



# PHENO-PHENOTYPES

## Symptomatological vs.

**Psychopathology Course**  
**Chieti University**

**Academic Year 2014/15**



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- G. Stanghellini, **Psychopathology Course – Academic Year 2014/15** from personal website [giovannistanghellini.it](http://giovannistanghellini.it)

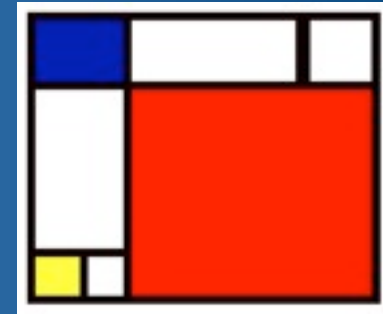


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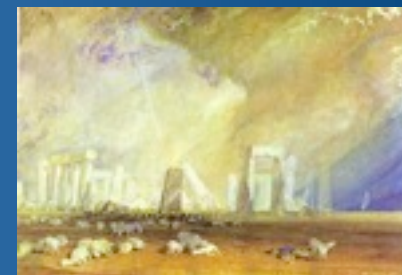
- M. Rossi Monti, G. Stanghellini, *Psychopathology: An Edgeless Razor?*, COMPREHENSIVE PSYCHIATRY, 1996.
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- G. Stanghellini, *Philosophical Resources for the psychiatric interview*. In KWM Fulford, M. Davis, R. Gipps, G. Graham, JZ Sadler, G. Stanghellini, T. Thornton: OXFORD HANDBOOK OF PHILOSOPHY AND PSYCHIATRY, Oxford University Press, 2013
- G. Stanghellini, R. Rossi, *Pheno-Phenotypes: A Holistic Approach to the Psychopathology of Schizophrenia*, CURRENT OPINION IN PSYCHIATRY, 2104.
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# Agenda

