The Clinician in the Psychiatric Diagnostic Process

Massimo Biondi
Angelo Picardi
Mauro Pallagrosi
Laura Fonzi
Editors

Springer

The Clinician in the Psychiatric Diagnostic Process

Massimo Biondi • Angelo Picardi
Mauro Pallagrosi • Laura Fonzi
Editors

The Clinician in the Psychiatric Diagnostic Process

Springer

Editors
Massimo Biondi
Department of Human Neurosciences
Sapienza University of Rome
Rome, Italy

Mauro Pallagrosi
Community Service for Prevention and
Early Intervention in Mental Health
Rome 1 Local Health Unit
Rome, Italy

Angelo Picardi
Centre for Behavioural Sciences and
Mental Health
Italian National Institute of Health
Rome, Italy

Laura Fonzi
National Institute of Training
Italian Psychoanalytic Society
Rome, Italy

ISBN 978-3-030-90430-2 ISBN 978-3-030-90431-9 (eBook)
https://doi.org/10.1007/978-3-030-90431-9

This Springer imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Foreword

Several years ago, as a junior doctor I had just joined the Maudsley Hospital in London to be trained to become a psychiatrist. We were a group of young clinicians, having an induction on mental state and risk assessment, and at one point our tutor said to us "sometimes you are sitting with a patient, and you will have a subjective feeling, which you will find difficult to relate back to their words or categorise, but you should pay attention to that, and not ignore it just because it is not explicit in the words of that person." I have never forgotten that day and that advice, which just brought to us what many psychopathologists had extensively written about, and which has continued to resonate in my clinical practice even now as a senior consultant. It is thus with great pleasure that I see in this book an entire, sophisticated body of work able to capture the essence, implications, and full potential of the clinician's subjective experience in the diagnosis and treatment of mental health problems.

To fully appreciate the contemporary relevance of this work, it would be helpful to take a step back, and look at the use, right or wrong, we have been making of diagnostic manuals. On one side, these manuals have allowed us to speak a "common language" in the diagnosis of mental disorders, with great advantages in having a more reliable and comparable way to study mental disorders, across countries and across cultures. Still, these manuals have not left space to the role of intersubjectivity or of the clinician's subjective experience, in fact, rather the opposite. Generations of clinicians have been trained, and entire services evaluated on the basis of either DSM or ICD diagnostic criteria, with little space to the development of other clinical skills, or to the understanding of the complexity of mental health problems and their diagnosis, management, treatment, and outcomes. Furthermore, the distinct nosological categories of diagnostic manuals have not found the same discrete correspondence in the neurobiology of such categories. If anything, genetics, biology, neuroimaging, or cognitive sciences have shown us that the areas of overlap are so many that distinct neuropathological processes or biomarkers for separate diagnostic categories are yet to be identified. Some of the limitations imposed by these symptom-based diagnostic systems were the push for the creation of the RDOC framework, which has aimed to offer an integration of multiple levels of information (from genomics and circuits to behavior and self-report) to allow the evaluation of dimensions of functioning spanning the full range of human behavior, of which mental illnesses could be seen as extremes.

While both diagnostic manuals or RDOC constructs could, to an extent, help research investigations, they cannot help exploit the potential that the consideration and evaluation of the intersubjective experience offers to our understanding of mental illness and psychopathology. As Jaspers argued after all, human communities, in contrast to animal communities, are "mediated through a relation to something other: through a relation to commonly known purposes in the world, through a relation to truth, through a relation to God (transcendence)" (Jaspers K: Vernunft und Existenz, ed 4. München/Zürich, Piper, 1935/1987; p. 59), and like him we should recognize the impact that intersubjectivity has for us as human beings.

The time is thus ripe for the body of work presented in this book. Starting from a historical perspective of the contribution that many psychopathologists have made to our understanding of the role that the intersubjective clinician–patient interaction can play in the diagnostic process, moving to a critical appraisal of how to approach the diagnostic and semi-structured interview, with a discussion of the implications of first-second- and third-person relations. The chapters then run from the knowledge that can be derived from the understanding of the other, to the potential that an appraisal of intersubjectivity has in informing the therapeutic relationship and processes. A central key part of the book is devoted to how neuroscience can help us understand the basis for the intersubjective experience, and how it is actually possible to obtain a reliable psychometric assessment of the multidimensional profile of the psychiatrist's lived experience during the interview, which can then be validated back to specific psychopathological characteristics.

Although much has been written about the quantification of the intersubjective experience in psychiatry, here we find in fact presented in detail the validation and clinical application of a psychometric instrument (the "Assessment of Clinician's Subjective Experience (ACSE)" scale), which investigates clinicians' feelings, thoughts, and perceptions related to the clinical encounter in a measurable and quantifiable way. This represents an excellent endeavor in capturing the reliability of the intersubjective experience, on which clinicians themselves can reflect and from which they can then draw to learn about the ongoing relationship, such that the experience derived from the clinical encounter truly informs the diagnostic and therapeutic process, from the very initial phase.

