Theory and History in the Human and Social Sciences

Ivana S. Marková
Eric Chen *Editors*

# Rethinking Psychopathology

## Creative Convergences

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*Festschrift for Germán Elías Berrios*

# Series Editor Foreword

## Psychiatry Innovated: How History Matters

The centrally important finding of this book is diagnostic—Germán Berrios and his students have benefitted from the lifetime of *chronic bibliofilia* of the founder of the Cambridge School of Psychiatry. This deep love for books—old and new—has made it possible for Berrios to create a deeply international tradition within psychiatry that values interdisciplinary work between psychopathology, history, and psychology. The Cambridge School of Psychiatry that has been established by his diligent work on the border zone of history of psychiatry and theoretical innovations in our understanding of psychopathology has much to offer psychology.

Berrios' tradition has proliferated all over the world where many like-minded specialists—represented in this book—have in different intricate ways resisted the takeover of the human mind by waves of social and historical myopic fashions. In psychiatry—as well as in popular presentations of its subject matter in the media—varieties of naïve efforts to reduce the complexity of the mind to brain structures on either end of the *corpus callosum* have proliferated. This is the nature of the common sense mentality—it tries to reduce the mind to its simple parts. Berrios and the contributors to this book understand that any kind of intellectual reductionism—be that of neuroscientific or socio-ideological beliefs in "artificial intelligence" or "big data"—is doomed to failure. His deep knowledge of history of psychiatry has kept his mind delightfully perceptive of the naivete of any reductionism. Writing on the history of hallucinations, he commented how in the nineteenth century

> … hallucinations became 'natural kinds'– i.e., 'objects of nature' such as dogs, gold, cells, mitochondria, neurotransmitter molecules, patterns of electric firing or of blood flow in the brain – rather than abstract entities such as meaning, belief, beauty, virtue, quality, interpretation, and so on. This transformation affected the way in which certain human experiences were socially interpreted, for example, mystical visions were no longer countenanced as reflecting reality. In relation to the naturalization of hallucinations the role of the historian is to explain how it came to pass (Berrios 2005, p. 231)

It is precisely in the "science wars" of the nineteenth century where the theoretical problems that haunt us in the twenty-first century were set up (Valsiner 2012). The focus on complexity of phenomena that was maintained within the *Natur**philosophie*** of the first decades of the nineteenth century was replaced by the mechanistic intellectual engine power of *Natur**wissenschaften***. The result is an intellectual amnesia of our contemporary looks at history of the human sciences that disconnects our thinking from the first efforts of development of ideas in the second half of nineteenth century in psychology and psychiatry. These efforts remain buried on the pages of many books published in that century—and it takes a history-oriented bibliophile like Berrios to bring these out to his students.

Why have sciences over the twentieth century become aversive to philosophies? After all, our specific scientific ideas are the result of generalizing abstraction—often done without self-reflexivity. This is different in the Cambridge School of Psychiatry—here, the historical self-reflexivity of the discipline leads to the understanding of the human *psyche*. It focuses on the phenomenology of the human mind—rather than on the manualized empirical accumulations of summary data.

How can human sciences become alienated from phenomenology? I would claim that the culprit here is the ideology of empiricism—"science is empirical!" is the slogan we hear over and over again. But can this be true? There are two ways to answer that question. First, no science can be completely empirical ("data-driven") since any setup of an "empirical investigation" is embedded in a network of implicit or explicit theoretical ideas. Hence, any science cannot be "empirical only"—or if it pretends to be, it ends up being pseudo-empirical as Jan Smedslund has repeatedly pointed out about psychology (Smedslund 1991, 1995, 2016—in this book series covered by Lindstad et al. 2020). The absence of theoretical self-reflexivity does not make a science "empirical." It makes it confused.

The second way to make sense of the "empirical" is to look into the history of the meaning of that term. In the second half of the nineteenth century, it was used in the meaning of *experiential*—based on experience. The experience involved was that of the researcher or practitioner—rather than that of the person under investigation. Franz Brentano's *Psychologie vom empirischen Standpunkte* (Brentano 1874) that was of key relevance for efforts to maintain focus on intentionality of the human *psyche* used "empirical" in that sense. The primary experience of the Other is that of the psychologist or psychiatrist or of natural or social scientist in general. This makes German Berrios' many small excursions into the history of psychiatry particularly valuable.[1] He does not write *about* the experiences of the classic psychiatric authors; in his many introductions to his translations of the original texts, he *writes with* the authors. This allows him to penetrate into the emerging thinking of the classic writers in psychiatry and psychology and to show how specific terms now used routinely and unreflectively in psychology and psychiatry were results of

[1] In his journal *History of Psychiatry* (Sage), he has the habit of publishing short key texts of original authors of his translations, furnished with his introductory comments. These comments serve the function of linking the original ideas of the past with our possible future advancements of the field. History is in the service of the future.

painstaking efforts to generalize from common observations of the immediate experience. Again, science needs to transcend this empirical experience, while practice needs to recontextualize the abstracted knowledge in the new real case—a patient, an event, and, most importantly, the social encounter of the researcher and the researchee and of the doctor and the patient.

The contributions to this book emphasize the point of the dialogical nature of psychiatry—based on the reciprocity in the work of a psychiatrist with a patient. This work leads to the establishment of *cultural configurations* that set up cultural frames for biological or symbolic signals on a deep level, guiding the processes involved in the formation of symptoms. This gives us a general model of emergence of symptoms—the cultural configurators can weaken, distort, or annihilate the specificity of the biological signals and the information linked to the primary experience. This work of cultural configurations is accomplished by the direct process of Person-Others (including the case of doctor-patient) relations, under the guidance of the set of social representations inherent in the socialized human minds. The linkages of the new psychiatry of the Cambridge School with the new traditions of cultural psychology—those of Social Representation Theory of Serge Moscovici (2001) and the Dialogical Self Theory of Hubert Hermans (2018)—become visible in this volume. The interdisciplinary effort toward synthesis of psychiatry with other human sciences is one of the credos of the Cambridge School of Psychiatry.

Reading through this volume, I discover remarkable similarities between the histories of psychiatry and psychology over the last two centuries. Both started from the phenomena of deeply subjective kind (the "soul"—*Seele*—in its many manifestations) and went through a similar defense of their independence from the mechanistic natural sciences over the nineteenth century: it was a struggle which both lost. The *soul* was lost or became hidden under scientific-looking terms like *mind* and *self*. Poets—but not psychiatrists or psychologists—could operate further with the soul, science, no more.

Now—another hundred years later—we can see the rebirth of the original focus on in-depth phenomena in both psychology and psychiatry, yet maintaining the subdominant role in respect to the "evidence-based" medicine and science. The phenomena in psychopathology are of poorly definable boundaries—relying on the introspective revelations by the persons. This is an extension from the ordinary higher-level phenomena of the human *psyche* in psychology where the phenomena might be describable only in vague terms, but they have very concrete implications for the person's conduct (Janet 1921). The person—in one's ordinary roles or in that of a psychiatric patient—lives within one's own meaningful world. It is a world characterized by totality of the field. The new direction in psychiatry that the Cambridge School brings to psychiatry builds on the same general efforts that *Ganzheitspsychologie* tried—and failed—hundred years ago (Diriwächter 2008). Instead of figuring out how the vague abstract fields—like justice, honesty, corruption, fidelity, etc.—operate in human lives, science demanded the forgetting of the whole and counting its parts as if these told us the full story. They never did.

It is perhaps time for both psychiatry and psychology to try again—based on the axiom that *precision in the case of mental phenomena is in their vagueness* of

presentation by signs. This has profound implications for our research practices—instead of "measurement" of the mental symptoms as objects (something that is), the focus would need to be on the potential for emergence. The borders of psychopathology are being tested constantly in our ordinary minds that comes close—but need not usually surpass—the vague border of "norm" and "pathology." Where does the ordinary imagery of one's parents' voices in everyday life ("I hear my mother saying be careful!") transcend to the state where these voices become felt as if overwhelmingly "controlling," "surveying," or "torturing" the person. The latter case is that of crossing the border on the normal road from ordinary to pathological state of mind—a novelty *added on* to the previous normal state (Marková and Berrios 2011). Psychopathology can be a domain of growth—albeit in a discomforting direction—rather than a loss of previously normal function. As such, these growth moments are parts of the general personal life course where different individual life trajectories can converge upon similar general state. Chen's example (Chapter 8 in this volume) illustrates the equifinality in the emergence of symptoms:

> In a real-life clinical example, a civil servant who had for a few years been under investigation for corruption was notified that the investigation concluded with no charges against him. Nevertheless, for many years afterwards, he continued to feel under surveillance and being followed on the streets. The perception of surveillance took place in a context of past events (i.e. a diachronic context). This situation is expected to carry very different weight from another person who feels that he/she is being followed on the streets *de novo* without the same background. Symptoms that occur directly in response to a stressor are more likely to subside when the stressor is removed. A symptom that emerges without an explicit external stressor would be expected to be less likely to subside with changes in the environment (p. 69, added underlining)

What follows from this example—and many other ideas expressed by the contributors to this book—is not the generic call "context is important!" but its developmental relevance (cf. Villagrán Moreno and Luque, Chapter 11). There are many ways to the same (looking) symptom—a basic principle in any open systemic phenomenon. *Contexts—and the phenomena they are contexts for—emerge and transform in time and in relation to macro-social meanings* (e.g., "corruption," "abuse," etc.) that constitute social valuation imperatives in the given society at the given time. The development of such macro-social meanings is expected to be divergent from the meaning construction of individual persons. I as a father of a by now adult daughter might have had no idea that my gentle embracing her as she was a beautiful adolescent could be by now—retrospectively—viewable as "abuse." The reverse divergence is also possible—a mother may be convinced that she has been hitting her adolescent daughter and accusing herself—"I am an abuser and feel guilty of it"—until it was found out that none of this actually happened (Museaus and Brinkmann 2011). Psychopathology becomes discovered in the latter, not the former. It is the insight into one's own feelings and thinking rather than responses to standardized questionnaires that is the focus of clinical practice and—ideally—of research. The distinction of awareness from insight (Marková and Berrios 2011) is crucial for both psychiatry and psychology.

Last—but not least—it is the profoundly international nature of scholarship that characterizes the Cambridge School of German Berrios, and that is visible all through this book. The integration of perspectives from South America and Europe, with their further extensions to the rest of the world, gives us a true example of how scholars from very different backgrounds intellectually fertilize one another on the path of searching for new solutions in a developing medical science as psychiatry is. There is much for all of us to learn from the Peruvian-accented European thinking that the love for books brings to our new science.

Aalborg, Denmark Jaan Valsiner
November 2019

## References

Berrios, G. E. (2005). Introduction to "On the fantastic apparitions of vision" by Johannes Müller. *History of Psychiatry, 16*(2), 229–246.

Brentano, F. (1874). *Psychologie vom empirischen Standpunkte*. Leipzig: Verlag von Duncker & Humblot.

Diriwächter, R. (2008). Genetic *Ganzheitspsychologie*. In R. Diriwächter & J. Valsiner (Eds.), *Striving for the Whole* (pp. 21–47). New Brunswick: Transaction.

Hermans, H. J. M. (2018). *Society in the self*. Oxford: Oxford University Press.

Janet, P. (1921). The fear of action. *Journal of Abnormal Psychology and Social Psychology, 15*(1), 150–160.

Lindstad, T., Stänicke, E., & Valsiner, J. (Eds.). (2020). *Respect for thought*. New York: Springer.

Marková, I. S., & Berrios, G. (2011). Awareness and insight in psychopathology: An essential distinction? *Theory & Psychology, 21*(4), 421–437.

Moscovici, S. (2001). *Social representations*. New York: New York University Press.

Museeus, P., & Brinkmann, S. (2011). The semiosis of family conflict: A case of home-based psychotherapy. *Culture & Psychology, 17*(1), 47–63.

Smedslund, J. (1991). The pseudoempirical in psychology and the case for Psychologic. *Psychological Inquiry, 2*(4), 325–330.

Smedslund, J. (1995). Psychologic: Common sense and the pseudoempirical. In J. A. Smith, R. Harre, & L. van Langenhoeve (Eds.), *Rethinking psychology* (pp. 196–206). London: Sage.

Smedslund, J. (2016). Why psychology cannot be an empirical science. *IPBS: Integrative Psychological & Behavioral Science, 50*, 185–195.

Valsiner, J. (2012). *A guided science: History of psychology in the mirror of its making*. New Brunswick: Transaction Publishers.

Valsiner, J. (Ed.). (2020). *Social Philosophy of science for the social sciences*. New York: Springer.

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# Chapter 1
# Introduction


**Ivana S. Marková and Eric Chen**

## Contents



At the heart of psychiatry lies psychopathology, the language that was created over the course of the nineteenth century to systematically describe and capture anomalies in mental states and behaviours of those deemed to be mentally disordered (Berrios 1996). Constructed at a time when the natural sciences were facing challenges from the newly arising human/social sciences in the search for explanation of human beings, psychopathology became imbued with the same tensions. As such, its foundations sit somewhat uneasily between both the natural sciences and the social/human sciences. This has had lasting and important consequences. Foremost among these has been the result that understanding and research into psychopathology has tended to polarize and oscillate between approaches that are either firmly neurobiological on the one hand or social constructionist on the other. Currently, the neurobiological drive is particularly strong and leads to a narrow and mechanistic conception of the nature of mental phenomena and underlying psychological processes.

Eschewing such divisions and taking an original and epistemologically justified approach, Germán Berrios and his school of psychopathology argue that the foundations of psychopathology need to be understood as hybrid in nature. And, hybrid has to be understood in the literal sense, that is, in the sense that deeply incongruous elements are jointly involved in the constitution and structure of psychopathology. This is the central and crucial thesis. So, what then are these incongruous elements?

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Firstly, there is *neurobiology*, the material element that forms a medium through which we can exist and function. There is no disputing that our brains and nervous systems are necessary for the functioning of our mental processes. Secondly there is *meaning,* a fluid-like, non-material element that carries both personal and collective (family, peer, social, cultural) components. The incongruity is obvious. We have one element composed of matter, present in time and space and fixed within one person. We have another element, non-material, non-tangible, present in time but not the same kind of space and extending beyond the one person. Yet both these elements are necessary and are woven together to form the clinical phenomena that are described and captured by the language of psychopathology. Our understanding of both psychopathology and our research needs to be based on this epistemological foundation.

This epistemological position does raise certain challenges. Firstly, how such incongruous elements, the material and the non-material, can be bound to form a complex remains a question, one, moreover, whose answers must be sought in what seems like a no man's land at the interface of science and philosophy. Acknowledgement of this problem, however, does not obviate the significance of this fundamental position and its consequences. Indeed, it serves to highlight the need to recognize that mental states and behaviours are inherently complex. We would stand to lose a lot in terms of our future understanding and knowledge should these be reduced to either the neurobiological or the sociocultural. The biopsychosocial model, so often used in relation to our understanding of mental states and behaviours, is a pragmatic approach where neurobiological, psychological, and social factors are all viewed as important influences in the presentation of clinical phenomena. However, it is not a justified epistemological position. On this model, the neurobiological, psychological, and social factors work in an additive way rather than in any real interactive sense.

Secondly, there is the challenge of determining the extent to which each element might contribute to the structure of individual psychopathological phenomena and hence give them their structural and clinical salience. Given that psychopathological structures, whether mental symptoms or disorders, are heterogeneous, it is likely that there is considerable variation in the degree to which *neurobiology* and *meaning* carry the weight or 'sense' of the symptom. This is important also because of the possible therapeutic implications but is a question that may be more amenable to empirical research.

Thirdly, there is the challenge of addressing, in a serious way, the nature of *meaning*, the nebulous, non-material component of psychopathological phenomena. Exploring the *meaning* underlying mental phenomena and how this may be configured is a particularly complicated endeavour. It entails an approach that draws on history, psychology, culture, linguistics, anthropology, and hermeneutics among others. In addition, however, it involves a twofold interrelated exploration in which simultaneously the content or sense of the meaning is sought along with how it becomes configured in the first place. Understanding the nature and role of such configurators becomes particularly relevant when making sense of psychopathological phenomena and their development.

Building on this hybrid epistemology and its challenges underlying psychopathology, Germán Berrios has been the central figure and creative pioneer. Through his teaching and collaborations with students and colleagues from all over the world, he has developed a rich and original framework on which this field continues to grow and evolve. An inspirational scholar and teacher, whose thinking cuts across subject domains and professional disciplines and whose imaginative ideas forge new paths in the exploration of reality, Berrios makes us question assumptions, helps us examine concepts and phenomena in novel ways, and stimulates in all of us new questions and new directions of enquiries. His contribution to psychopathology is immense, seen through not only his substantive and significant outputs such as his acclaimed *History of Mental Symptoms* (1996) but in the publication of an extensive body of original articles. There, among other things, he provides conceptual analyses on mental symptoms, showing how historical, cultural, and psychological factors contribute to their construction and how and why this is made possible within specific historical epistemes (e.g. Berrios 1981, 1988, 1990, 1995, 1998, 1999). His journal, *History of Psychiatry*, started with Roy Porter is renowned for its epistemological focus as well as historical depth. His wealth and breadth of knowledge in history, philosophy, psychology, statistics, and psychiatry has attracted students and colleagues from all over the world. Much of the resultant collaborative work has become known as the Cambridge school of psychopathology.

This volume is a small homage from some of his students and colleagues. We are all too aware that we have not been able to include everybody who would have wanted to contribute. We have had to rely on the contacts we knew about or found out about from others, and this task was complicated by the fact that his collaborators spanned not only geographical distances but also generations. We apologize to those we have been unable to contact. As such, the contributors here come from all continents of the world, and the chapters focus on different aspects of the broad transdisciplinary approach to the exploration of psychopathology as developed by Germán Berrios and the Cambridge school of psychopathology.

Despite not being fully representative from the perspective of contributor inclusion, in other ways the chapters that follow reflect very much the multifaceted and variegated approaches to the study of psychopathology and related areas that characterize and/or are inspired by the work and ideas of Germán Berrios. The contributions are diverse. There is no particular underlying theme around which the chapters are focused. Instead, each chapter brings its own particular interest and emphasis. Each addresses its own specific issues. We thus have a mosaic of articles whose common link is that they have each been influenced in one way or another by the work and ideas of Berrios.

We have divided the volume into parts for ease of reference. However, reflecting the consequences of a root hybrid epistemology, many of the chapters do overlap these divisions both in content and in approach. The first part is a personal one. It begins with an account of some of the early background factors important in the work and development of ideas of Berrios (Huarcaya-Victoria). This is followed by three separate recollections of working with Berrios, each giving a different slant on their experiences (Castagnini; García Caballero & García Lado; Kirkby).

The second part deals with epistemological enquiries. Here we begin with a detailed analysis of some of the main threads underlying the psychopathological work of Berrios (Fuentenebro & Chiva). After this, there are chapters that address specific epistemological problems relating to psychopathology. Here we first delve into the question of how can we define or understand psychiatry (Marková). Then, we discuss the nature and importance of contextual factors in descriptive psychopathology (Chen). This is followed by consideration of the role of conceptual analysis in psychiatric nosology, illustrating this specifically with the concepts of stress and distress (Starkstein). The meaning and role of cultural configurators in the construction of mental symptoms are then examined (Luque & Villagrán), followed by an analysis of the problem of psychogenesis (Villagrán & Luque). Finally, in this part, Ihara explores the concept of supervenience and the mind-body problem in depression.

The third part addresses psychopathology and related medical areas from a historical perspective. Again these represent diverse areas of study. Aragona offers an examination of hermeneutic psychopathology, emphasizing its relevance and ubiquity and exploring its historical roots in order that we can develop better ways of making sense of patients' experiences. Other chapters are more narrowly focused on specific historical studies. Thus we have an account of the development of epidemiological studies into psychopathological syndromes over a 15-year period in particular regions of Santiago, Chile (Alvarado & Valdivia), a description of how psychiatry and psychopathology evolved in Portugal between 1915 and 1940 (Pereira), and there is a historical reassessment of the contribution to medicine of Valverde, a sixteenth-century Spanish anatomist (Rodríguez). Taking a different approach, Dudas focuses on the relevance of historical understanding for the practising clinician. And Schioldann completes this part with a detailed analysis of Wimmer's concept of psychogenic psychoses.

The fourth part is more specifically focused on psychopathology, and the chapters here again explore various and distinct aspects of this. Thus one chapter examines the concept of formal thought disorder and argues for the need to explore possible meaning hidden in or symbolized through this psychopathological phenomenon in order to enhance communication with patients (Barrera). Then there is a critical exploration of the concept of post-traumatic stress disorder and the debates this syndrome generates (Shalev). This is followed by a chapter focusing specifically on the notion of time in psychopathology, exploring the contribution of time distortions to psychopathological phenomena (Holguin Lew). In a completely different vein, we have an analysis of the symbology in Frida Kahlo's art and its possible associations with psychopathology (Quintanilla-Madero). Lastly, the chapter by Avila seeks to apply the Cambridge school of psychopathology model of symptom formation to the development of medically unexplained symptoms.

The final part contains two chapters focusing on neuropsychiatric aspects of psychopathology. Here, some of the issues concerning the disentangling of *neurobiology* and *meaning* alluded to earlier can be more concretely raised in relation to

specific neuropsychiatric conditions. Thus, Dening explores the nature of psychopathological phenomena in patients with Wilson's disease, and Quemada examines the structure of psychopathological phenomena in patients with acquired brain injury.

As already mentioned, the contributions in this volume tend to take approaches that cross the divisions marked by the parts. Thus, there are, for example, epistemological considerations in most of the chapters. Similarly, explorations of psychopathology are present in all parts, and historical approaches are deliberated in both the epistemological and psychopathological parts. While not pretending to match the scholarship of Germán Berrios, these methods, seeking to explore concepts in depth and from a multitude of perspectives, are a tribute to his work and teaching. More importantly, however, they form the basis to a legacy of thinking and approaches to the study of human behaviour and mental states that is vital for ongoing meaningful research into psychopathology and for the ensuing benefits to patients.

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## References

Berrios, G. E. (1981). Stupor: A conceptual history. *Psychological Medicine, 11*, 677–688.
Berrios, G. E. (1988). Melancholia and depression during the 19th century: A conceptual history. *British Journal of Psychiatry, 153*, 298–304.
Berrios, G. E. (1990). Feelings of fatigue and psychopathology: A conceptual history. *Comprehensive Psychiatry, 31*, 140–151.
Berrios, G. E. (1995). Déjà vu in France during the 19th century: A conceptual history. *Comprehensive Psychiatry, 36*, 123–129.
Berrios, G. E. (1996). *The history of mental symptoms*. Cambridge: Cambridge University Press.
Berrios, G. E. (1998). Confabulations: A conceptual history. *Journal of the History of Neurosciences, 7*, 225–241.
Berrios, G. E. (1999). Anxiety disorders: A conceptual history. *Journal of Affective Disorders, 56*, 83–94.

# Part I
# Personal

# Chapter 2
# The Academic Beginnings of Germán Berrios at the 'Universidad Nacional Mayor De San Marcos'


**Jeff Huarcaya-Victoria**

## Contents



## Introduction

Psychiatry is currently in a weakened epistemological position due to various internal conceptual anomalies. Research in the epistemological history of psychiatry shows us that this crisis may be due, in part, to the implicit theoretical presumption that mental symptoms are observed at a purely descriptive level (Marková and Berrios 2016; Aragona and Marková 2015). During the last decades, biologically oriented empirical research, independent of culture and language, has been dominant in psychiatry. However, despite these decades of research, our understanding of mental disorders and our available treatments are still limited (Berrios 2013). This would indicate that the aforementioned empirical research may not be sufficient or that we are not tackling the problem in a comprehensive way. Therefore, it is necessary to return to the conceptual bases of psychiatry and explore once again the conceptual underpinnings of psychiatry, mental disorders and mental symptoms.

Although the vast majority of psychiatric literature focuses on studying the causes and treatments of mental disorders, there are a few but important research groups in charge of the conceptual study of mental symptoms. One of these groups is that of the Cambridge School, which began its work in 1977. This school consists

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of more than 50 international scholars, mainly clinical academics. They approach research in psychiatry through the tripod of philosophy, history and empirical perspectives and have yielded very good results, as seen in more than 500 articles written by the school in different languages.

The renowned Peruvian psychiatrist Germán Elías Berrios leads this successful school. Berrios' academic work is well known. Here we want to focus on his academic beginnings, because these were critical to the development of his prolific thinking and to the later establishment of the Cambridge School. Thus, the main objective of this work is to trace professor Berrios' first ideas during his training as a physician and philosopher at the 'Universidad Nacional Mayor de San Marcos' (UNMSM).

## The Beginnings and Context of the Protagonist

Germán Elías Berrios Marca was born on April 17, 1940, in the city of Tacna, in southern Peru. He pursued his first studies at the 'Colegio Nacional Coronel Bolognesi'. Later he moved to Lima to study, at the same time and almost clandestinely, medicine and philosophy at the UNMSM. Berrios began his work experience in psychiatry in 1957 during his first years of medical training. At this time, he started working at the 'Clínica Delgado' in Lima and had to take care of patients with mental disorders in order to earn money to help finance his education. After a short while, he started participating in medical visits organised by Honorio Delgado at the 'Hospital Víctor Larco Herrera'. These early experiences taught him that mental disorders were very complex and that they required more resources than medicine could provide. Later on, he participated in the student movements of the early 1960s in the UNMSM. In 1961, he married Doris Alvarado Contreras, daughter of a famous Peruvian motorist (Gambetta 2008). Initially they lived near the university, as he himself recalls: '… in a small room on the third floor, on a street called *La Colmena*' (Berrios 2000). It was in that small room where prominent figures of the Peruvian *intelligentsia* of the time came together, such as the great indigenist José María Arguedas, from whom the young couple learned about Peruvian literature and ethnology. During that time, they enjoyed the friendship of various prominent figures, some of whom are currently top intellectuals in Peru, such as Max Hernández, Saúl Peña, and Mirko Lauer, among others (Berrios 2000). Berrios was able to complete his training as a doctor in 1965, after completing his medical internship at the then-called 'Hospital del Empleado' (Mazzotti 1996).

During the 1950s and 1960s, the time when Berrios was educated, the Peruvian academic context in general and philosophical context in particular were not determined by the continuation of a long intellectual tradition reaching its maturity but rather by various socio-political crises that marked Peruvian life (Salazar-Bondy 1967). Those years were characterised by the spreading of the social ideas of Peruvian thinkers such as José Carlos Mariátegui and Víctor Raúl Haya de la Torre. At the UNMSM's School of Philosophy, Berrios had Augusto Salazar-Bondy as his

professor, a renowned Peruvian philosopher who questioned and criticised the philosophy that had been developing in Peru and America, and subsequently advanced these ideas in his book *¿Existe una filosofía de nuestra América?* (Is There a Philosophy of Our America?) (Salazar-Bondy 2006). Another of his outstanding professors was Víctor Li-Carrillo Chia (1929–1988), a disciple of Martín Heidegger, who helped Berrios obtain a scholarship for a doctorate in philosophy in Freiburg under the tutelage of Heidegger. In the event, he was unable to pursue this for nonacademic reasons, and instead went on to the University of Oxford. One of Li-Carrillo's postulates was that the relationship between objects and names was merely accidental, which hinders us from coming to know the former through the latter (Vexler 2000). All of this went hand in hand with the changes that were occurring throughout the world, such as the weakening of the logical positivism of the Vienna Circle. Instrumental to this was the use of Popper's falsification principle as a criterion of demarcation for science instead of verificationism. In addition, the dissemination of the works of Kuhn, Foucault and Feyerabend, among others, changed the way in which science was understood and taught. Emphasis was no longer put on men, and instead people began to talk about ideas as living entities that evolved over time and that used men in order to manifest themselves as expressions of social, political and economic changes (Levy and Vaschetto 2010).

These new views on science and the social justice model that sought to build a better world with fewer economic differences among social groups made their way into the UNMSM's School of Medicine. There, they came into conflict with the traditional ideas of the old-school doctors, reaching a point of maximum disagreement in the schism of 1961 (Zárate and Cárdenas 2017; Bustíos 2006).

The state of Peruvian psychiatry during the 1950s and 1960s was no less complicated. The undisputed major figure at that time was Honorio Delgado, a Peruvian psychiatrist with philosophical interests, and an early theoretical approach to psychoanalysis (Delgado 1919, 1926). Delgado was later influenced by the psychiatry and philosophy of Jaspers, and came to be considered as 'the South American that knows Jaspers best' (Jaspers 1955), and was, according to Berrios, '… probably the Peruvian psychiatrist with the best philosophical education' (Berrios 1966, p. 32). Delgado, in his day, was the only Peruvian psychiatrist that concerned himself with the concepts of psychiatry. The open rejection subsequently shown by Delgado towards psychoanalytic ideas, along with his apprehension of an organic and phenomenological model, prevented any possible vocation for psychoanalysis in the new psychiatrists of the first half of the twentieth century (Silva 1979). However, after the 1950s, the first non-official schooling of psychiatrists in Peru was carried out under the leadership of Carlos Alberto Seguin. Up until then, Delgado had been the only professor of Peruvian psychiatry recognised as such. Seguin, at the 'Hospital Obrero de Lima', created the 'Grupo del Obrero', in which several psychiatrists were trained under a psychodynamic and psychosomatic model (Huarcaya-Victoria 2016). Due to the clear ideological differences between these psychiatrists, the disagreements, sometimes extending beyond the academic became increasingly pressing. This rivalry came to a head in 1961, because of the strike at that time for the co-governance of the UNMSM's School of Medicine. After this, Delgado and

another group of doctors resigned from their positions as professors and founded their own university. This caused Berrios to distance himself from Delgado. By 1964, apart from the two schools already mentioned, other groups were organised: one led by Humberto Rotondo of psychobiological ideology at the 'Hospital Hermilio Valdizán' and another led by Raúl Jerí of eclectic ideology at the 'Hospital de la Policía' (Valdivia 1964). It was common for several of the psychiatrists who were training in the 1950s and 1960s to take part in one of these schools, taking them on with great enthusiasm and often without critical rigour. However, this was not the case with Berrios, who, thanks to his philosophical training, was able to observe and question critically the different psychiatric schools of that time and use this as the basis for writing his bachelor's degree thesis.

## The 'Problems of Contemporary Psychiatry'

Let us now review Berrios' first thesis entitled '*Problems of Contemporary Psychiatry*'. We found this thesis in the library of the 'Hospital Hermilio Valdizán' in Lima, which has the original annotations of one of its reviewers: Humberto Rotondo (the other reviewers of his thesis were Raúl Jerí and Óscar Valdivia).

In the first pages of his thesis, we can find the following paragraph:

> … accentuating the clearly positivist thinking that permeates Peruvian medicine will not lead to important scientific contributions, but far from it, going over and over certain topics constricts and transforms a thesis work into a rushed and inaccurate, statistical, numerical work whose usefulness is relegated to only a single aspect of the medical endeavour: the diagnosis. (Berrios 1966, p. 32)

We can see that here Berrios was warning about the predominance of empirical over conceptual research. As a foreshadowing of what his future works would be like (Marková and Berrios 2012; Berrios 2011b), he defended the right to be able to carry out epistemological work, pointing out that this had both a theoretical and a practical value. The proposed epistemology of psychiatry should include an analysis along several perspectives: (1) historical, giving a sort of biography of the concepts; (2) systematic, placing the concepts within the referential framework to which they correspond; (3) problematic, explaining the situation in its context; and (4) dialectical, explaining the elements. With this, he did not seek to propose solutions to the problems of psychiatry but to give an approximation to a metapsychiatry or epistemology of psychiatry.

Berrios, when trying to demarcate the limitations of his thesis, mentioned:

> In the worst-case scenario, all of the problems presented will have already been solved in the intellectual evolution of the psychiatrist readers. (Berrios 1966, p. 7)

What were the problems in psychiatry that he alluded to at the time of writing his thesis? There are mainly two problems: (1) the classification of psychiatry within medicine and (2) its relationship with other scientific areas. Regarding the first problem, Valdivia wrote: '… the paths of psychiatry belong to medicine' (Valdivia

1964). However, this did not seem completely correct to Berrios, who wrote that medicine, being a natural science, could not do full justice to psychiatry which he conceived as a 'special type of science' (Berrios 1966). If we considered psychiatry as a natural science, this would place it under the aegis of medicine. Alternatively, however we could understand psychiatry as a hybrid science, one that lies between the human and natural sciences. The latter option would lead us to having to rethink its classification within medicine or indeed to redefining medicine itself. These initial considerations were not simply theoretical, since psychiatrists are eminently practical in trying to help their patients. The acute perception of Berrios allowed him to realise that, in the context of the 1960s, there were problems with psychiatric treatment (a thesis he would maintain and support in his future work). In this connection, he wrote:

> The supreme hour has arrived when treatments multiply, successes are statistically similar, and one is floating in an area of dead water, where we are never sure about a treatment, where we use the euphemism of 'readaptation,' etc., and where all of the incoherencies that we usually placate with our eclecticisms receive full luminosity. (Berrios 1966, p. 17)

The second problem, concerning the relationship between psychiatry and other scientific areas, was widely covered in the subsequent chapters of his thesis. We will review the most important ideas of each of these relationships.

## *Concerning Psychiatry and Philosophy*

Berrios began this chapter by mentioning that the relationship between psychiatry and philosophy has not been adequately studied. This is a fundamental problem since the philosophical currents that are prominent in a certain time period will shape the way of thinking in medicine. Psychiatrists, therefore, should have philosophical training. How though should such training be given? For Berrios, it should be a comprehensive process consisting of incorporating philosophy into education and life itself. What do we look for in philosophical training? We seek to incorporate the corrective elements in our referential systems, in addition to guaranteeing an adequately consistent function. However, he warns us that in search of this consistency, we should not fall into eclecticism, which is dangerous for psychiatry since it does not guarantee an adequate epistemological consistency.

## *Concerning Psychiatry and Science*

Given the challenges faced by the sciences, there are two courses open to them in order to survive, the licit and the illicit. He listed some illicit courses used by psychiatry to survive by drawing on various resources. Firstly, there were heteronomous resources, in other words, involving the use of deus ex machina explanations

as in psychoanalytic ideology. Secondly, there were poietic resources, which involved the creation of new postulates, increasingly distant from the initial theories, as in the case of the aforementioned eclectic psychiatry. Thirdly and, perhaps, most interestingly, there were semantic resources, in relation to which he said:

> The circulation of terms is so profuse in psychiatry and, above all, the words are so substantialised, that a time comes when, as Ortega denounced Kant in regard to another topic, 'reality is forced into certain schemes': in our case, nosological labels or 'interpretations'. (Berrios 1966, p. 37)

A very striking as well as disturbing assertion lies in this question: might it be that some nosological labels are mere semantic resources that seek to keep the scientificity of psychiatry safe? He wrote that 'the scientific search for psychiatry has died', to which we can add that psychiatrists have killed it, to paraphrase Nietzsche.

What licit solutions are there to the problem of the survival of psychiatry as a science? There is a theoretical solution: to define clearly what is the object of study of psychiatry. However, a new problem emerges, namely, if medicine has already defined its object of study and its problems, what space is there left for psychiatry? Should it set new limits or should it follow those already established by medicine? For Berrios, it is clear that we must define new limits for psychiatry and its relationship with medical science. Psychiatry is then:

> … the study of psychological meanings, that is to say, that it has as its object the singular and dense tissue of the psychological fact insofar as this is a complication of the disease, or a result of the disease *per se* whose aetiology, or rather, the knowledge of whose aetiology will not change any particular approach. (Berrios 1966, p. 41)

This psychological meaning refers to the particular sense inherent to patients' reasoning that in turn has to be understood in the context of their biological, physical, biochemical and social aspects. A different solution, a practical one, would be for psychiatry to be assimilated by neurology or for it to become a medical psychology. In other words, this would then lead to the disappearance of psychiatry as a discipline.

## *Concerning Psychiatry and Neurology*

If we do not want psychiatry to be absorbed by neurology, we must independently and properly delimit the psychological fact or meaning. However, we confront another problem. Changes in the neurophysiological paradigms and new interpretations of the singularisation of the person have led to the assimilation of psychological meaning to neurophysiology. Berrios had to point out the limitations of this assimilation. In this regard, he wrote:

> … neurophysiology is a natural science that treats man in the 'third person.' Its work has to be at the level of generalisations, of statistics. It is eminently inductive: it moves away from the specific in merit of a legal search that confirms it as a science. (Berrios 1966, p. 48)

In other words, neurophysiology (and we can extend this to current neurobiology) is not in the realm of being able to understand complex meaning. The object of psychiatry needs to be based on the complex relations that exist between consciousness and the organic, between the psychological and the social. This would entail an area of work in its own right. These ideas were later developed by his professor Pedro Ortiz, who proposed a theory of the 'psychobiology of man' (Ortiz 2010, 2012). However, two further problems do not allow for the adequate independence and delimitation of the psychological fact:

1. The first is the differentiation between organic and functional aspects. Making a historic analysis, Berrios mentioned that the paradigm shift in medical pathology, driven by new endocrinological discoveries, was carried over to psychiatry, with which the concept of functional pathologies was introduced. The difficulty occurs when people, accustomed to a false dichotomy, mention that a functional problem, lacking a material substrate, necessarily needs to be spiritual. The solution would be for psychiatrists to begin to understand function as understood by other physicians, who have already left the old causality model of diseases and are now more interested in relational schemes or functions.
2. The second is the problem of mind-body dualism. There are up to four possible approaches to tackling this problem:

   (a) The body does not matter since everything is psychological: an idealistic postulate that, according to Bunge, cannot be accepted because it is incompatible with the sciences (Bunge 2011).
   (b) The body is a sign of the soul.
   (c) The body and soul are manifestations of another substance: a thesis that worked as the basis for psychophysical parallelism.
   (d) The body is a way of being lived: it is not merely an object in the world but our way of communicating with it, thus leaving the world to be understood not as a simple sum of objects but as a place where our experience occurs (Merleau-Ponty 1957). In future works, Berrios elaborated on these initial ideas of the problem of the mind-body relationship (Berrios 2018).

If we were able to solve these problems, then it would no longer make sense to talk about diseases of the body or the soul. The disease then emerges:

> … as a complex phenomenon that is explicit on levels determined by the type of approach imposed on it and whose various aspects will integrate themselves to the extent that the semantics of each area so allows, but will never be reduced because they mean only another type of knowledge, but at the same time another type of language. (Berrios 1966, pp. 62–63)

Another type of knowledge (epistemology of psychiatry) and another type of language (psychopathology) are the elements that delimit the field of psychiatry, making its absorption by neurology impossible.

## *Concerning Psychiatry and Psychology*

Psychology presents itself to psychiatry with two major problems: methodological and theoretical. Concerning the first problem, we could ask ourselves: what kind of approach should psychiatrists have in regard to the specific study object of psychiatry, natural-scientific or psychological? Berrios is categorical in his response:

> In addition to the psychological methods that work to explicitly determine a behaviour, do *the natural-scientific methods work for psychiatrists? The answer must be negative*. (my italics) (Berrios 1966, p. 66)

> If, as we have seen, the object of psychiatry turns out to be a sector of phenomena of special psychological texture, with laws that psychology requires and that are given in regard to human beings or rather to 'sick' human beings, then the research topic, *the main concern of psychiatry, is not to be neither the biochemical nor the neuropathological work, etc., it will be the psychological field, the significance of the symptomatology*, its diversity and uniqueness compared to a common noxa. It will not be, we iterate, the noxa itself. (my italics) (Berrios 1966, p. 65)

These ideas were the beginning of his studies about the relationship between the human and natural sciences and the object of study of psychiatry (Berrios 2011c). Psychiatry is part of both the human and natural sciences, with the first being responsible for providing the definition of mental disorder while the second seeks the possible relationships between these 'mental disorders' and brain alterations. Therefore, natural sciences themselves are not enough to define mental disorders (Berrios 2011a). Continuing with the review of his thesis, we are faced with an affirmation about so-called biological psychiatry:

> Thorough knowledge of the mechanism of action, for example, of MAO inhibitors at the humoral, synaptic, etc. level, does not help in the least the understanding of the psychological phenomenon that causes the symptom of depression, with a particular history, etc., to disappear in a patient… we have the secret hope that the 'aetiology' of the mental illness will contribute to its understanding and, above all, to all of the psychological phenomena that constitute it. (Berrios 1966, p. 66)

He again highlights an idea that served as a common denominator to many of his works. The explanatory power of biological psychiatry and its neurobiological language soon ends, since what is demanded by people suffering from a mental illness is dialogue and understanding (Berrios 2011a).

After these methodological problems, we encounter theoretical problems. Taking the psychoanalytic school as an example, he made a critical analysis of its ideological bases: the existence of the unconscious, the predominance of the affective life over reason, the existence of driving forces and the psychological determinism, after which the epistemological flaws of psychoanalysis emerge. Berrios pointed out that psychiatrists are obliged to know the theoretical bases of the psychological school they adopt, for which they must have a philosophical training in order not to be easily misled, as in the case of psychoanalysis. It is significant that psychoanalysis is the dominant topic in this section of his thesis. He is silent about other psychological schools, which is in line with the time when this was written.

### *Concerning Psychiatry and Politics*

Compared with the previous chapters, this is the shortest, but not the least important. Psychiatrists have a transforming essence; they are not purely theoretical or practical, since people with mental illnesses are situated in a socio-political context that cannot be ignored. However, traditionally, medicine and psychiatry had to remain as far as possible from politics. Berrios experienced this situation first-hand with the fight for student governance in the UNMSM's School of Medicine in the 1960s. At that time, medical students were not allowed to participate in political issues. In this regard, Alberto Hurtado wrote:

> … the student comes to the university to study, to acquire knowledge, and is not qualified, within the most elementary reasoning, to govern…. (Zárate and Cárdenas 2017, p. 82)

This constant political struggle led Berrios to ask himself why people wanted to separate politics from medicine, in general, and from psychiatry, in particular. In his thesis, he wrote about two possible explanations. Firstly, if one considers that mental illnesses have an essentially organic cause, and that social factors only superficially model the symptoms, then the socio-political structure within which the psychiatrist works would be deemed irrelevant. Instead, treatment would focus on the organic origin. Secondly, despite socio-political changes and revolutions, the incidence of mental illnesses is the same in different realities. With respect to the first explanation, there is not much to add to what was previously reviewed. Concerning the second explanation, he wrote that, although the quantitative changes might not be significant, qualitative modifications would indeed be observed.

What then is psychiatrists' task as far as their context is concerned? Quoting Frantz Fanon, he wrote that we must 'cure society because socialising therapy became absurd and tragic…' (Berrios 1966, p. 80). Psychiatry is clearly laden with values, influenced by our conception of what kind of people we should be and what sort of society we should aspire to (Reznek 1991).

## Conclusions

As we were able to see from his thesis, Berrios pointed out several problems facing psychiatry in the 1950s and 1960s. He himself stated that the solutions to these problems were still far from reach. It was no wonder that the reviewers of his thesis accused him of 'fighting against windmills' and the text itself to be a '… fatuous and vain attempt to deny the scientific method… remaining no more than a verbalist formulation' and even to suspect an alleged plagiarism (UNC PRES 2013). We do not want to fall into a Whig interpretation of history and point to a progressive and a reactionary group. Rather we want simply to observe that these two parties differed in the question of what the next step in the progress of the psychiatry should be (Butterfield 1951). It seems that the reviewers did not understand the intention of

this epistemological thesis, which was to bring to attention the various problems within psychiatry that were observed by a philosophy student who wanted to be a psychiatrist. As Salazar-Bondy would say, referring to the human sciences, the epistemological weakness that Berrios pointed out does not deny the possibility of a psychiatric science (as the reviewers of his thesis apparently assumed). Instead, it '… should rather lead to underlining the essential difference of this kind of scientific discourse with respect to others and to pose in a more adequate way the problems of its constitution' (Salazar-Bondy 2010, pp. 252–253).

Are these problems as pointed out by Berrios pseudo-problems? Were they already resolved? Daily psychiatric clinical practice shows us that it is not about pseudo-problems: the delimitation of an object of study characteristic of psychiatry is still in debate, no longer under the neurophysiology of the 1960s but of neurobiology and, more recently, of neuroimaging and neurosciences. Concerning the question if they were already resolved, we could ask ourselves if the problems of psychiatry would be resolved one day. To paraphrase Arnold Toynbee, we can say that the vision of psychiatrists is always and everywhere conditioned by their own location in time and space and that psychiatric ideologies or narratives continually change. Therefore, no psychiatric narrative can ever be a permanent narrative that tells us, once and for all, everything in a way that is acceptable to psychiatrists of all ages, not even for all those who are living in the same time but in a different space. Psychiatrists, according to the context in which they find themselves, will reconceptualise problems and find new 'solutions' to the classic problems (Toynbee 1986). As pointed out by Fuentenebro, Berrios' work may be understood as a reaction towards an epistemological crisis affecting psychiatry, as well as a radical criticism towards its current antihistorical and antitheoretical position (Fuentenebro 1997).

What is there from Germán Berrios in this thesis, besides his name? Well, there is a deep interest and sincere concern for what is being done in psychiatry. The main conceptual contribution of his thesis was to delimit an object of study specific to psychiatry, on which he could work freely later. In addition to this, we perceive another great contribution, perhaps the most important one: the philosophical, nonconformist attitude with simple explanations. Young psychiatrists must continue along the path initiated by Berrios and the Cambridge School. This is the appreciation of a Peruvian psychiatrist who seeks to identify himself with professor Berrios not only because of the anecdotal fact of a shared nationality but also because of a shared need to continually question what we do as psychiatrists.

## References

Aragona, M., & Marková, I. S. (2015). The hermeneutics of mental symptoms in the Cambridge School. *Rev Latioam Psicopat Fund, 18*, 599–618. https://doi.org/10.1590/1415-4714.2015.v18n4p599.2.

Berrios, G. E. (1966). *Problemas de Psiquiatría Contemporánea. Tesis de titulación en medicina*. Lima: Universidad Nacional Mayor de San Marcos.

Berrios, G. E. (2000). Heildelberg y Cambridge: historia de dos departamentos universitarios. *Rev Asoc Esp Neuropsiq, 20*(74), 319–330.
Berrios, G. E. (2011a). Filosofía e historia de la Psiquiatría y la Psicopatología. 2a Parte. *Vertex (Buenos Aires), 22*(Suppl), 19–30.
Berrios, G. E. (2011b). *Hacia una nueva epistemología de la psiquiatría*. Buenos Aires: Editorial Polemon.
Berrios, G. E. (2011c). Psychiatry and its objects. *Revista de Psiquiatria y Salud Mental, 4*, 179–182. https://doi.org/10.1016/j.rpsm.2011.09.001.
Berrios, G. E. (2013). The history of psychiatric therapies. In P. Tyrer & K. R. Silk (Eds.), *Cambridge textbook of effective treatments in psychiatry* (pp. 16–43). Cambridge: Cambridge University Press.
Berrios, G. E. (2018). Historical epistemology of the body-mind interaction in psychiatry. *Dialogues in Clinical Neuroscience, 20*, 5–13.
Bunge, M. (2011). *El problema mente-cerebro. Un enfoque psicológico* (3rd ed.). Madrid: Editorial Tecnos.
Bustíos, C. (2006). *Educación Médica y su Contexto: Facultad de Medicina de San Fernando. Perú: 1856–1969*. Lima: Universidad Nacional Mayor de San Marcos.
Butterfield, H. (1951). *The Whig interpretation of history*. London: G. Bell and Sons.
Delgado, H. (1919). *El Psicoanálisis*. Lima: Sanmarti y Ca.
Delgado, H. (1926). *Sigmund Freud*. Lima: Talleres Gráficos de C.F. Southwell.
Fuentenebro, F. (1997). El trabajo histórico conceptual de Germán E. Berrios. Una crítica del razonamiento psicopatológico. *Revista de Neuro-Psiquiatría, 60*, 14–23.
Gambetta, F. (2008). *Orden del Sol para un Tacneño Ilustre*. http://diariocorreo.pe/opinion/orden-del-sol-para-un-tacneno-ilustre-151829/. Accessed 25 Oct 2018.
Huarcaya-Victoria, J. (2016). Carlos Alberto Seguin: A 75 años de su labor asistencial en el Hospital Nacional Guillermo Almenara Irigoyen. *An Fac med, 77*, 403–408.
Jaspers, K. (1955). *Psicopatología General*. Buenos Aires: Editorial Beta.
Levy, E., & Vaschetto, E. (2010). *Conversación con Germán E. Berríos. Fundación Descartes*. http://www.descartes.org.ar/etexts-yeyati11.htm. Accessed 12 ene 2019.
Marková, I. S., & Berrios, G. E. (2012). Epistemology of psychiatry. *Psychopathology, 45*, 220–227. https://doi.org/10.1159/000331599.
Marková, I. S., & Berrios, G. E. (2016). Research in psychiatry: Concepts and conceptual analysis. *Psychopathology, 49*, 188–194. https://doi.org/10.1159/000447596.
Mazzotti, G. (1996). Personalia German E. Berrios. *Rev Neuropsiquiatr, 59*, 69–71.
Merleau-Ponty, M. (1957). *Fenomenología de la percepción*. Fondo de Cultura Económica: México D.F.
Ortiz, P. (2010). *Introducción a una Psicobiología del Hombre* (2nd ed.). Lima: Universidad Nacional Mayor de San Marcos.
Ortiz, P. (2012). *La Explicación Científica del Hombre*. Lima: Universidad Nacional Mayor de San Marcos.
Reznek, L. (1991). *The philosophical defence of psychiatry*. London: Routledge.
Salazar-Bondy, A. (1967). *Historia de las ideas en el Perú contemporáneo* (Vol. 2). Lima: Francisco Moncloa Editores.
Salazar-Bondy, A. (2006). *¿Existe una filosofía de nuestra América?* (17th ed.). México D.F: Siglo XXI.
Salazar-Bondy, A. (2010). *Para una filosofía del valor*. Madrid: Fondo de Cultura Económica de España.
Silva, M. (1979). *Conversaciones con Seguin*. Lima: Mosca Azul Editores.
Toynbee, A. J. (1986). *La Europa de Hitler*. Madrid: Sarpe.
UNC PRES. (2013). *Germán Berrios conversa con Aaron Saal.* https://vimeo.com/56025962. Accessed 20 Dec 2018.
Valdivia, O. (1964). *Historia de la Psiquiatría Peruana*. Lima: Gráfica Morsom.

Vexler, M. (2000). Pensadores peruanos y contemporáneos: Las contribuciones filosóficas de Víctor Li Carrillo al pensamiento peruano. *Logos Latinoamericano, 5*, 37–61.

Zárate, E., & Cárdenas, M. (2017). *Sociedad y Cogobierno en San Marcos. Lima* (1961. San Fernando y su mayor crisis). Lima: Universidad Nacional Mayor de San Marcos.

# Chapter 3
# Notes on the Work of Professor German E. Berrios


**Augusto C. Castagnini**

**Contents**



When I was invited to write a contribution to Professor Berrios' 80-year Festschrift, I thought that this was the ideal place to address briefly the following questions: What is an intellectual debt? Namely, what we do owe to our teachers when we are lucky enough to meet them? And how we can repay them? Someone said that 'students must surpass their teachers', but the task is certainly not easy, particularly when it comes to masters who have been unparalleled for generations.

I have known Professor Berrios for more than 20 years. After studying medicine and psychiatry, I decided to undertake research and achieve further qualification abroad; my background convinced him that I would do well, and we started exploring the issue of atypical psychoses, which would become the core of my Cambridge PhD (Darwin College 2001–2004), and - later on - the topic of a monograph currently in preparation for Cambridge University Press.

When I joined his research group in Cambridge, Professor Berrios was renowned for his 'conceptual approach' to psychopathology and had already received a number of awards, prizes, and honorary degrees. Psychiatrists flocked from all over the world to San Marcos, a 'laboratory' where generations of clinicians and researchers were forged and equipped for their profession. He was attentive and curious about anyone and promoted the creation of an international network of alumni interested

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in historical and psychopathological research. Several of these went on to become professors.

At that time, the history of psychiatry was still a physical task no less than an intellectual one, involving laborious data collection and systematic and rigorous analysis of primary sources: a discipline that demanded a strong commitment and shaped both intelligence and character. None was more productive in this field than Professor Berrios, and the publication of his book *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* in 1996 was hailed as 'a remarkable account of the mappings of the mind through a study that transcends the private technicalities of psychiatry to shed light on the changing representations of the Western psyche itself' (Porter 1996, p. 289).

Professor Berrios' work reflected an impressive level of intellectual activity; both the quality and variety of topics made him closer to a *savant* of the Enlightenment, who was able to move among the genres of scientific knowledge, history, and philosophy, than mere 'academics' ever could. The method of intellectual history enabled him to explain through detailed accounts of psychiatric texts how the convergence of words, concepts, and 'abnormal' behaviours influences the historical and epistemological continuity of mental symptoms. It offers a powerful antidote to an ahistorical 'presentism', which naively assumes that mental symptoms and disorders have remained unchanged, and challenges modern symptom-based psychiatric classification as no atheoretical diagnostic language exists.

Paraphrasing what the Nobel prize winner poet Iosif Brodsky (1983) wrote about the work of Derek Walcott (the Nobel Laureate in Literature 1992), it is more than 40 years since Professor Berrios first started to rewrite the history of psychopathology, an activity which he has continued unabated, and without his contribution the map of modern psychiatry would resemble wallpaper. His work supplies a concrete way in which we can understand Dostoevsky's statement that 'beauty will save the world'.

## References

Brodsky, I. (1983). On Derek Walcott. The New York Review of Books, 10 November, 1983.
Porter, R. (1996). Mind maps. (Book review). *Nature, 381*, 288–289.

# Chapter 4
# From Neuropsychiatry to Social Cognition: A Journey with Berrios


**Alejandro García-Caballero and Isabel García-Lado**

## Contents



In 1999, thanks to Filiberto Fuentenebro and under the auspices of Tiburcio Angosto (Head of the Psychiatric Department in Vigo), we met Professor Berrios. During our initial conversations, Berrios suggested that we collaborate with Matilde Blanco, a young psychiatrist from Seville who had been working on the concept of alexithymia (Blanco 2003). Alongside Berrios, she had been developing an instrument to evaluate alexithymia and to compare this with the Toronto Alexithymia Scale [TAS] (Bagby et al. 1994), which was the gold standard at that time. We were happy to take on this project and received some of the materials from Matilde before setting off for England in September 2000.

At the beginning of the course, and in order to build connections and relationships within the community, Berrios organized a welcome party for his students together with colleagues from the University and hospital. At this party and in the weeks that followed, we got to know the small community of expatriates that, in one way or another, were working with Berrios. These included the Chilean Álvaro Barrera who was starting his doctoral thesis on language and schizophrenia (Barrera et al. 2008, 2009) and with whom we shared hours of clinics and learning

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experiences, Jose Villagran (Berrios et al. 2003) who lived in the same building as us by the riverbanks, Edith Pomarol- Clotet (Lorente-Rovira et al. 2007), Peter McKenna (Barrera et al. 2009), Mauricio Sierra (Sierra and Berrios 2000), Robert Dudas (Dudas et al. 2005), Areti Spyropoulou, Lazslo Antonio Avila, as well as AC and Suvarna Wagle (Berrios et al. 2001) who supervised us in the memory clinic. At this welcome party we also were introduced to John Hodges, professor of behavioural neurology, the nowadays-famous neuroscientist Facundo Manes, and Thomas Bak, the world expert in bilingualism and dementia. Through this meeting, we became close friends, people from different countries, with diverse backgrounds, and with different specialisms and academic interests.

After sorting permits and logistical issues, we began working with Matilde's research on alexithymia. We evaluated her instrument together with the TAS in a clinic for patients with inflammatory bowel diseases. We compared patients with Crohn's disease and ulcerative colitis with patients with irritable bowel syndrome with the aim of determining if alexithymia was a language problem or if it was a problem relating to awareness and sensations.

In addition to our research work, we also participated in the memory clinic that took place 1 day a week from 9 am to 5 pm. This was a multidisciplinary clinic where patients with memory complaints were assessed in turn by neurologists, neuropsychologists, and psychiatrists. At the end of the clinic, there would be the multidisciplinary team meeting chaired by Prof. Berrios. This meeting became a true 'master class' in that patients were discussed in depth from a variety of perspectives. Prof. Berrios would analyse the cases, drawing on historical and contemporary references alike and bringing things together in a scholarly fashion. An immense amount of neuropsychiatric knowledge was covered by the team including Huntington's disease (Berrios et al. 2001), Alzheimer's disease, Lewy body dementia, frontal dementias including at the time recently differentiated semantic dementia (Hodges et al. 1992), the differential diagnosis of transient amnesias, and Korsakov's syndrome and its history (Berrios 1998). In addition, the non-organic factors were explored in depth, and psychiatric and psychological contributors to patients' presentations were discussed such as mnesic hypochondria and functional cognitive disorganization (Berrios et al. 2000). In these multidisciplinary team meetings, discussions thus covered many topics and specialities. Berrios was an expert in statistics and able to guide discussions in this area as well as in linguistic pragmatics and the epistemology of science. We recall in particular his critical and premonitory appraisal of the non-selective use of fMRI as a research technique (Berrios 1999; Marková and Berrios 2009). His deep knowledge in all these areas, going back to the original concepts, the history behind them, and the individuals and societies associated with them, gave a rich uniqueness to the clinical meetings.

In addition to expanding our knowledge in psychiatry and learning about the usefulness of the Addenbrooke's Cognitive Examination (ACE), the memory clinic in Cambridge had at least two further important consequences.

First, it had significant international and cultural effects. One of us (Garcia-Caballero) asked Prof. Berrios about the possibility of adapting and validating the ACE for the Galician population, in particular for those with a low level of schooling and a bilingual culture (García-Caballero et al. 2006a, b). The problem with adapting these neuropsychological tests is highly complex because it requires maintaining comparability across different cultures and languages. Problems that may appear trivial, such as the choice of a letter in order to explore phonemic fluency or the placement of the pentagons in the Mini-Mental State Examination [MMSE] (different in the original version in English with respect to its most widely used counterpart), could be considerable when tested in different languages; the results also depend on the educational level of the patient. During this phase of my thesis, Berrios also proposed, we translate, 'Memory Disorders in Psychiatric Practice' (Berrios and Hodges 2000). Published in English in 2000, our Spanish translation was released in 2003 (Berrios and Hodges 2003). The text was extremely challenging, especially the chapters written by Berrios himself or the ones for which he was a co-author. It was difficult to translate not only stylistically but also on account of the extensive searching for the canonical translations of classics in Spanish at a time when the Internet was not developed as it is now.

The second consequence of our Cambridge experience concerned our transition from neuropsychiatry to a broad and historically based study of social cognition in schizophrenia. Throughout the following years, we continued our work in the neuropsychiatric and neuropsychological domains (García-Caballero et al. 2006c, 2007), but it proved impossible to run a memory clinic as in Cambridge, where psychiatrists were able to work together with neurologists and neuropsychologists. Instead we had to return to psychiatry. Nevertheless, we were able to benefit from the experience in Cambridge. Through the study of emotional recognition and social cognition, drawing on the wider approaches we had learnt from neuropsychiatry and neuropsychology to understand such concepts, we have been able to advance in the field of social cognition (SC). We have since created an online rehabilitation program devised for severe mental disorders that comprises the main subdomains of SC, i.e. face, body language and prosodic emotional recognition, theory of mind, and attributional biases. The complete program www.e-motionaltraining.com reached an agreement with Janssen in 2015 to be distributed free of charge throughout Spain, surpassing 1000 users in more than 60 therapeutic centres. In 2018, the program won the prestigious Albert Jovell award for Humanization in Medicine (Vázquez-Campo et al. 2016; Maroño Souto et al. 2018; Lado-Codesido et al. 2019).

Apart therefore from the advances that the Cambridge school has made at the psychopathological and epistemological levels, another part of its contribution has been at the neuropsychiatric and neuropsychological levels. In our case, this has borne fruit in domains such as rehabilitation in schizophrenia and other severe mental disorders. For this, and for his extreme generosity in supporting us, advising us, and welcoming us to the international and interdisciplinary community in Cambridge, we owe Prof. Berrios a gratitude beyond words.

## References


Bagby, R. M., Parker, J. D. A., & Taylor, G. J. (1994). The twenty-item Toronto Alexithymia scale—I. Item selection and cross-validation of the factor structure. *Journal of Psychosomatic Research, 38*, 23–32.

Barrera, Á., McKenna, P. J., & Berrios, G. E. (2008). Two new scales of formal thought disorder in schizophrenia. *Psychiatry Research, 157*, 225–234.

Barrera, Á., McKenna, P. J., & Berrios, G. E. (2009). Formal thought disorder, neuropsychology and insight in schizophrenia. *Psychopathology, 42*, 264–269.

Berrios, G. E. (1998). Confabulations: A conceptual history. *Journal of the History of the Neurosciences, 7*, 225–241.

Berrios, G. E. (1999). Towards a new descriptive psychopathology: A sine qua non for neurobiological research in psychiatry. *Brain Research Bulletin, 50*, 457–458.

Berrios, G. E., & Hodges, J. (Eds.). (2000). *Memory disorders in psychiatric practice*. Cambridge: Cambridge University Press.

Berrios, G. E., & Hodges, J. R. (Eds.). (2003). *Trastornos de memoria en la práctica psiquiátrica*. Masson: Barcelona.

Berrios, G. E., Marková, I. S., & Girala, N. (2000). Functional memory complaints: Hypochondria and disorganization. In G. E. Berrios & J. R. Hodges (Eds.), *Memory disorders in psychiatric practice* (pp. 384–399). Cambridge: Cambridge University Press.

Berrios, G. E., Wagle, A. C., Marková, I. S., Wagle, S. A., Ho, L. W., Rubinsztein, D. C., Whittaker, J., Ffrench-Constant, C., Kershaw, A., Rosser, A., Bak, T., & Hodges, J. R. (2001). Psychiatric symptoms and CAG repeats in neurologically asymptomatic Huntington's disease gene carriers. *Psychiatry Research, 102*, 217–225.

Berrios, G. E., Luque, R., & Villagrán, J. (2003). Schizophrenia: A conceptual history. *International Journal of Psychology and Psychological Therapy, 3*, 111–140.

Blanco, M. (2003). Alexithymia: A literary case. *Archivos de Psiquiatría (Madrid), 66*, 77–88.

Dudas, R. B., Berrios, G. E., & Hodges, J. R. (2005). The Addenbrooke's Cognitive Examination (ACE) in the differential diagnosis of early dementias versus affective disorder. *The American Journal of Geriatric Psychiatry, 13*, 218–226.

García-Caballero, A., García-Lado, I., González-Hermida, J., Recimil, M., Area, R., Manes, F., Lamas, S., & Berrios, G. E. (2006a). Validation of the Spanish version of the Addenbrooke's Cognitive Examination in a rural community in Spain. *International Journal of Geriatric Psychiatry, 21*, 239–245.

García-Caballero, A., Recimil, M. J., García-Lado, I., Gayoso, P., Cadarso-Suárez, C., González-Hermida, J., Area, R., & Lamas, S. (2006b). ACE clock scoring: A comparison with eight standard correction methods in a population of low educational level. *Journal of Geriatric Psychiatry and Neurology, 19*, 216–219.

García-Caballero, A., González-Hermida, J., García-Lado, I., & Recimil, M. (2006c). Impaired facial emotion recognition in a case of right frontotemporal dementia. *Actas Españolas de Psiquiatría, 34*, 416–419.

García-Caballero, A., García-Lado, I., González-Hermida, J., Area, R., Recimil, M. J., Juncos Rabadán, O., Lamas, S., Ozaita, G., & Jorge, F. J. (2007). Paradoxical recovery in a bilingual patient with aphasia after right capsuloputaminal infarction. *Journal of Neurology, Neurosurgery, and Psychiatry, 78*, 89–91.

Hodges, J., Patterson, K., Oxbury, S., & Funnell, E. (1992). Semantic dementia. Progressive fluent aphasia with temporal lobe atrophy. *Brain: A Journal of Neurology, 115*, 1783–1806.

Lado-Codesido, M., Mendez, C., Mateos, R., Olivares, J. M., & García-Caballero, A. (2019). Improving emotion recognition in schizophrenia with "VOICES": An on-line prosodic self-training. *PLoS One, 1*, 1–19.

Lorente-Rovira, E., Pomarol-Clotet, E., McCarthy, R., Berrios, G. E., & McKenna, P. (2007). Confabulation in schizophrenia and its relationship to clinical and neuropsychological features of the disorder. *Psychological Medicine, 37*, 1403–1412.

Marková, I. S., & Berrios, G. E. (2009). Epistemology of mental symptoms. *Psychopathology, 42*, 343–349.

Maroño Souto, Y., Vázquez Campo, M., Díaz Llenderrozas, F., Rodríguez Álvarez, M., Mateos, R., & García Caballero, A. (2018). Randomized clinical trial with e-Motional Training® 1.0 for social cognition rehabilitation in Schizophrenia. *Frontiers in Psychiatry, 9*, 1–9.

Sierra, M., & Berrios, G. E. (2000). The Cambridge depersonalisation scale: A new instrument for the measurement of depersonalisation. *Psychiatry Research, 93*, 153–164.

Vázquez-Campo, M., Maroño, Y., Lahera, G., Mateos, R., & García-Caballero, A. (2016). E-Motional Training®: Pilot study on a novel online training program on social cognition for patients with schizophrenia. *Schizophrenia Research: Cognition, 4*, 10–17.

# Chapter 5
# Conceptual Histories in Psychiatry: Perspectives Across Time, Language and Culture in the Work of German Berrios


**Kenneth C. Kirkby**

**Contents**



## Introduction

Psychiatry deals with inherently complex subject matter, it is at once imponderable and a source of endless fascination. Much has been written on the subject, and one of the largest collections of the extant material is archived in German Berrios' personal library. The synthesis of this material has come to life through his rare powers of intellect, eidetic memory and decades of voracious early-morning reading in a variety of languages. Its expression has taken many forms, notably including a series of conceptual histories on psychiatric topics. Conceptual history teases out the historical semantics of a concept, what did it mean to people using the term in different ages, in different languages, against what contextual background. Implicit is a further challenge. What can be gleaned from past views to strengthen or validate

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contemporary version(s) of the concept? How should we refine or pursue this concept in the future? The depth and breadth of this enquiry can be gauged from the 30 articles published (listed on PubMed) by Berrios with 'conceptual history' in the title. They range from disquisitions on the putative diseases in the psychiatric pantheon to key symptoms, and to abstractions such as classification. Throughout, these articles capture the fascination of their subject matter; the malleability and at times fragility of our concepts, changing frames of reference; and the insistent siren call of philosophy including that of empirical science. Accompanying German Berrios on these journeys has for many clinicians, academics and interested lay people been a stimulating, thought-provoking and mind-opening experience. An early adopter of and advocate for information technology in publishing both old and new, Berrios continues to influence the way we think, and his legacy will shape the minds of many people addressing the many remaining mysteries in the mind and brain sciences in years to come. This chapter attempts to bring together some of the extraordinary characteristics of German as a person and his extraordinary contributions to scholarship.

## The Question

I once attended a conference in Rome. The delegates made frequent sorties to take in the sites and treasures that the city displays in abundance. Dinner conversation was largely taken up with reflections on what people had seen. One party had visited the pantheon and expressed surprise that any fuss was made of it. There was a hole in the roof, the upper walls were bare, and they saw it as a gloomy ruin. They were unaware of its provenance from ancient Roman times, the outstanding architectural achievement of its huge unsupported dome, the proportionality of the oculus and that the bronze clad interior had been pilfered towards the extravagant and exquisite *baldacchino* canopy over the papal altar in St. Peters. A combination of curiosity, imagination and the assistance of a storyteller is required to bring the subject to life, the tale in this case ranging widely from the physical form of the building to the mythological portent of the Roman pantheon.

In psychiatry, the elucidation of the similarly rich interconnections of contextual and conceptual knowledge is exemplified in the work of German Berrios and comes to the fore in his publications on conceptual history.

The extent of Berrios' contribution to this genre is illustrated by the results of a PubMed search for 'English [language] AND [conceptual history [title] AND Berrios [au]'. These search terms return 30 papers, 29 with Berrios as the first author of which 19 as the sole author, published between 1981 and 2003. The same search with NOT Berrios [au] returns 19 papers by other authors, 8 between 1979 and 2003 and an additional 11 between 2004 and 2018. Thus worldwide, over half the papers meeting these criteria over a 40-year period have issued from the pen/keyboard and collaborations of German Berrios.

More revealing still is that 15 of the 19 papers not authored by Berrios were one-off forays in the genre, addressing an individual interest of the author(s). The four exceptions comprised one paper each by authors who had previously co-authored a paper with Berrios (Berrios and Beer 1994; Beer 1996) (Fuentenebro de Diego and Berrios 1995; Fuentenebro de Diego and Valiente Ots 2014) and only one other author who appears on two papers (Nicoglou and Wolfe 2018; Wolfe 2014).

This somewhat extraordinary state of affairs begs the question: what is it about the genre of conceptual history and what is it about German Berrios that lead to this standout contribution to the field within medicine? In addressing this question, I shall draw on two sources of knowledge, firstly the corpus of the Berrios publications in this area and secondly some illustrative excerpts from my personal recollections of encounters with German over the past quarter of a century.

## The Corpus

The field of conceptual history had its origins in mid-twentieth-century Germany under the equivalent term *Begriffsgeschichte*. It is an interdisciplinary field of enquiry, particularly engaging philosophers and historians. In psychiatry, given the central importance of symbolic language and communication to the expression, understanding and explanation of mental phenomena, the analysis of concepts and their historical contexts is of particular relevance (Marková and Berrios 2016). In addition, since concepts often 'migrate' from one culture to another, they may acquire shifts in meaning through non-correspondence of the languages or differing cultural references. The practice of conceptual history therefore places a premium on research across literature written in diverse languages and from a historical perspective, particularly in medicine which thrives on cross-cultural exchanges of knowledge and therapeutics.

Berrios and his co-authors have ranged widely through the semantic web of psychiatry, examining the conceptual history of a variety of symptoms, diagnoses and classifications. This approach is intellectually liberating in that the changing fortunes of many perspectives on psychiatry are well represented (see Table 5.1) rather than a mere catalogue of those currently in favour.

As can be readily seen from the conceptual history papers listed, the range of topics is broad. A number of papers are focussed on specific time periods and countries/languages, for example, 'in France during the nineteenth century'. These nominated time periods range from the seventeenth to the twentieth century. Researching these periods is greatly facilitated by the appearance of historical dictionaries and encyclopaedias from the mid-eighteenth century onwards. In addition to these reference works, there is an increasing volume of primary source material in journals and books. Access to this material is of critical importance to the researcher. One helpful factor for Berrios was that the University of Cambridge Library is one of the world's leading copyright libraries with vast holdings. More importantly, Berrios is a book collector of consequence.

**Table 5.1** Publications in English with 'conceptual history' in title and Berrios as an author, in a chronological order

| Topic of the conceptual history | Citation |
|---|---|
| Delirium and confusion in the nineteenth century | Berrios (1981a) |
| Stupor | Berrios (1981b) |
| Epilepsy and insanity during the early nineteenth century | Berrios (1984) |
| Positive and negative symptoms and Jackson | Berrios (1985) |
| Dementia during the seventeenth and eighteenth centuries | Berrios (1987) |
| Melancholia and depression during the nineteenth century | Berrios (1988) |
| The early development of Kraepelin's ideas on classification | Berrios and Hauser (1988) |
| Obsessive-compulsive disorder in France during the nineteenth century | Berrios (1989) |
| Feelings of fatigue and psychopathology | Berrios (1990) |
| Durkheim and French psychiatric views on suicide during the nineteenth century | Berrios and Mohanna (1990) |
| Delusions as 'wrong beliefs' | Berrios (1991a) |
| French views on positive and negative symptoms | Berrios (1991b) |
| Phenomenology, psychopathology and Jaspers | Berrios (1992) |
| European views on personality disorders | Berrios (1993) |
| The notion of a unitary psychosis | Berrios and Beer (1994) |
| Déjà vu in France during the nineteenth century | Berrios (1995) |
| Abulia and impulsiveness revisited | Berrios and Gili (1995) |
| Cotard's delusion or syndrome | Berrios and Luque (1995) |
| The anhedonias | Berrios and Olivares (1995) |
| The predelusional state | Fuentenebro de Diego and Berrios (1995) |
| Pseudo-hallucinations | Berrios and Dening (1996) |
| The scientific origin of electroconvulsive therapy | Berrios (1997) |
| Depersonalisation | Berrios and Sierra (1997) |
| Confabulations | Berrios (1998) |
| Anxiety disorders | Berrios (1999a) |
| Falret, Séglas, Morselli and Masselon and the 'language of the insane' | Berrios (1999c) |
| Classifications in psychiatry | Berrios (1999b) |
| Erotomania | Berrios and Kennedy (2002) |
| Assessment and measurement in neuropsychiatry | Berrios and Marková (2002) |
| The insanities of the third age – paraphrenia | Berrios (2003) |

## The Bibliophile

Berrios has amassed one of the world's leading private collections of books on the topic of psychiatry, psychology, philosophy and related disciplines. This personal library has sequestered a goodly portion of his home, kept in place and in check by numerous bookshelves and a set of compactors. The collection is indexed, both formally and in German's head; he is quick to pull a book from the vast array to

illustrate a point. The historical dimension is immediately evident, with many original editions. Included are early encyclopaedias and dictionaries in a variety of languages. The collection is predominantly in the European languages, with particular strengths in English, French, German and Spanish source materials. This book collection was amassed over decades of rummaging in Antiquarian bookshops and exchanges with like-minded bibliophiles.

Through his extensive reading habits, the contents of his library and the contents of his mind had become intrinsically linked, the one feeding the other. The books were the reference and evidentiary material of the history of concepts, and his intellect was the driving force in synthesising the disparate sources.

Whilst a collector of consequence, German was not captive to the musty odours of the past. With the advent of Project Gutenberg, he enthusiastically welcomed the improved access to rare reference texts that the new electronic media enabled, and added several of these newly available resources to his holdings, lodged in the modern world's version of the compactor system, computer hard drives and servers.

## The Linguist

As a native Spanish speaker, German's erudite Oxbridge English is accented and immediately announces his dual linguistic heritage. He researches source material in a number of languages, for example, he has published translations into English of excerpts of German, French, Spanish and Danish seminal texts, in his own right and in collaboration with native speakers as appropriate. He has also published a number of papers in Spanish, including several on conceptual histories, though generally he publishes in English in conformity with its current standing as the international language of academe. Notably he is concerned with the meaning of words and concepts in their historical and cultural context, which can become more distinct and better contested when viewed through the prism of different cultural and language traditions.

German has no hesitation in encouraging students he is supervising to tackle documents in a language that is foreign to them. His own interests in psychiatry have largely involved the French and German literature. French is readily accessible to him as a romance language similar in many respects to Spanish; German is an obligatory language for primary source investigations in psychiatry.

German's fluency in both Spanish and English has enabled him to serve as an important bridge between the English-speaking world and the Spanish-speaking world of psychiatry, and he has been in frequent demand as a speaker and as a visiting professor in both Peninsular Spain and Hispano-America.

In addition to the source material in his library and the language abilities needed to decipher it, a further requirement is to find enough hours in the day to cover the ground.

## The Early Riser

I first knew of German by repute; he was an outstanding contributor to the field of the history of psychiatry. It came to my attention that we were both attending a medical conference on the Iberian Peninsula, where he was a keynote speaker. I sought him out and he kindly offered to discuss my research on early nineteenth-century German psychiatry. He suggested the next morning at breakfast time. Great, when would that be? Say 6 am! We met the next morning in the breakfast hall which was deserted, serving did not start until 7.30 am, and German generously heard me out and imparted some good advice.

This was followed up with an invitation for German to attend the Australian Society for the History of Medicine Conference 1993 in Hobart, Tasmania, Australia. German and Doris stayed at our home, and I became better acquainted with German's early starts. Rising at my customary 7.30 am, I would find him ensconced with a book or a paper which he had already spent several hours on.

He once explained that he had trained himself to need only 5 or so hours of sleep by gradual restriction of sleep time, ostensibly an established tradition in Oxford and Cambridge.

The next task is to retain and process the information.

## Memory

Whilst in Tasmania, German was entertained by the convenor of the History of Medicine Conference. Her husband hailed from an expatriate English family in Antofagasta, Peru. It was quickly established much to their astonishment that German was well acquainted with their family tree through having read and memorised details of gravestones in the graveyard in Antofagasta, in his native Peru whilst waiting for the bus.

His prodigious memory abilities were routinely evident in his ability to recall chapter and verse from many of the texts in his personal library, not infrequently citing the page number. Obliquely, these mnemonic abilities were mirrored by several of his clinical interests, running specialist NHS clinics for memory disorders and for neuropsychiatric disorders in Cambridge.

These factors of linguistic capabilities, dedication of time, memory capacity and the contents of his personal library were all dedicated to the academic and clinical enterprise, but there was another key ingredient.

## Fellowship

German embraced the social and intellectual opportunities of the Cambridge don with ready access to many fine minds and the constant stream of visitors and postgraduate students from around the world. As a fellow of Robinson College, he actively sought to provide residential sabbatical opportunities for visiting scholars. I was privileged to take up a Bye-fellowship at Robinson in 1993/1994 and enjoyed the intellectual stimulation of the senior common room. German also hosted regular 'think tanks' on the history of medicine and on neuropsychiatry, in his home surrounded by his book collection. These think tank meetings provided an avenue for sharing and critiquing ideas and hypotheses, methods and conclusions on a range of research topics with a mixed audience of postgraduate PhD students, academics and clinicians. His home hosted many visitors to Cambridge and he and Doris were an impressive team.

German was instrumental in cultivating links between Cambridge University and the University of Heidelberg, the respective Departments of Psychiatry enjoying reciprocal visits every few years. Having spent a previous sabbatical in Heidelberg, I was delighted to assist in organising the program for one of their visits to Cambridge.

Berrios' international reach was such that most countries have a German Berrios story. Others can elaborate on his close ties to Hong Kong and to the Spanish-speaking world. I shall touch on his links to Australia.

## Australian Connections

Before taking up his position in Cambridge, Berrios worked in Leeds with Max Hamilton who was influential in introducing approaches to psychopathology from Germany, particularly promulgating *Fish's Clinical Psychopathology*. Leeds was also a leading centre of the debate about reactive versus endogenous depression, which enjoyed a strong following in Australia.

At Cambridge University, the Head of Psychiatry Martin Roth (1975–1985) and his successor the New Zealander Eugene Paykel were well connected to Australasian psychiatry and ensured a regular stream of academic visitors from the Antipodes.

During my sabbatical visit, I was cycling back from Addenbrooke's Hospital to Robinson College over the backs when I spied Gordon Parker from Sydney barechested and wielding a punting pole on the Cam. He was visiting German, and we travelled as a threesome to a psychopathology conference in Leeds. It was a small world. A number of other Australian psychiatrists also had the opportunity of spending sabbaticals at Robinson College.

Sid Bloch who had previously held an academic post in psychotherapy in England and was prominently involved in the controversy regarding treatment of

dissidents in Russia recalled his regular early hours of communications with German and other academic night owls in the UK.

Rob Barrett from Adelaide, whom I first met over a long conversation about Johann Christian Heinroth at a suburban railway station, was fascinated by German's reputation as a polymath. Rob was himself a fascinating character, holding a joint chair in psychiatry and anthropology and given to wearing a pith helmet on his research forays in the rainforests of Borneo. Rob arranged for German to take up a visiting professorship at Adelaide University.

Assen Jablensky, who knew German from WHO days, invited German to speak on the topic of descriptive psychopathology at an RANZCP Congress in Perth, Western Australia. As was his custom, German made himself readily available to delegates and was enthusiastically received by the history and philosophy of psychiatry interest group.

## The Pantheon

In modern usage a pantheon refers to 'The group of people or things most revered by an individual, nation, profession, etc.; a group of people particularly respected, famous, or otherwise significant in some capacity; a set of things having acknowledged value or importance' (Oxford English Dictionary).

As will be evident from this brief account, German Berrios has made an immense and in some respects unique contribution to psychiatry through his erudite and bounteous scholarship, his ability to communicate his enthusiasms to others whether in writing or in person, his prosocial links to colleagues throughout the world, his fostering of the work of others and his ongoing curiosity and thinking about the many unresolved issues in psychiatry. In a society preoccupied by the present, he gave weight and respect to the past; in his spare time, German would visit and tend the grave of Wittgenstein. Yet German defied definition. When he was nearing NHS retirement age, I recall him telling me to my surprise that his primary interest was in the mathematics of psychiatry. I am reminded of the hole in the roof, the oculus, of the pantheon in Rome, which lets the light in and connects to the cosmos; it is an enigma.

