yard of my house and I heard the female voice that I already knew and then three aliens came out of a hole in the ground and I walked towards them and I was ready to throw myself into their arms not knowing that they were the incarnation of evil. As I have already said I was four when the aliens took me with them on a journey into another reality controlled by a different logic from ours. I was there for an indefinite time which might have been all of eternity, though compared to time on Earth it was just a moment". In spite of the evidently severe hallucinatory dimension causing delusional interpretations, there is no evidence that shows NPS is able to induce thought directly. However, NPS severely compromises reality testing. How are criticism and judgment really effective in the reality testing? NPS probably compromises human *sensorial* knowledge. Firstly, classic consciousness philosophy, based on Descartes' and Kant's conception, is no longer a good model for NPS induced synthetic psychosis [6-9] [e]. "The man thinks, not the brain" was the conclusion of E. Straus, the author of "The Sense of the Senses" (1930), in which sensorial consciousness is common to animals and human beings [10]. From the perspective of these authors the world of life is embodied, there is a logic of living, we can find an *a priori* structure of feeling, there is a spatial-temporal horizon of feeling, the sensorial experience is active and cognitive, the *pathic* dimension of existence has a communicative structure. In Straus's theory (1930), *seeing* is the immediate consciousness of spatial distance. It is a sort of temporal scanner, and *touching* is the nearness receptor. Aesthesiology ("Theory of Feeling") by Straus allows us to understand that the approach to reality is based on and guaranteed not by criticism and judgment but by pre-verbal, pre-reflexive arguments; that the perception-movement cycle is crucial in the structure of common sense. As a consequence, drastic modifications of the perception-movement cycle, caused by NPS, can influence (though only in a secondary way) both criticism and judgment [7]. Therefore, chemical delusions are not primary, but secondary to strong modifications of the relationship with reality, based on perception-movement distortion induced by NPS.

"Synthetic" psychosis versus "classic" schizophrenia: a differential diagnosis

Various typical psychopathological signs of schizophrenic syndromes (e.g. the crisis of "Me-ness" and the invasion of "overconcern me relationships" (Schneider, 1950), the crisis of "basic trust" (Husserl, 1907) [11], perplexity (Callieri, 1997) [12], the "exclusion of casuality" (Berner, 1981) [13] and the "loss of overall perspective" (Conrad, 1958) [14] are unknown in these synthetic syndromes. Where, then, are the classic psychopathological

[c] Sense of self, self-experience, proto-self, self-agency, self-coherence, selfhood, self-consciousness, ownership – are all domains severely compromised by lifetime drug abuse.

[d] The "Alice in Wonderland syndrome" was described by Todd (1955), Lippman (1952) in migraine and epilepsy, and is characterised by morphological fluctuation, such as Metamorphopsia, Micropsia, Macropsia, Temporal distorsion, Temporo-occipital lesion, Parieto-occipital lesion.

[e] The idea of the Gestalt's cycle (Gestaltkreis) by Victor Von Weizsaecker (1886-1957), instead, is a better model to understand NPS psychosis. The cycle "perception-movement" is probably the first and the principal target of NPS. H. Plessner (1892-1985) and M. Merlaeau-Ponty (1908-1961) gave a strong contribution to identify and define this perception/sensation area. J. Zutt (1893-1980) also wrote about this aesthetic field of lived experience (Das aesthaetisches Erlebnisbereich).

signs, such as delusional atmosphere or delusional perception, in these post-modern *chemical* patients? How is counter-transference or attunement possible in these postmodern psychonauts? Is it still important to understand life history versus the hallucinogenic power of the "plants of God"?[f] In chemical delusions, for example, we do not have: 1) a delusional atmosphere; 2) delusional perception; 3) primary delusions. The NPS are not really able to induce thought disorders. Chemical delusion is characterised by *confirmation* and *interpretation*, not by *revelation*, and by fantastic contents. NPS delusions are like paraphrenic delusions[g], with a feeling of unreality while at the same time maintaining the ability to analyse this feeling [15]. On these differential signs, it is possible to set a precise distinction between chemical delusions secondary to NPS *sensory* modification and primary delusions of classic endogenic psychosis. The core gestalt of these contemporary psychonauts' psychosis is far from that of classic naïve psychotic patients. For acute syndromes, the exogenic psychosis[h] is still a good model. Many acute clinical conditions in these "chemical patients" are brain organic syndromes (*Durchsgang-syndromen*). After acute symptomatology, differential diagnosis is often possible between naïve patients and chemical patients. De Clerambault's concept of delusion[i], based on the mental automatism syndrome[j], is a very good model to understand this synthetic psychosis. In this atypical psychosis, a part of the patient's ego remains a critical spectator of his or her own pathology (a spectator of the internal/ extraneous psychoma) [16]. The ego goes mad in its desperate attempt to "synthesise" (repair) the profound wound opened by dissociative drugs (Table I).