As a clinician and a researcher, I cannot but be incredibly attracted by the statement of Fonzi and colleagues in this book (Chap. 8) that "the data collected so far seem solid enough to claim that the clinician's subjective experience, far from being an individual volatile and idiosyncratic reaction, should be seen as an intrinsic, meaningful and exploitable part of the psychiatric assessment." This shows us that we can not only learn at the individual level, but we can also use this experience to understand more about the psychopathology that is presented to us and about the possible neurobiological underpinnings of such presentation and interaction.

Reading this book and learning about the role of intersubjective experience in psychiatry should not be limited to a niche of passionate phenomenologists, but

instead used as a precious resource to raise more questions, and attract the attention of educators and trainees, as well as of those already trained, and at the same time be a source of inspiration for those interested in studying the neuroscientific basis of the human experience.

July 2021

Paola Dazzan
Institute of Psychiatry, Psychology and Neuroscience
King's College London
London, UK

Preface

It was the year 2008 when the four of us, a small group of researchers of different ages, with diverse clinical experiences and professional lives, teamed up to reflect on the role of the clinician's subjectivity in the process of psychiatric assessment and therapeutic intervention. While some of us were more involved in clinical work and others in research, we all shared a deep interest in the rich psychopathological literature about the psychiatrist's ability to "feel" the patient. We were puzzled by the degree to which the concepts in this literature, which we found useful in our clinical work, were largely neglected by the mainstream scientific discourse.

At that time, we were all collaborating with the psychiatric department of the Sapienza University of Rome, where interest in phenomenological psychopathology dated back to the days of the direction of Giancarlo Reda, who in the 1970s had spread Minkowski's thinking through the wards of the psychiatric clinic. Since then, it has always been a major concern, in the department, to teach classical psychopathology to young psychiatrists and to promote the development of a sharp clinical eye.

Possibly, our group drew strength from the fact that we were at different stages of our careers and that our professional interests ranged from clinical psychiatry to psychotherapy, research, and teaching. At any rate, given that we all shared a deep interest both in the clinical diagnostic process and in scientific research, we felt we could try to pursue the aim of approaching the heritage of the classical authors from a new, empirical perspective, from which this body of scholarship could command greater attention.

After all, during those very years, new empirical instruments, such as the *Examination of Anomalous Self-Experience* (EASE), began to spread across academic and clinical settings. These new instruments encouraged novel approaches to clinical assessment and a reappraisal of the "old-fashioned" phenomenological and psychopathological concepts.

However, when we started our reflection, we faced the reality of a world where mainstream psychiatry ignored the clinician's subjectivity altogether, while a small professional niche deeply rooted in the phenomenological tradition believed in the diagnostic value of the clinician's feelings despite the absence of solid empirical support for this notion. It was, after all, impossible to provide such support, given the lack of validated measures of the psychiatrist's subjective experience during the clinical assessment.

In order to have any hope of being able to substantially contribute to the field, it was necessary, as daunting as such a task appeared, to attempt to develop and

validate a measure of the clinician's subjective experience. Such an instrument would be necessary to test whether the great phenomenological psychopathologists of the twentieth century were on a reasonably valid path.

In this book, we provide a detailed overview of the theoretical background, the methodology, the findings, and the future perspectives of our decade-long work along this line of research. The common thread of the book is the role of the clinician's subjective experience in clinical diagnosis, including its theoretical and practical implications. The diversity of views on the subject is also illustrated, through the lens of a number of contemporary scholars in phenomenology, psychopathology, and psychotherapy.

In Chap. 1, we present an overview of the classical authors, who more than other leaders in psychiatry have dealt with the significance of feelings, empathy, and intuition in diagnostic reasoning, thus building the foundations for the current reflection.

In Chaps. 2 through 5, a philosophical and clinical outline of the fundamental nature of the processes involved in the psychiatric encounter is drawn, with a focus on the modes of human knowing and psychopathological understanding.

Chapter 6 explores the question of whether neuroscience can help, and how, in the development of a better conceptual understanding of the explicit and implicit processes related to intersubjective dynamics.

In Chaps. 7 and 8, we describe in detail the development and research applications of the *Assessment of Clinician's Subjective Experience* (ACSE) self-report questionnaire, while Chap. 9 illustrates a different empirical approach to the concept of *Praecox Feeling* and its use in the diagnosis of schizophrenia.

In Chaps. 10 and 11, the psychotherapeutic perspective is highlighted and discussed, starting with the classical and contemporary psychoanalytic view and ending with viewpoints from the field of cognitive therapy.

Finally, Chaps. 12 and 13 offer a deep and thoughtful look at the most profound sense of mental illness, which—as a fundamentally human experience—requires human comprehension as well as human care.