These recollections of my own association with German are fragments of a much larger story with many voices, experiences and dimensions. His place in the modern pantheon of psychiatry is assured, but more important is the challenge to take forwards his passion for engagement of self and others in understanding and discovery in the field of psychiatry.

## References


Beer, M. D. (1996). The endogenous psychoses: A conceptual history. *History of Psychiatry, 7*, 1–29.

Berrios, G. E. (1981a). Delirium and confusion in the 19th century: A conceptual history. *The British Journal of Psychiatry, 139*, 439–449.

Berrios, G. E. (1981b). Stupor: A conceptual history. *Psychological Medicine, 11*, 677–688.

Berrios, G. E. (1984). Epilepsy and insanity during the early 19th century. A conceptual history. *Archives of Neurology, 41*, 978–981.

Berrios, G. E. (1985). Positive and negative symptoms and Jackson. A conceptual history. *Archives of General Psychiatry, 42*, 95–97.

Berrios, G. E. (1987). Dementia during the seventeenth and eighteenth centuries: A conceptual history. *Psychological Medicine, 17*, 829–837.

Berrios, G. E. (1988). Melancholia and depression during the 19th century: A conceptual history. *The British Journal of Psychiatry, 153*, 298–304.

Berrios, G. E. (1989). Obsessive-compulsive disorder: Its conceptual history in France during the 19th century. *Comprehensive Psychiatry, 30*, 283–295.

Berrios, G. E. (1990). Feelings of fatigue and psychopathology: A conceptual history. *Comprehensive Psychiatry, 31*, 140–151.

Berrios, G. E. (1991a). Delusions as 'wrong beliefs': A conceptual history. *The British Journal of Psychiatry. Supplement, 159*, 6–13.

Berrios, G. E. (1991b). French views on positive and negative symptoms: A conceptual history. *Comprehensive Psychiatry, 32*, 395–403.

Berrios, G. E. (1992). Phenomenology, psychopathology and Jaspers: A conceptual history. *History of Psychiatry, 3*, 303–327.

Berrios, G. E. (1993). European views on personality disorders: A conceptual history. *Comprehensive Psychiatry, 34*, 14–30.

Berrios, G. E. (1995). Déjà vu in France during the 19th century: A conceptual history. *Comprehensive Psychiatry, 36*, 123–129.

Berrios, G. E. (1997). The scientific origins of electroconvulsive therapy: A conceptual history. *History of Psychiatry, 8*, 105–119.

Berrios, G. E. (1998). Confabulations: A conceptual history. *Journal of the History of the Neurosciences, 7*, 225–241.

Berrios, G. E. (1999a). Anxiety disorders: A conceptual history. *Journal of Affective Disorders, 56*, 83–94.

Berrios, G. E. (1999b). Classifications in psychiatry: A conceptual history. *The Australian and New Zealand Journal of Psychiatry, 33*, 145–160.

Berrios, G. E. (1999c). Falret, Seglas, Morselli, and Masselon, and the 'language of the insane': A conceptual history. *Brain and Language, 69*, 56–75.

Berrios, G. E. (2003). The insanities of the third age: A conceptual history of paraphrenia. *The Journal of Nutrition, Health & Aging, 7*, 394–399.

Berrios, G. E., & Beer, D. (1994). The notion of a unitary psychosis: A conceptual history. *History of Psychiatry, 5*, 13–36.

Berrios, G. E., & Dening, T. R. (1996). Pseudohallucinations: A conceptual history. *Psychological Medicine, 26*, 753–763.

Berrios, G. E., & Gili, M. (1995). Abulia and impulsiveness revisited: A conceptual history. *Acta Psychiatrica Scandinavica, 92*, 161–167.

Berrios, G. E., & Hauser, R. (1988). The early development of Kraepelin's ideas on classification: A conceptual history. *Psychological Medicine, 18*, 813–821.

Berrios, G. E., & Kennedy, N. (2002). Erotomania: A conceptual history. *History of Psychiatry, 13*, 381–400.

Berrios, G. E., & Luque, R. (1995). Cotard's delusion or syndrome?: A conceptual history. *Comprehensive Psychiatry, 36*, 218–223.

Berrios, G. E., & Marková, I. S. (2002). Assessment and measurement in neuropsychiatry: A conceptual history. *Seminars in Clinical Neuropsychiatry, 7*, 3–10.
Berrios, G. E., & Mohanna, M. (1990). Durkheim and French psychiatric views on suicide during the 19th century. A conceptual history. *The British Journal of Psychiatry, 156*, 1–9.
Berrios, G. E., & Olivares, J. M. (1995). The anhedonias: A conceptual history. *History of Psychiatry, 6*, 453–470.
Berrios, G. E., & Sierra, M. (1997). Depersonalization: A conceptual history. *History of Psychiatry, 8*, 213–229.
Fuentenebro de Diego, F., & Berrios, G. E. (1995). The predelusional state: A conceptual history. *Comprehensive Psychiatry, 36*, 251–259.
Fuentenebro de Diego, F., & Valiente Ots, C. (2014). Nostalgia: a conceptual history. *History of Psychiatry, 25*, 404–411.
Marková, I. S., & Berrios, G. E. (2016). Research in psychiatry: Concepts and conceptual analysis. *Psychopathology, 49*, 188–194.
Nicoglou, A., & Wolfe, C. T. (2018). Introduction: Sketches of a conceptual history of epigenesis. *History and Philosophy of Life Sciences, 40*, 64.
Wolfe, C. T. (2014). The organism as ontological go-between: Hybridity, boundaries and degrees of reality in its conceptual history. *Studies in History and Philosophy of Science, 48*(Pt B), 151–161.

# Part II
# Epistemological

# Chapter 6
# Critique of Psychopathological Reason: The Work of G.E. Berrios

**Filiberto Fuentenebro and Luis M. Chiva**

## Contents



> I adhere to the view that the world spirit has given the age marching orders. These orders are being obeyed. The world spirit, this essential, proceeds irresistibly like a closely drawn armoured phalanx advancing with imperceptible movement, much as the sun through thick and thin. Innumerable light troops flank it on all sides, throwing themselves into the balance for or against its progress, though most of them are entirely ignorant of what is at stake and merely take head blows as from an invisible hand. (…) Surely the safest thing to do both externally and internally is to keep one's gaze fixed on the advancing giant.
>
> *Hegel, Letter to Niethammer, July 5, 1816*
> <<Frente, Novum, Ultimum>>

We wanted to borrow Bloch's (1977) categories to metaphorically situate this work since perhaps these, more than any other philosophical frameworks, can serve to properly highlight the significance of Berrios's work within the bleak epistemic scene of current psychiatry. Our vision here is underpinned by a warm spirit of 'militant optimism' that we deem desirable for present-day psychiatric thought.

The contemporary epistemic crisis in psychopathology and psychiatry must be understood in its theoretical and ahistorical situation. In the 1980s, Berrios suggested that the psychiatric intellectual framework was rooted in conceptual premises that were established more than a century ago and also that psychiatric knowledge should always be historical. This is the semiologic task of understanding the development of psychopathology. On the one hand, there is the 'internal' or conceptual development of clinical and psychopathological knowledge. And on the other hand, there is also the understanding of its 'external' side, namely, its

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contextual development and the process of sociohistorical reflection. This can be summarized as the dialectic between an Althusserian first-order knowledge, centred on the conceptual apparatus of psychiatry itself, and a second-order knowledge, centred in the social and historical situation (institutions, ideas, practices, etc.). The current time is extremely interesting from the perspective of considering the development of both processes:

1. The internal process or 'intellectual history' of concepts in psychiatry, which developed a simple, linear, and uncritical development of biographies and hagiographies until it was seriously questioned by the 'externalist' critics
2. The 'external' critique, somewhat radical, which has been replaced in our days by a reflexive form of knowledge, more academic and rigorous in its methods, that nevertheless needs the support of the 'internal history' in order to achieve a complete understanding

All these approaches, necessary for the construction of a comprehensive history, have focused on different aspects: (a) e.g. the social and historiographical aspects, through the external reconstructions of Foucault or Dörner, (b) the analysis of institutions, publications, and the professional advent of alienism (Weiner, Goldstein, Scull, Dowbiggin), and (c) the history of the concepts, symptoms, and clinical entities (Berrios).

It is not possible to delimit Berrios's work into clearly separated sections; nonetheless and for reasons of analysis, we will demarcate three stages that can be viewed as analogous to those of the Goethean periods: learning, travelling, and teaching. In this way, we will consider his initial works, his semiological research, and finally his doctrinal work.

## Initial Works

> Since the 19th century, alienists have been aware of the fact that understanding and creativity in psychiatry may be enhanced by knowledge of its history. (G. E. Berrios)

> A sign of psychiatry's estrangement of its history and of historical consciousness may be the fact that the essential historical works are less and less cited in specialized psychiatric journals, while they can be often found in the polished publications of the large pharmaceutical firms. Then the sales representatives send those publications to the psychiatrist practitioners as cultural superstructures of propaganda and boundless scientific value. (K. Dörner)

The time of psychiatric thinking in which Berrios's initial works appear has been studied by Scull (1991) and Micale (1990). Scull shows that until the 1980s, history of psychiatry was written by non-professional historian authors (apart from some exceptions), and among these in particular were the psychiatrists themselves (e.g. Hunter and MacAlpine or Parry-Jones). On account of this, the results of these works need to be questioned in terms of their academic value since they tend to create versions of the past with the purpose of legitimating certain professional

attitudes or establishing an anecdotal and/or hagiographical knowledge reaching a limited historiographical standard. The investigation of this first generation of historians of psychiatry (1930–1950: Semelaigne, Deutsch, Zilboorg, Alexander and Selesnick) developed an often moralizing and altruistic vision of this history. They developed a linear narrative about ideas concerning mental illness, conceiving these and the subsequent clinical practices according to the views of their time. Praise was given to the replacement of cruelty and superstition by a rational and humanistic medical science.

Micale remarks that this historiographical optimism was concurrent with the highest rates of psychiatry's prestige in Europe and North America. The cultural radicalism of the 1960s was projected in the critical work of Laing, Foucault, Goffman, and Szazs. Despite their intellectual differences, they converged in their criticism of the humanistic and scientific pretensions held by psychiatry. They highlighted the coercive aspects of the asylums, as well as the idealistic and self-praising historiography of the previous generation. After the anti-psychiatry movement, in the 1970s appeared a new series of studies that widened the perspective of both the analysis and the historiography of psychiatry. The work of authors like Dörner, Rothman, Castel, and Scull produced a sort of 'social history' of psychiatry. This history was analysed in terms of the nature of 'moral treatment', the dynamics and growth of asylums, and the parallel development of total institutions. They basically focused on the first seven decades of the nineteenth century.

The beginning of the 1980s left little space to either the radical sociologists or the 'disaffected' psychiatrists. On the contrary, an outstanding new generation of medical, social, and scientific historians took over with a great dose of eclecticism. Writers like McDonald, Porter, Jacyne, Clark, Dowbiggin, or Berrios promoted a wide vision of the historical subjects. The systematic use of rigorous historiographical material was combined with concern around the medical, social, and intellectual aspects of the object of enquiry. This generation was named by Micale (1990) as 'the new history of psychiatry'. It is in this framework that Berrios's initial works (1974a, b) constitute an opening to a particular vision of history and establish a milestone of extraordinary importance.

We will consider now 'On the History of Psychiatry' (Berrios 1974a). In this work, the history of psychiatry is defined as 'the conceptual analysis of that language (as well as the institutions and characters associated with it) developed by societies to describe, explain and treat the phenomenon of the deviation of behaviour' (1974a, p.62, my translation). Psychiatry is understood 'not as a branch of medicine, but as an intellectual task, whose object of study consists in the social and personal meaning of specific forms of behaviour and integration' (1974a, p.63, my translation). In this sense, and with these limitations considered, 'the historian of psychiatry can choose between many historical forms and styles. Biographical as well as instrumental, legal and conceptual history can be chosen, for psychiatry can provide material enough to develop any of those styles' (1974a, p.63, my translation).

The question of whether 'should psychiatry develop its own historiography or conform with that developed by the history of science and the history of medicine'

(1974a, p.63, my translation) is raised and explored. It is also noted that *'a conceptual analysis shows swiftly that psychiatric language is more likely to be featured as a second-order language rather than a first-order one'* (1974a, p.63, my translation).

Some of the considerable difficulties involved in studying the history of psychiatry now become evident: Those difficulties can be ascribed to the fact that writing the history of second-order languages is a complicated burdensome task.

Moreover, Berrios considers that the kind of history that the historian should produce 'goes beyond the cultural or humanistic requirements for a psychiatrist. History must provide essential knowledge of another kind, for the Clinical Psychiatrist, in his daily work, is submerged in the conceptual framework of his own history' (1974a, p.64, my translation). In conclusion: 'If Psychiatry is considered as a kind of language much wider than the medical language, in which the inductivistic scientific perspective is not of much help; then it is easy to understand that since its consolidation more than a century ago, the psychiatric language has not evolved conceptually. Therefore, it is historical in a real sense: that is to say, in their daily clinical practice, clinical psychiatrists are using historical material in a manner which differs, for instance, from the way that a physicist or a biochemist use historical material' (1974a, p.71, my translation). This historical information and its historiographical support are based on the methodology of historical processes (short-, medium-, and long-term periods) as proposed by Braudel (1968) in his work.

This path opened by Berrios allows the proper 'study units' for the history of psychiatry to be established. All of his further work will bear this mark. The conceptual and historical analysis of psychiatric semiology will be imbued with this multifaceted perspective, which facilitates a reflection on the past and establishes new language categories for psychiatry and psychopathology in order to 'recalibrate the symptoms'.

'Historiography of mental symptoms and diseases' (Berrios 1994), written from a somewhat passionate perspective against some theoretical excesses, offers a manual for the new generations of clinicians and historians and a clear invitation to work in collaboration. Historical understanding is necessary not only for clarifying the structure of psychiatry but also for deepening our clinical knowledge. It is with these historiographical tools that we are able to analyse, from a diachronic perspective, the stable phenomena arising from a neurobiological signal, as well as the changeable phenomena as modulated by the late codification of the disorder or by the induced 'psychosocial noise' or indeed by the hermeneutic codes of each culture.

## The Semiological Research

In this period, Berrios offers a historical and conceptual analysis of different syndromes and clinical entities. In each case, he considers the epistemic framework that allowed their appearance and development, as well as the philosophical and/or ideological background that determined their semantic boundaries. This task was performed in a series of papers, monographs, and chapters of books that were sub-

sequently concluded with an enormous work on 'The History of Mental Symptoms' (1996). This research comprises a wide range of themes: stupor, delirium, confusion, dementia, obsessive-compulsive disorder, Alzheimer disease, delusion, etc. In this present paper, we will approach three specific entities: obsessive-compulsive disorder (Berrios 1985a, 1989), dementia (Berrios 1987, 1990a, b, 1991a), and affectivity (Berrios 1985b, 1988, 1992a).

## *Obsessive-Compulsive Disorder (OCD)*

In his study of OCD, Berrios offers a good example of the analysis of historical semantics (or the history of the words) along with a conceptual history and shows how both were affected by the epistemic changes in psychiatric thinking of the nineteenth century. These theoretical changes had an impact on both the terminology and taxonomy, promoting the development of certain terms (obsession, imperative idea, ananchasm, impulsion, compulsion, etc.) to be used to refer to the forms of behaviour generally known as an obsession. At the same time, these terms were not 'passive labels', since their etymologies evoke images and metaphors that have been influential on the clinical and aetiological analysis of obsessive disorders.

With regard to taxonomy, three stages are observed in the development of these disorders. They were first considered a form of insanity or monomania, then later on had a period of transition after the collapse of the concept, and finally became understood as neurotic disorders in the second half of the nineteenth century. This reclassification, as Berrios observes, required two major conceptual changes. From a descriptive point of view, obsessions had to be redefined as 'non-delusional'. And from an aetiological perspective, they had to be considered as 'functional disorders'. This last process culminated with the work of both Janet, whose psychological theory still contained traces of degeneration theory, and Freud, who conceptualized obsessions as different from phobias, thus affirming the nosological independence of the syndrome. Therefore, as the different psychological hypotheses were followed to sustain the nosological concept of obsession (first as the old notion of neurosis and then briefly as a new concept of psychosis to be finally reinstituted as a post-1880 notion of neurosis), different volitional, intellectual, and emotional alterations were also successively proposed.

## *Affectivity*

Affective disorders have had little prominence in descriptive psychopathology, and thus the symptoms included in this category usually have not been included in a comprehensive manner in the definition of mental illness. This may be due to the secondary role assigned to the emotions when it comes to defining the human being. In turn this may also explain the conceptual difficulties involved for clinicians in

developing a descriptive language. According to Berrios, this elusive aspect concerning the emotions has given place to a 'terminological palimpsest' that even to this day remains opaque and polysemic. An intellectualist understanding of madness has continued to the present times, neglecting the role of emotions, which have been terminologically carved into dozens of terms and concepts. The affective conditions consist of experiences that are vague in their nature and not properly defined in time and duration. The privileged position of the person experiencing such conditions is easily questioned when it comes to objectifying and coding them, especially when the mental condition of that person is highly compromised due to the disorder.

After studying the historical development of the passions in philosophy, further analysis is carried out on the role of emotions in nineteenth-century psychopathology. Emotions were seen as a cause or result of mental illness. The causal role led to the conclusion that manipulating emotions could have a therapeutic value: moral treatment. This intellectual emphasis in the understanding of mental illness during the nineteenth century came to be revised on account of four factors:

(a) The establishment of affectivity as an autonomous mental function by faculty psychology
(b) The exaltation of sentiments during the Romantic Movement
(c) The observation that a purely intellectualist view of madness was very restrictive
(d) The development of a clinical science of signs and symptoms as a conceptual requirement of an anatomo-clinical understanding of the diseases

Nevertheless, despite these favourable circumstances, affective disorders did not play an important role in this new psychiatric semiology. The inherent complexity of feelings and sentiments and their presence and their symptomatic stability remained a problematical issue during the nineteenth century. The opportunity to develop a descriptive psychopathology of affectivity during the second half of the nineteenth century was hindered by three ideological changes:

(a) Darwinism, in the sense that emotions were understood to represent stereotyped behavioural programs and primitive responses, which resulted in emphasis on the aspect of 'expression' rather than on the subjective experience.
(b) A somewhat partial conception of emotions as subjective echoes of changes in the autonomic nervous system (even when this led to the development of behaviourism and the physiological correlates of emotions, it didn't help improve the semiology of affectivity).
(c) The study of brain localization. Work in this field emphasized the relationship with language, movement, and perception.

All the aforementioned factors contributed to psychiatry lacking the required elements to develop a semiology of affectivity. Even though Freud widened the concept, turning it into a descriptive category, a mechanism and a source of energy, it didn't lead to further improvement in the phenomenological aspects of affectivity. Later authors such as Jaspers, Bleuler, Regis, Kraepelin, and Schneider either

neglected this concept or described it indirectly. Questions therefore remain concerning the reasons why there is this neglect of affect in psychopathology and in current clinical practice, and it becomes necessary to analyse the underlying historical factors so that hypotheses can be formed and research carried out to help explain this situation.

### *Dementia*

The work by Berrios on dementia, through conceptual, historical, and clinical exploration, raises a series of key issues. There is the differentiation between concepts from the different schools of thought (French, German, and British) during the nineteenth century to the analysis of Alzheimer's work and its formulation by Kraepelin. This last was a remarkable clinical example on how a correlational process of inferring signs and symptoms from histological changes can be established.

Of particular importance is the assumption of the cognitive paradigm, which was determined by several factors: the clinical fact that many institutionalized patients presented with cognitive impairments and the view of the intellect as a defining element of the human species and, from this, the intellectualist perspective of madness. Cognition, however, was a function too wide to be properly measured, and therefore the evaluation of memory was chosen (as memory was the only intellectual function whose measurement was properly developed by 1880). As a result, memory deficits became, de facto, the key features in the diagnosis of dementia. This paradigm however needs to be broadened when it comes to the evaluation of early and advanced stages of dementia. Specifically in this regard, it is important to consider psychotic symptoms, which may be ignored or denied in the clinical situation.

## Doctrinal Works

A common feature of these works is promoting a paradigm shift, a break, and a new formulation of key aspects in psychopathology, clinical psychiatry, and the philosophy of psychiatry. We will focus on the issues concerning descriptive psychopathology (Berrios 1984), delusion (Berrios 1991b), and phenomenology (Berrios 1992b, 1993).

### *Descriptive Psychopathology*

In the work on descriptive psychopathology from 1884, Berrios established 14 theses that we will try now to summarize:

1. Descriptive psychiatry was *created* during the first half of the nineteenth century. This process was accomplished first in France and then in other countries.
2. It was established as a descriptive language. As such, it contained a terminology, structure, relationships, and rules for its application.
3. The meaning of each term depended on its relationship with a specific form of behaviour (sign-function) and with the relationship with other terms within the descriptive system (compatibility function).
4. The rules for applying each term made reference to:
   (a) The examination by an observer of the severity, duration, and the experiential quality of the symptoms described by a patient
   (b) The number of allowed associations according to which the presence of one symptom is considered in terms of the presence or absence of other symptoms within a given system
5. The historical origin of descriptive psychopathology is determined by multiple factors including biological and social.
6. An important social factor, in relation to the descriptive aspect of psychopathology, was the requirement for the first alienists to keep accurate medical records. For this purpose, the common terms (melancholy, mania, phrenitis) proved insufficient. Fragmentation of these categories was needed. This was accomplished by using the terms and notions made available from associationism and faculty psychology, the two mainstream psychological theories in France at the beginning of the nineteenth century.
7. Another important factor was the growth of medical theories. The anatomoclinical model of disease, developed in France at the beginning of the nineteenth century, demanded that a correlation had to be made between a histological injury and an external manifestation of that lesion, through, for example, signs and phenomena.
8. The initial descriptivism was soon to be turned into a semiology, i.e. a cognitive system. This new system tried to achieve an epistemic legitimacy by returning to a Baconian concept of science, specifically as reinterpreted by the positivism of Comte.
9. The fragmentation of the categories of madness was implemented according to the threefold classification of faculties developed by Kant and the Scottish philosophers of Common Sense. Over time both distinctions, symptomatic and nosological, were accomplished under the same principles. For instance, hallucinations (which initially referred only to visual experiences) became classified as general disorders of perception; monomania (a clinical condition) was divided into intellectual, emotional, and volitional.
10. Out of this fragmentation followed two kinds of symptoms. Some disorders, such as hallucinations, could be considered as exaggerations or disorders of a normal function and thus constituted a ‘continuum’ perspective. Others referred to bizarre conditions (obsessions, delusions, stupor) for which a normal counterpoint could not be found, constituting a ‘non-continuum’ perspective. This

double system has lasted to our days. The first perspective can be found in the work of Freud and Eysenck and the latter in the work of Jaspers, Weibrecht, Bash, and Conrad. These two views show very accurately the conceptual shifts that correlated the 'normal' and the 'pathological' during the nineteenth century.

11. At the beginning of the nineteenth century, descriptive psychopathology was based on the data collected from the observation of 'open' behaviour. The progressive use of 'psychological' or 'subjective' data legitimated the semiological value of the contents of consciousness. This historical development helps to understand the origin of the form-content dichotomy.
12. After 1850, a selection process took place such that some symptoms remained (such as delusions) and others were discarded (like 'unilateral hallucinations'). The mechanisms and ideology that led to such selection still require further elucidation. Actually, only a few symptoms survived into the twentieth century. At the end of the nineteenth century, this limited number of symptoms (and symptomatic combinations) proved insufficient to make a reliable and cross-sectional diagnosis. Therefore, nosologists of the late nineteenth century such as Magnan and Kraepelin tried to solve this problem by introducing longitudinal or diachronic diagnostic features, such as irreversibility and natural course. However, this sometimes led to a relative underestimation of descriptive symptoms. For instance, Kraepelin 'often gave delusions very little diagnostic or prognostic value' (Havens 1965, p.23).
13. At the end of the nineteenth century, the remaining symptoms were clustered in certain syndromes. Some of them, like delirium, showed very little variation as the result of fragmentation. Others, like manic-depressive illness or the obsessive disorders, acquired new configurations. Some of the classic notions were also reused (mania, melancholy, paranoia, dementia, stupor), with a different meaning.
14. At the beginning of the twentieth century, descriptive psychopathology met with phenomenology. This alliance could be better described as a marriage of convenience. It was in this period when the conceptual grounding of psychopathology became stagnant (following the decline of classical psychology of the nineteenth century), thus needing a renewal. Phenomenology, with its emphasis on subjectivity and neutral descriptions, was the 'perfect match'. But phenomenology itself needed an empirical grounding. This was due to the fact that despite its anti-psychologism and its demand for neutrality, phenomenology itself had turned into another sort of psychology and thus was theoretically compromised. The juvenile eloquence of Jaspers made it seem as if phenomenology was working on a specific task, and this is a belief that remains to this day. Nevertheless, a careful examination of the clinical meanings and the use of the basic symptoms before and after 1913 shows that phenomenology has made no significant change to descriptive psychopathology. This is not surprising, as in this early stage the use of phenomenology described by Jaspers was purely methodological: 'this preliminary work of representing, defining and classifying psychic phenomena (…), pursued as an *independent* activity, constitutes

phenomenology' (Berrios 1993, p.214). Following phenomenology, there arrived a mixture of different schools of thought. Although some of them were important in developing psychology and existential therapies, phenomenology was too abstract and heterogeneous as a methodological tool to be of relevance for descriptive psychopathology.

This set of theses can be considered as the Magna Carta of Berrios's thought on descriptive psychopathology, and they constitute a mandatory milestone for any attempt to historically or conceptually reconstruct its doctrinal groundings.

## *Delusion*

The revolutionary review of the concept of delusion (as an 'empty act of speech') offers a remarkable new perspective and a radical paradigm shift from Jaspersian psychopathology. It is not surprising that Berrios's analysis begins with the examination of the Jaspersian notion of delusion, the notion that Jaspers had transmitted rather than created. This 'received notion', which came to be officially 'definitive', had been conceptually structured during the nineteenth century. It could be summarized this way:

(a) Delusions were symptoms and thus it was possible to classify them, according to complex criteria, in terms of form, content, mechanisms, origins, etc.
(b) They were acts of speech with a semantic weight and thereby could be considered as wrong and pathological beliefs.
(c) They arose as declarative acts of speech; therefore, it could be assumed that they bore some information about the world, the self, etc.

However, this conceptual structure was based on an obsolete theory of language and on intentionality criteria that did not allow for the possibility of 'empty' speech acts. Hence, Berrios proposed a definition of delusion that took into account the possibility of including such empty speech acts as a grounding to what we understand as delusion.

Indeed, considering delusion as an empty speech act has the advantage of being able to explain some of its other features:

(a) The 'information' that drives the delusion is of a truncated form.
(b) The origin of a delusion can be random or can come from neurobiological events that are quite 'remote' for the observer.
(c) The notion of wrong belief has no solid basis to justify it.
(d) The content of delusion is more likely to consist of fragments of information, caught randomly in the moment of its crystallization, and thus some redundant sociocultural themes are more likely to lend themselves as labels for those fragments.

(e) Approaching the study of delusion from this perspective suggests the need to reexamine the diachronic sequence of its development, i.e. the pre-delusional stages. These constitute fertile ground for study and will be more informative from a clinical and neurobiological perspective.

In this manner, the approach taken by Berrios to the concept of delusion has opened a new field of study and new directions of exploration.

## *Phenomenology, Psychopathology, and Jaspers*

In the work by Berrios devoted to the analysis of phenomenology and the work of Jaspers, two crucial aspects must be examined. First is the demystification of Jaspers and his work through a rigorous conceptual analysis. Second is reviewing the claims of other writers (like Chaslin), neglected mainly due to the intellectual prominence of phenomenology. It is necessary to determine whether phenomenology, this philosophical school of thought that was inserted into psychopathology, really did contribute in a significant manner to psychopathology.

From a theoretical perspective, a serious effort has been made to emphasize the importance of phenomenology in psychopathology on the basis of three main lines of thought: It was viewed as an appropriate method to capture empathetically mental states, its intellectual basis was to be found in Husserl, and Jaspers introduced it into psychopathology. Berrios makes a radical proposition: Jaspers's contribution to descriptive psychopathology is, at its core, independent from the philosophical movement called phenomenology. Therefore there is no need to appeal to Husserlian phenomenology to explain or legitimize Jaspers's work. Instead, after determining and clarifying the main ideas and authors of the phenomenological movement, an important task is to contextualize Jaspers's work (mainly *Allgemeine Psychopathologie*) not only within the framework of phenomenology but also within the descriptive psychopathology of the time. This brings to light the role played by the French clinicians (Séglas, Chaslin) in psychopathological descriptivism, previously obscured by the Jaspersian reformulation. After revising the phenomenological and psychiatric contexts at the time of Jaspers, thoroughly examining the theoretical influences in the *Allgemeine Psychopathologie* and identifying what properly corresponded to the respective influences of Husserl, Weber, and Dilthey, Berrios has achieved a crucial revision in the official historical account, providing a balance to the canonization and repetition of unsupported theories.

The conclusions presented by Berrios (which even now may be considered somewhat unorthodox) are summarized here:

(a) Husserlian phenomenology did not play a significant role in the *Allgemeine Psychopathologie*.

(b) Jaspers wanted to retain the term 'phenomenology' to describe a certain particular style and method of gathering information and of understanding (description through empathy).
(c) For the elaboration of the Jaspersian ideas, authors such as Kant, Dilthey, and Weber seem to be of much more relevance, particularly regarding the content-form and explanation-understanding dichotomies.

In summary, certain Jaspersian concepts, such as 'description of the symptoms' or 'psychological element', do not differ from those that were in common use at that time. What Berrios proposes is that the encounter between phenomenology and descriptive psychopathology was, as has been said already, more a 'marriage of convenience' than a proper alliance: The 'phenomenological approach' offered no real conceptual changes.

## *Discussion and Conclusions*

Three aspects should be emphasized when analysing Berrios's work, which at the same time are configured around three fundamental categories: totality, history, and categorical closure.

In the current theoretical frame of psychiatry, Berrios's work represents the first attempt to structure such ideas from the perspective of totality. Organizing historically and conceptually, both symptoms and clinical practice, involves a new, original approach (in the sense of the 'intellectual ecumenism' of Bloch or Sterling) to a fractured scene that can only be articulated through the notion of totality. In the words of Kosik (1967, p49, my translation):

> So that man can know and understand this both chaotic and hazy whole, it is necessary to take a detour (a historical one in the case of Berrios' work): what is concrete becomes comprehensible through the abstract: the whole by means of the part. The path of truth is a detour: der Weg der Warheit ist Umweg'. In this sense, Kosik realizes: 'totality does not mean all the facts. Totality means: reality as a dialectic and structured whole, in which any fact can be rationally understood', 'if reality is understood as concretion and as a whole, that possesses its own structure (and thus is not chaotic), which develops (and thus is not immutable, given for once and for all) and continues its growth (…) from that notion of reality some methodological conclusions are drawn, which turn into heuristic codes and epistemic principles to studying, describing and understanding certain thematized sections of reality'. (Kosik 1967, p55–56, my translation)

It is within this category of totality from which we can understand the threefold division of Berrios's work: the historical 'detour', the concrete study of the symptoms, and finally the establishment of new conclusions. For instance, to understand delusion as an empty speech act is only possible if we frame it in the assumption that for the current semantics and pragmatics, such speech acts are actually possible. The delusions are framed in the totality of the 'delusional dialogicity' (Fuentenebro 1995).

The introduction of the historical categories in psychiatry and psychopathology means giving a new dimension to clinical thinking. In contrast to the old conception of history (inert, descriptivist, and static, i.e. mute in the face of conceptual developments), in Berrios's work history arises with a vital and active role, as a solid framework. It becomes a powerful tool with which to conceptualize and calibrate the symptoms. Witnessing the role of the psychiatric ideas at the moment of a symptom's emergence, its codification, allows for the formation of an 'archaeology' of psychopathological knowledge. In Braudel's (1968) system of ideas (which is followed by Berrios), history and specifically long-term processes (*longue durée*) provide structure. In the development that we are currently dealing with, this history becomes a solid structure that considers symptoms as signals (mutable or immutable) from the dawn of their concretion and appearance. Frequently, the history of psychiatry has been instrumentalized by 'episodic histories' (*évenémentielles*) of brief periods of time, biographies, events, or situational descriptions. It is only the perspective from the history of *longue durée* that allows for the integration of both internalist and externalist historical accounts.

The history of psychiatry in terms of creating clinical and epistemological accounts and elaborating a grammar or geometry of psychiatric notions thus becomes possible. On the other hand, the problems and limitations with the current diagnostic criteria (DSM, ICD) are revealed: their reductionism, the loss of information produced by their lack of historicity, and the consequent neglect of the categories of descriptive psychopathology. In turn, this is likely to mean that in the near future, footnotes are going to be essential (as Steiner 1994 predicts will happen for literature), for we will lack the key concepts and the grounding elements of psychiatric language.

The final significance of Berrios's work relates to the last category mentioned, namely, providing psychiatry with the notion of categorical closure (Bueno 1972). The claims of some thinking (e.g. that of the 'pharmacological pseudopsychopathology', Fuentenebro 1994, p.129) have generated the illusion of an 'epistemological rupture' in the advancement of psychiatry while assuming a path of scientific progress (despite a lack of historicity and conceptual development) based on prescientific premises. Berrios's work, on the other hand, can itself be viewed as an attempt in 'categorical closure' in psychiatry. His work challenges the current epistemic situation, which works with the premise of the aforementioned 'epistemological rupture'. This breach consists in considering the object of study as perfectly constituted so that the ideas surrounding such an object are seen as concealing entities that should be removed. 'This way, the configuration of this object will take the form of a removal, a rupture from the ideas that we first considered were covering it' (Bueno 1972, p.22, my translation). These 'naive' or atheoretical developments of current psychiatric thinking take on, without being fully aware of it, the theoretical position of an epistemological rupture. They believe that certain developments (usually biological and psychopharmacological), which willingly discard the historical and theoretical elements, generate progress. This theory:

> attempts to explain the constitution of a science invoking a certain process in which by means of removing the ideologies (including philosophy as part of it) that conceal the 'scientific contents', these latter appear brightly. The alternative to the epistemological rupture is the categorical closure, (…) i.e., the establishment of an operative relationships system, which has the power to lead us to new terms and notions. During the course of this process, a disjunction is made with other fields: but these disjunctions (epistemological ruptures) are not the origin of the closure as much as the result of them, either explicitly or implicitly. (Bueno 1972, pp. 25–31, my translation)

When applying the theory of the epistemological rupture to the process of constitution of philosophy itself, rupturing with a previous hypothetical mythical knowledge, Bueno (1972) recalls:

> we find ourselves in front of theses similar to those of Ortega y Gasset. When faith fades and departs, as it produces a deep cut (a 'tremendous wound'), philosophy appears, to fill that void, to cauterize that wound. The theory of the categorical closure is otherwise different: it is the constitution of philosophical reason itself that generates the wound, in many occasions not in purpose. Jaeger recalled that Greek philosophers desired to be somehow like the 'purifiers' of the Greek faith. By doing so they were also its destroyers. (p.32, my translation)

It is in this sense that Berrios's 'radical' works, with their inherent philosophical depth, represent a categorical closure in psychiatry. The labour of 'demolition' done by Berrios in those radical works (*radical* in the sense of *radix*, of reaching to the conceptual root of psychopathology, delusion, or Jaspers's work) entails the necessary work of theoretical refinement, as well as a critique of the current psychopathological (pseudo) reason.

## References

Berrios, G. E. (1974a). Sobre la historia de la Psiquiatría. *Revista de Occidente, 137*, 62–74.

Berrios, G. E. (1974b). Nuevas tendencias en historiografía de la Psicología. *Revista de Occidente, 138*, 155–169.

Berrios, G. E. (1984). Descriptive psychopathology: Conceptual and historical aspects. *Psychological Medicine, 14*, 303–313.

Berrios, G. E. (1985a). Obsesional disorders during the nineteenth century: a conceptual History. Terminological and classificatory issues. In W. F. Bynum, R. Porter, & M. Shepherd (Eds.), *The anatomy of madness* (Vol. I, pp. 166–187). London: Tavistock.

Berrios, G. E. (1985b). The psychopathology of affectivity: Conceptual and historical aspects. *Psychological Medicine, 15*, 745–758.

Berrios, G. E. (1987). Dementia during the 17th and 18th century. A conceptual history. *Psychological Medicine, 17*, 829–837.

Berrios, G. E. (1988). Melancholia and depression during the 19th century. A conceptual history. *British Journal of Psychiatry, 153*, 298–304.

Berrios, G. E. (1989). Obsessive compulsive disorder: Its conceptual history in France during the 19th century. *Comprehensive Psychiatry, 30*, 166–187.

Berrios, G. E. (1990a). Alzheimer's disease: A conceptual history'. *International Journal of Geriatric Psychiatry, 5*, 355–365.

Berrios, G. E. (1990b). Memory and the cognitive paradigm of dementia. The 16th Squibb Lecture. In R. M. Murray & T. H. Turner (Eds.), *Lectures on the history of psychiatry* (pp. 194–211). London: Gaskell.
Berrios, G. E. (1991a). Dementia before the 20th century. In G. E. Berrios & H. Freeman (Eds.), *Alzheimer and the dementias* (pp. 9–28). London: Royal Society of Medicine.
Berrios, G. E. (1991b). Delusions as 'wrong beliefs': A conceptual history. *British Journal of Psychiatry, 159*(Suppl. 14), 6–13.
Berrios, G. E. (1992a). The history of affective disorders. In E. S. Paykel (Ed.), *Handbook of affective disorders* (2nd ed., pp. 43–56). London: Churchill Livingstone.
Berrios, G. E. (1992b). Phenomenology, psychopathology and Jaspers: A conceptual history. *History of Psychiatry, 3*, 303–327.
Berrios, G. E. (1993). Phenomenology and psychopathology: Was there ever a relationship? *Comprehensive Psychiatry, 34*, 213–220.
Berrios, G. E. (1994). Historiography of mental symptoms and diseases. *History of Psychiatry, 5*, 175–190.
Berrios, G. E. (1996). *The history of mental symptoms*. Cambridge: Cambridge University Press.
Bloch, E. (1977). *El principio esperanza*. Madrid: Aguilar.
Braudel, F. (1968). *La Historia y las Ciencias sociales*. Madrid: Alianza.
Bueno, G. (1972). *Ensayo sobre las categorías de la economía política*. Barcelona: La Gaya Ciencia.
Fuentenebro, F. (1994). De las variaciones de la melancolía al concepto de dilución en psicopatología descriptiva. *Psiquiatría Pública, 6*, 125–131.
Fuentenebro, F. (1995). Delirio. Un enfoque pragmático de la dialogicidad delirante. *Revista de Psiquiatría de la Facultad de Medicina de Barcelona, 22*, 42–47.
Havens, L. L. (1965). Emil Kraepelin. *The Journal of Nervous and Mental Disease, 141*: 1, 16–25.
Kosik, K. (1967). *Dialéctica de lo concreto*. Mexico: Grijalbo.
Micale, M. S. (1990). Hysteria and historiography: The future perspective. *History of Psychiatry, 1*, 33–124.
Scull, A. (1991). Psychiatry and its history. *History of Psychiatry, 11*, 239–250.
Steiner, G. (1994). *En diálogo con Ramin Jahanbegloo*. Madrid: Anaya y Mario Muchnik.

# Chapter 7
# What Is Psychiatry?

## Was ist das, die Psychiatrie?

**Ivana S. Marková**

**Contents**



## Why Ask the Question?

At first glance, it seems a peculiar question to ask – particularly from the perspective of a psychiatrist. Surely, it could be countered, this is, if not an empty question, then a rhetorical one since psychiatry is the daily business of clinicians. Years of learning, training and practice would entail understanding of the subject. Nonetheless, as soon as we begin to try to answer the question, we are very quickly confronted with difficulties or complexities at various levels.

Firstly, at what is the question directed? Is it at 'psychiatry'? In that case, are we asking about the meaning of the specific term? Or, are we trying to understand Reil's concept of psychiatry (Reil 1808) when he introduced the term into medicine in 1808? Alternatively, should we be trying to make sense of the concept as it existed under a different guise, such as alienism? Perhaps we should be defining it as it is understood now in current clinical practice and academic interest and framed within the different terminological boundaries of mental health problems.

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On the other hand, the question may be directed at the 'what', in which case, we would want to know what sort of thing is psychiatry or what its nature is. For example, is it a medical specialism, a particular discipline, a science or art, a cultural object, a social/moral issue (how we live our lives) and so on? Clearly, how one asks the question and where the focus is will determine different ways of tackling it and will result in a range of different answers.

This would suggest that perhaps it is an important question to consider. If there are many different ways of answering the question, then this carries vital implications for clinical practice as well as for research in psychiatry. How we assess and manage patients with psychiatric disorders depends on what we understand by psychiatry and its objects (mental symptoms and mental disorders). For example, if we look at psychiatry as a medical specialism dealing with neurobiological problems manifested by changes in behaviours and mental states, then our understanding of patients and problems will be quite different from that if we understand psychiatry as a discipline dealing with peoples' difficulties in managing life events and traumas. Similarly, research into psychiatry is driven by what we understand psychiatry is about. A view of psychiatry as a natural science, for example, will determine questions and methodologies that are quite different from those arising in the case where psychiatry is viewed, say, as a social science or as a cultural object.

Furthermore, it raises yet other questions, the most important being, arguably, whether there is something invariant that we can identify that, in some form, threads throughout the multiplicity of conceptions and throughout the terminological and conceptual changes taking place over time.

## How to Tackle the Question?

Given that there are many different ways of addressing this question, what approach should be taken? Clearly much will depend on the reasons why the question is being asked, for example, whether this is about contextualising psychiatry in contemporary clinical domains, whether it is about explaining its nature and methods to various formal or informal parties or whether it is about understanding the historical processes that brought about its construction. In order to fulfil these sorts of purposes, then the approaches to tackling the question will share a perspective that involves examining the question from the *outside*, so to speak. They will take psychiatry or its 'what-ness' as an external object and seek to unravel it from a so-called third-person perspective. This is necessary to provide objective expositions to the question and meet the specifically posed aims.

What we want to do here, however, is to take another approach, one that tries to tackle the question from *within*. In this we want to draw directly on Heidegger's method and analysis and borrow unapologetically from his way of dealing with this question in relation to philosophy (Heidegger 1956/2003). The aim here is to try to get at what the essence of psychiatry is about, to make perhaps some sense of what invariance there may or may not be.

## One Particular Path

Amongst the many different paths that can be taken to answer what is psychiatry, we are thus embarking on a particular path, one that we hope will touch on its underlying core or essence. We cannot however travel exactly the same path as the one taken by Heidegger, who tried to reach, in a very real sense, the meaning of philosophy through its origin in the Greek thought. He identified the term 'philosophia' as the path that needs to be taken, a path whose course of necessity runs in and through the Greek language. This, for Heidegger, constitutes the *logos* and hence encompasses the only way in which to frame and answer the question. It has to be heard with a Greek ear, he says, in order to hear and understand its direct presentation. The Greek language, he insists, is very different from other European languages, and it is only through listening and speaking through the Greek language that we can, by making sense of the historical tradition borne by it, trace the meaning carried in the original terms. In this way, his historical and etymological exploration leads him to a meaning of philosophy that becomes a complex of thinking, a need for questioning, a yearning for understanding what is being and what drives the being of *Being*. In turn, this entails an ongoing dialogue, a conversing within and between philosophers in which the Beings in being are attuned, in co-respondence with each other. The complexity of Heidegger's thought here, however, is well beyond the scope of this paper. Here we want to simply emphasise his view on philosophy as a quest, a constant questioning of the nature of being through *Being*, the source of man's uniqueness and creativity.

What, however, does Heidegger's path have to do with our understanding of what is psychiatry? As already mentioned, we cannot follow the same path for whilst the term 'psychiatry' is derived from the Greek, its introduction into medicine was relatively recent. Reil's choice of the term was determined by his pre-existing conception of its referent, namely, what he viewed as an essential and indeed intrinsic component of medicine, along with surgery and pharmacology (Marneros and Pillmann 2005). In order therefore to try to explore psychiatry from *within*, we cannot, like Heidegger, begin with the term itself but instead have to turn to the subject matter that has throughout time been the source of the term and indeed other terms, labels and conceptions. We have to ask: what is this subject matter that seems to give rise to so many different ways of conceptualisation and categorisation?

When we try to tease this apart, then it starts to become clear that it has to do with two related elements. Firstly, it involves some sort of judgement or appraisal concerning another's mental state and/or behaviour in which the other is understood to be in some form of distress, and, secondly, there is, correspondingly, a need to alleviate this. Thus, in the first place, we have a recognition of sorts that the said mental state and/or behaviour of the other does not accord with the expected or accepted. It is a recognition of a difference in the other that is sufficient to arouse judgements of various kinds concerning the nature of such a difference. Historical analysis has shown such judgements to have ranged over time and cultures from beliefs of illness, possession, witchcraft, punishments/blessings by God, evil, deviancy, etc. In turn,

society has dealt with these differences in mental states and behaviours of others in accordance with such judgements, and hence 'management' has included the intervention of physicians, priests, jailers, special communities, etc. (Scull 1981; Porter 1987). Leaving aside such judgements, which are themselves determined by the historical episteme and sociocultural context in which we are situated (Berrios 1996; Berrios and Porter 1995), together with the ensuing ways of dealing with the differences in mental states and behaviours, we want to focus instead on this recognition of difference in the other. What is this recognition about? How is it that we identify a mental state or behaviour in the other as anomalous or in distress in some way?

The obvious and simple answer would be that as we look at the other, we listen to what they say and make judgements accordingly. For example, we see a person looking sad or distressed and they may say that they feel low, and we then make a judgement to that effect. However, as soon as we examine this a little closer, then it becomes apparent that this cannot be the entire story. The same words and/or similar expressions and behaviours in others can invoke in us very different feelings and judgements. Thus, for example, we can engage on separate occasions with two people who are both complaining of feeling distressed, who are both tearful and who both have histories of traumas or losses. And yet, we may appraise them very differently and may make quite different sorts of judgements about them. So, if uttered words and appearances in the other are not sufficient to induce the specific judgements that we make, then what else is there that enables us to identify or recognise in the other an anomalous or distressed state?

Again, taking a closer look, the crucial issue here is that human engagement is always an interaction. When we engage with another, we are in a reciprocal relationship; our appearances, our words and our actions will respond to those of the other, and those of the other will respond to ours. Our communication at all levels will be a product of such interaction, and hence the meanings we derive from such communication will be meanings that become a complex of that what is ours, so to speak, and that what is of the other (Marková and Berrios 2019). We thus influence each other through our interactions. This is in direct contrast to the use of 'interrogation of nature' as a metaphor for the scientific exploration (and eventual control) of the world around us. We do not just observe, ask and listen neutrally to one another; we interact and thus are mutually influenced by one another.

We can then ask: but, what does this interaction actually mean? How does it happen? What does it depend on? Teasing this apart becomes much more difficult – from an empirical perspective anyway. We can observe two people talking; we can analyse their responses, surmise as to the influence of certain words used, expressions held, behaviours shown, gestures made and so on. We can speculate as to the possible motivations, conscious or unconscious, in each which might be driving the direction and strength of the interactional forces. We can make conjectures about the possible asymmetries in their relationship that may be influencing their interactional course. Nonetheless, despite all these possible elements to the process, we cannot seem to grasp interaction as a whole. It is surely not simply parts of us, whether our faces, gestures or choices of words, that respond to the individual parts of another. This same point is made compellingly by Tarkovsky in his analysis of his

film work when, in relation to the effect that one of Leonardo da Vinci's paintings exerts its effect on us, he says:

> If you try to analyse Leonardo's portrait, separating it into its components, it will not work. At any rate it will explain nothing….it is impossible to find in her anything that we can definitely prefer, to single out any one detail from the whole…to achieve a balance in the way we look at the image presented to us. And so there opens up before us the possibility of interaction with infinity…towards which our reason and our feelings go soaring…Such feeling is awoken by the completeness of the image: it affects us by this very fact of being impossible to dismember. In isolation, each component part will be dead…A true artistic image gives the beholder a simultaneous experience of the most complex, contradictory, sometimes even mutually exclusive feelings. (Tarkovsky 1987, pp. 108–109)

When we engage with an 'other', in an authentic sense, it is with our whole selves that we communicate. We may try to capture this engagement in terms of, for example, our feelings, our perceptions, our interests, our senses or our drives. However, these are distinctions and categories that we, as a particular culture and society, have constructed for ourselves. Our language both reflects and creates such categories and as such cannot be viewed as depicting as absolute reality the world in general and humans in particular or indeed as 'carving nature at its joints'. This means that at best, language will capture only aspects of what we are trying to express or describe, and these will to a lesser or greater extent cohere with different narratives of reality.

Where does this leave us with respect to interaction? Our language may break this up into different elements that we believe may play a part in the process, but, ultimately, we interact with our whole selves. That is, the interaction is between human beings. We could say that it is communication between human beings. Indeed, we could even say that there is a particular kind of exchange between *Beings* in Heidegger's sense. Such a jump immediately brings a different emphasis to the process. Here, we are led into a conceptualisation of a process infinitely more multifaceted, one that draws on the complexity of man's nature as a unique, thinking, questing, human being.

What then does this mean for psychiatry? If, exploring psychiatry from *within*, we are saying that its subject matter is about recognising and seeking to alleviate anomalous and distressed states in another, then perhaps we can reformulate this. We can say that psychiatry can be conceived as a form of interpersonal interaction in which there is a particular or specific reaching out of one *Being* to another. It is a 'specific reaching out' because, following the recognition through the interaction between *Being* that the other is in some form of distress, there is the corresponding need to assuage.

## Why Is This Important?

It could be argued that defining or formulating psychiatry in philosophical or metaphysical terms has little place in clinical practice. Reil himself, despite jointly publishing the volume in which the term 'psychiatry' first appeared together with

Hoffbauer, a professor of philosophy, was very clear that psychiatry was purely a medical discipline (Reil and Hoffbauer 1808). He stated explicitly that philosophy should concentrate on the pure science of the real and ideal nature of man whereas psychiatry, on account of its focus on healing, belonged to medicine (Marneros and Pillmann 2005). The relationship between philosophy and medicine and/or science has undergone critical changes over time, and debates concerning the nature of this relationship are ongoing (Ferrater 1958). As science and medicine have expanded and developed increasing specialisms, so philosophy, the *fons et origo* of the sciences and, from the beginning, intrinsically linked with them, has been progressively constricted and separated out. And, in relation to medicine/psychiatry/science, much of contemporary Anglo-American analytic philosophical work seems to have become a justificatory enterprise (Berrios 2006, 2009).

Here, however, we are in effect saying that philosophy should have an active part to play in any study of man. The path we have followed in trying to define psychiatry from *within* suggests that a philosophical formulation or apprehension of psychiatry may play an important even crucial role in our understanding of psychiatry. Moreover, we would argue that it carries essential implications for both clinical practice and research in psychiatry. So why then is it the case, that formulating psychiatry in terms of 'reaching out by *Beings* to one another in a particular way', carries important implications for psychiatric practice and research? After all, it could be argued that this kind of formulation is simply an intellectual exercise, with no place in any 'scientific' understanding or in any clinical intervention.

It comes back to what was said earlier about our interaction as human beings and specifically about the role that our language plays in describing and capturing this process and its resultant communicated meaning. Through our language we break up the interactional process and the elicited meanings into particular elements which will accord with what we perceive is taking place and with how this fits within contemporary understanding of psychological and physiological processes. This is necessary for organising our knowledge and for communicative exchange. Whilst clearly useful for these purposes, at the same time, it can also be misleading as it gives the impression that what is expressed reflects directly, and often exactly and completely, what is actually going on. In consequence, such broken up elements, whether these are, say, depressed mood, thought disorder, anxiety, poor rapport, delusions, emotional unstable personality and so on, become the scientific units of analysis, the objects against which neurobiological correlations are sought and research directed. Almost inadvertently they become reified, conceived as real entities, made the foci of questionnaires and rating scales and encourage a simplistic and mechanistic approach to the assessment and management of human mental states and behaviours.

When on the other hand we hold a formulation of psychiatry as a 'reaching out by *Beings* to one another in a particular way', this conjures up a very different conception of what may be taking place. This is not to say that '*Beings*' should then be the subject of scientific analysis in terms of breaking up, measurement and quantification, for indeed the term belongs to a very different category of meaning (Ryle 1990). Rather, the formulation serves as a valuable reminder of two important issues relevant to both clinical practice and research.

Firstly, the reaching out of *Beings* in a particular way to one another brings to the forefront the idea of human beings engaging and communicating with one another in a special and specific manner. The emphasis is on the interaction between people as a complex process of mutual exchange. Here, the meaning of the other's distress emerges as the product of such an exchange. This is the crucial issue. As mentioned earlier, even with the clinician's questioning, this is not an interrogation of a passive subject who simply provides direct answers through his/her speech and/or appearance and behaviour. Instead, it is through the interaction between the clinician and subject that the meaning of a particular utterance or behaviour transpires. It is through the way that each responds to the other, reacts and feels and reflects in and through evoked feelings, associations, gestures and so on. As such, the meaning or understanding of another's mental state and behaviour becomes to a greater or lesser extent co-created. It follows from this that the meaning as derived from the communication between two people is different from the meaning derived from questionnaires and rating scales. It is why people can have similar ratings on such measures and yet be undergoing quite different experiences. In light of the current focus on the reality and validity of scores on measures, on their reified states as correlational variables and on the importance they play in directing treatments, then this issue of meaning created through interaction becomes particularly important to grasp.

The clinician is a human being as well as a professional, and both these aspects are involved in the interactional process when trying to make sense of what is going on. Sources of mental distress and anomaly are manifold, spanning both biological and non-biological domains and associated with corresponding hybrid clinical presentations (Berrios and Marková 2015; Marková and Berrios 2012). For the clinician, this means that there has to be a twofold engagement. On the one hand, there is interaction where the search for meaning is made between two human beings trying to make sense of experiences in their presented contexts. On the other hand, there is, at the same time, the interaction between the professional and the patient in which the clinician has to try to unravel the respective roles of neurobiological factors and the personal and sociocultural factors that are contributing to the presentation.

Secondly, the notion of exchange between *Beings* also emphasises the unity with which we communicate and interact. Again it simply helps to remind us that with our language, we are picking up only aspects of meaning and only aspects of what is going on during the interaction. As alluded to previously, our language is both a reflection and a creation of our society's conception of reality and its organisation. We generate this to gain some control, to help our understanding and to facilitate explicit communication, but we cannot assume that we are capturing the totality of reality at any one time. Thus, during the interaction we are communicating beyond what is captured by language. It is the reason why classification systems such as the ICD (World Health Organization) or the DSM (American Psychiatric Association) cannot or should not be used as recipe books to classify patients according to number, severity and duration of symptoms. It is also one of the reasons why we often struggle to fit clinical presentations into the conventional descriptions.

In the face of a psychiatry that is driven ever more by a neurobiological reductionism in research and by a mechanistic and algorithmic approach to the assessment and management of patients, it is increasingly important to rethink a formulation of psychiatry from *within*. Conceiving this as the reaching out in a particular way by *Beings* to one another is not a scientific reformulation nor is it open to scientific exploration. It serves, however, as a catalyst to the need for research in psychiatry to develop novel methods of exploring an area that remains complex and constantly evolving (Marková and Berrios 2016). Furthermore it is a vital reminder of what is surely the central issue here, namely, the search for understanding another's distress through an authentic engagement.

## References

Berrios, G. E. (1996). *The history of mental symptoms*. Cambridge: Cambridge University Press.

Berrios, G. E. (2006). 'Mind in general' by Sir Alexander Crichton. *History of Psychiatry, 17*, 469–497.

Berrios, G. E. (2009). Excerpt from De la Folie…by P. Despine (1875). *History of Psychiatry, 20*, 393–400.

Berrios, G. E., & Marková, I. S. (2015). Towards a new epistemology of psychiatry. In L. J. Kirmayer, R. Lemelson, & C. Cummings (Eds.), *Revisioning psychiatry. Cultural phenomenology, critical neuroscience and global mental health* (pp. 41–64). New York: Cambridge University Press.

Berrios, G. E., & Porter, R. (1995). *A history of clinical psychiatry*. London: The Athlone Press.

Ferrater, M. J. (1958). *Diccionario de filosofía*. Buenos Aires: Editorial Sudamericana.

Heidegger, M. (1956/2003). *What is philosophy?* (J. T.Wilde, & W. Kluback, Trans.). Maryland: Rowman & Littlefield Publisher Inc.

Marková, I. S., & Berrios, G. E. (2012). The epistemology of psychiatry. *Psychopathology, 45*, 220–227.

Marková, I. S., & Berrios, G. E. (2016). Research in psychiatry: Concepts and conceptual analysis. *Psychopathology, 49*, 188–194.

Marková, I. S., & Berrios, G. E. (2019). Nature of the interactional field: Psychopathological configurators. In G. Francesetti & T. Griffero (Eds.), *Neither inside nor outside. Psychopathology and atmospheres* (pp. 119–140). Newcastle upon Tyne: Cambridge Scholars Publishing.

Marneros, A., & Pillmann, F. (2005). *Das Wort Psychiatrie würde in Halle geboren*. Stuttgart: Schattauer.

Porter, R. (1987). *Mind-forg'd manacles*. London: Penguin Books.

Reil, J. C. (1808). Ueber den Begriff der Medicin und ihre Verzweigungen, besonders in Beziehung auf die Berichtigung der Topik der Psychiaterie. In J. C. Reil & J. C. Hoffbauer (Eds.), *Beyträge zur Beförderung einer Kurmethode auf psychischem Wege* (pp. 161–279). Halle: Curtsche Buchhandlung.

Reil, J. C., & Hoffbauer, J. C. (1808). *Beyträge zur Beförderung einer Kurmethode auf psychischem Wege*. Halle: Curtsche Buchhandlung.

Ryle, G. (1990). *The concept of mind*. London: Penguin Books.

Scull, A. T. (1981). *Madhouses, mad-doctors and madmen. The social history of psychiatry in the Victorian era*. London: The Athlone Press.

Tarkovsky, A. (1987). *Sculpting in time* (K. Hunter-Blair, Trans.). Austin: University of Texas Press.

# Chapter 8
# Recovering the Context in Psychopathology


**Eric Chen**

## Contents



## Introduction

The discipline of descriptive psychopathology does not feature prominently in the modern practice of psychiatry. The evaluation of mental symptoms nevertheless remains the cornerstone in the diagnosis and treatment of mental disorders. An impoverished discipline of psychopathology can impede progress in the identification, classification and treatment of mental conditions. One of the modern tendencies in the practice of psychopathology is to isolate mental symptoms as discrete and independent entities, separate from the sociocultural environmental, and the personal developmental contexts. Such narrow demarcation of symptoms compromises the potentials for a richer understanding of illness mechanisms and the prediction of outcome.

This paper explores some of the historical factors contributing to the current circumstances. Through clinical examples, several directions for accomplishing a more nuanced handling of symptoms are suggested.

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## The Context in Psychopathology

'Context' refers to 'The circumstances that form the setting for an event, statement, or idea, and in terms of which it can be fully understood' (Oxford English Dictionary 1989). In the understanding of mental symptoms, such circumstances may arise (1) from the recent and distant past (e.g. in the previous experiences of the individual, i.e. a diachronic context). It may also arise (2) ecologically through an appreciation of the environmental background in which the anomalous experience took place (i.e. a synchronic context). Contextual consideration refers to the extent to which such information is considered in the evaluation of symptoms.

## Background Context for the Decontextualisation of Psychopathology

The recognition of subjective experiences as 'mental symptoms' has evolved as a gradual process. Since the Enlightenment, increasing awareness of individual subjective experiences was documented in literature, philosophy and medicine. With the rise in explorations into mental disorders in the nineteenth century, descriptions of anomalous experiences gradually developed into a system (descriptive psychopathology) (Berrios 2008; Berrios and Marková 2018). Analysis of these experiences as 'symptoms' enabled the development of definitions and classifications. Symptom analysis was detailed and often took into consideration such background information as the development and past experiences of the person. It also addressed the detailed psychosocial background against which the symptoms appeared (Berrios 1991).

This emphasis on contextual information in early psychopathology was related to a presupposition that mental symptoms could be better understood if the relevant past and current background information were accessible. On this perspective, the more extensive the contextual information, the richer the opportunities for 'understanding' the symptom. Such presupposition motivated detailed descriptions of the background information in the hope that this information would help to understand the unusual experiences.

This endeavour to understand anomalous experience has been continued in different eras with different intensities. The effort is determined by the contemporaneous views towards the causation of mental illnesses (Berrios 1991). Towards the turn of the twentieth century, the trend to explore past developmental experiences of a person became widespread. These attempts initially adopted a tentative stance. In this spirit, detailed accounts were documented of the developmental and social backgrounds of the patient. There was a readiness to apply the detailed biographical information to various frameworks of understanding. This trend was related to the rising awareness of the notion of the 'unconscious' (Jaspers 1963, p. 580), which had been gradually developed in the eighteenth and then nineteenth centuries. This

trend eventually led to the advent of the psychodynamic approaches (Ellenberger 1970).

The flourishing of the psychodynamic schools eventually advanced this trend towards a new horizon. Psychodynamic theories claimed to provide causal explanations based on past experiences in terms of the 'unconscious mind'. Case histories were written as voluminous books (e.g. Freud 1905). Biographical histories of patients provided detailed accounts of backgrounds as well as subjective experiences. This fashion blossomed with the in vogue psychodynamic therapies, as well as the 'stream of consciousness' styles in literary circles (e.g. Joyce 1922; Proust 1913).

Consequently, the practice of obtaining detailed histories became associated with the psychodynamic approaches. They shared the luxurious demand for professional time and lack of empirical vigour. However, they also subsequently shared the decline when the limitations of the psychodynamic approach became more apparent. It is worth noting that in anthropology, a similar, richly contextualised approach has developed into a 'thick description' ethological methodology for capturing the meaning systems in unfamiliar cultures and settings (e.g. Geertz 1973).

The exclusive use of psychological theories to explain mental conditions became more restrained when genetic studies revealed a high degree of inheritance in many mental disorders. The partial success of pharmacological treatments also reinforced a view that the primary drivers for mental disorders may operate at a more 'biological' level, rather than in the realm of subjective experiences. The era of biological psychiatry is characterised by viewing mental disorder primarily from a brain perspective. In the prevailing paradigm that mental disorders reflect brain disorders, clinicians align themselves with an approach more akin to internal medicine.

## Decontextualisation of Symptoms in the Era of Biological Psychiatry

Signs and symptoms in patients usually present within relatively simple contexts in internal medicine. In psychiatry, however, the contexts for clinical presentations are often more complex (see below). The rise of biological psychiatry promoted a way of thinking in which mental symptoms and their contexts were viewed as similar to those in somatic medicine. Biological psychiatry, therefore, tended to treat symptoms as relatively simple, decontextualised entities. Thus, for example, questionnaires are often used to quantify symptoms, and questionnaires are decontextualising instruments par excellence. By using a generic stem (e.g. 'I feel tense'), standardisation is achieved by removing contextual variations. Subjects are requested to indicate a response 'in general', rather than referring to a specific experience under a specific circumstance.

Removal of contextual information from symptoms results in a reduction in the information that can be captured. The discarding of individualised contextual

information limits the details in which experiences can be explicated. In the quest for earlier identification of illness through the elucidation of early anomalous experiences, the disregard of contextual information may compromise the sensitivity of detection.

The consideration of context is indispensable when evolving symptoms are tracked in a longitudinal time frame. Symptoms evolve with time. They interact with life experiences and undergo transformations, growth and decline. The interaction between symptoms and the ecological life context has been increasingly emphasised in attempts to understand the early emergence of symptoms (e.g. Borsboom 2017). In this perspective, a symptom may become a context in which other symptoms develop. Factors that determine the persistence and accentuation of symptoms become crucial in the prevention of illness onset. Understanding the contextual factors that drive the evolution of a symptom becomes an important anchor for preventative intervention.

## Contexts in Psychotic-Like Experiences

It is recognised that psychotic experiences are widespread in the general population. For the identification of at-risk states for psychosis (i.e. those who have an increased risk of developing psychosis within a specified time frame, usually up to 2 years), the identification of (1) milder (attenuated) symptoms or (2) brief and transient (intermittent) symptoms has been widely used. They are captured in the form of a rating scale (e.g. the Comprehensive Assessment of At-Risk Mental States [CAARMS]), which has the advantage of established reliability. However, the specificity of the CAARMS-positive subjects for developing psychosis is not high (Yung et al. 2005).

Further enhancement of the specificity of the tools is an important agenda for developing indicated-preventative strategies. Apart from the duration of the symptom, one important dimension is to appraise the qualitative characteristics of the symptoms, e.g. how much the symptom experience departs from the expected experience given the life context and psychosocial background of the individual (Jaspers 1963). Such information is currently seldom elaborated in rating instruments. For example, hearing the voices of a deceased relative in the context of a bereavement carries a clinical significance very different from hearing one's neighbours scolding oneself. Hearing a neighbour scolding is very different in a crowded environment with some neighbourhood conflicts, compared to an open area with neighbours located some distance away. The semantic continuity between the psychopathological experience (understandability) and the lifeworld context is thus an important signal. The more context-dependent, the more likely the symptom will subside when the environment changes. Within our current diagnostic criteria, a limited amount of contextual consideration is operationalised for a small number of symptoms and conditions (e.g. in adjustment disorders). However, for the vast majority of symptoms, there is as yet no such specification. This current omission potentially

concedes a large amount of useful information which could enhance the predictive power. Whether a symptom is meaningfully connected with a significant stressor is another important determinant.

In a real-life clinical example, a civil servant who had for a few years been under investigation for corruption was notified that the investigation concluded with no charges against him. Nevertheless, for many years afterwards, he continued to feel under surveillance and being followed on the streets. The perception of surveillance took place in a context of past events (i.e. a diachronic context). This situation is expected to carry very different weight from another person who feels that he/she is being followed on the streets *de novo* without the same background. Symptoms that occur directly in response to a stressor are more likely to subside when the stressor is removed. A symptom that emerges without an explicit external stressor would be expected to be less likely to subside with changes in the environment.

## Contexts in Ideas of Reference

Another example of how the context is crucial in determining a symptom is in the assessment of an *idea or delusion of reference* (i.e. the spurious feeling that phenomena in the environment are related to oneself). The identification and evaluation of a referential idea requires an assessment of how excessive the self-reference experience is, compared to what can be expected in a particular environment based on common sense. For example, when Mr. John Smith heard someone call the name 'John', how much he felt that this referred to himself would depend on the environmental context. For the same experience of hearing the name 'John' being called (assuming it is not a hallucination), the sense of self-reference is expected to be lower in a busy street in London but would be less expected in a quiet street in rural Thailand. Currently such details are not explicitly and systematically spelled out except in highly specific rating instruments. Making explicit such background considerations (synchronic context) should enhance the sensitivity of assessments (Wong et al. 2012).

## Context in Formal Thought Disorder

Contextual information is essential in the assessment of 'formal thought disorder'. In the evaluation of anomalous experiences, a distinction between the 'form' and the 'content' of an experience is made (Jaspers 1963, p. 58). The 'form' of an experience refers to structural characteristics of the experience. In the considerations of 'form', the clinician will deliberate on the dimension which provides the structural scaffolding which can be filled with a variety of experiential contents in different times for the same person or in different persons. Inherent to this perspective is that the same form could be filled with different contents on different occasions. For

example, an auditory perceptual experience can be characterised by the structural (formal) characteristics of being vivid, located in external space, and is not subject to voluntary control. Healthy perceptual experiences share these formal characteristics, and so do hallucinations, but these formal characteristics are not shared by the experiences of 'rumination' or 'imagery'. The exact semantic content of the hallucinated voices is considered as individualised 'content'.

The form is considered more invariant across time and individuals, whereas content is presumed to be more personalised and dependent on contextual circumstances. On this perspective, the content of a symptom is the component that could be influenced by context, whereas the form is supposed to reflect more 'stable' brain processes. This separation, however, is not absolute. Form and content may interact with each other in constituting symptoms. One classic abnormality of form is 'formal' thought disorder, where the structural organisation of speech is anomalous. For example, in the evaluation of 'formal thought disorders', an abnormality primarily in 'form' (the organisational form of the linguistic output), a judgement based on contextual meaning is still required. Whether a person's utterance is intelligible and meaningful depends on how it matches the meaning (context) of the system. In the classic symptoms of 'loosening of association', the judgement of whether 'association' has been 'loosened' depends on a contextual assessment. In a clinical situation where a patient's speech is not understandable, the incomprehensibility may be due to the presence of missing referential links in the utterance (i.e. many pointers in the speech are used without adequate antecedents, resulting in unclear referents; 'how did you got here today?'; 'I took his advice', where there has not been any previous mention of anything related to 'him' or his 'advice'). This situation produces an incoherent speech in which an idea (his advice) appears to be inserted without meaningful connections with the rest of the utterance. This speech pattern is suggestive of 'loosening of associations' in 'formal thought disorder'. Further explorations, however, may show that the patient is talking as if the referential links have already been communicated. The patient may indeed have assumed that the clinician had already received the information as a result of earlier communication (e.g. following the preceding example, the previous communication might have been 'an invisible fellow has been helping me'). In an actual clinical case, the patient thought he had communicated these links previously through telepathy. The source of the abnormality lies more in the realm of delusions rather than formal thought disorders. This clinical example illustrates how evaluation of the contextual background is vital to clarification in descriptive psychopathology.

## Conclusions

The re-emphasis of 'the context' in psychopathology is consistent with the Cambridge school of psychopathology, in which symptoms are construed as 'hybrid objects' comprising a neurobiological signal, experienced subjectively in a sociocultural context and elaborated by concepts and language of the patient (Marková

and Berrios 2012). Cultural and linguistic factors specific to the person contribute towards the eventual packaging of the experience. The symptom is then elaborated through a clinical dialogue with the clinician. The dialogue clarifies the symptom and grounds it in a shared semantic space between the individual and the clinician, as well as a wider circle of people involved in the healing team (professionals, peer workers, friends and carers). The symptom also interacts through action in the subject's lifeworld. Some of these actions reinforce the symptom, while others limit its progression. The balance of these factors eventually determines the fate of the symptoms and the course of the development of the condition (Borsboom 2017). The access to this information is often through a clinical dialogue, which usually takes place retrospectively when the person presents for medical attention. More recent attempts to engage individuals at earlier risk stages, as well as a cohort of people with known risks for specific disorders (e.g. genetic risks for psychosis), enable prospective tracking of individuals and provide opportunities towards observations made contemporaneous to the onset of symptoms. The use of experience sampling methods enables the capture of data in real-life contexts (Myin-Germeys et al. 2018). Much richer information to complement a clinical dialogue is expected to emerge from such methodologies. These approaches can facilitate the re-emphasis of the context in which anomalous experience occurs.

In this brief discussion, the importance of contextual considerations in the assessment of symptoms is highlighted. Prevailing views about the nature of mental distress influence the extents to which contexts are valued in the assessment of symptoms. This review revealed a trend towards decontextualisation of symptoms in the era of biological psychiatry. The neglect of context is reflected in contemporary concepts of symptoms and the rating instruments used to evaluate symptoms. Decontextualised symptoms may be more standardised and reliably assessed, but there is also a loss of information which ultimately compromises the usefulness of the symptom in understanding and predicting outcomes. Several examples illustrate how crucial contexts may be recovered in the assessment of symptoms and how future approaches may include contextual information to enable a more enriched approach to psychopathology.

## References

Berrios, G. E. (1991). British psychopathology since the early 20th century. In G. E. Berrios & H. Freeman (Eds.), *150 years of British psychiatry 1841–1991* (pp. 232–244). London: Gaskell for the Royal College of Psychiatrists.

Berrios, G. E. (2008). Descriptive psychiatry and psychiatric nosology during the nineteenth century. In E. R. Wallace & J. Gach (Eds.), *History of psychiatry and medical psychology: With an epilogue on psychiatry and the mind-body relation* (pp. 353–379). New York: Springer.

Berrios, G. E., & Marková, I. S. (2018). History of developments in understanding abnormal behaviour. In J. N. Butcher (Ed.), *APA handbook of psychopathology vol 1 psychopathology: Understanding, assessing, and treating adult mental disorders* (pp. 13–39). Washington: APA.

Borsboom, D. (2017). A network theory of mental disorders. *World Psychiatry, 16*, 5–13.

Ellenberger, H. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York: Basic books.

Freud, S. (1905[1901]). Dora, fragments of an analysis of a case of hysteria. In *Standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 1–122). London: Hogarth Press.

Geertz, C. (1973). *The interpretation of cultures*. New York: Basic books.

Jaspers, K. (1963). *General psychopathology* (J. Hoenig & M. W. Hamilton, Trans.). Manchester: Manchester University Press.

Joyce, J. (1922). *Ulysses*. Paris: Shakespeare and Company.

Marková, I. S., & Berrios, G. E. (2012). Epistemology of psychiatry. *Psychopathology, 45*, 220–227.

Myin-Germeys, I., Kasanova, Z., Vaessen, T., Vachon, H., Kirtley, O., Viechtbauer, W., & Reininghaus, U. (2018). Experience sample methodology in mental health research: New insights and technical developments. *World Psychiatry, 17*, 123–132.

*Oxford English Dictionary*. (1989). Oxford: Oxford University Press.

Proust, M. (1913–1927). *In Search of Lost Time* (À la recherche du temps perdu published in seven volumes, previously translated as Remembrance of Things Past), (Edited and annotated by William C. Carter. New Haven: Yale University Press, 2013, 2015, 2018).

Wong, G. H. Y., Hui, C. L. M., Tang, J. Y. M., Chiu, C. P., Lam, M. M., Chan, S. K., Chang, W. C., & Chen, E. Y. (2012). Screening and assessing ideas and delusions of reference using a semi-structured interview scale: A validation study of the Ideas of Reference Interview Scale (IRIS) in early psychosis patients. *Schizophrenia Research, 135*, 158–163.

Yung, A. R., Yuen, H. P., McGorry, P. D., Phillips, L. J., Kelly, D., Dell'Olio, M., Francey, S. M., Cosgrave, E. M., Killackey, E., Stanford, C., Godfrey, K., & Buskby, J. (2005). Mapping the onset of psychosis – The Comprehensive Assessment of At Risk Mental States (CAARMS). *The Australian and New Zealand Journal of Psychiatry, 39*, 964–971.

# Chapter 9
# Stress and Distress in Psychiatry: A Conceptual Analysis

**Sergio E. Starkstein**

**Contents**



## Introduction

This chapter discusses how concepts are used in contemporary psychiatry, using the terms *stress* and *distress* as examples. It has been Professor German Berrios who strongly advanced the relevance of conceptual analysis in psychiatry, by examining the use of words, the creation of concepts, and descriptions of behaviours for a better understanding of relevant nosological and phenomenological aspects of psychiatric disorders. Professor Berrios' *ouvre* is at the forefront of conceptual analysis in psychiatry, and this chapter is dedicated to his attempts (hopefully successful) to teach me the art and science of using the conceptual tools of philosophy and historiography to better understand the concepts of contemporary psychiatry.

First, I discuss the meaning of concepts, how they are used, and their relevance in psychiatric epistemology. After examining some dictionary definitions, I briefly discuss the meaning of concepts based on the work of the Austrian philosopher Ludwig Wittgenstein, whose insights are valuable for the epistemology of concepts and for the conceptual analysis of emotions. I finish by discussing the use of the terms *stress* and *distress* in contemporary psychiatry as an example of the relevance of conceptual analysis in our field.

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## Concepts

What is a concept? Whereas answers to this question may be found in generic and specialized dictionaries, encyclopaedias, and philosophical writings, the complexity of this term needs philosophical unpacking. The *Oxford English Dictionary* (OED) (Kay 2009) states that the word *concept* derives from two roots: (1) the Latin *conceptum*, meaning an idea or what is conceived in the mind, and (2) the Latin past participial stem of *concipere*, to conceive. In fifteenth-century French philosophy, the term *concept* was defined as 'idea, mental image'. In the early sixteenth century, both in Dutch and in German, the terms *concept* and *Koncept*, respectively, had the meaning of 'plan, design, and draft,' whereas the English *concept* has been used since the sixteenth century with the meaning of 'a general idea or notion, a universal; a mental representation of the essential or typical properties of something, considered without regard to the peculiar properties of any specific instance or example' (Kay 2009).

Based on the application of psychological methods to lexical semantics, the *MIT Encyclopaedia of Cognitive Sciences* (Hampton 1999, p. 176) discusses five models for understanding the ontology of *concepts*. There is (1) a 'classical' model, which considers concepts as defined by necessary and sufficient factors; (2) a 'prototype' model, which considers concepts as represented by an 'archetype' that includes the most common attributes of a given category; (3) an 'exemplar' model, which considers lexical concepts as based on mental representations; (4) a 'theory-based' model, which considers concepts as produced by a relation of attributes in a complex network of causal and explanatory links represented in a schema; and (5) 'psychological essentialism', which argues for a psychological 'core' definition of concepts.[1]

From a psychiatric perspective, Marková and Berrios defined concept in a broad sense, as 'a procedure to make possible the description, classification and prediction of any object susceptible of being known' (Marková and Berrios 2016), whereas the etymology of *concept* was defined as related to a biological state of gestation, and to the action of grabbing (from the Latin *comprehendere*). They pointed out that concepts in psychiatry have to consider (1) the object of enquiry, (2) an account of the sociocultural context, (3) the personality of the agent as well as her history, education, etc., and (4) the interaction between the clinician and the patient (Marková and Berrios 2016). This requires the use of ancillary methods of investigation, such as historiography, social psychology, anthropology, and philosophy, among others (Marková and Berrios 2012), and this sophisticated use of different sources for the study of concepts constitutes the 'Cambridge model of symptom formation' (Marková and Berrios 2012). The importance of concepts in psychiatry is that they are at the core of any taxonomy (Berrios 1999b). Berrios points out that one limitation common to all nosologies in psychiatry is the conceptualization of psychiatric syndromes as 'prototypes', a problem that is later discussed in the text (Berrios 1999b).

[1] Discussion of these interesting remarks is beyond the scope of this work.

The discussion on the ontology and epistemology of concepts is not recent. Similar conflicting theories of concepts were raised by Greek philosophers. Thus, the Platonic-Socratic tradition postulates the existence of a world of 'ideas' or prototypes from which every object derives. Against this tradition, the Sophists argued that 'ideas' are purely subjective, given that, for example, the word *fear* has different connotations and therefore cannot be reduced to a single prototype. The philosophical analysis of concepts has a rich tradition, and I shall focus on briefly describing Wittgenstein's philosophy of concepts which is relevant for understanding the role of concepts in the formulation of nosological and phenomenological aspects of contemporary psychiatry. Based on Wittgenstein's philosophical perspectives, I argue that the term *concept* evokes a wide variety of meanings and defies a single definition.

## Wittgenstein's Philosophy of Concepts

Wittgenstein considers that a concept 'is a technique for using a word' (Wittgenstein 2001, p. 128), and this technique depends on the activity of social structures based on traditions and habits. The formation of a concept consists in seeing new experiences from different and evolving perspectives, whereas older concepts remain 'present in the background' (Glock 2008, p. 103). That is, *words* may remain extant but their meanings may change, reflecting new realities with novel meanings. Old concepts, that is, old techniques for the use of words, may progressively decline until their use disappears altogether and are replaced by a new use.

Thus, for Wittgenstein, the creation of concepts involved agreement in uses of language and judgments. Wittgenstein labelled the interweaving of language with their judgements and agreements about the use of words as 'language games'[2] (Rosenman and Nasti 2012). Using this model of *concept*, the ontology of psychiatric terms such as *stress* and *distress* is not determined by empirical methods or necessary and sufficient factors, but by the way in which concepts are used. As stated by Berrios (Berrios 1999b), 'a pluralistic and outward-looking discipline will stretch and modify its language and concepts continuously as it grapples with its problems'. Therefore, a psychiatric diagnosis is made within the context of activities and professions that provide meaning to a variety of symptoms, rather than on putative mental or brain processes or metaphysical entities.