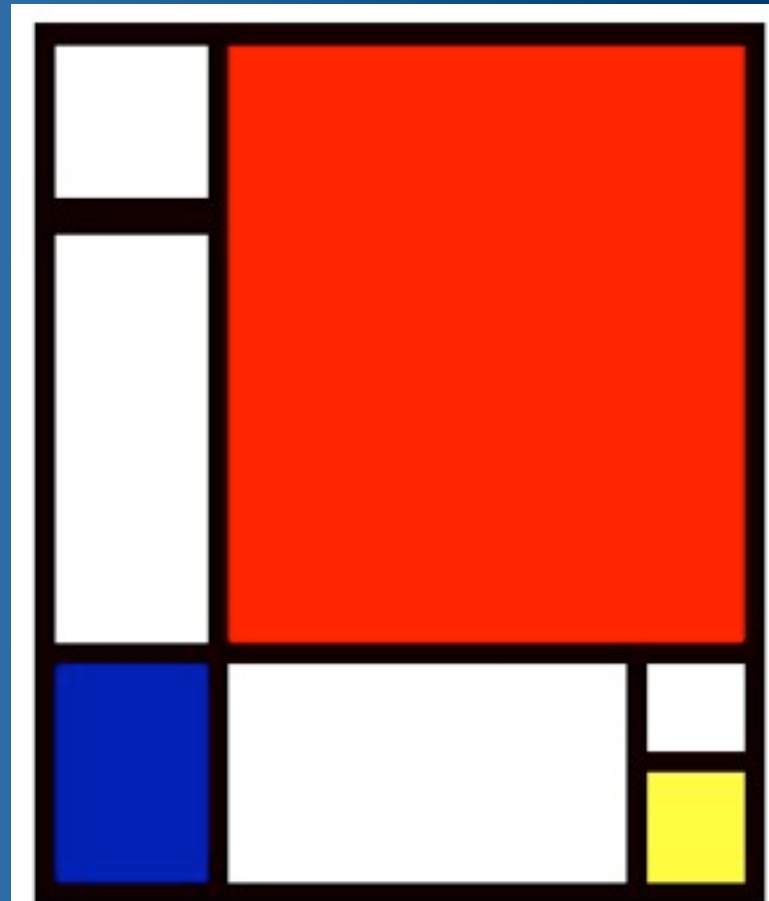
- Symptomatological phenotypes

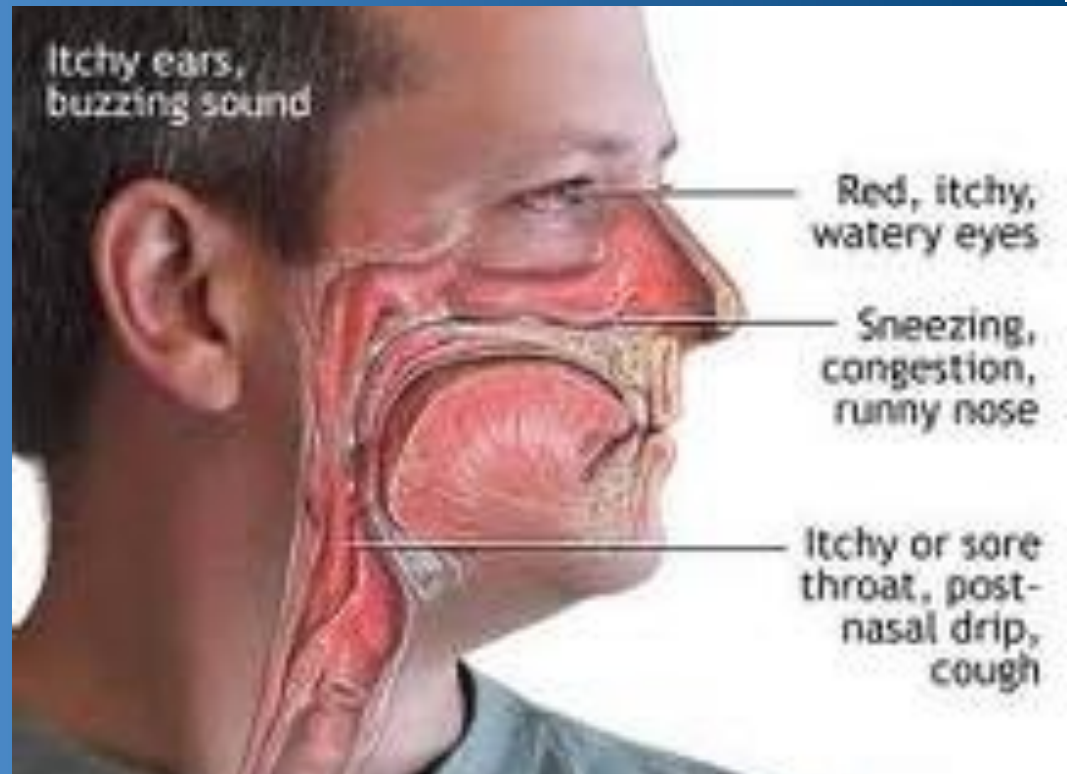


- Pheno-phenotypes



SYMPTOMATOLOGICAL

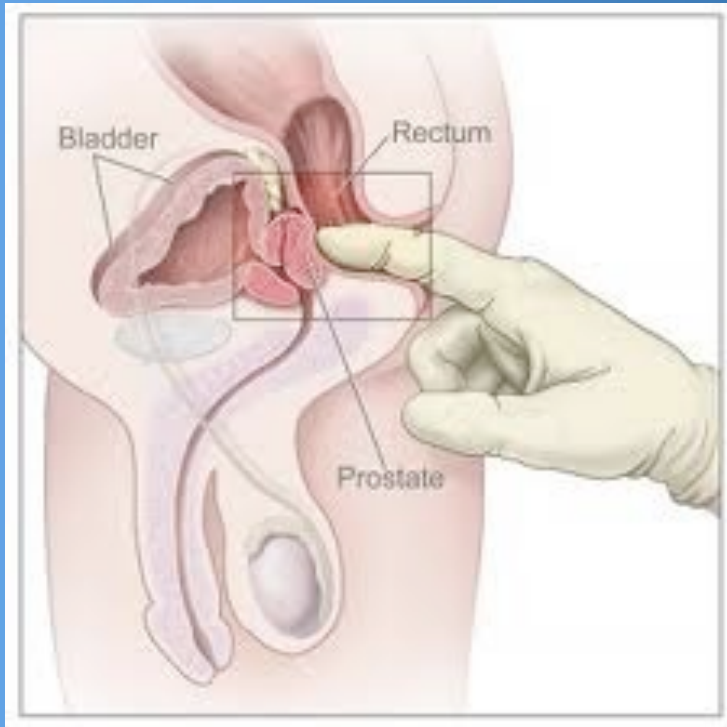




## Symptoms: What are they?

Diagnosis, compromise, metaphor, and truth

# Symptoms in bio-medicine



- A symptom is an index for nosographical diagnosis.
- It is the manifestation of an underlying/subpersonal pathology or dysfunction.