This comprehensive overview should allow the reader to become familiar with both the theoretical and practical aspects of studying the clinician's subjective emotions and perception during the diagnostic process, and how this experience can be used to gain insight into the patient's condition. Indeed, we hope that our readers, be them students, residents, trainees, experienced clinicians, or researchers, will be intrigued by the possibility of regaining their own centrality as irreplaceable and scientifically valid instruments of knowing.

We deeply thank Claudia S. Copeland, PhD, for her masterful help in editing the chapters. We also express our gratitude to Prof. Paola Dazzan for kindly writing an inspiring foreword to this book.

Rome, Italy — Massimo Biondi
Rome, Italy — Angelo Picardi
Rome, Italy — Mauro Pallagrosi
Rome, Italy — Laura Fonzi

Contents

The Clinician's Subjective Feeling in Psychiatric Diagnosis: A Historical Excursus

1

Matteo Buonarroti, Laura Fonzi, and Mauro Pallagrosi

1.1 Introduction

Since the beginning of the twentieth century, several psychopathologists have focused their research on the clarification of the essential nature of psychiatric illnesses, with particular attention to severe conditions such as schizophrenia and manic depressive disorder. Unsatisfied with the objectifying approach originally introduced by Kraepelin, according to which psychiatric nosology should rely on clinical descriptions made in a "third-person" perspective, they turned their attention to proposals coming from phenomenological philosophy. The seminal work of Husserl (and of a number of philosophers such as Scheler, Stein, Heidegger, Merleau-Ponty, among others) on the constitution of consciousness, and on the essential structures of human experience and existence, represented indeed a fundamental input for deep investigations about the process of understanding and the conceptualization of the patient's experience. Psychopathologists aimed to disclose the essential, invariant properties of abnormal phenomena and to identify diagnostic entities definable as "certain typical modes of human experience, possessing a meaningful whole reflected in their invariant phenomenological structures" [1].

In clinical work, such research required the acknowledgement of the centrality of the epistemological issue: *how can we know, or more precisely comprehend, the*

M. Buonarroti (✉)
Department of Human Neurosciences, Sapienza University of Rome, Rome, Italy
e-mail: matteobuonarroti@gmail.com

L. Fonzi
National Institute of Training, Italian Psychoanalytic Society, Rome, Italy
e-mail: laura.fonzi@hotmail.it

M. Pallagrosi
Community Service for Prevention and Early Intervention in Mental Health, Rome 1 Local Health Unit, Rome, Italy
e-mail: mauro.pallagrosi@uniroma1.it

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_1

inner world of the patient? Concepts like intuition, empathy, sympathy, and feeling were advanced in an attempt to answer this question. They also became the object of in-depth analyses, being identified by many psychopathologists as useful—sometimes crucial—tools in the diagnostic process. They claimed, in fact, that empathic connection or its specific failures could provide the clinician with essential clinical data, enabling him to grasp the trademarks of the patient's condition. The integration of the clinician's personality and interpersonal sensitivity came to be seen as necessary for objective epistemology, to the point that notions like "diagnostic feeling" or "diagnostic intuition" became part of the shared knowledge of most psychiatrists.

During the second half of the century, such reflection experienced further development, since the epistemological issue was explicitly put into a wider theoretical field regarding the intersubjective foundation of mental processes. The clinical encounter started to be viewed as a particular case of the universal nature of human interaction, characterized by mutual and reciprocal influences, and then became a new preferential subject for the observations of those who were interested in the phenomenology of understanding (and diagnosing) in psychiatry. Psychopathologists no longer spoke of a mere "diagnostic feeling," but acknowledged a process of "intersubjective (second person) comprehension." This line of thought, also pushed by new philosophical proposals like those of Martin Buber (*I-Thou*) [2] and Hans-Georg Gadamer (*hermeneutic circle*) [3], laid the foundations for a renewed approach to psychopathology, which still today places intersubjectivity at the center of psychiatric research and clinical work [4–7].

1.2 The first Half of the 1900s: Empathy, Intuition, and Feeling

1.2.1 Karl Jaspers

Karl Jaspers (1883–1969) occupies a prominent position in the history of psychopathology due to his pioneering work on the systematic description of mental illness within a phenomenologically oriented conceptual framework [8]. He not only provided an articulated classification of the common psychopathological experiences, but also introduced the idea that reflection upon the methodological apparatus is needed for a thorough assessment of the patient's subjectivity.