This is not to say that all concepts are fully determined by culture and context, given that some of them such as stress may be partially determined by physiological changes. This important aspect has been analysed by the philosopher Daniele Moyal-Sharrock, who examined the relation between biological and linguistic processes in the creation of concepts (Moyal-Sharrock 2013, p. 24). A relevant question

[2] The term 'language game' signifies that a term is used with specific purposes within a specific context in which it is established.

she poses is whether emotional concepts may be fully explained by necessary and sufficient biological factors.[3] Moyal-Sharrock notes that natural facts constitute the 'bedrock' of concepts through a 'non-epistemic process, like repeated exposure or training '(Moyal-Sharrock 2013, p. 156). Therefore, concepts are not exclusively based on grammar, given that this would result in an infinite regress of grammatical explanations. But once a natural fact connects with grammar, concepts are formed by the habitual use of a family of terms. Similarly, the philosopher Hans Glock suggests that a conceptual system thus created is articulated using propositions, whose meanings are provided by a 'set of practices' or regularities in human habits (Glock 2008, p. 659). Thus, words gain a specific meaning depending on the practice in which they are used. For instance, DSM symptom criteria may endow the term *anxiety* with a meaning that is useful for the practice of psychiatry in western settings, but the term is simultaneously used colloquially with a much broader meaning. In the end, concepts result from an 'agreement in norm of life' (Wittgenstein 2001, p. 241), an agreement that is based both in biological facts and in human practices of reaching consensus on how to understand life events and how to act in given contexts (Moyal-Sharrock 2013, p. 158). Thus, Moyal-Sharrock concludes that, whereas concepts have roots in natural events, their 'anchorage' in life depends on social practices rather than on arbitrary decisions (Moyal-Sharrock 2013).

The philosopher Ilham Dilman provides additional insights into the Wittgenstenian account of concepts (Dilman 2002; Wittgenstein 1969). Agreeing with Moyal-Sharrock that natural history and the physical structure of the world both influence the creation of concepts, he considers that the classification of non-arbitrary objects is heavily dependent on the 'language games' that surround them, as well as the place where the word is used with a specific role and identity. This is illustrated by Wittgenstein's aphorism that the use of words is 'held fast by what lies around them', and 'what lies around' is dependent not only on language games but also on human natural reactions and objects of nature (Dilman 2002). For instance, at the basic level, the feeling and behavioural expression of fear is not purely dependent on language since these natural events may be inferred in non-human animals. On the other hand, a specific language framework is necessary for bringing the concept to human consciousness, allowing its expression in a myriad of ways understandable in the complex context of human life. Thus, the word *stress,* while expressing a dimension of reality, eventually develops into more specific linguistic expressions with grammatical rules. Possessing a concept, therefore, is to have mastered the use of a given expression (Glock 2008). For example, in order to answer 'What is stress?' we have to determine the grammatical rules for using this word (Wittgenstein 2001, p. 371, 383). In consonance, Glock denies that words have an intrinsic linguistic meaning, arguing instead that meaning is provided by speakers using a term in a certain way (Glock 2008).[4] Concepts cut across words, since different words

[3] Wittgenstein stressed that 'the correspondence between our grammar and general facts of nature does concern us' (Wittgenstein 2001) (230a), and in *On Certainty*, Wittgenstein considered that the construction of language games is conditioned by natural facts (617).

[4] Glock (2009) considers the 'concept of a concept' (p. 98) as 'partially constituted by the knowl-

may express similar concepts at different times (e.g. in certain contexts, the words fear, stress, and anxiety may be used interchangeably) (Moyal-Sharrock 2013; Wittgenstein 1969).[5] Another example is the word *stress* which was initially used in the field of physics and later on became a psychiatric concept.

To conclude, Glock summarizes Wittgenstein's perspective on concepts as follows (Glock 2009): (1) Concepts can be analysed by examining how words are used. (2) Concepts are part of 'a form of life', that is, they acquire meaning against the backdrop of a given culture. (3) Concepts vary between individuals and groups and are subject to change. (4) The formation of concepts (i.e., the adoption and modification of concepts) and their conceptual scheme (i.e. the family of words that go with the concept) provide a pre-empirical framework or 'meta-concept'. (5) To possess a concept is to possess a range of abilities, especially linguistic ones.

## The Creation of Concepts in Psychiatry

Berrios suggests that in psychiatry there are concepts which connect directly with an object, which may be termed *primary* concepts (Berrios 2010). For instance, the concept of anxiety includes a variety of somatic and psychological objects such as worrying, fear, dread, shortness of breath, palpitations, and poor sleep. Berrios further considers that psychiatric concepts are construed by a variety of symptoms gathered across different historical periods, through an interplay of changes in emphasis and the social context in which they are collected (Berrios 1999a). Thus, the concept becomes reduced to a specific definition in psychiatric nomenclatures. Nevertheless, concepts have vague boundaries, which may change depending on use and context (Berrios et al. 2003). In line with the philosophers discussed above, Berrios states that the object of a concept is a construct which, for a proper interpretation, requires specific sociocultural and historical contexts working as 'intrinsic variants', providing stability to the object. Berrios further suggests that the first descriptions of symptoms of mental disorders can be traced back 'to specific historical conjunctures or "convergence"' (Berrios et al. 2003). By this term, Berrios refers to a new or recycled term that is made into a concept. I shall illustrate this by discussing how the concepts of *stress* and *distress* became relevant in psychiatry nosology.

edge of those who employ them', which is manifested in their cognitive and linguistic abilities.

[5] 'When "language games" change, then concepts also change, and with the concept the meaning of words' *On Certainty*, p. 65.

## *The Concepts of* Stress *and* Distress *in Psychiatry*

The term *stress* was already in use in the fourteenth-century English vernacular, with the meaning of 'hardship, straits, adversity, affliction' (fourteenth to eighteenth century), 'force or pressure exercised on a person for the purpose of compulsion or extortion' (fourteenth to seventeenth century), and later, as to 'strain upon endurance' (sixteenth to seventeenth century) and as the 'over powering pressure of some adverse force or influence' (sixteenth to twentieth century) (Kay 2009). In a psychological and biological sense, stress has the meaning of a 'physical strain of a load or weight' (fifteenth to nineteenth century), 'a force acting on or within a body or structure and tending to deform it' (nineteenth to twentieth century), and 'an adverse circumstance that disturbs, or is likely to disturb, the normal physiological or psychological functioning of an individual' (twentieth century).[6, 7] Thus, while the word stress was already in use with psychological connotations in the fourteenth century, its use increased during the twentieth century (Kay 2009).

*Distress* is explained in the OED Thesaurus as a noun and a verb. As a noun, distress was used, as 'the sore pressure or strain from adversity, trouble, sickness, pain, or sorrow; anguish or affliction affecting the body, spirit or community', and its first use dates from the thirteenth century. As a verb, *to distress* has been used since the early sixteenth century[8] as 'to cause pain, suffering agony or anxiety; to afflict, vex, make miserable (Kay 2009).'[9]

In the current English vernacular, the words 'stress' and 'distress' are frequently used in their psychological connotation. In his research into the sources and psychological meanings of stress, the sociologist Andrew Abbott stated that this word was used to denote a 'general anxiety' rooted in the cares of life, which dates from about 1914 (Abbott 1990, p. 6). The shift in the concept of stress within the biomedical sciences started when the biologist Hans Selye (1907–1982) used the term *stress* to denote psychophysiological changes produced by mostly negative

[6] Related compounds are 'stress reaction', 'stress situation', 'stress symptom', 'stress disease', and 'stress-free' (all in use during the twentieth century).

[7] The compound 'stress relaxation' is not conveyed by the OED in its current psychological meaning but defined as 'a decrease of stress occurring in a material when the associated deformation remains constant' (twentieth century), whereas the term 'stress counsellor' was added in 2003. As a verb, 'to stress' is conveyed as 'to subject (a person) to force or compulsion' (fourteenth to sixteenth century), 'to subject to hardship: to afflict, distress, harass, oppress' (sixteenth to nineteenth century), 'to subject (a material thing, a bodily organ, a mental faculty) to stress or strain' (sixteenth to nineteenth century). The lexically related word 'distress' was already in use in the fifteenth century as 'the sore pressure or strain of adversity, trouble, sickness, pain, or sorrow; anguish or affliction, affecting the body, spirit, or community'.

[8] Bible (King James) 2 Cor. Iv.8: 'We are troubled on every side, yet not distressed' (OED).

[9] 'Bitter tears, which copiously…fell from my distressed eyes' (OED).

contextual events, or *stressors*, in the new jargon (Selye 1955).[10,11,12] Abbott states that before Selye's work, the term *stress* had been already conceptualized in a psychological sense as the effect of the heavy load that life circumstances may impose upon humans, with the consequent emotional strain and organic disease. Selye wrote about the adaptation syndrome since 1936, but the word 'stress' was only included in the Index Medicus in 1950. The term stress soon appeared in the popular literature, and in 1956 Selye himself wrote *The Stress of Life* (Selye 1956), a book for the general public.

Abbott surveyed the popular literature from 1900 to 1957 and elaborated several groupings of words related to the term *stress*. The most relevant group he termed *anxiety,* which included the words *anxiety*, *fear*, *physiological stress*, *tension*, and *worry*.[13] By the time *stress* was used frequently in the colloquial English of the twentieth century, the term *anxiety* was mostly associated with fear and worry about potential economic crises and wars. Abbott also pointed out that, on the one hand, stress could be conceptualized as the process of successfully performing under pressure, whereas on the other hand, it could be considered a state of psychological anxiety with negative somatic repercussions. Because stress allows humans to adapt to different biomedical conditions, Selye considered stress as a positive psychological event.[14,15] The emergence of this psychological concept of stress gradually displaced the old concept of 'nervousness', whereas the creation of a biological account for stress by Selye provided, for the first time, a biochemical hypothesis for the mechanism of a psychiatric condition (Cantor and Ramsden 2014).

In the Prologue to *The Age of Stress* (Jackson 2013, p. 1), the historian Mark Jackson states that 'We are living in a stressful world, already traumatised perhaps by material anxieties…'. Stress started to be considered a consequence of negative life events such as bullying, excessive expectations, long working hours, poverty, lack of safety at home and work, and the challenge to adjust to fast technological changes. Jackson acknowledges that whereas stress may be 'intuitively' recognized, its definition is not precise and its concept 'remains elusive', adding that the concept

[10] See also Cannon WB, Stress and strains of homeostasis, Am J Med Sci 1935; 1:189.

[11] It is necessary to clarify the meanings for the terms *denote* and *connote* as used in this text. To denote is 'to designate or be a name of, to be predicated of' (OED). To connote is defined as 'to imply or indicate the attributes involved while denoting the subject' (OED).

[12] This term was created by Selye in 1950 to refer to external triggers of stress reaction (Abbott 1990) (p. 149). Thus, the word *stressor* replaced the term *precipitating factors*, and the concept of stress became a human body condition now amenable to scientific investigation (Abbott 1990) (p. 151).

[13] Additional groupings are (2) *mind/body*, including psychosomatic medicine, mental healing, mind, and body; (3) *performance*, including fatigue and rest; (4) *hygiene*, including social adjustment and mental hygiene; (5) *nervous disease*, including neuroses and nervousness; (6) *mental disease*; and (7) *nervous system*.

[14] 'Stress cannot and should not be avoided…' Selye, H. 1955. Stress and disease. *Science,* 122**,** 625–631.

[15] We shall see a very different concept of stress in the current psychiatric nosology, where stress and distress are the common denominator of most psychiatric disorders.

of stress is construed by biological and sociological factors tightly related to the concept of anxiety (Jackson 2013).[16,17] Thus, Lawrence Hinkle (Hinkle 1987) considers that for the social sciences, the concept of stress is related to the way different societies prescribe forms of appropriate behaviours, which eventually become guidelines to be followed to achieve an acceptable way of life. Within this normative, stress arises whenever an individual is faced with moral values and behaviours that are outside the social norms (Hinkle 1987).

The well-known 'age of anxiety', as proclaimed by the poet W.H. Auden (1907–1973), 'appeared to have ushered in a new age of stress' (Auden 2011, p. 14). We can observe how the terms 'anxiety' and 'stress' became enmeshed with each other, with anxiety becoming a cause (rather than a symptom) of stress.[18] Jackson (2013) points to an important component of 'social construction' in psychiatric concepts given the major changes in working and health conditions, lifestyles, political-cultural factors, and scientific developments.[19] In conclusion, during the last half of the twentieth century, *stress* has become a useful term to convey feelings of malaise in the context of a fast-developing psychological and medical establishment in need of new terms. I shall now discuss how the term stress was incorporated into social language and how it influenced the scientific concept.

Watkins (2014) examined how stress entered the American vernacular, noting the porous boundary between the scientific and the lay use of language (mainly through journalistic and literary domains). Non-scientific texts slowly incorporated concepts such as stress from the scientific literature, and as scientists likewise read the lay literature, they also used the concept in the non-scientific context. The term *stress* acquired several meanings, including somatic and/or psychological changes, a response to social challenges, or a definite pathological state.[20,21] Watkins (2014) further considered that the way the term stress was used in the vernacular resulted from contemporary concepts of brain-mind interaction in the current sociocultural context. The words 'stress', 'strain', 'anxiety', 'tension', 'nerves', and 'nervousness' began to be used interchangeably. With a strong influence from clinicians, most of the lay literature was focused on providing recommendation on how to deal with daily stress, on the understanding that too much stress could result in a 'ner-

[16] 'The science that legitimates and fuels current anxieties about stress has been shaped by a wide range of sociological and cultural as well as biological factors' (p. 2).

[17] This statement semantically separates anxiety from stress, with stress acquiring the meaning of a painful state of mind, whereas anxiety having the connotation of a state of fear.

[18] Jackson cites a prominent cardiologist of the mid-twentieth century stating that 'the stress of modern life' is an important factor in the production of 'anxiety neurosis' (p. 77) and considers as prototypical the example of the anxious suburban wife living with an overworked husband (p. 143).

[19] 'Scientists, psychologists, politicians, and patients have mobilized the concept of stress for heuristic, professional, and emotional purposes' (p. 15).

[20] 'Defined by Selye as a set of psychological responses he called "the general adaptation syndrome", stress has morphed into a catchall term for a vast range of human experience' (p. 50).

[21] As stated by Paul Rosch (foreword to Anthology of Stress Revisited, by James H. Humphrey, New York: Novinka Books, 2005, viii–ix), 'attempting to define stress is like trying to nail a piece of jelly to a tree'.

vous breakdown'. Thus, from the 1950s onwards, the terms *stress* and *anxiety* shared similar conceptualizations in terms of descriptions, the booming use of anxiolytics to treat them, and as risk factors for organic chronic disorders.[22] It was the fast development and enormous sales of anxiolytics and their advertising in the popular press which helped to bring the terms stress and anxiety to common parlance, and, in a circular way, the rapid spreading of these words in the colloquial started to influence their medical connotations (Tone 2007).

Besides the psychological connotations, the concept of stress also has somatic ones, which explains Jackson's central thesis that 'stress is a hybrid phenomenon' (Jackson 2013, p. 16),[23] also including sociological aspects. Both scientific and popular concepts of stress became strongly related to cultural anxieties triggered by major sociopolitical changes of western societies. As already mentioned, s*tress* has been considered a cause of anxiety, a state of physiological changes, and a psychological entity in its own right.[24] Since the medical concepts of 'the stress diseases' and the specialty of 'stress medicine' were created in the 1950s (Jackson 2013, p. 145), *stress* has challenged the concept of anxiety 'as the negative condition of the age' (Jackson 2013, p. 146). Thus, the concept of stress bifurcated in the 1950s to become incorporated into the diagnosis of anxiety for which anxiolytics were prescribed, as well as becoming a risk factor for organic medical illness.[25] From the above, it is also clear that the semantic boundaries of the words *stress* are fuzzy. *Stress* is used to denote a physiological state of unease due to the expectation of negative events, and this overlaps with the concepts of stress, fear, and anxiety, as stress is also used to denote a negative state produced by adverse events. Anxiety may be considered a cause of stress, but it may also be the result of stress, further blurring the semantic boundaries between these terms. After the second half of the twentieth century, the 'stress of life' became a prominent figure of speech in non-specialized magazines and newspapers, both in Europe and in the USA, and both *stress* and *anxiety* have figured prominently and at times interchangeable in popular, psychological, and psychoanalytical parlance. The concepts of stress and anxiety show how, unlike classifications in the natural sciences, the classes and concepts identified by psychiatric nosologies are theory-laden or conventional, adapting to human values and personal and social interests (Berrios 1999a).

[22] 'Hypotheses about stress as a risk factor for hypertension and other chronic disease hardened into axioms starting in the 1950s' (p. 60).

[23] The product of both biological and cultural forces rendered visible by the technology and language of biomedical science' (p. 16).

[24] Advertisements for anxiolytics in the 1960s used the terms 'anxiety', 'tension', and 'stress' indifferently.

[25] As nicely put by Ffrangcon Roberts, author of a book on the origin of medical terms, 'stress…in addition to being itself and the result of itself, is also a cause of itself' (In Jackson 2013, p. 154).

## *The Concept of Stress in Psychiatry: A Contemporary Example of Concept Formation*

The term *stress* entered the psychiatric nosology by the beginning of the twentieth century, and in the first classification manuals such as the *Diagnostic and Statistical Manual of Mental Disorders-first edition* (DSM-I) (American Psychiatric Association 1952), stress was considered both as a cause of neurosis[26] and as a paranoid reaction (p. 12).[27] The main DSM-I category for stress is the 'Gross Stress Reaction' (p. 40), described as occurring whenever a 'normal personality' uses specific patterns of reaction to deal with the 'overwhelming fear' of 'great or unusual stress'[28] such as war or civilian catastrophe. The difference between this syndrome and neuroses or psychoses is its transient duration and reversibility. The DSM-I also includes the concept of 'External Precipitating Stress', stating that the degree of stress must be evaluated 'in terms of its effect on the "average man" and the society "from which the patient comes"' (p. 47). Thus, not only the DSM-I reified the word *stress* into a specific psychiatric entity but also advanced the concept of a twentieth-century 'average man' from a psychiatric perspective.

An excursus through the evolution of the subsequent DSM editions illustrates how some psychiatric concepts such as stress and distress are construed. The DSM-II (1968) (American Psychiatric Association 1968) includes 'subjective distress' as a generic symptom of neurosis (p. 39) and 'obsessive compulsive neurosis' as a more specific type (p. 40). The DSM-II also lists the symptom of 'oversensitivity to physical and emotional stress' as a cause for the 'asthenic personality' (p. 43). The DSM-I construct of 'Gross Stress Reaction' (54.0) is retained in the DSM-II, but the name is changed to 'Adjustment Reaction of Adult Life' (307.30). Finally, the DSM-II introduces the construct of 'Transient Situational Disturbances', defined as 'a reaction to overwhelming stress' (p. 43).

The concept of *distress* assumes a crucial role in the DSM-III (1980) (American Psychiatric Association 1980), since distress becomes the 'principal symptom' of most psychiatric disorders (p. 6) and is placed at the core of most 'mental disorders.'[29] An innovation of the DSM-III was to rate individuals along different axes, including a specific axis (IV) to measure 'psychological stressors' (p. 8). Thus, axis IV (i.e. 'severity of psychosocial stressors') is assessed by the clinician, who has to judge the severity of the stressor for an 'average person' (p. 26).

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[26] The DSM-I conceptualized stress as either 'external' or 'endopsychic' (p. 36).

[27] The DSM-I also considered personality disorders as having 'minimal subjective anxiety and little or no sense of distress' (p. 34).

[28] The circularity of this definition and the lack of a glossary leave the concept of stress in obscurity.

[29] The DSM-III conceptualized *mental disorder* as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability (p. 363).

The DSM-III also includes other changes relevant to the concepts of stress and distress. The by then almost defunct concept of 'neurotic disorders' is now conceptualized as 'a group of symptoms that [are] distressing…' (pp. 9–10) and as a 'transitory reaction to stressors' [p. 10]. The DSM-III also includes the novel construct of 'post-traumatic stress disorder (PTSD)'. The main criterion for PTSD is the almost circular statement that this disorder corresponds to the 'existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone' (p. 239), with symptoms developing 'in a setting of extreme psychological stress' (p. 245).[30] The diagnostic criteria for the new category of 'adjustment disorder' consist of 'a maladaptive reaction to an identifiable psychosocial stressor' (p. 300) which is of lesser magnitude as compared to stressors producing PTSD. *Stress* is conceptualized as both a psychological and an organic symptom, such as *gastrointestinal distress* considered a symptom of both 'overanxious disorder' (313.00) (p. 55) and 'tobacco dependence' (p. 177). The diagnosis of 'identity disorder' includes the symptom of 'severe subjective distress' as an essential feature (p. 65) and 'a stressful life situation' as a relevant predisposing factor (p. 68). 'Severe stresses' may predispose to a 'paranoid disorder' (p. 196), whereas a 'brief reaction psychosis' follows a 'psychosocial stressor' of such a magnitude that it 'would evoke significant symptoms of distress in almost anyone' (p. 200). 'Social phobia' (p. 227) is defined as a significant source of distress, and criterion B states that 'significant distress' is produced by 'the recognition by the individual that his or her fear is excessive or unreasonable' (p. 228).[31]

A major boost for the concept of distress is introduced in the DSM-IV (American Psychiatric Association 1994) which specifies that *every* major psychiatric disorder must be accompanied by clinically significant distress or some interference in various areas of functioning. The text implicitly considers that anxiety and distress are different entities, as the definition of agoraphobia (p. 396) states that 'situations are avoided…with marked distress *or* with anxiety (my italics)…'. Finally, distress is also considered the product of 'constant worry' (p. 433), resulting from fear, anxiety, or avoidance (p. 203).

In the DSM-5 (American Psychiatric Association 2013), the novel construction of 'anxious distress' is considered as a specifier for other psychiatric disorders (p. 149). This entity consists of at least two of the following symptoms: (1) feeling keyed up or tense, (2) feeling unusually restless, (3) having difficulty concentrating because of worry, (4) fear that something awful may happen, and (5) feeling that the individual might lose control of himself or herself. Whereas conceptual problems with this construct are beyond the focus of this chapter, it provides a good example on how words may fluctuate in the making of concepts in psychiatry by gaining new meanings, being combined with other terms, and losing old concepts. Finally, these

[30] The circularity lies in that *stressor* is defined as whatever produces distress, whereas, by definition, *distress* is produced by a stressor. Unfortunately, definitions for stressor and distress are lacking in the DSM-III.

[31] The same is true for the category of 'simple phobia' (300.29).

DSM-5 entries also illustrate the conceptual overlap of fuzzy borders of forms such as *anxiety*, *fear*, and *distress*.[32]

## *New Directions in the Contemporary Concepts of Stress and Distress*

Distress is at the core of the definition of mental disorder in the DSM-5 and previous editions, defined as being 'usually associated with significant distress' (p. 20). The DSM-5 defines 'psychological distress' as 'a range of symptoms and experiences of a person's internal life that are commonly held to be troubling, confusing, or out of the ordinary (p. 20)'. An effort is made in the DSM-5 to consider the impact of social factors in the mechanism of stress, and the text includes a new entity termed 'normative stress reactions', described as 'When bad things happen, most people get upset. This is not an adjustment disorder. The diagnosis should only be made when the magnitude of the distress (e.g. alterations in mood, anxiety, or conduct)[33] exceeds what would normally be expected…' (p. 289).[34] Somatic symptoms are described as 'idioms of distress' because 'they may have special meanings and shape patients' clinical interactions in the particular cultural contexts' (p. 313). The individual's distress 'emanates…from his or her anxiety about the meaning, significance or cause of the [somatic] complaint' (p. 315). This paragraph suggests that distress is produced by anxiety about somatic changes, but how distress is phenomenologically different from anxiety is not clarified. It is also unclear why somatic but not psychological components are relevant to the production of anxiety.[35]

These efforts at relating stress and distress with cultural aspects are more specifically addressed with the inclusion in the DSM-5 of 'cultural concepts of distress' and 'cultural idioms of distress'. The DSM-5 defines 'cultural concepts of distress' as 'ways that cultural groups experience, understand, and communicate suffering, behavioural problems, or troubling thoughts and emotions' (p. 788).[36] Less clear is the concept of 'cultural idioms of distress' which is defined as 'ways of expressing distress that may not involve specific symptoms or syndromes, but that provide col-

[32] The DSM-5 includes a Glossary with definitions of anxiety, stress, and related terms that is worth commenting upon. Anxiety is defined as 'the apprehensive anticipation of future danger or misfortune accompanied by a feeling of worry, distress, and/or somatic symptom of tension'. Based on this definition, distress is construed as a symptom of anxiety, whereas based on the DSM-5 diagnostic scheme, in order to become a mental disorder, anxiety has to result in significant distress, thus making the concepts of anxiety and distress circular.

[33] Note here the unclear nosological position of anxiety.

[34] Unfortunately, the text does not specify what it is that is 'to be normally expected'.

[35] Here, it is implied that distress is produced by anxiety about a somatic condition, a reaction which may be normal or not, although there are no definitions or criteria provided for the concept of 'normality'.

[36] 'Cultural syndromes' are defined as 'clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts' (758).

lective, shared ways of experiencing and talking about personal or social concerns'. Thus, everyday talk about 'nerves' or 'depression' may refer to 'widely varying forms of suffering without mapping onto a discrete set of symptoms, syndrome or disorder' (p. 788). In other words, the DSM-5 accepts, albeit in an Appendix, that different cultures may use different names for similar set of symptoms and that some set of symptoms may not qualify for specific DSM-5 criteria. This raises questions about the validity of the DSM nosology for different cultures and is explicit in the text, with the statement that 'cultural syndromes' present four key nosological features, namely, (1) a lack of a one-to-one correspondence of cultural concepts with DSM diagnostic categories; (2) the fact that cultural concepts include 'presentations' that do not fit any DSM category; (3) that a single cultural term may denote more than one type of cultural concept; and (4) that cultural concepts change over time due to contextual features.[37] These key features point to major conceptual problems for current psychiatric nosology. For instance, given that, by definition, a cultural syndrome of anxiety or distress does not correspond to the DSM-5 concept of anxiety disorder, the question arises as to which of these concepts (i.e. the cultural or the DSM-5 disorder) should be given diagnostic priority.[38]

The DSM-5 also provides an aetiological framework for causes of distress, stating that 'cultural explanations of perceived causes are labels, attributions or features of an explanatory model that indicate culturally recognised meaning or etiology for symptoms, illness or distress'. In other words, the authors of the DSM-5 consider that cultures may construe symptoms depending on idiosyncratic causes and explanations for causation and clinical manifestations, thus creating their own concepts of distress.[39] They further consider that the concept of syndromes, idioms, and explanations 'are more relevant to clinical practice' than the previous formulation in specific disorders, since '*all* [italics in the original] forms of distress are locally shaped, including the DSM disorders' (p. 758). This startling statement could be interpreted as a capitulation for establishing a universal, valid, and reliable nosology for mental disorders. If the culturally idiosyncratic concept of symptoms are clinically more relevant than standardized nosologies, the clinical usefulness of the latter is being questioned. This DSM-5 section also states that 'many DSM diagnoses can be understood as operationalized *prototypes* (my italics) that started out as cultural

[37] 'Like culture and DSM itself, cultural concepts may change over time in response to both local and global influences' (p. 758).

[38] The DSM-5 acknowledges that cultural concepts are relevant for a psychiatric diagnosis so as to 'avoid misdiagnosis', to obtain clinical information, to improve clinical rapport by 'speaking the language of the patient', to improve 'therapeutic efficacy', to guide research, and to better inform cultural research on the epidemiology of psychiatric disorders (p. 758).

[39] This paragraph suggests that distress is construed as a syndrome, although this is not defined in the DSM-5 glossary. The DSM authors also state that their previous formulation of a 'culture-bound syndrome' ignores the fact that 'clinically important cultural differences often involve explanations or experiences of distress rather than culturally distinctive configurations of symptoms'. This seems to imply that cultural differences are manifested by distress rather than peculiar symptoms, but this obscure formulation is not further elaborated.

syndromes, and become widely accepted as a result of their clinical and research utility' (p. 758).

Berrios' discussion on the complexity of prototypes or as concepts in psychiatry has been ignored, and it is important to provide some clarification on this matter. Berrios considers that a prototype is a model ontologically related to popular beliefs (Berrios 1999b).[40] As also discussed by Ellenberger (2014), the intellectual beliefs of individuals making classifications should be considered with care, as these beliefs exert a direct influence upon the nosological numerical, linguistic, and sociocultural conceptions. Berrios questions that prototypes in psychiatry should be used in the sense of Platonic 'ideas', noting that mental disorders have a history ('the received view of the disease'), but they are also the subjects of clinical practice (the 'lived experience') (p. 150). As time goes by, and based on biological and sociocultural changes, models of psychiatric disorders are modified by 'trimming' and 'recalibration' of old models. Berrios stresses that it is a mistake to consider that the latest prototype is better than older ones, as scientific progress is non-linear and the 'biological invariant'[41] is no more stable than the 'sociocultural invariant' (Berrios 1999b, p. 150). Berrios concludes that prototypes 'do not really advance our knowledge about disease' (Berrios 1999b, p. 150).

It is unclear, however, how these DSM prototypes may emerge as cultural syndromes, since the previous paragraphs imply that culture imposes its own idiosyncrasies to symptoms, to syndromes, and to what qualifies as distress. One possible interpretation is that prototypes are biological factors, which may interact with cultural factors to produce symptoms and syndromes. Questions also arise as to how a given behaviour is recognized as a 'form of distress', whether the phenomenology varies across cultures, and what are the criteria for their recognition. Unfortunately, a definition of 'forms of distress' is not provided in the DSM-5, which strongly limits the understanding of cultural concepts.[42]

While the inclusion of contextual factors should be considered an important addition to the DSM nosology, several conceptual issues about the role of cultural factors in the formulation of psychiatric disorders require further analysis. The question arises as to the meaning of 'cultural syndromes'. The DSM-5 refers to 'cultural concepts' as arising from local folk or professional diagnostic systems for mental and emotional distress, thus reflecting the influence of biomedical concepts. The words *stress* and *distress* are for the DSM-5 authors, 'symptoms', 'responses', or 'experiences,' which constitute the essence of psychiatric disorders, and may be

[40] 'As each successive generation trim and recalculate the 'received' prototype, new ones are being added' (p. 150).

[41] Perhaps the qualifier of 'invariant' is too strong for a concept that does change with time, but Berrios may have wanted to point that biology and culture are axes around which concepts are built.

[42] There are further epistemological problems with these DSM-5 statements. Among others are which is the validity of the different 'forms of distress', how are they 'locally shaped', whether this includes the DSM disorders, and why is distress used in the DSM disorders in an homogeneous way when it is suggested that there are forms of distress that are culturally bound.

influenced by cultural and contextual factors.[43] Nevertheless, a conceptual investigation of the use of these terms in psychiatry is still lacking. In the colloquial language, there is no 'essence' for those terms, to the extent that 'stress…seems to involve anything and everything' (Cantor and Ramsden 2014). It is here that the DSM diagnostic scheme becomes conceptually confusing. To meet the criteria for a given disorder, most of the DSM syndromes must produce distress, and as we have discussed, the very concept of distress is conceptualized in a rather obscure way, which makes it difficult to operationalize.

In conclusion, the DSM-5 is conceding that there is a strong component of social construction in the production and manifestation of psychiatric symptoms such as distress, even though the impact of this relevant concession is not further discussed. Given the 'agnostic' stance of the DSM in terms of causation, the complex 'bonding' of cultural construction of psychiatric symptoms and syndromes and the validity of research into the organic causes of mental disorders is mentioned but not further addressed.

## Conclusion

The classification of psychiatric disorders is a never ending task. This is due, as masterfully discussed by Professor German Berrios, to the fact that words are associated with concepts and behaviours that change with the *zeitgeist* of societies. This may at least partially explain why the efforts of classifying mental disorders may fail unless these changes are properly considered.

The main aim of this chapter was to discuss how concepts are formed and their relevance in psychiatry. For this, I used the example of the concepts of *stress* and *distress* as used in the DSM. The discussion highlighted the major role Professor German Berrios has had in illuminating the task of conceptual analysis in contemporary psychiatry. I examined the different ways in which the words *stress* and *distress* are used in different contexts and how by analysing the grammar of these terms their concept is clarified. As an important element in human 'form of life', the words *stress* and *distress* entered frequent colloquial use in the second half of the twentieth century and have been included as relevant terms in contemporary psychiatric nosologies. Based on Jackson's work (Jackson 2013) and the analysis of the use of the word *stress* and *distress* in the successive DSM editions, I discussed how these concepts have changed over time. I also provided a critical discussion on how the last DSM edition treats for the first time the role of culture in the creation of psychiatric words, concepts, and behaviours. This conceptual broadening is a positive step

[43] The DSM-5 defines 'stress' as 'the pattern of specific or nonspecific responses a person makes to stimulus events that disturb his or her equilibrium and tax or exceed his or her ability to cope', while stressor is defined as 'any emotional, physical, social, economic, or other factor that disrupts the normal physiological, cognitive, emotional, or behavioral balance of an individual' (p. 829). These definitions are in consonance with previous editions.

forward, but it also brings new challenges that conceptual analysis may help to clarify. The work of Professor German Berrios has been of great importance to help unravel the conceptual knots that still pervade current psychiatric nosologies, and his research, both empirical and conceptual, will be hopefully continued by the younger generations.

## References


Abbott, A. (1990). Positivism and interpretation in sociology: Lessons for sociologists from the history of stress research. *Sociological Forum, 5*, 435–458.

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders (Dsm-I)*. American Psychiatric Association Mental Hospital Service: Washington, DC.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). American Psychiatric Association: Washington, DC.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association: Washington, DC.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (Dsm-Iv)*. Washington, DC: American Psychiatric Press.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association: Arlington.

Auden, W. H. (2011). *The age of anxiety*. Princeton University Press: Princeton.

Berrios, G. (1999a). Anxiety disorders: A conceptual history. *Journal of Affective Disorders, 56*, 83–94.

Berrios, G. E. (1999b). Classifications in psychiatry: A conceptual history. *The Australian and New Zealand Journal of Psychiatry, 33*, 145–160.

Berrios, G. E. (2010). How to write a useful history of schizophrenia. *Vertex, 21*, 349–358.

Berrios, G. E., Luque, R., & Villagran, J. M. (2003). Schizophrenia: A conceptual history. *International Journal of Psychology and Psychological Therapy, 3*, 111–140.

Cantor, D., & Ramsden, E. (2014). *Stress, shock and adaptation in the twentieth century*. Rochester: University of Rochester Press.

Dilman, I. (2002). *Wittgenstein's Copernican revolution: The question of linguistic idealism*. London: Palgrave.

Ellenberger, H. F. (2014). Les Illusions De La Classification Psichiatrique. *L'Evolution Psychiatrique, 79*, 23–37.

Glock, H. J. (2008). *What is analytical philosophy?* Cambridge: Cambridge University Press.

Glock, H. J. (2009). Concepts: Where subjectivism goes wrong. *Philosophy, 84*, 5–29.

Hampton, J. A. (1999). *The MIT encyclopedia of the cognitive sciences*. Cambridge: The MIT Press.

Hinkle, L. E. (1987). Stress and disease: The concept after 50 years. *Social Sciences of Medicine, 25*, 561–566.

Jackson, M. (2013). *The age of stress*. Oxford: Oxford University Press.

Kay, C. (2009). *Historical thesaurus of the Oxford English dictionary*. Oxford: Oxford University Press.

Marková, I. S., & Berrios, G. E. (2012). Epistemology of psychiatry. *Psychopathology, 45*, 220–227.

Marková, I. S., & Berrios, G. E. (2016). Research in psychiatry: Concepts and conceptual analysis. *Psychopathology, 49*, 188–194.

Moyal-Sharrock, D. (2013). *A Wittgensteinian perspective on the use of conceptual analysis in psychology*. Basingstoke: Palgrave Macmillan.

Rosenman, S., & Nasti, J. (2012). Psychiatric diagnoses are not mental processes: Wittgenstein on conceptual confusion. *The Australian and New Zealand Journal of Psychiatry, 46*, 1046–1052.
Selye, H. (1955). Stress and disease. *Science, 122*, 625–631.
Selye, H. (1956). *The stress of life*. New York: McGraw-Hill Book Company.
Tone, A. (2007). Tranquilizers. In E. S. Watkins (Ed.), *Medicating modern America: Prescription drugs in history*. New York: New York University Press.
Watkins, E. S. (2014). *Stress and the American vernacular: Popular perceptions of disease causality*. Rochester: University Of Rochester Press.
Wittgenstein, L. (1969). *On certainty*. New York: Harper Torchbooks.
Wittgenstein, L. (2001). *Philosophical investigations*. Oxford: Blackwell.

# Chapter 10
# Cultural Configurators and the Formation of Mental Symptoms


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## Contents



## Introduction

It has long been acknowledged that human beings are the products of dynamic interactions between their biological components (nature) and their social and environmental conditions (nurture). A series of concepts have historically been deployed to explain the ways in which culture shapes nature, including Descartes' pineal gland, Locke's reflective thinking, Kant's categories, Herder's and Humboldt's model of language and Darwin's adaptability. Recently, other dichotomies have been proposed, including genotype/phenotype, as well as notions such as epigenesis and

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Kuhn's paradigms. These generic concepts share the same underlying structure by acknowledging the existence of a series of independent patterns and units of information which configure and partition preformed internal systems. The mechanisms involved in natural systems (whether physical or chemical) are generally clearer and more easily mapped than those driving social and cultural processes, perhaps because the latter are inherently more complex. The failure to illuminate social and cultural processes has resulted in repeated attempts to naturalise them; in other words, to reduce culture to biological mechanisms (Berrios 2018).

## The Epistemological Structure of Psychiatry

Psychiatry is a relatively young discipline, historically and epistemologically speaking. It was built during the nineteenth century, under the auspices of medicine and with its foundations in both the social and natural sciences. The former provide the social, ethical and aesthetic criteria for the categorisation and classification of anomalous conduct. Psychiatric investigation initially strives to understand, in each historical period, why society considers certain conducts to be deviant. Subsequently, the goal is to understand why particular people develop such mental deviances. Once anomalous conducts have been established in social terms, the natural sciences attempt to link such conducts to the brain in physical, chemical and biological terms. But in and of themselves, the natural sciences do not have the capacity to formulate new definitions and categories of mental disorders; as a result, the social sciences and humanities hold epistemological primacy over them.

In this context, the Cambridge School has proposed a new epistemology of psychiatry (EP), which seeks to understand the origin, structure and usefulness of all narratives developed to capture what are called 'mental afflictions'. The EP stands on a 'methodological tripod' constituted by historical, conceptual and empirical research. Psychiatry is a hybrid in both its structure (as a discipline) and its objects (the mental symptoms and disorders). That is, psychiatry is configured by theories and practices borrowed from both the natural and the human sciences (Berrios 2011a, 2013; Marková and Berrios 2012; Berrios and Marková 2015). This hybrid nature distinguishes psychiatry from other medical disciplines and should guide psychiatric teaching, research and practice (Berrios 2011a, 2015a; Marková and Berrios 2016; Marková 2018).

## The Formation and Configuration of Mental Symptoms

Mental symptoms were constructed in the historical and cultural context of alienism in the nineteenth century (Berrios 1984, 1996). According to the Cambridge School's model of mental-symptom formation, symptoms are psychic phenomena constituted by a rudimentary signal, of biological or semantic origin, which reaches

the subject's consciousness. The primordial information is preconceptual and prelinguistic, and for it to be communicated, it first has to be understood cognitively and emotionally by the patient (Berrios 2011a, b, 2015a, b; Berrios and Marková 2015; Marková and Berrios 2009, 2012). During this process, the patient configures the signal according to cultural factors. It is this understanding that defines and confers meaning and stability to mental symptoms.

This model stipulates that there are two types of psychiatric symptoms, which differ in how they are represented in the brain. The first of these is characteristic of organic psychoses: it originates in the primary brain 'disease' process, which sends disturbed signals to the subject's consciousness and triggers experiences that are ineffable and prelinguistic. Such experiences can only be semantically interpreted and cognitively and emotionally understood by comparing them with standard semantic templates, which are learnt over the course of the subject's life and serve as references for recognising and classifying known, everyday knowledge. This kind of interpretation is necessary for the verbal expression of experience.

The second type of mental symptom has a different origin and corresponds to a secondary brain inscription. In this instance, the symptom arises from an intersubjective space through a process triggered by factors outside the individual, such as symbols or conflicts. The social and symbolic intersubjectivity of all human beings is persistently stirred by conflicts and distortions, both acute and chronic. These conflicts often generate relatively novel experiences, sometimes resembling those induced by changes in the brain. To handle them, human beings resort to the same store of configurators, generating similar complaints to primary mental symptoms. Therefore, in the first group, the substrate to be configured is located in the brain; in the second group, it is a symbolic or emotional affliction. In both cases, the cultural configurators are the same.

This process is repetitive for almost the entire stream of information arriving from within the body and the external world; therefore, it is carried out routinely and unconsciously. However, when the information is novel, the process becomes conscious and generates anxiety, fear and perplexity, because the subject lacks relevant templates or configurators with which to shape it and thereby imbue it with meaning. This is what happens at the beginning of psychosis when the subject's conscience receives new experiences. After a period of perplexity – well described in the psychiatric literature (Conrad 1958; Fuentenebro and Berrios 1995) – the subject is forced to select semantic configurators to allow him or her to understand the new information. It is likely that valid configurators belong to received models of madness for their historical period. This would explain why the clinical ailments which the subject communicates greatly resemble those of contemporaneous patients, as well as official definitions of the mental illness, whilst differing greatly from those expressed in other historical periods (Aragona and Marková 2015).

The cultural factors which configure the construction of symptoms are involved throughout the process. Generally, these patterns vary in three ways:

Firstly, according to the characterisation of the experience, including the rate at which it appears, the context in which it emerges and its novelty or familiarity

Secondly, variation due to internal and external factors (the former include personality traits, educational level, intelligence, past experiences, imagination and introspection and the latter family relations, society and culture)

Thirdly, variation arising from the constellation of meanings which results from the interactions between the subject and the clinician (or someone else), which contributes to crystallising and formulating the experience

## Configurators and Social Factors in Psychiatry

To configure means to frame by construction, to fashion, to shape or to give a configuration to (Oxford English Dictionary 1993). For the Cambridge School, configurators are the mechanisms responsible for the shaping effects of culture on the biological signal. Configurators are asymmetrical agents, because they force something else to change more than the 'something else' changes them. Cultural configurators act on rudimentary biological or symbolic signals on a deep level, thereby formatting the cascade of processes implicated in the formation of symptoms. This means that configurators can weaken, distort or annihilate the specificity of the biological signal and the information linked to the primary experience. Therefore, signals arising in different locations in the brain can be configured as the same symptom and signals from the same location as different symptoms. Although always present, the neurobiological substrate is not fundamental to the understanding and handling of mental symptoms, which can only be grasped at a symbolic or semantic level.

Ever since Durkheim, there have been debates over the ontology and epistemology of social factors (Gilbert 1989; Greenwood 2003; Little 2007). According to some, social factors ought to be more relevant in psychiatry than in other branches of medicine. Social factors, in a broad sense, have been well recognised since the early stages of alienism. For instance, Esquirol (1838) identified a series of life events that cause 'madness'. Twenty years later, Bucknill and Tuke (1858) contended that civilisation (i.e. social factors) is responsible for the higher levels of madness in the nineteenth century. This idea spread to other European countries, and by the end of the nineteenth century, several books on the specific role of social factors in madness had been published (Duprat 1900; Lunier 1874). For them to be useful in psychiatry, social factors must be something more than a presumed presence in an aetiological map. Up until now, their function has been limited to the triggering of, and providing of content to, mental symptoms. The triggering of the symptoms consisted of the role conventionally attributed to life events during the 1970s, when it used to be thought that, mediated by stress, social factors caused mental disorders. The idea that social factors provide content to mental symptoms has been used in transcultural psychiatry to explain why the object of the mental symptom changes depending on the patients' cultural backgrounds.

Nonetheless, the Cambridge School considers the intervention of social factors to be much deeper than the mere provision of different contents to the symptoms. In other words, culture is thought to penetrate the subject's consciousness sufficiently

deeply to allow it to configure the mental symptoms with a moderate level of invariance. According to this model, social factors are constitutive of the symptom; and therefore they are both causes and effects (Berrios 2015b).

## Configurators and Pathoplasty

The concept of pathoplasticity was coined by Karl Birnbaum in the early twentieth century and is semantically complementary to 'pathogenic' (Birnbaum 1923). For Birnbaum, pathoplastic refers to the 'form' of the clinical category and pathogenesis to the aetiology. He believed that the basic clinical phenomena of any illness are composed of two elements. In the first place, there are those referring to the aetiology of the illness (pathogenesis), which determine its character and specific qualities. In the second place, there are the factors that configure the disorder (pathoplasty) by shaping and giving content to the basic form of the biologically established category. Within these elements, Birnbaum distinguished further structural components – predisposition and provoking factors – that affect either process in varying degrees, but which in general are of less clinical significance than the pathogenic or pathoplastic factors themselves. Birnbaum used both of these concepts as constituents of a metalanguage and a set of mechanisms which he tried to group together to explain the formation of psychosis. He called the mechanisms 'structural analysis'. Birnbaum's aim was to move beyond the fatalist and organicist model of psychosis that dominated Germany at the time, sustained by Kraepelin's and Nissl's theories.

Birnbaum described a broad range of pathoplastic factors. He believed that their influence is more profound than either the mere determination of the symptom's content or the reflection of the cultural context in which the illness emerges. Pathoplastic factors, according to Birnbaum, are responsible for framing the illness, directing its development and determining its outcome. But despite employing the term 'pathoplasty' to describe, explain and classify illnesses, Birnbaum did not suggest any mechanisms whereby pathoplastic factors could shape the illness.

Dilthey's theory of psychology was highly influential in Birnbaum's ideas (Dilthey 1945, 1976). In fact, Birnbaum's pathoplastic factors drew heavily from Dilthey's sociocultural factors (although the former are secondary with respect to organic factors). For Birnbaum, psychosis had a hierarchical structure, and pathoplastic factors shaped the illness.

In contrast, according to the Cambridge School's model of symptom formation, the distinction between pathoplasty and pathogenesis is artificial, in the sense that there exist neither hierarchies nor significant differences between organic and cultural factors. This is because cultural factors are able to profoundly penetrate the subject's consciousness and thereby generate a new symptom. Indeed, their effects can be sufficiently intense to modify the specificity of the neurobiological signal. As previously explained, the same signal can generate different symptoms and vice versa.

Another key difference between Birnbaum's pathoplastic factors and the Cambridge School's configurators is that the former apply to diseases whilst the latter are specific to the symptoms. This difference is not merely quantitative, but qualitative, due to the fact that the Cambridge model questions the distinction between pathoplasty and pathogenesis. This is why Birnbaum scarcely spoke about 'psychogenesis' – it was of little relevance to his model. In sharp contrast, the Cambridge School considers psychogenesis (via configurators) to be a core concept in psychiatry.

## Configurators and Social Representations

We owe the concept of social representation to Serge Moscovici (1961, 2001). Moscovici aimed to reformulate Durkheim's (1893) concept of collective representation in psychosocial terms. According to Durkheim, collective representations are socially constructed forms of knowledge which cannot be explained as epiphenomena of individual life. In the same way that individual representations ought to be considered purely psychic phenomena, which cannot be reduced to the activity of the brain, collective representations cannot be reduced to the aggregate of individuals' representations.

Moscovici argued that social representations are constituted by a series of concepts, statements and explanations which originate in the communication between individuals in their day-to-day lives. They are the equivalent of myths and belief systems in 'traditional' societies; therefore, they are the contemporary version of common sense, 'that sum of knowledge which constitutes the substratum of images and meanings without which no collective can operate' (Moscovici 1981, p. 185). It follows that social representations are symbolic constructs of the mind, created over the course of social interactions. That is, they are specific ways of understanding and communicating reality, influencing but also influenced by persons through their interactions.

Social representation does not consist of reproducing or copying the properties of an object (it is not the image of that object). Neither is it an accurate reflection of external reality. Rather, social representation is a reshaping of reality, involving both the transformation and the mental construction of the object. Such ways of understanding and constructing reality are constituted by symbolic elements, because they have the capacity to assign meaning to social reality. In the words of Moscovici (2001, p. 37), 'the purpose of all representations is to make something unfamiliar, or unfamiliarity itself, familiar'.

Social representations are generated by two processes. The first of these, referred to as 'anchoring', consists of the process of categorisation through which objects (people and things) are named and classified. The second process, objectivation, is the transformation of abstract entities into something concrete and material – the transformation of the products of thinking into physical realities and of concepts into images (Moscovici 1981). Throughout representation, individuals' grasp of reality is conditioned by their values, social roles, needs and other sociocultural factors.

The concept of social representation is a psychological-sociological hybrid, with references to anthropology and history. In recent decades, it has been an object of research in yet other areas, including communication studies (Moscovici 2001), social cohesion (Duveen 2008), social cognition (Augoustinos et al. 2005), epistemology and dialogicality (Marková 2008; Marková 2016) and discourse (Wagner and Hayes 2005). Seen through the lens of the Cambridge model, social representations resemble configurators and blueprints in the sense that they are a constellation of meanings or reference systems that enable the subject to classify or interpret reality's phenomena and circumstances and even give meaning to the unexpected ('voire de donner un sens à l'inattendu' (Jodelet 1984, p. 369)).

## Configurators and Intersubjectivity

The concept of intersubjectivity is vague and disperse and has been studied in a variety of disciplines including philosophy, psychopathology, psychiatry, psychology, linguistics, sociology, anthropology, phenomenology and moral philosophy (Owens 1970; Crossley 1996; Fuchs 2010, 2015; Galbusera and Fellin 2014; Vaitkus 1991; Frie 1997; Mills 2005; Verhagen 2005; Gillespie and Cornish 2010; Zahavi and Overgaard 2013). Generally speaking, two approaches to intersubjectivity can be identified. In Anglo-Saxon philosophy, intersubjectivity is an epistemological way of defining objectivity – it is the possibility of objective knowledge, as collectively agreed by all subjects. The second approach considers intersubjectivity to be a semantic space and an interpersonal matrix which enables persons to share the meanings of their experiences.

Edmund Husserl, the founding father of phenomenology, undertook the first systematic study of the concept of intersubjectivity. Husserl used this term to designate a plurality of subjects and the relation that exists between them (Husserl 1973). Despite claims that from 1910 onwards Husserl dedicated much of his work to the elaboration of a single transcendental theory of intersubjectivity (Vergés Ramírez 1995; Zahavi 2001; Moran 2017), really two stages can be identified in Husserl's work on this. For the early Husserl of *Logical Investigations* (Husserl 2001) and *Cartesian Meditations* (Husserl 1986), the world is but the experience of our consciousness, which is necessarily intentional. Here Husserl maintains that we account for the reality of another consciousness by means of an imaginative analogical transfer of our own experiences onto others. In this sense, it is always my individual transcendental ego that conveys meaning onto other persons in the world around me. This view has been criticised for being solipsist. According to this early Husserl, the subject is constituted exclusively through observation and analogical apperception, but this precludes the possibility that meanings can be shared and communicated, because persons observe and experience each other but never interact, thereby excluding the role of talk and language. Speech and language are more obviously related to intersubjectivity than perception and imagination.

On the other hand, Husserl's later work (Husserl 1973, 2005) provides a holistic phenomenological description of the totality of 'life consciousness' (*Bewusstseinsleben*) or 'life of spirit' (*Geistesleben*), exploring intersubjectivity in an original and intersubjective way including human sociality, communalisation, historicality, generativity and life culture and tradition (Moran 2017). For example, in *Ideen II,* Husserl (2005) employs the terms 'surrounding world' (*Umwelt*) and, in an intersubjective sense, 'common surrounding world' to describe the higher-order subjectivities or personalities that constitute a conglomerate of persons participating in a contiguous world in multiple ways (communicative, affective, emotive, cognitive), thereby forming communities possessing a 'higher level of integration' through acts of personal determination taking place on a base of mutual understandings. In this sense, Husserl's intersubjectivity links up with the social and communicative dimensions of the person (Husserl 2005, p. 239).

Drawing from Husserl's phenomenology and Weber's comprehensive sociology, Alfred Schütz (1972) analyses intersubjectivity based on social interaction networks. What really interests Schütz is the interpretation of the meanings of the world and the actions and interactions of social subjects. Intersubjectivity is sociality's raw material. Intersubjectivity has also been studied from a phenomenological standpoint by philosophers including Max Scheler and Merleau-Ponty. For Scheler (1942), sociality is the most basic characteristic of experience, the true constitutive essence of being human. Consequently, Scheler sees the problem of intersubjectivity as one of the ultimate questions in any examination of the foundation of the social sciences.

Merleau-Ponty (1945) considers intersubjectivity to be a basic element of perception, which is understood not as the simple experience of objects but as a pre-reflective interaction with the world. This dialectic process between the subject and other persons generates a shared world – an intersubjective system which involves a combination of perception, language, talk and affectivity. Hans Gadamer (1989) also identifies a similar intersubjectivity system in linguistic communication. Gadamer develops a dialogical theory of hermeneutics that reflects a dialogical conception of truth and meaning. Understanding another's action is a process that always happens in a pragmatic and cultural context.

Consequently, human subjectivity is not a private inner world. Rather, human action and experience emerge from dialogical systems or situations, which cannot be reduced to individual human subjects. Intersubjectivity would therefore consist of an interworld of shared meanings. Broadly speaking, this is the received approach in cognitive science, which understands intersubjectivity as 'the sharing of experimental content (e.g. feelings, perceptions, thoughts, and meanings) among a plurality of subjects' (Zlatev et al. 2008). For these authors, human beings are primordially connected in their subjectivity rather than functioning as monads. The sharing of experiences is based on embodied interaction, e.g. empathetic perception, imitation, gesture and practical collaboration. The Cambridge School conceives of intersubjectivity as the creation of spaces for communication and exchanges between subjects, the process of creativity and the forming of the self. But they also see intersubjectivity as the source of conflicts and disagreements which, in some cases, can be important for the genesis of symptoms in psychopathology.

## Conclusions

The Cambridge School has proposed a new epistemology of psychiatry based on a 'methodological tripod' constituted by historical, conceptual and empirical research. Both the structure (the discipline of psychiatry) and the objects of psychiatry (the mental symptoms and mental disorders) have a hybrid nature, that is, they are configured by forms and practices borrowed from the natural and human sciences.

According to the Cambridge School's model of mental-symptom formation, symptoms are psychic phenomena constituted by a rudimentary signal, of biological or semantic origin, which reaches the subject's consciousness and which the patient must configure through cultural processes. The relevant aspects of configuration occur at semantic or symbolic levels, which can only be grasped by metalanguage. Several tasks will be necessary to assemble the process of symptom formation and configuration. The first will involve developing a methodology which allows the identification of the elements and structures of cultural configurators. The second will concern the implementing of a methodology which lends itself to empirical verification. And the third will necessitate the creation of an explanatory model of action of configurators which accounts for their ability to attenuate, distort or abolish the biological signal. The realisation of these tasks will be essential both for a better understanding of psychiatry and for the patients' sake.

## References

Aragona, M., & Marková, I. S. (2015). The hermeneutics of mental symptoms in the Cambridge school. *Revista Latinoamericana de Psicopatologia Fundamentale, 18*, 599–618. https://doi.org/10.1590/1415-4714.2015v18n4p599.2.

Augoustinos, M., Walker, I., & Donaghue, N. (2005). *Social cognition: An integrated introduction*. London: Sage.

Berrios, G. E. (1984). Descriptive psychopathology: Conceptual and historical aspects. *Psychological Medicine, 14*, 303–313. https://doi.org/10.1017/S0033291700003573.

Berrios, G. E. (1996). *The history of mental symptoms*. Cambridge: Cambridge University Press.

Berrios, G. E. (2011a). *Hacia una nueva epistemología de la Psiquiatría*. Buenos Aires: Polemos.

Berrios, G. E. (2011b). Psychiatry and its objects. *Revista de Psiquiatría Salud Mental, 4*, 179–182. https://doi.org/10.1016/j.rpsmen.2011.09.001.

Berrios, G. E. (2013). Formation and meaning of mental symptoms: History and epistemology. *Dialogues in Philosophy, Mental and Neuro Sciences, 6*, 39–48.

Berrios, G. E. (2015a). History and epistemology of psychopathology. In K. S. Kendler & J. Parnas (Eds.), *Philosophical issues in psychiatry III: The nature and sources of historical change* (pp. 30–50). Oxford: Oxford University Press.

Berrios, G. E. (2015b). The role of cultural configurators in the formation of mental symptoms. In K. S. Kendler & J. Parnas (Eds.), *Philosophical issues in psychiatry III: The nature and sources of historical change* (pp. 107–115). Oxford: Oxford University Press.

Berrios, G. E. (2018). Historical epistemology of the body-mind interaction in psychiatry. *Dialogues in Clinical Neuroscience, 20*, 5–13.

Berrios, G. E., & Marková, I. S. (2015). Towards a new epistemology of psychiatry. In L. J. Kirmayer, R. Lemelson, & C. A. Cummings (Eds.), *Re-visioning psychiatry. Cultural*

*phenomenology, critical neuroscience and global mental health* (pp. 41–64). Cambridge: Cambridge University Press. https://doi.org/10.1017/CBO9781139424745.005.
Birnbaum, K. (1923). *Der Aufbau der Psychose. Grundzüge der Psychiatrischen Strukturanalyse*. Berlin: Springer. English edition (Chapters I and II): Hirsch, S. R., & Shepherd, M. (1974). *Themes and variations in European psychiatry* (H. Marshall, Trans., pp. 199–238). Charlottesville: University Press of Virginia.
Bucknill, J., & Tuke, D. H. (1858). *A manual of psychological medicine*. London: Churchill.
Conrad, K. (1958). *Die beginnende Schizophrenie*. Stuttgart: Thième.
Crossley, N. (1996). *Intersubjectivity. The fabric of social becoming*. London: Sage.
Dilthey, W. (1945). *Psicología y teoría del conocimiento*. México: Fondo de Cultura Económica.
Dilthey, W. (1976). *Selected writings* (H. P. Rickman, Ed., Trans., pp. 87–97). Cambridge: Cambridge University Press.
Duprat, G. L. (1900). *Les Causes Sociales de la Folie*. Paris: Alcan.
Durkheim, E. (1893). Représentations individuelles et représentations collectives. *Revue de Métaphysique et de Morale, VI*, 273–302.
Duveen, G. (2008). Social actors and social groups: A return to heterogeneity in social psychology. *Journal for the Theory of Social Behaviour, 38*, 369–374.
Esquirol, E. (1838). *Des Maladies Mentales* (Vol. 1). Paris: Bailliére.
Frie, R. (1997). *Subjectivity and intersubjectivity in modern philosophy and psychoanalysis*. Lanham: Rowan & Littlefield Publishers.
Fuchs, T. (2010). Subjectivity and intersubjectivity in psychiatric diagnosis. *Psychopathology, 43*, 268–274. https://doi.org/10.1159/000315126.
Fuchs, T. (2015). The intersubjectivity of delusions. *World Psychiatry, 14*, 178–179. https://doi.org/10.1002/wps.20209.
Fuentenebro, F., & Berrios, G. E. (1995). The predelusional state. *Comprehensive Psychiatry, 36*, 251–259.
Gadamer, H. G. (1989). *Truth and method*. London: Sheed & Ward.
Galbusera, L., & Fellin, L. (2014). The intersubjectivity endeavor of psychopathology research: Methodological reflections on a second-person perspective approach. *Frontiers in Psychology, 5*, 1–14. https://doi.org/10.3389/fpsyg.2014.01150.
Gilbert, M. (1989). *On social facts*. Princeton: Princeton University Press.
Gillespie, A., & Cornish, F. (2010). Intersubjectivity: Towards a dialogical analysis. *Journal for the Theory of Social Behaviour, 40*, 19–46.
Greenwood, J. D. (2003). Social facts, social groups and social explanation. *Noús, 37*, 93–112.
Husserl, E. (1973). *Zur Phänomenologie der Intersubjektivität I-III*. Husserliana XIII-XV (I. Kern, Ed.). The Hague: Nijhoff.
Husserl, E. (1986). *Meditaciones cartesianas* (M. A. Presas, Trans.). Madrid: Tecnos.
Husserl, E. (2001). *Logical investigations* (2 vols., J. N. Findlay, Trans.; D. Moran, Ed.). London: Routledge.
Husserl, E. (2005). *Ideas relativas a una fenomenología pura y una filosofía fenomenológica. Libro Segundo: Investigaciones fenomenológicas sobre la constitución*. México: Fondo de Cultura Económica.
Jodelet, D. (1984). Représentations sociales: phénomènes, concept et théorie. In S. Moscovici (Ed.), *Psychologie sociale* (pp. 357–371). Paris: PUF.
Little, D. (2007). Levels of the social. In S. P. Turner & M. W. Risjord (Eds.), *Handbook of the philosophy of science: Philosophy of anthropology and sociology* (pp. 343–372). Amsterdam: Elsevier.
Lunier, L. (1874). *De L'influence des Grandes Commotions Politiques et Sociales sur le développement des maladies mentales*. Paris: Savy.
Marková, I. (2008). The epistemological significance of the theory of social representations. *Journal for the Theory of Social Behaviour, 38*, 461–487.
Marková, I. (2016). *The dialogical mind: Common sense and ethics*. Cambridge: Cambridge University Press.

Marková, I. S. (2018). Translational neuroscience and psychiatry: A conceptual analysis. *Journal of Evaluation in Clinical Practice, 24*, 791–796. https://doi.org/10.1111/jep.12914.
Marková, I. S., & Berrios, G. E. (2009). Epistemology of mental symptoms. *Psychopathology, 42*, 343–349. https://doi.org/10.1159/000236905.
Marková, I. S., & Berrios, G. E. (2012). Epistemology of psychiatry. *Psychopathology, 45*, 220–227. https://doi.org/10.1159/000331599.
Marková, I. S., & Berrios, G. E. (2016). Research in psychiatry: Concepts and conceptual analysis. *Psychopathology, 49*, 188–194. https://doi.org/10.1159/000447596.
Merlau-Ponty, M. (1945). *Phénomènologie de la perception*. Paris: Gallimard.
Mills, J. (Ed.). (2005). *Relational and intersubjective perspectives in psychoanalysis*. Lanham: Jason Aronson.
Moran, D. (2017). Intercorporeality and intersubjectivity: A phenomenological exploration of embodiment. In C. Durt, T. Fuchs, & C. Tewes (Eds.), *Embodiment, enaction, and culture. Investigating the constitution of the shared world* (pp. 25–46). Cambridge, MA: The MIT Press.
Moscovici, S. (1961). *La Psychanalyse: Son Image et Son Public*. Paris: Presses Universitaires de France.
Moscovici, S. (1981). On social representations. In J. P. Forgas (Ed.), *Social cognition. Perspectives on everyday understanding* (pp. 181–209). London: Academic.
Moscovici, S. (2001). In G. Duveen (Ed.), *Social representations*. New York: New York University Press.
Owens, T. J. (1970). *Phenomenology and intersubjectivity*. The Hague: Martins Nijhoff.
*Oxford English Dictionary*. (1993). (2nd ed.). New York: Oxford University Press.
Scheler, M. (1942). *Esencias y formas de la simpatía*. Buenos Aires: Losada.
Schütz, A. (1972). *Fenomenología del mundo social. Introducción a la sociología comprensiva*. Buenos Aires: Losada.
Vaitkus, S. (1991). *How is society possible?* Dordrecht: Kluwer Academic Publishers.
Vergés Ramírez, S. (1995). *La intersubjetividad en Husserl*. Barcelona: Promociones y Publicaciones Universitarias.
Verhagen, A. (2005). *Constructions of intersubjectivity*. Oxford: Oxford University Press.
Wagner, W., & Hayes, N. (2005). *Everyday discourse and common sense*. Basingstoke: Palgrave Macmillan.
Zahavi, D. (2001). *Husserl and transcendental intersubjectivity, a response to the linguistic-pragmatic critique* (E. Behnke, Trans.). Athens: Ohio University Press.
Zahavi, D., & Overgaard, S. (2013). Intersubjectivity. In H. Lafollette (Ed.), *International encyclopedia of ethics*. https://onlinelibrary.wiley.com/doi/full/10.1002/9781444367072.wbiee274. https://doi.org/10.1002/9781444367072.wbiee274
Zlatev, J., Racien, T. P., Sinha, C., & Itkonen, E. (Eds.). (2008). *Shared mind: Perspectives of intersubjectivity*. Amsterdam: Benjamins.

# Chapter 11
# Psychogenesis: Conceptual Analysis


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## Contents



Psychiatry has long been divided by two opposed views: that of those who, although admitting that mental disorders may have brain representation, emphasize that in a substantial number of cases this representation may be irrelevant to their definition, meaning, generation, and treatment and that of those who contend that all causes of mental disorders are to be found in brain dysfunctions, whether they are mental symptoms or mere epiphenomena of them. The former does not deny organic accounts of mental disorders; it simply holds that such accounts may sometimes be incomplete. The latter does not deny the use of mental or social variables or descrip-

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tions; it simply urges psychiatrists, if possible, to reduce them to low-level (neural) descriptions, even when, by doing it, crucial and causally related semantic elements may be disposed of.

The subject of debate is, therefore, whether mental disorders may be the result of complex, interactive, semantically pregnant actions and, thus, *psychogenetically* caused. A corollary question is how this can be conceptualized. This psychogenesis debate has ontological and epistemological consequences but also clinical and organizational derivatives. Since the early nineteenth century, the dichotomy 'organic-psychogenic' has been built into the definition of psychiatry. That is why the possibility of psychogenesis can be considered the fundamental question in psychiatry, from which all other questions follow (Berrios 2003).

## Psychogenesis and Its Convergences

Two main convergences of a term, a concept and a cluster of behavioural referents, can be identified in the history of psychogenesis (Berrios 2018a). On the one hand, since before the nineteenth century, psychogenesis had referred to the process whereby the soul (later the mind and personality) was constructed. This convergence, ontological in nature but with epistemological consequences, explains its etymological origin and is still being used, coexisting during the nineteenth and twentieth centuries with the second convergence in such diverse fields as philosophy (Baldwin 1902), sociology (Elias 2000), pedagogy (Pruzzo 2017), psychology (Preyer and Talbot 1881; Hill 1892; Morgan 1892; Andriezen 1894; Piaget and Garcia 1983; Wallon 2007), and also psychiatry (Dide 1926).

On the other hand, during the nineteenth century, psychogenesis started to refer to the mechanism whereby the mind can generate mental disorder. First used in psychiatry and mainly epistemological in its origin but with ontological consequences, this second convergence stems from the old notion of moral causation of insanity, present in the first half of the nineteenth century in the works of, among others, Esquirol (1845) and already anticipated in seventeenth century authors such as Cullen (1789).

The second convergence is said to be created by Robert Sommer in his book *Diagnostik der Geisteskrankheiten*, in which he uses the words *Psychogenie* and *Psychogene* to name the process through which hysteria is explained (Sommer 1894, pp. 125–127). Later on, he again uses the term to refer to "psychogenic neuroses" (*psychogener neuroses*) (Sommer 1906, p. 51). In both cases, Sommer attributes to them a causal sense: they refer to pathological states (*Krankheitszustände*) induced or influenced by ideas (*Vorstellungen*). Over the next decades, psychogenesis appears with slightly different meanings in the work of many authors (Savill 1909; Glueck 1912; Wimmer 2003; Jung 1919; Prince 1920; Birnbaum 1918, 1928; Braun 1928) and contributes to the explanation of obscure psychological phenom-

ena such as dissociation and hypnotism and of various mental disorders (Berrios 2018a). Two main meanings can be distinguished (Faergeman 1963). On the one hand, from the A*nglo-Saxon* tradition, there is the notion of psychogenesis as something produced and developed *in* mental space; on the other hand, the *continental* view that psychogenesis is something produced by environmental (including relational) factors on the mind. Although for this reason some authors have advised to provide a 'decent burial' to the concept (Lewis 1972), the fact that psychogenesis has a variety of meanings does not seem to warrant getting rid of it (Berrios 2003).

## Psychogenesis: Epistemological Context

Berrios (2018a) proposed a number of contextual epistemological factors or structures that already begin to appear in the eighteenth century and contribute to the conceptual development of psychogenesis from the nineteenth century to this day:

(a) Kant's epistemology and his view of mind as active in the knowing process and the structuring and forming of experiences arrived at by applying his categories of understanding (Hartnack 1977)
(b) The evolutionary theories of Spencer and Darwin, which held that, in the course of evolution, new properties and behaviours emerge (like life, mind, and reflective thought) that cannot be predicted from the already existing entities they emerged from (Morgan 1927)
(c) The gradual development of the ontological concept of self, initiated by Luther in the sixteenth century, which gained a more active role with Fichte in the nineteenth century (Berrios and Marková 2003a)
(d) Changes in the concept of meaning and the relationship between language and reality, which emerge from the linguistic debates at the end of the eighteenth century (from Herder, Rousseau to Humboldt) and posit that language, with its semantic space full of symbols, creates reality and influences human behaviour (Formigari 2004)
(e) The questioning of dualist models, in particular the Cartesian one, which do not protect *res cogitans*, making this one dependent on changes in *res extensa* (Berrios 2018b)
(f) The notion of *inner sense*, a sort of inward experience different from outward (sense) impressions, and its role as an important source and basis of knowledge, which influenced the individualist French spiritualism of the nineteenth century (De Biran 2016)
(g) The concept of reaction, introduced as 'irritability' in medicine by Glisson in the seventeenth century, and its application to psychology as a response to external stimuli (Starobinski 1974)

These epistemological changes favoured the notion of psychogenesis and made it acceptable and understandable in the nineteenth century culture, either as description or explanation.[1] As the latter, it gained stability when opposed to the concept of *somatogenesis*.

In contrast to psychogenesis, somatogenesis is the view that holds that mental disorders are caused by specific modification of the body. Accordingly, the presence of a specific somatic lesion is necessary and sufficient to account for the mental disorder. The notion of lesion in psychiatry changed during the nineteenth century. While up to the 1820s it was conceptualized in anatomical or structural terms, from then up to the 1880s physiological lesions were hypothesized as causes of mental pathology (Moreau de Tours 1845; Griesinger 1845). Only in the transition from the nineteenth to the twentieth century could a psychological mechanism be entertained and, generally, only when a somatic one could not be found (Cossa 1969; Berrios 2018a).

In the eighteenth century, Frank Mesmer (1779) proposed a new modulating cause of human behaviour, an external, magnetic fluid ontologically different from the somatic changes accepted until then. In contrast, Faria (1906) denied the existence of this fluid and proposed that the *sommeil lucide* (hypnosis) is caused by a mechanism inherent to the individual himself (in his imagination[2]) that can be manipulated through suggestion. With Freud, Janet, and others, this internal force became more subtle and psychological. At the turn of the century, the adjective psychogenic was used in conditions that could be cured (or improved for long periods of time) by hypnosis, suggestion, analytic work, or some sort of 'moral' or persuasive treatment (Ellenberger 1976).[3]

Throughout the twentieth century, psychogenesis is used to describe (a) how the body generates mental events; (b) how it generates personality; (c) how these mental events take part in the development of the latter; (d) how they cause mental disorders, directly or through personality, such as psychogenic psychoses, hysteria, folie à deux, dissociation, post-traumatic stress disorder, etc.; (e) how mental events influence the body and take part in the origin of physical disorders (which led to psychosomatic medicine); or (f) how mental events generate unexplained somatic symptoms (somatization disorders and hypochondriasis) (Berrios 2018a).

[1] This acceptance implies that psychogenesis cannot be reduced to inferior ontological levels, and hence, as Heidegger claimed, it must keep its own epistemological space (Boss 2001; Berrios 2018a).

[2] Montaigne, in the sixteenth century, already dedicated one of his *Essays* to the 'force of imagination' and, while subscribing the ancient dictum *Fortis imagination generat casum* (a strong imagination produces the event), affirmed that 'it may provoke fever and even death to those who let it act' (de Montaigne 2003, ch. XXI, p. 139).

[3] At that time, the idea of a psychogenesis of a mental disorder came from a rather circular reasoning: The disorder was psychogenic as far as it was improved by psychotherapy, and this was effective because it was treating a psychogenic disorder (Lantéri-Laura 2000, p. 282).

## The Methodenstreit

The use of the notion of psychogenesis in psychiatry is embedded in another important debate (known as the *Methodenstreit* or 'methodological debate') that was happening at that time: the debate over the nature or status of the human sciences and whether their methods are the same as those of the natural sciences (Fulford et al. 2006). This debate, launched in the middle of the eighteenth century by John Stuart Mill (1974), had a considerable influence on Jaspers through the views of authors such as Dilthey, Weber, or Rickert, who sought to counter Mills' claims that there were no substantive differences between the methods and aims of the human and natural sciences. The debate ran into the first decade of the twentieth century and re-emerged several decades later triggered by the logical positivist idea of a unified conception of science (Oppenheim and Putnam 1958; Hempel 1962).

Proponents of a distinctive method for both sciences distinguished between *understanding* (giving an account that concerns the meaning of an action or event) and *explanation* (giving a causal account). Understanding is the process of grasping a *meaningful* connection between events, while explaining is the way of identifying a *logical* connection.

## Psychogenesis in Freud

Although the term psychogenesis appears several times in Freud's works and is included in the title of one of his famous clinical cases,[4] the concept has a problematic integration (Meléndez 2004). This may be the reason why Jung initially felt uncomfortable in dealing with this subject (Jung 1960, p. 211). Freud considered psychoanalysis a natural science and, thus, sidestepped the *Methodenstreit* and the distinction between explanation and understanding. Freudian interpretation is a modality of explanation as long as it searches for a causal account from the effects but assumes the latter are overdetermined and therefore there is not a linear connection between causes and effects. Freud, unlike Jaspers, does not take a point of synthesis such as personality as the basis of the understandable or meaningful connections of an individual. Rather, he establishes as a starting point a structural division of the individual so that a primary or original scene can be identified, through analytical work, as the base upon which symbolic construction is built.

[4] Freud S. Sobre la psicogénesis de un caso de homosexualidad femenina (1920). In Obras completas. Tomo VII, Madrid, Biblioteca Nueva, 1974, pp. 2545–60

## Psychogenesis in Jaspers

It is stated that Jaspers' main contribution to psychiatry was the introduction of Dilthey's psychology and the notion of understanding (Tellenbach 1969, p. 14). The fact is that Jaspers' view on the distinction between understanding and explanation is not clear enough (Fulford et al. 2006, p. 219). While in the first section of his 1913 paper on the topic (Jaspers 1913/1974, pp. 82–3) he seems to follow Dilthey's view that understanding and explanation are two ways of apprehending *two separate realms* of reality, in another part of the same paper (p. 86), he seems to endorse Weber and Rickert's view that they are two different methods to approach *the same* reality, either mental or physical.

Jaspers suggests that in psychopathology, apart from causal links between sensory data coming from our sense organs that natural explanation (*erklären*) can account for, there are meaningful connections that can be grasped by psychological understanding (*verstehen*) or empathic representation of psychic data.[5] Accordingly, Jaspers distinguishes between *process* and *development*. Process is the alien factor that makes empathic, genetic understanding impossible, and, thus, building a *Weltanschauung* or global meaning is not allowed. Processes are all the pathological phenomena that produce a permanent change in the meaningful connections of personality.[6]

For Jaspers, this dialectical notion (Lantéri-Laura 1962), opposed to that of development and reaction, and parasitic upon the notion of the non-understandable (*(un)verständlich*), is central to psychiatry and makes the aetiological question (whether the ultimate cause of mental disorder is a metabolic dysfunction or an unconscious dynamism) secondary. Thus, the aim of psychiatry is the search for process symptoms (primary or fundamental, as opposed to secondary ones) and their pathogenic mechanisms (Jaspers 1910/1977). However, the fuzzy boundaries of the concept of psychological understanding, its excessive flexibility to extend beyond them, and the overvaluation of the position of the observer were correctly criticized as leading to the idea that all pathological manifestations of mental disorders may have a psychogenic origin (Pichot 1984, p. 82; Castilla del Pino 1980).

[5] To Jaspers, subjective psychology (as opposed to the objective one) was made up of two different ways of understanding mental states: *static* understanding (which considers mental events in isolation and is concerned with phenomenology) and *genetic* understanding which, through empathy, apprehends meaningful connections between mental events. The latter would belong to the realm of meaningful (*verstenhende*) psychology, with names such as Janet or Freud as predecessors (Jaspers 1980, p. 352; Jaspers 1913/1974, p. 84).

[6] On the other hand, in development (*Entwicklung*) and reaction (*Reaktion*), there are meaningful connections between the content of pathological mental phenomena and personality that can be understood (Jaspers 1910/1977).

## Psychogenesis in Wimmer

Wimmer, in his 1916 book on psychogenic psychoses (Wimmer 2003), defines psychogenesis according to four criteria: (a) predisposition, (b) psychological causes determining the course (onset, evolution, and end) of the disorder, (c) psychological causes shaping its form and content, and (d) marked tendency to recovery.

Although it has been claimed (Faergeman 1963; Garrabé and Cousin 2001) that Wimmer's criteria draw on Jaspers's reactive psychoses, he might have been much influenced by his own clinical observations (included in his 1902 doctoral dissertation) and the views of Magnan, Legrain, or Reiss (Schioldann 2003). Be that as it may, Schneider's reformulation of the concept of psychosis,[7] with the impossibility of a non-organic aetiology, and Swiss psychiatry's (Bleuler, Jung) extension of understanding to a wide variety of mental disorders which made superfluous the delimitation of a specific group of reactive psychoses (Gabriel 1987) contributed to the disappearance of psychogenic psychosis after the Second World War, at least in German psychiatry (Strömgrem 1974, 1986, 1989).

## Psychogenesis in Lacan

Lacan's views on psychogenesis can be analysed in three different periods. In his 1932 doctoral thesis, Lacan considers psychogenic[8] a symptom (either physical or mental) whose causes are expressed through complex mechanisms of personality, whose manifestations reflect them, and whose treatment may depend upon them (Lacan 1987, p. 41). He affirms that a psychogenic symptom still rests upon an organic basis, generally pathological, sometimes identified as a lesion (p. 42), and distinguishes between organic (either functional or lesion) and psychogenic causality of a disorder, both being mutually compatible.

The notion of *psychogeny* of this first Lacan differs from Jaspers' view (Lantéri-Laura 1984b). As mentioned above, Jaspers empathic understanding (*verstehen*) differentiated between normal and pathological (or process), whereas Lacan considers that even process can be understood in its *psychogenic* meaning (i.e. by psychoanalytic theory) (Casarotti 2018).[9] He draws on Jaspers' concept of *psychic process* (as opposed, on the one hand, to development and, on the other, to organic process),

[7] Once reconceptualized, the notion of psychogenic psychosis was a *contradictio in terminis* to Schneider. He even disowned his contribution on psychogenic conditions to Aschaffenburg's 1927 treaty and prohibited his pupils to mention or list it (Strömgren 1994; Schioldann 2003).

[8] Lacan prefers to use the terms *psychogeny* and *psychogenic* instead of the more used *psychogenesis* and *psychogenetic* for the sake of language economy (Lacan 1932/1987, p. 41, footnote 31).

[9] According to Jaspers, the impossibility of *verstehen* will lead to pathology, but in order to consider psychogeny, a superior understanding, a sort of *überverstehen*, has to be established. Lacan states that this can be facilitated by Freudian theory, which, according to Lantéri-Laura (1984a), will act as a sort of *erklären* (Teixeira 2012).

which, by introducing a new and heterogeneous element in personality, conforms again to meaningful connections and understanding (Lacan 1932/1987, pp. 128–131).[10]

In his contribution to the third Bonneval colloquium in 1946, Lacan (1975) changes his views. In his paper 'Propos sur la causalité psychique' (Observations on Psychic Causality), he opposes his view to Ey's organo-dynamism, which he considers to be a variety of mechanistic organicism (p. 147). He no longer draws on Freudian theory to find, in a basically epistemological stance, psychogenic mechanisms that differentiate some delusional disorders from some other organically determined. Rather, in an ontological turn, he centres on man as the root of mental alienation and affirms that madness, from its origin, is entirely experienced in the register of meaning, in what makes human experience specific, that is, language (pp. 165–166).