Clinical Psychopathology  
is the organon of this  
conceptualization/use of  
symptoms



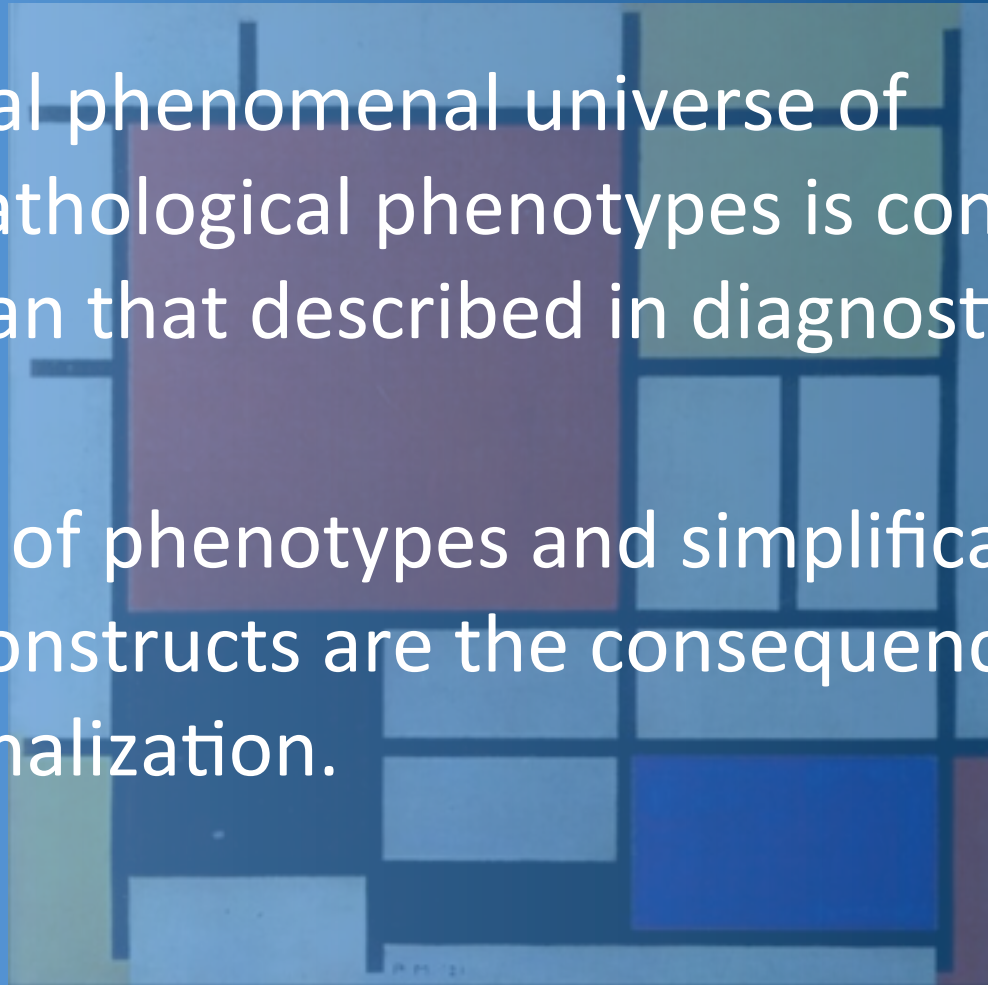
# Reliability

- Emphasis on reliability has progressively accentuated the focus on easy-to-assess, 'surface' operationalizable phenomena.
- Operational criteria are instrumental in achieving high reliability in the domain of the diagnostic schema, primarily because of their reduction of criterion variance.
- Operational criteria did some good to psychiatric practice and research, *but*:
  - contributed to shift the clinicians' focus away from the patients' personal style of experience and action and the meaning-contexts in which they are situated.



# Validity

- The actual phenomenal universe of psychopathological phenotypes is considerably larger than that described in diagnostic manuals.
- Thinness of phenotypes and simplification of clinical constructs are the consequences of operationalization.