Jaspers first proposed the centrality of the *person* of the psychiatrist and of his inner attitude in the investigation of the patient's experience, laying the foundations for a new clinical epistemology that was no longer solely grounded in a third-person observation. He considered the active involvement of the psychiatrist in the relationship with the patient as an essential instrument for knowledge acquisition: the doctor, in fact, should *empathically resonate* with the patient. It is indeed the combination of the patient's subjective narration and the clinician's empathic engagement (*Einfühlung*) that represents the most suitable tool to yield meaning regarding the patient's pathological experience, providing a direct access to his or her subjective suffering:

> The investigator, however, is more than a vessel into which knowledge can be poured. He is a living being and as such an indispensable instrument of his or her own research […] The most vital part of the psychopathologist's knowledge is drawn from his *contact* with people. What he or she gains from this depends upon the particular way he or she gives himself or herself and as therapist partakes in events, whether he illuminates himself as well as his patients. The process is not only one of simple observation, like reading off a measurement, but the exercise of a self-involving vision in which the psyche itself is glimpsed.

> There is a natural way of empathic listening to others in which we simultaneously keep touch with ourselves. Every psychopathologist depends on his or her power to see and experience and on the range, receptivity, and complexity of such power. There is an immense difference between those who blunder about among the sick and those who take an unhesitating course in the light of their sensitive perceptions. ([9]; p. 21)

Taking into account Dilthey's distinction between natural sciences (*Naturwissenschaften*) and spiritual sciences (*Geisteswissenschaften*), Jaspers posits that if sensory perceptions are indispensable to experiencing natural objects, only empathic understanding can provide critical information about the human subjective experience. Understanding (*Verstehen*) a patient entails an intuitive feeling that emerges in the clinician from the inside, and that has nothing to do with the rational and piece-by-piece analysis of the psychopathological manifestations: "Rational understanding is merely an aid to psychology, empathic understanding brings us to psychology itself" ([9]; p. 304).

Every psychiatrist should then refer to two main ways of knowing: understanding the patient's experience through empathic participation and examining analytically the individual psychopathological elements [10]. Both of these are necessary in order to reach a reliable clinical judgement:

> This sympathetic tremulation of one psyche with the experiences of another means that, if we are to be scientific, we must objectify such experience critically. Sympathy is not the same as knowledge, but from it springs that vision of things, which provides knowledge with indispensable material. Completely dispassionate observation misses the essence of things. Detachment and sympathy belong together and should not be seen in opposition. *If we are to gain in scientific knowledge, the interplay of both is needed*. The psychopathologist with this genuine vision has a psychic life vibrant with experiences, which he or she is constantly subduing to a rational order. ([9]; p. 22, emphasis added)

Speaking of empathy, Jaspers was no doubt inspired by phenomenological philosophy; however, he did not literally follow the phenomenologists' formulation (see Stanghellini [11] and Luft [12] for a detailed discussion). Indeed, Jaspers spoke about a kind of intentional experience in which the perception of the other person leads one to immediately grasp his or her personal experience; nevertheless, this perception is to be intended only as a *first* and *partial* pre-reflective description of the other's world.

> We make use of our own *first impressions* on meeting an individual. These are unrepeatable, immediate, unique, and sometimes give us a feeling of something that is only confirmed a good deal later on. ([9]; p. 826)

Empathy, for Jaspers, is not the key to an exhaustive comprehension of the patient's psychopathological essence, nor is it able to fully capture the nature of his or her first-person experience. The patient's narrative remains in fact a critical element required to gain a fair knowledge of the patient's experience, as the latter's lifeworld has an irreducible individual character, which lies beyond the realm of empathic comprehensibility [11]. In addition, in his or her opinion, some psychopathological experiences are so extreme that they naturally elude the possibility of an empathic understanding. In particular, he or she devoted much space to the intrinsically incomprehensible nature of schizophrenic delusional experiences, and, even though he or she did not explicitly conceive a form of diagnostic "feeling", he or she nonetheless highlighted the *alien* character of those experiences as an almost pathognomonic factor of schizophrenia. Regardless of the criticisms made by many psychopathologists about the controversial nature of this "incomprehensibility," it seems that Jaspers identified in those cases a rupture in the prereflectively shared world of the clinician–patient dyad, a situation that would be extensively studied by his or her successors.

1.2.2 Elmer Ernest Southard

During roughly the same years as Jaspers' substantial reflection on empathy, on the other side of the Atlantic, Elmer Ernest Southard (1876–1920) was hypothesizing and attempting to systematize the role of the psychiatrist's empathic feeling in the diagnostic process.

Southard was an American neuropathologist and clinical psychiatrist, whose notable contribution to the morphological nature of schizophrenia (a term he preferred to the Kraepelinian *dementia praecox*) and to the concurrent nosological debate failed to exert widespread influence due to his premature death in 1920 from Spanish influenza. As Director of the Boston Psychopathic Hospital, he collected a great number of clinical observations, together with just as many neuropathological examination reports, and his open disposition toward both the functional and organic aspects of psychiatric illness allowed him to unreservedly reflect upon the diagnostic criteria to be used in everyday clinical practice [13].