In his seminar on psychoses in 1955, psychogenesis is finally excluded from psychoanalysis with his much quoted sentence: '…if this [understanding in Jaspersian sense] is psychogenesis, then the great secret of psychoanalysis is that there is no psychogenesis' (Lacan 1984, p. 17). By rejecting understanding as a method of identification of the psychogenic, and relying on his symbolic, imaginary, and real triad presented a few years earlier, Lacan proposed to overcome dualism and the distinction between psychogenesis and organogenesis, thereby questioning the very etiological enterprise in psychiatry.[11]

## Psychogenesis in Ey

Probably the most important and conceptually profound debate on psychogenesis during the twentieth century was that of the Third Bonneval Colloquium organized by Henry Ey in 1946 (Bonnafé et al. 1950). Following the topic of the second colloquium held in 1943 (dedicated to the *inferior* limits of psychiatry, i.e. its relationship with neurology), Ey (1950) proposed as the theme for the third edition the *superior* limits of psychiatry; that is, what differentiates mental pathology from normal mental life. He contributed to the debate with a paper called 'The limits of psychiatry: the problem of psychogenesis', which generated replies by Lacan (see above), Rouart, and Bonnafé and Follin. Rouart's contribution (Rouart 2004) is interesting from an epistemological point of view, as he criticizes the subordination

[10] Ey, in his comments on Lacan's thesis (1932), does not seem to appreciate this distinction as he criticizes Lacan for defending two contradictory ideas: on the one hand, the process nature of paranoia (as exemplified by Aimée's case) and, on the other, its dependence on personality (Casarotti 2018).

[11] Lacan's final position on this question may be interpreted in a *strong* sense, as questioning psychology and psychiatry as scientific enterprises (but saving animal ethology), or in a *weak* sense, as suggesting a shift in psychiatry from the search of causes and aetiologies to that of risk factors or mechanisms involved (Teixeira 2012).

of psychic causes of mental disorders to physical ones and proposes a three-part causality (sociological, psychological, and biological) with a different contribution of each cause in every case, concluding that all mental disorders have a psychic origin but in different degrees (Berrios 2018a).

In his paper, Ey seems to use the term psychogenesis in its two meanings, as the development of mental functions and as psychic causation of mental disorders. He criticized, as he had done in an earlier paper (Ey 1932), the notion of constitution as a necessary condition to the development of mental pathology and followed Jaspers' concept of process as the pathology criterion. Drawing on Jaspers' notion of psychic process, he defended his doctrine of organo-dynamism against Lacan and herewith repudiated psychic causality of mental disorders. On the other hand, he emphasizes the processes of normal psychogenesis, which lead to a synthetic organization of adaptive functions, and claims that mental disorder is both the process of unstructuring or dissolution of psychic structure (into an inferior level of psychic organization) and the expression of this dissolution in every form of mental pathology (Casarotti 2018). In a later paper, Ey (1974) criticizes the notion of reactive mental pathology by affirming that what is pathological is reactivity itself, expressed through a disorganization of psychic life.

## The Notion of Reaction

This concept, probably introduced in the thirteenth century, had acquired both vitalistic and mechanistic meanings by the seventeenth century, which have run in parallel ever since (Starobinski 1974, 1977, 1999; Berrios 2003).

The ontological space in which reactions take place has changed from matter (from Glisson's notion of irritability to Newton's mechanistic view or Boyle's reaction to reagents) to mind (in Breuer and Freud's notion of abreaction or in Jaspers' meaningful genuine reactions). When taking place in the latter, reactivity and psychogenesis overlap.

Adolf Meyer introduced reactivity into twentieth-century psychiatry, and since then it has been applied to many categories. However, it remains unclear whether the term means the same in all of them and how all these are connected to the notion of psychogenesis. It is also unclear what the relationship is between reaction and its trigger, whether reaction acts as a reason or a cause (Berrios 2003).

## Psychogenesis in Symptom Formation

The modelling of descriptive psychopathology on semiology, its development during the nineteenth century trying to link specific signs and symptoms with brain lesions, and its later exclusive dependence on correlational accounts neglected the possibility that non-lesion factors (social, semantic) could play a crucial role in the

construction of mental symptoms. Mental symptoms may arise from complex interactions between brain signals and semantic information. There can be two types of symptoms according to its brain representation (Berrios and Marková 2003b). On the one hand, there are those that originate in a putative, more or less specific brain signal, which penetrate awareness and are first experienced in a formless, prelinguistic experience, which is later formatted through a configurative process into verbal or behavioural tokens. On the other hand, there are those that originate from a reconfiguration process of the former. This reformatting activity occurs in a semantic (linguistic, symbolic) space in which personal, relational, and social clues are crucial. It also has a brain representation, but this is not necessarily specific nor sufficient to fully account for it. Symptoms resulting from this reformatting process may be similar to the first type and constitute behavioural *phenocopies* (Berrios and Marková 2002, 2003b) and lead to medically and psychologically unexplained symptoms.

Mental disorders built upon this second type of symptom constitute veritable 'pathologies of meaning' and should be formulated in terms of reasons rather than causes.

## How Does Psychogenesis Exert Its Causal Power?

Three positions can be adopted regarding the causality of mental events: (a) mental events *do not* cause; they are just folk descriptions of the real causal processes to which they can be reduced. This is the view supported by all reductionist accounts of action explanation, including those of philosophers of mind such as Gilbert Ryle (1963) or AI Melden (1961) for whom reasons can *never* be causes; (b) mental events *do* cause; reasons (at least some of them) can be causes, assuming a nomological account of causation; (c) mental events *do* cause, and reasons can be causes but assuming a non-nomological account of causation.

The most influential example of the b) position is Donald Davidson's Anomalous Monism (Davidson 1980). Davidson states that mental concepts cannot be structured in natural laws, but mental events to which they apply are part of the causal fabric of the world. An action is an event that may have different descriptions depending on their relational properties. Action explanation is a method of fitting one action into a broader pattern, and reasons are an appropriate way of rationalizing them, making sense of them through contextualization. But, reason explanation is, to Davidson, also a form of causal explanation. Although reasons and causes structure reality in different ways, this does not imply that what is being structured is not the same in both. Davidson, however, does not provide an answer to the question of how mental properties play a part in causal explanation of action, as he assumes that properties that are invoked in the nomological account of the causal efficacy of mental events are exclusively physical (Tanney 1995; Fulford et al. 2006, p. 728).

But what if the nomological, Hempelian, Newtonian notion of cause is insufficient? This notion excludes important aspects of human behaviour such as time and

context. If human beings and their behaviour are complex adaptive phenomena, their actions are unpredictable, making covering-law models clearly inadequate to explain these processes. This is the view held, for example, by Juarrero (1999) for whom the causal mechanism at work between levels of hierarchical organization can best be understood as the operations of context-sensitive constraints. High levels of self-organization of the human brain and nervous system can access different states with different properties than less complex and uncorrelated neuronal processes can. These include meaning, intentionality, purposiveness, and the like. Thus, higher level's self-organization is the change of probability of the lower-level events. Top-down causes cause by changing the prior probability of the component's behaviour. What follows is a non-reductive model of explanation, one which includes historical narratives (Juarrero, pp. 131–150).

## Conclusion

Psychogenesis may be an out-of-fashion concept (Lewis 1972), but there are important reasons not to reject it, as part of contemporary neuroscience does (Berrios 2018a). On the one hand, the rejection of psychogenesis contradicts the results of clinical, historical, and epistemological analyses of mental disorders, assuming a very narrow notion of them. Moreover, the study of psychogenesis may offer an important key to the understanding and effective handling of many mental disorders. On the other hand, the epistemological caveats that have been shown regarding the causality of mental events dissolve when the proper notion of causality departs from the linear cause-effect, covering-law model, and the excessive dependence on correlations (with brain activity) as the only confirmed evidence of the existence of a causal link between mental events. The issue here is not whether a known disease of the brain can 'cause' people to behave in strange ways; it is whether every time a person behaves in a strange way the claim can be made that something is wrong with his/her brain. If that is not the case, psychiatry must have the tools to distinguish those mental disorders in which brain representation is causal and primary, and the target for treatment, from those in which it is secondary and non-causal, and hence the treatment target lies on the semantic and symbolic network at the origin of that mental disorder (Berrios 2018b).

## References

Andriezen, W. L. (1894). On some of the newer aspects of the pathology of insanity: Law of psychogenesis. *Brain, 17*, 645–646.

Baldwin, J. M. (Ed.). (1902). *Dictionary of philosophy and psychology* (Vol. 2). London: Macmillan.

Berrios, G. E. (2003). Foreword. In A. Wimmer (Ed.), *Psychogenic psychoses* (J. Schioldann, Trans., Ed., pp. 9–15). Adelaide: Adelaide Academic Press.

Berrios, G. E. (2018a). Psicogénesis: ¿concepto central de las disciplinas de la mente? *Vertex Revista Argentina de Psiquiat, XXIX*, 187–194.
Berrios, G. E. (2018b). Historical epistemology of the body-mind interaction in psychiatry. *Dialogues in Clinical Neuroscience, 20*, 5–12.
Berrios, G. E., & Marková, I. S. (2002). Conceptual issues. In H. D'haenen, J. A. den Boer, & P. Willner (Eds.), *Biological psychiatry* (pp. 3–24). Chichester: Wiley.
Berrios, G. E., & Marková, I. S. (2003a). The self and psychiatry: A conceptual history. In T. Kircher & A. David (Eds.), *The self in neuroscience and psychiatry* (pp. 9–39). Cambridge: Cambridge University Press.
Berrios, G. E., & Marková, I. S. (2003b). Symptoms – Historical perspective and effect on diagnosis. In M. Blumenfield & J. J. Strain (Eds.), *Psychosomatic medicine* (pp. 27–38). Baltimore: Lippincott Williams & Wilkins.
Birnbaum, K. (1918). *Psychische Verursachung seelischer und die psychisch bedingten abnormen Seelenvorgänge*. Wiesbaden: Bergmann.
Birnbaum, K. (1928). Die psycho-reaktiven (psychogenen) Symptom-bildungen. In O. Bumke (Ed.), *Handbuch der Geisteskrankheiten* (Vol. 2, pp. 92–133). Berlin: Springer.
Bonnafé, L., Ey, H., Follin, S., Lacan, J., & Rouart, J. (1950). *Le problème de la psychogenèse des névroses et des psychoses.* (1946). III Colloque de Bonneval. París: Desclée de Brouwer.
Boss, M. (Ed.). (2001). *Martin Heidegger's Zollikon seminars*. Evanston: Northwestern University Press.
Braun, E. (1928). Psychogene Reaktionen. In O. Bumke (Ed.), *Handbuch der Geisteskrankheiten* (Vol. 5, pp. 12–226). Berlin: Springer.
Casarotti, H. (2018). III Coloquio de Bonneval: Ey y Lacan discuten sobre la realidad de la enfermedad mental. *Vertex, Revista Argentina de Psiquiat, 29*(139), 203–213.
Castilla del Pino, C. (1980). *Introducción a la Psiquiatría. I. Problemas generales. Psico(pato) logia*. Madrid: Alianza Editorial.
Cossa, P. (1969). Organogenèse ou psychogenèse des troubles mentaux? *Bulletin de l'Académie Nationale de Médecine, 153*, 345–348.
Cullen, W. (1789). *First lines of the practice of physic* (Vol. 4). Edinburgh: Elliot.
Davidson, D. (1980). Actions, reasons and causes. In *Essays on actions and events* (pp. 3–19). Oxford: Oxford University Press.
De Biran, M. (2016). The relationship between the physical and the moral in man: Copenhagen treatise (1811). In D. Meachan & J. Spadola (Eds.), *The relationship between the physical and the moral in man* (pp. 139–156). London: Bloomsbury.
de Montaigne, M. (2003). De la fuerza de la imaginación. In *Ensayos completos chap. XXI* (pp. 139–147). Madrid: Cátedra.
Dide, M. (1926). *Introduction à l'Étude de la Psychogénèse*. Paris: Masson.
Elias, N. (2000). *The civilizing process. Sociogenetic and psychogenetic investigations* (Rev. ed.). Oxford: Blackwell.
Ellenberger, H. F. (1976). *El descubrimiento del inconsciente*. Madrid: Gredos.
Esquirol, E. (1845). *Mental maladies. A treatise on insanity*. Philadelphia: Lea and Blanchard.
Ey, H. (1932). A propos de: Lacan J. De la psychose paranoïaque dans ses rapports avec la personnalité. *L'Encéphale, II*, 851–856.
Ey, H. (1950). Les limites de la psychiatrie, le problème de la psychogenése. In L. Bonnafé, H. Ey, S. Follin, J. Lacan, & J. Rouart (Eds.), *Le problème de la psychogenèse des névroses et des psychoses.* III Colloque de Bonneval (1946) (pp. 9–20). París: Desclée de Brouwer.
Ey, H. (1974). La notion de 'réaction' en psychopathologie (Essai critique). *Confrontations psychiatriques, 12*, 43–62.
Faergeman, P. M. (1963). *Psychogenic psychoses*. London: Butterworth.
Faria, A. (1906). *De la cause du sommeil lucide ou étude de la nature de l'homme* (1819). Paris: Jouve.
Formigari, L. (2004). *A history of language philosophies*. Amsterdam: John Benjamins.

Freud, S. (1974). Sobre la psicogénesis de un caso de homosexualidad femenina (1920). In *Obras completas. Tomo VII* (pp. 2545–2560). Madrid: Biblioteca Nueva.
Fulford, K. W. M., Thorton, T., & Graham, G. (2006). Psychopathology and the 'Methodenstreit'. In K. W. M. Fulford, T. Thorton, & G. Graham (Eds.), *Oxford textbook of philosophy and psychiatry, Chap. 10* (pp. 211–238). Oxford: Oxford University Press.
Gabriel, E. (1987). Continental viewpoints on the concept of reactive psychoses. *Psychopathology, 20*, 87–91.
Garrabé, J., & Cousin, F. R. (2001). Acute and transient psychotic disorders. In M. G. Gelder, J. J. López-Ibor Jr., & N. C. Andreasen (Eds.), *New Oxford textbook of psychiatry* (Vol. 1, pp. 644–649). Oxford: Oxford University Press.
Glueck, B. (1912). A contribution to the study of the psychogenesis in the psychoses. *American Journal of Insanity, 68*, 371–429.
Griesinger, W. (1845). *Die Pathologie und Therapie der psychischen Krankheiten*. Stuttgart: Verlag von Adolf Krabbe.
Hartnack, J. (1977). *La teoría del conocimiento de Kant*. Madrid: Cátedra.
Hempel, C. G. (1962). Deductive-nomological vs. statistical explanation. In H. Feigl & G. Maxwell (Eds.), *Scientific explanation, space & time* (Minnesota studies in the philosophy of science) (Vol. III, pp. 98–169). Minneapolis: University of Minnesota Press.
Hill, D. J. (1892). Psychogenesis. *The Philosophical Review, 1*, 481–503.
Jaspers, K. (1910/1977). Delirios celotípico, contribución al problema: ¿desarrollo de una personalidad o proceso? In *Escritos psicopatológicos* (pp. 111–181). Madrid: Gredos.
Jaspers, K. (1913/1974). Causal and 'meaningful' connexions between life history and psychosis. In S. R. Hirsch & M. Shepherd (Eds.), *Themes and variations in European psychiatry. An anthology* (pp. 80–93). Bristol: John Wright & Sons.
Jaspers, K. (1980). *Psicopatología General*. Trad 4ª German ed. 1942. B. Aires: Beta.
Juarrero, A. (1999). *Dynamics in action. Intentional behavior as a complex system*. Cambridge, MA: MIT Press.
Jung, C. G. (1919). On the problem of the psychogenesis in mental diseases. *Proceedings of the Royal Society of Medicine, 12*(Sect_Psych), 63–76.
Jung, C. G. (1960). *The psychogenesis of mental disease [Bollinger series]*. Princeton: Princeton University Press.
Lacan, J. (1932/1987). *De la psicosis paranoica en sus relaciones con la personalidad*. 5ª ed. México: Siglo XXI Ed.
Lacan, J. (1975). Acerca de la causalidad psíquica. In J. Lacan (Ed.), *Escritos* (pp. 142–187). Buenos Aires: Paidós.
Lacan, J. (1984). *El seminario III. Las psicosis (1955–1956)* (pp. 16–17). Barcelona: Paidós.
Lantéri-Laura, G. (1962). La notion de processus dans la pensée psychopathologique de K. Jaspers. *L'Evolution Psychiatrique, 4*, 459–499.
Lantéri-Laura, G. (1984a). Le concept opératoire de psychogènese et son évolution. *Psychologie Médicale, 8*, 1375–1379.
Lantéri-Laura, G. (1984b). Processus et psychogenèse dans l'oeuvre de J. Lacan. *L'Évolution Psychiatrique, 49*, 975–990.
Lantéri-Laura, G. (2000). *Ensayo sobre los paradigmas de la psiquiatría moderna*. Madrid: Triacastela.
Lewis, A. (1972). 'Psychogenic': A word and its mutations. *Psychological Medicine, 2*, 209–215.
Melden, A. J. (1961). *Free action*. London: Routledge.
Meléndez, F. (2004). La inexistencia de la psicogénesis: el gran secreto del psicoanálisis. *Investigación en Salud, VI*, 43–49.
Mesmer, F. A. (1779). *Mémoire sur la découverte du magnétisme animal*. Geneve: Didot.
Moreau de Tours, J. (1845). *Du hachisch et de l'aliénation mentale. Études psychologiques*. Paris: De Fortin, Masson et Cie.
Morgan, C. L. (1892). The law of psychogenesis. *Mind, New Series, 1*, 72–93.
Morgan, C. L. (1927). *Emergent evolution*. London: Williams & Norgate.

Oppenheim, P., & Putnam, H. (1958). Unity of science as a working hypothesis. In H. Feigl, M. Scriven, & G. Maxwell (Eds.), *Concepts, theories, and the mind-body problem* (Minnesota studies in the philosophy of science) (Vol. II, pp. 3–36). Minneapolis: University of Minnesota Press.

Piaget, J., & Garcia, R. (1983). *Psychogenèse et histoire des sciences*. Paris: Flammarion.

Pichot, P. (1984). *A century of psychiatry*. Paris: Dacosta.

Preyer, W., & Talbot, M. (1881). Psychogenesis. *The Journal of Speculative Philosophy, 15*, 159–188.

Prince, M. (1920). Miss Beauchamp. The theory of the psychogenesis of multiple personality. *Journal of Abnormal Psychology, 15*, 67–135.

Pruzzo, V. (2017). Desde la psicogénesis a las neurociencias: discusiones y aportes a la alfabetización. *Pilquen, 14*, 34–43.

Rouart, J. (2004). Y a-t-il des maladies mentales d'origine psychique? In H. Ey (Ed.), *Le problème de la psychogenèse des Névroses et des Psychoses* (pp. 63–90). Paris: Tchou.

Ryle, G. (1963). *The concept of mind*. London: Penguin.

Savill, T. D. (1909). The psychology and psychogenesis of hysteria and the role of the sympathetic system. *Lancet, 173*(4459), 443–448.

Schioldann, J. (2003). August Wimmer's clinical concept *Psychogenic Psychoses*: An introductory conceptual history. In A. Wimmer (Ed.), *Psychogenic psychoses* (J. Schioldann, Trans., Ed., pp. 19–73). Adelaide: Adelaide Academic Press.

Sommer, R. (1894). *Diagnostik der Geisteskrankheiten* (pp. 125–127). Wien: Urban und Schwarzenberg.

Sommer, R. (1906). Geistesschwäche bei psychogener Neurose mit Bezug auf § 6.1 des Bürgerlichen Gesetzbuches. In R. Sommer (Ed.), *Klinik für psychische un nervöse Krankheiten* (pp. 51–64). Halle: Carl Marhold.

Starobinski, J. (1974). Reaction. Le mot et ses usages. *Confrontations psychiatriques, 12*, 19–42.

Starobinski, J. (1977). The word reaction: From physics to psychiatry. *Psychological Medicine, 7*, 373–386.

Starobinski, J. (1999). *Action et Réaction: vie et aventures d'un couple*. Paris: Editions de Seuil.

Strömgrem, E. (1974). Psychogenic psychoses. In S. R. Hirsch & M. Shepherd (Eds.), *Themes and variations in European psychiatry. An anthology* (pp. 97–117). Bristol: John Wright & Sons.

Strömgren, E. (1986). The development of the concept of reactive psychoses. *Psychopathology, 20*, 62–67.

Strömgren, E. (1989). The development of the concept of reactive psychoses. *British Journal of Psychiatry, 154*(suppl. 4), 47–50.

Strömgren, E. (1994). Recent history of European Psychiatry – ideas, developments, and personalities. The Annual Eliot Slater Lecture [1986]. *American Journal of Medical Genetics, 54*, 405–410.

Stuart Mill, J. (1974). *The collected works of John Stuart Mill*, volume VIII – A system of logic ratiocinative and inductive, Being a connected view of the principles of evidence and the methods of scientific investigation (Books IV-VI and appendices), J. M. Robson (Ed.). Toronto: University of Toronto Press.

Tanney, J. (1995). Why reasons may not be causes. *Mind and Language, 10*, 105–128.

Teixeira, P. (2012). Una articulación de la psicogénesis y la psicosis en la teoría de Jacques Lacan. *Perspectivas en psicología, 9*, 92–99.

Tellenbach, H. (1969). *Estudio sobre la patogénesis de las perturbaciones psíquicas*. México: FCE.

Wallon, H. (2007). *La evolución psicológica del niño*. Barcelona: Ares y Mares.

Wimmer, A. (2003). *Psychogenic psychoses* (J. Schioldann, Trans., Ed., pp. 9–15). Adelaide: Adelaide Academic Press.

# Chapter 12
# Supervenience and the Mind-Body Problem in Psychiatry


**Hiroshi Ihara**

## Contents



## Pre-introduction

The first time I heard the technical word ‘supervenience’ was perhaps in 1996 when I was a PhD student in the Department of Psychiatry at the University of Cambridge. The reason I enrolled in a PhD course under the supervision of Prof. German Berrios, professor of epistemology of psychiatry in Cambridge, was not to conduct empirical research but to investigate theoretical aspects of psychiatry. I had no doubt that the core of the conceptual complexities in psychiatry lay in the

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mind-body problem; hence I attempted to investigate the mystery of the mind-body relationship. I surveyed a vast body of literature concerning philosophy of mind. During this time, Prof. Berrios advised me to peruse Jaegwon Kim's (1993) *Supervenience and Mind*. At first glance, I vaguely anticipated that Kim's perspective would provide a powerful tool to illuminate the relationship between mental processes and brain processes. At the same time, I soon recognized that I did not have enough time to examine such a complicated topic in the few years of my PhD course. I was realistic enough to abandon epistemological research and to turn to an empirical study. As a result, I conducted data-based research concerning disorders of 'executive functions', possibly on account of the dysfunction of their putative biological bases, i.e. the prefrontal cortex and its affiliated structures.

Since receiving my PhD, I have thought about the thesis of mind-body supervenience on occasion. Now I am honoured to have the opportunity to submit a piece of homework assigned to me by Prof. Berrios after more than 20 years.

## Introduction

While the mind-body problem has occupied the minds of philosophers for centuries, today it is rephrased as the mind-brain problem. Since psychiatry is inevitably concerned with both the mental and biological aspects of psychiatric illnesses, the epistemology of psychiatry cannot escape this problem. The objective of this article is to address the mind-brain problem from the viewpoint of 'supervenience' (Kim 1993), one of the cardinal notions of analytic philosophy.

The word 'supervenience' derives from the Latin word *supervenio*, which means 'to overtake or to come upon'. It is used in the vernacular to mean 'to follow closely' or 'to occur as an unexpected or extraneous development' (Collins English Dictionary 2018). However, this use of 'supervenience' is not equivalent to the philosophical use of the term.

When discussed in analytic philosophy, supervenience is described as follows: a set of properties *A* (the supervenient set) supervenes upon another set of properties *B* (the subvenient set or supervenience base) if and only if no two things can differ with respect to *A* properties without also differing with respect to their *B* properties. In other words, there cannot be a change in the supervenient set without a related change in the subvenient set. Consequently, it has been stated in moral philosophy that moral properties supervene on natural properties; similarly, aesthetic properties supervene on non-aesthetic properties in philosophy of art. In the case of the mind-body problem, or rather the mind-brain problem, this can be paraphrased as follows: a mental process supervenes on its supervenience base, i.e. a neurobiological process. Therefore, there cannot be a change in mental processes without there being a change in the underlying neurobiological processes.

## A Short History of Supervenience

It has been speculated that the first philosopher to use the word 'supervenience' was Lloyd Morgan (1923), the British emergentist. Characterizing the nature of emergence, he argued that emergent properties 'supervene' on their base properties. For him, emergence is characterized as a relation in which emergent properties are distinct from their subvenient properties and arise unpredictably from them. However, his use of the term was in its vernacular sense, rather than in its current philosophical use.

It is often claimed that the philosophical thesis of supervenience can be traced back to moral philosophy in the works of such philosophers as G. E. Moore and R. M. Hare. For example, G. E. Moore (1922, p. 273) maintained that 'one of the most important facts about qualitative difference…[is that] two things cannot differ in quality without differing in intrinsic nature'. Although he did not use the word 'supervenience', he was essentially describing this thesis. R. M. Hare (1952) evidently made use of the word in its contemporary meaning, when he delineated a moral-natural relationship. According to his view, ethical predicates are 'supervenient predicates', in that there could be no difference in a moral respect without a difference in some descriptive (non-moral) respect. It is obvious that this idea can be applied to any two sets of properties.

Through the lens of philosophy of mind, Donald Davidson (1980) was the first to apply the term 'supervenience' to discussions associated with the mind-brain relation. He wrote as follows:

[M]ental characteristics are in some sense dependent, or supervenient, on physical characteristics. Such supervenience might be taken to mean that there cannot be two events alike in all physical respects but differing in some mental respect, or that an object cannot alter in some mental respect without altering in some physical respect. (Davidson 1980, p. 141)

When he used the idea of 'supervenience', he intended to refute reductionism, the belief that mental properties are reducible to their physical properties. He wrote: 'Dependence or supervenience of this kind does not entail reducibility through law or definition…' (Davidson 1980, p. 141).

The concept of supervenience has been deepened since the time of Davidson's argument. This advance was made possible by philosophers of non-reductive physicalism or those of analytic aesthetics. The former include Terence Horgan (1982, 1993), Jaegwon Kim (1993, 1998) and David Lewis (1983) and the latter Frank Sibley (1965), Jerrold Levinson (1983) and Nick Zangwill (1994).

## Supervenience and Philosophy of Mind

The concept of supervenience associated with the mind-brain relation has three implications: *dependence, covariation* and *non-reducibility* (Kim 1993). First, mental processes are dependent on their subvenient neurobiological bases. Mentality is

physically based, anchored in the physical nature of objects. Second, there is a pattern of property covariation between the mental and the neurobiological. The mental properties vary in concurrence with neurobiological properties. Third, property covariation involved in supervenience can exist even when mental properties are not reducible to their subvenient neurobiological bases. The mind-brain supervenience is necessary, but not wholly sufficient for the reduction of mind to brain.

## Aesthetics and Philosophy of Mind

Links between aesthetics and the philosophy of mind had not been well-recognized before Frank Sibley (1965) discussed relationships between the aesthetic and the non-aesthetic. An application of his conception of supervenience as it relates to the mind-body problem will be discussed later. Aesthetics is a branch of philosophy which investigates the conceptual and theoretical aspects of art and aesthetic experience. Aesthetic properties, whose nature is considered to be one of the main topics of aesthetics, have been examined in order to understand when and how a work of art carries aesthetic values. Levinson (2009) listed some of the hallmarks of aesthetic property status as follows: having a gestalt character, requiring taste for discernment, having an evaluative aspect, affording pleasure or displeasure in mere contemplation, being non-condition-governed, being emergent on lower-level perceptual properties, requiring imagination for attribution, requiring metaphorical thought for attribution, being notably a focus of aesthetic experience and being notably present in works of art.

Although the status of aesthetic properties is open to some debate, there is a wide agreement that aesthetic properties are qualitative properties; that is to say, they are perceptual, observable and directly experienceable. These properties are relevant to the aesthetically attractive value of the work to which they are attributed. Philosophers with special interest in aesthetics have debated whether work of art is physical or mental, abstract or concrete, created or discovered and culturally free or culturally bound (Levinson 1983). Such questions regarding dichotomous properties, associated with art, are of particular importance to philosophy of mind. This is because most lively discussions concerning the relationships between the aesthetic and the non-aesthetic are, with minor modifications, applicable to the relationships between the mental and the neurobiological.

## Supervenience and Aesthetics

In philosophy of mind, the irreducibility of qualia to physical entities has always been at the very heart of the mind-body problem. The term ‘qualia’ in this case refers to the qualitative aspects of our mental lives, which are introspectively accessible and genuinely subjective. The literature on qualia includes thought experi-

ments, such as 'Mary's room' (Jackson 1982), 'a philosophical zombie' (Chalmers 1996) and discussions about 'being a bat' (Nagel 1974). However, instead of delicate devices of imagination, more appropriate and more concrete examples are provided by aesthetic supervenience. It is self-evident that aesthetic properties are qualitative, phenomenal and irreducible to their physical bases. Nevertheless, they are anchored in the physical nature of objects. To improve the qualia of a painting, a certain chromatic work is necessary so as to change its physical base. To make the qualia of a piece of music more beautiful, a certain physical operation is necessary in order to improve its acoustic waves. There is no doubt that, regardless of the artistic medium in which they are found, aesthetic properties have their own non-aesthetic, physical bases; hence, through an examination of the supervenience between the aesthetic and the non-aesthetic, the potential consequences of the supervenience between the mental and the physical in question can be illuminated without resorting to a fantasy of delicate and complicated argument.

The claim of aesthetic supervenience received its first impetus from Frank Sibley (1965). According to Sibley, (a) aesthetic properties are distinguishable from non-aesthetic properties, (b) the existence of aesthetic properties depends on the existence of non-aesthetic properties, and (c) aesthetic properties are established by non-aesthetic properties. Therefore, any changes in aesthetic properties cannot occur without a change in non-aesthetic properties. Sibley did not mention the notion of 'supervenience'; nevertheless, his characterization of aesthetic–non-aesthetic relationships bears a strong resemblance to the supervenience model in the mind-body debate. While it remains open to argument whether the debate surrounding aesthetic supervenience is attributable to Sibley, his idea has been followed by subsequent philosophers, such as Jerrold Levinson (1983), Gregory Currie (1990) and Nick Zangwill (2001). Levinson defined aesthetic supervenience as follows: 'Two objects (e.g., artworks) that differ *aesthetically* necessarily differ *nonaesthetically* (i.e. there could not be two objects that are aesthetically *different* yet nonaesthetically *identical*): fixing the nonaesthetic properties of an object fixes its aesthetic properties' (Levinson 1983, p. 93). At the same time, the explicative strength of aesthetic supervenience has been questioned (Benovsky 2012; Currie 1990; MacKinnon 2001). Aesthetic supervenience certainly tells us little regarding what physical properties are relevant for aesthetic attribution, even though an aesthetic property of a work of art is entirely based on its subvenient properties. Aesthetic supervenience remains only a phenomenological relation between covarying patterns of aesthetic and non-aesthetic properties. It is doubtful that aesthetic supervenience might explain how the aesthetic properties emerge from non-aesthetic properties.

## The Mind-Body Supervenience in Depression

The mind-body problem is of importance to psychiatry for the following reason: every day, a psychiatrist is inevitably concerned with both the subjective and objective aspects of psychiatric illnesses. Whether it is mental or biological, the psychia-

trist is like a hyperactive teenager switching between two TV channels, one referring to the mind and the other to the brain. Aetiological theories of mental illnesses are either mind-based or brain-based. Likewise, psychiatric therapies are either psychologically based or biologically based. Whatever the practice, a psychiatrist cannot escape the mind-brain problem.

A study by Setoyama et al. (2016) provides an example of research concerning the mind-body problem. In their article titled 'Plasma Metabolites Predict Severity of Depression and Suicidal Ideation in Psychiatric Patients-A Multicenter Pilot Analysis', the authors discuss the data they collected for the severity of depression and suicidal ideation as well as the metabolome analysis of blood plasma. They found that five plasma metabolites (3-hydroxybutyrate (3HB), betaine, citrate, creatinine and gamma-aminobutyric acid (GABA)) were associated with the severity of depression and suicidal ideation. Then, the authors attempted to create a classification model to discriminate between patients with suicidal ideation and those without suicidal ideation, using artificial intelligence learning techniques. They succeeded in producing a pilot algorithm to predict a grade of suicidal ideation according to levels of citrate and kynurenine.

This study is based merely on correlation. Even when these two variables are found to be significantly correlated, correlation does not imply causation. Therefore, no one can maintain that plasma metabolites cause depression and suicidal ideation. Even so, this type of research would be advanced by the use of sophisticated techniques, and an enormous amount of data would be accumulated that could maintain the biological foundations of mental symptoms such as depression and suicidal ideation. If further minute findings regarding metabolites could be obtained hereafter, the philosophical question of how to understand the relationship between the metabolites and mental states could arise.

The relationship between the metabolites and mental states is related to supervenience as follows: a set of mental states supervenes upon a set of brain metabolites only if no two things can differ with respect to mental states without also differing with respect to their metabolite states. In other words, there cannot be a mental difference without a neurobiological difference. In Kim's sense, 'mental properties supervene on physical properties, in that necessarily, for any mental property $M$, if anything has $M$ at time $t$, there exists a physical base (or supervenient) property $P$ such that it has $P$ at $t$, and necessarily anything that has $P$ at a time has $M$ at that time' (Kim 1993, p. 313). From this viewpoint, the mind-brain supervenience states a pattern of property covariation between the mental and the physical. However, this relation does not elucidate the nature of the dependence relation that might explain why the mental supervenes on the physical.

## The Aesthetic–Non-aesthetic Supervenience and the Mind-Body Supervenience

Kim explained *supervenience* by using an example of a painting and its physical base:

'To make your painting more beautiful, more expressive, or more dramatic, you must do physical work on the painting and thereby alter the physical supervenience base of the aesthetic properties you want to improve. There is no direct way of making your painting more beautiful or less beautiful: you must change it physically if you want to change it aesthetically – there is no other way' (Kim 1998, p. 43).

In this context, the beauty of a painting supervenes on the physical properties.

We may compare the aesthetic-physical supervenience with the mind-body supervenience. In the case of aesthetic-physical supervenience, we can use two examples: a painting and music. In both of these, aesthetic properties supervene on non-aesthetic properties. For example, an abstract painting is dynamic or peaceful due to a certain visuospatial arrangement of colours and shapes, and a symphony performance is uplifting or solemn because of a certain acoustic arrangement of sounds. This means that an object has the aesthetic properties by virtue of its non-aesthetic properties. If something has an aesthetic property, then it has some non-aesthetic property that is sufficient for the aesthetic property.

However, there is an important difference between a painting and a piece of music: a painting is static, whereas a piece of music is dynamic. Music is in a sense a physical acoustic phenomenon with the vibration of microphysical properties. Over a period of time, music is performed simultaneously with sound waves. This is why the music-acoustic supervenience is more reminiscent of the mind-body supervenience than the picture-chromatic supervenience. The mental process proceeds continuously over time. Likewise, the neurobiological process proceeds continuously over time. For this reason, music is a more suitable example for understanding the mind-brain supervenience.

## The Music-Acoustic Supervenience

Since music is composed of the interplay of multiple dimensions, the elements of a piece of music can be described as follows: rhythm, dynamics, melody, harmony, tone colour, texture and form, etc. As the stream of consciousness is the flow of thought in the conscious mind (James 1890), all of the musical elements are presented in the flow of sonic sequence according to a temporal axis. For example, rhythm consists of duration and tempo; the former is concerned with the length of a sound or silence and the latter with the speed of the beat. Melody is the element associated with the linear series of pitches, which is the quality of notes perceived as 'higher' or 'lower'. From another point of view, both rhythm and melody are acoustic phenomena coming from a musician's instrument or a singer's vocal cords, those are physical in nature.

Because of the physical nature of musical elements, a supervenience consists of the relation between a piece of music and the acoustic properties of sound waves, the former supervenes on the latter. In the music-acoustic supervenience, there are three conditions: *dependence, covariation* and *non-reducibility*. First, sound flows in music are dependent upon their subvenient acoustic processes. A piece of music is not free-floating but physically based, and it is anchored in the acoustic nature of

sound waves. Second, a pattern of covariation holds between the musical properties and the acoustic properties. The musical properties vary simultaneously with the subvenient acoustic properties. Third, even though the music-acoustic supervenience involves a covarying relationship, musical properties are not reducible to their subvenient acoustic bases. The music-acoustic supervenience does not justify the reduction of music to acoustic physics.

## Understanding the Mind-Brain Supervenience in Depression Through Musical Supervenience

With reference to musical supervenience, the mind-brain supervenience in depression can be examined. When transposing music into a painting, Kim's own description regarding the aesthetic-physical supervenience in a painting can be paraphrased as follows: melody and rhythm supervene on physical acoustic events; there is no difference in melody or rhythm without some difference in a physical acoustic phenomenon; to make your music more beautiful, you must perform physical acoustic operations and thereby alter the acoustic subvenient bases of the musical properties you want to improve. When it comes to depression, the mind-brain relationship can be described as follows: mental states, such as depression and suicidal ideation, supervene on neurobiological events; there is no difference in depression and suicidal ideation without some difference in a neurobiological phenomenon; to improve mental states, neurobiological operations are essential, and thereby the neurobiological subvenient bases of the mental states are altered. There is no other way of improving mental states: neurobiological states must change if mental states change. Every time depression worsens or improves, there are changes occurring in the neurobiological bases such as changes in metabolites. Without changes in the neurobiological subvenient bases, any mental states cannot alter.

The musical supervenience and the mind-brain supervenience can be juxtaposed as follows: music is anchored in the physical nature of sound waves, and likewise, a mental process is anchored in the physical nature of objects and events. There is no free-floating music without a physical base, and likewise, there is no free-floating depression or suicidal ideation without a neurobiological base. Musical properties are varying in concurrence with physical acoustic properties, and in the same way, the mental properties are varying in concurrence with neurobiological properties.

## The Nature of Covariance in the Mind-Body Supervenience in Light of Musical Supervenience

The mental-biological supervenience means that it is mental-neurobiological covariance. The mental varies simultaneously with the neurobiological. However, the mental-biological supervenience thesis itself is silent on the nature of the covariance

involved. It tells us neither what kind of covariance it is nor how the covariance grounds or explains the relationship between properties. A hint can be obtained when we consider the relationship between a scale in music and its emotional atmosphere. Here, a scale means a collection of pitches. Each scale has its own characteristic feeling. For example, a major scale expresses a happy, hopeful and joyful feeling. A minor scale conveys a depressive, sad and subdued mood. Another scale is the Okinawan scale. This scale carries a unique, tranquil, subtropical atmosphere.

By comparing the major and Okinawan scales, we can see the differences in the frequencies.

An octave of the major scale consists of seven tones: Do, Re, Mi, Fa, So, La and Te. On the other hand, in the Okinawan scale, Re and La drop out from the major scale, resulting in a scale comprised of only Do, Mi, Fa, So and Te (Fig. 12.1). The difference between the major and Okinawan scales is merely the presence or the absence of Re and La. The major scale has its own happy and joyful atmosphere. The Okinawan scale has a more exotic, delightful and peaceful feeling, which is distinctly different from that of the major scale. However, the difference in atmosphere between the two scales is due to the presence or the absence of Re and La. Theoretically, every piece of music can be arranged into a piece of music having an Okinawan flavour, only by excluding Re and La. This exclusion is a physical acoustical operation in nature (Fig. 12.2).

The analogy of two things, i.e. the difference between the major scale and the Okinawan scale on the one hand, and the difference between severe depression and mild depression on the other, could be thought as follows: a piece of music with the major scale *M* supervenes on a series of the acoustic physical events with Do, Re, Mi, Fa, So, La, and Te, while a piece of music with Okinawan scale *M'* arranged from *M* supervenes on a series of the acoustic physical events with Do, Mi, Fa, So, and Te. Equally, severe suicidal ideation would supervene on the neurobiological states *A* of metabolites, and mild suicidal ideation would supervene on the neurobiological states *A'* of metabolites. The difference of musical qualia between *M* and *M'* supervenes on the difference between the presence and absence of Re and La, which is physical in nature. Equally, the difference of mental qualia between severe and mild suicidal ideation would be due to the difference between the neurobiological state of *A* and that of *A'*, which is biological in nature.

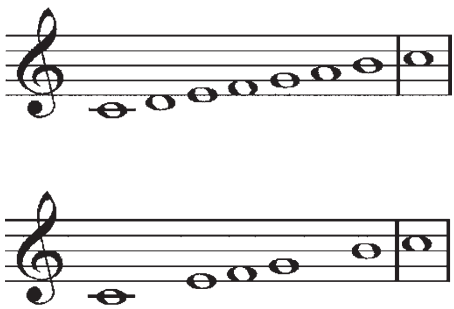

**Fig. 12.1** The major and Okinawan scales

**Fig. 12.2** The acoustic differences between the major and Okinawan scales

**The ratio between the frequencies of all the notes of the major and Okinawan scales**

| The Major Scale | | | | | | | |
|---|---|---|---|---|---|---|---|
| Do | Re | Mi | Fa | So | La | Te | Do |
| 1 | 9/8 | 5/4 | 4/3 | 3/2 | 5/3 | 15/8 | 2 |
| **Okinawan Scale** | | | | | | | |
| Do | | Mi | Fa | So | | Te | Do |
| 1 | | 5/4 | 4/3 | 3/2 | | 15/8 | 2 |

## Conclusions

To summarize, musical properties have their own non-musical, physical bases, and likewise, mental properties have their own non-mental, biological bases. Music supervenes on the acoustic event, whereas the mental process supervenes on the neurobiological event. A scale in music has its own emotional atmosphere, while a mental process has its own emotional atmosphere. The difference in atmosphere between the two scales exists by virtue of the acoustic difference between the two scales, a difference that is physical in nature. Equally, the difference in qualia between the two mental processes would exist by virtue of the difference between the two neurobiological events, a difference which is likewise physical in nature.

These considerations should discourage one from coming to the conclusion that the concept of supervenience can illuminate the enigma of the mind-body relation. No one can contend that musical supervenience would elucidate the special fascination that a piece of music possesses for the listener. This is equally true for the mind-body supervenience. While the supervenience thesis can explain why we recognize a mental process as distinct from its biological base, it leaves unexplained why the relationship called supervenience exists in the first place. Even so, the supervenience thesis is useful to us, as it is a concrete natural relationship. The idea of musical supervenience contradicts the view that a piece of music is free-floating. Equally, the mind-body supervenience contends that the nature of mentality is anchored in the physical nature of biological processes. It is true that supervenience reveals little to us about what biological properties are relevant for mental attribution. However, a comparison between one mental state and another, followed by a comparison between their biological bases, respectively, would elucidate what biological properties are critical for mental processes. The presence or absence of Re and La is a critical point for the comparison between the major and Okinawan scales. Similarly, the presence or absence of particular biological properties would play a decisive role in the difference between the presence and absence of particular mental processes.

So far, the mysterious nature of the mind-body problem has been overemphasized. Certainly, it is mysterious. Nevertheless, the degree of mystery present in the

mind-body problem is, in fact, equal to that in the relationship between aesthetical properties and non-aesthetic properties. The relationship between the mental and the physical is as mysterious as the relationship between a piece of music and its subvenient bases, i.e. the vibration of microphysical properties.

## References


Benovsky, J. (2012). Aesthetic supervenience vs aesthetic grounding. *The Central European Journal of Aesthetics, XLIX/V*(2), 166–178.

Chalmers, D. (1996). *The conscious mind*. New York: Oxford University Press.

Collins English Dictionary. (2018). *Collins English Dictionary* (13th ed.). Glasgow: Harper Collins.

Currie, G. (1990). Supervenience, essentialism and aesthetic properties. *Philosophical Studies, 58*, 243–257.

Davidson, D. (1980). Mental events. In D. Donaldson (Ed.), *Essays on actions and events* (pp. 137–149). Oxford: Clarendon Press.

Hare, R. M. (1952). *The language of morals*. Oxford: Oxford University Press.

Horgan, T. (1982). Supervenience and microphysics. *Pacific Philosophical Quarterly, 63*, 29–43.

Horgan, T. (1993). From supervenience to superdupervenience: Meeting the demands of a material world. *Mind, 102*, 555–586.

Jackson, F. (1982). Epiphenomenal Qualia. *The Philosophical Quarterly, 32*(127), 127–136. https://doi.org/10.2307/2960077. JSTOR 2960077.

James, W. (1890). *The principles of psychology*. New York: Henry Holt and Company.

Kim, J. (1993). *Supervenience and mind*. Cambridge: Cambridge University Press.

Kim, J. (1998). *Mind in a physical world: An essay on the mind-body problem and mental causation*. Cambridge, MA: MIT Press.

Levinson, J. (1983). Aesthetic supervenience. *Southern Journal of Philosophy, 22*(S1), 93–110.

Levinson, J. (2009). Philosophical aesthetics: An overview. *Oxford Handbooks Online*. Online Publication Date: Sep 2009. https://doi.org/10.1093/oxfordhb/9780199279456.003.0001.

Lewis, D. K. (1983). Extrinsic properties. *Philosophical Studies, 44*, 197–200.

MacKinnon, J. E. (2001). Aesthetic supervenience: For and against. *British Journal of Aesthetics, 41*, 59–75.

Moore, G. E. (1922). *Philosophical studies*. London: Routledge.

Morgan, L. (1923). *Emergent Evolution*. London: Williams & Norgate.

Nagel, T. (1974). What is it like to be a bat? *The Philosophical Review, 83*, 435–450. https://doi.org/10.2307/2183914. JSTOR 2183914.

Setoyama, D., Kato, T. A., Hashimoto, R., Kunugi, H., Hattori, K., Hayakawa, K., Sato-Kasai, M., Shimokawa, N., Kaneko, S., Yoshida, S., Goto, Y.-I., Yasuda, Y., Yamamori, H., Ohgidani, M., Sagata, N., Miura, D., Kang, D., & Kanba, S. (2016). Plasma metabolites predict severity of depression and suicidal ideation in psychiatric patients-a multicenter pilot analysis. *PLoS One, 11*(12), e0165267. https://doi.org/10.1371/journal.pone.0165267.

Sibley, F. (1965). Aesthetic and nonaesthetic. *Philosophical Review, 74*, 135–159.

Zangwill, N. (1994). Moral mind-independence. *Australasian Journal of Philosophy, 72*, 205–219.

Zangwill, N. (2001). *The metaphysics of beauty*. Ithaca: Cornell University Press.

# Part III
# Historical

# Chapter 13
# At the Origins of Hermeneutic Psychopathology


**Massimiliano Aragona**

**Contents**



## Introduction

Hermeneutics, the art of interpretation, was practiced long before the discipline officially started. Similarly, psychiatrists were already practicing psychopathology when a young Karl Jaspers (1913) published his *Allgemeine Psychopathologie*, which is considered to signal the birth of psychopathology as a specific discipline. Beyond this general similarity, what do they have in common? Does it make sense to talk about a "hermeneutic psychopathology"? And what are its roots?

Although in psychiatry and psychology we are inclined to immediately associate hermeneutics with psychoanalysis, the field of the art and techniques of interpretation is much larger than that of psychoanalytic interpretations, the latter being only a small subset of virtually unlimited possible interpretive strategies. Interpretation, as "explanation or opinion of what something means" (Cambridge Dictionary, accessed April 29, 2019), is intrinsically related to a meaning-making activity. As such, it goes far beyond technically formalized interpretation to cover several forms of making sense, including "ecological," ordinary life strategies which are often implicit. Interpreted in this way, there are numerous instances of encounters between hermeneutics and psychopathological issues. For example, it was shown that despite their neo-positivist shape, operationally formalized psychiatric diagnoses rely on an implicit hermeneutic circle (Aragona 2013). Similarly, conceptual analysis has drawn attention to the fact that the construction of mental symptoms is largely based on semantic configurators

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which are part of an implicit self-hermeneutic activity shaping unstructured mental experiences into communicable phenomena (Marková and Berrios 2009; Berrios 2013; Aragona and Marková 2015). Finally, before being crystallized and captured by rating scales, mental symptoms are part of a dialogical encounter between patient and clinician which is responsible for an ideally shared hermeneutic co-construction (Marková and Berrios 2009; Berrios 2013; Aragona and Marková 2015).

Accordingly, it is a hermeneutic act when we consider the implicit self-interpretation undertaken by the patient who, while noting and reporting his symptoms, shapes them in conformity with his implicit and explicit categories of meaning. It is a hermeneutic act the explicit action of the patient who tries to understand why he experienced them and what they can mean. It is a hermeneutic act the activity of the clinician who grasps his own cognitive and affective resonance to what the patient is communicating. It is a hermeneutic act the shared construction of the mental disorder negotiated jointly by the patient and the clinician, during that interaction between the subjective experience of the illness and the objective views about diseases as described years ago in medical anthropology (Kleinman et al. 1978). In sum, hermeneutics are everywhere in psychiatric practice and carried out mainly as an implicit activity of which agents become aware only after reflection. However, a psychopathological hermeneutics explicitly formalizing the technical rules governing this activity is more a project than an achievement. But if a general system of hermeneutic psychopathology does not yet exist, there are many concrete examples of hermeneutic approaches in psychopathology.

This contribution will focus on the first available example of deliberate transposition of a hermeneutic procedure (the method of the "understanding"), already available in the human sciences of the time, into the realm of clinical psychopathology. In the first section, I consider the concept of understanding (*Verstehen*) in the hermeneutic tradition and in the epistemological debate about human sciences in late nineteenth and early twentieth centuries. The second section explores the characteristics of the *Verstehen* as it was used in the *General Psychopathology* written by Karl Jaspers (1913). Finally, the third section deals with the problem of the coexistence, in the same concept of *Verstehen*, of intuition and interpretation, showing that Jaspers inaugurated a new hermeneutic approach but did not complete this task, leaving it in a sketchy form.

## Hermeneutics and Human Sciences in the Nineteenth and Early Twentieth Centuries

### *Friedrich Schleiermacher*

Hermeneutics as an "art of interpretation" has a long history. Although as a specific technical term it dates only from the seventeenth century, textual exegesis and interpretation theories date back to antiquity in religion, literary, and legal domains (cfr. Palmer 1969). In the first half of the nineteenth century, there was a turn from several

content-related hermeneutic approaches (a variety of interpretation rules and strategies strictly connected to the specificities of particular texts) to a general hermeneutics, well expressed by Schleiermacher (1978, p. 1) who wrote: "Hermeneutics as the art of understanding does not exist as a general field, only as a plurality of specialized hermeneutics." His aim was to create such a not yet existing general hermeneutics. Schleiermacher developed his idea of a general hermeneutics in explicit dialogue with Friedrich Ast and Friedrich August Wolf. The former wrote that the philologist understands a text by somehow repeating (the term used was *Nachbildung*) the creative process that originated the text. This is possible because we all participate in the general spiritual unity of the humanities (*Einheit des Geistes*), so in this way we can grasp the spirit of an individual author by placing it into the context of the general spirit of his time (Ast 1808). For the latter, the aim of hermeneutics was "to grasp the written or even only spoken thoughts of another as he would have liked them to be grasped" (Wolf 1831, p. 293), distinguishing between understanding (*verstehenden*) and explanatory (*erklärenden*) activity. On this view, understanding is conceived as a sort of intuitive act which is only possible if the interpreter has "a general talent for empathizing with the thoughts of others […] an aptitude for dialogue, for entering into the mental world of another person" (Palmer 1969, p. 81). Schleiermacher follows this path by making a distinction between explanation, which belongs to the "art of presentation" (*Kunst des Darstellens*), and understanding. His general hermeneutics is primarily an "art of understanding," consisting of two complementary parts (*Momenten*), understanding speech as it derives from language, and as a fact in the thinking of the speaker (Schleiermacher 1978, p. 2 and p. 16, n.4). Grammatical interpretation (considering the discourse at linguistic level) and psychological interpretation (considering a discourse as a product of the soul) are both necessary in order to perform the task of hermeneutics. This is defined as understanding "the discourse just as well and even better than its creator" (Schleiermacher 1978, p. 9), a task of "divination" which is possible if one equates oneself "with the other by objective and subjective reconstruction" through "an identification with the author" (Schleiermacher 1978, p. 10).

To sum up, in the hermeneutics of the first half of the nineteenth century, the concept of understanding (*Verstehen*) is crucial as the intuitive transposition of oneself into the author, through the text. The task of hermeneutics is that of finding the spirit (*Geist*) of the author and/or of the time in and through the object to be interpreted.

## *Wilhelm Dilthey*

A similar stance will reappear in the epistemological debate of the second half of the century, as a reaction against positivism and in defense of a specificity of the methods used in the human sciences. This discussion on methods (*Methodenstreit*) involved several related disciplines including philosophy, history, sociology, political economy, psychology, etc., with individual scholars often crossing disciplinary boundaries.

A key figure in this debate is philosopher Wilhelm Dilthey, who was influenced by Romantic thinkers (especially Goethe and Schleiermacher) but who was also very sensible to scientific and epistemological issues. He considered Kant one of the greatest philosophers because he had definitively banished metaphysic speculation and had grounded philosophy on a critique of knowledge. In Dilthey's view, Kant's *Critique of Pure Reason* had laid the epistemological foundations for the sciences, but his categories (space, time, cause, etc.) were not appropriate for the human disciplines. Dilthey's project was to further develop the Kantian critical stance in the category of self-interpretation [*Selbstbesinnung*], projecting a *critique of historical reason* respectful of the specificities of the human disciplines (which in that historical period were called the "sciences of the spirit," *Geisteswissenschaften*): the issue was what did they have in common, what was the proper method for their study and what was their unifying subject. In his sui generis "empiricist" approach, experience (*Erlebnis*) has the key role. For example, Dilthey (1894/2010) criticizes experimental psychology because it proceeds from hypothetical constructions (the psychological basic elements) and then seeks how to reconstruct more complex entities using theoretical laws, disregarding concrete experience in itself. On the contrary, he argues, if psychology is to remain strongly connected to real life, then we need to return to the facts of consciousness as they are actually experienced. Accordingly, we need a "descriptive and analytical science" (*beschreibende und zergliedernde Wissenschaft*) starting from the concrete complexities of life, distinguishing and cataloguing their simplest components, and observing the relations between them. In this text we find Dilthey's famous motto "We explain nature, we understand mental life" (*die Natur erklären wir, das Seelenleben verstehen wir*) (Dilthey 1894/2010, p. 89), where understanding is linked to our direct appraisal of internal experiences which the human sciences methodically lead to progressive clarity. So lived experience (*Erlebnis*) and understanding (*Verstehen*) are strictly interconnected. Moreover, understanding is not confined only to self-understanding: we also need to understand others as minded agents, so understanding refers to the experience in which the person becomes aware of his own inner life (*Selbstbesinnung*) as well as being capable of grasping that of others:

> We explain by means of purely intellectual processes, but we understand by means of combined activity of all the mental powers in apprehension. And, in understanding, we proceed from the system of the whole, which is given to us in living experience (*lebendig gegeben*), to make the particular intelligible to ourselves in terms of it. It is the fact that we live in the consciousness of the system of the whole which enables us to understand a particular sentence, a particular gesture, or a particular action. All psychological thought has this fundamental trait, that the apprehension of the whole makes possible and determines the interpretation of the detail. Even the theoretical reconstruction (*die Nachkonstruktion*) of human nature in general in psychology must hold fast to the original procedure of understanding, if it is to remain sound, vital, informed, fruitful for the understanding of life. (Dilthey, quoted in Hodges 1952, pp. 124–125)

So, in Dilthey, understanding (*Verstehen*) is the crucial methodological concept on which the sciences of the spirit rest. It is strictly connected with lived experience (*Erlebnis*) as it presents itself in our stream of consciousness and is based on the

transposition of ourselves into others. We are able to understand others because as human beings we are all similar, so that we also have experience in ourselves of those mental contents that we find in the others' expressions. This is what Dilthey (1910/2010, p. 208) means when he writes that "Understanding is a rediscovery of the I in the Thou."

## *Georg Simmel*

A second prominent figure in this debate is that of the sociologist and historian Georg Simmel. Like Dilthey, Simmel also had a Kantian heritage, the essence of his study being an ongoing attempt to reconcile Kant's critical epistemology, as it was elaborated by the neo-Kantians Windelband and Rickert on the one hand and the philosophy of life (vitalism) on the other hand (Zijderveld 2006). In particular, Simmel shares with the neo-Kantians the view that historical reconstruction is perspectival depending on the concepts we use to grasp it, but rejects the idea that they are a priori: concepts are themselves components of life, because man is a thinking being whose concepts are constituents of an ongoing process of life made of thinking but also of emotions and bodily experiences. According to Simmel (1905), all external facts (political, social, religious, economical, etc.) would be uninteresting and non-understandable if they were not coming from movements of the soul and did not arouse movements of the soul. The history would be a history of puppets if psychic processes were left aside. In fact, history has to do with individuality, i.e., with absolutely unique and unrepeatable personalities and with the decisions and acts they are responsible for. We grasp all this through historical understanding, taking place at three levels: first, the understanding of single expressions; second, the understanding of many expressions as part of a coherent whole represented by a given personality; and third, the "genetic" understanding in which antecedent experience and consequent reactions are linked in a motivational chain (a psychological causality that differs from physical causality because it is not mechanical but motivational). Concerning the characteristics defining this historical understanding, there are several nuances and changes in Simmel's ideas. He starts by conceiving it as a hypothetical inference, giving the impression of a conscious and deliberate process. However, a few lines later the example given is that of the spontaneous and unconscious integration of images operated by the senses, and later on the understanding is characterized by a "psychic transposition" of a representation or feeling onto a historical personality. As in Dilthey, also in Simmel the precondition for understanding is human similarity, the possibility of understanding being facilitated or hampered depending on the degree of similarity or dissimilarity between our own internal disposition and that of the other to be understood. Hence, in extreme cases understanding is impossible, because the man who has never loved cannot understand the lover and the choleric person will never understand the phlegmatic one. However, he also adds, in apparent contradiction, that one does not need to be Caesar in order to understand Caesar (Simmel 1905). Simmel also traces a distinction

between "understanding a sentence" and "understanding the speaker," which echoes Schleiermacher's distinction reported above, but with some differences. When we understand a sentence, we understand its meaning independently from the underlying reasons held by the speaker and the circumstances in which the speech occurs. In the second case, we take into account the different reasons the speaker may have to talk, and we can understand him in the historical sense only if we figure out his possible motivations, i.e., we understand by inferences which are not immediately logical but depend on real psychological experience.

## *Max Weber*

Together with Georg Simmel, Max Weber is the other founding father of German sociology. Like Simmel, he is in line with a post-Kantian stance and stresses the importance of conceptual and methodological clarification. Max Weber's main ideas can be summarized as follows:

(a) History cannot be a reproduction of facts as they really happened. There is always a value-based selection and organization of the material by the historian (Weber 1903/1975).
(b) The values in question are not transcendental a priori values; they are relative to the interests and purposes of the researcher (Weber 1904/1949).
(c) This does not push sociocultural sciences outside the scientific discourse, because the causal explanations they find have objective value: i.e., as in the explanation of any concrete natural process, it is only the adequacy of the material that decides if the causal imputation is valid (Weber 1906/1949).
(d) The explanation of the production of human actions is an ideal-typical task, the *Idealtypus* being an "ideal limit concept" which is "formed by the one-sided *accentuation* of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent, *concrete individual* phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified *analytical* construct" (Weber 1904/1949, p. 90).

Regarding the concept of understanding, Weber claims that historical explanation is logically similar to the explanation of *individual* natural events, although reality is *historical* insofar as it *means* something to us, i.e., explananda are interesting for the cultural sciences as far as they are *meaningful* (e.g., artifacts). Accordingly, meaningful phenomena require interpretation: "in the interpretation of human 'action', we are not satisfied by merely establishing a relationship between the action and a purely empirical *generalization* […] We require the interpretation of the 'meaning' of the action" (Weber, 1905–1906/1975, p. 128, slightly modified). Accordingly, in human sciences we are concerned not with "laws" in the narrower exact natural science sense "but with *adequate* causal relationships" (Weber 1904/1949, p. 80). In other words, in this field nomological knowledge derives from the generalization of first-person and empathic experience of regularities observed

in "normal" (i.e., *rational*) usual reactions. It is a "knowledge of certain known empirical rules, particularly those relating to the ways in which human beings are prone to react under given situations […] derived from our own experience and our knowledge of the conduct of others" (Weber 1906/1949, p. 174). It should be emphasized that, as we can see, Weber admits a role for empathic intuition *but* this is simply the basic material, i.e., understanding is not just "an act of intuition but becomes the formalization of interpretive hypotheses that wait to be empirically verified" (Rossi 1997, p. 22).

## *Theodor Lipps*

Outside the *Methodenstreit* but of interest for our analysis is the contribution of a few psychologists concerning the issue of empathy (*Einfühlung*). In fact, although they don't use the word *Verstehen*, the two concepts clearly overlap. At the intersection of aesthetics and experimental psychology is the work of Theodor Lipps, who views empathy as an unconscious, instinctual, and internally imitative process of fusion between the observer and the observed object (Lipps 1897). In his view, the aesthetic object is the expression (*Ausdruck*) of "something interior or soul-like" (Lipps 1906, p. 1), and the latter is caught through a projection of our own feelings onto the object. For example, when we see an acrobat on a tight rope, the perception of his movements activates an internal resonance in us that we project onto him. From experimental psychology, Lipps' views had large resonance in the philosophical debate, where they were criticized by several authors including Edith Stein and Max Scheler. Lipps also influenced the psychopathological debate, but more through his studies on optical illusions than empathy (at least directly).

## *Moritz Geiger*

Less famous but of particular interest for our discussion is one of Lipps' collaborators, who was also part of Edmund Husserl's followers in Munich. Indeed, his ability in reviewing and discussing the concept of empathy at the conceptual level was appreciated and used by the young Karl Jaspers in the preparation of his *Allgemeine Psychopathologie*. In a lecture at the IV German Congress of Experimental Psychology, Geiger (1911/2015a, 1911/2015b) reviews the concept of empathy focusing on the question of how it is possible to know the minds of others. He stresses that this question is complex and needs clarification, so it has to be divided into three basic questions: the first is phenomenological, what is the conscious experience of empathy? The second relates to the psychological function performed by the empathic act. The third asks whether and how empathy is acquired during personal development. It is the first question that interests us in the present context: i.e., what sort of experiences are in my consciousness while I'm empathizing? Geiger

writes as an example: “I see a man angry or sad, happy or disappointed. What kind of awareness [do] we find here?” (Geiger 1911/2015a, p. 20). Together with the sensory data coming from the other’s body, it is given “a particular spiritual life, feelings and emotions and acts of will, a foreign animated personality that for me lays in that forms of the body” (Geiger 1911/2015a, p. 20). But, is such an external “spiritual life” experienced or imagined? As is the case in Lipps, Geiger emphasizes that it is actually experienced, but he distinguishes the experience of empathy as being one [*Einssein*], which corresponds to Lipps’ view, from subsequent reflection, which “makes effective the separation between me and the foreign beings” (Geiger 1911/2015a, p. 22). Finally, another original contribution is that Geiger introduces a distinction between basic empathy (the fact that I understand the other’s gesture as an expression of internal experience in the here and now) at one side and reliving (*Nacherleben*) on the other side. The latter is a form of reliving in the sense of reliving after the event (*Hinterhererleben*), which Geiger explains by means of an example: the observer sees a child reaching for an apple on a tree, and, as he cannot manage to grasp the apple, he starts crying. What is understood is not only the two isolated facts (the grasping for the apple and the crying), but also their inner correlation, i.e., the child is sad because it could not get the apple. Here, the child’s correlation of motivation [*Motivzusammenhänge*] is inwardly reconstructed (Geiger 1911/2015a, p. 27).

## The Concept of *Verstehen* in the Psychopathology of Karl Jaspers

Jaspers borrows this concept from the ideas discussed in the previous section. Following Dilthey, he sharply distinguishes between the realm of the natural sciences (*Naturwissenschaften*), where explaining (*Erklären*) is the proper method, and that of the human sciences, or sciences of the spirit (*Geisteswissenschaften*), where the researcher has to understand (*Verstehen*) empathically what the other thinks or feels (see Aragona, 2015–2016). Following Weber, he considers the reconstruction of the other’s internal reasons not a definite truth but an ideal-typical relation (Aragona 2019). From Simmel, he borrows the distinction between understanding what has been said and understanding the speaker (*rational* and *empathic* understanding in Jaspers’ terms (Aragona 2018)). Finally, drawing on both Simmel and Geiger (especially the latter), he traces the distinction between *static* and *genetic* understanding (Aragona 2016, 2018).

As opposed to the neurobiological reductionism of his time, Jaspers’ (1913) major point is that, while in the natural sciences we objectively observe, make inductions, and elaborate explanatory theories, psychopathology cannot be reduced only to naturalistic methods (although they have a relevant place in it). Indeed, we also need to capture subjective experiences and to figure out their meaningful connections, i.e., the motivations of human experiences and actions. *Verstehen* is the

methodological tool to perform both steps of this scientific task, i.e., the direct capture, here and now, of what the patient in front of us is experiencing and the retrospective reconstruction of the psychological origins of his mental symptoms.

The main characteristics of Jaspers' *Verstehen* have been summarized in previous articles to which the reader is referred for details (e.g., Villareal and Aragona 2014). In short, Jaspers' *Verstehen* has the following characteristics:

(a) It is an intuitive act of self-transposal of oneself into the other's lived experience, a way to put oneself into the other's shoes
(b) It is based on the possibility of a shared lived experience (*Miterleben*).
(c) It is not a merely rational understanding (concerning what is said from a logical point of view, e.g., understanding the meaning of a sentence) but an empathic understanding (*ein fühlendes Verstehen*) trying to capture how the person feels and acts/reacts on the basis of his wishes, fears, or desires.
(d) Actual understanding is intuitional and immediately elicits a sense of evidence in the person who is understanding.
(e) It is grounded on personal abilities of the psychopathologist which are typically humanistic, i.e., the willingness and capability to actualize and represent in himself the psychic events occurring in the other person.
(f) However, the perceived evidence of what has been understood does not guarantee reality, i.e., the other person may feel something different, or the meaningful connection we found does not hold in his case.
(g) Accordingly, empathic understanding is not yet knowledge but only its phenomenal basis. In practice intuition must be complemented by interpretation supported by objective facts, e.g., observable expressions and gestures.
(h) Despite the fact that there are many understandable phenomena, in many instances understanding fails, i.e., it arrives at a limit beyond which the phenomenon is no more understandable.
(i) The possibility to understand and its limits depend on several factors, some of them being related to the context (e.g., time at one's disposal, kind of setting, degree of knowledge of the other's life context, etc.), some depending on the capacities of the clinician (empathic abilities) and some related to the phenomenon itself (the most classical and debated example being the non-understandability of primary delusions, which Jaspers considers to be genetically non-derivable).
(j) Accordingly, understanding is a complex relational emergent phenomenon.
(k) The boundaries of understanding are not fixed but can change with time, depending on the degree of knowledge that has been reached.
(l) Once the limit of non-understandability is finally reached, this method must be consciously stopped. In Jaspers' view, possible ways to surmount these limits are causal explanations and psychological or existential interpretations.
(m) Finally, there is an epistemological asymmetry in the genetic understanding, because this method is useful for a posteriori reconstruction of the events that had already occurred but does not allow scientific prediction.

## Understanding as Hermeneutics in the Psychopathology of Karl Jaspers

Although Jaspers' *Verstehen* is usually depicted as emotionally based intuition, and contrasted to hermeneutic approaches like those of other phenomenologically oriented psychopathologists (*in primis* Ludwig Binswanger), I defend the idea that Jaspers' *Verstehen* was already a hermeneutic performance.

On the one hand, Jaspers clearly stresses that understanding is not rational inference but empathic resonance of the clinician with the lived experience of the patient. This applies to both static (I feel, I grasp intuitively what the other is feeling here and now) and genetic understanding (I imagine myself to be in his shoes and consider how I would have reacted if I was in the same situation). The contrast between inferential interpretation and intuitional understanding is so sharp that Jaspers adds that the more we interpret, the less we understand (Jaspers 1913).

On the other hand, however, Jaspers' position appears contrary to this when he writes that, in practice, all understanding "remains more or less an interpretation" (Jaspers 1913/1974, p. 85). This sentence will be included in the *General Psychopathology* (Jaspers 1913) and maintained in subsequent editions of the same text, suggesting it was considered important.

So, at one side understanding and interpretation are contradictory poles, while at the other side interpretation is part of the act of understanding. This apparent contradiction has been brilliantly resolved by Kumazaki (2013, p. 217), who noted that understanding and interpretation are ideal-typically opposite, but empirically intertwined. In other words, Jaspers follows Weber (as did Simmel) in using the concept of *Idealtypus*, intended as an ideal construction to be compared to real instances, in order to give the researcher a means to evaluate the distance between the two levels. A key point, here, is the concept of *evidence*. In fact, Weber and Jaspers similarly stress that the sense of evidence we experience when we capture a sound meaningful relationship should not be misinterpreted as a mark of its reality. The judgment about the latter depends on objective, concrete facts that support (or do not support) the interpretation: "although Weber and Jaspers apparently differ in the importance they assign to intuition and interpretation within the act of understanding, they are not so distant because in both (even though with different emphases) empathic intuition and interpretation coexist" (Aragona 2019, p. 14).

Schematically, we can sum up this part as follows: Jaspers distinguishes between ideal-typical level and concrete, practical level. Ideally, interpretation and understanding are opposite, the former being mainly rational inference and the latter being empathic intuition. At the concrete level, however, this distinction is nuanced, and interpretation and intuition coexist in the same act of understanding. Ideal-typically, understanding is evident and convincing, whereas interpretation is speculative. In practice, intuitional understanding is incomplete and must be complemented by interpretation supported by objective cues (e.g., visible signs in facial expression, gestures, etc.).

## Conclusions

As seen, Jaspers' understanding (*Verstehen*) is a core concept in his methodological contribution to psychopathology. Jaspers borrows it from the epistemological debate of his time, where the concept arrived from the hermeneutic tradition started by Schleiermacher.

I analyzed the intrinsic characteristics of static and genetic understanding, and, although they are clearly a form of empathy, I think there is enough historical material to reject the assumption that Jaspers' understanding was only emotional intuition. Accordingly, in practical clinical activity, there is no sharp division between rational and empathic understanding, between intuition and interpretation, between subjective and objective understanding (as in the Binswangerian tradition), and the like. On the contrary, Jaspers' empathic understanding is a complex mixture of intuition and interpretation, feelings and rationality, subjective reaction and objective observation, and affective resonance and detached description. We could say that in the end, it is a craftsmanship contemporarily based on technical means and human sensibility, as it is the case with many other instances including histology (Jaspers' preferred example) and any good hermeneutics.

The problem is that Jaspers did not explore in detail his formidable methodological instrument, limiting himself to an overall description and a few remarkable but generic aphorisms. Hence, misunderstandings and internal inconsistencies undermined the scientific reception of Jaspers' *Verstehen* in mainstream psychiatry, which as a result is rather poor in technical instruments to access human experiences and their meaning for the person.

If this is so, the future is not to say that Jaspers has been surmounted by new approaches proposing existential analysis in Heideggerian style as a radical, incompatible alternative. Rather, we shall consider Jasper's *Verstehen* as a first, still inchoate example of a hermeneutic approach to psychopathology, which needs to be developed further and complemented by other contributions, including those arrived from the phenomenological/existential tradition. To conclude, what is needed is a comprehensive hermeneutic psychopathology clearly aware of the technical properties of the interpretive instruments we intuitively use when we empathize, because it is starting from here that we can refine our ability to study the patients' experiences.

## References

Aragona, M. (2013). Neopositivism and the DSM psychiatric classification. An epistemological history. Part 2: Historical pathways, epistemological developments and present-day needs. *History of Psychiatry, 24*, 415–426.

Aragona, M. (2015–2016). Empatia ed ermeneutica: il concetto di comprendere (*Verstehen*) nella filosofia di Wilhelm Dilthey. *Comprendre, 25–26*, 65–86.

Aragona, M. (2016). The roots of psychopathological understanding: Karl Jaspers' *Verstehen* and the influence of Moritz Geiger's empathy. *Dialogues in Philosophy, Mental and Neuro Sciences, 9*, 36–42.
Aragona, M. (2018). The influence of Georg Simmel on Karl Jaspers' empathic understanding (*Verstehen*). *Dialogues in Philosophy, Mental and Neuro Sciences, 11*, 1–11.
Aragona, M. (2019). The influence of Max Weber on the concept of empathic understanding (*Verstehen*) in the psychopathology of Karl Jaspers. *History of Psychiatry, 30*(3), 283–299.
Aragona, M., & Marková, I. S. (2015). The hermeneutics of mental symptoms in the Cambridge School. *Revista Latinoamericana de Psicopatologia Fundamental, 18*, 599–618.
Ast, F. (1808). *Grundlilien der Grammatik, Hermeneutik und Kritik*. Landshut: Thomann.
Berrios, G. E. (2013). Formation and meaning of mental symptoms: History and epistemology. *Dialogues in Philosophy, Mental and Neuro Sciences, 6*, 39–48.
Cambridge Dictionary. (2019). Interpretation. https://dictionary.cambridge.org/dictionary/english/interpretation
Dilthey, W. (1894/2010). Ideas about a descriptive and analytical psychology. In W. Dilthey (Ed.), *Selected writings* (pp. 88–97). Cambridge: Cambridge University Press.
Dilthey, W. (1910/2010). The formation of the historical world in the human sciences. In W. Dilthey (Ed.), *Selected writings* (pp. 170–245). Cambridge: Cambridge University Press.
Geiger, M. (1911/2015a). On the essence and meaning of empathy, Part I. *Dialogues in Philosophy, Mental and Neuro Sciences,* 8: 19–31.
Geiger, M. (1911/2015b). On the essence and meaning of empathy, Part II. *Dialogues in Philosophy, Mental and Neuro Sciences,* 8: 75–86.
Hodges, H. A. (1952). *The philosophy of Wilhelm Dilthey*. Abingdon/New York: Routledge.
Jaspers, K. (1913). *Allgemeine Psychopathologie*. Berlin: Springer.
Jaspers, K. (1913/1974). Causal and 'meaningful' connections between life history and psychosis. In: S. R. Hirsch and M. Shepherd. (Eds.) *Themes and variations in European psychiatry: An anthology.* Bristol: Wright & Sons, pp. 81-93.
Kleinman, A., Eisenberg, L., & Good, B. J. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88*, 251–258.
Kumazaki, T. (2013). The theoretical root of Karl Jaspers' General Psychopathology. Part 1: Reconsidering the influence of phenomenology and hermeneutics. *History of Psychiatry, 24*, 212–226.
Lipps, T. (1897). *Raumästhetik und geometrisch-optische Täuschungen*. Leipzig: Verlag von Johann Ambrosius Barth.
Lipps, T. (1906). *Ästhetik: Psychologie des Schönen und der Kunst*. Hamburg/Leipzig: Leopold Voss.
Marková, I. S., & Berrios, G. E. (2009). Epistemology of mental symptoms. *Psychopathology, 42*, 342–349.
Palmer, R. E. (1969). *Hermeneutics*. Evanston: Northwestern University Press.
Rossi, P. (1997). Introduzione. In M. Weber (Ed.), *Il metodo delle scienze storico-sociali* (pp. 9–43). Torino: Einaudi.
Schleiermacher, F. (1978). The hermeneutics: Outline of the 1819 lectures. *New Literary History, 10*, 1–16.
Simmel, G. (1905). *Die Probleme der Geschichtsphilosophie: eine erkenntnistheoretische Studie* (Zweite Auflage ed.). Leipzig: Verlag von Dunker & Humblot.
Villareal, H., & Aragona, M. (2014). El concepto de 'comprensión' (*Verstehen*) en Karl Jaspers. *Vertex, 25*, 262–265.
Weber, M. (1903/1975). Roscher's 'historical method'. In M. Weber (Ed.), *Roscher and Knies: The logical problems of historical economics* (pp. 55–91) (Trans. and introduction: Oakes, G.). New York: The Free Press.
Weber, M. (1904/1949). 'Objectivity' in social science and social policy. In M. Weber (Ed.), *The methodology of the social sciences* (pp. 50–112). Illinois: The Free Press of Glencoe.

Weber, M. (1905–1906/1975). Knies and the problem of irrationality. In M. Weber (Ed.), *Roscher and Knies: The logical problems of historical economics* (pp. 93–207) (Trans. and introduction: Oakes, G.). New York: The Free Press.

Weber, M. (1906/1949). Critical studies in the logic of the cultural sciences. In M. Weber (Ed.), *The methodology of the social sciences* (pp. 113–188). Glencoe: The Free Press of Glencoe.

Wolf, F. A. (1831). *Vorlesung über die Enzyklopädie der Altertumswissenschaft*. Leipzig: Lehnhold.

Zijderveld, A. C. (2006). *Rickert's relevance. The ontological nature and epistemological functions of values*. Leiden: Brill.

# Chapter 14
# The Discontents of Psychiatry: What Can the History of Psychiatry and Values-Based Medicine Contribute to Resolving Them?

**Robert Dudas**

## Contents



This chapter examines how a better understanding of how our current scientific views regarding psychiatric diagnosis and treatment have evolved may help us understand why many of the criticisms levelled against psychiatry make little sense or apply only in a qualified way. It was written from the point of view of a practising clinician. I will not present new findings from the history of psychiatry here; instead, I will endeavour to argue the potential usefulness of those for the clinician. I will also look at how approaching the history of psychiatry from the perspective of values-based medicine (VBM) could enhance our historical analysis, especially for the purposes of developing a theoretical approach and clinical practice of psychiatry that is more suited to our needs and preferences.

Psychiatry is one of the most often criticised medical specialties, perhaps because it deals with conditions that can be more visible to others through their effect on behaviour and impact on a wide range of things in one's life beyond what is typically affected by nonpsychiatric conditions. Also, psychiatry is concerned with areas of human experience and behaviour in which human values are particularly diverse. Many of the modern criticisms levelled against psychiatry are old problems appearing in new disguises. The division between mental and physical health, the

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idea that psychiatry is unscientific, the arbitrariness of where one draws the line between mental disorder and normality or the necessary criteria for diagnoses, the lack of identified biological causes for most disorders or biological tests to aid diagnosis or that psychiatrists focus too much on the brain and the biological and ignore the psychological and social aspects of mental disorder are hardly new contentions.

We can argue about the level of success with which they operate, but the primary interest of psychiatrists, like in other medical specialties, is to help the patient. As German Berrios puts it at the beginning of his monumental volume on *The History of Mental Symptoms* (Berrios 1996, p. 10), 'clinicians are primarily interested in the capacity of psychopathological descriptions to diagnose disease and predict clinical outcome'.

## How can the History of Psychiatry Help us Better Understand Our Current Theory and Practice?

It is important to note that psychiatry, lying at the intersections of neuroscience, psychology, sociology and social care, philosophy and law, occupies a unique position in that it behaves in some respect as a natural science but in other respects as a so-called inexact science. If one regards the history of an exact or empirical science as a history of ideas or practices that have been proven incorrect or wrong and the history of an inexact science as the science itself, psychiatry will share features of both.

As German Berrios (1996) points out, nineteenth-century alienists understood that 'knowledge of history', by which he means how our conceptual understanding developed, enhances our understanding of psychopathology. This was evidenced by them writing entire books or at least including a chapter in their textbooks on the history of psychiatry.

The history of descriptive psychopathology can help us identify symptoms that have been described consistently in not just one episteme but show consistency over several ones. The distinction between 'form' (the impersonal element with stability) and 'content' was one of the most important contributions of nineteenth-century psychopathology in this regard (Berrios 1996). In order to explain mental symptoms, the clinician will seek a correlation between these and certain entities (e.g. a neurobiological variable) or concepts (e.g. a psychological variable). An important question is to what extent a particular entity or concept is invariant (i.e. has trans-epistemic continuity) and to what extent this is due to ontological invariance versus social construction. Depending on this, as Berrios explains, one could think of the clinician's job as cataloguing plants in a garden (the traditional medical history approach) or carving out shapes from formless matter like a sculptor (the constructionist approach, exerting more influence in current studies).