TABLE I.
Classic schizophrenia symptoms compared with synthetic psychosis symptoms.

ENDOGENIC psychosis (classical psychosis)	Exogenic psychosis (synthetic psychosis)
Lucid consciousness	Twilight consciousness
Thought	Sensory perception
Self-concerning ontological insecurity	Object-concerning instability
Delusion: primary, metaphysical, systematic transcendental ego	Delusion: secondary, everyday, phantastic empiric ego
Fusionality, passivity	Insight, agency
Bizarre and inexplicable behaviour	Impulse discontrol and aggressivity
Autism	Anaclitism
Progression	Basic and germinative
Distance/apathy	Overexcited/excessive emotivity

[f] These are often sold as something else, e.g. mystical incenses, plant chemicals and bath salts, herbal smoking blend (synthetic cannabinoids, Spice drugs, mephedrone).

[g] Illusions and acoustic, olfactory, gustative and cynesthetic hallucinations, but especially chronic delusion in which imagination and fantasy, leading to bizarre and unrealistic situation, are fundamental. Another common case is the feeling of being persecuted by strange electronic machines. Other cases include patients who believed they were: without vital organs, responsible for "the end of the world", the son of famous historical figures, protagonists of epic events and in communication with aliens. In differential diagnosis with schizophrenia, the personality cohesion and the affective participation in these cases are not completely damaged, and social skills and personal autonomy are well maintained. The patient lives two lives at the same time (one real and another imaginary and delusional), which, however, does not completely compromise his behaviour and his relation with reality.

[h] Toxic psychosis, traumatic psychosis, brain disease psychosis, delirium, progressive paralysis, withdrawal psychosis: these are the exogenic psychosis described by Bonhoeffer in 1914.

[i] G. de Clerambault was the Director of the Special Infirmary for the Insane (prefecture de police, Paris 1905). He described many patients intoxicated by absinthe, clorhalius hidratus, ether, hashish and alcohol.

[j] The mental automatism syndrome is characterised by: ideoverbal basal syndrome, various different types of voices, usually threatening, different kinds of hallucinations and pseudo-hallucinations, inside spoken thoughts, stolen thoughts, and visual, taste, olfactory, cynesthetic and sensorial hallucinations. Parasitism of abnormal perceptions: tingling, irritation, itchiness; in de Clerambault's conceptions delusion is secondary to hallucinations. Delusion is not primary, the hallucinations are primary and the delusion is only the secondary interpretation of delusion. Motorial: cynesthetic impressions, sudden shudders, forced movement.

The phenomenological perspective : comparing the "floating" world and the "frozen" world

Obviously, being a human being is something completely different from being a crystal, a drop of water, or a plant. The relationship that exists between man and reality is a clearly understandable system of intentional acts. This *being-at-the-world*, seen from a phenomenological perspective, is the ontological structure of every human being, and is based on the connection between the subjective (living) consciousness and the objective (lived) world. Intentionality (aboutness, directedness) embodies the immediate contact with the world.

Drug addiction undermines intentional consciousness. Whereas in normal conditions we have a fluid intentionality and our common sense is the obviously pre-reflexive result of this situation, under the influence of a drug intoxication we lose this intentional stability and, as a consequence, suffer from a kind of intentional instability, which we can identify with the term *floating world*. This floating world is characterized by splitting, vibration and a multiplication of images which can be both sequential or overlapping. On the other hand, following chronic drug assumption, we have a sort of an intentional dramatic capture or seizure of the world, which we can call *frozen* world. The lived time, space, body and other existential parameters differ enormously in these two contrasting ways of being.