# Utility

- The principal utility of any system of medical taxonomy relies on  
*“its capacity to identify specific entities to allow prediction of natural history and response to therapeutic intervention”*  
*(Bell, 2010).*
- Do SP identify specific entities?
  - They did not succeed to bridge the gap between clinical phenomena and their putative subpersonal causes (Heckers, 2008).
- Are SP predictive? Do SP guide therapeutic prescription?
  - They have not been successful in guiding treatment (van Praag, 1993).



# Symptomatological phenotypes:

- Operational criteria have become the phenomenal universe of what is assessed – but this universe is a virtual one.
- Diagnostic domains based on categorical and symptomatological criteria are *armchair abstractions* that have not been successful in portraying the breadth and depth and extreme variability of ‘real’ clinical phenotypes.



# Atomistic vs. holistic approach

- SP paradigm: symptoms are merely diagnostic indexes, crystallized into categorical concepts,
- Not as opportunities to access the patient's subjectivity.
- Symptoms
  - can be phenomena through which the hidden, yet operative dimension of existence is made manifest.
  - are not accidental to that patient, rather manifestations of implicit “core” dimension of her subjectivity.
- The overall change in the fundamental structures of subjectivity transpires through the single symptoms, but the specificity of the core is only graspable at a more comprehensive Gestalt-level, and not on the level of single features like symptoms (Parnas 2011).
- This *holisitc* approach bears little resemblance to the current *atomistic*



# SYMPTOMS IN OTHER PARADIGMS

# Symptoms



- Neurotic symptoms are the outcome of a conflict.
- The conflict generates anxiety.
- Anxiety alerts the Ego that a defence is necessary.
- Defences lead to a compromise between the Ego and the Id.

# Symptoms



- A symptom is therefore a compromise that at the same time defends from the desire that emerges from the Id, and satisfies this desire in a masked form.

# Symptoms as metaphors



- A symptom is a signifier that takes the place of a signified that has been repressed.
- As such, it is a metaphor, a meaningful event



# Symptoms as truth



- A symptom has the same structure of Heidegger's *aletheia*: it is the place where truth manifests while hiding itself.
- It is the contingent opportunity of a possible encounter with the repressed truth of one's

# PHENO-PHENOTYPES





# Symptomatological vs.

## Symptomatological phenotypes

- Consciousness
- Orientation
- Attention/Memory
- Formal thought disorders
- Phobias and obsessions
- Delusions
- Perception
- Ego disorders
- Affectivity
- Vital energy and psychomotricity
- ...

## Pheno-phenotypes

- Selfhood
- Embodiment
- Otherness
- Temporality
- Spatiality
- Physiognomy
- ...