I concur with Howells that 'By knowing the past, we are better oriented to judge the present' (Howells 1975, p xviii). Reviewing the neurobiological story of psychiatry offers an opportunity for reflection. Certain themes have been in the focus of

attention throughout, such as the issue of how many different diagnostic categories exist (fluctuating between very few and very many), to what extent mental disorders have an organic (i.e. the brain) origin, whether mental illness should be viewed as a moral problem (e.g. whether patients bring it onto themselves) or even the question of whether mental illness represents degeneracy or progression. As Braslow (1997, p. 274) points out, 'For Berrios, who is a psychiatrist as well as a historian, psychiatric disease is real in the sense that it has a neurobiological substrate. However, its apprehension as a disease is always mediated by the physician's theoretical framework and his or her social and cultural milieu'. This theoretical approach is also reflected by including a clinical and a social section within each chapter in his earlier book coedited with Roy Porter, *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (Berrios and Porter 1995).

The objective of neurobiological research in psychiatry is to identify the biological causes of mental disorder and to develop treatments for it. Although scientific theories linking disordered functioning of the mind to lesions of the brain can be traced back to antiquity, a major strand of criticism of psychiatry has been that research has failed to produce evidence for any biological causes for most mental disorders. The fact that our understanding of the causes of mental disorders has been, for the most part, partial explains why discoveries of neurobiological treatments have often, though not always, happened to a large extent through chance.[1] Because of the level of their complexity, the comprehensive explanation of most mental disorders is likely to include, in addition to neurobiological causes, social, cultural or even economic contributory factors. Most of these tend to change at a timescale only historical research can grasp; therefore, history of psychiatry will be instrumental in understanding them.

As regards the lack of biomarkers, the biological tests relevant to psychiatry are more likely to be found at behavioural rather than molecular or tissue level. There is a relatively long tradition of measurement of mental phenomena at the behavioural level. The idea that psychological experience was measurable can be traced back to Christian Wolff (1679–1754), the German philosopher Johann Friedrich Herbart (1776–1841) who envisaged the 'statistics' of the soul and Wilhelm Wundt (1832–1920) and Emil Kraepelin (1856–1926) who developed techniques to measure psychiatric symptoms, including fatigue and memory impairment (Berrios 1996). In some conditions psychometric measurement can reach sensitivity and specificity on par with biochemical laboratory tests for physical health conditions (e.g. the Addenbrooke's Cognitive Examination in the diagnosis of progressive degenerative dementia (Mioshi et al. 2006; Dudas et al. 2005)). The incorporation of subjective experience into descriptive psychopathology was a major achievement of nineteenth-century psychiatry. This process was helped by changes in psychological theory that made the study of inner experience and the content of consciousness on the basis of introspection possible (Berrios 1996).

[1] Only future scholarship in history of psychiatry can describe the exact impact on this of the current academic and funding structure and the way research ethics works.

Clinicians operate in the given economic, social and cultural context of their era. They are guided by what is considered state of the art at the time and, to the extent they are aware of it, the knowledge and skills that the profession has accrued over its history. These contextual elements influence their pre-existing knowledge, attitudes, interests, needs and preferences and have an impact on what they think constitutes a symptom or appropriate treatment for it. The thought that throughout the ages thinking about insanity reflected social and political values was present in historical thinking as early as the nineteenth century (Gine y Partagas 1876). Tracing the influences of great thinkers in different disciplines on each other is common practice, but research comparing the psychiatric curriculum during a particular time period in undergraduate and specialty training and contemporaneous curricula in the natural sciences and the arts and humanities can also provide valuable insight.

Various strands of psychiatry have held more sway at various points in the history of psychiatry. For example, after the burst of neurobiological research towards the second half of the nineteenth century, the first half of the twentieth century saw the rise of the behaviourist approach which viewed pathology as socially maladaptive or deficient behaviour. Psychoanalysis also exerted a very powerful influence around the same time. In recent decades, cognitive science and medical neuroscience have become more dominant. The risk is, of course, that in a specialty where multiple viewpoints are not just legitimately present but necessary to develop a full understanding, one persuasion holding all the dominant positions of academic and clinical power, filling all textbooks, receiving all the honours and distinctions and last but not least controlling all the funding can be a serious obstacle to progress. Historical research can contribute in (at least) two important ways here. First, it can provide vital insight into how psychiatric conditions arose in certain epistemological orientations. Second, it can show how dominant schools of thought and their infrastructure developed and influenced the way society looked after the mentally ill.

Working with historians of cognate fields can enhance our chances of success here. There have been some examples of genuine multidisciplinary working, although not with a focus on historical studies. Yale University's Institute of Human Relations was started up around 1930 and operated until the early 1960s. Its objective was to encourage collaboration between psychologists, psychiatrists, sociologists and anthropologists. A similarly multidisciplinary institution in the United Kingdom, the Tavistock Clinic, was set up during the same era.

Some patterns seem to repeat themselves throughout history, for example, fluctuating between holistic and dualistic approaches as regards the relationship between body and mind (i.e. somatic and psychic illness and medicine). For the most part, we do not have enough detailed records to do an analysis on how each of these approaches worked for various forms of psychiatric illness in various circumstances (e.g. data on the prevailing cultural, economic, geographical, political and ecological factors). Methodological insight from history of psychiatry could be instrumental in designing and documenting current-day treatment trials and other research (e.g. epidemiological or phenomenological studies) in order to make the data more usable for future historical studies. A relevant area to benefit from the usefulness of

such an approach could be the appearance of anorexia nervosa in Hong Kong and other societies going through Westernisation.

In conclusion, having an understanding of how psychiatric concepts and treatments were developed in their historical context will help us to recognise their value in different circumstances. In other words, it will help us to understand why certain treatments were effective and what factors contributed to this at different times and in different situations. In turn, this should give us some tools to enable us to design better or more useful treatments and services in the future.

## Towards a Model of Values-Based Psychiatry

As noted earlier, psychiatry is concerned with areas of human experience and behaviour in which values are particularly diverse. If values are so different, is there any framework that could help us handle this value diversity? Values-based medicine is a parallel approach to evidence-based medicine, whereas in the latter the emphasis is on producing objective evidence about the efficacy and safety of diagnostic and treatment interventions by removing subjectivity, values-based medicine focuses specifically on the subjective value of these for the patient.[2] One would be right to observe that there is nothing fundamentally new in doing so, as medicine has always aimed to combine the technological aspects of medical science with the art of tending to the ailing person with his or her preferences. What makes VBM original, and a powerful tool, is combining the abstract logical orientation of analytic ethics (i.e. the meaning and implications of value terms) with the empirical aspects of psychiatry (Fulford 2011).

Whilst both the history of descriptive psychopathology and VBM pay careful attention to the language of description of psychiatric symptoms, the former is primarily interested in the trans-epistemic continuity of symptoms, and the latter is concerned principally with the value of terms inherent in symptom descriptions and diagnostic criteria. Values-based medicine posits that although certain aspects of being ill may not have changed for millennia, the rapid growth of scientific knowledge and the changing way we live often create new challenges in everyday clinical decision-making. The focus is not on necessarily finding the one 'right' solution, but instead, it suggests 10 principles (Table 14.1, adapted from Fulford 2007) that can guide us as to how to have a good 'process' (Fulford 2007). Values-based medicine entertains, where necessary, dissensus as an outcome. This is where it can go further than conventional bioethics. In dissensual decision-making, different values remain in play. They are balanced sometimes one way and sometimes in others,

[2] A lesson from history epitomising the inappropriateness of excluding the subjective or introspective in order to be 'scientific' in psychiatry is behaviourism which, although reaching a high degree of sophistication at its peak, failed to provide a plausible explanation of mental illness or to produce treatments for more than a few forms of it (e.g. systematic desensitisation for some phobias).

**Table 14.1** The ten principles of VBM

| | | |
|---|---|---|
| **Theory principles** | | |
| 1 | The 'two-feet' principle | Clinical decisions stand on two feet: values and facts |
| 2 | The 'squeaky wheel' principle' | We tend to notice values when they are diverse or conflicting and likely to be problematic |
| 3 | The 'science-driven' principle | Scientific progress opens up more choices and increasingly brings the full diversity of human values into play in healthcare |
| 4 | The 'patient-perspective' principle | The first call for information is the perspective of the patient or patient group |
| 5 | The 'multi-perspective' principle | Conflicts of values are resolved primarily, not by reference to rule prescribing a 'right' outcome, but by processes designed to support balancing legitimately different perspectives |
| **Practice principles** | | |
| 6 | The 'values blindness' principle | Raising awareness of values through careful attention to language |
| 7 | The 'values myopia' principle | There is a variety of empirical and philosophical methods to improve our knowledge of other people's values |
| 8 | The 'space of values' principle | Ethical reasoning is used to explore differences of values rather than to determine what is 'right' |
| 9 | The 'how it's done' principle | Communication skills have a substantive as opposed to merely executive role in clinical decision-making |
| 10 | The 'who decides?' principle | VBM, although involving a partnership with ethicists and lawyers, puts the decision-making back where it belongs, i.e. with users and providers at the clinical coalface |

depending on the circumstances of the case (Fulford 2014). A somewhat related idea in Berrios (1996) is the need for periodic 'recalibration' of the language of psychiatry due to changes in biology (e.g. caused by genetic mutation), psychology (e.g. new models of behaviour) or sociology (e.g. redefinition of abnormal behaviour). A behaviour that was a symptom in a certain society at a certain time point, for example, may not remain a symptom in a different social context. This recalibration is based on conceptual-historical analyses and data from clinical observation (Berrios and Porter 1995).

It is reasonable to assume that many of the criticisms of psychiatry have been the result of the perception that certain values of people were not acknowledged or taken into consideration. Studying the extent to which the application of the principles explicated in VBM can be traced back into past eras in psychiatry may help us understand the origin of some current discontents. Values-based medicine describes four core skills: *raised awareness of the diversity of values* involved in psychiatric diagnosis and treatment decisions, *ethical reasoning* with an emphasis on opening up different perspectives rather than closing down on prescribed 'solutions', knowing how to find and use *knowledge of values* and *communication skills* for eliciting values and conflict resolution. The contribution of history of psychiatry to resolving psychiatry's current discontents could be through further elucidating

how psychiatric practice developed and was accepted by society in earlier eras. What were its underlying explicit and implied values at the time? A considerable amount of historical research has been done on certain value-laden issues, such as coercion, detention and the setting up and demolishment of the asylum system, perhaps less on the value spaces of various symptoms, diagnoses and treatments – something lying very much at the heart of current discontents with psychiatry. The existing body of scholarship on the moral content of mental illness could be further enhanced by improving our understanding of the ethical reasoning behind earlier practices. History of psychiatry could also provide us with some knowledge about how psychiatric diagnosis or treatment was discussed with patients and relatives and in public discourse in the context of prevailing thinking, practices and values of the time.

On a related note, there seems to be a gap between public understanding and actual current practice of psychiatry. Public understanding seems to reflect earlier practice or, sometimes, simply an inaccurate image. History of psychiatry research could elucidate how this gap changed over time and what the factors involved were. For example, historical research reveals that views as to whether mental illness is permanent once it has developed have changed over time (Berrios 1996), and one can speculate to what extent the deinstitutionalisation of mental patients that has led to the current predominance of community-based treatment has contributed to increased expectations of the public that mental illness would be(come) less severe and that a fatal outcome (e.g. suicide) should always be preventable.

As a fundamental aspect of how psychiatry is practised, VBM actively embraces multidisciplinarity not only for the professional skill sets but also for the multiple value perspectives other professionals can bring. It is important to note that during much of its history, psychiatry was an interdisciplinary enterprise; its practitioners and theoreticians often came from other fields or were practising polymaths themselves. Wilhelm Maximilian Wundt, who is often credited with the establishment of experimental psychology, wrote on medical physics and also, extensively, on philosophy. Sigmund Freud (1856–1939) trained as a medical doctor and specialised in nervous disorders but also was a polyglot, well-versed in literature and mythology. In a similar vein, breakthroughs in psychiatry were often made possible by developments in other fields (e.g. refined histopathology in the second half of the nineteenth century through developments in histological staining and lighting techniques in light microscopy or improved diagnostic differentiation in recent decades owing to the development of brain imaging techniques).

Is there a risk of ‘opinions over facts’ with values-based medicine? There should not be, because it places equal emphasis on the importance of both facts and values. It entertains the idea of legitimately different views and promotes mutual respect. Patient-centred care means focusing primarily on the patient’s values, but other values (including those of the treatment team) are also taken into consideration; it does not put either the patient or the clinician into a god-like position. In a specialty where subjectivity plays such an important role, VBM-informed history of psychiatry research can teach us important lessons on how to avoid some future pitfalls.

## References

Berrios, G. E. (1996). *The history of mental symptoms: Descriptive psychopathology since the nineteenth century*. Cambridge: Cambridge University Press.

Berrios, G. E., & Porter, R. (Eds.). (1995). *A history of clinical psychiatry: The origin and history of psychiatric disorders*. London: Athlone.

Braslow, W. J. (1997). The history of mental symptoms. *Journal of the History of the Behavioral Sciences, 33*, 274–276.

Dudas, R. B., Berrios, G. E., & Hodges, J. R. (2005). The Addenbrooke's Cognitive Examination (ACE) in the differential diagnosis of early dementias versus affective disorder. *The American Journal of Geriatric Psychiatry, 13*, 218–226.

Fulford, K. W. M. (2007). Facts/values: Ten principles of values-based medicine. In J. Radden (Ed.), *The philosophy of psychiatry: A companion* (pp. 205–234). Oxford: Oxford University Press.

Fulford, K. W. M. (2011). Neuroscience and values: A case study illustrating developments in policy, training and research in the UK and internationally. *Mens Sana Monographs, 9*, 79–92.

Fulford, K. W. M. (2014). Values-based practice: The facts. In M. Loughlin (Ed.), *Debates in values-based practice: Arguments for and against* (pp. 150–170). Cambridge: Cambridge University Press.

Gine y Partagas, D. (1876). *Tratado Teorico-practico de Frenopatologia*. Madrid: Moya y Plaza.

Howells, J. G. (Ed.). (1975). *World history of psychiatry*. London: Baillière Tindall.

Mioshi, E., Dawson, K., Mitchell, J., Arnold, R., & Hodges, J. R. (2006). The Addenbrooke's Cognitive Examination Revised (ACE-R): A brief cognitive test battery for dementia screening. *International Journal of Geriatric Psychiatry, 21*, 1078–1085.

# Chapter 15
# The Origins of Psychiatric Epidemiology in Chile in the Twentieth Century, as a Tool for Community Action: An Historical Analysis


**Rubén Alvarado and Leonel Valdivia**

**Contents**



## Introduction

Epidemiology is a discipline that seeks to describe health and disease phenomena in specific populations. Its purpose is to develop causal explanations of disease phenomena at various levels (biological, psychological, environmental and social) and identify appropriate interventions to improve the health and quality of life of such populations. Thus, epidemiology is a discipline that focuses on populations within their contexts in order to offer multicausal explanations of disease phenomena, even while being strongly action-oriented. Its transformative aim has been present since its inception, as illustrated by the landmark case of the cholera outbreak in London in 1848. John Snow, who is considered the 'father' of modern epidemiology, not only was able to trace clusters of cholera cases using an epidemiological map but also identified the source of the outbreak (contaminated drinking water) and proposed actions to stop the outbreak, namely, changing the drinking water system. Interestingly, the germ theory of disease had not yet been theorized at this time. So

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while John Snow could not know the exact mechanism of cholera transmission (the *Vibrio cholerae* agent), he was still able to identify the means of contagion (the drinking water) and take action to stop the contagion from spreading further.

As an applied scientific discipline, epidemiology has followed a number of different paradigms throughout its history. Susser and Susser (1996) have described two distinct paradigms that have dominated the field since the mid-twentieth century: the 'black box' and the 'Chinese boxes'. The 'black box' paradigm emerged as chronic non-communicable diseases were being studied during the latter half of the twentieth century. This approach considers risk factors at the individual level, using findings to make inferences about the population though without taking other societal factors into account (e.g. social stratification, organizational theory, social capital). Hence, the proposed interventions focus on controlling risk factors at the individual level, for example, through behaviour modification and physiological parameters. Within this paradigm, the population level only serves as a means by which interventions are channelled towards the individual, without itself becoming a subject of intervention.

Susser and Susser (1996) note that a new model of causal analysis arose during the 1980s. They refer to it as the 'Chinese boxes'. This paradigm explores a number of different aspects (from the biological and individual to the physical and social aspects) as well as the phenomena that exist at each level and their interactions with one another. As such, the Chinese boxes paradigm provides a multilevel and ecological analytical approach when addressing epidemiological problems. The authors refer to this period in history as the era of the eco-epidemiology. The growing popularity of this paradigm over the past three decades is evident in a burgeoning body of research on social epidemiology, the social determinants of health and the multilevel mechanisms that affect population health. In the era of eco-epidemiology or the 'Chinese boxes', interventions must be coordinated to address a variety of aspects, such as behavioural change, public policy and community action.

Today, we can see the tension between these two paradigms in epidemiological research, practice and teaching. Traditional epidemiology texts diverge so significantly from those of social epidemiology that readers may view them as two completely different disciplines. Furthermore, important contrasts become evident when the two paradigms are applied to interventions. As an example, clinical epidemiology considers the individual, while social epidemiology puts emphasis on community action and social policy. The conflict between the two paradigms coincided with the rise of social epidemiology worldwide. In this chapter, we offer a case study from psychiatric epidemiology during the 1950s and 1960s, which was led by a group of mental health practitioners and researchers at the University of Chile (Santiago, Chile). Below, we offer a historical description of this initiative and explore the conditions that made it successful.

## The First Studies in Epidemiology of Mental Disorders in Chile

There is a dearth of historical and epistemological research in the field of epidemiology (Morabia 2004). This is particularly true of mental disorder epidemiology despite the acknowledged importance of defining what we call mental health disorders in order to study them from a population-focused perspective (Berrios 1996, 1999; Marková and Berrios 2009). Case definition is a critical starting point for epidemiological studies. For this purpose, a classification system that contains precise definitions is necessary, as are validated instruments that can be used to identify and classify cases (Morabia 2004). However, developing such measurement tools has been a weak area in the study of mental health disorders. It was not until the mid-twentieth century that an initial clinical consensus on mental health disorders was established with the publication of the first Diagnostic and Statistical Manual (DSM) (APA 1952), although its application to epidemiological studies was further delayed by two decades.

Due to the above-mentioned reasons, the first task that confronted the University of Chile team in the late 1950s was to develop theoretical and operational definitions of mental disorders. This initiative gave birth to what Juan Marconi defined as the six basic psychopathological models for epidemiological transcultural studies, which include alcoholism, neurosis, psychosis, dementia, mental retardation and epilepsy (Horwitz and Marconi 1965). As an example, in Table 15.1 we show the conceptual and operative criteria and the indicators that these authors used for alcoholism (Horwitz and Marconi 1965).

The University of Chile programme was led by professors Juan Marconi and Jose Horwitz. Juan Marconi Tassara (1924–2005) was a Distinguished Professor of Psychiatry. A multifaceted and inspiring man, he conducted research into the basic sciences and epidemiology while also participating at the community level. He drew

**Table 15.1** Conceptual, operational criteria and indicators to alcoholism, for cross-cultural epidemiological studies

| *Alcoholism* |
|---|
| *Conceptual criteria*: irreversible physical ethanol dependency |
| *Operational criteria:* current or past "abstinence inability" and/or "quitting inability" |
| *Indicators*: |
| Experience of quitting inability |
| Alcohol intake crisis |
| Experience of abstinence inability |
| Repeated alcohol withdrawal symptoms: medium and high intensity |

on diverse disciplines to apply their lessons to his area of greatest interest, i.e. improving the mental health of communities through an active involvement with them. He was a man of his time; he participated in the university reform process of 1968 and advocated for the transformation of medical education. He eventually focused on developing community mental health programmes (1969–1973), to be described later in this chapter.

Jose Horwitz Barack (1908–1978) was a Professor of Psychiatry at the University of Chile and later became the Director of the Psychiatric Institute (Santiago de Chile). He was widely known for his studies on alcoholism from a basic science, epidemiology and clinical perspective. He belonged to a family of public health pioneers in Chile. His brother, Abraham Horwitz, was the Director of the University of Chile, School of Public Health; Director of the first National Health Service; and Regional Director of the Pan American Health Organization (PAHO/WHO) between 1950 and 1975.

During the 1960s, several psychiatrists joined in conducting mental health epidemiological studies such as Laura Moya and Leonardo Muñoz. They were soon joined by young professionals undergoing psychiatry residencies such as Alberto Minoletti, Alfredo Pemjean, Rogelio Aravena, Domingo Asun, Patricia Hamel and Carlos Nuñez. During the period of the military dictatorship of the 1970s and 1980s, these young professionals maintained alive the heritage of the mental health pioneers. They also passed on this tradition to the incoming generations of mental health professionals. Once democracy was restored in the early 1990s, they became the leaders of the reform of the psychiatric care services that adopted a community-based approach (Pemjean 1996; Minoletti and Zaccaría 2005).

After briefly identifying the protagonists of the mental health epidemiology in Chile, we turn back to the decades of the 1950s and 1960s to retrace the step undertaken by them. These authors applied the above-mentioned definitions in their studies particularly in the latter two conducted in 1966 and 1967 and in 1967 and 1968, respectively. The first of these studies defines the six psychopathological models but without establishing either operational criteria or indicators. The second study provides field testing for these definitions as well as for the survey designed to collect specified indicators.

It is worth noting the conceptual evolution from purely theoretical definitions to operational definitions that lead to the formulation of indicators allowing greater precision in case identification (including the design and administration of a structured survey measuring specifically defined indicators). The latter constitutes one of the main achievements of this period and is a pioneering study in population-based mental disorder epidemiology in Chile (Horwitz and Marconi 1965).

There were three studies conducted during the period 1957–1968 that applied theoretical and operational criteria in the case identification of psychopathological disorders. Table 15.2 presents the results of these studies.

The first study was conducted between 1957 and 1958 and covered three districts of Santiago, representing three different social strata (Central Santiago, Ñuñoa and San Miguel). Eighty city blocks were randomly selected, a first dwelling was drawn up, and then one in every five was selected until a full round of the block was completed. One

**Table 15.2** Prevalence results by type of psychopathological disorder, in the three population epidemiological studies that were conducted in Chile, between 1957 and 1968

| Psychopathological disorder | Referred population (age) | Santiago 1957–1958 | Independencia 1965–1966 | Santiago 1967–1968 |
|---|---|---|---|---|
| Mental retardation | + 1 year | 1.2% | 1.1% | 1.6% |
| Epilepsy | + 5 years | 2.0% | 0.9% | 0.9% |
| Neurosis | + 15 years | 10.0% | 8.0% | 16.7% |
| Psychosis | + 15 years | 0.7% | 0.4% | 0.3% |
| Dementia | + 15 years | 0.7% | 1.4% | 1.5% |
| Alcoholism | + 15 years | 5.1% | 1.9% | 2.4% |
| Total | | 19.0% | 11.9% | 19.8% |

*Note:* Independencia is a district in the northern area of the city of Santiago

adult person was interviewed at each dwelling selected, most often a housewife who was able to provide information concerning her family members (Horwitz et al. 1958).

The second study was conducted between 1965 and 1966 in the Independencia district of Santiago. This study was used to field test criteria and survey methods to be applied in a third larger study that the authors were already designing for the entire city of Santiago (corresponding to the third study described below) (Moya et al. 1969). One of the most interesting aspects of this study was that it was designed to measure the relationship between socio-economic status and prevalence of mental disorders. To this end, the authors chose three neighbourhoods with differing social status within the district (lower middle class, Independencia; unionized working class, La Palma; and marginal working class, Santa Mónica). The authors compared prevalence rates within groups in the manner of an ecological study design. They reported prevalence rates for epilepsy, neurosis and alcoholism among the working class that were double or triple those of the middle class neighbourhoods. Thus, the authors were already incorporating the 'social determinants perspective' much like it is done at present in the field of social epidemiology (Moya et al. 1969).

The third study was conducted in 1967 and 1968 and covered the totality of districts of the city of Santiago. The study selected a stratified sample based on district maps and randomly selected specific dwellings within the districts. The survey instrument was enhanced with pre-coded questions on personal data, family socio-economic conditions and indicators related to the six basic psychopathological models. The administration of the survey was also enhanced by deploying specially trained nurses (see Marconi and Muñoz 1970, p. 124).

Table 15.2 shows the results of the three studies, and it can be observed that the figures obtained are quite similar to those found in more recent studies in Chile (Vicente et al. 2006). This may indicate that the criteria and procedure used six decades ago achieved a good quality standard.

## The Interest in the 'Social Question' at the Base of Epidemiological Studies

Prior to the epidemiological studies mentioned above, great interest can be traced back to the nineteenth century on the social conditions determining mortality and ill health among the most deprived sectors of the Chilean society. As described elsewhere (Vielmas et al. 2015), a variety of institutions emerged as a reaction to these conditions, among them the School of Public Health of the University of Chile. In 1939, the then Minister of Health, Dr Salvador Allende, issued a report entitled 'The Chilean social-medical situation' (Allende 1939) that may be considered the first study on the social determinants of health conducted in Chile. Its author dedicated one chapter to alcoholism, in which he concluded the following:

> The data reported in this chapter demonstrate how evidently the problem of alcoholic intoxication impact of morbidity and mortality in the country and, therefore, how acutely important it is that the Government deals with it in a serious plan of improvement of the health status of the country (Allende 1939, p. 122).

The Institute of Alcoholism Research was established at the University of Chile in the early 1950s. Its first director was Dr Jorge Mardones, who 2 years later (1952) became the first Director General of the National Health Service, a first experience in Latin America at establishing a unified healthcare service covering the whole country (a system similar to the British NHS). Between 1952 and 1957, three small-scale epidemiological studies on alcoholism were carried out. These studies render evidence on the public health relevance of this problem and led to the foundation of the National Program for the Control and Prevention of Alcoholism under the auspices of the Ministry of Health. The three epidemiological studies on alcoholism were as follows:

(a) The first study conducted in 1952 studied 534 working class families associated with School No. 50 in Santiago. Results of this study showed that 7.1% of fathers and 0.5% of mothers were alcoholics (see Marconi and Muñoz 1970, p. 116).
(b) Between January and May 1954, the first population-based study was conducted in the Quinta Normal district of Santiago over a random sample of 787 families and 1976 people above the age of 15. At that time, a classification of types of alcohol drinkers had been developed as well as the clinical criteria for alcoholism diagnosis using data on inebriation frequency and duration of intoxication crisis. The results were 4.2% alcoholics and 28.3% excessive drinkers (Marconi et al. 1955).
(c) The third study was carried out in 1956 and 1957 in a predominantly working class district. The study used direct interviews and a classification of cases based on the WHO Technical Report No. 48 (1951). The results were similar to the earlier study: 5.7% were alcoholics (12.7% among men and 0.4% among women) (see Marconi and Muñoz 1970, p. 116).

One important characteristic of the studies during this period is the search for a social and institutional response to the perceived health problems. Epidemiological data is used as a foundation to highlight the problems and seek causal explanations at the societal level. This is clearly stated by Marconi and Muñoz in one of their publications: 'The knowledge obtained has been helpful if rationally planning actions for the control and prevention of mental disorders, as well as to begin the evaluation of already established services' (Marconi and Muñoz 1970, p. 115). These authors had taken up an increasingly critical position towards the traditional psychiatric services, to which they referred to as the 'asylum approach' alluding to the care provided by psychiatric hospitals. They put forward a proposal 'that turns around health planning by placing within the community itself the axis of change and problem solution at a massive scale' (Marconi and Muñoz 1970, p. 115). This proposal was termed 'the intracommunity approach to mental health' (p. 119).

## From Epidemiology to Community Action

Around 1968, Juan Marconi had rallied a team of faculty staff, professionals and students who were developing intracommunity mental health programmes in several neighbourhoods in the south of the city that came to be known as the Centre for Mental Health Research in the southern district of Santiago. These programmes were a major departure from the traditional ways to care for persons with mental illness and focused particularly on the diagnosis of mental illness and on prevention. Marconi points out that all the solutions proposed up until then were characterized by being authoritarian and ethnocentric, ignoring the existence of cultural barriers that impaired communication between professionals and the community and rendered ineffective most interventions (Marconi 1969, 1973).

By contrast, intracommunity programmes were characterized by being democratic in nature, with symmetrical power relations and respect to diverse cultural outlooks on health and disease. The work was organized around small sectors of the community through a system of delegation of tasks and responsibilities. This work system could be likened to a pyramid with five levels of responsibility. Each level of responsibility corresponded to a community-based actor, each provided with special training and supervision, with clearly stated objectives and with a manual to guide the work (Marconi 1971, 1973).

As an example, we will describe the Intracommunity Program on Alcoholism, which was the first to be implemented and lasted for some 6 years (through 1973) (Marconi 1971, 1992). The top of the pyramid was composed of general practice physicians working in the primary healthcare centres who received special mental healthcare training. In turn they were responsible for training non-medical personnel with whom they worked in the primary healthcare centres, such as nurses, psychologists and social workers. Likewise, these primary care professionals trained nurse auxiliaries and technicians, teachers or priests, who constituted the third level

of the pyramid and who resided in the community. The latter then trained community leaders (fourth level) that in the case of this programme were alcoholics who had received treatment and were in recovery. These community leaders organized meetings and other activities to talk about alcoholism, so that it was regarded as an illness and a problem in the life of the person. They were provided with handbooks that clearly described the objectives and content of each community activity. In some places, these recovered alcoholics were trained to provide initial care to other alcoholics, particularly in handling the withdrawal symptoms (with rest, diet, hydration and medications) (Marconi 1992).

Latterly, intracommunity programmes were developed for neurosis (Marconi 1971; Minoletti et al. 1972), mental retardation (Marconi 1971; Pemjean et al. 1972) and psychosis (Marconi et al. 1980). All these programmes were interrupted after the establishment of the military dictatorship in 1973 (Marconi 1976).

## Conclusions

We have described and analysed a period in the history of the mental health disorder epidemiology in Chile with a focus on the period of 1957–1973. This review allows an appreciation of an important conceptual and methodological evolution within the discipline, even though Chile, at the time, was not a centre of major influence and knowledge as compared with Europe and the United States. Nevertheless, developments in Chile did contribute to similar disciplinary work being undertaken in other Latin American countries such as Colombia, Costa Rica, Mexico and Peru.

One of the most valuable features of the work performed – and perhaps also the engine of its own development – was the linking of epidemiology with the search for solutions based on community action. Only recently, after some four decades, they begin to reappear in mental health public policy (Alvarado et al. 2012). In this case, once again, history is not linear, nor does it advance in a sustained and irretrievable manner towards improved conditions for humanity. Such an illusion, evocative of the Age of Enlightenment, is thus again refuted in the history described in this chapter.

## References

Allende, S. (1939). *La realidad médico social chilena* [The Chilean social medical situation]. Santiago: Ministerio de Salubridad.

Alvarado, R., Minoletti, A., Torres-González, F., Moreno-Küstner, B., Madariaga, C., & Sepúlveda, R. (2012). Development of community care for people with schizophrenia in Chile. *International Journal of Mental Health, 41*, 48–61.

American Psychiatric Association. (1952). *Diagnostic and statistical manual: Mental disorders*. Washington DC: APA.

Berrios, G. E. (1996). *The history of mental symptoms*. Cambridge: Cambridge University Press.

Berrios, G. E. (1999). Classifications in psychiatry: A conceptual history. *Australian and New Zealand Journal of Psychiatry, 33*, 145–160.

Horwitz, J., & Marconi, J. (1965). *Evaluación de definiciones trasnculturales para estudios epidemiológicos en salud mental: aspectos metodológicos* [Evaluation of transcultural definitions for epidemiological studies in mental health: Methodological aspects]. Santiago: Servicio Nacional de Salud – Universidad de Chile.

Horwitz, J., Muñoz, L., et al. (1958). Investigaciones epidemiológicas acerca de morbilidad mental en Chile [Epidemiological research on mental morbidity in Chile]. *Revista del Servicio Nacional de Salud, 3*, 277–309.

Marconi, J. (1969). Barreras culturales en la comunicación que afectan el desarrollo de programas de control y prevención del alcoholismo [Cultural barriers in communication that affect the development of alcoholism control and prevention programs]. *Acta Psiquiátrica y Psicológica de América Latina, 15*, 351–355.

Marconi, J. (1971). Asistencia psiquiátrica intracomunitaria en el Área Sur de Santiago [Intracommunity psychiatric assistance in the South Area of Santiago]. *Acta Psiquiátrica y Psicológica de América Latina, 17*, 255–264.

Marconi, J. (1973). La revolución cultural chilena en programas de salud mental [Chilean cultural revolution in the programs of mental health]. *Acta Psiquiátrica y Psicológica de América Latina, 19*, 17–33.

Marconi, J. (1976). Política de salud mental en América Latina [Mental health policy in Latin America]. *Acta Psiquiátrica y Psicológica de América Latina, 22*, 112–118.

Marconi, J. (1992, November). *Programa integral de control y prevención del alcoholismo* [Comprehensive program for the control and prevention of alcoholism]. Inaugural conference at the First congress of alcohol and drugs of the Ibero-American Association for the Study of Alcohol and Drug Problems, Santiago, Chile.

Marconi, J., & Muñoz, L. (1970). Visión general de la investigación epidemiológica en salud mental en Chile [Overview of epidemiological research in mental health in Chile]. In J. Mariategui & G. A. Castro (Eds.), *Estudios de epidemiología psiquiátrica en América Latina* (pp. 115–125). Buenos Aires: ACTA.

Marconi, J., Varela, A., Rosenblat, E., Solari, G., et al. (1955). A survey on the prevalence of alcoholism among the adult population of a suburb of Santiago. *Quarterly Journal of Studies on Alcohol, 16*, 438–446.

Marconi, J., Díaz, J. P., & Mourgues, C. (1980). Programa integral de psicosis [Comprehensive program of psychosis]. *Acta Psiquiátrica y Psicológica de América Latina, 26*, 211–222.

Marková, I. S., & Berrios, G. E. (2009). Epistemology of mental symptoms. *Psychopathology, 42*, 343–349.

Minoletti, A., & Zaccaría, A. (2005). Plan Nacional de Salud Mental en Chile: 10 años de experiencia [National Plan of Mental Health in Chile: Ten years of experience]. *Pan American Journal of Public Health, 18*, 346–358.

Minoletti, A., Marconi, J., Infland, S., & Naser, S. (1972). Programa intracomunitario de neurosis. Un modelo tentativo de prevención secundario en adultos. Comunicación preliminar [Intracommunity neurosis program. A tentative model of secondary prevention in adults. Preliminary communication]. *Acta Psiquiátrica y Psicológica de América Latina, 18*, 15–21.

Morabia, A. (2004). Epidemiology: An epistemological perspective. In A. Morabia (Ed.), *History of epidemiologic methods and concepts* (pp. 3–124). Birkhaüser Verlag: Basel.

Moya, L., Marconi, J., Horwitz, J., Muñoz, L., et al. (1969). Estudio de prevalencia de desórdenes mentales en el área norte de Santiago. Comparación de poblaciones de tres niveles socioeconómicos [Prevalence study of mental disorders in the northern area of Santiago. Comparison of populations of three socioeconomic levels]. *Acta Psiquiátrica y Psicológica de América Latina, 15*, 137–148.

Pemjean, A. (1996). El proceso de reestructuración de la atención en salud mental y psiquiatría en Chile (1990–1996) [The process of restructuring mental health and psychiatric care in Chile (1990–1996)]. *Cuadernos Médico Sociales, 37*, 5–17.

Pemjean, A., Montenegro, H., Marconi, J., & Daniels, G. (1972). Formulación de un programa intracomunitario para combatir la deprivación cultural en la población de preescolares, de clase obrera, urbana chilena [Inner community program to counteract cultural deprivation in preschool youngsters of Chilean, urban, working class]. *Revista Chilena de Neuro-Psiquiatría, 11*, 51–56.

Susser, M., & Susser, E. (1996). Choosing a future for epidemiology. II. From black box to Chinese boxes and eco-epidemiology. *American Journal of Public Health, 86*, 674–677.

Vicente, B., Kohn, R., Rioseco, P., Saldivia, S., Levav, I., & Torres, S. (2006). Lifetime and 12-months prevalence of DSM-III-R disorders in the Chile psychiatry prevalence study. *The American Journal of Psychiatry, 163*, 1362–1370.

Vielmas, S., Jorquera, M. J., & Alvarado, R. (2015). La salud como derecho en la mission fundacional de la Escuela de Salud Pública, de la Facultad de Medicina de la Universidad de Chile: un análisis histórico [Health as a right in the founding mission of the School of Public Health, in the Faculty of Medicine of the University of Chile: a historical analysis]. *Revista de Salud Pública, 19*, 69–76.

# Chapter 16
# The Evolution of Portuguese Psychiatry in the First Decades of the Twentieth Century


**José Morgado Pereira**

**Contents**



## Introduction

The complete institutionalization of psychiatry in Portugal occurred after 1911 with the reform of Júlio de Matos (1856–1922) following the republican revolution of 1910, consecrating the official teaching of neurology, psychiatry and forensic psychiatry in the three medical schools at Lisbon, Porto and Coimbra. The country had lagged behind in following the evolution of European psychiatric thought, and it was not until the mid-1880s that a great drive came from the alienist doctors for the reforms to take place in an area that up until then had been neglected. There was a continuing struggle in the name of science and social progress to create institutions and legislation for care, to treat the mentally ill and to protect society. Philosophies such as evolutionism and positivism became linked to liberal and republican ideas, criticizing the monarchy which was blamed for the social, economic and political backwardness of the country.

Decisive figures in this evolution were Miguel Bombarda, Magalhães Lemos and Júlio de Matos. From a psychopathological perspective, Bombarda (1851–1910) described delusional jealousy as a specific entity. Lemos (1855–1931) was a neuropsychiatrist whose works reveal an expertise in the psychopathology of Jules Séglas, and Júlio de Matos was the protagonist in this historical phase. Republican since his

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youth, he was the founder of the journal 'O Positivismo', exponent of legal medicine and author of reference books and a vast body of medico-legal reports. He was responsible for the decree of May 1911 on 'care of the insane' authorizing the government of the Republic to build seven new asylums and ten agricultural colonies. Psychiatric thinking was dominated by Matos' positivism until his death in 1922. He wrote '*Elementos de Psiquiatria*' in 1911 which was reissued in 1923, maintaining classifications based on the work of Eugenio Tanzi. Writing about the main clinical presentations, but faithful to evolutionist thought, he ignored the psychiatric and psychodynamic orientations that were developing at that time.

## Psychopathological Renewal

Sobral Cid (1877–1941) overtook the positivist period with the publication of two works in 1924. In his work 'Classificação e sistemática geral das psicoses' (Cid 1924/1983), he introduced into Portugal the authors of psychiatric modernity, Kraepelin, Bleuler and Kretschmer. In his classification of the psychoses, Cid followed the Kraepelinian synthesis but removed the concept of degeneration. In the same year, he published 'A vida psíquica dos esquizofrénicos' (Cid 1924/1983), a work strongly influenced by Bleuler and Kretschmer whose ideas he sought to harmonize. In it, he tried to show the evolutionary and dynamic character of the symptoms, using the psychological mechanisms of defence and incorporating the concepts of Freud and Jung. Sobral Cid did not limit himself to the conceptual domain, and in 1927 he advocated the transformation of the asylum into a set of differentiated care organizations, taking into account the patient's therapy, prophylaxis and social revaluation. He proposed the construction of psychiatric ambulatories, the location of the psychiatric hospital near the University, open clinics, occupational therapy, social assistance and family care and also asylum units and agricultural colonies for the totally disabled. He recognized the drawbacks of hospitalism and the importance of avoiding prolonged hospitalizations.

Egas Moniz (1874–1955), a neurologist, was another innovative figure of influence on Portuguese psychiatry. In 1915, he published in the journal '*A Medicina Contemporânea*' a paper, 'As bases da psicanálise' (Moniz 1915), which is of historical importance because it was the first scientific work to be published in Portugal on the subject. Based on the ideas of Régis and Hesnard (1914/1929), Moniz defined psychoanalysis as a psychic method of exploration and treatment of the psychoneuroses. The book by Régis and Hesnard was the first work of dissemination of psychoanalysis in France, and it also influenced Sobral Cid and Alberto Brochado. It was based on the investigation and explanation of most forms of psychic activity, whether normal or pathological, and in the analysis of affective tendencies, always derived from the sexual instinct (Moniz 1915). Moniz presented a different notion of affect, broader and more flexible than the classical conception. He then referred to pansexualism, Bleuler's term, and argued that this notion of sexual instinct had a

greater latitude and carried a new meaning as the origin of all affectivity and primary source of all psychic energy.

In 1921, he published 'O conflito sexual' (Moniz 1921), in which he summarized the case of Anna O., the hysterical patient that Breuer (1895/1956) was able to cure by means of cathartic therapy and which was influential in Freud's development of the new process of psychoanalysis. He also described the case of a 25-year-old patient, with melancholic anxiety, where through the analysis of dreams and the psychological analysis of associations of ideas, he was able to help bring to the patient's consciousness what was an intimate dislike of a sexual nature, and thereby heal the patient.

Another relevant contribution of Egas Moniz was the publication of '*A Neurologia na Guerra*' (Moniz 1917), where he described the main psychopathological disorders observed in soldiers during the Great War (1914–1918). He included neurological syndromes, neuroses, the 'battle psychoses', hallucinatory onirism, and mental confusion with amnesia. He also reviewed the concept of hysteria and, in this context, focused on the difficulties in distinguishing simulation from psychoneurosis. Referring to the rights of the war wounded, in which Clovis Vincent had been accused of using violent treatments (torpedoing), Moniz advocated the use of electrical treatment associated with psychotherapy.

Another medical figure, Alberto Brochado (1893–1944), gave an inaugural dissertation on the psycho-physiological aspects of music. He wrote about hysteria (Brochado 1922a) expressing criticism of Babinski and defending Pierre Janet's ideas. The publication of 'A Patologia da linguagem e da percepção' (Brochado 1922b) contributed to the updating of psychopathology in Portugal in the domains of language and perception. He criticized the doctrine of aphasias, in which different aphasic syndromes were conceived as arising from the destruction of various brain centres for images, pointing out that this had the disastrous consequence of disconnecting it from all psychic activities. Referring to Pierre Marie's critique of 1908 in which psychological features of aphasia were acknowledged, he then quoted Von Monakow saying that the normal functioning of language would depend on a more extensive nervous area than the one whose injury caused a deficit or a functional inhibition. Thus, disagreeing with the old localization doctrine, he established a clear distinction between the location of the syndrome and the location of the function.

Influential in his criticism of the localization doctrine was the work of Henri Bergson whom he followed in stating that the mental synthesis he defended was essentially dynamic and distinct from its component parts. In effect this was the argument for a gestalt conception of language. The influence of Bergson appeared also in an important theoretical work by Eduardo Coelho, 'Das relações do estado cerebral com o estado mental. O critério biológico em neurologia' (Coelho 1923). Coelho, who was well read in philosophy, dared to diverge from the scientific thinking of the time in Portugal and, following Bergson, emphasized the importance of a psychology, free from intellectualism and associationism. Amongst neurologists, he held up Hughlings Jackson and Von Monakow for having abandoned the exclusively anatomo-pathological method, and for applying biological criteria and

psychological analysis to the study of aphasias and agnosias. He also viewed Bergson's psychology as bringing valuable insights to the discoveries of Pierre Janet, Freud, and Jung in revealing the dynamic nature of psychic organization and emphasizing that personality could only be explained in psychic terms, these being different from the concepts of matter and physical energy.

In 1925 in Coimbra the first doctoral thesis on psychoanalysis was presented, '*A Psicanálise de Freud*' (Monteiro 1925), by António Laranjo Ferreira Monteiro. The author summarized the psychological basis of psychic life, defining the unconscious, and going on to talk about censorship and repression, and the psychic complexes that he considered to be equivalent to Pierre Janet's notion of psychic energy sources. These he described as the sum of affective energy in motion. He also referred to instincts, as a category that included sexual complexes, personal conservation and social or association complexes.

We have thus witnessed the progressive delimitation of the neurological, psychiatric and psychological fields that marked the future of these disciplines to the present time. Despite the predominance of the positivist mentality in the 1920s, there were already examples of medical articles and dissertations that sought to correct the excesses and limitations of positive science and replace this with a biopsychological attitude.

Barahona Fernandes (1907–1992) showed variously how the prevalence of Comte's positivism marked Portuguese thinking from the late nineteenth to the early twentieth century. Referring to his apprenticeship at the Faculty of Medicine of Lisbon in the years 1925–1930, he spoke of the frankly positivist orientation of medicine at the time (Fernandes 1956). No one dared to question naturalistic positivism, and the vitalistic considerations that were renewed by the publication of the work by Von Monakow and Mourgue (1928) were dismissed as unscientific. Medical knowledge from the beginning of the second quarter of the twentieth century was essentially based on pathological anatomy, bacteriology, and experimental physiology.

In the thirties, the studies of Barahona Fernandes began under the direction of Sobral Cid. Then between 1934 and 1936, he studied in Germany with Kleist and later with Kurt Schneider, who provided him with opposing perspectives, cerebral pathological and psychopathological, respectively. On his return from Germany, he published 'Psicopatologia e patologia cerebral: Um ponto de vista convergente na apreciação dos fenómenos patológicos das psicoses e das doenças cerebrais orgânicas' (Fernandes 1937/1998). There he sought to define a critical convergence between the different categories of physiological, material and psychic phenomena, drawing on the philosophy of Nicolai Hartmann, whose work had been introduced to him by Kurt Schneider. This convergence point of view was always assumed by Barahona Fernandes, who later called it 'phenomenological-structural-dynamic'. He acknowledged that Jaspers' psychopathology was known in Portugal through a French translation, but was only really influential through the more accessible clinical work of Kurt Schneider (Fernandes 1966). In the meantime Kurt Schneider's book, '*Lições de psiquiatria para médicos*' (1937), was published with a translation by Fernando Ferreira, another disciple of Sobral Cid, who had also trained in

Germany, and who, in an initial note, emphasized the importance of this work for the general practitioner.

Finally, from a psychopathological perspective, Alberto Brochado stands out. In his paper 'As alucinações segundo Clérambault' (1928), he analised mental automatisms. He criticized de Clérambault's theory of hallucinations as parasitic phenomena independent of ideation and affectivity, agreeing instead with Von Monakow and Mourgue on the major role played by instinct and affectivity, even in aphasias and agnosias. He subsequently published widely on schizophrenia and on the Capgras syndrome. He later practiced with Sakel in Vienna, and then devoted himself to the study of insulin shock therapy, creating the insulin therapy unit at the Hospital do Conde de Ferreira in 1937.

## Social and Political Context

In 1926, a military dictatorship put an end to the republican regime (1910–1926); a new constitution appeared in 1933, resulting in an antidemocratic regime that defended conservative and authoritarian conceptions and ideological censorship that covered political, social and moral ideas, and would extend until 1974. The consequences on freedom of expression, teaching and scientific dissemination were important, because the regime feared the spread of 'subversive' ideas and acted through previous censorship on books or journals that supposedly threatened political and social order. Teaching was a fundamental and sensitive area, and therefore the ideology of 'Estado Novo' denied the pedagogical principles of liberalism and republicanism, and consequently, the ideal of a compulsory and free school (Mónica 1977). Barahona Fernandes wrote that culture in Portugal in the 1930s was despised and even repressed (Fernandes 1983). There were several vicissitudes that for decades inhibited the genesis and effectiveness of the university teaching of psychology in Portugal (Fernandes 1998). The official teaching of medical psychology began only in 1955, having been delayed by political pressures to assume a 'spiritual character' (Vieira 1982). The psychology degree was only created in 1977. As for psychoanalysis, the moral order reservations were even stronger. Freud's first translation was from 1932 (Freud 1932), entitled '*Sexualidade*' and corresponded to the book *Three Essays on the Theory of Sexuality*. The translator was Jose Osorio de Oliveira, a nationalist writer, who in a short explanatory note warned that 'from Freud's theories a true pan-sexualism resulted' that opposed 'our spiritual conception of life, daughter of Platonism, Christianity and Romanticism', and then 'if the Freudian theories about child sexuality mainly contradict, offend and hurt our moral sensibility, what is certain is that we owe them a share of truth' (Oliveira 1932). The diffusion of psychoanalysis only occurred in Portugal in the decades of 1950–1960.

Another notable example of moral and religious censorship, was the publication of '*O Amor Místico. Noção e valor da experiencia religiosa*' by Silvio Lima (1935), a professor of the College of Letters of the University of Coimbra. The author was expelled from the university and readmitted 6 years later but prevented from

reinstatement to his chair. The central theme of the book was based on the erotogenic theory of mysticism and the interpretation of mystical symbolism, especially its psychoanalytic theoretical basis (Fernandes 1979). Its last chapter concluded that religious phenomena were not reducible to sexual phenomena (Lima 1935).

## Evolution of Psychiatric Care and New Therapies

Ideological vicissitudes conditioned psychiatric care. The Republican project of reform was never put into practice, and no planned hospital and facilities were built, except for the Hospital Júlio de Matos which was built in 1942 following decades of delay. Rilhafoles, the old psychiatric hospital in Lisbon renamed as Hospital Miguel Bombarda, was always overcrowded at the beginning of the 1930s, and Sobral Cid's denunciations and complaints were seemingly not even understood by the government, something which caused him severe distress in the last decade of his life (Fernandes 1983). Sobral Cid wrote that in matters of public psychiatric care, the high powers of the state did not hear, and if they did hear then, they did not always understand, and when they did understand then, they were slow to move (Cid 1931/1984). It was the same situation, albeit of lesser importance, in the Hospital Conde Ferreira in Porto. In Coimbra, since there were no psychiatric hospitals, Elísio de Moura taught and treated the patients in neurological and other wards. The struggle for the psychiatric hospital continued until the 1940s. In 1934, Bissaya Barreto, a surgeon and professor in Medical College, who had considerable social and political influence, launched a campaign in the regional press with the theme 'Who will help our fools?', which contributed to the building of the Hospital Sobral Cid in the next decade.

Psychiatric therapies consisted of hydrotherapy, hypnotics, sedatives, bromides, phenobarbital and Salvarsan, but in the psychoses, treatments were limited. In 1917, Von Jauregg's malaria therapy created some optimism for its use in general paralysis, which was a common and fatal disease. After 1935, shock treatments, insulin therapy, cardiazol and electroconvulsive therapy seemed to offer hope, and there was enthusiasm amongst psychiatrists who thought that they could treat schizophrenia with insulin shock therapy (or Sakel's cure). It should be noted that both Brochado and Barahona Fernandes trained in Vienna with Manfred Sakel. At that time, these therapies represented a sign of progress with a medical redefinition of psychiatry, and hospitalization was mandatory for severe cases.

Another type of therapy was prefrontal leucotomy, carried out at the end of 1935 by Egas Moniz with the collaboration of the neurosurgeon Almeida Lima. In 1936, Moniz published in France the description of the first twenty cases, '*Tentatives operatoires dans le traitement de certaines psychoses*' (Moniz 1936). In 1937, Moniz and the neurologist Diogo Furtado presented a paper in a session of the Societé Médico-Psychologique de Paris, 'Essais de traitement de la schizophrenie par la leucotomie pré-frontale' (Moniz and Furtado 1937). They viewed this method particularly effective in psychoses characterized by distress and anxiety akin to

cases of chronic anxious melancholy where they claimed the treatment was curative. They stated that the 'doctrine of the functional fixation of certain cell-connective groupings' was only a working hypothesis, since the reason underlying improvement in some psychopathological cases was not yet understood. They emphasized that the numbers of patients with schizophrenia who could be cured by leucotomy were small. However, they insisted that the treatment caused no deficit to the higher intellectual functions and hence was a safe intervention. Following the presentation, Sobral Cid made a critical comment comparing the leucotomized patient to someone with frontal lobe damage following a brain injury from the war. He attributed the improvements seen following leucotomy to the resultant general state of akinetic apathy as seen in frontal lobe damage. He felt that the only syndromes that would benefit would be depressive syndromes of anxious tonality and manic states and hyperkinetic syndromes. Thus, the intervention was merely a symptomatic therapy, only suppressing those hallucinations and delusional ideas that were affective in nature (Cid 1937/1983). He then questioned whether one had the right to inflict such a permanent central mutilation given that there could be spontaneous recovery over time. He also warned of the insidious set-up of late posttraumatic states, which would lead to a chronic disturbance of mental life with a possible subsequent degradation of personality. In relation to Moniz's hypothesis of 'functional fixation' where channels conducting morbid ideas were cut off, Cid was scathing, considering this to be 'pure cerebral mythology'. The controversy did not continue, but Cid's comments remained central to the subsequent discussions taking place in the following decades.

## References

Brochado, A. (1922a). O delírio histérico. *A Medicina Moderna.* (Separata, no. 358. 16 pp).

Brochado, A. (1922b). A patologia da linguagem e da percepção. *A Medicina Moderna.* (Separata, 111 pp).

Brochado, A. (1928). As alucinações segundo Clérambault. *Portugal Médico*, (Separata. no 8. 14 pp).

Cid, J. S. (1924/1983). Classificação e sistemática geral das psicoses. In *Obras I*. Lisboa: Fundação Calouste Gulbenkian. pp 73–102.

Cid, J. S. (1924/1983). A Vida psíquica dos esquizofrénicos. In *Obras I*. Lisboa: Fundação Calouste Gulbenkian. pp 103–161.

Cid, J. S. (1931/1984). Processo histórico e moderna orientação da assistência psiquiátrica. In *Obras II*. Lisboa: Fundação Calouste Gulbenkian. pp 127–148.

Cid, J. S. (1937/1983). La leucotomie pré-frontale. Sessão de 26 de Julho de 1937 da Sociedade Médico-Psicológica – Paris. In *Obras I*. Lisboa: Fundação Calouste Gulbenkian. pp 267–269.

Coelho, E. (1923). *Das Relações do Estado Cerebral com o Estado Mental. O critério biológico em Neurologia*. Lisboa: Faculdade de Medicina da Universidade de Lisboa.

Fernandes, H. B. (1937/1998). Psicopatologia e Patologia Cerebral. In *Antropociencias da Psiquiatria e da Saúde Mental*. Lisboa: Fundação Calouste Gulbenkian. pp 359–377.

Fernandes, H. B. (1956). Novas perspectivas da Medicina. In *Associação Portuguesa para o Progresso das Ciencias. Tomo I*. Coimbra: Coimbra Editora. pp 187–208

Fernandes, H. B. (1966). *Filosofia e Psiquiatria. Experiencia portuguesa e suas raízes*. Coimbra: Atlântida Editora. pp 164–165.
Fernandes, H. B. (1979). Revivendo um ensaio de Sílvio Lima decapitado pela censura "O Amor Místico". *Biblos*. Coimbra. (Separata LV, 33 pp).
Fernandes, H. B. (1983). Prefácio. In J. M. Sobral Cid (Ed.), *Obras I*. Lisboa: Fundação Calouste Gulbenkian. pp VII-LXVIII.
Fernandes, H. B. (1998). Curso superior universitário de Psicologia. In *Antropociências da Psiquiatria e da Saúde Mental*. Lisboa: Fundação Calouste Gulbenkian. pp 349–351.
Freud, S. & Breuer, J. (1895/1956). *Études sur L'Hystérie.* Paris: PUF. pp 14–35.
Freud, S. (1932). *Sexualidade*. Lisboa: Editorial Ática.
Lima, S. (1935). *O Amor Místico. Noção e valor da experiencia religiosa*. Coimbra: Imprensa da Universidade de Coimbra.
Matos, J. (1911/1923). *Elementos de Psichiatria*. Porto: Livraria Chardron de Lello e Irmão editores.
Mónica, M. F. (1977). "Deve-se ensinar o povo a ler?": A questão do analfabetismo (1926–39). *Análise Social*, Vol. XIII (50). pp 321–353.
Moniz, E. (1915). As bases da Psychoanalyse. Lição do Curso de Neurologia. *A Medicina Contemporanea*. no 47. pp 377–383.
Moniz, E. (1917). *A Neurologia na Guerra*. Lisboa: Livraria Ferreira.
Moniz, E. (1921). O Conflito Sexual. *Portugal Médico*. no 9. pp 385–401.
Moniz, E. (1936). *Tentatives opératoires dans le traitement de certaines psychoses*. Paris: Masson.
Moniz, E. & Furtado, D. (1937). Essais de traitement de la schizophrénie par la leucotomie préfrontale. *Annales Médico-Psychologiques*. no 2. Juillet. pp 298–309.
Monteiro, A. F. (1925). *A Psico-Analise de Freud*. Coimbra: Tipografia Bizarro.
Oliveira, J. O. (1932). Nota explicativa da intenção do tradutor. In S. Freud (Ed.), *Sexualidade*. Lisboa: Ática.
Régis, E. & Hesnard, A. (1914/1929). *La psychoanalyse des nevroses et des psychoses. Ses applications médicales et extra-médicales*. Paris: Alcan.
Schneider, K. (1937). *Lições de Psiquiatria para médicos*. Coimbra: Instituto Alemão da Universidade de Coimbra.
Vieira, A. B. (1982). A psiquiatria perante o fascismo: contributo para a compreensão da experiencia portuguesa. In *Actas do Colóquio O Fascismo em Portugal*. Lisboa: A Regra do Jogo. pp 443–453
Von Monakow, C. V., & Mourgue, R. (1928). *Introduction Biologique à l'Étude de la Neurologie et de la Psychopathologie*. Paris: Felix Alcan.

# Chapter 17
# Recalibrating the Work of Juan Valverde de Amusco in the Sixteenth-Century Anatomical Revolution

**L. J. Fernández Rodríguez**

**Contents**



## Introduction

One of the main interests of Prof. Germán Berrios is the history of psychiatry. The study of some important figures and their recalibration in the history of medicine (physicians, not only alienists) has been a part of this work, which was recognized recently by the University of Alcalá de Henares (Lección Magistral Andrés Laguna). It is in this sense that this chapter draws on Valverde, a sixteenth-century Spanish anatomist, whose work and place in history have been the subject of much controversy. Here, taking a historiographical approach, we want to explore some of his work in its historical context to help shed light and balance to this particular figure in the history of medicine. Valverde has not been an easy figure for historiography: current studies must address the lack of biographical information and provide a cautious analysis of his scientific work.

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## An Unknown Biography

It is known that Valverde was born in Amusco (Palencia, Spain) around 1525 (Riera 1986). He initially studied humanities and philosophy, possibly in Palencia or Valladolid (Andretta 2009), and he perhaps felt an early vocation for medicine in one of the multiple hospital brotherhoods that existed at the time in his village, such as San Millán de los Palmeros or San Sebastián's. A historical fact gives us a certain light on his possible intervention as physician in that brotherhood: Paulo IV (1558) granted a bull in 1558 for the brotherhood of the Lord of San Sebastián de Amusco, for which Gabriel Guzmán, the abbot of the convent of San Sebastiano fuori le mura of Rome, authorized him to transfer the chaplaincy of San Sebastián from San Pedro of Amusco to the hermitage of Santa María de las Fuentes also in Amusco, with similar privileges to that of Rome (Redín Michaus 2007). It was possibly a gesture of gratitude from Valverde towards the confraternity and the hospital that could give him the opportunity to learn medicine.

It is likely that Valverde moved to Italy when he was very young, around the age of 17, on account of his possible Jewish origins (the Catholic monarchs had expelled the Jews from Castile only a few years earlier, in 1492), or because of the protection afforded to him by a son of the Duke of Alba: Cardinal Fray Juan Álvarez de Toledo, bishop of Burgos, Córdoba and Santiago and general inquisitor of Rome (González González 1984). However, it has also been suggested that he did not know him until the fifties, consistent with the fact that he dedicated his first book to Verallo (Hernández Mansilla 2014). Alternatively, his move may have been simply the result of his desire to learn anatomy, which in the Spain of the sixteenth century was limited by lack of teachers whilst, in Italy, it was at its peak. Several authors propose that Valverde lived in Padua, receiving his first lessons in anatomy from Realdo Colombo. The latter, since 1541, had the chair of surgery (which included anatomy). However, there is no documentary evidence for this. Two years later, Colombo moved to Pisa, where he held the chair of anatomy, and Valverde, at this point, was one of his assistants. Both were at this time possibly investigating the minor circulation of blood (Ballesteros Massó et al. 2000).

After a whole decade under the teaching of Colombo, we believe (again there is a lack of documents) that Valverde set out to achieve his professional title around the fifties in Rome. He lived there for most of his life, his presence first documented in 1550, at the autopsy of Cardinal Cibo (Riera 1986). It is documented that he taught medicine at the Holy Spirit Hospital of Rome in 1555, being a disciple of Eustachio, in the Faculty Medicae della Sapienza (Hernández Mansilla 2014).

There is no documentary evidence of his death, nor is it known where he is buried. The last documents of Valverde date from 1587, when, together with the custodian of the Vatican Library, Federico Rinaldi, he assigned the prices to the Greek and Latin manuscripts of Cardinal Sirleto (which were finally deposited in the library of the Escorial) (Redín Michaus 2007). However, a historical fact gives us a certain understanding: the existing documentation about the papal bull to the brotherhood of San Sebastián referred to previously (Cofradía de San Sebastián 1602),

which belonged to the hermitage, lets us know that Valverde had already died in 1602. The Latin edition in 1589 is no longer dedicated to Felipe II, which suggests that he could have died earlier – on the assumption that if he had lived, he would have continued dedicating his books to his king. Some authors think that he might have died in the previous year (Riera 1986).

It is unknown for certain if he returned to Spain. The authors who claim this base it on the existence of a text of the brotherhood referring to indulgences, which literally says that 'Dr Juan Valverde brought these indulgences'. The use of the word 'brought' rather than 'sent' is suggestive, and several authors think this happened in 1558 (Fernández Ruiz and Díaz-Caneja Candanedo 1959).

## Scientific Work

Throughout the Renaissance and Baroque periods, the descriptive phase of the human body was greatly developed: Vesalio, Realdo Colombo, Valverde de Amusco, Miguel Servet and William Harvey, along with many contemporaries, forever changed anatomical science, leaving us a vast number of anatomical structures to which their names were assigned (e.g. Eustacchio, Falloppio). It is in his Roman period that Valverde de Amusco wrote two known works, the first one in Latin, which was the scientific language of the time (1552), 'De Animi et Corporis Sanitate Tuenda Libellus', and the second, his main work, published four years later in 1556 in Spanish, 'Historia de la Composición del Cuerpo Humano'.

### *De Animi et Corporis Sanitate Tuenda Libellus (1552)*

At the time when hygiene treaties were proliferating, with the majority inspired by Galen's work, Valverde published a book of hygienic type, making multiple references to classical authors (Hippocrates, Celsus, Homer, Lucretius) (De la Cámara García 2017). There were two editions made of this book that, aside from some text in Italian, were written in Latin: one in Paris, in 1552, edited by Carolus Stephanum, and another in Venice, in 1553, edited by Domingo Lilio and dedicated to Cardinal Verallo (Fig. 17.1).

### *History of the Composition of the Human Body (1556)*

This second book, written initially in Spanish, brought Valverde to great recognition in the scientific world of the sixteenth century, though not without controversy, according to the historiography of Northern Europe. The main value of this treaty was in its dissemination of the new studies on anatomy by Vesalio and Realdo

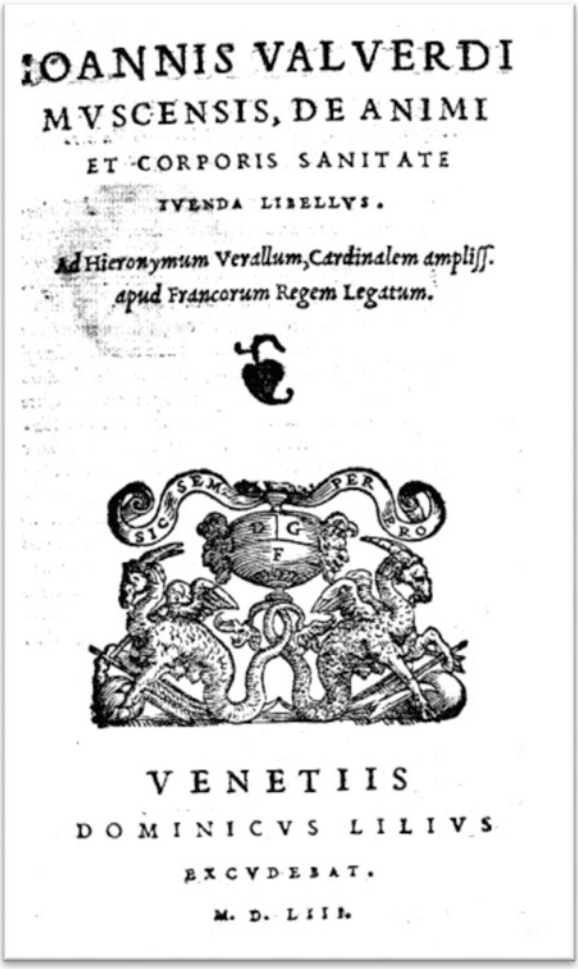
IOANNIS VALVERDI
MVSCENSIS, DE ANIMI
ET CORPORIS SANITATE
TVENDA LIBELLVS.
Ad Hieronymum Verallum, Cardinalem ampliſſ.
apud Francorum Regem Legatum.
VENETIIS
DOMINICVS LILIVS
EXCVDEBAT.
M. D. LIII.

**Fig. 17.1** De animi et corporis sanitate tuenda libellus. Venetian edition, 1553

Colombo, which Valverde completed or corrected following his own research, without neglecting to acknowledge his debt to both doctors (Granjel 1980). His knowledge of classical medicine is evident from the prologue of this work. Here he presents a compilation of the history of anatomy, from Hippocrates to Galen, and explains the reasons why he considers Galen's anatomical notions erroneous. In contrast to Galen, who based his study on the findings obtained from corpses of monkeys, the anatomist from Amusco (1556) studied in the human corpse:

> …so that anatomy was not only forbidden among living men, but it was also ordered that even in the dead it could not be done ... ... and it seemed to him that there was very little difference between the making of man and the monkey, he wrote this story of the composition of our body having, when he wrote, the female monkey in front... (Ballesteros Massó et al. 2000, p. 19) (Fig. 17.2).


**Fig. 17.2** Historia de la composición del cuerpo humano. First Spanish edition. Rome, 1556

This great work is composed of seven books and follows the same descriptive line of Vesalius – the prevailing idea of the time – and is in line with the concepts shown by Renaissance painting (Laín Entralgo 1991):

- Book I: Studies and describes the bones and cartilages of the skull, ear, face and teeth, with seven sheets of osteology; the hyoid; the spine; and the extremities.
- Book II: Corrects the teachings of Vesalius, and dedicates it to the nuclei and ligaments. It also includes 16 sheets of myelogy.
- Books III, IV and V: Studies the morphology of the organs of digestion and generation, the thoracic cavity, the cranioencephalic formations, viscera (digestive and urogenital apparatus, with six sheets of representation), a sheet of cardiorespiratory organs, three sheets of the central nervous system and the eyeball.

- Books VI and VII: Refers to the vascular system – with five laminae of the arteriovenous system and peripheral vessels – and to the cranial nerves and peripheral nervous system, four sheets on peripheral nerves.

In addition to making several corrections to Vesalio – up to 32 explicit rectifications –Valverde made important original contributions that may not have had the historical acknowledgement they deserve.

What stands out most in Valverde's work are, possibly, the chapters referring to osteology and myology – especially the ocular musculature – and the graphic representation, for the first time, of one of the ossicles of the middle ear previously described by Pedro Jimeno and Luis Collado: the stapes (López Piñero 2003). He also describes in his anatomy a theory, new at that time, that he learned from Colombo. He stated that the blood does not pass through the interventricular septum but arrives from the right ventricle to the left through the lungs (Alberti 1948).This description of the minor or pulmonary circulation of Valverde was published later than the description done by Miguel de Villanueva or Servet in his work *Cristianismi Restitutio*, three years before, in 1553 (González Echeverría 2011), which according to some authors Valverde possibly did not know (Guerra 1967). Valverde attests that, in terms of knowledge about the pulmonary circulation, his description is based on the findings of Realdo Colombo, but he publishes ahead of his teacher whose work does not arrive until 1559.

## The Illustrations

At that time, the most accurate method to capture or reflect a drawing was copper engraving (intaglio). However, it was more expensive and needed more time for its realization than wood engraving (xylography). The illustration of Vesalio's *La Fabrica,* drawn by Jan Stefan van Kalkar, a disciple of Tiziano, is good but presented some limitations in comparison to the one by Valverde: the figures were printed by woodcuts, whereas Valverde's anatomy is printed from copper engravings. This provided more precision and more elegance in the line although with its own limitation: copper plates could not be interspersed in the text: the illustrations are grouped at the end. Valverde acknowledges in the introduction that the images inserted in his book correspond, for the most part, to the engravings that Kalkar made for *La Fabrica*: out of a total of 254 illustrations, only 15 are original (Meyer and Wirt 1943), amongst which we can highlight the following:

- The skinned man (Fig. 17.3), depicting the direction of the muscular fibres*:*
  *... the shadows show the walk of the thread of the meat according to which in each 'morcillo' (muscle) they particularly walk...* (Book 2, Table 1),
- Image of the urethra in longitudinal section (Book 2, Table 16),

**Fig. 17.3** Historia de la composición del cuerpo humano. The skinned man

- The Venus with the open abdomen (Book 3, Table 6),
- Eye muscles (Book 2, Table 15),
- Images of the superficial vein tree (Book 6, Table 1).

Only two of them have a signature, with the initials 'NB', that belong to the copyist and engraver Nicolas Beatrizet, who also signs the portrait of Juan Valverde in his anatomy.

But Beatrizet was only the engraver. The drawings are attributed mostly to Gaspar Becerra, with some disagreements that are based on the fact that Valverde did not name Becerra but, rather, flattered the painter Pedro de Rubiales in his work (Redín Michaus 2007).

## The Editions and the Great Diffusion

The writing of the book was completed in September 1554, when he finishes the prologue. Two years later, in 1556, Valverde's book was published for the first time in Rome, in Spanish, by three printers: Martínez de Salamanca, Antonio Lafrèri and Antonio Baldo de Asola. He initially thought about dedicating the book to Pope Paulo IV, who granted a papal bull authorizing the work and the license granted for its publication. It also imposed *excomunion latae* (lactation excommunication) and a fine of 100 ducats to those who sold or printed the work without the consent of the author over a period of 10 years. But the book was finally dedicated to his protector and patient Juan Álvarez de Toledo, already cardinal and inquisitor general of Rome. In the dedication, Valverde writes the following:

> Considering, Illustrious Lord, the great lack that our nation has of men who understand Anatomy... Because it is an ugly thing among the Spanish to tear the dead bodies apart, as there are few who came to Italy where they could learn it ... ... and seen the damage that follows to the whole Spanish nation, in part by the surgeons (who most need not understand it) to know little Latin, in part for having written Vesalius so obscurely that it can hardly be understood, but rather those who have sometimes had the body before their eyes, and a very good teacher to declare it, it seemed to me very convenient to write this history in our language, because those for whom I write could better enjoy my fatigue and because in Latin they have written so many, that it did not seem so necessary to work so much ... (Valverde de Amusco 1556, p. ∗ii, my translation).

Perhaps due to the conciseness and clarity of Valverde, the diffusion was made very fast. Three years later it was published by Nicolo Bevilacqua, bookseller in Vico sanctae Martinae, Venice, with the title 'Anatomia del corpo humano'. This edition is already dedicated to Felipe II, possibly because Juan Álvarez de Toledo had died two years before, in 1557. It was reissued the following year, 1560. Another edition was printed, in Venice, at Giunta publishers, in 1586, with reprints in 1606, 1608 and 1682. It was also translated into Latin. In Amberes, Christophe Plantin made a compilation in 1566 that was translated by the French doctor Thorius: 'Vivæ imagines partium corporis humani æreis formis expressae' (reprinted in 1572, 1579). In 1589, in Venice, the publisher Giunta published it with a translation by Michelle Colombo, where some more sheets were added – also on copper. It was reprinted in 1607 and 1608. Subsequently other editions appeared in 1657 and 1682, in Venice. Two years after the first translation into Latin, we can see the tables translated into Flamenco, but not in its entirety. It is Christophe Plantin, in Amberes in 1568, 1572 and 1583, who entitled it 'Anatomie, oft levende beelden vande deelen des menschelicken lichaems'. Much later, in 1730, we can see it in a reduced version in French, in Paris (F. Gerard Jollain): L'anatomie universelle de toutes les parties du corps humain. And in 1738, Patousas and Petakes translated it into Greek.

There were also numerous partial publications and others that copied its covers. Such a number of editions, reprints or partial publications have affirmed to researchers in this field that it was the book of anatomy more read and more studied than any other in the Renaissance period, above those of Vesalio or Colombo (Castiglioni 1941).

## Controversy with Vesalio

Some specific indications appear in the book expressly to highlight several errors of Vesalio (1543) in his famous *On the Fabric of the Human Body*, such as the proximal insertion of the abdominal rectus muscles – which Vesalius carries to the clavicles – and the description of the stapes of the middle ear and the nasal septum, the joints, the fingers, the hands or the aponeurosis of the abdominal muscles. Valverde also makes corrections in his anatomical sheets (1556), modifying those of Vesalio when he believes it necessary, always explaining the reason for what he does: '... I just want to warn the reader that the first figure is different from Vesalio's because his is not well done as each one will see...', or '... This figure differs from that of Vesalio because in this we do not see the "morcillos" but as they are in man, and in his there are some that are found in monkeys and other brute animals ...', or '... This figure differs from that of Vesalio because in this the second pair of "morcillos" of the head is not like his because it seems to me very confusing ...' (Valverde de Amusco 1556, p. ∗Mii, my translation).

Such corrections and drawing of attention to errors in the work of Vesalio, in the critical anatomical environment of the time, might have in turn influenced Vesalio (1564) (who had read the enthusiastic defence made by Falloppio [also Valverde's teacher] of his work) to issue a harsh criticism of Valverde:

> Who never used his hands to cut neither for medicine, nor for the vine, is ignorant of the main disciplines. And I translate to the Spanish language in this our art only because of the clumsy gain (clumsy profit) (Vesalio 1564, pp. 72–73).

Despite the corrections, Valverde had not confronted Vesalius in a hostile manner, but made constant references to his scientific contributions, in which his respect for the master is evident: ... 'but I will do so for deviating from Vesalio as little as possible.' In the prologue (addressed to the reader), he justifies his use of the Vesalio illustrations: 'Although it seemed to some friends of mine that I should make new figures, without using Vesalio's, I did not want to do it to avoid the confusion that could arise from not knowing so easily in what I agree or disagree with him, and because his figures are so well done that I felt like invidia or malignancy, not wanting to take advantage of them.' (Valverde de Amusco 1556, p. ∗ii, my translation). Similar treatment was granted to Colombo: when he mentions the minor circulation of blood, at the time recently studied by his teacher, he makes it stand out.

## Conclusions About Valverde's Anatomy Book

Within the historiography, we appreciate three positions on the figure of Valverde.

First is the favourable position like that taken by Chinchilla (1841) or Hernández Morejón (1842), who, with Spanish fervour, say that Valverde's work is preferable for many reasons to that of Vesalio. They dismiss as slanderous the opinion of

historians who classify him as an abbreviated copy of Vesalio. Similarly, Broussais (1834) extols the figure of Valverde, pointing out that his was the only anatomy of our country (forgetting that of Laguna).

Second is the position of those who simply ignore Valverde's contribution to modern anatomy, such as Burggraeve (1880) or Singer (1925). And, the third position is the one taken up by those who view the work of Valverde as a copy or mere continuation of the anatomical revolution initiated by Vesalius. Amongst these we can highlight Kurt and Sprengel (1840) or Eloy (1755). The latter affirmed that the greatest praise Valverde has been given is that he manifested a greater zeal to encourage his compatriots to study anatomy than to illustrate them with his writings. This third position lasted until August Hirsch (1962) rectified it.

We believe that his novel contributions (e.g. the minor circulation, the description of the stapes), his use of the scientific method and his role as cultural mediator connecting the academy and the actual exercise of medicine should be recognized. We also believe that, even though Valverde's anatomical work was initially carried out 'so that the Spaniards can better enjoy my fatigue... and because in Latin... I did not feel the need for new work' (referring to Vesalio's *La Fabrica*) (Valverde de Amusco 1556, p. ∗ii, my translation), the fact that it was the most read anatomy book in the Renaissance should be acknowledged in history.

There remains the curious fact that although Valverde clearly identified himself with Vesalio's work, nevertheless, Vesalio's harsh response to Valverde (which went beyond professional criticism) was able to influence the position of the Northern European historiography that accuses Valverde of plagiarism (we must remember that Vesalio was born in Brussels). However, we do not think that the said historiography has responded satisfactorily to two very simple questions: Why was the clarification that Valverde makes in his prologue not considered valid and sufficient? Why has there been this black legend created about Valverde over so many years?

We would argue that these accusations of plagiarism are not supported by solid arguments and that even a relatively superficial examination of his work is enough to understand Valverde's intentions. A contextualized study of Valverde's work justifies neither the accusation of plagiarism of *La Fabrica* nor the reactive and excessive praise by the historians of Spanish medicine. Rather, he should be considered as a researcher who uses the scientific method, who gathers information from his teachers and who, on occasion, criticizes them. As López Piñero (2002 p. 218, my translation) says, 'It cannot fit into [...] the so-called Spanish Vesalian movement. Although written in Spanish by a doctor born in Spain, it was the result of a work carried out in post-Vesalio Italy'.

Therefore, the position we hold is the one shared by those who study their anatomical lexicon and their iconographic representations and who try to base their judgements about the anatomist and his work on the investigation of primary sources and their historical contextualization.

## References


Alberti, L. (1948). *La anatomía y los anatomistas españoles del Renacimiento* (pp. 81–130). Madrid: CSIC.

Andretta, E. (2009). *Juan Valverde, or building a 'Spanish anatomy' in 16th century Rome*. Florence: San Domenico di Fiesole: EUI Working Papers.

Ballesteros Massó, R., Gomez, E., Jumilla, J. L., Chacon, M., Ferrer, M. M., Moreno, R., González, M., Vicente, J. R., Prados, J. C., Vélez, C., Castro, R., Martín, M., & Melguizo, C. (2000). *Láminas Anatómicas de Juan Valverde de Amusco*. Granada: ICN Ibérica.

Broussais, F. J. V. (1834). *Atlas historique et bibliographique de la médecine*. Paris: Bailière.

Burggraeve, A. (1880). *L'Histoire de l'Anatomie*. Paris: Ch. Chanteaud et Cie.

Castiglioni, A. (1941). *A history of medicine*. New York: Alfred A. Knopf.

Chinchilla, A. (1841). *Historia de la medicina española. Volumen 1*. Valencia: Valencia, Imprenta de López y Compañía.

Cofradía de San Sebastián (Amusco, Palencia). (1602). *Documento*. Palencia: Archivo diocesano de Palencia.

De la Cámara García, M. L. (2017). *Juan Valverde de Amusco: ¿un médico galenista o anti-galenista?*. En Santamaría Hernández, M. (Ed.). *Traducción y transmisión doctrinal de la medicina grecolatina desde la Antigüedad hasta el mundo moderno* (pp. 109–132). Cuenca: Universidad de Castilla-La Mancha.

Eloy, N. F. J. (1755). *Dictionnaire historique de la médecine*. Liége: Bassompierre.

Fernández Ruiz, C., & Díaz-Caneja Candanedo, E. (1959). *Historia de la medicina palentina*. Palencia: Tello Téllez de Meneses.

González Echeverría, F. J. (2011). *El amor a la verdad. Vida y obra de Miguel Servet* (pp. 38–68). Pamplona: Publicaciones del Gobierno de Navarra.

González González, J. (1984). *Historia de Palencia. Excma*. Palencia: Diputación Provincial de Palencia.

Granjel, L. (1980). *La medicina española renacentista*. Salamanca: Ediciones Universidad de Salamanca.

Guerra, F. (1967). *Juan Valverde de Amusco. En Clio Med II,* 339–362.

Hernández Mansilla, J.M. (2014). *La idea de hombre en Juan Valverde de Amusco*. (Doctoral thesis) Universidad Complutense. Madrid.