In 1918, just two years before his death, Southard [14] published the article entitled "*The empathic index in the diagnosis of mental diseases*," in which, inspired by Titchener's work [15], he proposed his personal view on empathy as a diagnostic tool to be used within the patient–doctor relationship. In the paper, he starts with an in-depth examination of the two concepts of "empathy" and "sympathy." The main difference between them, in his view, is that while in the "sympathizing" process, we feel *with* the other, *next-to* the other, when we "empathize" we feel *into* the other, that is, we are able to *identify* ourselves with the one we are dealing with. We can "sympathize" and have compassion for someone's misfortunes even without empathizing with him or her, as when, for example, we feel sorry for distant people suffering in a war, but we can't really "put ourselves in their shoes." Empathy operates, according to Southard, through imaginative, associative, and perceptual processes.

More precisely, following Titchener, Southard states that we can experience ourselves in what we perceive (even objects) through the ability to relate our own image to what we are perceiving, via an imaginative process that also involves kinesthetic sensations. According to Southard, the empathic process does not necessarily imply an *emotional* engagement, but requires an integrative process on both visual and somesthetic levels. "Empathy, it is plain, is more *intellectual* than emotional" (p. 203, emphasis added).

The ability to empathize is a distinctive feature of the human being and can be particularly effective in dealing with his or her fellows: *one touch of nature makes the whole world kin*, as Shakespeare wrote. However, such natural capacity cannot be taken for granted when facing mentally disturbed people. This particular situation is, according to Southard, worthy of study, especially since empathic variations may help in detecting certain psychopathological characteristics that often elude the analytic and fragmented perspective of metric psychology. In other words, the psychiatrist should be able to integrate the rational and investigative faculties with the empathic ones:

> Upon what should we rely? The so-called unconscious of the diagnostician, or his conscious power? Decidedly, so far as possible, the latter. Provided that a man has a right to be a psychiatrist at all, he is probably able to empathize successfully, make a Cliffordian eject of his fellowman, homologize himself with this man, animate him, as it were, with his own type of soul, and see his own reflection in his fellows in difficulties. ([14]; p.206)

The most desirable attitude for a psychiatrist should then be grounded in the ability to use the human empathic capacity without disregarding analytic reasoning, even if Southard seems to prefer, in less-than-ideal cases, the former to the latter. "In short, though it is finer to be synthetic than to be naïve, it may prove practically better to be naïve than to be analytic […] What we crave is, however, neither naïveté nor analysis, but a synthetic general result of a reaction made upon the analytic data". ([14]; p. 207, 212)

Therefore, Southard hypothesizes the possibility of setting an *empathic index*, preferably standardized, to be administered to the psychiatrist when he or she interacts with a patient. The author goes as far as proposing some possible questions to ask the psychiatrist; for example: "Can you identify yourself with the patient?" "Is the likeness to your own probable reactions specific rather than generic?" or "Does this patient's reaction seem intrinsically human or is there something extrinsic and nonhuman about the reaction?" He was convinced, in fact, that the *empathic index* could be profitably used for the diagnosis of a wide range of psychiatric conditions.

Following a personal classification consisting of eleven broad morbid categories, Southard enumerates the "empathic" resonances typical of each psychiatric disorder. For instance, with regards to both syphilitics and patients suffering from other organic pathologies, the clinician is perfectly able to empathize, relating to them as "somatic" patients, while the interaction with "hypophrenics" (mentally retarded individuals) and epileptics was generally characterized by an uncertain empathic reaction. The greatest differential value of the empathic test, however, was attributed by Southard to the evaluation of schizophrenic and "cyclothymic" (bipolar)

patients. Despite not focusing his work on schizophrenia (as was the focus of most of the scholars who followed him), in fact, he points out that the relationship with schizophrenic patients is highly distinctive, evoking in the clinician a very typical feeling of *queerness*, probably due to their dissociative characteristics. Southard goes further to state that, in the case of schizophrenia, it is possible to make the diagnosis solely on the basis of the *empathic index*: "I venture the prediction that an offhand diagnosis of dementia praecox can often be made (as against the cyclothymic) from the *general impressions* conveyed by the patient" (p. 211, emphasis added). For this reason, he also highlights the importance of training young psychiatrists in recognizing and using their own empathic attitude, recommending the practice of *autognosis* (self-knowledge) for all psychiatrists.

1.2.3 Ludwig Binswanger

Ludwig Binswanger (1881–1966) is known as one of the most prominent scholars in the field of psychopathology. Usually remembered as the father of existential analysis (*Daseinsanalyse*), he devoted a sizable part of his work to the epistemology of the clinic, substantially expanding the body of thought on the phenomenology of the clinician–patient encounter [16].

Since the 1922 "*Introduction to the General Problems of Psychology*," Binswanger [17] declared his intention to seek the possibility of developing a discipline founded on the human encounter as the means to provide the psychiatrist with an implicit knowledge of the patient's psychology (*Person-wissenschaft*). The author referred to a direct, "empathic" understanding of the other (*Einfühlung*), which implies the recognition—in the other—of something that belongs to one's own personal experience. As this comprehension is based on an internal perception, it is essential for the individual (the psychiatrist) to gain a deep self-knowledge.