For example, there exists a violent twilight state of consciousness in patients who are suffering from the effects of drugs and are, consequently, in the situation of a floating world. Their lived body has become disjointed. Their senses have started to become something like a wild kaleidoscopic. The lived space is haemorrhagic and the perception is of a loss of space, of being nowhere.

The patient's existence is centred around where the pusher is – the exact square, the road, the underpass. There is a contrast between the cold space of substance suffering which can be defined with the word "absence", and the hot space of substance enjoying which can be defined with the word "presence", and with the vanishing space under substance effect (which turns the addict into a maniac).

Lived time is liquid and indefinite. There is no present, no past, no future. Having lost the connection of interior time all the drug addict has left is the transient moment of satisfaction. However, as soon as the drug addict achieves a moment of pleasure it suddenly vanishes and he is condemned to impulsive and compulsive repetition. When the patient experiences craving, both past and future have been lost. The past is reduced exclusively to "the last time in which I have taken drugs". When the patient experiences highness, he feels so absorbed in the present that he is no longer able to see the future. Not experiencing the past and having lost touch with the future the patient ends up being unable to grasp the present. "The addict is trapped in this repetition with no chance of moving forward" [17]. The instantaneity[k], the pure instant is the "hole" between the last dose and the next one: the liquid instant of "high" rules. The moment of altered consciousness and the time of the depthless instant dominate everything else. Thus, the patient is trapped in a sort of circular liquidity of lived time, and suffers the pure illusion of linear movement. Everything is manipulated and everyone is reduced to just being an obstacle in the way of the addicts only remaining relationship – with the drugs he takes.

On the other hand, following chronic intoxication, the patients' consciousness becomes viscous, and the lived body is blocked – now he finds himself in the state we call the frozen world. The body is modified on a neurobiological level by a chemical graft which inserts a relevant new artificial element into the lived body. The object body (*Koerper*) is the vehicle of powerful substances which can successfully alter all sensations and perceptions, and the whole world experience, reducing the addict's self into nothing more than a denatured, mineralized body (*Koerper-ding*). His intentionality is coagulated, time is insular and has been reduced to a pure frozen present without past and without future until the complete loss of the passing of time[l] is experienced) – others have become unattainable objects which are lifeless, like unattainable distant snow-men. Tragically these patients become mere bystanders to their own existence. In order to feel themselves still alive they need more substances. The crisis of the temporal-spatial vortex eventually and inevitably

[k] "Under the influence of hashish the mind can fall into the strangest illusions of time and space. The time seems to pass incredibly slowly. Minutes become hours, hours become days; soon any precise idea of duration is lost, past and present are mixed up. The speed with which our thoughts follow each other, the resulting ecstatic condition, explain this phenomenon, because if time seems to be longer than it would have been if measured with clocks, it is the actions and events that occur in this period of time , that extend the time limits with their magnitude" (Moreau de Tours, *Du Haschish et de l'aliénation mentale*. 1845).

[l] "Time is dead; years, months, hours will no longer exist; time is dead and we'll go to its funeral. […] The clock hand will stay on the minute in which time ceased to be, and your torment will be to go back and look at the motionless hand, and to sit down again in order to start all over again, and this will go on until you find yourself walking on the bones of your feet […] The suns will explode and become dust before the metal hand has moved one millionth part of a millimetre" (T. Gautier, *Le club des hashishin*, 1845).

TABLE II.
Progressive development of the addict life-world, identified by the modification of the fundamental existential parameters.

"Erlebnisse" characteristics			
Psychopathology	Vulnerable personality	Psychopathy	Synthetic psychosis
Intentional consciousness	All is easy →	"High" friendliness to soft soap →	Intentionality collapse
Spatiality	Emptiness →	Mask or facade →	Dasein collapse or rupture
Temporality	Fluttering	Instantaneity	Time stands still (zeitstillstand)

leads to the blow of the void (*le coup de vide*): the experience of unreality or no self experience. The total collapse of the world is the common final destination/ result of the breaking down of the temporal and spatial structure of "being-there"("Da-sein"). *Being-in-nothingness* becomes the typical state of addicts in the frozen condition (Table II). In this case, the frozen condition has become a sort of terminal point in the existence of addicts.