Hernández Morejón, A. (1842). *Historia Bibliográfica de la Medicina Española. Obra Póstuma de Don Antonio Hernández Morejón*. Valencia: Ed. Viuda de Jordán e hijos.

Hirsch, A. (1962). *A Biographisches Lexikon der hervorragenden Aerztealler Zeiten*. Wien: Urban & Schwarzenberg.

Kurt, P., & Sprengel, J. (1840). *Storia prammatica della medicina*. Florence: Tipografia della Speranza.

Laín Entralgo, P. (1991). *Presentación de la reproducción facsímil Historia de la composición del Cuerpo Humano. Biblioteca de clásicos de la medicina Española*. Madrid: Fundación Ciencias de la Salud Ed.

López Piñero, J. M. (2002). *La medicina en la historia*. Madrid: La Esfera de los Libros.

Lopez Piñero, J. M. (2003). *Los saberes morfológicos y la ilustración anatómica desde el renacimiento al siglo XX*. [Online] Issuu. Available at: https://issuu.com/faximil/docs/estudio-pinero. Accessed 30 Apr 2019.

Meyer, A. W., & Wirt, S. K. (1943). The Amuscan illustrations. *Bulletin of the History of Medicine, 14*, 667–687.

Paulo, I. V. (1558). *Bula papal*. Palencia: Archivo episcopal.

Redín Michaus, G. (2007). *Pedro Rubiales, Gaspar Becerra y los pintores españoles en Roma, 1527–1600*. Madrid: Consejo superior de investigaciones científicas.

Riera, J. (1986). *Juan Valverde de Amusco y la medicina del Renacimiento*. Valladolid: Universidad de Valladolid.
Singer, C. (1925). *The evolution of anatomy*. London: Kegan Paul.
Valverde de Amusco, J. (1552). *De animi et corporis sanitate tuenda libellus*. Paris: Carolus Stephanum.
Valverde de Amusco, J. (1556). *Historia de la Composición del cuerpo humano*. Roma: Antonio de Salamanca & Antonio Lafrèri.
Vesalio, A. (1543). *Humani corporis fabrica*. Brussels: Joannis Oporini.
Vesalio, A. (1564). *Anatomicarum Gabrielis Falloppi observationum examen*. Venecia: Francesco de' Franceschi da Siena.

# Chapter 18
# August Wimmer's Concept: Psychogenic Psychoses, *a Source-Critical Study*


**Johan Schioldann**

*Nobody working [under August Wimmer] could escape his urgent demands for the understanding and description of [the] patients – understanding before description*
Erik Strömgren, 1975

*There is one truly serious question in psychiatry and that is psychogenesis*
German E. Berrios 2003

## Contents



As Strömgren wrote to Berrios (Stromgren correspondence, 28 Dec. 1989), 'although on several occasions, I have written on the psychogenic psychosis, it is obvious that there are still fundamental misunderstandings concerning this concept' (see Strömgren 1989). The object of the author's study is to explore in some depth Wimmer's texts on these forms of psychosis in order to shed light on the origin and development of his seminal concept and to establish the extent to which this was influenced by Magnan's doctrine of *terrain préparé (préformé), délire d'emblée* [d'emblée = at once]*, bouffée délirante* [bouffée = puff, gush]*, les délires des dégénérés* (Magnan 1893; Magnan and Legrain 1895; Magnan 1897), originally inspired by Morel's teachings (1857, 1860). Furthermore, the aim is to re-examine the much-debated issue whether or not Wimmer had based his definition of the psychogenic

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psychoses on the 'reactive psychoses' of Jaspers (1913a, b). To undertake this task, it is necessary to examine (1) Wimmer's doctorate 'Evolutive Paranoia' (1902), locked in the Danish language and (2) the unabridged translation of his monograph, 'Psychogenic Psychosis Forms' (1916), not rendered into English until 2003 (Schioldann 2003).

Strömgren (1940: 20–1, 92; Strömgren/Schioldann 2014) stated that Magnan's 'syndromes épisodiques' (1895) 'encompass both psychotic reactions and certain neurotic exacerbations' and that Magnan's psychosis types are 'first and foremost, psychogenic psychoses in psychopaths'. As a 'particularly well-known syndrome', he characterized 'the acute paranoid reaction', the so-called délire d'emblée, and with regard to its underlying paranoigenic temperament, he referred to Wimmer. (He had worked under him from 1935 until his death in 1937). In 1972 Strömgren succinctly summarized it to the effect that the first comprehensive descriptions of psychosis-like conditions are found in French psychiatry under the term 'Délires des dégénérés' (Magnan and Legrain), and that these paranoid reactions were observed to occur on the soil of constitutional fragility, in other words *terrain préparé (préformé)* in Magnan's doctrine. Strömgren (e.g. 1987, 1992) subsequently went on to show that the previous term 'constitutional psychoses' in Norwegian psychiatry and 'psychogenic psychoses' in Danish psychiatry dated back to 'the old French degeneration theory', thus the *bouffées délirantes*, and were to be found under the Magnanian categories and terms.

Wimmer's thesis was in his own words (p. 5) 'a study of paranoia conditions, which in Magnan are collected under the term, *délires systématisés des dégénérés'* (1893). He gave a comprehensive historical overview of the teachings of paranoia in the nineteenth century (9–31, 2018–19), foremost crediting the French psychiatrists with *'Magnan in the lead'* for having finally, during the 1880s and 1890s, provided a comprehensive, yet simple, *clinical* foundation for a *natural* classification of the paranoia forms. Until then, he said, French views had not advanced much beyond those of Lasègues and Morel; the paranoia forms had usually been described under the collective term *délire de persécution,* of which only its symptomatology had been explored in depth (Magnan and Legrain 1895: 15ff., 36ff.,). Still, according to Wimmer, it is to the great merit of Magnan and his pupils for pointing out that in the concept of paranoia by the earlier authors, a sharp distinction should be made between two kinds of paranoia, whose symptomatology, course and aetiology showed an essential difference (1902: 23 f.; 2018–19).

Magnan (1893: 236ff.; Wimmer 1902: 24, 2018–19) first separated out a group, termed *délire chronique à évolution systématique*, which generally affects previously healthy individuals, who show no signs of intellectual, moral or affective disturbances and which is characterized by its long duration and continuously progressive course. From these chronic conditions, Magnan sharply distinguished all non-chronic paranoid conditions and collected them under the term *délires des dégénéré.* According to Magnan's doctrine (Magnan 1893: 345; Wimmer 1902: 24 f., 2018), these heterogeneous conditions are held together in a *nosological main group* through (1) their absolute *connectedness* with *inheritability* and *psychic degeneracy*, (2) their mode of *development,* and lastly (3) their *outcome.* Since childhood, these

individuals have shown all the signs of 'déséquilibration mentale', *psychical* disharmony, and long before the onset of the illness, such abnormalities can have shown in their character – 'abnormal drives, obsessive thoughts etc.' – his 'stigmates psychiques'. In contradistinction to the chronic forms, the paranoia ideas erupt suddenly, '*d'emblée*', full blown, usually without hallucinations. There is no progression and no transformation of the *délire*; it is stable, 'is today as it was yesterday'. The persecutory and expansive ideas exist side by side, or the *délire* is even more 'polymorphous', a variegated and changing mixture of expansive, persecutory, religious, hypochondriacal, and other features. Their duration varies considerably; some cases with acute onset subside in days or weeks and others of more chronic development and more systematized persist unchanged for life, often with acute exacerbations ('*bouffées'*). The prognosis for these conditions is better than in *délire chronique*, and 'even if cure does not occur, termination in dementia is rare' (Wimmer 1902: 25, 97; Saury 1886; Magnan and Legrain 1895). Magnan terms the first form of these degenerative paranoia conditions *les persécutés persécuteurs* with the subgroups *les processifs, les menaçants, les hypochondriaques, les filiaux and les amoureux* (Magnan 1893: 321; Wimmer 1902: 25). Some cases develop into *délire systématisé chez les dégénérés* (1893: 334), which can develop already in infancy.

Wimmer (1902: 35, 2018) proceeded to describe 'the peculiar' *psychic* degeneracy condition, *paranoigenic degeneracy* (*temperament*), which *in nuce* contains all the elements of the ensuing paranoia. Its abnormal mode of thinking and feeling is preformed; nothing new needs to be inserted into the consciousness. It is a simple hypertrophy of the habitual character, a richness of all psychic abnormalities – 'and the paranoia is on the scene', the psycho-pathological process being that of a simple evolution. As the terminal paranoia only signifies a crystallization in an oversaturated compound through an *evolution,* Wimmer found that the term *evolutive* for these paranoia forms 'would be more telling' than the Magnanian *délires des dégénérés.*

Wimmer's (1902: 37ff., not in 2018 ed.) aim was to follow this up with his own studies on paranoid degeneracy, and in doing so to examine its pathophysiological basis, its possible anatomical substrate, its most 'essential' clinical features and a description of the symptomatology and classification of the evolutive paranoia forms. 'Supported by the authority of Magnan and continuing to draw on his wealth of clinical facts' (1902: *37*), he wanted to 'rewrite' a single field of the 'broad-ranging' psychical degeneracy conditions, such as they had been described since Morel (1857, 1860: 513ff. ) by, for instance, Campagne, Griesinger and Schüle. Nobody but Magnan, however, Wimmer emphasized, had been able to put together the '*protéiformes polymorphes'* pictures (Magnan 1897: 135) of the 'délires dégénératifs multiples', based on simple and clear viewpoints.

Magnan's three states of degeneracy were (1) the permanent mental state, *état mental* ('déséquilibration'), usually associated with more (2) episodic phenomena, *syndromes épisodiques*, culminating in (3) insanity proper, *état délirant* (Wimmer 1902: 38).

First Wimmer wished to examine more closely the habitual psychical abnormality of individuals belonging to group 1, to search for the roots of its 'multiples et

disparates' temperamental psycho-physiological aspects (Magnan 1897: 36–7), and pathophysiological basis (Wimmer 1902: 38). Wimmer (1902: 76) stated that the building blocks, i.e. delusions and hallucinations, of the two forms of evolutive paranoia (the degenerative and the chronic), are the same. Therefore, the differential diagnosis is based on their respective modes of development. In the 'degenerative' type, he distinguished between *juvenile forms* and *tardive forms* (at a more 'mature' age).

*Juvenile forms* (p. 93) are usually marked by a rather sudden onset, a *délire d'emblée* or subacutely. A polymorphous symptomatology is typical. The course can be interrupted by remissions, intermissions, resulting in partial or full insight into the illness. A relatively rapid manifestation of *dementia* can occur due to a less resistant brain, *ab ovo,* resulting in 'logical' (paranoid) 'démence vésanique' [ne sania, i.e. insanity], Wimmer emphasizing that this kind of dementia, in principle, is *unrelated* to Kraepelin's *dementia praecox* (hebephrenia, catatonia) (Wimmer 1902: 96–7). He included eight case histories.

*Tardive forms* (p. 115) – the latent psychoses – can occur *d'emblée,* but they usually reach their 'période de floraison' more gradually, interspersed with intervals (often marked by anxious depressive features). Polymorphous symptomatology is not typical; it is essentially *uniform,* as a persecutory paranoia or an expansive paranoia. The course is predominantly chronic. Wimmer divided them into two subgroups: (1) *persecutive forms* ('les persécuteurs processifs', 'morbid jealousy', 'paranoia sexualis', 'hypochondriacal paranoia') and (2) *expansive forms* ('les persécuteurs amoureux', 'monomanie érotique', 'erotomania', 'religious paranoia', 'délire mystique', and 'paranoia reformatoria sive inventoria', 'paranoia philantropica'). He included 10 case histories.

It is obvious that Wimmer's 1902 thesis foreshadowed his later concept: *psychogenic psychoses,* introduced into Scandinavian psychiatry, in 1913. The term *psychogenic* had been introduced by Sommer (1894). Reiss (1910) related that Magnan's views on paranoid illness were being confirmed by certain psychosis forms in criminals, developing in a specific 'degenerative' terrain as a 'corresponding' reaction to external unpleasurable conditions, and in individuals with querulous paranoia and in pathological swindlers. He referred to authorities, the likes of Birnbaum, Bonhoeffer, Siefert and Wilmans. Finally, he laid down comprehensive criteria for pure reactive depressions (*rein reaktive Depressionen*) (415ff.):

> The *precipitating* cause ('der Anlass') must be a severe emotional trauma capable of deeply shaking the patient. […]. The depression must develop in immediate connection to the trauma. The florid symptomatology must rapidly reach its climax, although, at times, it can subside abruptly or slowly, in accordance with the individual reaction mode. The content of the morbid ideas must be congruent with the precipitating experiences, or at least be directly understandable within the context of the individual's characteristics. The duration of the psychosis must not be too long. […]. [P]sychogenic symptoms also occur quite often in 'all forms of circular illnesses', not to mention the fact that in '*psychopathischen Reaktionen'* these can be predominant to the point of dominating the whole picture. [The latter] particularly occur in the 'more psychogenic type' with more easily provoked psychotic manifestations in the context of a tendency to violent outbursts of affect in response to emotional upheavals. (Translated by JS).

Subsequently, Jaspers (1913a/1963: 336–7) related that in Germany the 'verstehende Psychologie' had given psychiatry fresh impetus with the teachings of the '*reaktive Psykosen'* (Bonhoeffer, Wilmanns, Birnbaum, 'among others'), which especially were studied in the abnormal states of custody and incarceration [cf. Reiss' statements, added by JS] (translated by JS). The *reactive psychosis,* he emphasized, only erupts in response to unpleasurable experiences ('*unlustvolle Erlebnisse'*):

> In *reactive* psychoses one observes either an *immediate* reaction to a crucial experience or after *prolonged* unnoticed ripening in the understandable connection with the destiny ('Schicksal'), and the daily recurring impressions, as it were, an eruption ('eine Entladung'). Upon the termination ('Ablauf') of the psychosis, there certainly exists the ability unreservedly to judge it as sick. But there is tendency for an after-effect ('Nachwirkung') of the psychotic contents to persist, which have grown out of the destiny ('Schicksal'), also onto the further life and thus the tendency, in spite of *intellectually* correct judgment, not to be able *emotionally* and *instinctually* freely to face the morbid contents. (1913a: 329ff., 1963: 342) (Translated by JS).

In Jaspers' *Allgemeine Psychopathologie,* published later the same year (1913b), he recapitulated his exposition of '*reaktive Psychosen'* and 'summarized' what is common to *genuine reactions* ('echte Reaktionen') (p159f.) contrasting the *pure precipitation psychoses* ('bloss ausgelöste Psychosen'):

> The cause, which stands in close time-relationship with the reactive state, is sufficient for our understanding. There is an understandable connection between the contents of the experience and the contents of the abnormal reaction. […] As it is a matter of a reaction to an experience, the abnormality will remit in the course of time. Especially with the cessation of the cause […] the abnormal reaction ceases. In this way, the reactive abnormality contrasts with all spontaneously occurring morbid processes. (Translated by JS).

At the First Nordic Psychiatrists' Congress at Copenhagen, in August 1913, *psychogenic psychoses* were a main topic, presented by Ragnar Vogt of Oslo and Wimmer (Krabbe 1913: 1479–85). Vogt related that the *psychogenic psychoses* are excessive manifestations of normal psychic reactions, which are based on an anomaly of constitution and manifested as a low cohesion of personality. Wimmer stated that *psychogenic psychoses* are a reactive phenomenon, 'a natural elaboration of Magnan's teachings of degeneration', and that the doctrine of psychogenic psychoses in itself 'is not new', but which Kraepelin had 'checked too strongly'. Wimmer opined that the 'fundamental lack' in degeneracy is a *strong dissociability*, and if psychogenic psychoses ensue, it manifests itself in two different groups of individuals: (1) *emotional individuals*, in the form of *explosive-emotional psychoses* and (2) *individuals of paranoid temperament*, in the form of *psychogenic paranoid psychoses*, 'the essential features of which had been described by Magnan'.

Eventually, Wimmer (1916, 2003) published his *136-page* monograph: *Psychogenic Insanity Forms,* of which he gave the following precise, comprehensive definition (1916: 85; 2003: 87):

> In accordance with foreign authors, by psychogenic psychoses we will in the following understand the varied *clinically independent psychoses*, whose main feature is that, *most often, on a* (specific) *predisposed terrain, they are precipitated by psychic causal factors*

> ('psychic traumata') and in such a way that *these pathemata are determinant for the time of the eruption* of the psychosis, for the *movements* of the illness (remissions, intermissions, exacerbations), very often also for its *termination*, as well as, *in its form and content, the psychosis,* more or less directly and totally ('comprehensively'), *mirrors the precipitating psychic causal factor*. Moreover, to these criteria we can add the predominant tendency of these mental illnesses to *recovery*, specially that they *never terminate in dementia*. (Translated by JS).

Wimmer reiterated (1916: 85; 2003: 87) that it was 'a further elaboration of a speech delivered at the Copenhagen Congress, in August 1913', and next (p. 85) he referred to Reiss (1910). He also stressed the importance of individual factors and the importance of Magnan's teachings:

> The doctrine of the psychogenic psychoses testifies to a reaction against Kraepelin's earlier teachings, and it has found most of its advocates in Germany, also denoting a rapprochement to *French* psychiatry. […] In Magnan's teachings of *les délires des dégénérés*, many of the principal features of the psychogenic illness pictures are clearly outlined (1916: 85; 2003: 87).

As in 1913, Wimmer (1916) distinguished between (**A**) *affective psychogenic psychoses,* now with the subgroups (1) *psychogenic depressions,* (2) *psychogenic exaltations,* (3) *psychogenic stupor states* and (4) *affect crises,* and (**B**) *paranoid psychogenic psychoses* with the subgroups (1) *persecutory forms* and (2) *expansive forms*. He included 24 'fresh' illustrative case histories.

According to Wimmer, in psychogenic psychoses, the most essential task is to grasp the pathogenic psychomechanisms. The *outer appearance* of the condition is of more secondary interest. The same considerations apply to the question regarding *the diagnosis* of these mental illnesses. It can be asserted with confidence that these days no psychiatrist believes that we have isolated symptoms that are pathognomonic of certain forms of insanity, or pathognomonic illness pictures in *the* sense that it was presumed just a few years ago. The radical scepticism that has been voiced by various parties (e.g. Jaspers [Wimmer referring to Jaspers 1913b: 257 f. cf. [p. 264]) even concerning the mere *possibility* of a stringent psychiatric systematism, need not be shared to concede that the diagnosis of a concrete picture of insanity must not be made on the basis of certain kinds of delusions or hallucinations, 'catatonic' features, negativism, catalepsy, stereotypies, 'affectedness', speech confusion, Ganser's syndrome, emotional apathy, 'autism', impulsions, etc. (Wimmer 1916: 212; 2003: 227). [*But***,** added by JS] [t]he rather rich and particularly more *persistent combination* of certain symptoms *can* [emphasis by JS] point in the direction of certain more fixed illness pictures, but it is only by means of an *in-depth psychopathological scrutiny of the concrete case of illness*, by attempting to 'understand' its genesis, its symptomatological definiteness, etc., that *one can arrive at the right diagnosis with reasonable certainty* (Wimmer 1916: 212; 2003: 227, see Jaspers 1913b: [p. 264], quoted by Wimmer).

Wimmer would probably also have read Jaspers' publication, *Die Lehre von den reaktiven Psychosen* (1913a: 171ff., 1963: 339, 344), where he wrote:

> That the concept of reaction seems to have undergone a transformation from being one of a degenerative group of illnesses (*degenerative Krankheitsgruppe*) to a general

> psychopathological concept with which to denote abnormal mental states, which occur in all or many otherwise quite different psychoses […] We strictly distinguish the causal factor (*das kausale Moment*) from the understandable connections (*von den verständlichen Zusammenhängen*) [and] we never believe that a mental illness can be explained on the basis of a 'psychische Ursache' *alone*, even though, to a large extent, we can understand its way of manifesting psychologically. (Translated by JS).

It is evident that Wimmer does not agree with Jaspers. Wimmer also briefly mentioned jealousy paranoia (1916: 132, 203; 2003: 140, 217; 1936: 514; 2011: 486 f.), referring to a work by Jaspers, 'Eifersuchtswahn' (1910: 567ff; 1963), to point out that this paranoia form is an 'exquisitely' degenerative illness, 'a psychogenetically triggered hypertrophy of a specific paranoigenic predisposition', whereas in Jaspers' opinion it occurs in all types of psychoses and in psychopathic individuals.

Wimmer emphasized that it is only with the 'understanding psychopathological analysis' that *the individual symptoms or syndromes* attain their diagnostic value, though only *relatively.* The diagnosis of the psychogenic psychoses must be judged against most of the other insanity pictures. To a high degree, it is a *diagnosis of exclusion.* In practice it is generally a question of excluding three forms of insanity: manic-depressive psychosis, dementia praecox [Kraepelinian concept] and the schizophrenias [Bleulerian concept], and the paraphrenic insanities. The exclusion of the former two forms of insanity is especially important in relation to the affective-psychogenic psychoses, whereas in degenerative paranoia conditions it is especially the delimitation from the paraphrenias (Kraepelin) and dementia praecox paranoides.

The differential diagnosis, according to Wimmer, finds a *first point of support* in the generally demonstrable *psychogenic diathesis*, the explosive-emotional or paranoigenic temperament. *Another* point of support is the actual *psychic trauma* and the ensuing insanity's chronological-clinical connection with this and in the direct or more or less masked way in which the trauma is reflected in the psychosis. Finally, the *third general criterion* is the often readily visible way in which, *in accordance with external influences,* the illness picture *swings* in intensity, symptoms, etc. In particular, contrary to most manic-depressive and schizophrenic illnesses, *affective-psychogenic mental illnesses* frequently have an *acute or peracute onset* and just as brusque a *termination*. A residual *amnesia* for the illness attack, particularly when of a very absolute or elective nature, will usually point strongly towards a psychogenic form of insanity. Lastly, the affective-psychogenic insanities *do not terminate in dementia*. This *criterion* is crucial in the distinction between the *paranoid psychogenic psychoses* and the 'paraphrenias and dementia paranoides'. From a differential diagnostic point of view, in the degenerative paranoias, one must also give consideration to their psychogenic causation, their special genesis, their particular development or often lack of development ('sterility'), their 'monomaniac' stamp, the rather frequent admixture of contrary symptoms (delusions, etc.), or of affective-psychogenic episodes, or phases (sometimes with ensuing amnesia), and their constant, but varying conspicuous sensitivity to external impressions. Most decisive is the psychopathological *structure* of these paranoia forms. Vis-à-vis paranoid schizophrenias and paraphrenias, the *missing psychic dissolution process*

(possibly with catatonic features) is decisive, and a couple of factors, which can lead to diagnostic errors, if insufficiently analysed, must be emphasized.

In the earlier stages of the illness, or only manifesting gradually, Wimmer emphasized, an *emotional blunting* of varying degree can be encountered. Here it must be remembered, however, that this can be *habitual* for the particular patient (Bonhoeffer) and only temporarily masked by the strong emotional manifestations of the overvalued or paranoid ideas. At other times, for example, in certain cases of querulous and erotomaniac chronic forms of paranoia, the affective fading is an expression of the effect of *ageing* or an artefact, resulting from the monotonous life in the psychiatric hospital. Another factor is that in degenerative paranoias, the paranoid ideas either temporarily (e.g. during affect-caused exacerbations) or gradually can assume the stamp of the *singularly 'incomprehensible*', very easily leading to a diagnosis of dementia praecox. Wimmer thought that we are often too strict in our demands concerning 'the logic' of the paranoid ideas in these patients. Their ideas are *catathymic*, born out of emotions with their altered state of consciousness, which, subsequently, are maintained through the same strongly emotional psychomechanisms, and, therefore, we should not go too far concerning correct 'syllogisms' from the patients, but, as often also is the case in emotionally normal individuals, allow for some 'jumping to conclusions'. The paranoid person senses a great number of his paranoid ideas with his 'feelings', in the proper sense of the word, so that he can only poorly, or not at all, explain the underlying and connecting ideas to himself and the doctor.

Whilst, as Wimmer said, more detailed differential diagnostic *pointers* can, at times, be gleaned from the particular form of certain individual symptoms (Kraepelin 1915: 1774ff), these do not appear to be significant for the diagnosis of the *concrete* illness picture. All psychogenic illness pictures, including those of certain paranoia forms, demand their special and intimate psychoanalyses, because we are not dealing with 'illness entities' but at the most with 'types' (Wilmanns) or with individuals, who concerning the decisive aspects are 'only congruous with themselves'. As a last point, concluding his monograph, Wimmer reiterated that the *prognosis* of psychogenic psychoses is contained in 'our definition' of the concept. The vast majority of affective forms *are cured* and, likewise, a good many of the paranoid forms, but the risk of *recurrence* is ever present. Of the paranoid psychoses, some are cured but with residual paranoid ideas, whose content is usually reconcilable with the patient's whole paralogical view of life (Bonhoeffer), whereas other forms of paranoia are chronic/incurable. Therefore, in the psychogenic paranoid cases, the strength and nature of the paranoigenic temperament, the specific psychic trauma and the resultant paranoid idea together with external factors are of pronounced importance.

This source study proves beyond any doubt that the origin of Wimmer's seminal concept of the 'psychogenic psychosis forms' was inspired and based on Magnan's doctrine, thus confirming the views of Strömgren (e.g. 1940), and later supported by, for instance, Garrabé (personal communication, 2002) and Bertelsen (2007), whilst others have written against the sources, e.g. Pichot (1986, personal communication, 2002). Jablensky (2001) and Pillmann (2004) expressed strong reservation

(see Schioldann 2011: 352). Other than the analysis of Wimmer's work, his own statements per se (1916:87, 2003: 89): 'In Magnan's teachings of *les délires des dégénérés* many of the principal features of the psychogenic illness pictures are clearly outlined', as he had also stated at the 'Copenhagen Congress' in 1913, and initially illustrated in his 1902 doctorate, cannot and should not be ignored. Finally, in his chapter on the psychogenic psychoses in his 1936 textbook, the section on psychogenic paranoid psychoses is subtitled: 'Délires des dégénérés, Magnan' (Wimmer 1936: 505; English edition, 2011: 480). Furthermore, he concluded his definition of the psychogenic psychoses, as cited before: 'these mental illnesses *never terminate in dementia'*, a view, which undoubtedly reflects Magnan's doctrine (see Wimmer 1902: 25, 97; Saury 1886: 161; Magnan and Legrain 1895: 164), but in some of the later English translations of this definition, 'deterioration' has been substituted for 'dementia'! (e.g. see Marneros and Pillmann 2004: 30).

Concerning the issue whether or not Wimmer's comprehensive, precise definition of the psychogenic conditions was based on the work of Jaspers (1913a, 1913b), mixed views have been put forward by, for instance, Færgeman (1963), Strömgren (1968, 1974), Retterstøl (1975), Pichot (1986), Schioldann (1993, 2003, 2011), Ungvari and Mullen (2000), Mellergård (2000), Jablensky (2001), Garrabé and Cousin (2001), Marneros and Pillmann (2004), Pillmann (2004), Munk-Jørgensen (2007), Bertelsen (2007) and Krstev (2011) (see Schioldann 2011).

Before reaching a final conclusion regarding this question, the author shall draw attention to the following analysis of the sources to the effect that at the 'Copenhagen Congress' in 1913, Wimmer had referred to Magnan, but *not* to Jaspers. Wimmer would in all likelihood have read Jaspers' work: *Die Lehre von den reaktiven Psychosen* (1913a), preceding his '*Allgemeine Psychopathologie* (Jaspers 1913b). In his monograph, Wimmer defined his concept 'in accordance with foreign writers'. He referred to Reiss, and added that 'a couple of authors use the term, reactive psychosis', with reference to Bonhoeffer. However, in this very context he did not mention Jaspers. If anything, as mentioned before, he critically commented on Jaspers' views on 'stringent psychiatric systematism' with explicit reference to '*Allg[emeine] Psychopathologie. Berlin 1913. 257ff., [264]'* (see Wimmer 1916: 212; 203: 227). It is apparent that Wimmer did not agree with Jaspers. Jaspers referred to an 'allgemeine Psychopathologie' dimension, whereas Wimmer referred to sufficiently *specific* definable illness pictures and combinations with which to establish *specific* illness entities: e.g. psychogenic psychoses.

Finally, in the opinion of this author, it can be concluded with confidence that Wimmer's definition is a natural development of his extensive studies of the relevant French literature, especially the Magnanian teachings (Magnan and Legrain), and the German literature (e.g. Reiss), and his own clinical investigations: his 1902 doctorate and his 1916- monograph, thus confirming the views of Strömgren (1974), and Pichot (1986), and in more recent years supported by Pillmann (2004), Bertelsen (2007), and Schioldann (1993, 2003, 2011) to the effect that Jaspers' work *cannot* be considered Wimmer's original reference. Among those supporting Jaspers are, for instance, Færgeman (1963), Retterstøl (1975), Mellergård (2000), Garrabé and Cousin (2001), Marneros and Pillmann (2004), Munk-Jørgensen (2007) and Krstev (2011).

Strömgren (e.g. 1968, 1974, 1986, 1994), (see Schioldann 2003: 72; 2011: 345) expressed the opinion that Wimmer's monograph not only represented the first comprehensive survey of the whole field but probably also the best description of these psychoses ever written, and he had no doubt that it would have been of epoch-making importance internationally had it been translated into a world language soon after its first publication in 1916 (a view supported by Færgemann (1963: 7)), and thus possibly having been able to prevent most of the controversies between Scandinavian and Anglo-Saxon psychiatry. No less importantly, he related that the psychogenic psychoses became one of the most important stumbling blocks in achieving agreement on an international psychiatric nomenclature. He was obviously referring to Eliot Slater's (1964) scathing review of Færgeman's work (1963), which, in the main, had introduced these psychosis forms into Anglo-Saxon psychiatry. Other than harshly criticizing Færgeman's psychoanalytical approach, he concluded that the biggest *stumbling block* to correct diagnosis by Wimmer and his colleagues was schizophrenia, and he wondered whether Wimmer had done more than apply the label 'psychogenic', where 'the fancy' took him in an almost random selectioning of patients. No less scathing was Aubrey Lewis (1972: 214), who, grouping Wimmer, Strömgren and Færgeman among *orthodox psychogenic believers*, advised 'to give [this 'label'] decent burial, along with some of the fruitless controversies whose fire it has stoked', a position that Berrios (2003: 9) dismissed as 'nonsense'.

Strömgren must be acknowledged for his great contribution to the concept of psychogenic psychoses, not to mention his great contributions in many other fields of psychiatry (Schioldann and Strömgren 1996). For some *unknown* reason, he did not himself see to it that Wimmer's seminal monograph was translated into English. Therefore, a large gap persisted in the international psychiatric literature. German Berrios is owed great credit for having taken the initiative to fill this gap. Thus, at the inception stage of *History of Psychiatry*, in 1989, he invited Strömgren to write 'a long paper on the definitive history of the psychogenic psychosis', based on Wimmer's seminal monograph. As mentioned before, Strömgren had replied to Berrios that 'although on several occasions I have written on the psychogenic psychosis, it is obvious that there are still fundamental misunderstandings concerning this concept'. Berrios also wanted to publish other sections of Wimmer's works. Subsequently, this author became involved in the undertaking.

The first section of Wimmer's works that was published in the journal's *Classic Text* series was his pamphlet 'On Possession States' (1924) (Wimmer/Schioldann 1993), which is a captivating and instructive exposition of the psychogenic psychoses from a historical perspective, since the Middle Ages, Wimmer highlighting that although, throughout the ages these illness forms have altered in content, they have changed little in form.

Finally, the author's rendition of the 1916 monograph was published in 2003, unabridged (including the 24 case histories), and prefaced by a comprehensive conceptual history of these illness forms (pp. 19–73), together with forewords by Berrios, and Nils Retterstøl of Oslo. Emphasizing that Wimmer's monograph is not only of historical interest, Berrios put it (2003: 9–10):

> There is one truly serious question in psychiatry, and that is psychogenesis. Wimmer's book provided ['a new understanding of psychogenesis'] in detail and at a level of historical argument unsurpassed to this very day. In his extraordinary book, Wimmer makes a case for psychogenesis that has not yet been answered by modern psychiatry; it should encourage current psychiatrists to do so. Those interested in psychogenesis […] should start by reading Wimmer's magnificent book.

Subsequently, Castagnini revisited Wimmer's concept in 'History of Psychiatry' (2010) and, in the same journal, the following year, was published a translation of Wimmer's chapter on psychogenic psychoses from his textbook of 1936 (Wimmer/Schioldann 2011).

## References


Berrios, G. B. (2003). Foreword. In J. Schioldann (Ed.), *Psychogenic psychoses* (pp. 9–15) [translation of Wimmer, 1916]. Adelaide: Adelaide Academic Press.

Bertelsen, A. (2007). Reactive or psychogenic psychoses: The Scandinavian concept. *Revista do Serviço de Psiquiatria do Hospital Fernando Fonseca* (Lisbon), 26–31.

Castagnini, A. C. (2010). Wimmer's concept of psychogenic psychosis revisited. *History of Psychiatry, 81*, 54–66.

Færgeman, P. (1963). *Psychogenic psychoses*. London: Butterworths.

Garrabé, J., & Cousin, F. R. (2001). Acute and transient psychotic disorder. In *New Oxford textbook of psychiatry* (pp. 644–649). Oxford: Oxford University Press.

Jablensky, A. (2001). Classification of nonschizophrenic psychotic disorders: A historical perspective. *Current Psychiatry Reports, 3*, 326–331.

Jaspers, K. (1910). Eifersuchtswahn. Ein Beitrag zur Frage 'Entwicklung einer Persönlichkeit oder Prozess. *Zeitschrift für die gesamte Neurologie und Psychiatrie, 1*, 567–637 (reprint 1963: K. Jaspers: *Gesammelte Schriften zur Psychopathologie* (pp. 85–141). Berlin: Springer Verlag.

Jaspers, K. (1913a). Kausale und 'verständliche' Zusammenhänge zwischen Schicksal und Psychose bei der Dementia praecox (Schizophrenie). (I: Methodologische Übersicht. II: Die Lehre von den reaktiven Psychosen). *Zeitschrift für die gesamte Neurologie und Psychiatrie, 14,* 158–263 (171-8). (Reprint 1963: K. Jaspers: *Gesammelte Schriften zur Psychopathologie.* Berlin: Springer Verlag, 329-412 (329-38, 338-45).

Jaspers, K. (1913b). *Allgemeine Psychopathologie* (Berlin: Springer Verlag). 1913:159–64; 257–264.

Krabbe, K. H. (1913). Nordiske psykiatriske Kongres i København d. 26. og 27. August 1913. *Ugeskrift for Læger 75,* 1479–85.

Kraepelin, E. (1915). *Psychiatrie. Ein Lehrbuch für Studierende und Ärzte*. Achte Auflage. IV. Band: Klinische Psychiatrie, III. Teil. Leipzig: Barth.

Krstev, H. (2011). *Reactive psychoses in a first-episode psychosis population*. Melbourne: Victoria University.

Lewis, A. (1972). 'Psychogenic': A word and its mutations. *Psychological Medicine, 2*, 209–215.

Magnan, V. (1893). *Leçons cliniques sur les maladies mentales*. Paris: Bataille.

Magnan, V. (1897). *Leçons Cliniques Sur Les Maladies*. Paris: Alcan.

Magnan, V., & Legrain, P. M. (1895). *Les dégénérés. Etat mental et syndromes épisodiques*. Paris: Rueff et Cie.

Marneros, A., & Pillmann, F. (2004). *Acute and transient psychoses*. Cambridge: Cambridge University Press.

Mellergård, M. (2000). Wimmer og de psykogene psykoser. In *Epoker i dansk psykiatri* (Copenhagen), 89–97.

Morel, B. A. (1857). *Traité des dégénérescences physiques, intellectuelles et morales de l'éspèce humaine*. Paris: Baillère.

Morel, B. A. (1860). *Traité des maladies mentales*. Paris: Masson.

Munk-Jørgensen, P. (2007). Psychiatric epidemiology: A Scandinavian contribution to international psychiatry. *Acta Neuropsychiatrica, 19*, 6–10.

Pichot, P. (1986). The concept of 'bouffée délirante' with special reference to the Scandinavian concept of reactive psychosis. *Psychopathology, 19*, 35–43.

Pillmann, F. (2004). August Wimmer. Psychogenic psychoses. [Book review of 2003 edition by J. Schioldann]. *History of Psychiatry, 15*, 501–508.

Reiss, E. (1910). Konstitutionelle Verstimmung und manisch-depressives Irresein. Klinische Untersuchungen über den Zusammenhang von Veranlagerung und psychose. *Zeitschrift für die gesamte Neurologie und Psychiatrie, 2*, 368–384, 415–426.

Retterstøl, N. (1975). Scandinavia and Finland: Ideological trends. In J. G. Howells (Ed.), *World history of psychiatry* (p. 230). London: Tindall.

Saury, H. (1886). *Etude Clinique sur la folie héréditaire (les dégénérés)*. Paris: A. Delahaye & E. Lecrosnier.

Schioldann, J. (2003). August Wimmer's clinical concept of psychogenic psychoses: an introductory conceptual history. In Schioldann J. & Wimmer, A. (Eds.) *Psychogenic Psychoses. 1916*. Adelaide: Adelaide Academic Press.

Schioldann, J., & Strömgren, L. S. (1996). Erik Robert Volter Strömgren, 1909–1993. A biobibliography. Preface by N. Sartorius. *Acta Psychiatrica Scandinavica*, 283–302.

Schioldann, J. (2011). Introduction to August Wimmer: Psychogenic Psychoses (1936). Classic Text No. 87. *History of Psychiatry, 3*, 344–357.

Slater, E. (1964). Special syndromes and treatments. *British Journal of Psychiatry, 110*, 114–118.

Sommer, R. (1894). *Diagnostik der Geisteskrankheiten.* Wien & Leipzig: Urban & Schwarzenberg, 126–7, 154–5.

Strömgren, E. (1940). *De episodiske psykoser* (pp. 7–30). Copenhagen: Munksgaard.

Strömgren, E. (1968). Reactive psychoses. In: Strömgren, E.: Contributions to psychiatric epidemiology and genetics. *Acta Jutlandica* 40. Copenhagen: Munksgaard.

Strömgren, E. (1972). Atypische Psychosen. Reaktive (psychogene) Psychosen. In K. P. Kisker, J. E. Meyer, M. Müller & E. Strömgren (Eds.), *Psychiatrie der Gegenwart* (pp. 141–52). Berlin: Springer Verlag, Bd. II/Teil 1.

Strömgren, E. (1974). Psychogenic psychoses. In S. H. Hirsch & M. Shepherd (Eds.), *Themes and variations in European psychiatry: An anthology* (pp. 94–117). Bristol: John Wright.

Strömgren, E. (1975) Preface. In Schulsinger, F., Reisby, N., Høyer-Pedersen, W. et al. (eds) The Department of Psychiatry, Kommunehospitalet, Copenhagen 1875-1975. *Acta Psychiatrica Scandinavica*. (Suppl. 261), 5–6.

Strömgren, E. (1986). Psychogenen Psychosen. *Nervrnarzt*, 88–95.

Strömgren, E. (1987). The development of the concept of reactive psychoses. *Psychopathology, 20*, 62–67.

Strömgren, E. (1989). The development of the concept of reactive psychoses. *British Journal of Psychiatry, 4*(Suppl), 47–50.

Strömgren, E. (1992). Das Konzept der psychogenen (reaktiven) Psychosen. Tropon-symposium. In W. P. Kascha & E. Lungershausen (Eds.), *Paranoide Störungen* (pp. 149–159). Berlin: Springer Verlag.

Strömgren, E. (1994). Recent history of European psychiatry – ideas, developments, and personalities. Slater lecture (1986). *American Journal of Medical Genetics, 54*, 405–410.

Strömgren, E. (2014). 'Introduction' to Episodic psychoses [1940]. Translation and introduction by J. Schioldann (Classic Text). *History of Psychiatry, 25*(4), 492–508.

Ungvari, G. S., & Mullen, P. E. (2000). Reactive psychoses revisited. *Australian and New Zealand Journal of Psychiatry, 34*, 458–467.

Wimmer, A. (1902). *Evolutiv Paranoia. Bidrag til Forrykthedslæren* [Contributions to the teachings of paranoia]. Copenhagen: Lund.

Wimmer, A. (1916). *Psykogene Sindssygdomsformer.* [Psychogenic forms of insanity]. In: Wimmer (ed), *Sct. Hans Hospital 1816–1916. Jubilæumsskrift* (pp. 85–216). Copenhagen: Gad. Reprint 1981.

Wimmer, A. (1924). *Om Besættelser*. [On possession states]. Copenhagen: Levin & Munksgaard.

Wimmer. (1924/1993). Om Besættelser (On possession states). Introduction by J. Schioldann Classic Text No. 15. *History of Psychiatry*, 4, 413–440.

Wimmer, A. (1916/2003). *Psychogenic Psychoses*. Edited and translated with an introduction by J. Schioldann. Adelaide: Adelaide Academic Press.

Wimmer, A. (1936). Psykogene Psykoser. In: Wimmer: *Speciel klinisk Psykiatri for Studerende and Læger*. Copenhagen: Munksgaard. 489–505, 505–520 (Paranoiske Psykoser (Délires des dégénérés, Magnan)).

Wimmer, A. (2011). 'Psychogenic psychoses' (1936). Part I–II. Introduced and translated by J. Schioldann. (Classic Texts Nos. 87–88). *History of Psychiatry* 3–4, 344–67, 477–94.

Wimmer, A. (2018/19). From 'Evolutive paranoia'. [1902] Introduced by G. E. Berrios & J. Schioldann. Translation by J. Schioldann (Classic Text, 116–117). *History of Psychiatry, 4*, 478–95, 2019, 3,116–24.

# Part IV
# Psychopathological

# Chapter 19
# The Experience of People with Formal Thought Disorder


**Alvaro Barrera**

## Contents



## Introduction

Formal thought disorder (FTD) does not go away. One day, the psychiatric research community's efforts to describe it and explain it seem to have succeeded, and all seems reassuringly clear. But shortly afterwards, it re-emerges into the limelight of everyday clinical work giving rise to uncomfortable questions. This chapter does not seek to deny the research efforts undertaken over the last few decades, recently impressively summarised (Kircher et al. 2018; Sumner et al. 2018). In these reviews, we find somewhat contrasting views. Kircher et al. (2018, p. 523) optimistically conclude that 'we finally have a clear picture of the pathophysiology and neuroanatomy involved, so we now are in a good position to therapeutically target the symptoms of FTD'. Sumner et al. (2018, p. 59), on the other hand, comment, on a more sceptical vein, that 'to advance the field further, greater integration across structural, functional and behavioural measures is required, in addition to non-

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unitary considerations of TD.' It is likely that further technical methodological refinements will be introduced and that ever-increasingly sophisticated technological procedures will be used to study FTD in people with mental health issues.

We could however ask whether clinicians have the tools to try to understand what their patients are saying. If the answers to this question are negative, then we could ask whether we are trying to develop them. Are we asking whether clinicians and patients have the time, not in the neuropsychological or neuroimaging lab, but amid real-life healthcare organisations, to talk with patients and try to understand them? Are we identifying the institutional circumstances and the professional and personal biases and thresholds that make a clinician declare that a piece of discourse uttered by a fellow citizen is 'formally thought disordered'? Do we need to have a full biological understanding of the putative brain dysfunctions underlying FTD before attempting to understand, with compassion and empathy, the discourse of people with severe psychotic disorders? It is relevant here to mention that whilst cognitive and biological research on obsessive compulsive disorder (OCD) is ongoing, a very effective psychological intervention has existed for a long time to help people suffering from it. As a review on the epidemiology of FTD concluded, 'Lastly, research into interventions, other than antipsychotic medication, are warranted, given the impact of FTD on outcome and its persistence in subgroups of patients, despite standard treatment' (Roche et al. 2015, p. 957).

In this context, the aim of this chapter is a humble one. It aims at exploring how we can try to understand patients with a diagnosis of severe and enduring mental illness when what they say and speak, they do in a way that others consider to be very difficult to understand.

## Describing FTD

Formal thought disorder (FTD) continues to draw the attention of clinicians and researchers alike. Both young and seasoned clinicians remain perplexed, disturbed or enticed by instances of verbal communication with patients who, either haphazardly or consistently, produce utterances which, even if referring apparently to prosaic matters (e.g. their preferred football team), include elements such as words used with an unusual meaning; newly formed words; sentences with an absent or vague subject; sentences with a fragmentary, branched and off-target predicate; poorly cohesive sentences; or long pieces of speech that lack coherence despite words, sentences and their cohesion being duly well formed.

As with other psychopathological phenomena, FTD can be described from three perspectives, namely, from that of (1) a qualified observer who completes an instrument (e.g. a symptoms scale, linguistic survey or Cloze procedure), (2) the individual presenting with the alleged symptom and (3) a non-professional observer who knows the person well in a range of social contexts outside the clinical interview. In terms of clinical rating scales, the Thought, Language and Communication (TLC) Scale (Andreasen 1979) has become the canonical way of capturing these

instances or symptoms. Although widely accepted, the TLC scale is not without problems, but these are issues that will be discussed elsewhere. Other clinician-rated psychopathological instruments include the Thought Disorder Index (TDI) (Johnston and Holzman 1979) and the Bizarre-Idiosyncratic Thinking (BIT) Scale (Marengo et al. 1986; Harrow et al. 2004), which quantify speech abnormalities in response to Rorschach Test inkblots and the Wechsler Adult Intelligence Scale. On the other hand, the Clinical Language Disorder Rating Scale (CLANG) (Chen et al. 1999) and the Thought and Language Index (TLI) (Liddle et al. 2002) rate eight abnormalities of speech produced in response to the Thematic Apperception Test or the Rorschach Test. The other two perspectives (the patient's and the friend's/relative's) have been used less often. In order to provide that type of instrument, we developed two instruments, one completed by the speaker to get their views about their own speech as well as one completed by someone who knows the patient well; these are the Formal Thought Disorder Scales (FDT-Self Scale and the FDT-Other Scale). Both scales incorporate classical symptoms described in the French, British and German clinical traditions as well as non-verbal, paralinguistic and pragmatic aspects of spoken communication (Barrera et al. 2008). Of note, both scales are internally reliable and appear to have specific clinical and cognitive correlates, suggesting that both perspectives provide complementary information (Barrera et al. 2009).

## FTD Is Not Restricted to Clinical Populations

In our view, a key fact to try to understand people considered to exhibit FTD is to mention that a significant minority of non-clinical participants in studies of FTD appear to exhibit its features (Barrera 2006; Roche et al. 2015). According to Roche et al. (2015, p. 951), FTD 'once thought to be specific to schizophrenia is now known to manifest in affective psychoses, nonpsychotic illnesses, and normal controls'. On two separate samples of 300 and 150 unselected individuals who completed the Formal Thought Disorder-Self Scale (FTD-S) (Barrera et al. 2015), principal component analysis suggested a three-component solution of 'odd speech', 'conversational ability' and 'working memory' deficit, not dissimilar to the factors or components described in clinical populations. Of relevance, subclinical FTD is consistently found amongst relatives of patients with schizophrenia (Levy et al. 2010). In addition, the relatives of patients with schizophrenia, mania and schizoaffective disorders show a type of FTD that mirrors, with lower severity, that of their affected relatives. Importantly, symptoms of FTD can be observed in children considered to be at risk of schizophrenia, suggesting that the early detection of FTD might act as an endophenotypic marker of schizophrenia diathesis (Ott et al. 2002). These findings have been interpreted as supporting the view that FTD could have a genetic basis shared by biological relatives. A question here is whether a different interpretation could be considered, specifically whether there are shared social fac-

tors involved in the genesis of special patterns of verbal communication. This alternative interpretation is explored below.

## FTD: Its Impact on Communication with Self and Others

If reflexive conscious thinking takes place by the deployment of sentences of natural language in imagination (Carruthers 1996, p. 230), then the repercussions of FTD and its associated disrupted language production are likely to be devastating, both for the inner negotiation of the speaker with her own self and for the navigation of the social world.

## FTD, Inner Pragmatics, Cognitive Phenomenology

We use language as a tool in our internal dealings with ourselves (Stemmer 1999). Our inner speech enables the transformation of our vague inner cognitive movements into mental entities susceptible of utilisation (Tirassa 1999), in an analogous way into how we utilise language in our engagement with the social and physical environment. We need sentences of natural language acting as effective vehicles and constituents of our thinking processes. By internally using language, negotiations take place within our different aspects and aspirations, proclivities and reluctancies. From a phenomenological perspective, Gurwitsch (1964) says that the field of consciousness is organised around a 'theme' where data at the focus of our attention are organised according to Gestalt laws; the 'theme' is surrounded by the 'thematic field', where unattended data relevant to the theme are available; finally, the thematic field is surrounded by the 'marginal consciousness', where unattended data not relevant to the theme remain (Yoshimi and Vinson 2015). It is likely that when we need to reflect in a conscious way, the data inside the 'theme' must take the shape of well-formed sentences of natural language, for example, when reflecting on an ethical dilemma or on the meaning of something someone has just said which could be potentially threatening. On both occasions, no language has been uttered, but both are linguistic mental events that require the full availability and appropriate deployment of the resources of language production as well as language reception.

It is not difficult to imagine the effect of FTD on our experience of cognitive phenomenology (Chudnoff 2015). Initially, our thinking will lose its naturality and will become difficult, requiring more effort. Being unable to 'think in a clear way' will induce feelings of perplexity and alienation from our own self. Even worse, the sense of bewilderment will not only impact on the inner presentation of cognitive facts but also impair the ability to match the appropriate affect to it. For example, if in the sentence 'I found *politics* complicated, I do not understand *politics'* it is unclear for the speaker whether the word 'politics' he/she is using is referring to 'national politics' or the 'politics of the workplace' or the 'family

politics between her parents', it is then natural to expect that the affect saturating the said statement would be incongruent or inappropriate, for example, distant disdain towards national politics; sadness, isolation and a feeling of personal incompetence towards the politics of the workplace; or paranoia and anger towards the perceived deceitful politics of the parents. This mismatch between thought and affect will ultimately impact on our ability to handle and reflect on our own emotions and feelings. Thus, the usual concordance between thought and affect will get disrupted, perhaps helping to explain why FTD is associated with inappropriate affect in the disorganisation dimension of the schizophrenia symptoms (Barrera et al. 2019).

## FTD and External Pragmatics

In terms of our social engagements, we utilise language to navigate the exchanges, negotiations, excuses and declarations that enable us to achieve our goals and to collaborate with others in shared efforts. The coordination of our behaviours with the behaviour of others requires not only an organised inner world, both in thought and in affect as described above, but it also requires that linguistic, paralinguistic and non-verbal meanings be correctly conveyed and that we, as communicative agents, get our statements on target. Of course, the redundancy of communication (Newby 1998), the assumption of relevance (Sperber and Wilson 1995) and the active reparation of communication breakdown in which we all engage (Cheepen 1988) protect our discourse from being declared difficult to understand. However, above and beyond a certain threshold, these protective mechanisms become insufficient, and then, speech becomes formally thought disordered, and the perceived affect and behaviour of the speaker are regarded by their interlocutors as inappropriate and bizarre, respectively. In the absence of the scaffolding effect of cohesive and coherent speech, our perceived affect will be categorised as inappropriate and incongruent. As described by the French psychiatrist Philippe Chaslin (1857–1923), discordance would be a kind of 'second-order' phenomenon where there is a lack of the expected harmony between the gestures, emotions and content of a person's statements (Lanteri-Laura and Gros 1992). An example would be when a patient puzzlingly smiles whilst angrily describing fears of being poisoned by his friends. Such discordance would not be limited to language and affect, but it would also extend to behaviour, where, in the words of the ICD 10, behaviour becomes 'aimless, irresponsible and unpredictable, often with mannerisms'. FTD makes the actual behaviour bizarre to the person acting in that way, so patients ask themselves 'why am I doing that?' Also, those around him/her would be puzzled, and both effects might explain why FTD, bizarre behaviour and inappropriate affect are part of the disorganisation dimension of schizophrenia symptoms (Barrera et al. 2019).

## FTD and the Lived Life

The previous section dealt with the impact of FTD on the internal and external pragmatics from a third-person account. In this section, we envisage the impact of FTD on a person's life from a first-person perspective. In order to do this, we will follow Hatab (2017)'s account of the proto-phenomenology of the 'lived life'. In this approach, our everyday life is regarded as the way in which we dwell in language and through language into the world in a pre-reflective manner, engaging with and embedded in the factual nature of our natural, cultural and social environment. It is at this level of existence where language presents to us and discloses to us the world as meaningful. We remain in that smooth engagement with our world and come out of it only if disturbances or resistances to that practical engagement with the world arise (e.g. if whilst engaged in a fluent and friendly conversation, a sudden loud noise draws our attention). We then get into a state of explicit awareness of our intentions and the surrounding external conditions, and it is here where we think about ourselves from the third-person perspective (Hatab 2017). The same change of perspectives towards our own activity is described, on a different conceptual framework, by Choifer (2018), who mentions two first-person perspectives of our own conscious phenomena, one of a non-reflective perspective and a second one of detached and reflective consideration of our mental landscape. Next, we specifically focus on the possible impact of FTD on a person's pre-reflective proto-phenomenological engagement with their world.

Much of our immersed engagement with the word involves many instances of know-how, tacit knowledge and habit, all constructed, conveyed and permeated in and by language, the most important mode of dwelling in the world (Hatab 2017, p. 17). As the same author indicates, 'to have a human experience of something presupposes a wealth of prior understandings that go all the way back to childhood and the learning of language. Even an experience of something strange, unmeaningful or incomprehensible is engaged as such because of a default orientation towards meaning shaped by language' (Hatab 2017, p. 120).

What might be the impact of FTD on our pre-reflective embedded engagement with the world? The accounts collected by Freedman (1974) might give us an indication, despite some potential pitfalls on account of the diagnostic criteria utilised. This author analysed around 60 autobiographical books and articles written or recounted directly by people with a diagnosis of schizophrenia during or after their psychotic episodes. He found that these individuals often reported deficits in attention when reading, writing and speaking, describing their minds as wandering and making sustained thinking impossible. They also reported an experience of losing the meaning of words, objects and people as well as a frightening loss of control on their thoughts. In addition, they described slowed thoughts associated with mental exhaustion, experiences of thought blocking, confusion and thoughts described as hazy, dazed and disoriented, with some people even feeling spatially disoriented. Some accounts described disturbances in judgement and reasoning abilities, whilst others reported disruptions in speech production at either the morphological or the

syntactic level. Some patients described disturbances in the perception of speech (e.g. difficulty in verbal comprehension and interpreting homonyms and mixing up the literal and the figurative meaning of words) (Freedman 1974).

Another view of the impact of FTD on a person's subjective functioning is provided by Huber's basic symptoms model, in particular where it focuses on people's cognitive issues, such as thinking, concentration, attention or memory difficulties. These are all depicted as being effortful and energy-consuming, with thoughts often described as vague, blocked or empty (Koehler and Sauer 1984). In our own research, people with a diagnosis of schizophrenia suffering from FTD reliably endorsed items such as 'I forget the point I was trying to make in a conversation', 'I use long and unusual words to say simple things', 'I go on beating about the bush instead of getting to the point of the conversation' and 'I draw strange conclusions during conversations' (Barrera et al. 2008).

What might be the impact of these experiences on the lived life of the person? It could be speculated that, if we dwell in the world primarily through language and this has lost its smoothly protective quality, then we would be unable to submerge pre-reflectively into our everyday activity, leaving us with a hyper-reflective relationship with ourselves and the world. This hyper-reflective lived life would not be a voluntarily adopted philosophically fruitful one but one that would be experienced as painfully exhausting, lacking in spontaneity, out of the social flow of events and leading to isolation. It is not far-fetched to speculate that being in such a frame of mind might lead to hopelessness, substance misuse (to ameliorate such an unpleasant experience) and suicidal ideation. Of note, two systematic reviews on the risk of suicide amongst people with schizophrenia do not mention FTD (Hawton et al. 2005; Hor and Taylor 2010). Similarly, the association between FTD and substance misuse is not addressed in a recent systematic review on the epidemiology of FTD (Roche et al. 2015).

## FTD: A Meaning Beyond the Mechanism

The view explored here refuses to reduce FTD to its neurobiological causes. Most of the current research has assumed the 'received view' that FTD is just speech that is difficult to understand. It currently appears as though clinical psychiatry has given up the task of trying to understand FTD as a communicative phenomenon. The reasons for this can only be speculated upon, and there are probably more than one, but the increasingly abridged and simplistic schedule of the mental state examination and the institutional pressures on clinicians reducing their available time for interaction with patients are two factors that could be contributing.

Here, we claim that when treating FTD as mere noise resulting from a biological and cognitive dysfunction, whatever this can be, something deeply human is being lost, a meaning specific to the person who is uttering the utterances at that specific time of their lives and in that particular social context. FTD may be, at least on some

occasions, a form of linguistic communication, the aim of which is to convey to the interlocutor a sense of being immersed in and overwhelmed by ineffable experiences.

At any rate, even if the view of FTD as 'incomprehensible' is adopted as the criterion to identify it, it still remains unclear how the content of speech and the situational context of the communicative situation interact to influence the decision of giving up the task of trying to understand a person's speech and declare it formally thought disordered. Quantitative aspects such as how many utterances emitted by a subject must be regarded as incomprehensible before being considered thought disordered, or whether there are some symptoms of FTD 'more incomprehensible' than others, remain to be clarified. It is not clear whether individual differences amongst listeners may influence their appreciation of utterances as formally thought disordered. For example, might it be that a listener with experience in poetry or avant-garde art or who is more tolerant to ambiguity will have a higher threshold for diagnosing an utterance as FTD? In this connection, it is worth mentioning that pieces of speech not dissimilar to FTD have been recognised for a long time outside the boundaries of psychiatry. Religion has found it in the form of 'speaking in tongues' and oracular language. Some claim that cryptic language and symbolic thinking would not be the exclusive privilege of the poet or the 'unbalanced' mind; instead, they would be consubstantial to the human existence and prior to language and discursive reason (Eliade 1961). Symbols would reveal the deepest aspects of existence, those aspects of life that defy any other means of approaching them and that would never disappear from the human psyche. Their appearance could change, but their function would remain the same (Eliade 1961). In literature, the comprehensibility of the material has not been a requisite for its aesthetic appreciation (e.g. Finnegans Wake by James Joyce). However, even an open and 'creative listener' (Cox 1997; Rosenbaum and Burgaard 1993) may vary in different circumstances in her threshold to diagnose FTD, if, for example, he/she is less alert or worried about other issues. An interlocutor may also become increasingly receptive thanks to a longer therapeutic relationship with the patient, where invariance of symbols and themes may aid in the comprehension of what initially appeared to be obscure references. All these issues highlight the fact that FTD remains a construct that has, at its centre, a considerable cultural component.

Calls for trying to comprehend the FTD speech are not new. Jung (1917) indicated that even though we were far away from understanding the concatenations of the 'obscure world' of the psychoses, it could be maintained that, in dementia praecox, there was no symptom that could be described as psychologically baseless and meaningless: 'The most absurd things were in reality symbols of ideas that were not only generally understandable, but also universally operative in the human heart' (Jung 1917, p. 336). One way or another, the possibility of a fruitful interpretation of FTD has persisted. In this connection, Cox (1997) claimed that, at least in the initial phases of therapy and desirably in most of staff-patient interactions, therapists must retain their 'creative' reception of psychotic patients' unusual utterances. This attitude would foster empathic engagement, adequate emotional contact and, consequently, the unfolding of other therapeutic initiatives. Similarly, Johnston and Holzman (1979, p. 17) indicated that 'the mere expression of odd,

difficult-to-comprehend material does not by itself signal the breakthrough of logical thinking and hence the presence of psychotic incursions on cognitive functioning'. They continue, 'incomprehensibility is not a definition of thought disorder, although products of disordered thinking may be incomprehensible. The processes by which such incomprehensibility emerges help to determine whether or not is a result of thought disorder'. Johnston and Holzman (1979) also indicated that ascertaining the presence of FTD depended on an evaluation of several factors, such as the speaker's purpose and efforts to control the material, the effects on his audience and the speaker's capacity to shift towards a more socialised discourse. Incidentally, these very same factors are not considered by their Thought Disorder Index (TDI) scale, the instrument designed by them.

## Schizophrenia Patient's Language as Comprehensible

The notion of schizophrenic language as incomprehensible was radically criticised by Rosenbaum and Sonne (1986). These authors regarded such a view as just one of several possible interpretations, one that was contented with simply identifying cognitive or emotional communication problems in a given individual's communication and declaring it faulty. However, they indicated that such a view was wrong for two reasons. First, it ignores the enormous complexity of language, including the variety of strata, symbolic agents and interactions that occur within language, as well as language's essential role in constructing the representation of external and internal reality and as cause and effect of conscious and unconscious psychological processes. Second, the view of FTD as defective takes as its point of departure the belief that something like 'normal language' exists, which would express an abstract and logically developed 'normal' rationality. We call this view the 'narrow model' of rationality (NM-R). However, countless experiments have shown that people's reasoning and judgement deviate from the norms (Oaksford and Hall 2016). People use devices to reduce sources of uncertainty to a minimum as well as quick and available heuristics for finding conclusions (e.g. tossing coins) (Stenning and Monaghan 2004). We call this 'wide model' of rationality (WM-R). In order to accommodate real-life decision-making, this 'wide model' of rationality must be supplemented by pragmatics, the view of language as a social tool, where speakers and listeners engage in efficient communications whilst appearing oblivious to their many language 'errors', automatically penetrating the haze of false starts, mispronunciations, repetitions, infelicities and occasional ungrammaticalities, to get to the speaker's underlying intended target (Rubens and Garret 1991). Undoubtedly, a 'wide model' of rationality plus pragmatics (WM-R + P) would greatly assist clinicians to understand patients' FTD. However, it is suggested here that such an approach would not fully achieve such a goal.

Rosenbaum and Sonne (1986) indicated that the breakdown of discursive elements (cohesion, deixis, reported speech, speech acts) often associated with an intense experience of anxiety made the interlocutor feel excluded, confused or

bored, leading them to declare the person's speech as incomprehensible. These authors propose, in contrast, that a psychodynamic approach would gradually render the incomprehensible speech into a meaning that becomes comprehensible and sharable between patient and therapist. Here, we suggest that it is possible to use Rosenbaum and Sonne (1986)'s views whilst remaining agnostic towards their psychoanalytical approach. Next, we explain why this might be the case.

The view that social factors play a key role in the life process leading to schizophrenia has been widely accepted (Stilo and Murray 2010, p. 310). For these authors, 'the epidemiological evidence suggests that schizophrenia is a multifactorial disorder in which genes interact with each other and with environmental factors to push individuals over a threshold into expression of the disorder'. Thus, urban residence, migration, racism, parental loss or separation, child abuse, bullying, life events and social isolation are all factors that increase the risk of the disorder. More specifically focused on FTD, Toth et al. (2011) found that maltreated children exhibited more illogical thinking (in the clinically pathological range) than non-maltreated children; they also found that the occurrence of multiple subtypes of maltreatment and the chronicity of maltreatment also were associated with illogical thinking. Similarly, Bailey et al. (2018)'s systematic review and meta-analysis found that hallucinations in those with psychotic disorder were found to be related to the total level of childhood trauma, childhood sexual abuse and neglect. They also found a similar but less consistent association between childhood trauma and delusions. Of note, their data did not address the association between trauma and FTD. From a mechanistic point of view, Popovic et al. (2019) discuss that childhood trauma, in people with a diagnosis of schizophrenia and on those at ultra-high risk of developing it, is associated with impaired working memory, executive function, verbal learning and attention, with the effect of childhood trauma acting through genetic, hormonal and structural brain abnormalities. Again, these authors do not address FTD. It could be asked here whether the association between childhood trauma and FTD might be even stronger. In fact, Aulagnier (2001) reflects on the impact of childhood trauma on the child's basic psychological thinking and language development. Following from that, it could be asked whether FTD could be one of the childhood trauma's toxic effects. Next, we try to unpack how person, trauma and language might interact to produce FTD.

FTD is usually characterised as a problem in the way the person is speaking as opposed to the content of what is being talked about. By 'way' or 'manner', it is meant the relevance, coherence and cohesion of how a theme or topic is being expressed, described and managed. Such a view is what clinicians try to convey when they add the adjective 'formal' to thought disorder. In contrast, the position taken here is that this is a superficial characterisation that fails to do justice to the complexity of the phenomenon. More specifically, it is suggested that the issues involved in FTD pertain, at least in certain cases, to a marked instability of the basic three elements of communication, specifically *who* is doing the talking, *what* the subject of the talking is and *who* is the intended addressee of the talking. These aspects are discussed next.

The self who is talking and who has been damaged by trauma is psychologically fragmented. His/her speech is being interfered with by inner experiences such as flashbacks, perceptions and imaginations, all of which can be either overwhelming or ineffable or delusional or hallucinatory. Some of these experiences can bring painful memories, barely processed into language, of neglect, abuse, humiliation, guilt, horror and collusion, all referring to either recent or distant past experiences. So, who is doing the talking when a young patient speaks in a formally disordered way? The recently broken entrepreneur, or the sexually assaulted teenager or the severely neglected 2-year-old baby? Or do they all occupy the place of the 'I', appearing alternately in the talking? It is worth asking who could keep their cool and continue talking in the mainstream 'diurnal' way when bombarded by these sorts of experiences.

In FTD, the subject of the talk is also unstable. The Italian Sergio Piro studied, in schizophrenia, the semantic halo of verbal signs. By this he was referring to the notion that meanings have a certain extension which permits some ambiguity and indeterminacy in their use. For example, the word 'cat' has a far more restricted semantic halo than the word 'entity' (Piro 1987, p. 340). For Piro, abnormal fluctuations of the semantic halo of verbal signs would lead to concrete terms being used abstractly, abstract terms being used concretely and an ensuing ambiguous, indeterminate, metaphoric and symbolic language. Descriptions of this phenomenon of FTD in schizophrenia are endorsed by patients (Barrera et al. 2008) as well as captured objectively as increased semantic priming (Kircher et al. 2018). In FTD, words, phrases and punctuation can take at times a life of their own, pullulating in speech not as if powered by the rush of energy of manic episodes or stimulants, but by what Rosenbaum and Sonne (1986, p. 67) call 'metonymical sliding'. The question here is whether the person exhibiting FTD produces random metonymies which are neutral to the dialogic situation or, as it is contended here, the speaker's personal history and background are inherently biasing the direction of their uttered metonymies, making them slide into and revolve around topics of personal significance. And here, again, the subjects of angst, neglect, abuse, humiliation, guilt and collusion, all referring to either recent or distant past experiences of trauma, reappear as possible themes.

Finally, FTD can also display marked instability of the addressee to whom the talk is addressed. Ostensibly, in clinical situations the addressee is the clinician interviewer. However, an experienced clinician would have experienced the feeling of partial or total exclusion from what the person is talking about. In other words, the clinician would have the feeling that they, the interviewer, were not the addressee of the patient's utterances. After ruling out that the patient is not delirious, or hallucinating or under a delusional misidentification, one remaining option is that the patient is addressing the neglecting parent, the abusive brother, the bullying schoolmate, the insensitive priest, the ironic teacher, the racist neighbour, the condescending psychiatrist, the raging self, the well-meaning friend or all of them at different times of what feels, to the interviewer, a soliloquy, but in fact could be an unstable combination of past and present significant others.

## Conclusion

It is undoubtedly heartening to see cognitive behavioural therapy approaches help people with FTD through strategies such as structuring, summarising, repeating and clarifying the core issues and main emotions that the patient is trying to communicate, including using diagrams and reviewing audiotapes to elucidate the main themes (Wright et al. 2009). These interventions offer a scaffolding from where the person with FTD can communicate their inner world. However, clinicians should be careful to ensure that the scaffolding they provide does not foreclose what the speaker is trying to disclose, protest, challenge or denounce. The issue here is trying to avoid interventions that could be unwittingly forcing a deeply traumatised person, one whose trauma has impacted upon their thinking and language processes, to further repress their experiences. Trauma and its effects require respect, empathy and compassion. Although some could say that 'words are just words', a rather unfitting expression in this context, it is worth noticing the conspicuous absence of these terms in most of the research and reviews on FTD.

## References

Andreasen, N. C. (1979). Thought, language, and communication disorders I. clinical assessment, definition of terms, and evaluation of their reliability. *Archives of General Psychiatry, 36*, 1315–1321.

Aulagnier, P. (2001). *The violence of interpretation: From pictogram to statement*. New York: Routledge.

Bailey, T., Alvarez-Jimenez, M., Garcia-Sanchez, A. M., Hulbert, C., Barlow, E., & Bendall, S. (2018). Childhood trauma is associated with severity of hallucinations and delusions in psychotic disorders: A. *Schizophrenia Bulletin, 44*, 1111–1122.

Barrera, A. (2006). Formal thought disorder: Not only 'disorganised speech'. In A. Diez Patricio & R. Luque (Eds.), *Psicopatología de los síntomas psicótícos* (pp. 53–75). Madrid: Spanish Neuropsychiatry Association.

Barrera, A., McKenna, P. J., & Berrios, G. E. (2008). Two new scales of formal thought disorder in schizophrenia. *Psychiatry Research, 157*, 225–234.

Barrera, A., McKenna, P. J., & Berrios, G. E. (2009). Formal thought disorder, neuropsychology, and insight in schizophrenia. *Psychopathology, 42*, 264–269.

Barrera, A., Handel, A., Kondel, T. K., & Laws, K. R. (2015). Formal thought disorder in non-clinical populations. *International Journal of Psychology and Psychological Therapy, 15*, 155–167.

Barrera, A., Curwell-Parry, O., & Raphael, M. (2019). Hebephrenia is dead, long live hebephrenia, or why Hecker and Chaslin were on to something. *BJPsych Advances*, 1–4. https://doi.org/10.1192/bja.2019.24.

Carruthers, P. (1996). *Language, thought, and consciousness. An essay in philosophical psychology*. Cambridge: Cambridge University Press.

Cheepen, C. (1988). *The predictability of informal conversation*. London/New York: Pinter Publishers.

Chen, E. Y. H., Lam, L. C. W., Kan, C. S., Chan, C. K. Y., Kwok, C. L., Nguyen, D. G. H., & Chen, R. Y. L. (1999). Language disorganisation in schizophrenia: Validation and assessment with a new clinical rating instrument. *Hong Kong Journal of Psychiatry, 6*, 4–13.

Choifer, A. (2018). A new understanding of the first-person and third-person perspectives. *Philosophical Papers, 47*, 333–371. https://doi.org/10.1080/05568641.2018.1450160.
Chudnoff, E. (2015). *Cognitive phenomenology*. Abingdon: Routledge.
Cox, M. (1997). The great feast of languages: Passwords to the psychotic's inner world. In C. Mage & F. Margison (Eds.), *Psychotherapy of psychosis*. London: Gaskell.
Eliade, M. (1961). *Images and symbols. Studies in religious symbolism* (P. Mairet, Trans.). London: Havill Press.
Freedman, B. J. (1974). The subjective experience of perceptual and cognitive disturbances in schizophrenia. A Review of Autobiographical Accounts. *Archives of General Psychiatry, 30*, 333–340.
Gurwitsch, A. (1964). *The field of consciousness*. New York: Duquesne.
Harrow, M., Jobe, T. H., Herbener, E. S., Goldberg, J. F., & Kaplan, K. J. (2004). Thought disorder in schizophrenia: Working memory and impaired context. *The Journal of Nervous and Mental Disease, 192*, 3–11.
Hatab, L. J. (2017). *Proto-phenomenology and the nature of language*. London: Rowman & Littlefield.
Hawton, K., Sutton, L., Haw, C., Sinclair, J., & Deeks, J. J. (2005). Schizophrenia and suicide: Systematic review of risk factors. *The British Journal of Psychiatry, 187*, 9–20.
Hor, K., & Taylor, M. (2010). Suicide and schizophrenia: A systematic review of rates and risk factors. *Journal of Psychopharmacology, 24*, 81–90.
Johnston, M. H., & Holzman, P. S. (1979). *Assessing schizophrenic thinking. A clinical and research instrument for measuring thought disorder*. San Francisco: Jossey-Bass.
Jung, C. G. (1917). The content of the psychoses. In C. E. Long (Ed.), *Collected papers on analytical psychology*. London: Baillere, Tyndall & Cox.
Kircher, T., Bröhl, H., Meier, F., & Engelen, J. (2018). Formal thought disorders: From phenomenology to neurobiology. *Lancet Psychiatry, 5*, 515–526.
Koehler, K., & Sauer, H. (1984). Huber's basic symptoms: Another approach to negative psychopathology in schizophrenia. *Comprehensive Psychiatry, 25*, 174–182.
Lanteri-Laura, G., & Gros, M. (1992). *Essai sur la discordance dans la psychiatrie contemporaine*. Paris: Ecole Lacanienne de Psychanalyse.
Levy, D. L., Coleman, M. J., Sung, H., Ji, F., Matthysse, S., Mendell, N. R., & Debra Titone, D. (2010). The genetic basis of thought disorder and language and communication disturbances in schizophrenia. *Journal of Neurolinguistics, 23*, 176–192. https://doi.org/10.1016/j.jneuroling.2009.08.003.
Liddle, P. F., Ngan, E. T. C., Caissie, S. L., Anderson, C. M., Bates, A. T., Quested, D. J., White, R., & Weg, R. (2002). Thought and language index: An instrument for assessing thought and language in schizophrenia. *British Journal of Psychiatry, 181*, 326–330.
Marengo, J. T., Harrow, M., & Lanin-Kettering, I. (1986). Evaluating bizarre-idiosyncratic thinking: A comprehensive index of positive thought disorder. *Schizophrenia Bulletin, 12*, 497–511.
Newby, D. (1998). 'Cloze' procedure refined and modified. 'Modified cloze', 'reverse cloze' and the use of predictability as a measure of communication problems in psychosis. *British Journal of Psychiatry, 172*, 136–141.
Oaksford, M., & Hall, S. (2016). On the source of human irrationality. *Trends in Cognitive Sciences, 20*, 336–344. https://doi.org/10.1016/j.tics.2016.03.002.
Ott, S. L. S., Roberts, S., Rock, D., Allen, J., & Erlenmeyer-Kimling, L. (2002). Positive and negative thought disorder and psychopathology in childhood among subjects with adulthood schizophrenia. *Schizophrenia Research, 58*, 231–239.
Piro, S. (1987). *El Lenguaje Esquizofrenico*. Mexico: Fondo de Cultura Economica.
Popovic, D., Schmitt, A., Kaurani, L., Senner, F., Papiol, S., Malchow, B., Fischer, A., Schulze, T. G., Koutsouleris, N., & Falkai, P. (2019). Childhood trauma in schizophrenia: Current findings and research perspectives. *Frontiers in Neuroscience, 13*, 274.

Roche, E., Creed, L., MacMahon, D., Brennan, D., & Clarke, M. (2015). The epidemiology and associated phenomenology of formal thought disorder: A systematic review. *Schizophrenia Bulletin, 41*, 951–962.

Rosenbaum, B., & Burgaard, L. (1993). Psychotherapy of schizophrenia: Aspects of the therapist's position. In G. Benedetti & P. M. Furlan (Eds.), *The psychotherapy of schizophrenia. Effective clinical approaches-controversies, critiques and recommendations* (pp. 125–129). Toronto: Hogrefe and Huber Publishers.

Rosenbaum, B., & Sonne, H. (1986). *The language of psychosis*. New York/London: New York University Press.

Rubens, A. B., & Garret, M. F. (1991). Anosognosia of linguistic deficits in patients with neurological deficits. In G. P. Prigatano & D. L. Schacter (Eds.), *Awareness of deficit after brain injury. Clinical and theoretical issues* (pp. 40–52). New York/Oxford: Oxford University Press.

Sperber, D., & Wilson, D. (1995). *Relevance, communication and cognition* (2nd ed.). Oxford: Basil Blackwell.

Stemmer, B. (1999). Introduction. *Brain and Language, 68*, 389–391.

Stenning, K., & Monaghan, P. (2004). Strategies and knowledge representation. In J. P. Leighton & R. Stenberg (Eds.), *The nature of reasoning* (pp. 148–149). Cambridge: Cambridge University Press.

Stilo, S. A., & Murray, R. M. (2010). The epidemiology of schizophrenia: Replacing dogma with knowledge. *Dialogues Clin Neuroscience, 12*, 305–315.

Sumner, P. S., Bella, I. H., & Rossell, S. L. (2018). A systematic review of task-based functional neuroimaging studies investigating language, semantic and executive processes in thought disorder. *Neuroscience and Biobehavioral Reviews, 94*, 59–75.

Tirassa, M. (1999). Communicative competence and the architecture of the mind/brain. *Brain and Language, 68*, 419–441.

Toth, S. L., Stronach, E. P., Rogosch, F. A., Caplan, R., & Cicchetti, D. (2011). Illogical thinking and thought disorder in maltreated children. *Journal of the American Academy of Child and Adolescent Psychiatry, 50*, 659–668.

Wright, J. H., Turkington, D., Kingdon, D. G., & Ramirez, B. M. (2009). *Cognitive behaviour therapy for severe mental illness: An illustrated guide*. Washington, DC/London: American Psychiatric Publishing.

Yoshimi, J., & Vinson, D. W. (2015). Extending Gurwitsch's field theory of consciousness. *Consciousness and Cognition, 34*, 104–123.

# Chapter 20
# Paved with Good Intentions: Defining Traumatic Stress Disorders


**Arieh Y. Shalev**

**Contents**



## Introduction

Triggered by a life event, altering the reactivity of the central nervous system, and reported in an interpersonal space, post-traumatic stress disorder (PTSD) arguably offers the most tangible illustration of the intermediate space within which psychiatric disorders reside. Its short history additionally offers some of the most striking expressions of futile debates (and studies) emanating from objectifying and reifying the disorder's symptomatic expressions, confounding representations with an underlying object and underrating the social and interpersonal moderators of PTSD expression and development. Unlike better-established disorders, such as schizophrenia or depression, conflicts about the validity and the nature of PTSD are mainstream, explicit and blatant. These, thus, provide us an opportunity to explore, in the open, trends and misperceptions that may well apply to other conditions.

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## *Born in Sin*

PTSD detractors never cease to mention that this disorder regained formal recognition, in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-III 1980), following a partisan and politically motivated advocacy campaign (Young 1997; McHugh and Treisman 2007). PTSD, goes the argument, is uniquely linked to a triggering and diversely defined event (e.g. in successive DSM editions). This linkage allows the colouring of the triggering events as, alternatively, accidental, intended, evil or criminal with each category, of course, framed by unspoken value judgments. Such categorizations can then be used to justify compensation or retribution. PTSD has thus gained an acceptance and desirability not seen for other disorders and has become a cultural, as much as medical, construct. For some (e.g. Young 1997, 2000; Summerfield 2001), those are good-enough reasons to dismiss PTSD without further ado, as born in sin, expressing and at times expiating Western societies' moral conundrums and offering a 'Harmony of Illusion' rather than strict science.

For PTSD defenders, on the other hand, denying survivors' plight and ignoring the fact of 'psychological injury' is morally and humanely abhorrent and factually wrong: survivors readily express these symptoms after 'trauma' (whatever that is) and thus – post hoc *ergo propter hoc* – because of the 'trauma'.

One wonders, however, if PTSD detractors would have similarly dismissed a 1973 American Psychiatric Association committee's decision to scrap homosexuality from the DSM-II list of mental disorders, a move clearly linked with changing social norms and perceptions, and if the defenders, at their end, would be entirely satisfied with psychiatric diagnoses' use as a tool for social redress or, in other times, reprisal.

No construct exists without a social, historical and conceptual context – as the Cambridge School of Psychopathology has taught us. Accordingly, the salient error in both the pro and the con camps, is their accepting, as an object of their debate, the DSM – implied pretense of having found (and subsequently perfected) a universal, transcultural ever-solid diagnostic template. Alternatively, however, is PTSD, or however named traumatic stress disorder, merely 'in the eyes of the beholder?' What amount of plasticity (e.g. in definitional criteria (Hoge et al. 2016)) should lead us to perceive PTSD as a sheer phantom or else stick with it as tangible or at the least useful approximation? And even as a sheer phantom, can PTSD's success and widespread acceptance teach us something that we need to know?