The author came back to the issue in 1924, suggesting that the psychiatrist may experience a sort of specific diagnostic feeling when interacting with a patient. He explicitly spoke of *Gefühldiagnose* [18], maybe referring to the work of Bleuler, who in 1906 had introduced the concept of "intellectual feelings" during the diagnostic process [19]. Bleuler, in fact, inspired by the work of the psychologist Joseph Nahlowski, had spoken about a sort of clinical immediate perception, like the one we have when we "feel" that a patient has typhoid fever without being able to explain why. Such "intellectual feelings" are not related to affectivity, but are described as "intellectual (objective) processes," which are experienced in the form of "indefinite perceptions, conclusions and ideas" or simply "inner perceptions."

Binswanger, however, going beyond Bleuler, proposed the idea that the *Gefühldiagnose* represents not a merely "instinctive diagnosis," which may be based on unnoticed gestaltic perceptions, but a specific experience (*Erlebnis*) emerging in the context of a determined relationship with the other. He believed, in fact, that the *intersubjective* level of the psychiatrist–patient interaction plays a major role in the diagnostic dimension of the encounter [20].

> Another thing: if we diagnose a case of schizophrenia 'by feeling', 'feeling' is here (…) a vague and generic expression for *Erlebnis* of acts, and in this case of very specific acts of perception of others not yet, or not yet adequately, investigated. In this situation we do not actually diagnose according to the feeling, but *with* the feeling; that is, by means of a perceptual modality that has nothing in common with the term 'feeling', in the sense of sensitive or emotional feelings, apart from the name. ([21]; p. 319, our translation)

Binswanger compares the precision of this diagnostic feeling to that of bodily perception: both are basic human tools, subject to training through experience. In this regard, in a letter addressed to Minkowski [22], he stated that *Gefühldiagnose* can only be understood and exploited by experienced psychiatrists, since such a comprehensive perception requires both a trained sensibility and the ability to integrate it with a critical investigation of other psychopathological evidence.

Theoretically speaking, the centrality of the role of the psychiatrist's feeling (*Fühlen*) in Binswanger's formulation seems to be strictly connected with his main philosophical reference points: Scheler with his concept of *inner perception* [23] and Husserl with his concept of *categorial intuition* [24]. Under the influence of these phenomenologists, in fact, Binswanger claimed that the other's mind should be investigated through both careful observation of the patient and sensitive attention to one's internal feelings and resonances.

The most enlightening example of diagnostic feeling, according to Binswanger, is what happens when a psychiatrist meets a schizophrenic patient. He describes a feeling of being "rebuffed in oneself," that is, an impossibility to empathically reach the patient, as if there were an invisible wall between the two actors of the encounter. He ascribes this feeling to the lack of identification that the clinician perceives when he or she comes into contact with the eccentricity or *obliqueness* of the schizophrenic patient, a quality to which he devoted a well-known essay [25].

> (…) we primarily perceive a man as schizophrenic as a whole and only at a later time do we bring our attention to single schizophrenic traits. (…) What we call lack of relationship can sometimes be the only perception that I have of an unknown person, but nonetheless it can 'surprise' me enough to make me wince deep inside when the door opens and he/she enters. Naturally, I must be able to distinguish such a wince and its motives from the attraction or the aversion that I can experience only for reasons of sympathy or antipathy, but it is precisely for that reason that I am a psychiatrist. (…) ([21]; p. 319)

In truth, the lack of connection experienced with the schizophrenic patient does not prevent the clinician from thoroughly understanding the patient. In this regard, Binswanger distances himself from the Jaspersian position on the above-mentioned "experience of incomprehensibility." On the one hand, he, differently from Jaspers, attributes such incomprehensibility to a lack of interpersonal resonance rather than to an intellectual hermeneutic failure [12]. On the other hand, he seems to be persuaded that, through intuition and empathy, it is nonetheless possible to holistically understand the nature of psychotic existence.

These convictions probably stemmed also from Binswanger's familiarity with psychoanalytic discourse. Binswanger and Freud were indeed linked by a deep friendship and professional exchange [26]. In particular, the former found in the

psychoanalytic praxis a valuable starting point for the comprehension of relational dynamics, especially with regards to the concepts of transference and unconscious communication between analyst and patient. Nevertheless, he did not agree with the Freudian conceptualization of a neutral and "passive" analyst. On the contrary, he placed the analyst's (psychiatrist's) participation within the interpersonal field, referring to the phenomenological concepts of empathy and being-with (*Mit-sein*) to deal with this issue [27].

1.2.4 Eugène Minkowski

Eugéne Minkowski (1885–1972) is probably the most illustrious French-speaking psychopathologist of the twentieth century, and has provided seminal contributions to both research on the essence of schizophrenia and the epistemological debate [28].