A phenomenological approach to the treatment of addicts: the Dasein Group Analysis

This phenomenological approach to the psychotherapy of addicts has been applied since 1999[m] in addiction centres with everyday contact with patients, and always creates an intense emotional atmosphere[n]. In many of these patients, the human sense of identity is lost even where there is no psychotic symptomatology. In these cases, the only way to survive is to achieve vital contact with another person, feeling empathy for the emotional, affective dimension of another person. The "epochè" is the preliminary condition of this setting, especially when this requires the doctor to abandon his own role. The lived experiences mix freely in a totally emotional context [18 19]. Subsequently within the group the shared emotions reveal a truly meaningful lived dimension, made up of pain and pleasure, helplessness and happiness, loneliness and nearness, anger and friendship: a sort of "fundamental affective position" (Heidegger's *Befindlichkeit*). This group approach is centred on the search for an authentic inter-subjective encounter, as the crucial embodied event. This condition, which happens *face-to-face* between two human beings in the middle of the group, is the necessary step for any subsequent cure[o]. The phenomenological background has been extremely useful especially in the close encounter (*face-to-face*) with the patient who is seen more as a real person than as just another clinical case. The lived experience, here, (any lived experience including delusional or hallucinatory experiences), has its own intentionality (aboutness). These experiences in the emotional context of the phenomenological group freely mix with each other, producing change and transformation in all participants. The passage from initial negative emotions to final positive emotions in each group session is crucial. It is like a journey from helplessness to hope, from pain to light, from loneliness to intimate nearness. The therapist here is not outside the group, but completely inside it[p]. Both the therapist and the patient abandon their roles and are in the phenomenological group as human beings *body-to-body*, *existence-to-existence*, as persons who love, cry, feel without the barrier that exists between *therapists* and their *patients*. From being *one-next-to-another* (*Nebeneinandersein*) and from being *one-in-front-of-another* (*Voreinandersein*) to *being-one-with-another* (*Miteinandersein*).

[m] One of the most important ideas of phenomenology, in fact, is the deep union between the subject, other people and the world-of-life. This idea offers an enormous transforming potentiality, which is very useful in a modified setting of group psychotherapy.

[n] This idea of a plural phenomenology (*being-we-in-the-cure*), the realisation of Binswanger's *weness-which-loves*, in an emotional group composed of doctors and patients together, was a result of hopelessness due to failed encounters with the addicts' existences. The intention was to offer a common and intimate place, a new space, a new time, in which anyone was able to have the chance to feel his or her own existential condition completely. The chance to feel one's own body again and that of another, the possibility to feel one's own pain again and that of others, to feel the support of others, the possibility to cry one's heart out. Among some of these lost existences, this new phenomenological approach has become a sort of way out, which through cure can eventually lead to freedom and the world.

[o] This phenomenological approach to group therapy is quite different from the psychoanalytical approach to group therapy. In fact, it is based on consciousness and not on the unknown. The phenomenologist sees the essence of phenomena, he does not use interpretation, whereas the psychoanalyst is more interested in recording the hidden meanings beyond the phenomena.

[p] An evident difference when compared to psychoanalysis is the complete involvement of the therapist as a human being in the emotional dimension of the group, in the same way and at same level as the patient.

This gives them the chance to live in a space and time in which it is not important to answer the question "who am I?", but the question "what do I feel"? and "how do I feel"?[q]. Starting from a common emotional land, in which we can find our lost parts, in which we can give to others the parts they have lost which we can find in our own internal experience, and in which there is the chance to look for and discover these parts which are still alive[r]. Group participation is open to everybody, no matter what his or her condition is. Anyone from anywhere is admitted to this new kind of group. At the end of the group session, it is evident that not even heroin is able to calm anyone more than a warm hug between two human beings; and that life itself is a greater excitement than cocaine. From a phenomenological point of view, the form (i.e. essence or *eidos*) of the lived experience (*pathos*) is crucial. The form of lived clarifies itself. Sometimes the people who meet each other in the centre of group change. The atmosphere changes and gradually becomes more positive. The internal pain and anguish became hope and light. The lived experience (*Erlebnis*) recalls another lived experience, becomes another lived experience, looks for another lived experience. If it is authentic, it is also therapeutic. At the end of the group session all the participants feel harmony. The therapist concludes speaking about his lived experience. Two hours have passed. Someone is still crying silently. The mixture of pain, anger and helplessness has led to a feeling of relief. We may wonder how it has been possible to achieve positive emotions, starting from negative ones. Is it not, perhaps, the World-of-life (*Lebenswelt*)? [20 21 22].