For a professional centrally involved in studying PTSD, like myself, the spectre of dedicating one's work to studying futility was ever-haunting. However, the power to make changes in patients' lives and well-being, using the PTSD construct as a guide and metric, was a consolation of a sort. Both have fostered a sceptical, self-critical and agnostic approach, to which German Berrios' teaching offered a solid anchor. But before we get there, let us dive into some of the endless PTSD debates and firstly into illustrative expressions by both partisans and detractors.

For detractors, ' … *the concept of PTSD has moved the mental health field away from, rather than towards a better understanding of the natural psychological responses to trauma*' (McHugh and Treisman 2007, p. 211). Indeed:

> *Whether judged by promoting differential diagnosis, by fostering coherent psychological explanations, by initiating successful treatment programs, by improving the long-term outcomes of psychological casualties, or by advancing our discipline's body of knowledge through research, PTSD has generated a huge misdirection of effort and many victims of its own* (p. 220).

Others Depicted the disorder as lacking unity, as being put together by the very practices, technologies and narratives with which it has been explored, diagnosed and treated. Furthermore, such efforts into its research and management have been driven by the particular interests of certain bodies and institutions (Young 1997, 2001).

More recently:

> *… the diagnosis of post-traumatic stress disorder lacks specificity: it is imprecise in distinguishing between the physiology of normal distress and the physiology of pathological distress. The criteria in DSM-IV are subjective, and the diagnosis can be made in the absence of significant objective dysfunction. The objectification of distress or suffering means that subjective consciousness is reified; this reification risks being clinically meaningless and a 'pseudocondition'* (Summerfield 2001, p. 97).

In addition, '*each time the diagnosis is made, each time a new paper is published, each time a new claim for compensation is made, its (i.e. PTSD's) apparently free standing existence and natural place in the world is reaffirmed'* (Summerfield 2001, p. 97).

Joining the choir, data analytic magicians (Galatzer-Levy and Bryant 2013) have critically addressed the number of permutations of PTSD diagnostic criteria that can confer a diagnosis of PTSD:

> *In an attempt to capture the variety of symptoms that emerge following traumatic stress, the revision of posttraumatic stress disorder (PTSD) criteria in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) has expanded to include additional symptom presentations. One consequence of this expansion is that it increases the amorphous nature of the classification. Using a binomial equation to elucidate possible symptom combinations, we demonstrate that the DSM–IV criteria listed for PTSD have a high level of symptom profile heterogeneity (79,794 combinations); the changes, however, result in an eightfold expansion in the DSM–5, to 636,120 combinations* (p. 651).

One wonders what 'symptom profile heterogeneity' is, though. And from the horse's mouth: a recent sequence of radical modifications of formal PTSD diagnostic criteria brought about a situation in which three PTSD diagnostic templates (DSM-IV, DSM 5 and ICD-11) overlap a mere 33% of the times (Stein et al. 2014), a situation that, according to twelve PTSD 'top' experts gives rise to major concerns whether by changing the PTSD definition, its diagnosis and clinical care will actually be improved and what consequences this may have for generations of veterans (Hoge et al. 2016). Our own peregrinations through PTSD reclassification madness (Barbano et al. 2018, 2019) have only reinforced the impression that trying to improve precision will reduce accuracy. We found that, relative to ICD-10 PTSD,

ICD-11 diagnostic criteria misclassified 50% symptomatic survivors as having no PTSD. Moreover, instead of 'cleaning' PTSD from overlapping depression and anxiety, individuals identified as having PTSD by the ICD-11's restricted template (six PTSD-exclusive criteria compared with thirteen in ICD-10) were more depressed and equally anxious.

### *Success Story*

Judged by its prominence in both popular media and scientific literature, defining PTSD has been a very successful exercise. Medline cites 1534 English publications on PTSD human research in 2018 alone – and similar numbers in the five previous years. Research funding for PTSD is staggeringly high. Animal models for PTSD increasingly 'inform' intervention practices (Matar et al. 2009; Cohen et al. 2012). Brain imaging and psychophysiological and neurobehavioral studies converge to show typical, though rarely disorder-specific, findings (Pitman et al. 2012; Shalev et al. 2017). Within DSM taxonomy, PTSD, an anxiety disorder in DSM-IV, became an anchor condition for a new DSM-5 diagnostic group entitled *Trauma and Stressor Related Disorders*, a strong corroboration of the desirability of the link between a traumatic event, whatever that is, and specific disorders.

At the same time, PTSD is increasingly shied away from as a descriptor of a cohesive and distinct biological entity and efficient grouping factor for neurobehavioural research.

Finally, years of studying PTSD have not reduced the prevalence of the disorder (e.g. Marmar et al. 2015; Zatzick et al. 1997), treatment studies show conflicting results (Steenkamp and Litz 2013, 2014), pharmacotherapy is marginally efficient if at all (Hoskins et al. 2015, Ipser et al. 2009) and attaining stable remission – let alone recovery – remains elusive (Lee et al. 2016). As an act of final despair, studies increasingly resort to data-driven methods with the hope of better 'revealing' reality through markers' clustering rather than by conceptually or hypotheses-driven studies (e.g., Schultebraucks and Galatzer-Levy 2019). Nobody dares theorize anymore. Previous theories and explanatory constructs are displaced by stacks of accumulating, though haphazardly collected 'evidence'.

## Why?

Several reasons can be evinced to explain the combined success and shortcoming of the PTSD construct. First is the hubris underlying the idea that a prescriptive symptom template, generated via consensus (or committees), offers a descriptor that is valid across events and circumstances and good enough fot *rejecting non-cases*. The main point here is moving from description (e.g. an ordained inventory of the disorder's indicators) to prescription (a sine qua non 'must-have' list). As strongly argued

by McHugh and Treisman (2007), the dominance of DSM-III top-down symptoms' menus superseded a careful 'bottom up' diagnostic inquiry in clinical practice (suffice it, now, to ask the patient 17, or currently 21, previously sanctioned, universally informative questions). Such authoritarian standardization is commensurate with Medicine's increasing industrialization. Within this trend, the PTSD over-specified construct (21 symptom criteria, compared with 9 for major depression or 8 for obsessive compulsive disorder (Galatzer-Levy and Bryant 2013)) creates a hierarchy of essential and inessential features and provides a seductive sense of unquestionable (i.e. repeatedly uttered) knowledge, exactitude and 'truthfulness'.

Related are the captivating simplicity, accessibility and unequivocal decision rules offered by PTSD diagnostic templates (never mind their successful revisions). Here are the 17 or 21 items that you have to assess in order to reach a diagnosis – nothing else is required (e.g. had the person lost a leg, sustained a head injury, fully understands the questions). Such simplicity turns out to have been addictive. It has also led to reifying PTSD and confounding the menu (the set of pointers to neurobehavioral pathology) with the meal. For many (clinicians, students, researchers), PTSD templates became the disorder itself. The Galatzer-Levy and Bryant (2013) finding of 'too many ways to have PTSD' is an example of such confusion: representations' multiplicity does not necessarily negate the object's uniqueness.

The dominance of a general linear model and group-average comparisons (e.g. in adjudicating treatment efficacy) might have further obscured subgroups' heterogeneities and falsely assumed a good-enough coherence. This becomes even more problematic in multimodal studies that combine variables with different distributional patterns and grounding rules. Despite the often-overlooked fragility of the underlying models, the results of such efforts provide a sense of certainty and factuality, until, as usual, they fail to replicate, at which point other numbers are crowned, to keep us content and confident.

Most importantly, in their approach to PTSD, a disorder triggered by a human event, psychiatry and in particular biological psychiatry ignore the interpersonal and social space. Pertinent biology is within individuals' bodies or brains, acting (or being tested) one by one, extracted from their living environment. The brain is understood through its engineering patterns (circuitry, connectivity) or modulatory processes (e.g. dopamine or corticosteroids) extracted from their interpersonal and environmental role. PTSD brain research, therefore, successively idolized and rejected an amygdala-centric (fear conditioning) view of the disorder (Delgado et al. 2006; Mahan and Ressler 2012) – an amygdala – prefrontal lobe coupling dynamics (Liberzon and Sripada 2008; Liberzon and Phan 2003; Zubieta et al. 1999), resting-state connectivity abnormalities (Sripada et al. 2012; Imperatori et al. 2014) and a transcranial magnetic stimulation evidence of disorder-specific and therapeutic features (Keynan et al. 2016, Goodkind et al. 2015). None of these has produced good-enough explanatory or predictive models. Compared with these descriptors, the measurements of social or interpersonal effects in psychiatry are rudimentary, poorly researched and lacking consensus across investigators.

Finally, theory or theorizing is marginalized, such that the entire enterprise of research into PTSD fails to answer any systematic question or hypotheses but rather

follows an often individual thread of findings or better-liked hypotheses. The 'stress' in stress disorder has nothing to do with Selye's homeostatic model – it is a word deprived of sense, borrowed for its appeal and falsely implied clarity.

## Where Dr. Berrios' Teaching Opens a Path Forward

Good teachers help you learn new things. Great teachers change the way you see the world. My year in Cambridge was of the second kind, and although I have not been convinced that I should stop exploring the PTSD futility (the Cambridge environment of the time was keener on 'true' disorders such as depression and schizophrenia), I was brought to deeply rethink and critically organize my views and line of studies.

What kept me believing that the PTSD effort is a worthwhile exercise was the ability to consider the above-mentioned epistemic weaknesses of the born-in-sin disorder within a Berrios-inspired integration. Symptoms first: by including specific diagnostic criteria, DSM-III and the subsequent editions lure you to believe that you *know* what PTSD is. They take away the critically required epistemic questioning of your knowledge. When you know that, you can avoid engaging in DSM idolatry. Diagnostic criteria self-propagate and self-perpetuate when research is funded to specifically use them, and publications are sanctioned using samples defined by their usage. One needs a systematic way to, on the one hand, sing the common hymn strongly enough to survive (i.e. get funded and published) and, on the other hand, not confound the concreteness of a ritual with the true order of things and keep questioning despite inherent epistemic limitations. None of this would have been possible without the Cambridge School of Psychopathology's seeds.

## Reintroducing Simplicity

As things stand now, confusion reigns in PTSD diagnostics and syndrome-driven research. PTSD diagnostic templates identify partially overlapping subsets of symptomatic individuals. The boundaries between PTSD, depression and anxiety disorders remain blurred despite efforts to simplify PTSD diagnostic criteria (Barbano et al. 2019). Syndrome-guided functional brain imaging research shows overlapping features of PTSD, social anxiety disorder, specific phobia and fearful healthy individuals (Etkin and Wager 2007). Genetic research consistently shows pleiotropic effects of gene variants (e.g. Misganaw et al. 2019; Sharma and Ressler 2019). The rapidly expanding knowledge base associated with PTSD doesn't seem to converge. Modestly simplifying things might help. For example, the severity of early PTSD symptoms offers a robust and tight individual estimate of chronic PTSD risk (Shalev et al. 2019) – an effect most probably due to remaining within the same

domain (symptoms) and accepting the limitations of the PTSD template as good-enough **approximation** of an underlying condition.

Alternatively, it is perhaps time to reassess the extent to which the psychiatric 'thing' – exemplified by PTSD in this chapter – is entirely, or even satisfactorily quantifiable and measurable (Marková and Berrios 1995, 2012). Symptoms may exist, or emerge, or cross a threshold of self-awareness in a cultural, interpersonal or introspective space. As such they are crude, varying, but also best-of-kind pointers towards mental trouble. One doesn't really want to mystify the unaccountable, yet much of the PTSD conundrum might have resulted from assuming more computable objectivity than the construct can bear. This takes me straight back to the Cambridge School of Psychopathology's evening seminars: Looking backward, a year with German Berrios in Cambridge, still illuminates a forward-looking path.

## References

Barbano, A. C., Van Der Mei, W. F., Bryant, R. A., Delahanty, D. L., Deroon-Cassini, T. A., Matsuoka, Y. J., Olff, M., Qi, W., Ratanatharathorn, A., Schnyder, U., Seedat, S., Kessler, R. C., Koenen, K. C., & Shalev, A. Y. (2018). Clinical implications of the proposed Icd-11 PTSD diagnostic criteria. *Psychological Medicine, 49*, 483–490.

Barbano, A. C., Van Der Mei, W. F., Deroon-Cassini, T. A., Grauer, E., Lowe, S. R., Matsuoka, Y. J., O'donnell, M., Olff, M., Qi, W., Ratanatharathorn, A., Schnyder, U., Seedat, S., Kessler, R. C., Koenen, K. C., Shalev, A. Y., & International Consortium To Prevent, P. (2019). Differentiating PTSD from anxiety and depression: Lessons from the ICD-11 PTSD diagnostic criteria. *Depression and Anxiety, 36*, 490–498.

Cohen, H., Kozlovsky, N., Alona, C., Matar, M. A., & Joseph, Z. (2012). Animal model for PTSD: From clinical concept to translational research. *Neuropharmacology, 62*, 715–724.

Delgado, M. R., Olsson, A., & Phelps, E. A. (2006). Extending animal models of fear conditioning to humans. *Biological Psychology, 73*, 39–48.

Etkin, A., & Wager, T. D. (2007). Functional neuroimaging of anxiety: A meta-analysis of emotional processing in PTSD, social anxiety disorder, and specific phobia. *The American Journal of Psychiatry, 164*, 1476–1488.

Galatzer-Levy, I. R., & Bryant, R. A. (2013). 636,120 ways to have posttraumatic stress disorder. *Perspectives on Psychological Science, 8*, 651–662.

Goodkind, M., Eickoff, S., Oathes, D., Jiang, Y., Chang, A., Jones, L., Ortega, B., Zaiko, Y., Roach, E., Korgaonkar, M., Grieve, S., Galatzer-Levy, I. R., Fox, P., & Etkin, A. (2015). Identification of a common neurobiological substrate of mental illness. *JAMA Psychiatry, 72*, 305–315.

Hoge, C. W., Yehuda, R., Castro, C. A., Mcfarlane, A. C., Vermetten, E., Koenen, K. C., Greenberg, N., Shalev, A. Y., Rauch, S. A. M., Marmar, C. R., & Rothbaum, B. O. (2016). Unintended consequences of changing the definition of posttraumatic stress disorder in Dsm-5 critique and call for action. *JAMA Psychiatry, 73*, 750–752.

Hoskins, M., Pearce, J., Bethell, A., Dankova, L., Barbui, C., Tol, W. A., Van Ommeren, M., De Jong, J., Seedat, S., Chen, H., & Bisson, J. I. (2015). Pharmacotherapy for post-traumatic stress disorder: Systematic review and meta-analysis. *The British Journal of Psychiatry, 206*, 93–100.

Imperatori, C., Farina, B., Quintiliani, M. I., Onofri, A., Castelli Gattinara, P., Lepore, M., Gnoni, V., Mazzucchi, E., Contardi, A., & Della Marca, G. (2014). Aberrant Eeg functional connectivity and Eeg power spectra in resting state post-traumatic stress disorder: A Sloreta study. *Biological Psychology, 102*, 10–17.

Ipser, J. C., Sander, C., & Stein, D. J. (2009). Pharmacotherapy and psychotherapy for body dysmorphic disorder. *Cochrane Database of Systematic Reviews*, Cd005332.

Keynan, J. N., Meir-Hasson, Y., Gilam, G., Cohen, A., Jackont, G., Kinreich, S., Ikar, L., Or-Borichev, A., Etkin, A., & Gyurak, A. (2016). Limbic activity modulation guided by functional magnetic resonance imaging–inspired electroencephalography improves implicit emotion regulation. *Biological Psychiatry, 80*, 490–496.

Lee, D. J., Schnitzlein, C. W., Wolf, J. P., Vythilingam, M., Rasmusson, A. M., & Hoge, C. W. (2016). Psychotherapy versus pharmacotherapy for posttraumatic stress disorder: Systemic review and meta-analyses to determine first-line treatments. *Depression and Anxiety, 33*, 792–806.

Liberzon, I., & Phan, K. L. (2003). Brain-imaging studies of posttraumatic stress disorder. *CNS Spectrums, 8*, 641–650.

Liberzon, I., & Sripada, C. S. (2008). The functional neuroanatomy of PTSD: A critical review. *Progress in Brain Research, 167*, 151–169.

Mahan, A. L., & Ressler, K. J. (2012). Fear conditioning, synaptic plasticity and the amygdala: Implications for posttraumatic stress disorder. *Trends in Neurosciences, 35*, 24–35.

Marková, I. S., & Berrios, G. E. (1995). Mental symptoms: Are they similar phenomena? The problem of symptom heterogeneity. *Psychopathology, 28*, 147–157.

Marková, I. S., & Berrios, G. E. (2012). Epistemology of psychiatry. *Psychopathology, 45*, 220–227.

Marmar, C. R., Schlenger, W., Henn-Haase, C., Qian, M., Purchia, E., Li, M., Corry, N., Williams, C. S., Ho, C.-L., & Horesh, D. (2015). Course of posttraumatic stress disorder 40 years after the Vietnam war: Findings from the National Vietnam veterans longitudinal study. *JAMA Psychiatry, 72*, 875–881.

Matar, M. A., Zohar, J., Kaplan, Z., & Cohen, H. (2009). Alprazolam treatment immediately after stress exposure interferes with the Normal Hpa-stress response and increases vulnerability to subsequent stress in an animal model of PTSD. *European Neuropsychopharmacology, 19*, 283–295.

McHugh, P. R., & Treisman, G. (2007). PTSD: A problematic diagnostic category. *Journal of Anxiety Disorders, 21*, 211–222.

Misganaw, B., Guffanti, G., Lori, A., Abu-Amara, D., Flory, J. D., Mueller, S., Yehuda, R., Jett, M., Marmar, C. R., Ressler, K. J., & Doyle, F. J., 3rd. (2019). Polygenic risk associated with posttraumatic stress disorder onset and severity. *Translational Psychiatry, 9*, 165.

Pitman, R. K., Rasmusson, A. M., Koenen, K. C., Shin, L. M., Orr, S. P., Gilbertson, M. W., Milad, M. R., & Liberzon, I. (2012). Biological studies of post-traumatic stress disorder. *Nature Reviews. Neuroscience, 13*, 769–787.

Schultebraucks, K., & Galatzer-Levy, I. R. (2019). Machine learning for prediction of posttraumatic stress and resilience following trauma: An overview of basic concepts and recent advances. *Journal of Traumatic Stress, 32*, 215–225.

Shalev, A., Liberzon, I., & Marmar, C. (2017). Post-traumatic stress disorder. *The New England Journal of Medicine, 376*, 2459–2469.

Shalev, A. Y., Gevonden, M., Ratanatharathorn, A., Laska, E., Van Der Mei, W. F., Qi, W., Lowe, S., Lai, B. S., Bryant, R. A., Delahanty, D., Matsuoka, Y. J., Olff, M., Schnyder, U., Seedat, S., Deroon-Cassini, T. A., Kessler, R. C., Koenen, K. C., & International Consortium To Predict, P. (2019). Estimating the risk of PTSD in recent trauma survivors: Results of the international consortium to predict PTSD (Icpp). *World Psychiatry, 18*, 77–87.

Sharma, S., & Ressler, K. J. (2019). Genomic updates in understanding PTSD. *Progress in Neuro-Psychopharmacology & Biological Psychiatry, 90*, 197–203.

Sripada, R. K., King, A. P., Garfinkel, S. N., Wang, X., Sripada, C. S., Welsh, R. C., & Liberzon, I. (2012). Altered resting-state amygdala functional connectivity in men with posttraumatic stress disorder. *Journal of Psychiatry & Neuroscience: JPN, 37*, 241–249.

Steenkamp, M. M., & Litz, B. T. (2013). Psychotherapy for military-related posttraumatic stress disorder: Review of the evidence. *Clinical Psychology Review, 33*, 45–53.

Steenkamp, M. M., & Litz, B. T. (2014). One-size-fits-all approach to PTSD in the VA not supported by the evidence. *The American Psychologist, 69*, 706–707.

Stein, D. J., Mclaughlin, K. A., Koenen, K. C., Atwoli, L., Friedman, M. J., Hill, E. D., Maercker, A., Petukhova, M., Shahly, V., Van Ommeren, M., Alonso, J., Borges, G., De Girolamo, G., De Jonge, P., Demyttenaere, K., Florescu, S., Karam, E. G., Kawakami, N., Matschinger, H., Okoliyski, M., Posada-Villa, J., Scott, K. M., Viana, M. C., & Kessler, R. C. (2014). DSM-5 and ICD-11 definitions of posttraumatic stress disorder: Investigating 'narrow' and 'broad' approaches. *Depression and Anxiety, 31*, 494–505.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ, 322*, 95–98.

Young, A. (1997). *The harmony of illusion: Inventing post-traumatic stress disorder*. Princeton University Press: Princeton.

Young, A. (2000). An alternative history of traumatic stress. In *International handbook of human response to trauma*. Boston: Springer.

Young, A. (2001). Our traumatic neurosis and its brain. *Science in Context, 14*, 661–683.

Zatzick, D. F., Marmar, C. R., Weiss, D. S., Browner, W. S., Metzler, T. J., Golding, J. M., Stewart, A., Schlenger, W. E., & Wells, K. B. (1997). Posttraumatic stress disorder and functioning and quality of life outcomes in a nationally representative sample of male Vietnam veterans. *The American Journal of Psychiatry, 154*, 1690–1695.

Zubieta, J. K., Chinitz, J. A., Lombardi, U., Fig, L. M., Cameron, O. G., & Liberzon, I. (1999). Medial frontal cortex involvement in PTSD symptoms: A Spect study. *Journal of Psychiatric Research, 33*, 259–264.

# Chapter 21
# Distortions of Time Experience and Descriptive Psychopathology


**Jorge Carlos Holguín Lew**

## Contents



The study of the subjective aspects of time has followed a singular path in psychiatry and psychopathology. Although since the nineteenth century, psychiatrists have devoted some effort to the description and conceptualisation of unusual or 'distorted' time experiences (DTE) of patients, these phenomena are not part of the current 'pool of symptoms'. Thus, their clinical and theoretical value for contemporary clinical psychiatry remains uncertain. This paper has three main goals: firstly, to outline some historical and conceptual aspects of DTE; secondly, to provide an account of the descriptive psychopathology of DTE; and finally, to propose a preliminary classification of DTE to serve as the basis for future research. Accordingly, the paper has four main parts:

- Part I: General conceptual introduction
- Part II: A historical summary and analysis of psychiatric research on DTE
- Part III: The symptoms described
- Part IV: Towards a new classification for DTE

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# Part I: General Conceptual Introduction

> *You are asking me questions about time Dr…I am not very sure what do you mean. Tell me what do you mean by time and maybe I can tell you something about it….*
> **(GV a Colombian patient diagnosed with bipolar disorder, during a depressive episode)**

## *On Descriptive Psychopathology*

Because there are different schools and traditions within psychopathology, it is necessary to first briefly enounce the conceptual stance of this paper. Here, the approach descriptive psychopathology (DP) is based on the work of German E. Berrios and the Cambridge School of Psychopathology (Marková and Berrios 2009; Berrios 2011a; Aragona and Marková 2015). Within this conceptual context, DP means the following:

- A stable language containing assumptions, grammar, vocabulary and application rules.
- It is a cognitive system that is used for the capture of behaviour.
- This capture is made through the consistent application of words to fragments of patient's public behaviour and narratives about subjective states and experiences.
- The vocabulary referents called 'mental symptoms' are the result of identification and construction processes. These processes are not neutral but involve theoretical and ideological assumptions and decisions that must be made explicit.

Finally, DP is not equivalent to phenomenological psychopathology. There are significant differences in their conceptual bases, methods and goals and, therefore, they must be kept distinct. Both approaches and others have contributed to the set of narratives about DTE that are available in the psychiatric literature, and some of the research and findings of phenomenological psychopathology will be mentioned.

## *Time(s)*

It can be asserted that it seems difficult to imagine our life without reference to time and without time as a frame of reference. Nevertheless, what is time remains a matter of debate. Its existence, nature, features, etc., are conceived in different ways by different authors and disciplines. There is no single, unifying definition. Most researchers choose definitions and conceptualisations of time that are useful for their purposes. That is why authors talk about physics of time, sociology of time, philosophy of time and psychology of time, but also about the time of physics and

clocks, the time of societies and cultures and psychological time (Fraser 1987, 2007; Levine 1997, 2013; Flaherty 1999; Le Poidevin 2015).

In many cultures people talk about time and tend to refer to time as a physical feature of nature, especially in terms of sequence and succession (ordering) and duration (temporal magnitude) of events. Time is one of the coordinates, along with space, that are used to organise personal and social life. It is used for tracking, classifying and studying natural phenomena and for establishing a framework for social life. We will call it 'geophysical-public time' to emphasise that (a) it is used to refer to a particular feature of nature; (b) it is used as a coordinate, a contextual dimension in which objects and events are situated; and (c) it functions also as a reference tool to organise everyday life and social transactions. Geophysical-public time is the time that is conventionally measured using clocks and calendars. As a contextual dimension events of all sorts are inscribed in it. Their duration is measured, and the sequences of their unfolding are identified. The events are also labelled and conceived in relation to consensual temporal locations like after, before, now, past, future and January or September. (Fraser 2007; Mellor 1998; Kontopodis 2014).

Apart from geophysical-public time, people also talk about how time seems to happen in their personal, private psychological life. People in most cultures say things about time that have to do with the application of time not only to extrapersonal issues (its use as a tool for the actualisation of geophysical coordinates, or to measure and order happenings) but also to an (often) ineffable personal dimension. This ineffability of time as it is experienced frequently forces people to use analogies and metaphors and to construct special narratives to talk about it. Some of these metaphors, analogies and narratives are not only quite common but also seem to be historically and culturally stable and, importantly, interpersonally understandable. Other narratives about the subjective experience of time appear too private and difficult to understand. This psychological realm of time has also received many names. The expressions 'time experience' and 'experience of time' have been chosen for this paper, because of the intrapersonal and ineffable connotations of the word experience and because they pertain to what is generally accepted as 'subjectivity' (James 1886; Lakoff and Johnson 1999; Fulmer and Crosby 2014; Le Poidevin 2015).

## *On Time and Psychiatry*

Time has been conceived and used in clinical psychiatry in at least three different ways: as a contextual dimension, as an intrinsic feature of behaviour and as a subjective experience. As a *contextual dimension* the use of time broadly corresponds to what can be called longitudinal analysis of disease. The temporal features of mental disorders have been considered important carriers of clinical and causal information, a notion that has given a central role to time as a *variable* since the nineteenth century. Temporal location, sequence, duration and frequency of diseases and treatments have been studied and used to establish nosological limits and

differences and attempt predictions and are at the core of important concepts such as course, outcomes, prognosis and risk (Berrios 1996, 2011a).

As an *intrinsic feature of behaviour*, time is one of the features used to assess behavioural dysfunction in terms of the dislocations in rate, duration and sequence of motility and language (e.g. slowness, agitation, catatonia and thought disorders). This intrinsic feature of behaviour can also be translated to cyclical behaviours like sleeping, eating and menses (Summers and Anson 2009; Kornysheva 2016).

As a *subjective phenomenon*, aspects of time described in the narratives of patients that seem to depart from the ordinary are found in several psychiatric and neuropsychiatric conditions. In general, authors have been interested in DTE mainly because they have seen in them an indication of an altered subjectivity, in the broad sense of a disturbance of how the world and self are privately/personally appraised and experienced in mental illness (Lewis 1932; Jaspers 1963; Melges 1982, 1989, 1990; Cutting and Silzer 1990; Cutting 1997, 2012).

## *A Note on the Differences Between Experimental Psychology of Time and the Psychopathology of Time*

In experimental psychology, subjective time has been assessed through performance in 'time-related tasks' or 'timing skills' (e.g. time estimation) and operational definitions of time perspective. Differences in performance on such tasks between healthy subjects and patients have been usually conceived as part of a continuum ranging from normality to disorder. Importantly, time estimation and performance in time-related tasks are not equivalent to what is usually conceived as time experience in psychopathology. Subjective time is basically reduced to personal accounts of time estimation, and the goal of experimental psychological research is to replace these accounts by measures of efficiency of the individual's performance in time-related tasks (James 1886; Fraisse 1963, 1984; Grondin 2010; Block and Grondin 2014).

From the psychopathological perspective, subjective time refers to the *qualitative* aspects of time as they appear to the individual at a given moment or what has been traditionally called time experience. This approach emphasises the study of *what patients say* about time because it has been presumed that their narratives are relatively reliable and valid expressions of a particular subjective state involving temporality. Grounded in diverse philosophical and psychopathological traditions, it tends to assume a discontinuity between normal and abnormal temporal experiences and therefore consider them as qualitative variations rather than mere quantitative differences in performance (Jaspers 1963; Cutting 1997, 2012; Melges 1982, 1989, 1990). This paper focuses on *what patients say* about time in general, about some temporal features of events and about past, present and future.

## Part II: A Historical Summary and Analysis of Psychiatric Research on DTE

Some of the first explicit references to DTE can be found in the work of Moreau de Tours (1845). This French author described the unusual experiences of time arising during hashish intoxication and psychosis. He called them *'erreurs et illusions sur le temps'* (errors and illusions of time), terms that implied a sensory notion of subjective time. He explained them as the result of cerebral excitement in the nineteenth-century sense. Moreau de Tours described several distortions of time experience, for example, how actual events gave him the impression of having occurred a long time ago, or the altered duration of events (a protraction of time where 15 minutes seemed to him like 300 years), and the lack of unity of time, among other experiences. Browne (1874) described various altered time experiences in the context of various mental disorders. He noticed, for example, that in fever 'Days, weeks, months are blotted out from the Calendar of life' (p. 521). In Mania he speculated on the attention disturbance and on the 'extreme rapidity and tumultuousness' of thoughts and feelings (p. 523). Buccola (1883) studied the alterations of subjective time in different populations from an experimental perspective.

The end of the nineteenth century up to the 1960s marked the 'golden age' of the psychopathological study of time experience. The works of Minkowski and Janet in France and of Jaspers, Von Gebsattel, Binswanger and others in Germany contributed to the idea that (a) there were various disturbances of psychological time and time experience in mental illness, (b) these disturbances had the status of symptoms and (c) these symptoms were important for diagnosis and for therapy (e.g. Janet 1928; Minkowski 1958, 1962, 1995; Binswanger 1960; Jaspers 1963).

As symptoms, depending on the author's school of thought, they could be (a) the problem in itself (i.e. disturbed temporality), (b) phenomena secondary to a more fundamental disturbance of other functions (e.g. attention, memory) and (c) a symbol of other disturbed unconscious processes. The implications of the conceptual affiliation were profound. For Minkowski, their study would require a particular approach allowing their direct capture; for psychoanalysts the narratives were symbols of other more meaningful (unconscious) events and structures in need of interpretation (Minkowski 1958, 1962, 1995; Bonaparte 1940).

However, during the second half of the twentieth century, interest in DTE faded in mainstream psychiatry, and only few continued their research in a systematic way. Among them, F. Melges, J. Cutting[1] and more recently B. Shanon (2001) deserve a special mention, because they attempted to study these symptoms by proposing concepts, classifications and models that were suitable for empirical research. In the twenty-first century, a growing number of papers and book chapters were written by phenomenological psychiatrists. It is important to emphasise that they

[1] Although more recently Cutting has approached these phenomena from a phenomenological perspective (see Cutting 2012), the descriptions of DTE and the classification he offered in his 1997 book are akin to DP.

have kept the subject alive in psychiatry, although their work has not yet been influential in what could be called 'official' clinical psychiatry. Thus, in most clinical interview and diagnostic manuals, DTE continue to be absent.

Finally, studies based on experimental psychology of time have been done, using new paradigms and technologies, with the objective of delineating a timing profile in psychiatric patients.

Based on the above, it can be argued that since the nineteenth century patients' narratives about time have received at least five main competing interpretations:

(a) *As the direct expression of abnormalities in 'time function'*: It is assumed that humans possess some sort of knowledge of 'real time' that can be reliably expressed through language. On this approach, psychological or subjective time is the 'image of time' created by the brain and cognition, and this image corresponds more or less to geophysical time. It is also supposed that underlying mechanisms and/or causes can be determined by directly studying neurobiological/cognitive correlates in subjects. In this sense, DTE constitute stereotyped responses to brain dysfunction, and it is assumed that it is possible to find meaningful correlations between neurobiology and narratives. From this perspective, in DTE the distorted cerebral signal arises in conscious experience without an important degree of psychosocial formatting, suggesting that the 'brain clock' is malfunctioning.

(b) *As metaphors or symbols*: although humans possess some sort of direct knowledge of time, narratives about time and time distortions are metaphors or symbols of other processes. To talk about time is a way to talk about other sufferings. In this case narratives involving DTE are conceived as pure psychological phenomena. Hence, DTE must be examined using different methods, focusing on the analysis and interpretation of content (e.g. Bonaparte 1940; Abraham 1976).

(c) *As the result of alterations in other psychological processes:* psychological time is not conceived as an independent function, but as the product of the interplay between more 'basic' cognitive abilities (e.g. memory, emotion, attention and alertness) and environmental information. Therefore, DTE are viewed as phenomena arising in the context of 'primary' memory, emotional, attentional or alertness dysfunctions.

(d) *As the expression of other fundamental abnormal processes*: in this case, time is just *a content* captured in the process of formation of some more fundamental symptoms and/or syndromes (e.g. depersonalisation, hopelessness, delusions).

(e) *As the expression of a particular mode of existence or subjectivity (phenomenological and existential approaches)*: as stated by Fuchs and Pallagrosi (2018, p 290):

> …the impairment of lived time should not be considered as simply one symptom among others. On the contrary, it expresses a fundamentally altered mode of existence which cannot be reduced to brain dysfunctions. Indeed, a lack of attention to this aspect implies the loss of the possibility to articulate the subjectivity of the affected person in a comprehensive way, leading to a flawed psychopathological understanding.

In the phenomenological method the psychopathologist attempts to grasp the 'fundamental' troubles instead of mere epiphenomena, and hence, its use implies a quest for the pathognomonic features of mental disorders. Instead of collecting symptoms and narratives for subsequent grouping into syndromes, the clinicians attempt to uncover the particular 'mode of existence' of patients. For authors like Minkowski and Binswanger, the time narratives of patients were expressions of a particular mode of being in the world, of a non-ordinary reality that patients attempted to communicate to others using 'terms borrowed from their previous life', a life where the microstructure of consciousness and experience are deeply distorted (Minkowski 1958, 1962, 1995; Binswanger 1960; Jaspers 1963; Von Gebsattel 2013).

## *Why Are DTE Not Part of the Current 'Official List' of Symptoms?*

That some symptoms tend to disappear and others to endure across different historical periods is one of the most notable facts in the history of psychopathology. Diverse factors have been invoked to account for this including scientific, conceptual, sociopolitical and economical (Berrios 1996, 2011a). Thus, a central question is why DTE have not attained the status of other mental symptoms like delusions or hallucinations.

One way to understand this is to view it as a failure of convergence processes. Convergence has been defined by Berrios (Berrios and Marková 2004; Berrios 2011b) as the connection between terms, concepts and behaviours in the oeuvre of a given author from which a particular behavioural phenomenon emerges as a symptom. This is by no means a purely 'scientific' process. In fact, sociopolitical and cultural factors can be equally or more powerful driving forces underlying the incorporation of a given behavioural disturbance into the psychiatric corpus of knowledge. For example, as a consequence of its political power, the American Psychiatric Association (APA) definitions of symptoms are widely used in research and clinical practice. Although debates in the psychiatric community, based on research, are important for the identification and selection of putative symptoms, at some point other values and interests enter into operation and become the drivers of decisions and the determinants of the incorporation, postponement or elimination of symptoms and syndromes.

Berrios (1996, 2011b) has shown how the quality of convergence processes is a determinant for the historical stability of a symptom. Thus, symptoms arising from convergence processes where there is a strong correspondence between the observed behaviour and its terminology, description and conceptualisation would have greater likelihood of achieving historical stability. Symptoms arising from a 'strong' convergence will endure and become part of the psychiatric language. They will be considered informative and meaningful for clinical and theoretical purposes.

Conversely symptoms arising from convergence processes, in which the correspondence between those elements is 'fragile' or 'incomplete', will be less stable and, therefore, viewed as having less informative value. Consequently, an unstable or fragile symptom will be more likely to fall into the 'blindsight' area of clinicians and researchers and will be simply ignored and/or dismissed as irrelevant. The failed convergence as far as DTE are concerned can be explained as the result of several factors:

- The lack of a metalanguage for time experience in psychiatry
- The premature closure of psychopathology
- The lack of consistent results in empirical/clinical research

As a result, DTE have achieved only an incomplete and/or failed convergence and remain behavioural curiosities. Their value and meaning for research and clinical work have not been established. Even if patients talk about their experiences of time, clinicians do not know how to interpret these. At best they are taken to be peculiar contents of mentally ill patients or aspects of other more fundamental phenomena (e.g. delusions, hallucinations or psychosis).

## Part III: The Symptoms Described

### *Some General Aspects of Ordinary Time Experiences*

Flaherty (1999) proposes three basic experiences of time: synchronicity, compression and protraction. *Synchronicity* refers to what is the most frequent experience of time, where people do not notice its passage. There are no discrepancies between the personal experience of time passage and the happenings in the extrapersonal world and geophysical/clock time. Like other psychological and bodily phenomena, time experience is only noticed when something changes. *Compression* refers to the experience that time passes faster at a subjective level when compared with external cues/measures. *Protraction*, in contrast, refers to the experience that time passes slowly at a subjective level. Finally, another frequent experience is *retrospective compression*, in which time first seems to protract but later, when people are reminded of the event, it seems that it was faster than originally felt.

Ordinary time experience is sensitive to the effects of activity (mental or physical), attention, mood, the type and rate of events, temperature, culture and geography, music, handedness, personality, age and gender, among others (e.g. Lake 2016; Phillips 2012; Droit-Volet 2013; Wittmann and Paulus 2008; Wittmann and Lehnhoff 2005; Danckert and Allman 2005).

### Non-ordinary Time Experiences in Healthy People

Experiences of time that are non-ordinary and that can resemble those reported by patients include the effects of meditation, peak experiences, danger, fear and transient effects of drugs (Kramer et al. 2013; Arstila 2012; Tipples 2011; Bar-Haim et al. 2010). It is not yet clear if the reported similarities mean that these 'non-ordinary' but 'non-DTE' have mechanisms or origins in common or are but 'phenocopies' of each other.

## *DTE: The Phenomena and Their Descriptions*

Based on clinical cases and descriptions in the literature (Jaspers 1963; Melges 1982; Cutting 1997; Shanon 2001), this section summarises and describes DTE according to the traditional division between (1) time experience and (2) time perspective. Time experience refers to what patients say about events in terms of flow, sequence, rate, duration and so on. Time perspective refers to the narratives about past, present and future. However, in practice, this distinction is often difficult to make because of frequent overlap. Thus, it should be viewed more as a methodological resource. Also, it is important to emphasise that patients can report (a) having a single DTE, (b) several DTE at the same time, (c) the recurrence of the same DTE at different times during life or (d) different DTE at different times during life.

(1) **Distorted Time Experiences**

**Experiences of an Altered Rate of Time Passage**
That time seems to flow is one of its central subjective features. People usually have some concordance between the rate of their experienced passage of time and how time passage is measured by external cues, like the clock. In some psychiatric disorders, patients report a significant discrepancy between these two modes of time passage reckoning. This leads to the experience of time passing slower or faster. Although these experiences are frequent in healthy individuals, they appear exaggerated in patients with mental disorders and often with a negative or distressing emotional connotation. The experience of time passing slowly is by far the most frequently described in the psychiatric literature.

**Cessation of Time Passage**
Some patients report that time has been 'frozen', that it is not 'flowing anymore' or that time is 'standing still'. It is not clear if this experience corresponds to an extreme slowing down of time passage in which case it could be considered continuous with normal experience or if it is a separate phenomenon and hence, discontinuous with normal experience. Some patients describe this experience more as a feeling of

detachment from what is happening. Recently, a depressive patient complained that time had become an endless repetition of the same events and linked this to the feeling of time standing still. The cessation of time passage is sometimes accompanied by strong feelings of unreality or depersonalisation, sometimes by apathy, boredom or profound sadness.

**Experience of Altered Continuity in the Flow of Events**

Ordinarily events appear to happen in a more or less ordered way, and their before/after relationships make sense to people. There is a logical connection between events coming into being and passing away, permitting a certain narrative integrity and direction. Patients complain of a disorganised flow of events. Events do not seem to be 'connected' to each other in the usual or understandable way. For example, 'In the street everything felt quite strange. I could not follow what was happening, because it was not logical, a man raised his hand, a lady opens her bag, I heard the sound of a car's klaxon, a plane passed in the sky…it's like if my life was a collection of unconnected fragments…'. Other patients talk about this experience but only in terms of what happens to them and/or to their mental events. For example, one patient under intoxication with scopolamine reported that 'I was shaving, and then walking in the street, and then at home again, and then in the bus again… it was like cuts of a movie that were put together but in the wrong order or omitting some bits gave sense to the story. There was no continuity in my memories, feelings and thoughts'.

**Experience of an Altered Rate of External Events**

Patients can report that external events, objects and people seem to happen, move or speak at an unusual rate, either very fast, slow or alternating between extremes. Also, sometimes movements can seem 'jerky' or 'odd'. *Zeitrafferphänomen* (or 'time lapse phenomenon') is a term coined to name the experience of an acceleration of external events. A patient recalling a traumatic memory of a car accident recounted that 'everything was in slow motion, sounds were distant, people coming to help us took ages to arrive…it was not only my impression I really saw things this way…and then everything speeded up. When I am reliving the accident it always happens in slow motion, my memories of that terrible moment are always in slow motion'. This patient also had the experience of slowing of time passage during the traumatic event. It is not clear however if experiences like these can be dissociated from the experience of time passage or if, for example, in *Zeitrafferphänomen,* the personal experience of time passage is also always accelerated.

**Experiences of 'Unreality of Time'**

Patients can complain that time has changed in a strange way which they find difficult to describe. Events and/or time are reported as 'alien', 'detached' and 'wrong', or even 'a new kind of time' has emerged. However, in most cases reported in the literature, this impression of unreality does not appear to be restricted to time, but is found within the wider context of depersonalisation symptoms. Also, diverse DTE can coexist in patients reporting unreality of time (e.g. distortions in time passage, distortions of time perspective).

**Experience of 'Events Condensation' or 'Time Condensation'**
Some patients claim that a great number of events appear as being 'packed' or 'condensed' into very short time spans. Condensation of events has also been described in nonpsychiatric populations in the context of the so-called peak experiences. This experience occurs frequently with the use of hallucinogenic drugs but has also been reported by psychotic patients. Some authors have described how this experience and those of eternity, atemporality and unreality of time are sometimes accompanied by the impression that a special kind of insight has been gained. For example, a manic patient described how she re-experienced 'all her life in her mind' since her childhood whilst watching TV. She was astonished because the clock had only advanced a few seconds. Afterwards she was convinced that this experience was a revelation from God and that it was a message for her to undertake a mission. This interpretation acquired delusional intensity over several weeks. In spite of remission after treatment, she still considers this experience as a mystical phenomenon.

**Eternity and Atemporality**
Although time is often conceived as infinite, the usual human experience of time involves a duality of continuity and discreteness. On the one hand, the flow of time appears as continuous, but on the other hand, people can only grasp discrete moments. In the experience of eternity, patients describe that the usual finite time span in which their life and/or actions seem to take place has been extended infinitely, generally in terms of an unending present. Other patients describe atemporality in the sense that time has disappeared or that the notion of time is no longer applicable to them. They can report that time 'has ceased to exist' and/or that they are living 'outside time'. A patient recalling an ecstatic experience during a manic episode explained that 'time vanished and I felt that I was living eternity, an eternal moment or better, that to talk about time had no sense anymore…I felt freed from time and space and my body…you cannot imagine the pleasure, the immense serenity I felt. Everything was clear and I could understand everything that had happened in my life'. A patient after a catatonic episode resolved said that 'I was in hell. I can tell because everything ceased, there was no time, time as humans live it did not exist at all…I was trapped in the same moment…it was at the same time eternity and void'. The cases of patients describing experiences of eternity/atemporality reported in the literature seem to appear in the context of an altered level of alertness or/and altered self-consciousness.

## *Other Phenomena Conceived as DTE*

**Delusions Involving Time**
Delusions involving time constitute another heterogeneous group of phenomena. The boundaries between delusional and non-delusional narratives involving time are difficult to establish. This has been the case for the 'syndrome du temps figé', claims of continual death and rebirth, reduplication of time, eternity and immortality,

among others. It is not clear to what extent a distortion of time experience actually underlies these peculiar narratives.

**Reduplication of Time**
Instead of the experience of existing only in a given time and place, patients can report that they live simultaneously in two (or more) alternative times, and/or worlds. In these cases, patients seem to be keeping a true 'double accountancy' in the sense of the coexistence of two parallel/distinct time dimensions.

**'Syndrome du Temps Figé'/'Disorientation for Age'**
Moreau de Tours (1855) pointed to the fact that some patients when recovering seemed to suppress the time elapsed during the active phase of the illness, therefore giving the impression that time did not pass during that period. Vinchon (1920) described this syndrome and called it 'méconnaissance systématique' ('systematic neglect') in psychogeriatric populations. Le Guen (1958) coined the term 'syndrome du temps figé' (syndrome of frozen or stopped time). His aim was to study the changes in temporal behaviour in patients with chronic schizophrenia. The main features of this syndrome include a relatively accurate general orientation for time, a negation or distortion of the time elapsed since illness onset and a shortening or absence of future time perspective. Apparently unaware of the earlier French description, Crow and Stevens (1978) named this phenomenon 'disorientation for age'. They distinguished two main groups, the first constituted by patients with disorientation for age accompanied by a general disorientation for time and the second by patients with only disorientation for age. They viewed the former as underpinned by cognitive deficit and the latter as a delusion, a sign of cognitive deterioration and negative schizophrenia.

**'Miscellaneous' Distortions of Time Experience**
Some distortions in time experience possess a character of ineffability that makes it difficult for patients to express and for the clinician to understand clearly. An example involves changes in the 'meaning' of time for the individual, expressed using utterances like 'time has no meaning and to look at the clock is useless' or 'time has a new meaning'. These statements seem to appear in the context of a change from the way the patients used to experience the effects or consequences of the passage of time. This in turn seems linked to experiences of atemporality, eternity, depersonalisation and time condensation or to the syndrome of 'time figé'. Patients can 'feel' impervious to aging, decay or change and detached from time or say that they are 'living outside time'.

(2) **Altered Time Perspective**

Authors have also been interested in unusual narratives about past, present and future in psychiatric patients. Here, patients describe distortions in the way these time locations are experienced at a given moment. These also can be accompanied by experiences of unreality.

**Loss of the Limits Between Past, Present and Future**

Past, present and future can seem fused together, or one of the temporal locations recurrently intrudes into another, e.g. the impression of past intruding into the present. Even though some authors cite déjà vu as a distortion of time perspective, there is no agreement on this. Whilst it seems possible to define the phenomenon in terms of time (i.e. the past irrupting into the present), since very early it has been defined as a disturbance of memory or familiarity in which the reference to time is secondary. It appears to be best conceptualised as a false impression of remembering. Some authors have included presentments and precognitions in this group of time perspective disturbances. These seem to correspond to unusual experiences of expectation, in which the content is about the future happening of a particular event, or of an undefined adversity, but also of a good outcome.[2]

**Disappearance of Past and Future**

It has been usually reported in relation to the future. Moreover, the disturbances of future perspective have been incorporated as diagnostic features of depressive disorders by some authors. As well as with other DTE, it permits several interpretations:

- A 'narrowing of temporal horizon', in which patients can talk about their plans in the future but in an imprecise way.
- A difficulty or impossibility to make plans and therefore linked to cognitive (executive) deficit.
- A state in which patients seem unable to produce mental images about themselves as actors in their future. Although they can describe plans, they are not able to invoke mental images of the future. In this case the deficit would be one of mental imagery.
- A linguistic resource to describe the pessimistic value given to the future.

Other patients can complain of vanishing of the past, which gives them the impression that 'everything is starting anew all the time'. Two Colombian patients with schizophrenia claimed that they had 'completely lost their past', in that they could correctly enumerate diverse past events under questioning, but could not elicit mental images about them and that these events seemed to have lost their emotional value as if 'they belonged to someone else'. This experience was linked to ideas of continual death/rebirth and to a sense of loss of agency of their mental contents.

[2] One of the problems with the ubiquity of time (either as tense or as content) in ordinary, daily speech is that almost every narrative or utterance can be interpreted in terms of time. Déjà vu, jamais vu, déjà vécu, presentments, memories, etc. can be interpreted as DTE or as distorted memory, attention and expectation. That is why it seems better to include as DTE only those that can be easily assigned to one of the categories proposed that have at the very least some 'face validity'. The categories can be expanded later if research shows that it is necessary. It is also important to insist that references to time by patients can be just communicative resources and therefore misleading and finally that to ask about time is not easy. When asked about time, many patients do not understand (as in the quote at the beginning of the paper) the questions. How to ask questions about time or to choose the 'right' time narratives or fragments of narratives is still uncertain.

**Impression of 'Futurity' and 'Pastness'**
Events happening 'now' seem to belong to the future or to the past. This phenomenon must be distinguished from déjà vu. Although they might share common mechanisms, the symptomatic characteristics seem different. In déjà vu, people report the impression that the event happening now has been experienced before. There is an impression of memory. In the impression of 'futurity' or 'pastness', people are not reporting that the event has been experienced before, but that it possesses a subjective quality of 'pastness' or futurity, e.g. the scene 'seems past' or 'ancient' (like in movies). Some patients can report feeling detached from the past, and therefore, recent events appear to belong to a remote past. Some authors have talked of a 'telescoping of time'. For example, a patient with depersonalisation disorder complained that events that had just happened seemed to him 'to have occurred a long time ago'.

**Changes in the Ability to Ascribe Events to Past, Present or Future**
Patients can find it difficult to say if an event belongs to the past, present or future, or they can find it difficult to say if a given event is a memory, an actual experience or an expectation.

**Excessive Focus on Past, Present or Future**
Instead of alternating the attention paid to a particular time location from moment to moment, patients can appear 'stuck' in one of them. Examples include the excessive and recurrent concern with past or future events reported in depression and anxiety disorders.

**Change in the Value/Meaning of Past, Present or Future**
Patients seem to be biased towards the attribution of an excessively positive or negative value to temporal locations. For example, for depressive patients the future seems hopeless, for anxious patients a source of danger and worries and for manic/hypomanic patients full of positive opportunities and success.

## Part IV: Towards a New Classification for DTE

### *A Tentative Definition of Psychological Time for Descriptive Psychopathology*

Most authors distinguish intrapersonal (subjective-private) and extra-personal ('objective' or public) realms of psychological time. These domains are thought to interact in a highly dynamic fashion. The basic unit of psychological time in this sense is the *event*. Events can be broadly defined as 'things that happen or happenings' (Casati and Varzi 2015). Based on the above a preliminary definition of psychological time for descriptive psychopathology can go as follows:

Psychological time corresponds to the subjective and behavioural consequences of the processing of the temporal information of events happening in either the intrapersonal or extra-personal environments. These consequences can be observed

at the level of overt behaviour (e.g. timing and timed behaviours) or inferred from the content of the narratives produced by the individual (e.g. narratives about a particular time experience).

## *A Proposal for a New Classification of DTE*

According to their narrative format, DTE can be tentatively classified as follows:

1. Narratives about time in general
2. Narratives about the temporal generic traits of events
3. Narratives about temporal locations

**Narratives About Time in General**
In these narratives, patients acknowledge the existence of a particular entity called time and complain of changes that create significant and often disturbing *global differences* when compared with how time used to be. These include narratives about the following:

- Disappearance of time and atemporality: e.g. 'time has ceased to exist', and 'I am living outside time'.
- Eternity.
- Unreality of time: e.g. 'there is something wrong with time'; 'time is not as it used to be anymore'.
- Loss of the 'uniqueness' of time: reduplication of time.
- Distortions in the direction of time: e.g. 'time going backwards'.
- Some delusions with temporal content: e.g. Pethö's chronophrenia.

**Narratives About Temporal Generic Traits of Events**
Patients describe experiences of events (intra- and extra-personal) in terms of their generic temporal traits like rate, flow, order and continuity. Some examples could be as follows:

- Distortions of the flow of events: e.g. time passing slowly or quickly.
- Distorted duration of events: e.g. events seem to have an unusually long duration.
- Changes in the rate of events: e.g. *Zeitrafferphänomen*.
- Distorted continuity of events: e.g. 'things seem to follow each other like snapshots, with no connection between them'.
- Condensation of events: e.g. the impression of a great amount of events taking place in a few seconds or minutes.

**Narratives About Temporal Locations (Time Perspective)**
People distinguish three main temporal locations: the present, past and future, with each having their own particular characteristics and limits. There is a variable degree of overlap or interplay between them; e.g. the future can flow through the present

into the past, and therefore, events seem to retain a certain degree of each temporal location.

The narratives about alterations of temporal locations include the following:

- Distortions in the limits and order of time locations, e.g. time location's transpositions, mixtures and intrusions.
- Distortions in the extension of time locations; e.g. present seems too short.
- Disappearance of time locations, e.g. vanishing of past or future.
- Impression of 'pastness' and 'futurity'; e.g. present events seem ancient or futuristic.
- Inability to ascribe events to a particular time location, e.g. confusion between past and present.
- Excessive focus on a particular time location, e.g. excessive preoccupation with past, present or future.
- Changes in the meaning/value of temporal locations, e.g. the attribution of an excessively negative or positive value to past, present or future.

## *Alterations of Psychological Time in Psychiatric Patients*

Based on all the above, a tentative classification of the alterations of psychobiological time found in psychiatric patients can be proposed:

1. **Alterations of biological periodicities (psychiatric chronobiology)**: including disturbances in sleep, temperature, feeding and interpersonal rhythms but also disruptions in endocrine and other physiological processes that are expressed as a dysfunction in cyclic functions and behaviours.
2. **Alterations of timing**: including alterations of performance in tasks assessing time estimation, reaction time, sequence identification and formation, the temporal features of motor behaviours and irregularities in personal tempo.
3. **Disorientation and cognate disorders**: failure in the periodic actualisation of personal time in accordance with public/geophysical time. This includes phenomena like disorientation (proper), consequences of amnesic syndromes and distortions of autobiographic memory (Berrios 1982).
4. **Distortions of time experience**: including the qualitative disturbances of time experience. DTE are the set of narratives devised by patients to account for subjective/qualitative (intrapersonal) changes in time, temporal features of events and/or temporal locations.

At present it is not clear to what extent these alterations might overlap, influence each other or be found in isolation in psychiatric patients. This proposed classification is further underpinned by the following:

(a) The notion of the **event** as the core unit of analysis
(b) The notion of a set of experiences linked to the processing of the generic temporal features of events

(c) The notion that individuals depending on diverse circumstances refer to time in global terms or talk about discrete time episodes, using metaphors and/or constructs
(d) The notion of time perspective as a set of experiences, beliefs, mental imagery and emotions about events that are described in terms of their before-after relationships as temporal locations (past, present and future)
(e) The notion that an important degree of 'psychosocial formatting' can shape time experience and the narratives about it

## Summary and Conclusions

- Psychiatric patients produce peculiar narratives about their experience of time. These narratives have been viewed as symptoms of mental disorders.
- Despite the interest shown in DTE since the nineteenth century, at present they are not part of 'official' psychiatric psychopathology. Currently, most psychiatrists would struggle to handle them clinically. A failed convergence process can explain this state of affairs.
- Descriptive psychopathology is still lacking a metalanguage for psychological time and DTE.
- DTE are not equivalent to disturbances in performance on time-related tasks like time estimation, reproduction and finger tapping tasks.
- Phenomenological psychiatrists have kept the subject alive through theoretical and empirical work. However, descriptive psychopathology can also make meaningful and fruitful contributions to the study of DTE in patients with mental disorders.
- Although this paper does not provide definitive answers, it is hoped that it will encourage further research in the descriptive psychopathology of DTE.

## References

Abraham, G. (1976). The sense and concept of time in psychoanalysis. *International Review of Psychoanalysis, 3*, 461–472.

Aragona, M., & Marková, I. S. (2015). The hermeneutics of mental symptoms in the Cambridge school. *Revista Latinoamericana de Psicopatologia Fundamental, 18*, 599–618.

Arstila, V. (2012). Time slows down during accidents. *Frontiers in Psychology, 3*, 196.

Bar-Haim, Y., Kerem, A., Lamy, D., & Zakay, D. (2010). When time slows down: The influence of threat on time perception in anxiety. *Cognition and Emotion, 24*, 255–263.

Berrios, G. E. (1982). Disorientation states and psychiatry. *Comprehensive Psychiatry, 23*, 479–491.

Berrios, G. E. (1996). *The history of mental symptoms*. Cambridge: Cambridge University Press.

Berrios, G. E., & Marková, I. (2004). Insight in the psychoses: A conceptual history. In X. Amador & A. David (Eds.), *Insight and psychosis* (2nd ed., pp. 31–50). Oxford: Oxford University Press.

Berrios, G. E. (2011a). *Hacia una nueva epistemología de la psiquiatría*. Buenos Aires: Polemos.
Berrios, G. E. (2011b). Convergences that are no more. *History of Psychiatry, 22*, 133–136.
Block, R. A., & Grondin, S. (2014). Timing and time perception: A selective review and commentary on recent reviews. *Frontiers in Psychology, 5*, 648.
Binswanger, L. (1960). Symptom and time: A casuistic contribution. *Existential Inquiries, 1*, 14–18.
Bonaparte, M. (1940). Time and the unconscious. *International Journal of Psychoanalysis, 62*, 3–26.
Browne, W. (1874). The perception of time as a feature in mental disease. *Journal of Mental Science, 19*, 519–532.
Bucolla, G. (1883). *La legge del tempo nei fenomeni del penseiro*. Fratelli-Dumolard: Saggio di psicologia sperimentale.
Casati, R., & Varzi, A. (2015). Events, *The Stanford encyclopedia of philosophy* (Winter 2015 Edition, E. N. Zalta, Ed.). https://plato.stanford.edu/archives/win2015/entries/events/
Crow, T. J., & Stevens, M. (1978). Age disorientation in chronic schizophrenia: The nature of the cognitive deficit. *British Journal of Psychiatry, 133*, 137–142.
Cutting, J. (1997). *The principles of psychopathology: Two worlds, two minds, two hemispheres*. Oxford: Oxford University Press.
Cutting, J. (2012). *A critique of psychopathology*. East Sussex: Forest Publishing Company.
Cutting, J., & Silzer, H. (1990). Psychopathology of time in brain disease and schizophrenia. *Behavioural Neurology, 3*(8), 197–215.
Danckert, J. A., & Allman, A. A. A. (2005). Time flies when you're having fun: Temporal estimation and the experience of boredom. *Brain and Cognition, 59*, 236–245.
Droit-Volet, S. (2013). Time perception, emotions and mood disorders. *Journal of Physiology-Paris, 107*, 255–264.
Flaherty, M. (1999). *A watched pot: How we experience time*. New York/London: New York University Press.
Fraisse, P. (1963). *The psychology of time*. Oxford: Harper and Row.
Fraisse, P. (1984). Perception and estimation of time. *Annual Review of Psychology, 35*, 1–36.
Fraser, J. T. (2007). *Time and time again: Reports from a boundary of the universe*. Leiden: Brill.
Fuchs, T., & Pallagrosi, M. (2018). Phenomenology of temporality and dimensional psychopathology. In M. Biondi, M. Pasquini, & A. Picardi (Eds.), *Dimensional psychopathology* (pp. 287–300). Cham: Springer.
Fulmer, C. A., & Crosby, B. (2014). Cross-cultural perspectives on time. In A. Shipp & Y. Fried (Eds.), *Time and work* (Vol. 2, pp. 63–85). Routledge.
Grondin, S. (2010). Timing and time perception: A review of recent behavioral and neuroscience findings and theoretical directions. *Attention, Perception, & Psychophysics, 72*, 561–582.
James, W. (1886). The perception of time. *The Journal of Speculative Philosophy, 20*(4), 374.
Janet, P. (1928). *L'evolution de la memoire et de la notion de temps. (Vol I: Duration, vol II Mémoire elementaire, Vol III organisation du temps)*. Paris: Chahine.
Jaspers, K. (1963). *General psychopathology.* Trls. J. Hoenig and M. Hamilton. Manchester: Manchester University Press.
Kramer, R. S., Weger, U. W., & Sharma, D. (2013). The effect of mindfulness meditation on time perception. *Consciousness and Cognition, 22*, 846–852.
Kornysheva, K. (2016). Encoding temporal features of skilled movements—what, whether and how?. Progress in motor control. *Advances in Experimental Medicine and Biology, 957*, 35–54.
Kontopodis, M. (2014). Time. In T. Teo (Ed.), *Encyclopedia of critical psychology* (pp. 1969–1970). Dordrecht/New York: Springer.
Lake, J. I. (2016). Recent advances in understanding emotion-driven temporal distortions. *Current Opinion in Behavioral Sciences, 8*, 214–219.
Lakoff, G., & Johnson, M. (1999). Time. In G. Lakoff & M. Johnson (Eds.), *Philosophy in the flesh* (pp. 137–169). New York: Basic books.
Le Guen, C. (1958). Le temps figé du schizophréne. *L'Évolution Psychiatrique, 4*, 701–735.

Le Poidevin, R. (2015). The experience and perception of time. *The stanford encyclopedia of philosophy* (Summer 2015 Edition, E. N. Zalta, Ed.). https://plato.stanford.edu/archives/sum2019/entries/time-experience/.
Levine, R. V. (1997). *A geography of time*. New York: Perseus Books Group.
Levine, R. V. (2013). *Time and culture*. Champaign: DEF Publishers.
Lewis, A. L. (1932). The experience of time in mental disorder. *Proceedings of the Royal Society of Medicine, XXV*(Pt.1), 611–620.
Marková, I. S., & Berrios, G. E. (2009). Epistemology of mental symptoms. *Psychopathology, 42*, 343–349.
Melges, F. T. (1982). *Time and the inner future: A temporal approach to psychiatric disorders*. New York: Wiley.
Melges, F. T. (1989). Disorders of time and the brain in severe mental illness. In J. T. Fraser (Ed.), *Time and mind: Interdisciplinary issues* (pp. 99–124). Madison: International University Press.
Melges, F. T. (1990). Identity and temporal perspective. In R. Block (Ed.), *Cognitive models of psychological time* (pp. 255–265). New Jersey/London: Erlbaum.
Mellor, D. H. (1998). *Real time II*. New York/London: Routledge.
Minkowski, E. (1958). Le temps en psychopathologie. *Psychol Franc, 3*, 9–20.
Minkowski, E. (1962). Approches phenomenologiques de l'existence. *L'Evolution Psychiatrique, 27*, 433–458.
Minkowski, E. (1995). *Le temps vécu*. Paris: PUF.
Moreau de Tours, J. J. (1845). *Du hachisch et de l'aliénation mentale*. Paris: Fortin, Masson et Cie.
Moreau de Tours, J. J. (1855). De L'identité de l'état de rêve et de la folie. *Ann. Med Psych, 5*(3 série), 361–408.
Phillips, I. (2012). Attention to the passage of time. *Philosophical Perspectives, 26*, 277–308.
Shanon, B. (2001). Altered temporality. *Journal-of-Consciousness-Studies, 8*, 35–58.
Summers, J. J., & Anson, J. G. (2009). Current status of the motor program: Revisited. *Human Movement Science, 28*, 566–577.
Tipples, J. (2011). When time stands still: Fear-specific modulation of temporal bias due to threat. *Emotion, 11*, 74–80.
Vinchon, J. (1920). Quelques examples d'évaluation du temps chez les schizophrènes. *Jour de Psychol Norm et Path, 17*, 415–417.
Von Gebsattel, V. (2013). The world of the compulsive. In M. R. Broome, R. T. Harland, G. S. Owen, & A. Stringaris (Eds.), *The Maudsley reader in phenomenological psychiatry* (pp. 232–240). Cambridge: Cambridge University Press.
Wittmann, M., & Lehnhoff, S. (2005). Age effects in perception of time. *Psychological Reports, 97*, 921–935.
Wittmann, M., & Paulus, M. P. (2008). Decision making, impulsivity and time perception. *Trends in Cognitive Sciences, 12*, 7–12.

# Chapter 22
# Visual Symbology and Psychopathology in Frida Kahlo's Work

**María Beatriz Quintanilla-Madero**

## Contents



## Introduction and Background

There are many examples of how illness and suffering have made great artists. Genius and psychopathology appear to walk hand in hand on many occasions as we can see in the case of Van Gogh, Goya, Dostoyevsky, Mozart and others. 'Life and creation cannot be separated, and it might be considered that the manner in which the artist conceives and perceives is different from others, in the depiction of his life

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and soul in something material, because there is an intimate relationship between the artist and his creation. The artist also has a delicate sensibility to capture the beauty, details, dimensions and meanings hidden to others, even in their own time and culture … there is no doubt that many artists have been exceptional and different from the rest of people, and many of them, in spite of their illness, – mental or physical – have been able to create great oeuvres' (Quintanilla-Madero 2001, pp. 1–13, my translation).

Frida Kahlo [México 1907–1954], suffered chronic illness, medical problems and pain for most of her life. This paper analyses the visual symbology depicted in her oeuvre and its possible relation to some kind of psychopathology.

She was born in Coyoacán, from a German father, Guillermo Kahlo, and Matilde Calderón, a Mexican mestiza (Herrera 1984; Fuentes and Lowe 1995; Lozano 2007). As a child and teenager, she lived through the Mexican Revolution that began in 1910 (Cosío Villegas et al. 2000) and would have been aware of other armed conflicts that were taking place in Europe. In 1922, she became a student at the E*scuela Nacional Preparatoria*, where new ideas, movements, groups and political thoughts were to be experienced (Herrera 1984). There she also met the famous painter Diego Rivera, who would become her husband in 1929. They were divorced in 1939 and got married again in 1940 (Herrera 1984; Zamora 1987; Lozano 2007).

Following her marriage, Frida came to attention rapidly after she 'proposed herself, with the intention of making visible the sanctuary of the aesthetics of a nation that was threatened by Modernity, promoting a cultural nationalism, a Mexican way of life and the "Mexicanidad"' (Monsiváis 2008, p. 6, my translation). That has been well described in her life and work. But a new wave of appreciation began in the 1970s and reached what is now known as 'Fridomania' (Miranda 2014; Monsiváis 2008). Her clothing style and her face are recognized all over the world. She became a character, not only a person. Her work and life have been studied from every angle, with the latter gradually evolving into myth-like proportions and Frida herself becoming an icon. In serious art circles, however, the 'cult of personality that has surrounded her since her death […] has made her work to become lost, overshadowed by her celebrity'(Miranda 2014, p. 2).

## Medical History

Her father had grand mal epileptic seizures and her mother suffered from hysterical fits (Siltala 1998). Frida was born with spina bifida. She acquired polio at 6 years of age leaving her with a shorter right leg, a functional scoliosis and a post-polio syndrome with chronic pain and fatigue (Budrys 2006; Courtney et al. 2017). In 1925, when she was 18 years, she was in a major traffic accident. This brought her a lot of suffering, medical problems, treatments, surgeries and addictions to opi-

oids, tobacco and alcohol (Zamora 2015). She underwent over twenty-five surgeries mostly in her spine, right foot and leg. She had several miscarriages, was bed-ridden for months and had to wear orthopaedic shoes, corsets and plaster casts for almost all her life (Budrys 2006; Lozano 2007). In 1944, she underwent spinal fusion but with no benefit (Courtney et al. 2017). Between 1950 and 1951, she had seven surgeries in her spine and wrote in her journal[1] that she had experienced […] '*Desperation many times, a desperation of such a kind that no words could even begin to describe it. Nevertheless, I have already begun to paint'* (Fuentes and Lowe 1995, p. 252, my translation). In 1953, her gangrened right leg was amputated. This was the beginning of the end. Her fear about the amputation is described and depicted in her journal, where under a drawing of two amputated feet she wrote: '*Pies para qué los quiero si tengo alas para volar'* ['Feet, what do I want you for, if I have wings to fly?']. She also wrote, on 11th February 1954, *'I had my leg amputated six months ago. To me, it has been as centuries of torture, and for some moments I almost lost my mind. I still feel the wish to kill myself. […] I have never suffered this much in all my life. I will wait for some time'* (Fuentes and Lowe 1995, p. 278, my translation) She died shortly after that on 13th July 1954, at 47 years, and it is not clear if it was due to a pulmonary embolism, or from an opioids overdose. Aurora Reyes, a close friend of Frida, maintained that Frida 'tried to kill herself many times, because of the constant pain and immobility' and that on the night of her death, she […] 'took all the pain killers she had'. Diego himself showed her the next morning […] 'all the empty pill boxes that Frida had taken' (Zamora 2015, p. 31).

## Frida as a Painter

After the tram crash, she wrote in a letter in English, to her friend Julien Levy, 'I was *bored as hell and …my mother ordered for me a special easel* [adapted for her bed] *because I couldn't sit down, and I started to paint'* (Herrera 1984, pp. 63–64). She could paint while bedridden during the long recovery and used herself as a model with the help of a mirror (Zamora 1987; Lozano 2007). She spent many hours after the accident and throughout her life studying her face. Because of the sequelae left by the accident, she withdrew from school, but her illness was a turning point for the emergence of the artist, who, tested by these 'mental and physical ailments, […] was able to assimilate and overcome them to transmit her creative legacy' (Montes-Santiago 2013, p. 209).

[1] The *Faccimil* of the Journal of Frida Kahlo is used in this paper. It was published in: Fuentes, C. & Lowe, S. M. (1995). *El Diario de Frida Kahlo. Un íntimo autorretrato,* México, Distrito Federal, La Vaca Independiente S.A. de C.V. 5th reprint, 2014.

## Themes of Her Paintings

There are three major themes in her visual work: portraits, still lives and a vast majority of self-portraits [more than fifty].[2] She painted her own ideas, the way she understood the world, Mexico, – especially pre-Columbian Mexico –, Diego, herself and her suffering. André Breton called her a surrealist (Monsiváis 2008), something she explicitly rejected when she affirmed that 'I never painted dreams. I painted my own reality' (Herrera 1984, p. 266).

## Psychopathology

The florid symbols depicted in her paintings provide rich material on which we can speculate about her mental state and possible psychopathology. She has a meticulous and perfectionistic style, finely detailed and often produced in miniature form. The nature and variety of symbols she portrays suggest a more diverse psychopathology rather than a single psychopathological problem. Here we examine some of her symbology and put forward associations with possible psychopathological phenomena in the context of her life and experiences.

## Depressive Mood and Anxiety

These are the first kinds of symptoms that are perhaps most obviously evoked on examination of her paintings. Here we see in her self-portraits a very personal expression of her own feelings by means of clear, understandable and direct symbols of anguish, loss and depression. They appear to give a message of radical helplessness, total loneliness, emptiness, solitude, suffering, sadness and pain. We can see this in 'The Broken Column', 1944; 'Tree of Hope, Keep Firm', 1946; 'The Little Deer', 1946; 'Henry Ford Hospital', 1932; and in many self-portraits. Tears in her eyes dominate her face, which carries an immensely sad gaze. Often, at the same time, the gaze is fixed, staring at the spectator, like a mask, giving the impression that the face is of someone else or that she is feeling something different to what she is portraying. Colours are pale and dark. Skies are cloudy. The soil is dry and broken, and the land is barren: no trees, no plants, no flowers. In 'Tree of Hope, Keep Firm', the canvas is divided into day and night with the sun and moon and two self-portraits in the same painting. It is darker in the part where she is sitting down all dressed up, and she portrays herself as if she 'was sitting at the cliff edge' (Zamora 1987, p. 347).

[2] 'The Accident', 1926, may be found at https://www.pinterest.com.mx/pin/429530883182566955/. The other paintings mentioned in this paper may be found at https://www.frida-kahlo-foundation.org.

'The Little Deer' was a gift and was accompanied by a poem. In some verses, Frida points out that '*The deer was lonely around, / very sad and very wounded/…. Sadness is portrayed/ in all of my painting/ but that is my condition/ I cannot be mended…'* (Zamora 1987, p. 346). In 'The Broken Column', the nude open torso shows a spine that has been replaced with a Greek Ionic column broken in many parts [we could speculate here about nihilistic ideation or delusions]. She wears an orthopaedic corset, in order to maintain her standing posture. Numerous nails puncture her face and body. She holds a piece of cloth with both hands that covers the lower part of her body, but the nails are piercing also her right leg through the cloth. Courtney et al. suggest that the extension of the nails to the leg may represent a 'complex regional pain syndrome I or II' and that she might have experienced neuropathic pain with allodynia: 'the elicitation of pain with a non-noxious stimulus', meaning that the 'leg pain would have worsened and expanded beyond the original distribution' (Courtney et al. 2017, p. 94).

In 'Henry Ford Hospital', we see her nude, tears in her eyes, lying in a hospital bed, on sheets covered in her blood. Six bloody ribbons originating from her belly leave the body from under her left hand to spread out in space above and below her. Each ribbon is tied to a different object representing different aspects of her hospital experience. The central object is a male foetus denoting her miscarriage, attached to her by the red ribbon or umbilical cord and yet separated from her by the painted distance. The bed appears free-floating, alone in the open, surrounded by Detroit's industrial buildings and emphasizes a sense of desolation and separation. The whole impression is one of bleakness, depressed mood, isolation and pain.

Apart from the fairly explicit depressive symptomatology that can be read in such paintings, there are other symbols present in her art suggesting associations with other forms of psychopathology.

## Depersonalization

'The Accident', 1926. This pencil on paper drawing is signed and dated 17th September 1926, almost one year after it took place. It depicts the crash she was involved in when travelling by bus with her boyfriend, Alejandro Arias. Frida suffered fractures in her spine and serious wounds in many parts of her body; a metal handrail perforated her abdomen. An unknown workman, who was passing by, ripped out, on site, the handrail from Frida's body, causing more damage. Frida sometimes declared that this perforation was the cause of why she lost her virginity and why she could not have children. This was denied by Alejandro Arias because the handrail 'did not go through her uterus as she declared' (Zamora 2015, p. 105). In the drawing, she is at the same time the wounded woman on the stretcher and also the disembodied woman looking on, the observer from above. Here we can wonder whether she did indeed experience a disturbance of self-awareness such that she could detach herself from the traumatic experience either as a form of depersonalization (Bergé et al. 2009; Sierra and Berrios 1998) or even dissociation.

## Double Objects and Self-Portraits

We find various double self-portraits, or the presence of the sun and the moon, night and day, in the same canvas [Tree of Hope, Keep Firm], as well as other double objects. She explained in her journal that the origin of the double self-portraits was from her childhood, when she used to have an imaginary friend, another girl who kept her company and made her happy (Fuentes and Lowe 1995). However, in her paintings as an adult, the 'other' is another self-portrait, not another person. Again, we can wonder about this and speculate whether she was reflecting some kind of dissociative phenomenon. In *'*The Two Fridas*'*, she paints two self-portraits, sitting side by side, sharing the heart. In *'*Tree of Hope, Keep Firm*',* one self-portrait is looking to the spectator, fully dressed, and the other one is seen from the back, in a surgical bed. Could this represent autoscopic phenomena? There are certainly some similarities between her experiences and descriptions of such phenomena. For example, Dening and Berrios (1994) refer to 'vivid visual imagery and narcissistic tendencies […], depression, depersonalization, dissociation, anxiety symptoms, dysmorphophobia, substance abuse, extreme stress and fatigue, in a creative and 'narcissistic individuals, who indulge in excessive self-scrutiny and over-learn their facial appearance' [she produced more than fifty self-portraits, and her image appears in almost half of her oeuvre]. Furthermore, 'perhaps creative individuals are more able to 'produce' autoscopy in the absence of brain disease' […], and there might be 'putative associations of narcissism [increased personal identification] and visual imagery [increased face recognition] with autoscopy'. In Frida's case it […] 'would be added suggestibility and creative temperament' (Dening and Berrios 1994, pp. 810–814).

## Narcissism

She made herself a character, a personage, and used many cultural characteristics and significances to reinvent herself. She came from a town in the outskirts of Mexico City. She became impressed by Diego Rivera, many years older than her, a very famous man and important painter, circled by many intellectuals, politicians, artists, and wealthy and important people. She liked to be at the centre of attention, particularly that of Diego. Her dress may have been used for this purpose, and it became such a powerful symbol of her that we find some paintings where only the dress is represented and everyone knows that it is her. As Kernberg explains, narcissistic people 'have an unusual degree of self-reference in their interactions with other people, a great need to be loved and admired by others, and a curious apparent contradiction between a very inflated concept of themselves and an inordinate need for tribute from others. Their emotional life is shallow. […] The main characteristics of these narcissistic personalities are grandiosity, extreme self-centredness, and a remarkable absence of interest in and empathy for others in spite of the fact that they are so very eager to obtain admiration and approval from other people. […] They do

not experience real sadness, may present strong feelings of inferiority and insecurity, […] and what distinguishes them from the usual borderline patient is the relative good social functioning, […]some may appear as quite creative in their fields…may also be outstanding performers in some artistic domain' (Kernberg 1992, pp. 227–30).

## Borderline

She might also have displayed some 'borderline' traits, 'a term that should be preserved for those patients presenting a chronic characterological organization which is neither typically neurotic nor typically psychotic' (Kernberg 1992, p. 5). However, although narcissistic personality seems clear, borderline traits are not so clear, but there are some elements that can be analyzed: she is fascinated with depicting blood and violent subjects, which was unusual in her time. She had a likeness for topics that produced a strong impression in the viewer and maybe also in herself. For example, in the paintings of the abortions, or in 'A Few Small Nips' (1935) 'blood' is represented even in the frame. In the portrait that she was commissioned to do of Dorothy Hale (1938), instead of painting a conventional portrait, she produces a visual narrative of the stages of Dorothy's suicide, depicting her falling from a very high window balcony of a building to the street pavement, showing detailed expression and with 'blood' spots on the frame and even a legend at the bottom. We might consider that this shows a lack of empathy in her for the person who commissioned the portrait and for Dorothy's tragedy, or maybe she was not even thinking of the impact that this might have on other people.

There are many testimonies that described her as eccentric, bizarre and nonconventional, someone who liked to exaggerate and to do things that nobody would do in her time and produce scandals. She had various addictions: alcohol, pain killers and tobacco. She was bisexual, promiscuous with multiple partners, both men and women. She had a homosexual relationship with an older woman who worked at the preparatoria, when she was still a minor (Zamora 1987, 2015; Herrera 1984).

Many of her themes had never been represented before and certainly not with such crudity and explicitness, such as abortions, childbirth, blood, suicide, homicide or inner parts of the body. That it is why 'she both seduces and repels' (Havard 2006, p. 242). At the same time, however, she is recognized for her ability 'to make visible for others what has not always been tolerated in women's imagery' (Barth 1998, p. 158).

## Gender Dysphoria

Wearing trousers and long skirts might also have had another purpose apart from hiding her shorter leg. Might she have questioned her gender/sexual identity (ICD-10 (WHO 1992, F64.0) and DSM-IV-TR (APA 2000, 302. 85)) or experienced some

sort of gender dysphoria (DSM-5; APA 2013, 302.85). There are two photographs of her, in both family portraits, where she appears dressed up as a man. Women did not wear trousers in the very traditional society that was the Mexican one at that time (Herrera 1984; Lozano 2007). She was known as a tomboy, practised boy sports, knew and talked with slang and swear words, smoked, drank strong alcohol, and as she grew older she exaggerated her viriloid traits in her paintings such as the moustache or the one-line eyebrow; the 'The Little Deer', for example, depicts a male deer with Frida's face.

## Emotional Ambivalence

She expressed things she wanted and did not want at the same time. For example, she said that she wanted to be a mother and at the same time had voluntary abortions. She dressed up with a feminine attire and a carefully groomed hairstyle, with many collars and rings, but at the same time exaggerated viriloid traits. She loved Diego, and at the same time she cheated on him, perhaps in response to his cheating. She liked him as a husband, and a lover, but portrayed him and wrote about him as her baby.