Notably inspired by the work of Henri Bergson [29], Minkowski identified the "loss of vital contact with reality" as the core essence (*trouble générateur*) of schizophrenia [30]. The concept was modeled on the Bergsonian idea of *élan vital*, which referred to a mutual, harmonious, and dynamic connection between the individual and the world. The loss of such connection represents, in the author's opinion, a distinctive deformation of the general disposition of schizoid individuals, so that they are unable to attune themselves to the external "rhythm" of the world and to empathically connect with other human beings.

In Minkowski's view, the loss of vital contact with reality replaced the central but unsatisfying notion of *autism* developed by his mentor Bleuler. Bleuler had described this particular phenomenon as the consequence of a fundamental disturbance of thinking, expressed in the form of a morbid retreat and a predominance of inner life. Minkowski was on the contrary persuaded that a typical experiential quality (an *autistic* quality) imbues any activity of the schizophrenic patient, regardless of his or her apparent behavior. In other words, even common comportments are deeply affected by a lack of attunement with the surrounding world, and, indeed, this withdrawal from what Minkowski defines as the "common base" characterizes the schizophrenic patient as an alienated, "stranger" to others. Such a perception is heightened by the replacement of the naturalness and vitality of shared common ground with a fixed, static, and rational attitude, which further detaches the patient from the implicit field of human reciprocity.

Provided such a view, it is not surprising that Minkowski thought about the possibility of a holistic perception of the schizophrenic essence that arises directly from the clinical interaction. Since his 1927 contribution on schizophrenia [30], in fact, Minkowski spoke about the role of "feeling" in the evaluation of schizophrenic patients, coining the well-known expression of *diagnosis through penetration*:

> The notions of schizoidy and syntony concern, as we know, the behaviour of the individual towards the surrounding world, his or her ability to vibrate in unison with it and to keep contact with reality. These notions primarily relate to the affectivity and the activity of the individual. Well, in order to assess them, we have an infallible tool in us. *It is our own affectivity, our own personality*. […] It won't be enough for us to observe as impassive

> spectators like we do when we see a preparation under the microscope, to enumerate and to classify the psychotic symptoms in order to make a putative "scientific" diagnosis through pure reason. We will bring into play also our living personality and we will evaluate, through a comparison with it, the peculiarity of the patient's way of being. In addition to reason, we will use *feeling*, which obviously does not mean that we will get emotional about the fate of the patient, but that we will attempt to "feel" with him or her and to understand how he or she feels. We will consider this evaluation as an important element of our *psychiatric* opinion about him or her. ([31]; p. 41–42, our translation, emphasis added)

> In addition to "diagnosis through reason" there will be a "*diagnosis through feeling*" or, better, "*through penetration*", which will be often far more important. It is clear that the diagnosis through penetration cannot ever be reduced to the idea of diagnosis through a simple impression. Such a method needs, like any other method, to be expressed; and it can be gained only through lengthy experience. ([31]; p. 42, our translation)

Minkowski's proposal was very close to the concept of *Gefühlsdiagnose* introduced by Binswanger in 1924, and indeed the two scholars had a fine exchange about this formulation. In particular, both authors claimed that a holistic comprehension of the schizophrenic way of being must be integrated with the widespread psychiatric practice of objectively collecting symptoms and signs. However, Minkowski was more concerned about the use of the term "feeling," especially within the French scientific community, since in his opinion, there was a risk of semantic confusion with the subjective and emotional nuances of that term [32]. This is why he preferred to speak about *diagnosis through penetration*.

Minkowski returned to this issue once again in a passage of his 1933 essay on lived time [33], describing in detail how the progressive impoverishment of the schizophrenic patient's emotional life tends to elicit in the clinician a highly specific feeling:

> In the presence of this particular impoverishment of his [the patient's] life, we experience the painful sensation of knowing all about him. The base common to our fellow men is missing. The psyche of the patient is too well understood. We see it before us in complete detail, as a group of objects, not as a piece of theater behind which we feel the play of divine forces. The patient, uprooted from this common base, no longer has anything of the "fellow man" about him; *he is insane*. ([34]; p. 178, emphasis added)

It is mainly the flattening and the fixity of the patient's psychic life that induces in the clinician a painful feeling of *alienation* and guides the diagnostic reasoning. Thus, where Binswanger spoke about the effects of "obliqueness," Minkowski stressed the interpersonal weight of the "life sources exhaustion" of the schizophrenic existence. Both of these psychiatrists, however, referred to a similar way of knowing (which subsequently would have been called "intersubjective"), despite coming from different philosophical references. While Binswanger was significantly influenced by Husserl's thought, in fact, Minkowski made his Bergsonian inspiration about this issue very explicit:

> Sitting face to face with my patient, I am meticulously writing down his utterances, and then suddenly, like in a flash, one of his sentences illuminates everything with a particular clarity, and I have a feeling of having seized a complex living whole, of having grasped the

> '*trouble générateur*', which now appears as the touchstone of the whole clinical picture. Here we can speak of an example of Bergsonian intuition ([35]; p. 145).