Conclusion and perspectives

Basic psychosis and synthetic psychosis in addicts are characterised by an underlying symptomatology, because substances effectively cover and block the appearance of easily diagnosed mental disorders. Basic psychosis is made up of several clusters of basic symptoms, (i.e. basic stages), synthetic psychosis, on the other hand, is characterised by a paraphrenic syndrome reactive to a mental automatismus induced by NPS. These clinical forms of *non-classic psychosis* are pervasive and common disorders in addicts which limit social functioning of patient and encourage continued addictive behaviour. It is important to identify these forms of psychosis in addicts in order to treat them adequately. The destiny of an addict can depend entirely on the recognition and treatment of these disorders. Basic symptoms inventory (FBF) is very useful to identify the presence of a basic state and can lead to treatment. The aim of the recognition and early treatment of basic symptoms in addicts is: 1) to block the transition from basic psychosis to final psychosis; 2) to reverse basic symptoms when it is possible in ordinary experiences; 3) to help the patient in coming-out from substance abuse. In the NPS poly-abuser it has been possible to describe a new form of psychosis, not comparable with classic psychosis, such as that in schizophrenia or bipolar disorders. We can give this psychosis the name of "synthetic psychosis", or the "Alice in Wonderland syndrome". In this case, patients *are not* psychotic, they *have* a psychotic syndrome. This form of psychosis is nearest to organic psychosis or to psycho-organic syndromes. Both these psychotic syndromes are often non-responders to traditional antipsychotic treatment. However, these patients are not impossible to treat. Dasein group treatment is characterized by intense emotional warming [23 24 s]. In phenomenological Dasein group analysis, the experience shared by therapists and patients, session after session, is characterised by focusing consciousness on one's own internal experience, searching for the lost structure of one's own *being-at-the-world*, the encounter between one's own self and another, the rebirth of one's own ex-

[q] As the group therapist in an existential group session, I feel myself to be in search of a starting point from somewhere within my own personal experience in order to begin group therapy. In the penumbra of a deep silence I am waiting, for an intuition in my mind. Within the experience of my consciousness of the world of life (Lebenswelt), I find the concrete inter-subjectivity of the participants. This has specific colour, form, smell and sound. The initial silence within the group is complete. This pregnant silence is the necessary prelude to group therapy. What can I say about this special silence? What is this deep silence? I can feel the emergence of the anxiety of waiting in this silence. I can see the profiles of the faces, I can see the eyes, the bodies of everyone. I speak with simple words about my own lived experience, what I have in my heart and I use words from the heart. I am the doctor, the group leader, but at the same time I am the first patient of the group. I talk about what I am feeling simply, authentically as an ordinary human being at that moment: my anger, my pain, my tiredness, my shame, my guilt.

[r] Beyond the language of medicine and psychology, the essence of psychotic experience, for example, remains something that cannot be explained, even if it is possible to perceive it. Phenomenological language in this case must adapt itself to the heart of the lived experience.

[s] Empathizing means "feeling the other from within" (Stein, 1891). The "pathicity" of existence is the background of this phenomenological approach: Binswanger (1942,1957, 1958, 1963), Minkowski, (1971, 1973, 1980), Von Weizsaecker (1886-1957), Straus (1891-1975). Every feeling is a *feeling-of-something*: hate, disgust, love, desire, joy, sadness: H. Plessner (1892-1985), Scheler (1875-1928). Our feelings are not senseless state of consciousness or psychic facts, but concrete modes of existence in situations with others: F.J.J. Bujtendijk (1887-1974).

istential movements. Finding oneself and losing oneself, and finding one's self again, in an endless game of swapping of changing the intimate parts of oneself. The particular group atmosphere is composed of the following elements: lack of pre-selection, free accessibility into the group unrestricted by rigid rules, less structured actions, the presence of addicts, psychotics and normal people side by side, the assumption of the space and time of addicts (here and now) as group time. The desired objective is nothing less than freedom from addiction and stabilisation of psychotic syndromes.