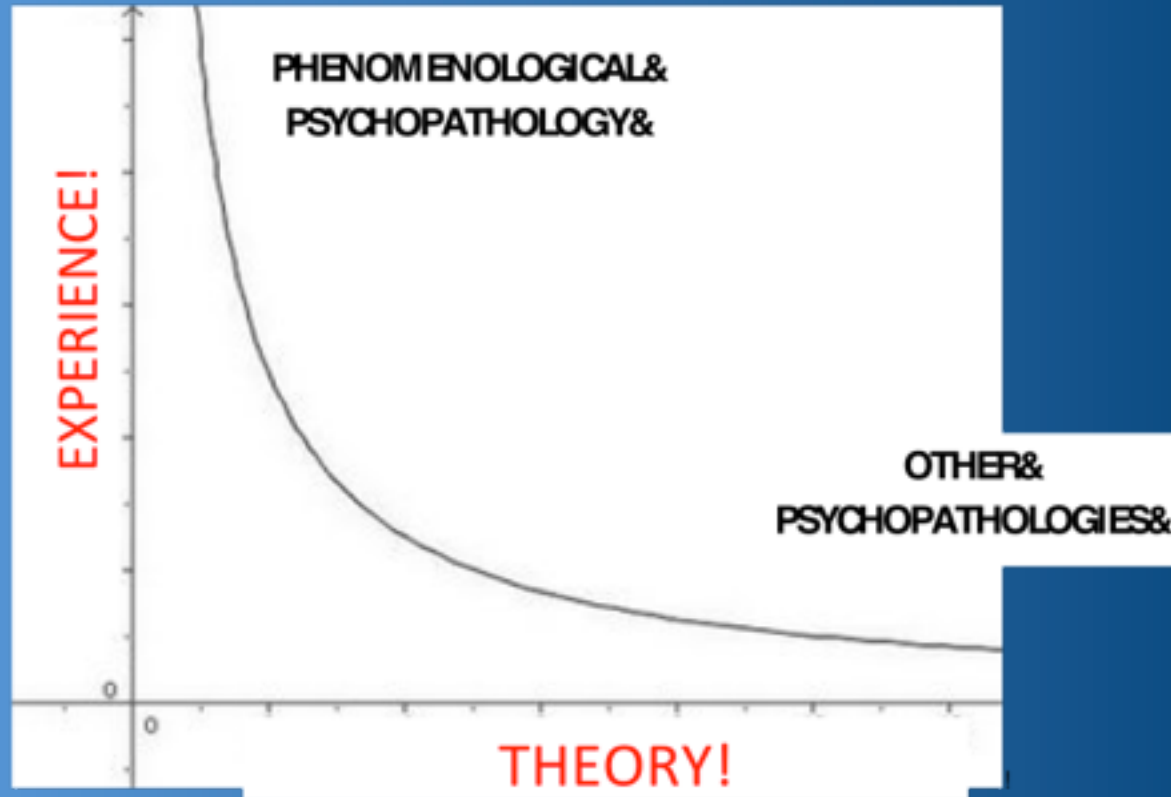
Source: *AMDP System*

# Phenomenological Psychopathology



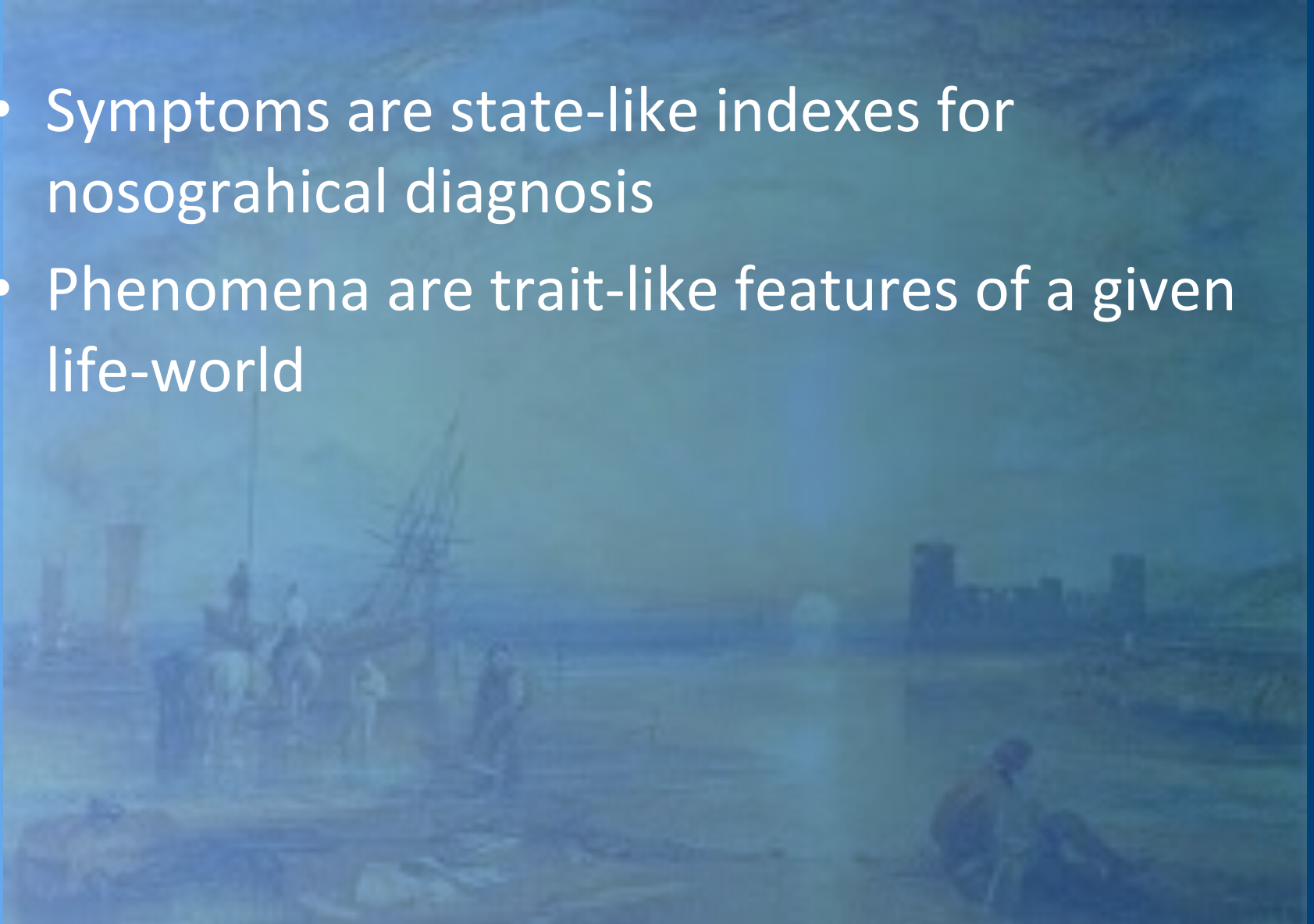
- Systematic knowledge of the patients' experiences,
  - features of a pathological condition emerge in their peculiar feel, meaning and value for the persons affected by them.
- The psychiatric object is the patient's subjectivity,
  - focus on the patients' states of mind as they are experienced and narrated by them.
- Faithful description of the manifold of phenomena in all of their concrete and distinctive features
- Revelation of those aspects that other approaches tend to overwrite with their strong theoretical and ontological claims.
- Prior to any causal accounts addressing subpersonal mechanisms:
  - theoretical assumptions are minimised and the structures of the patient's experience are prioritised.