## Confabulations

From her diary, some paintings and some interviews she gave, we learn that she told many inaccurate things about herself and her family. Was it because it made her more glamorous or interesting? For example, she gave wrong data about her birthday because she would have liked to make her birth coincide with the year of the Mexican Revolution in 1910. She said that her father had 'Jewish' ancestry, though it has been proved that her parents were German protestants (Lozano 2007). Did she really want to become a mother? In 'Henry Ford Hospital' (1932), where she depicts an abortion, her former boyfriend, Alejandro Gómez Arias, said that the abortion represented here never took place but was instead a large haemorrhage due to gynaecological problems and that she [Frida] knew it (Zamora 2015, p. 106). Alejandro also pointed out that Frida's abortions had been voluntary (Zamora 1987, p. 120). In fact, on a previous pencil sketch on paper of this painting, there is no foetus. There is also another painting, called 'The Cesarean' [a larger oil on canvas – 73 × 62 cm – circa 1931], at Frida Kahlo's museum, that represents herself at a hospital with a male newborn at her side. 'She had never had a Caesarean operation, but Frida mentioned to a friend, that a doctor had told her that in spite of her fractured pelvis and spine she would be able to have a child by Caesarean section' (Herrera 1984, p. 106). Were these some sort of confabulations, understanding confabulations as 'the production of false memories, without intention to deliberately lie, […] and the patient believes genuinely in them, […] in order to build up her past in a more favourable

way than it was? […] It is known that sometimes motivational factors may have a more important role to determine which memories are selected to be recuperated and accepted as true memories' (Lorente-Rovira et al. 2011, pp. 384–385).

## Deterioration

For most of her life, the many well-known medical problems, medical treatments (including at some time bismuth for a possible syphilitic problem) and surgeries left her in a poor state of health. In addition, this may have been compounded by a possible thiamine deficiency due to alcohol abuse and malnutrition (Zamora 1987). As a result, she would have been vulnerable to developing chronic cerebral and physical damage and deterioration. We see in her diary that at first she gives detailed information about herself and includes sketches of future paintings. However, as we go further, the drawings and the handwriting becomes less firm and progressively more careless. Many pages are ripped out. Many texts are written one above the other, with different colours and ink stains. There are reiterative repetitions and many references to Diego and to her faith in the communist party. Some of the drawings show characteristics of possible perceptual alterations. We can find certain symbols that look more 'psychotic-like' and repetitive. Towards the end of her life, she was in persistent, severe pain, very irritable, anxious and aggressive and was beating her caregivers with her cane. She finally died exhausted at 47 years old in her house in Coyoacán (Herrera 1984, pp. 422–427; Zamora 1987).

## Discussion and Conclusion

Clear symbols, of suffering, anguish, sadness, anguish, depression, pain, self-pity, loss, misery, distress, hopelessness and illness, are represented, with direct and simple symbology. In spite of this, most of her faces are expressionless, staring at the viewer in a defiant way. In many of her self-portraits, she duplicates herself; this could represent a form of dissociation or simply depersonalization. And there are other symbols that may indicate a deeper psychopathology, as described here.

Nevertheless, we can have some understanding of the nature of her emotions and how she was psychologically affected. She certainly 'had the ability to think about and communicate complex, contradictory, painful and potentially disturbing emotions' (Barth 1998, p. 7). Her works 'represent her suffering, but they also are attempts to understand and to reframe her traumatic events' (Becker 2016, pp. S527–S528). The majority of her self-portraits reveal narcissistic elaboration. They give the impression that she had a deep need for being heard and understood. Frida tries to make explicit the causes and nature of her pain and feelings and how important these events are in her life. No clear psychotic symbols in these paintings are found. Expressing these events through her work might have had a cathartic effect that

helped her to cope with suffering and reframe her experiences as a 'way for her of grappling with and processing the agonies, losses and pleasures of her life' (Barth 1998, p. 158). The very explicit symbols she used helped others to connect empathetically with her message, and these elements have helped to make her an icon and to be known and loved by millions of people as testified by the reproduction of her image on objects and materials all around the world.

## References

APA. (2000). *Diagnostic and statistical manual of mental disorders. Fourth Edition. Text Revision (DSM IV-TR)*. Washington, DC: American Psychiatric Association.

APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition. (DSM-5)*. Arlington: American Psychiatric Association.

Barth, D. F. (1998). Psyche and Soma: The body as canvas. Discussion of "I made a picture of my life – A life from the picture: The life of the body in the pictures and writings of Frida Kahlo" by Pirkko Siltala. *International Forum Psychoanalysis, 7*, 156–159.

Becker, J. (2016). 'Yo Soy La Desintegración': Helplessness and sublimation through Frida Kahlo's history. *European Psychiatry, 33*, S527–S528.

Bergé, D., Bulbena, A., Sperry, L., Pailhez, G., Valls, S., Martín-Santos, R., & Berrios, G. E. (2009). Síntomas de despersonalización en pacientes psiquiátricos: la nueva escala de despersonalización presente-vida (DP-PV). *Archivos de Psiquiatría, 72*, 1–13.

Budrys, V. (2006). Neurological deficits in the life and works of Frida Kahlo. *European Neurolgy, 55*, 4–10.

Cosío Villegas, D., Bernal, I., Moreno, T. A., González, L., Blanquel, E. & Meyer, L. (2000). *Historia Mínima de México* (Chapter V: La Revolución Mexicana, 137–147). México: El Colegio de México.

Courtney, C. A., O'Hearn, M. A., & Franck, C. C. (2017). Frida Kahlo: Portrait of chronic pain. *Physical Therapy, 97*, 90–96.

Dening, T. R., & Berrios, G. E. (1994). Autoscopic Phenomena. *The British Journal of Psychiatry, 165*, 808–817.

Fuentes, C. & Lowe, S. M. (1995). *El Diario de Frida Kahlo. Un íntimo autorretrato*. México, Distrito Federal: La Vaca Independiente S.A. de C.V.

Havard, L. A. (2006). Frida Kahlo, Mexicanidad and Máscaras: The search for identity in postcolonial Mexico. *Romance Studies, 24*, 241–251.

Herrera, H. (1984). *Frida, a biography of Frida Kahlo*. New York: Perennial.

Kernberg, O. F. (1992). *Borderline conditions and pathological narcissism*. Northvale: Jason Aronson Inc.

Lorente-Rovira, E., McKenna, P. J., Berrios, G. E., Villagrán-Moreno, J. M., & Moro-Ipola, M. (2011). Confabulaciones (II): Modelos explicativos. *Actas Españolas de Psiquiatría, 39*, 384–392.

Lozano, L. M. (2007). *Frida Kahlo. El Círculo de los Afectos*. Cangrejo Editores: Bogotá.

Miranda, C. A. (2014). Saving Frida Kahlo from her own celebrity. *ARTNEWS* [Online]. Accessed 18 July 2016].

Monsiváis, C. (2008). Frida Kahlo: de las etapas de su reconocimiento. *Debate Feminista. Cuerpos Sufrientes, 37*, 4–15.

Montes-Santiago, J. (2013). When art hurts but it saves: The cases of Modigliani, Matisse, Portinari and Rebeca Horn. *Revista Clínica Española, 213*, 208–211.

Quintanilla-Madero, M. B. (2001). Tras la creatividad: genialidad o locura. *Istmo, 5*, 1–13.

Sierra, M., & Berrios, G. E. (1998). Depersonalization: Neurobiological perspectives. *Biological Psychiatry, 44*, 898–908.

Siltala, P. (1998). I made a picture of my life – A life from the picture. The Life of the Body in the Pictures and Writings of Frida Kahlo. *International Forum of Psychoanalysis, 7*, 133–155.

WHO. (1992). *ICD 10. International statistical classification of diseases and related health problems. 10th revision. Chapter V. Mental and behavioural disorders*, Geneva: World Health Organization.

Zamora, M. (1987). *Frida. El Pincel de la Angustia*. La Herradura: Martha Zamora.

Zamora, M. (2015). *En Busca de Frida*. Huixquilucan: Zamora, Martha.

# Chapter 23
# The Contribution of the Cambridge School of Psychopathology for the Understanding of Psychosomatic Symptoms

**Lazslo A. Ávila**

## Contents



Professor Berrios' ideas impact profoundly on the contemporary debate on psychopathology and thus on sciences concerned with the mind. This book, in its comprehensiveness and varied strands, promotes and develops further understanding of this complex area. My particular contribution is in the field of psychosomatic symptoms. As a psychologist and psychoanalyst, my perspectives on issues studied by the Cambridge School of Psychopathology take a somewhat different path from those of my colleagues albeit sharing a common foundational base.

In the last decades, the Cambridge School of Psychopathology has carried out original work on the conceptual history of diverse mental symptoms. Under the leadership of Professor Berrios, it has demonstrated why mental phenomena cannot be the exclusive domain of biological psychiatry. Mental life is too complex and multi-determined to be understood solely from the restricted approach of biochemistry. The multitude of phenomena connected with the mind demands a broader-based knowledge, drawing on anthropology, sociology, linguistics, psychology, history, economics, semiotics and medicine. Two areas of philosophy are essential: epistemology and hermeneutics, as these help to organise and bind together the disparate elements coming from such broadly based knowledge.

Psychopathology is a complex area of knowledge that must be submitted to continuous historical and epistemological perusal. Its concepts, after critical evaluation,

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may need calibration or revision. It is in the core of Professor Berrios's thought that psychiatry, and, consequently, psychopathology, is hybrid in structure depending on both the biological and the human/social sciences. Biology and meaning are its fundamental components.

'Meaning' figures in all human actions, and its study demands a multifaceted approach supported by philosophical, historical and cultural perspectives. Amongst the fields inherently concerned with 'meaning' are the theory and practice of psychoanalysis.

Here I will present the results of my personal contribution to the debates on the project 'Insight and the Monitoring of the Bodily and Mental Functions', organised by Professor Berrios at the University of Cambridge. This material was published as a book (Ávila 2004a) and some papers (Ávila 2004b, 2005, 2010, 2016, 2019).

## The Cambridge Model of Symptom Formation

Marková and Berrios (1995a) presented a model of symptom formation which accounts for the heterogeneity of mental symptoms. This model has been applied to the discussion of insight (Marková and Berrios 1995b, c), to explain the origin of functional memory symptoms (Berrios et al. 2000), and since then, it has assumed central importance in the theory of a renewed epistemology of psychiatry (Marková and Berrios 2009, 2012; Berrios 2013, 2015).

Berrios and Marková's model proposes two possible pathways by means of which a putative brain signal reaches expression as a speech act or manifested behaviour. The process is triggered by a normal or dysfunctional brain signal, which follows one of three alternative pathways. Pathway (a) refers to a signal that is subjectively experienced as formless and ineffable (the so-called primordial soup). This 'raw' experience is subsequently conceptualized on the basis of previous experiences, acquired general knowledge, socio-cultural referents and interactional factors.

This mental process allows the now tamed experience to emerge as a conscious act of speech or of manifest behaviour. The result is a symptom conceptualized by the patient, and further modified through the interaction with a clinician or others. In the interview, both the patient and the clinician conceptualize and name the experience through an interactional negotiation in which their previous experiences and their relative knowledge, amongst other factors, will play a part.

As Aragona and Marková (2015, p. 602) say: 'This can be illustrated by looking at ways in which symptoms might arise. In this regard, four pathways of symptom formation have been postulated where nature (neurobiological activity), personal capacities and narratives, familial and social idioms of distress, and interpersonal negotiation of meaning, are all operative and intertwined at different levels.'

In pathway (b), the symptom bypasses awareness and hence the experience cannot be conceptualized (i.e. it remains as an unconscious representation of the brain signal), but can nevertheless be recognized as a symptom by the clinician. As in the

previous pathway, both the clinician and the patient jointly participate in the 'construction' of the symptom. However, in this pathway, the patient's participation takes place retrospectively, upon a symptom experienced as non-related to mental processes and manifested as a bodily phenomenon. In Marková and Berrios' view, these symptoms take the form of thought disorders, neologisms, disinhibited behaviour and tardive dyskinesia, among others.

Between stage 1 (brain signal) and 5 (speech act), intervening stages represent progressive distortions of the original signal. This determines the heterogeneity and individual variation of symptoms.

Symptoms having conscious representations become speech acts by three possible processes: Pathway C(a) represents a symptom whose concept shows a direct representation. Symptom formation along pathway C(c1) returns to the 'primordial soup', and hence entails a process of secondary concept formation (i.e. not directly related to the original signal). In this case, symptom formation draws on other sources of experiences, which further build on the primary construct. In pathway C(c2), the symptom arises from a previously existing concept. The new, secondary concept may in turn act as a template for the generation of subsequent symptoms. Both conscious awareness (i.e. insight) and judgement play a crucial role in symptom formation on pathways C(c1) and C(c2).

It has been proposed that the process of symptom awareness entails a parallel process, called 'echoing function', whereby the experience being 'formatted' is related to biographical and cultural contexts. Through this process, the experience is perceived as 'normal', or as a symptom, with the information contained in the 'echo' being compared against templates of previous experiences in order to form judgements. Those are processes for 'reading' the subjective experience. The symptoms are assimilated into 'subjective states' composed of a nucleus of neurobiological signalling, which is processed and conceptualised by means of the subject's personal, cultural and environmental resources. Later, a new concept or evaluation is generated, relating to the meaning and to the impact of the symptom on the patient's life. All those factors interact to create the varied complexity of mental symptoms.

The richness and heuristic power of the proposed schema are evident. As a psychoanalyst, I understood that one component of the model might be useful in the investigation of a problem that has innermost importance for the interaction and dialogue of psychoanalysis with medicine and the neurosciences, that is, the psychoanalytical concept of an unconscious mind in relation to other conceptions of mind and consciousness.

Many psychoanalysts dedicated attention to the problems arising from symptoms that reach and affect the body instead of the mind. First of all, Freud himself with his many studies on conversion hysteria and the so-called actual neurosis (Freud 1974a), followed by Groddeck (1977, 1989), Balint (1957), Bion (1961, 1962, 1995), Alexander (1950), Anzieu (1985), Winnicott (1989) and McDougall (1989), to quote just some of the most significant authors.

The Cambridge model for symptom formation can contribute to the understanding of two central questions in a psychodynamic investigation on the genesis of

those bodily symptoms, in their relation to the conscious and unconscious mind. These questions are how are psychosomatic symptoms formed? How may the psychotherapy as practised by psychoanalysis unveil (or construct) the meaning of psychosomatic symptoms and successfully modify them?

It is my contention that the Cambridge model can clarify the processes leading to the formation of psychosomatic symptoms. In particular, I propose that pathway b, in as much as it depicts a process bypassing conscious awareness, is most relevant in describing the genesis of the psychosomatisation. Indeed, an inherent feature of psychosomatic phenomena is their unconscious construction. The patient is 'surprised' by the appearance of such symptoms and expects the clinician to acknowledge and categorise them in a manner that in a medical consultation normally results in an organic diagnosis. For a psychoanalyst, the appearance of a 'bodily symptom' leads to the investigation of the possible unconscious drives that strive for representation in the conscious mind. Such drives may assume many different formats, some psychical, others behavioural and still others in the somatic field of expression. In psychoanalytical treatment, after excluding organic pathology, the bodily symptom is analysed in exactly the same way as any other clinical manifestation of the person. All of his or her symptoms, physical or psychical, contain aspects of the subjectivity that is essential in order to understand the uniqueness of the individual.

Pathway b, in its original proposition, is the way to form symptoms that remain unperceived by the patient, such as utterances of neologisms or disinhibition (Marková and Berrios 1995a; Berrios 2015). However, in my view, it also describes the route of unconscious emotions and thoughts that are blocked from consciousness due to failure of representation and are then expressed as bodily symptoms. Through pathway b of the model, we follow the 'construction' of psychosomatic symptoms and by this means seek to explore new approaches for diagnosis and treatment.

Psychotherapeutic interventions work by enabling the opening up of pathway c, thereby allowing the patient to reach a conscious representation of his/her symptoms. During the therapy, a symptom that originally was devoid of representation (pathway b) is 'transformed', by means of concepts offered by the clinician, into a symptom that acquires a representation. In particular, it is proposed that the concepts provided by the clinician act as a type of 'conceptual prosthesis' or template. Such a template becomes a supporting structure by means of which the patient is able to develop his/her own representations (i.e. secondary and tertiary constructs), hence allowing him/her to modify the symptom by means of pathways Cc1 and Cc2. This new symptom, in turn, is more pliable and amenable for psychotherapeutic work.

Therefore, it is possible to reach a symptomatic substitution: instead of a 'mute' symptom, of which the patient is unaware, it emerges as a verbally uttered and conceptually represented symptom, suitable for re-conceptualisation. We say 'mute', despite the fact that the symptom is brought to the attention of the clinician by means of a verbal complaint by the patient. It is our contention, however, that this speech act represents only the 'external' perception of a symptom unconsciously produced. The subsequent interaction between the psychoanalyst and the patient

provides a new opportunity for the patient to conceptualise his/her subjective experiences.

We can see in this way that pathway b of Berrios and Marková's model, from this perspective, describes the process by which psychosomatic symptoms are generated. Pathway c, with its components Cc1 and Cc2, can represent the symptom changes that occur through the psychotherapeutic process, namely, how a psychosomatic symptom is transformed into a pliable and conscious manifestation. In other words, we propose that psychotherapy allows a symptom that is unconsciously produced and without mental representation, to achieve a conceptual form capable of psychological elaboration. Once translated and named, the symptom is freed from its somatic expression.

The question arises: why are there some personal experiences that seemingly cannot be conceptualised? On the psychoanalytical view some psychological processes are so painful that the mind may feel incapable of dealing with them. If they occur too early in life, for example, or if they have a nature that, for the individual, is unbearable, they may remain excluded from consciousness, and they may be felt as 'unthinkable'. In contrast to the mechanism of repression, we suggest that in the psychosomatic process, whilst the individual is living through a certain experience, at the same time, he/she is unable to think of it and is unable to conceptualise it. Such an experience may be, for example, trauma. There are many possible and different traumatic experiences, but amongst these, psychoanalysis considers the loss of someone close, someone essential to the individual, as one of the most painful traumatic personal events possible.

What is the nature of such an experience lived through by patients in this process of loss? On the one hand, this may be a 'normal' grief or mourning. On the other hand, sometimes it may take on a pathological expression. In that case, we hypothesise that a certain 'nucleus' of their subjective states remains devoid of representation. A 'nucleus of irrepresentability' could be the 'seed' of the somatisation process. That might happen perhaps on account of the intensity of the psychic pain that would emerge if there were a full understanding of the meanings connected to the loss. Or perhaps we may view this as a 'symbiosis' (Mahler 1968) where there has been extreme emotional investment in the person who is lost. In this situation, and in analogy to the case of Siamese twins sharing vital organs, some people can be viewed as sharing vital emotional links. Whereas in the case of the Siamese twins, a rupture in their physical link would turn into a threat to the life of the two subjects, in the case of the latter, we could metaphorise that a rupture in their emotional link could represent the same dangerous menace to the survival of the individual.

Let us turn to the model proposed by Freud in 1917 (Freud 1974b) to describe the genesis of melancholy and pathological mourning. Using this, we suggest that unconscious processes such as hostility or guilt could supply an underlying structure that impedes consciousness from becoming attached to the attributed meaning of a given loss. This would then block the possibility of this meaning from becoming fully represented. In this way, there would be a failure in the process of the psychic registration of such a loss. This would be happening alongside other experiences

which, in contrast to the experience of loss, could be named and hence generate judgements. Thus, in effect, a sum experience could consist of symptoms underpinned by 'mute processes' and left without conceptualisation and named together with symptoms underpinned by explicit hermeneutical processes and hence conceptualised and named.

We propose that this 'nucleus of irrepresentability' would provide the fundamental impulse for the construction of psychosomatic symptoms. A loss has undeniable aspects, recognised by the subject and by the environment that surrounds him/her. Only in psychotic conditions do we meet the absolute denial of an experience. Many authors have drawn attention to this psychotic component in the psychosomatic diseases (Bion 1995; Békei 1992; Winnicott 1989; McDougall 1989). We here are highlighting that this 'nucleus of irrepresentability' acts as a fragment of the subject's total experience and as a focal process of non-nomination of a subjective state. We suggest that this nucleus can come to be investigated and analysed during the therapeutic process, arriving at a 'name', a representation, through the aid of the analyst, providing a 'secondary construction'.

In this second use of the model of symptom formation, we look for its application in the understanding of the transformation or substitution of symptoms, that is to say, to describe the therapeutic process. We consider that the model can be useful in the analysis of the possible evolution of psychosomatic symptoms from what appears initially to be an unalterable condition. One of the most remarkable features of those symptoms relates to their characteristic rigidity and repetitiveness, showing extreme resistance to therapeutic modification.

The 'echoing model' allows us to understand that this immutability may relate to a concurrent lack of resources in terms of available concepts that could facilitate the representation of the symptom. The 'echoing function' is an internal unfolding of the experiences for the emotional and cognitive registration, which then can be confronted with the templates of previous experiences, in order to form concepts. But if the experience comes 'without a voice', it cannot be echoed. The echoing function fails in its own basis, because here the experience is 'mute'. In order to have 'voice', or 'thought', it is necessary to endow the experience with a representation, either by the most habitual process, passing through the 'primordial soup', or via an external or 'prosthetic' process. Sometimes it is necessary to endow the patient with the concepts that he/she lacks. This is the therapeutic task. From the viewpoint adopted here, this necessitates the subject's active participation in the process of rebuilding his/her symptoms – this always occurs during a psychoanalytical psychotherapy.

In conclusion, we can say that with the model of symptom formation, we can reach a better description and understanding of the origin and development of psychosomatic symptoms. This model also facilitates a description of the processes of symptomatic substitution, by means of the endowment of new conceptualisation resources during the clinician-patient interaction. We pointed as fundamental in the genesis of the psychosomatic symptom a 'nucleus of irrepresentability'. One example of this process is the so-called pathological mourning. The conceptualisation of the subjective experiences is of central importance for the treatment of those symptoms, as this enables them to become represented. The subject depends upon his/her

personal background of experiences and the available cultural resources of nomination. In the same way the clinician acts, using his/her knowledge and experiences to aid the representation of the symptoms. Thus, the cultural processes that endow the clinician and the patient with the necessary categories to accomplish the conceptualisation of the experiences are as much essential for the genesis as they are for the future processing of the symptom. To endow the symptom with a representation is the same as to give it a meaning. Without meaning, the subject cannot make use of his or her experiences, cannot learn and cannot evolve.

The contribution of the Cambridge School of Psychopathology to psychoanalysis is only beginning. We hope that many other possibilities of dialogue and mutual fertilisation will develop in the future.

## References

Alexander, F. (1950). *Psychosomatic medicine: Its principles and applications*. New York: W. Norton.

Anzieu, D. (1985). *Le moi-peau*. Paris: Editions Dunod.

Aragona, M., & Marková, I. S. (2015). The hermeneutics of mental symptoms in the ambridge School. Revista Latinoamericana de Psicopatologia Fundamental [online], 18, 599–618. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1415-47142015000400599&lng=en&nrm=iso

Ávila, L. A. (2004a). *O Eu e o Corpo* [The self and the body]. São Paulo: Escuta.

Ávila, L. A. (2004b). Grupo e Corpo, no enfoque do modelo de Cambridge [Group and the body, from the perspective of the Cambridge model]. *Vínculo, I*, 23–29.

Ávila, L. A. (2005). Um modelo para representar o 'irrepresentado' na mente [A model to represent the 'irrepresented' in the mind']. *Revista Latinoamericana de Psicopatologia Fundamental, VIII*, 187–203.

Ávila, L. A. (2010). Psychosomatic symptoms and the group mind. *Psychology and Psychotherapy: Theory, Practice and Research, 83*, 255–271.

Ávila, L. A. (2016). Corpo e mente em questão: em busca da gênese dos sintomas psicossomáticos [The body and the mind into question: Searching for the genesis of the psychosomatic symptoms]. *Ide, 61*(38), 51–61.

Ávila, L. A. (2019). Psicanálise e Neurociências: as pulsões e o psicossoma' [Psychoanalysis and neurosciences: Drives and the psicosoma]. *Revista Brasileira de Psicanálise* (in press).

Balint, M. (1957). *The doctor, his patient and the illness*. London: Pitman.

Békei, M. (1992). Coincidencias y contradicciones en las teorias psicoanalíticas sobre la psicosomatosis. *Revista de Psicoanálisis (Argentina), 49*(3/4), 543–553.

Berrios, G. E. (2013). Formation and meaning of mental symptoms: History and epistemology. *Dialogues in Philosophy, Mental and Neuro Sciences, 6*, 39–48.

Berrios, G. E. (2015). *Rumo a uma nova Epistemologia da Psiquiatria* [Towards a new epistemology of psychiatry]. São Paulo: Escuta.

Berrios, G. E., Marková, I. S., & Girala, N. (2000). Persistent memory complaints: Hypochondria and disorganization. In G. E. Berrios & J. R. Hodges (Eds.), *Memory disorders in psychiatric practice* (pp. 384–399). Cambridge: Cambridge University Press.

Bion, W. R. (1961). *Experiences with groups*. London: Tavistock.

Bion, W. R. (1962). *Learning from experience*. New York: Basic Books.

Bion, W. R. (1995). *Second thoughts – Selected papers on psychoanalysis*. London: Maresfield.

Freud, S. (1974a). *The standard edition of the complete psychological works of Sigmund Freud*. London: The Hogarth Press.

Freud, S. (1974b). Mourning and melancholia. In *The standard edition of the complete psychological works of Sigmund Freud, Volume XIV, Papers on metapsychology and other works* (pp. 237–258). London: The Hogarth Press.

Groddeck, G. (1977). *The meaning of illness. Selected psychoanalytic writings*. London: The Hogarth Press and the Institute of Psychoanalysis.

Groddeck, G. (1989). *Exploring the unconscious*. London: Vision.

Mahler, M. S. (1968). *On human symbiosis and the vicissitudes of individuation: Infantile psychosis*. New York: International Universities.

Marková, I. S., & Berrios, G. E. (1995a). Mental symptoms: Are they similar phenomena? *Psychopathology, 28*, 147–157.

Marková, I. S., & Berrios, G. E. (1995b). Insight in clinical psychiatry: A new model. *Journal of Nervous and Mental Disease, 183*, 743–751.

Marková, I. S., & Berrios, G. E. (1995c). Insight in clinical psychiatry revisited. *Comprehensive Psychiatry, 5*, 367–376.

Marková, I. S., & Berrios, G. E. (2009). Epistemology of mental symptoms. *Psychopathology, 42*, 342–349.

Marková, I. S., & Berrios, G. E. (2012). Epistemology of psychiatry. *Psychopathology, 45*, 220–227.

McDougall, J. (1989). *Theatres of the body: A psychoanalytical approach to the psychosomatic illness*. New York: Norton.

Winnicott, D. W. (1989). *Psychoanalytic explorations*. London: Karnac.

# Part V
# Neuropsychiatry

# Chapter 24
# Researching Wilson's Disease


**Tom Dening**

## Contents



She was a tall girl in her early 20s. She had blonde hair and was neatly dressed. She looked and sounded pretty much normal. Only a slight heaviness about her movements made her seem a bit ungainly, and her speech was slightly slurred if you paid attention. She had taken a small overdose of tablets the previous weekend, on impulse after a row with her boyfriend. In retrospect, she thought this had been a mistake, and she certainly didn't seem depressed or suicidal today. So why was she being seen by me, the professor of psychiatry's trainee, in the outpatient clinic?

It so happened that Jane had Wilson's disease (WD). She had been on treatment for about 10 years since her diagnosis, but there were occasional lapses, and unfortunately her neurological signs had developed while she was rebelling against having treatment. With her mother, she had moved to Cambridge a few years ago to be close to Wilson's clinic run by Dr John Walshe at Addenbrooke's Hospital. Dr Walshe followed his patients with great care and individual attention, and he would periodically make referrals to Sir Martin Roth if he thought they needed psychiatric assessment, hence Jane's referral.

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She was allocated to be seen by me as a new patient and then presented to the professor. Our interview took place in the old outpatient clinic at 2 Bene't Place, a gracious but shabby building now long surrendered by the NHS to Cambridge University. I recall being at least as interested in the background of Wilson's disease and the effect it had had upon Jane's life as upon the immediate crisis in her life. Perhaps this could be excused as matters did seem to have settled down. After taking my history, I presented the case to Sir Martin, and he also interviewed the patient briefly. I recall that his interview style was a bit like a neurological examination but using words rather than a patella hammer. I think the outcome was that I made a follow-up appointment and then discharged her. In our discussion of the case, Sir Martin said something like 'Interesting condition, Wilson's disease, the psychiatry needs more research…'.

## Historical Background

### *The Emergence of Wilson's Disease*

Wilson's disease (WD) must have existed for centuries. Cases that may have been WD appear in the literature in the mid-nineteenth or even in the eighteenth century (Walshe 2017) but are obviously unverifiable. What we now recognise as WD has two important forebears: Kinnier Wilson's progressive lenticular degeneration and the largely German entity of 'pseudosclerosis', which is generally attributed to Westphal and Strümpell. Pseudosclerosis was a clinical syndrome resembling multiple sclerosis but without plaques at post-mortem. The concept, much used in Europe from the 1880s and 1890s, did not attain much support in the United Kingdom or the United States, however.

The clinical picture of pseudosclerosis was refined, and eventually, following the work of Kayser and Fleischer in reporting the characteristic corneal rings that are now named after them, cases that are clearly of Wilson's disease were reported. The most notable paper was published by Fleischer in 1912 (see Fleischer et al. 1990 for translation) when he described a 'hitherto unknown disease resembling pseudosclerosis' characterised by 'tremor, mental disorders, brownish pigmentation of certain tissues especially of the cornea, cirrhosis of the liver' (p. 408).

It may be asked (Fleischer et al. 1990) why Fleischer's description of this disease combining brain, liver and corneal involvement did not receive wider recognition. Possible reasons include his background as an ophthalmologist, which meant that he was more interested in the corneal rings than in the neuropathology. He was also distracted by skin pigmentation which he supposed was related to haemochromatosis, and he and his pathologist disagreed about whether there was true cirrhosis and whether congenital syphilis was responsible. Thus, there was a less persuasive account than that offered by Wilson.

## *Samuel Alexander Kinnier Wilson*

Wilson (1874–1937) was born in New Jersey but was brought up in Edinburgh after the early death of his father. He studied medicine in Edinburgh, graduating MB in 1902 (Critchley and McConnell 2004). After spending some time in Paris and Leipzig, he came to work at the National Hospital in Queen Square, London, where he remained for the rest of his career. His reputation was made by his reporting of the condition that he referred to as progressive lenticular degeneration. Wilson's contribution was a detailed clinical characterisation of the disorder, together with probably the first detailed clinico-pathological correlation of basal ganglia lesions and identifying cirrhosis as part of the syndrome. He reported a total of 12 cases, four of whom he had studied himself and the others from other sources. He did not observe corneal rings and was apparently sceptical that they were part of the disease (Walshe 2006).

In the next few years, there emerged a recognition that the condition was inherited in a recessive mode, that copper may be implicated, and that hepato-lenticular degeneration (as it was often called) was the same condition as pseudosclerosis (Walshe 2017). Confirmation of the importance of copper came in 1948, opening the possibility that eliminating copper from the body might be a useful therapeutic strategy. Low or absent levels of the copper-containing protein were reported in 1952 (Walshe 2009).

## *A Tale of Two Fathers and Sons*

Kinnier Wilson had two sons but they did not become physicians. Indeed, James Kinnier Wilson (b. 1921) became a distinguished assyriologist at Cambridge University. He nonetheless contributed to the medical literature in partnership with the neurologist Ted Reynolds, with publications on epilepsy and other neuropsychiatric disorders as described in ancient Babylonian scripts (e.g. Reynolds and Wilson 1990, 2013).

One of Kinnier Wilson's colleagues at Queen Square was the neurologist Sir Francis Walshe (1885–1973). Also from an Anglo-Irish background, Walshe had a long and distinguished career, being elected as a Fellow of the Royal Society in 1946, and he was the editor of *Brain* from 1937 to 1953. He had a reputation for sharp, articulate and witty repartee (Critchley 1973). He owned and retired to a large house at Hemingford Grey, in Cambridgeshire, which was passed to his son.

Walshe's son, John Walshe (b. 1920), as did his father, studied medicine at University College Hospital (UCH). His interests were more in metabolic medicine and liver disease than in neurology however. His first contact with penicillamine was in 1953, and it was shortly after this that it occurred to Walshe that penicillamine

should be able to chelate copper. Walshe (2009) describes in detail the process of discovery leading to the publication of his findings in 1956 (Walshe 1956). He moved from UCH to Cambridge in 1957, where he worked until his retirement in 1987. He subsequently held an honorary appointment at the Middlesex Hospital until his full retirement.

## *Molecular Genetics and Beyond*

The WD gene (*ATP7B*) is located on chromosome 13. It was first identified in 1993 and soon shown to be susceptible to a range of different mutations (Thomas et al. 1995) which vary in their frequency in different ethnic groups; *ATP7B* codes for a protein called ATP7B (or WD protein) which is located in the trans-Golgi network of the liver and brain. Its function is to balance the copper level in the body by excreting excess copper into bile and plasma. To date, around 500 mutations of the gene have been reported (Walshe 2017). This genetic heterogeneity doubtless contributes to the differences in clinical presentations, including age of onset of symptoms, but given the complexity it is difficult to match a given genotype with a particular phenotype.

Current management of WD still centres on chelating agents – penicillamine, trientene and tetrathiomolybdate – which increase copper excretion into urine. Zinc salts can also be used to block copper absorption from the gut. Liver transplantation cures the genetic defect but of course requires lifelong immunosuppressive therapy. So far, there are no treatments around genetic modification or replacement.

## *Researching WD: Getting Started*

There were then a series of fortunate circumstances, one of which was that Germán Berrios, who was then the tutor for trainee psychiatrists, had obtained some money to support a regional research essay prize in psychiatry. I had been thinking about potential topics, but it seemed that reading up on Wilson's disease would be an obvious topic and would make good material for an entry. This proved to be great fun, for example, tracking down a 1912 copy of *Brain* in the University's anatomy library and ordering some obscure papers from journals I'd never heard of. Wilson's seminal paper is in fact his Edinburgh MD thesis, published more or less in full (Wilson 1912). I was moved then, and still am, by the photos of his patients before and after their illness took hold. In particular, patient 1 (Sylvia T) was rather beautiful. Her image has been on display in my office ever since.

The second fortunate circumstance was that my essay (kindly typed by the late Mary Coburn) won the 1984 prize. Whether it was the only entry, I don't know. I had very positive feedback from Germán, who suggested that I should publish an

abridged version of the essay. The next fortunate circumstance was that the British Journal of Psychiatry accepted it (Dening 1985).

The paper drew on about 30 relevant clinical papers, describing around 650 patients in total, and suggested that there were four main symptom clusters commonly described: affective, behavioural, schizophrenia-like and cognitive. It was clear that the psychiatric diagnostic criteria used were quite variable, especially in relation to psychosis and schizophrenia, and publication biases would make it impossible to estimate any prevalence figures for these symptom clusters.

By this time, several other things started to happen. We had sent a copy of the essay to John Walshe, and he, recognising that I was interested in the subject, began to invite me to interview his patients when they visited his clinic. As they were from all over the United Kingdom and Europe, they would often be in Cambridge for a few days while he ran his tests, so they welcomed talking to me to ease the boredom. He would also refer me patients who needed assessing, as he soon realised that I was abroad far less often than Sir Martin and therefore could offer a very quick service, even if less erudite. Alongside this, Germán was encouraging me to seek funding to do an MD on the subject using John Walshe's unique cohort of patients. I was successful in obtaining 18-month funding from the Regional Health Authority as a research fellow, and we figured that I would be able to complete the research during the allocated sessions when I started training as a senior registrar after that.

## *Research Fellow (1986–1988)*

In a slightly mad fortnight in the summer of 1986, my daughter was born; I turned 30 and moved from clinical training to being a researcher at the Cambridge University. It felt slightly surreal and a little nerve-wracking. Back then, the medical novels of Colin Douglas were more widely read. One of these, *The Greatest Breakthrough Since Lunchtime* (Douglas 1977), is about the hero's experience of a research job. He clearly has no idea what he is meant to be doing and makes an art form out of appearing to be busy, for example, counting paperclips and looking preoccupied. I had more focus than this, but part of it I could identify with completely.

The plan was to study Walshe's meticulously documented records of patients, which went back to 1955, and also during the course of the fellowship to interview and study patients as they came to visit him. For various reasons, Walshe preferred to keep his own records that were separate from Addenbrooke's Hospital notes. He performed his own biochemical analyses in the laboratory adjoining his office and kept his own appointments system. He typed his own notes after each consultation. These were detailed and usually included, especially at first consultation, descriptions of the patient's appearance and behaviour. Walshe avoided using jargon, and he made no attempt to give psychiatric diagnoses or to make psychological interpretations of patients' behaviours, so these records were an amazing unique resource of observational data. And there were nearly 200 records, which had not been studied for psychiatric purposes before.

I was based in the University Department of Psychiatry, on level 4, so one floor beneath the Department of Medicine, where Walshe was, so I would borrow his notes in batches of about 10 at a time. I was allowed to take them to my office for perusal, which was a great privilege. Nowadays, of course, data entry would be directly into a computer, but this was 1986. Instead, the data were entered onto a standard form. For purposes of analysis, we used SPSS, but this was only available on the university mainframe computer, and at this point in time, there was no editing facility in SPSS. So data entry had to be done in one go, and it had to be perfect. With 195 cases and over 50 variables for each case, this was no mean feat. It required undisturbed access to the room with the computer terminal. I did the data entry one night, trembling at the prospect of making an error.

## Methods

These are described in more detail in the relevant papers. The research consisted of a retrospective cross-sectional study (Dening and Berrios 1989a), a prospective study (Dening and Berrios 1989b), a multivariate study of clinical groups (Dening and Berrios 1989c) and a longitudinal analysis of case note data (Dening and Berrios 1990). In addition, we published a case series on WD and epilepsy (Dening et al. 1988) and two reviews of the behavioural neurology and neuropsychiatry of WD (Dening and Berrios 1989d; Dening 1991).

### *Retrospective Study*

This involved 195 case files from John Walshe's series. We collected demographic data, psychiatric data (15 symptoms, operationally defined, mainly from accepted glossaries, but we needed to generate our own criteria for 'cognitive impairment', 'incongruous behaviour' and 'personality change'), neurological and hepatic symptoms, biochemical variables, outcome and treatment measures. Psychiatric symptoms could be added to produce a psychiatric symptom score. We used a global assessment score (GAS) of 0–100 and a drug risk number (DRN) which was in effect to calculate the anticholinergic burden of psychotropic medication prescribed.

### *Prospective Study*

A clinical protocol was developed, which included demographic and current biochemical measurements, and used several standard assessments for neurological symptoms. Psychiatric assessment was performed using the Comprehensive

Psychopathological Rating Scale (CPRS; Åsberg et al. 1978), and there were also several cognitive measures. We also ascertained the GAS and DRN as for the retrospective study.

### *Multivariate Study*

This study used data from the Walshe series and from three other published series, giving a total of 400 patients. The data from each series were analysed using factor and cluster analysis to produce clinically relevant groups, which were then compared across the four studies.

### *Longitudinal Study*

The retrospective study just drew on data from the first (index) contact with John Walshe. However, most patients visited on subsequent occasions, usually six-monthly or annually. We collected data on up to two follow-up visits, F1 and F2. To include the longest possible time span, F2 was always the most recent visit and F1 intermediate between the index visit and F2. Thus for a patient seen 11 times, data would be collected from the index, sixth and eleventh visits. Psychiatric, neurological and hepatic symptoms were rated as previously on each occasion along with biochemical variables. The frequencies of clinical variables at index, F1 and F2, were compared, and ANOVA was used to look at patterns of change for variable between each of the time points.

## Findings

### *Retrospective Study*

Of the 195 patients, 103 (53%) were male and 131 (67%) were from the United Kingdom. Their mean age was 19.7 years (SD 8.7). Almost half ($N = 93$; 48%) had a family history of WD, and over half ($N = 122$; 63%) had received previous treatment for WD. At the time of the study, 39 patients (20%) were known to have died, the commonest causes being liver disease and chest infections.

Ninety-nine patients (51%) were rated as having at least one psychiatric symptom at index admission, and 39 patients (20%) had been previously seen by a psychiatrist. The commonest psychiatric symptoms rated by us at index admission were incongruous behaviour, irritability, aggression, personality change, cognitive impairment and depression, though for the last two of these the symptom was often

rated as possibly present rather than definite. Delusions, hallucinations, suicidal behaviour and substance misuse were all uncommon. We divided the sample into psychiatric 'cases' and 'non-cases' with a threshold psychiatric score of 0/1, so there were 99 cases with scores ranging from 1 to 17. We could then compare the two groups in relation to other variables. To summarise, the strongest associations were between psychiatric symptoms such as incongruous behaviour and irritability and neurological symptoms. There was also an association between hepatic symptoms and disorientation, doubtless due to delirium. We also used discriminant function analysis to predict various outcomes in relation to other variables. For example, dysarthria was a strong predictor of psychiatric caseness.

This study clearly had some limitations. The sample had various selection biases. For example, most patients had been diagnosed at other centres and started on treatment before referral to Cambridge. Therefore, the findings perhaps do not reflect the frequency of presenting symptoms in WD. Also, cases with acute presentations in hepatic failure will have been under-represented. Nonetheless, the study had some strengths, not least the large sample size. The main findings were that the more behavioural symptoms were commonest and appeared to be linked to certain neurological features. Among the other symptom groups identified in my literature review, cognitive and affective symptoms seemed quite common but were harder to rate with confidence from the case records. To our surprise, schizophrenia-like symptoms were uncommon, probably no more than would be expected by chance. This ran contrary to the most influential review of the subject current at the time of study (Davison and Bagley 1969) which had suggested that schizophrenia-like psychoses were associated with WD.

## *Prospective Study*

Of the 31 patients assessed by me for this study, 19 (61%) were female, and 25 (81%) were from the United Kingdom. Only four (13%) were newly diagnosed cases, their mean age was 27.4 years (SD 7.1) and almost half ($N = 15$; 48%) had a family history of WD. Although the sample included the full spectrum of illness, with some patients who were mute and bed-bound and others who had never had any WD symptoms, there was a bias in favour of relatively healthy patients. This was reflected in the higher mean global assessment score of 71 compared with 56 in the retrospective study.

Ten patients (32%) were GHQ 'cases', and 16 out of 28 (57%) assessed on the Personality Assessment Schedule (PAS) were rated as abnormal (score of 4 or more) on at least one item. Cognitive impairments were not severe, with only four individuals scoring below threshold on the Mini-Mental State Examination. We divided the CPRS items into 'depressive' and 'non-depressive' symptoms, and when we did so there were significant correlations between the non-depressive symptoms and neurological symptoms such as bradykinesia and dysarthria, but not between depressive symptoms and neurology. There were no correlations between any current biochemical variables and neuropsychiatric symptoms. Principal components analysis

yielded four factors, accounting for 73% of the variance, which were named 'neurological', 'cognitive', 'hepatic' and 'psychiatric'. The neurological factor included a 'psychopathic' variable derived from the PAS as well as more obvious symptoms like gait and dysarthria. The sample was characterised by being relatively well, and most biochemical variables were in the normal range, reflecting that patients had been on effective treatment for some time. Nonetheless, the findings were of interest. The main area of psychopathology was in the domain of personality, with a certain amount of affective symptoms and relatively little cognitive impairment. There were no patients with psychotic symptoms. We were again struck by the way that certain psychiatric features seemed to hang together with certain neurological variables.

## *Multivariate Study*

The Cambridge sample of John Walshe was larger than the other three cohorts from published papers and included a more detailed description with more variable. There were 195 Cambridge patients with 39 variables, whereas the other cohorts varied in size from 49 to 88 patients and reported between 8 and 11 clinical and biochemical variables.

Factor analysis of the published studies revealed a 'hepatic' and a 'neurological' factor in each, one of the studies having a third factor around age and sex. The Walshe data had four factors, two 'neurological', one 'psychiatric' and one 'hepatic'. When we reduced the number of variables for comparison with the other studies, the psychiatric factor combined with the neurological factor that included dysarthria, whereas tremor, older age and presence of Kayser-Fleischer (KF) rings remained in a separate factor that we called 'pseudosclerosis' as it resembled that old clinical entity. We also used cluster analysis to derive groups of patients and attained rather similar four-group solutions from each sample. For example, the Walshe cohort produced groups that we named 'hepatic', 'neuropsychiatric', 'neurological' and 'asymptomatic'.

The strength of the study was that it used data from 400 patients from different countries and assessed by different clinical teams. Analysing the data showed consistency, and the groups thus derived were clinically relevant. The association between certain psychiatric and neurological symptoms was apparent in this study too.

## *Longitudinal Study*

Of the 195 patients in the Walshe series, 150 had at least two assessments (index and F1), and 129 had at least three (index, F1 and F2). The main causes of attrition were death, geography or simply that the index admission had been too recent. The mean index-F1 interval was 3.5 years and from F1 to F2 was 6.8 years. When we analysed those patients with a psychiatric score of at least 1 at index (psychiatric 'cases',

$N = 69$, 53% of sample), certain variables fell significantly from index to F1 but not from F1 to F2 (i.e. they showed an early response but then remained reasonably stable): psychiatric symptom score, neurological score, hepatic score, cognitive impairment, incongruous behaviour, dysarthria, rigidity, caeruloplasmin, 'free' (non-caeruloplasmin bound) copper and urinary copper excretion. Other variables changed significantly (all decreased) in both time periods: tremor, KF rings, number of spider naevi and dose of chelating agent.

Thus, some psychiatric symptoms seemed to improve, but others, notably depression and irritability, remained persistent at F2. Overall, most clinical and biochemical impairment occurred relatively early. The more florid psychiatric manifestations of incongruous behaviour and cognitive impairment settled, but a level of often milder symptoms often remained. The association seen in the other studies between dysarthria and incongruous behaviour was found here too.

The main limitations of the study were the bias towards survivors being included and the difficulty in rating certain symptoms, especially depression, with confidence, based solely on case note entries. However, the study was unique in following a large sample with a combination of clinical and biochemical variables for a mean period of over 10 years.

## Conclusions

This research was awarded an MD degree by the University of Newcastle upon Tyne in 1989. Its strengths were the size of the sample of patients with WD and the exceptional standard of documentation. The study was the first to use operational definitions of psychiatric symptoms and standardised neuropsychiatric/neuropsychological instruments in studying psychopathology in WD, as well as being the first to use multivariate statistical analyses to study large cohorts of WD.

The main findings were the following:

1. Psychiatric symptoms are common in WD. These include changes in behaviour and personality, cognitive impairment and mood symptoms. Wilson (1912) regarded mental symptoms as 'important though perhaps not integral', whereas Fleischer (Fleischer et al. 1990) saw them as fundamental to the condition. We side with the latter view.
2. Certain psychiatric symptoms (incongruous behaviour, irritability, personality changes) were consistently associated with certain neurological symptoms (dysarthria, rigidity, bradykinesia but less so with others like tremor), indicating that they were closely linked to cerebral pathology, presumably damage to frontal corticostriatal pathways.
3. Psychiatric manifestations tended to persist over time though perhaps becoming less florid with successful treatment with chelating agents.
4. Psychotic symptoms were uncommon and not a specific feature of WD, in contrast to the then prevailing opinion (Davison and Bagley 1969).

Finally, what has happened since this research? There have been plenty of publications on the psychiatry of WD. A PubMed search of Wilson's disease and psychiatry at the time of writing yielded 165 references. Many of these are case reports, with a small number of reviews, of which the most comprehensive is by Zimbrean and Schilsky (2014). Litwin et al. (2018) have provided a review of treatment of psychiatric disorders. Beyond refining the picture described above from our research, these newer papers have made suggestions about new areas for research, for instance, more attention to changes in psychopathology in response to different forms of treatment and the potential for mental symptoms in WD to throw light on pathogenesis of symptoms that may be more widely applicable.

## References

Åsberg, M., Montgomery, S. A., Perris, C., Schalling, D., & Sedvall, G. (1978). A comprehensive psychopathological rating scale. *Acta Psychiatrica Scandinavica, 57*, 5–27.

Critchley, M. D. (1973). Obituary: Sir Francis Walshe (1886–1973). *Journal of the Neurological Sciences, 19*, 255–256.

Critchley, M. D., & McConnell, A. (2004). Wilson, Samuel Alexander Kinnier (1874–1937). *Oxford Dictionary of National Biography.* http://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-36968. Accessed 20 Feb 2019.

Davison, K., & Bagley, C. R. (1969). Schizophrenia-like psychoses associated with organic disorders of the central nervous system: A review of the literature. In: R. N. Herrington (Ed.). *Current problems in neuropsychiatry: Schizophrenia, epilepsy, the temporal lobe.* (*British Journal of Psychiatry*. Special Publication No. 4, pp. 113–184). Ashford: Headley Brothers.

Dening, T. R. (1985). Psychiatric aspects of Wilson's disease. *British Journal of Psychiatry, 147*, 677–682.

Dening, T. R. (1991). The neuropsychiatry of Wilson's disease: A review. *International Journal of Psychiatry in Medicine, 21*, 135–148.

Dening, T. R., & Berrios, G. E. (1989a). Wilson's disease: Psychiatric symptoms in 195 cases. *Archives of General Psychiatry, 46*, 1126–1134.

Dening, T. R., & Berrios, G. E. (1989b). Wilson's disease: A prospective study of psychopathology in 31 cases. *British Journal of Psychiatry, 155*, 206–213.

Dening, T. R., & Berrios, G. E. (1989c). Wilson's disease: Clinical subgroups in 400 cases. *Acta Neurologica Scandinavica, 80*, 527–534.

Dening, T. R., & Berrios, G. E. (1989d). The behavioural neurology of Wilson's disease. *Behavioural Neurology, 2*, 89–100.

Dening, T. R., & Berrios, G. E. (1990). Wilson's disease: A longitudinal study of psychiatric symptoms. *Biological Psychiatry, 28*, 255–265.

Dening, T. R., Berrios, G. E., & Walshe, J. M. (1988). Wilson's disease and epilepsy. *Brain, 111*, 1139–1155.

Douglas, C. (1977). *The greatest breakthrough before lunchtime*. Edinburgh: Canongate.

Fleischer, B., Dening, T. R., & Dening, R. G. (1990). Concerning a hitherto unknown disease resembling pseudosclerosis. Classic text No. 4. *History of Psychiatry, 1*, 403–418.

Litwin, T., Dusek, P., Szafrańsk, T., Dzieżyc, K., Członkowska, A., & Rybakowski, J. K. (2018). Psychiatric manifestations in Wilson's disease: Possibilities and difficulties for treatment. *Therapeutic Advances in Psychopharmacology, 8*, 199–211.

Reynolds, E. H., & Wilson, J. V. K. (1990). Translation and analysis of a cuneiform text forming part of a Babylonian treatise on epilepsy. *Medical History, 34*, 185–198.

Reynolds, E. H., & Wilson, J. V. K. (2013). Depression and anxiety in Babylon. *Journal of the Royal Society of Medicine, 106*, 478–481.

Thomas, G. R., Forbes, J. R., Roberts, E. A., Walshe, J. M., & Cox, D. W. (1995). The Wilson disease gene: Spectrum of mutations and their consequences. *Nature Genetics, 9*, 210–217.

Walshe, J. M. (1956). Penicillamine: A new oral therapy for Wilson's disease. *American Journal of Medicine, 21*, 487–495.

Walshe, J. M. (2006). History of Wilson's disease: 1912 to 2000. *Movement Disorders, 21*, 142–147.

Walshe, J. M. (2009). The conquest of Wilson's disease. *Brain, 132*, 2289–2295.

Walshe, J. M. (2017). History of Wilson's disease: A personal account. In A. Członkowska & M. L. Schilsky (Eds.), *Handbook of clinical neurology, Vol. 142 Wilson's disease* (pp. 1–5). Amsterdam: Elsevier.

Wilson, S. A. K. (1912). Progressive lenticular degeneration: A familial nervous disease associated with cirrhosis of the liver. *Brain, 34*, 295–507.

Zimbrean, P. C., & Schilsky, M. L. (2014). Psychiatric aspects of Wilson disease: A review. *General Hospital Psychiatry, 36*, 53–62.

# Chapter 25
# Reflections on the Psychopathology of Acquired Brain Injury


**Jose Ignacio Quemada**

**Contents**



## Introduction

Acquired brain injury (ABI) has not been systematically studied by psychiatrists; those of us that have spent our professional lives caring for these patients have struggled trying to apply psychiatric nosology and psychopathological language to the behavioural changes presented by this group of patients. This chapter presents clinical data and a selection of clinical cases that will be used to propose a critical reflection on the adequacy and limitations of our main descriptive tool, psychopathology, and its underlying model of mind.

Psychopathology is the descriptive language of psychiatry and is based on a specific model of human psychological functioning known as 'the trilogy of mind' (Hilgard 1980). The Kantian tripartite concept of mind and faculty psychology laid the foundations for Western psychiatry to classify mental disorders in terms of the weakening of one of these functions: volition, emotion and ideas or cognition; Kant considered these functions 'irreducible faculties of the mind'. Outlining the history of this process in detail and drawing on Esquirol, Prichard, Bucknill and Tuke, amongst others, Berrios (1996, p. 18) wrote, 'delusional, emotional and volitional

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insanities … provided the template for groupings that lasted to this day'. Psychiatry has tended to define mental insanity on the basis of disorders of thinking, has seen the decline of the concept of will since the end of the nineteenth century and has failed in the development of a rich psychopathology of emotions (Berrios 1985). The result of these processes is an intellectualistic definition of mental illness.

Psychopathology, the language used to describe psychological and behavioural alterations, has been organized following these three groups of phenomena: disorders of will, emotion and reasoning. Symptoms, such as delusions, obsessions or hallucinations, represent the derangement within the cognitive functions; sadness and elation are the prototypes of emotional disorders, whilst abulia, more recently apathy, compulsions and impulsivity represent volitional disorders.

The consequence of adherence to this model is that clinical descriptions use a collection of terms that have to fit in one of these conceptual categories. As a result, symptoms that seem to share emotional, cognitive and volitional components are presented with only the most salient aspect (cognitive, emotional or volitional) as their sole component. Clinicians are thus geared towards producing only partial or amputated descriptions of clinical phenomena. Indeed, entire disciplines, such as neuropsychology, otherwise very fertile, focus mainly on one dimension, namely, cognition. This has led to an overrepresentation of cognitive elements in description of clinical cases. It is argued here that reality is more complex and that none of the classical neuropsychiatric symptoms can be fully described if descriptions are limited exclusively to one of these psychological functions. Most symptoms in neuropsychiatry (and probably also in general psychiatry), when examined closely and described carefully, present a multiplicity of psychopathological faces. A variety of neglected emotional changes will be apparent and will confront us with the need for a solid psychopathology of emotions.

This chapter examines behavioural changes after ABI from two different perspectives: firstly, we look at data from patient cohorts that will illustrate the prevalence of different symptoms and of the presence of 'organic personality disorder'; secondly, we explore single cases that allow us an in-depth account of symptoms and their possible pathogenesis. In the last two cases, memory disorder is initially the salient problem, but the concurrent presence of delusional ideas and emotional changes will offer an opportunity to discuss the adequacy of the tripartite model of mind and the role emotional changes play in the generation of delusions and some behavioural changes.

## Behavioural Changes

One of the successful terms in the study of neuropsychiatry of ABI is '(neuro)behavioural changes'. This is loosely defined and refers to both the appearance of new behaviours that interfere with social functioning or the absence of expected behaviours in line with the previous personality as described by close relatives or friends. When we describe permanent, repeated and significant neurobehavioural changes in a patient with ABI, the diagnosis that follows is 'organic personality disorder' (OPD)

(Quemada et al. 2007). The subtype of OPD depends on the most salient behavioural changes; DSM-5 includes labile, aggressive, apathetic, paranoid and disinhibited under the diagnosis of 'personality change due to another medical condition'.

## *Data from Patient Cohorts*

These behavioural changes were explored in three distinct PhD projects in Spain, and the findings will be briefly described here. Castaño (2013) completed her PhD on the 'Neuropsychiatry of Traumatic Brain Injury'. From the cross-sectional analysis of a chronic TBI patient sample, Castaño et al. (2012) noted that there were 53 patients with severe TBI, between 2 and 8 years after trauma and they were relatively young (mean age 35) and mainly male (85%). Only three patients were free of neuropsychiatric symptoms according to the results from the Neuropsychiatric Inventory (NPI). Figure 25.1 summarizes the prevalence of psychiatric symptoms when the NPI was used. The first finding to highlight is the relative absence of clas-

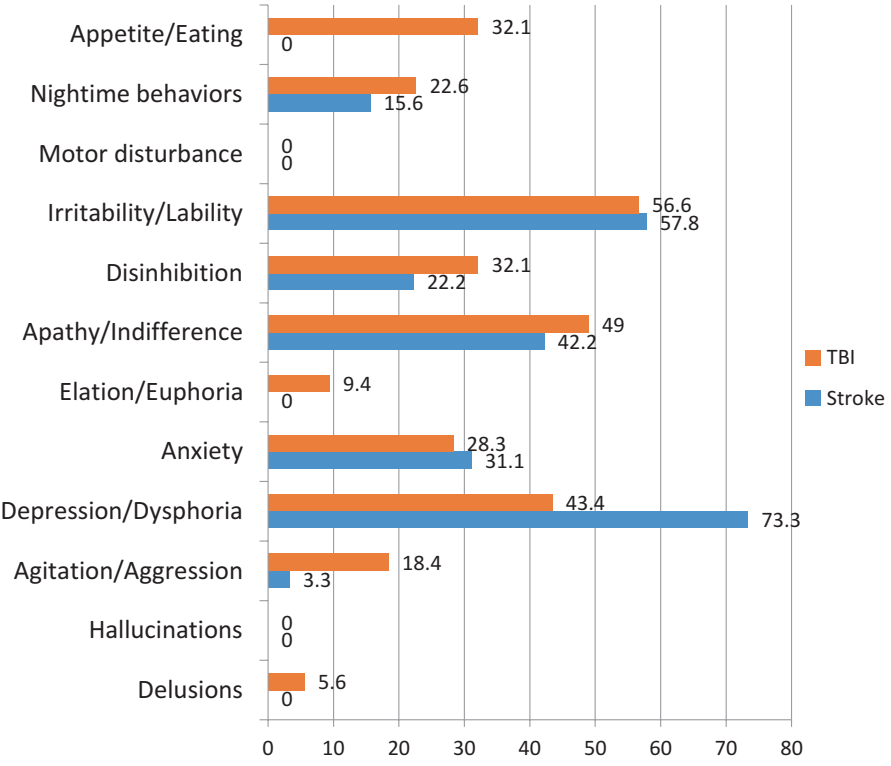


**Fig. 25.1** Percentage of stroke and TBI patients scoring in items of the NPI (PhD thesis of Mimentza 2019 and Castaño 2013)

sical psychotic symptoms: none of the subjects presented with hallucinations, and only three had delusions. On the other hand 56% of the patients presented with irritability/lability, 49% with apathy and 43% with depression; disinhibition and changes in eating pattern were detected in 32% of the sample.

The same author, in her PhD, compared subacute patients (n = 50) with two samples of chronic patients (2–4 years post-TBI, n = 54, and 5–8 years post-TBI, n = 52). Patients had predominantly sustained severe TBI (80%). Relatives reported personality changes in 80% of the patients in the three samples; a minority of the changes qualified as positive: more communicative, emotionally more expressive or less impulsive. In the three samples more than 90% of the patients presented psychopathological symptoms using the NPI with the same three symptoms coming out top in each case, namely, apathy, irritability/lability and disinhibition.

Sanchez-Cubillo's PhD (2010) focused on the description and measurement of disinhibited behaviours in ABI. This research was carried out in a different hospital and city. The study included 93 patients attending a neurorehabilitation clinic, 70 following TBI and 23 following stroke, with mean age of 36 and a majority of male subjects (72). Fifty-eight (62%) patients were diagnosed as having an organic personality disorder (37 disinhibited type, 7 apathetic type and 14 mixed type). Despite the high prevalence of apathy as a symptom identified with the NPI and other neurobehavioural scales, a relatively low proportion of patients was classified as OPD apathetic type. This probably reflects two facts: the high comorbidity of apathy and disinhibition and the clinical prominence of disinhibition when compared to apathy. Only the most severe cases of apathy, in the absence of aggressive or disinhibited behaviours, attract the diagnosis of OPD apathetic type.

Mimentza's PhD (2019) focused upon the longitudinal analysis of the psychopathology of stroke patients. Forty-five stroke patients (mean age 60, 34 male) attending a neurorehabilitation inpatient clinic were assessed at different points in time. When assessed with the NPI 3 months after stroke, none of them showed hallucinations or delusions, but 73% scored on depression, 58% on irritability/lability and 42% on apathy (see Fig. 25.1).

Taking these three studies together, we can confidently say that the most common behavioural changes in ABI are apathy, irritability/lability, disinhibition and depression. Each of these symptoms includes a wide collection of overt behaviours (childishness, over-talkativeness, inappropriate comments, lack of concern for others, lack of initiation, verbal abuse, hostile comments, crying) and a variety of subjective experiences (inner tension, sadness, indifference). In addition, limitation in the awareness of the behavioural and psychological changes is a very common accompanying phenomenon that is not included in the NPI.

Next, we shall describe and discuss two single cases in which some of these behavioural symptoms are displayed.

## *Case 1: Severe Behavioural Disorder*

RR is a 65-year-old man living with his wife. He was a very healthy, active, sociable and witty man. For years the couple has maintained a close relationship with a group of friends, meeting every Friday and Saturday evening for a few glasses of wine and spending weekends and holidays together in a shared holiday home in the country. At the age of 60 whilst on his bicycle, he was run over by a lorry and sustained TBI: GCS 7, coma 7 days and 10 weeks of posttraumatic amnesia (PTA) and bilateral contusions at the base of his frontal lobes. He needed a ventriculo-peritoneal shunt to manage his hydrocephalus. He also developed epilepsy.

During rehabilitation he underwent full motor recovery and became independent in basic activities of daily living; he was able to walk around his town and meet acquaintances on his own. A severe memory disorder, occasional confabulations and executive dysfunction were permanent sequelae. He also showed marked changes in personality: apathy, lack of insight, no flexibility, irritability and verbal abuse.

Four years after the injury, his wife brought him to the clinic complaining bitterly of the persistence of irritability and verbal abuse focused on some of their friends. The impact on their social life was very important and put the couple under the risk of isolation. She was suffering emotionally as a result of the whole situation, whilst he did not appear to be affected. She described brief episodes of abuse towards some of their friends: 'he feels aversion towards some of the friends, shouts at them and insults them which generates very uncomfortable situations'; 'one of our friends has Parkinson's disease, and he can hardly walk on his own; his wife finds it difficult to walk him on her own; rather than helping them, he shouts at him for being slow'. She also complained that her husband no longer understood jokes or irony which had been one of his more developed social abilities prior to the TBI. He interpreted every statement literally which also led to social conflicts. Staying very long hours in bed was another of the behavioural changes noted. At a more personal level, she complained of his lack of tenderness, the absence of intimacy and basic physical proximity: 'he never kisses me or hugs me'. When the patient was confronted with the wife's account of his behaviour, a number of issues became apparent: he was not aware of the marked inadequacy of his behaviour; he felt no compassion whatsoever for his friend with Parkinson's disease and lacked concern for his wife's suffering; when asked about his inner emotional state, he responded with a smile and said that he was well.

This is a common case of very severe TBI followed by cognitive disorder (mainly memory and executive functions) and neurobehavioural symptoms (irritability, verbal aggression, apathy). That is how clinicians would tend to summarize such cases, focusing on the most problematic of areas in behaviour and cognition. However, a more detailed account of the disorder would also include concrete thinking, unawareness of the cognitive and behavioural changes, lack of sense of humour and inability to use irony or double meanings. If we look at the 'emotional faculties', there are a number of changes worth mentioning in this case: severe abolition of

compassion and empathy, emotional indifference (lack of emotional suffering), exaggerated reactions of dislike and anger and loss of control over the associated behaviour (shouting, insults) and very short duration of the emotion.

Let us analyse apathy in a little more detail. Lack of emotions is frequently associated with reduced activity (apathy); apathetic patients with good capacity for introspection will also mention the reduction in their generation of internal ideas. How are these three components related, lack of emotions, reduced generation of ideas and lack of initiative? It seems clear that social behaviour is the final consequence of other underlying psychological phenomena; whether 'lack of emotions' or 'poor spontaneous generation of ideas' has a primary role, or whether both depend upon a distorted third function, is still a matter for research. Clinical observations however lead us to consider disorders of emotions as having a greater contributory role in the development of apathy than that of generation of ideas and behaviours (see cases 3 and 4). Patients with severe expressive aphasia will very likely lack ideas formulated with sentences and words, but that does not stop them from being active and taking initiatives.

## *Case 2: Lack of Social Skills and Social Rejection*

VV is a 33-year-old single man who suffered a severe TBI in a bicycle accident 10 years previously: GCS 6, 12 days in coma and PTA 30 days. CT scan showed haemorrhagic contusions in the right frontal lobe and in the internal capsule. He was first seen in our rehabilitation service 2 years after injury. He lived confined to his room; he had lost the relationship with his girlfriend and avoided contact with his sisters who were the main focus of his hostility and verbal aggression. Rehabilitation focused upon the reduction of aggressive behaviours, tolerance of the presence of his sisters, self-care, abstinence of alcohol, autonomy in activities of daily living and the development of conversational skills. For years he attended a day centre but refused to enter sheltered employment because he felt exploited.

Mental state examination 10 years after injury revealed marked verbosity and prolixity. It was difficult to maintain a conversation with him, partly because he would talk endlessly but also because he connected themes in a very lax way; a word or part of a sentence would allow him to continue his speech with a complete new and unrelated topic; content of the conversation was limited and repetitive. He would get easily excited, showing a mixture of anxiety and euphoria, and showed stereotyped gestures such as rubbing his face and his hands. He invaded interpersonal space making it uncomfortable for the interlocutor. He followed a stereotyped routine during the day, showing no apathy, and his behaviour could be overfamiliar and childish. He also had right-sided anosmia. The final result was social rejection and isolation even in the day centre where other people shared some of his difficulties.

Memory was grossly intact. Neuropsychological examination of this case 10 years after injury included classical attention and executive function tests (Trail Making Test, Stroop test, FAS, Wisconsin Card Sorting Test, Tower of London

(Lezak 1995)) together with assessment of his theory of mind, facial emotion recognition, gambling task and 'go-no go' test. He showed good results in all the executive function tests and in the gambling task; he was right in 1 out of 6 of the stories that assessed theory of mind, 2 out of 17 in the go-no go test and 11 out of 24 in the facial emotion recognition test.

In summary, VV showed enduring behavioural changes of a disinhibited type without apathy. He showed preservation of the classical cognitive functions (attention, memory, executive function) and showed problems with some of the functions studied under the heading of 'social cognition'. It is therefore tempting to link behavioural changes to disorders of theory of mind, motor inhibition and facial emotional recognition. Going beyond the label of 'disinhibition' is always of interest: in this case there was a failure in the pragmatic aspects of communication, and the patient did not seem to understand the bilateral aspect of communication and failed to recognize the signals of the other person conveying boredom or being lost in the conversation; he had difficulties with non-verbal communication getting far too close to the other person and displaying stereotyped gestures; he also experienced or expressed emotions in an exaggerated manner. The outbursts of emotions were short-lived and were triggered by minor stimuli such as meeting someone he knew. Emotional empathy and compassion were not formally assessed, but his prior behaviour towards his sisters suggested the presence of difficulties.

Neuropsychology has been focusing increasingly on exploration of a relatively new construct of 'social cognition' in relation to the study of behavioural changes in neuropsychiatric disorders (Quemada et al. 2017). This incorporates both cognitive abilities (theory of mind, for example) and emotional capacities (empathy, emotional regulation).

## Memory Disorders and Distorted Beliefs

Language, attention, executive functions and memory form the classical chapters of any book on cognitive neuropsychology. Each of these 'big functions' includes a model composed of multiple modules and certain rules of interaction. Some of the modules have defined brain localization: Broca and Wernicke's areas are the clearest examples in language; mammillary bodies and the hippocampus are key areas for the understanding of memory. Cognitive models only include modules that deal with the processing of information; they lack volitional or emotional components. It is as if those 'faculties' of the psyche had nothing to say when it comes to memory, for example. The dimensions used in the design of memory models confirm this exclusive 'cognitive approach': time (short- and long-term memories), nature of the information (episodic and semantic memory, procedural and declarative memory), processing of the information (coding, storage and retrieval) and type of access (implicit and explicit).

Twenty years ago Berrios and Hodges (2000) highlighted the narrow concept of memory disorders operating since 1880: the exclusion of 'old memory disorders' such as memory hallucinations or delusions and the anecdotal status of the Ganser syndrome or hysterical fugue; it is as if memory disorders could only be defined by the loss of short-term information or the presence of deep retrograde amnesia characteristic of Korsakoff syndrome. Two patients with severe memory disorders following brain injury are reported here. Special attention will be paid to the accompanying psychopathology and its relation to the prevailing memory models.

## *Case 3: Persistent 'Déjà Vu'*

XX is a 43-year-old journalist who suffered a severe traumatic brain injury in a road traffic accident. The description of the injury included 3 days in coma, 3 weeks of posttraumatic amnesia (PTA) and a right fronto-parietal haemorrhagic contusion on CT scan. He started a rehabilitation programme 3 months after injury. He was severely amnesic (very poor short-term memory), apathetic and with very limited sight; he had gross preservation of other cognitive abilities as assessed by the WAIS.

Ten months after the injury, he started to describe subjective feelings of familiarity related to every new situation he experienced. He would say things like 'I feel that I have already lived everything that occurs, … I have that same feeling regarding events that are about to happen, … I feel I know that I have already experienced them'. Days went by and he continued having these 'déjà vu' experiences and started producing more elaborate explanations: 'It may well be that time really flows from the present to the past, and that is why I have already lived it all, I may be the only one aware of it'. When asked to consider his assertion from an outside point of view, he had no hesitation in saying that it had 'no logic' and that if someone said that to him, he would try to correct his judgement. Following that, he would explain that his experience ('vivencia' in Spanish) did confer a degree of certainty that was far more persuasive than logical reasoning. A few months later the explanatory ideas had become more complex and bizarre and referred to immortality and reincarnation: 'I have lived several lives, I can jump off a window and I will not die'. He learned to avoid these themes in conversation as he realized that people thought he was mentally disturbed. After a few months these ideas seemed to vanish. To this day he continues to have severe cognitive and behavioural disturbance and has experienced several depressive and manic episodes.

Let us tackle some of the issues posed. Firstly, what is the nature of familiarity? When we say 'feeling of familiarity' or 'sensación de familiaridad' in Spanish, we are closer to the realm of emotions than to any of the other two main 'mental faculties'. Secondly, has 'déjà vu' anything to do with memory? In this case 'déjà vu' misclassifies new events as already lived experiences; false episodic memories are generated. Thirdly, it seems to be the feeling that drives the creation of beliefs, much more directly than the convictions derived from logical reasoning. In summary, this case illustrates an important emotional dimension of memory (familiarity or nov-

elty) that has been excluded from current memory models and shows the power of emotions in the generation of beliefs (delusional or non-delusional).

## *Case 4: Capgras Syndrome*

YY is a 24-year-old student with a family history of severe depressive disorders in two aunts and grandmother. He suffered a severe traumatic brain injury in a motorbike accident: coma 9 days and 4 weeks of PTA. Early CT scan showed brain swelling, subarachnoid haemorrhage and left fronto-temporal haemorrhagic contusions. MRI, a few months later, showed old lesions in left fronto-temporal and right frontal lobes. Neuropsychological assessment showed verbal IQ of 110, manipulative IQ of 130 and very poor verbal memory (Barcelona test, verbal memory Pc < 10).

After the PTA he became irritable, restless and talkative for a few days; this was followed by a depressive episode that lasted several months; in subsequent months the cycle of a 2-week manic episode and a 2-month depressive episode was repeated on several occasions. At the peak of the depressive episodes, the patient expressed some peculiar ideas: 'my parents are really strange creatures, they are extraterrestrial, they come from another world, they seem disguised aliens that keep an external resemblance to my parents'. These ideas disappeared after improvement from the depressive episode. In the depressive phase the patient described lack of feelings rather than sadness and some suicidal thoughts; he showed hypersomnia, lack of appetite, difficulty with vocalization and some irritable reactions. During the hypomanic episodes there were no delusional ideas; he felt very capable, remained very active and full of energy, vocalized very well and recovered a good appetite.

In this case, failure in the recognition of close relatives has nothing to do with visual or agnostic difficulties. Context (family home) and physical appearance of the people in the house suggest a recognition that was not finally completed. The validation process seems to be truncated. What is lacking in the recognition procedure? The patient describes a bizarre belief, 'my parents are aliens', but also an absence of feelings. Once the affective state recovers to either a euthymic state or a manic state, the recognition process returns to normal, and the delusional ideas disappear. It seems as if the emotional colouring of the experience is a requirement in the recognition process. As in the previous case, the 'strange feeling' (lack of it in this case) leads to abnormal beliefs, the 'Capgras delusion'. This case also illustrates that the process of recognition (a key process in memory) requires the integrity of the experience of emotions of familiarity, the 'warmth' that accompanies certain perceptions. Without a careful description of the emotional dimension of the case, the account would only focus on the distorted belief, leading to an assignment of the phenomenon as 'primary delusion'.

## Discussion

### *Cohorts and Single Cases*

In this chapter, clinical data presented are of two different types: on the one hand, cohorts studied in rehabilitation settings, and on the other hand, a handful of single cases. Cohorts were assessed with standardized scales. The NPI was chosen for this chapter and produced results on prevalence of symptoms, clustering of the symptoms and correlations between scales. Information was obtained from both the global results of the scales and their individual items. However, aspects of reality that are not included in the scales are irremediably lost. For example, in the NPI, irritability and lability are both part of a single item, and it is therefore not possible to disentangle which of the two are represented by the score, or lack of empathy or lack of awareness will never be represented because they are not included in the list of items of the scale. Thus, cohorts studied in this way can be very good in providing an overall picture of the psychopathology of ABI but do not allow for a detailed or critical discussion on the psychopathology of ABI. Nor is it possible to suggest mechanisms of production of symptoms that are endorsed.

Single cases allow for detailed qualitative descriptions that can include the personal account of the patient. Nothing is excluded a priori, and the clinician can describe every aspect of the behaviour observed and of the introspective account given by the patient. They are not systematic in terms of data collection and can be biased by the interest of the clinician. That is certainly the case in the ones included in this chapter. It is worth remembering that although we live in the era of quantification and statistics, most of the consolidated knowledge on the brain-behaviour relationship have been obtained from the qualitative study of single cases or small samples. One thing to remember is that single cases tell us nothing on the prevalence of the finding but can highlight an aspect of the psychopathology that would otherwise remain hidden.

### *Psychopathology of Emotions in ABI*

The three samples reported in this chapter suggest that apathy, irritability, lability, disinhibition and depression (in stroke) are the commonest psychopathological symptoms in ABI. I am going to argue that although apathy, irritability and disinhibition are commonly classified as behavioural changes, none of the principal psychopathological changes after ABI can be understood without a core emotional disorder as part of the symptom: apathy, as seen in case 1 and in many others, includes emotional indifference or lack (or marked reduction) of emotions; disinhibition is a much wider concept than apathy and probably a final common pathway of many different types and combinations of underlying disorders; in case 2 it is

related to exaggerated emotional responses to minor stimuli, 'getting rapidly excited', that operate, at least, in conjunction with impaired theory of mind, limited recognition of facial emotions and motor impulsivity; in case 1, the aggressive behaviours (irritability) were related to sudden outbursts of fleeting anger directed towards specific persons or situations that are not filtered and modified by emotional empathy, another expected component of human emotional systems. These observations have implications both for the need to develop the psychopathology of emotions in neuropsychiatry and for the revision of the 'trilogy of mind' as the philosophical background in psychopathology.

Cases 3 and 4 are unusual clinical presentations, persistent déjà vu leading to delusional ideas of grandiosity and transitory Capgras syndrome related to a depressive phase (absence of feelings, no sadness and suicidal thoughts) in a bipolar-type presentation. The common side of both cases is that a disorder in the 'feeling of familiarity' is central to the development of delusional beliefs. In regard to the psychological nature of familiarity, the word 'feeling of' points towards the emotional realm, and if we think of extreme experiences of familiarity or of lack of it, the images that come to mind have to do with psychological warmth and relaxation on the one hand or surprise, strangeness, inner tension and alertness in the other. The other common aspect to both cases is that an abnormal presence or absence of familiarity leads to bizarre beliefs that easily defeat the control of rationality. The sequence of psychological events in both cases suggests that emotional changes have a causative role in the generation of beliefs. The presentation of the delusional beliefs as the central, unique or salient aspect of the case would be a truncated description, as invited by the 'trilogy of mind' model. The same truncated descriptions would happen if we present apathy exclusively as 'lack of initiative', irritability as 'verbal aggression' or disinhibition as 'inappropriate social manners or inadequate sexual remarks'.

The question is why is it so clear that we have to assess short-term memory (words, stories, visual, verbal, etc.) in all ABI patients but we do not seem to feel the same need when it comes to emotional functioning? The clinical cases presented in this chapter face us with the need to explain several emotional disorders that are frequently overlooked (unlike the cognitive disorders): emotional indifference, fleeting outbursts of anger, lack of emotional empathy and compassion, exaggerated and short-lived excitement (anxiety, euphoria) and abnormal presence or absence of familiarity. The psychopathology of emotions will have to address a number of issues such as the difference between affective states (long-lasting, not reactive to external stimuli and non-adaptive) and emotions and how both relate to each other, the potential dissociation of content and expression of the emotions, the list of affective states and emotions and the parameters worth assessing (presence and intensity, speed, duration and stability, salience, valence, type of content, insight, interference with social adaptation).

In summary, an attempt has been made to show that single neuropsychiatric symptoms, apathy and disinhibition, as the main examples, tend to include emotional, cognitive and volitional components. When a classical cognitive function such as memory has been looked at with the help of single cases, emotional compo-

nents such as familiarity have emerged as necessary ingredients that are not included in the classical cognitive models of memory. It is concluded that the 'trilogy of mind' model is didactic but also predisposes to 'truncated clinical accounts' with a tendency for the cognitive components to be overrepresented at the expense of emotional information. A more sophisticated psychopathology of emotions, fully integrated with cognitive functioning, generation of beliefs and volition, is waiting to be developed.

## References

Berrios, G. E. (1985). The psychopathology of affectivity: Conceptual and historical aspects. *Psychological Medicine, 15*, 745–758.

Berrios, G. E. (1996). *The history of mental symptoms: Descriptive psychopathology since the nineteenth century*. Cambridge: Cambridge University Press.

Berrios, G. E., & Hodges, J. R. (Eds.). (2000). *Memory disorders in psychiatric practice*. Cambridge: Cambridge University Press.

Castaño, B. (2013). *Características clínicas y evolución psicopatológica de los cambios conductuales secundarios a traumatismo cráneo encefálico* (Tesis doctoral, Universidad autónoma de Barcelona). Badalona: Institut Guttmann.

Castaño, B., Bernabeu, M., Lopez, R., Bulbena, A., & Quemada, J. I. (2012). Perfil psicopatológico de pacientes con traumatismo craneoencefálico evaluados mediante el inventario neuropsiquiátrico. *Revista de Psiquiatría Biológica y Salud Mental, 5*, 160–166.

Hilgard, E. R. (1980). The trilogy of mind: Cognition, affection and conation. *Journal of the History of Behavioural Science, 16*, 107–117.

Lezak, M. D. (1995). *Neuropsychological assessment* (3rd ed.). New York: Oxford University Press.

Mimentza, N. (2019). *Análisis longitudinal y correlacional de la psicopatología post-ictus e impacto en la funcionalidad*. Bilbao: Tesis doctoral, Universidad de Deusto.

Quemada, J. I., Sánchez-Cubillo, I., & Muñoz-Céspedes, J. M. (2007). El trastorno orgánico de la personalidad: análisis conceptual y estrategias para la investigación. *Actas Españolas de Psiquiatría, 35*, 115–121.

Quemada, J. I., Rusu, O., & Fonseca, P. (2017). La cognición social y su contribución a la rehabilitación de los trastornos de la conducta por traumatismo craneal. *Revista colombiana de psiquiatría, 46*(S 1), 36–42.

Sánchez-Cubillo, I. (2010). *Evaluación neuropsicológica de la desinhibición conductual en pacientes con daño cerebral adquirido*. Madrid: Tesis doctoral, Universidad Complutense de Madrid.

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