Conflict of interest

None.

References

1 Jaspers K. *Allgemeine psychopathologie*. Berlin: Springer-Verlag 1973.

2 Schneider K. *Psicopatologia clinica*. Roma: Città Nuova 1983.

3 De Clerambault G. *Automatismo mentale. Psicosi passionali*. Chiesti: Metis 1994.

4 Klosterkötter J. *Cosa hanno a che fare i sintomi base con i sintomi schizofrenici?* In: Staghellini G, editor. *Verso la schizofrenia*. Napoli: Idelson 1992.

5 Gross G, Huber G et al. *BSABS. Bonner Skala für die Beurteilung von Basissymptomen*. Berlin-Heidelberg-New York: Springer 1987.

6 Weizsaecker von V. *Pathosophie*. Goettingen: Vandenhoeck & Ruprecht 1967.

7 Weizsaecker von V. *Der Gestaltkreis. Theorie der Einheit von Warnhemen und Bewegen,* Stuttgart: Thieme 1968.

8 Merleau-Ponty M. *Fenomenologia della percezione*. Milano: Il Saggiatore 1965. Zutt J. *Zur anthropologie der sucht, in auf dem wege zu einer anthropologischen psychiatrie*. Berlin: Springer 1963, pp. 423-30.

9 Zutt J. *Zur Anthropologie der Sucht*. In: *Auf dem Wege zu einer Anthropologischen Psychiatrie*. Berlin: Springer 1963, pp. 423-30.

10 Straus E. *Vom sinne der sinne*. Berlin: Springer 1930.

11 Husserl E. *L'idea della fenomenologia*. Milano: Il Saggiatore 1988.

12 Callieri B. *Wahnstimmung e perplessità: la sospensione di significato tra gli esordi del delirare schizofrenico*. In: Rossi Monti M, editor. *Psicopatologia della schizofrenia*. Milano: Raffaello Cortina Editore 1997.

13 Berner P. *The demarcation between schizophrenia and cyclothymia*. Arch Neurol Psychat 1981:18:147-59.

14 Conrad K. *Die beginnende schizophrenie. Versuch einer gestaltanalyse des wahns*. Stuttgart: Thieme 1958.

15 Callieri B. *Aspetti psicopatologico-clinici della "Wahnstimmung"*. In: Kranz H, editor. *Psychopathologie Heute*. Stuttgart: Thieme 1962, pp. 72-80.

16 Cargnello D, Callieri B, et al. *Le psicosi sperimentali*. Milano: Feltrinelli 1962.

17 von Gebsattel VE. *Das Menschenbild der Seelenheilkunde. Drei Vorlesungen zur Kritik des dynamischen Psychologismus*. Berlin: Springer Verlag 1957.

18 Binswanger L. *Daseinsanalyse und psychotherapie, aktuelle psychotherapie*. Zurich: Speer 1957.

19 Binswanger L. *Daseinsanalyse, Psychiatrie, Schizophrenie*. Conferenza tenuta a Zurigo al II Congresso Internazionale degli Psichiatri (1958). Schweiz Arch Neurol Psychiat LXXXI, ½, 1958; trad.it. di Esposito S. In: Attualità in Psicologia 2003;18:197-204.

20 Di Petta G. *Gruppo analisi dell'esserci: tossicomania e terapia delle emozioni condivise*. Milano: Franco Angeli Editore 2006.

21 Di Petta G. *Nella terra di nessuno. Doppia diagnosi e presa in carico integrata: l'approccio fenomenologico*. Roma: Edizioni Universitarie romane 2009.