# Phenomenological Psychopathology



# From symptoms to phenomena

- Symptoms are state-like indexes for nosographical diagnosis
- Phenomena are trait-like features of a given life-world





# The Life-World

- The reality which seems self-evident to men remaining within the natural attitude. This reality is the everyday life-world.
- The region of reality in which man can **engage** himself and which can change while he operates in it by means of his **animate organism**.
- The object and events which are already found in this realm limit his free possibility of action.
- Only within this realm can one be understood by his fellow-men, and only in it can he work together with them.
- [Only within it] can a common, communicative, surrounding world be



Alfred Schutz & Thomas Luckmann,  
*The Structures of the Life-World*. 1973

# The core of the Life-World

- Emotions are **kinetic, dynamic forces** that drive us in our ongoing interactions with the environment (Plutchik 1980; Sheets-Johnstone 1999a, 1999b).
- *Functional* states which motivate and may produce movements (Rosfort and Stanghellini 2009).
- *Protentional* states which project the person into the future providing a felt readiness for action (Gallagher 2005).





# Emotions and the life-world

- Emotions are the lived motivation for movement.
- As such they organize the life-world, i.e. the **lived space, time, self, otherness, and materiality** of objects in the world that surrounds a person.
- Emotions are the **core of the life-world**.
- An emotion situates a person, allows him to see the things that surrounds him as disclosing certain (and not other) possibilities, i.e. a given set of affordable actions



# Emotions as the “spatialising-temporalising vortex”

- There is a close resemblance between **emotion** – an impulse to move outward –
- and **intentionality** – an arrow directed at a target.
- **E m o t i o n s , a s e m b o d i e d i n t e n t i o n a l i t y**, provide my orientation in the life-world.
  - They make me turn my attention to a given direction, to be absorbed by a more or less defined object, to move (or move away from) in a given direction.
  - Emotions orient my receptivity.





# Exploring the phenomenal level

*What is the patient's style of experience and action?*

- How does the patient experience his or her world? How does he/she express, move, and define **space** as an embodied subject?
- What is the subject's experience of existential **time**? Is there a sense of continuity over time, or are there breaks or fadings of self-awareness?
- Does the patient feel effective as an **agent** in the world, or rather as only being exposed to the world?
- Is there a tendency to take an external **perspective** to one's body, actions, and self? Do the knowing and the feeling subject coincide or diverge?



# A staff for life-world descriptions

Time  
Space  
Body  
Self  
Other



# Vulnerable domains

- The result will be a rich and detailed collection of the patients' self-descriptions related to each dimension, e.g.,
  - temporal continuity/discontinuity,
  - space flat/filled with saliences,
  - bodily coherence/fragmentation,
  - self-world demarcation/permeability,
  - self-other attunement/disattunement, etc.
- In this way, starting with first-person accounts, we detect the critical points where the constitution of experience and