22 Di Petta G. *Il mondo tossicomane, fenomenologia e psicopatologia*. Milano: Franco Angeli 2004.

23 Minkowski E. *Trattato di psicopatologia*. Feltrinelli: Milano 1973.

24 Minkowski E. *La schizofrenia*. Verona: Bertani 1980.

Psychopathology and clinical practice: a course for early career psychiatrists

Florence (Italy) September 24-25-26, 2015

Under the aegis of Scuola di Psicoterapia e Fenomenologia Clinica - Firenze

FACULTY

Director of the Course
GIOVANNI STANGHELLINI
(Chieti)

Teacher
JOSEPH PARNAS
(Copenaghen)

Teacher
ANDREA RABALLO
(Reggio Emilia)

TOPICS

The main topics of the Course will be:

- What is Psychopathology?
- Psychopathology and Assessment in Clinical and Research Settings
- How to write a Clinical File?
- Psychopathology and Diagnosis
- Psychopathology and Drug Prescription
- Psychopathology, Understanding and Medical Psychotherapy
- What are Emotions and what is their Relevance in the Assessment and the Clinics of Mood Disorders?
- Phenomenology of Depressions and Mania
- Phenomenology of Borderline Personality Disorder and Borderline Depression
- Vulnerability to Mood Disorders
- Vulnerability to Schizophrenias
- What are Self-Disorders and what is their Relevance in the Assessment and the Clinics of Schizophrenias?
- Phenomenology of Early Schizophrenia and of schizophrenic Delusions and Hallucinations

Applications should be sent no later than June 27, 2015 to info@schoolpsychopathology.eu

Organized by

EPA Section on Philosophy and Psychiatry

Scuola di Psicoterapia e Fenomenologia Clinica

Organizing Secretariat

MORE COMUNICAZIONE EVENTI & MORE

Via Monte Zebio, 9
00195, Roma
Tel. +39 06 89011781 Fax +39 06 94443440
info@morecomunicazione.it
morecomunicazione.it

A practical course on

Phenomenological Psychotherapy

THE PSYCHOPATHOLOGICAL BASES OF THE THERAPY OF SEVERE MENTAL DISORDERS

Florence April 9-10-11, 2015

Under the aegis of Scuola di Psicoterapia e Fenomenologia Clinica - Firenze

Faculty

Director of the Course

GIOVANNI STANGHELLINI
(Chieti, IT)

Faculty Members

GIOVANNI STANGHELLINI
(Chieti, IT)

THOMAS FUCHS
(Heidelberg, D)

ANDREA RABALLO
(Reggio Emilia, IT)

BORUT SKODLAR
(Ljubljana, SLO)

Topics

- **Phenomenological Psychotherapy**
  - P.H.D. System:
    - Phenomenological unfolding (P)
    - Hermeneutic analysis (H)
    - Dynamic analysis (D)
  - Levels of Phenomenological Psychotherapy:
    - Unfolding of the patient's personal style of experience and action
    - Analysis of the pathogenetic situation
    - Analysis of vulnerable structure
    - Analysis of therapeutic situation
    - Re-construction of world-project
- **Phenomenological Psychotherapy of the main vulnerable structures:**
  - Schizophrenia
  - Melancholia and Mania
  - Borderline personality disorder
- **Case studies: supervision and intervision**

Organizers and audience

Organized by

EPA Section on Philosophy and Psychiatry

EPA Early Career Psychiatrists Committee

Director of the Course:
Giovanni Stanghellini

PARTICIPANTS

30 psychiatrists, psychologists or mental health professionals selected by the Faculty upon evaluation of CV and motivation letters

APPLICATION FILES SHOULD INCLUDE:

- Curriculum Vitae
- Motivation letter
- Certificate of proficiency in English language

Applications have to be sent no later than February 27, 2015 to the info@schoolpsychopathology.eu

REGISTRATION FEE: 1,000 euros including teaching materials, accommodation in a 3-star hotel and meals

Organized by

EPA Section on Philosophy and Psychiatry

Scuola di Psicoterapia e Fenomenologia Clinica

Organizing Secretariat

MORE++ COMUNICAZIONE EVENTI & MORE

Via Monte Zebio, 9
00195, Roma
Tel. +39 06 89011781 Fax +39 06 94443440
info@morecomunicazione.it
morecomunicazione.it