Thus, even though Bergson was not an explicit interlocutor for his coeval Husserl, the contemporary development of the concepts of *intuition* (Bergson) and *categorial* or *eidetic intuition* (Husserl) laid a common ground for epistemological reflection in psychiatry, conveying, through Minkowski's and Binswanger's work, the idea that, as philosophers but also as psychiatrists, we cannot consider ourselves as external observers of reality. On the contrary, we are so immersed in reality that our subjective point of view is a unique and essential means of knowledge. Feeling, penetration, and intuition are, then, only different ways to approach the description of an immediate and irreplaceable method of grasping the essence of the Other.

1.2.5 Henricus Cornelius Rümke

The name of Henricus Cornelius Rümke (1893–1967), a Dutch psychiatrist, is probably the name most often associated with the issue of diagnosis through feeling. His concept of *praecox feeling* (*Praecox Gefühl)* is generally mentioned by authors who deal with the intuitive element inherent in the diagnosis of schizophrenia, and it maintains its appeal to this day among clinicians in their everyday practice [36–38]. This particular renown is probably attributable to both the semantic efficacy and the operational suitability of his formulation with respect to the concepts proposed by other psychopathologists, as a recent renewed interest supports [39, 40].

Rümke introduced the concept of *praecox feeling* in 1941, claiming that schizophrenic patients tend to evoke, in experienced psychiatrists, a typical feeling that they often use, even implicitly, to make a diagnosis [41]:

> It is remarkable that it is rare for a diagnostician to be able to indicate exactly how he arrives at a diagnosis of schizophrenia […] The conclusion will often be that the proponent has sensed a specific *schizophrenia or praecox feeling* during the interview of this patient – he has noticed that this patient's mental state has a specific schizophrenic colour ([42]; p.335, emphasis added)

The term *praecox* was borrowed from the Kraepelinian notion of *dementia praecox*, which Rümke considered as the most convincing definition of the "true" schizophrenic disease, not to be confused with other psychotic disorders included in Bleuler's looser concept of "schizophrenia" [43]. Indeed, Rümke intended to describe an interpersonal phenomenon specifically related to the encounter with the "true" schizophrenic that is genuinely conceivable as a pathognomonic experience. Even though Rümke acknowledged that this *feeling* generally arises in the clinician from the early stages of the interaction – when her attitude is still "disinterested and neutral" – he never used the term *praecox* to allude to its *precocious* appearance, as has often been reported by authors speaking of "diagnosis in the first minutes" [39]. Actually, in Rümke's view, *praecox feeling* was not intended as a simple *diagnosis*

at a glance, quickly emerging during the encounter, but rather represented a complex intuitive experience belonging to the interpersonal field of clinical interaction.

In the 1941 paper, Rümke describes *praecox feeling* as a subjective perception of whole discomfort, as if something is going wrong in the mutual interaction: the clinician "notices something out of order within himself; *he cannot find the patient*" ([42]; p. 336, emphasis added). The author attributes this strange impression mainly to three characteristics of the patient: "affective disturbances," "anomalies of thought," and "psychomotor symptoms." In particular, he devotes extensive space to the first element, claiming that the schizophrenic affect and interaction behavior, typically marked by a lack of "intercourse" or a poor "rapprochement instinct," prevents the clinician from successfully building a reciprocal relationship, that is, in *empathizing*, with the patient. The most apparent signs of schizophrenia, like anomalies of thought or bodily expression, probably elicit a rapid, gestaltic, and prototypical impression. Yet, Rümke identifies the very core aspect of the *praecox feeling* as being most apparent during immersion in the particular intersubjective *milieu* of the encounter. It is in fact mainly through the uncomfortable impossibility to attune with the patient that the clinician prereflectively *senses* his "schizophrenicity."

Even though Rümke did not make explicit reference to the work of Binswanger or Minkowski, it is clear that his position was very close to theirs. All three were influenced by phenomenological psychopathology (Rümke studied under Bleuler) and came into contact with psychoanalytic discourse (Rümke underwent analysis training in Switzerland), so it is not surprising that they were so interested in understanding the role of the clinician's subjective experience. In essence, they similarly conceptualized the dimension of *feeling* as an acute perception basically grounded in the intersubjective dynamics related to the patient's way of *being-with*.

> Most helpful to me in my clinical practice has been the following: I am guided by the "schizophrenia-feeling" or maybe inasmuch as this is not a true feeling, more correctly by the "schizophrenia experience", which arises in the examiner. Only highly experienced psychiatrists, however, will be able to use this "experience" as an instrument of guidance. Whenever this feeling is not aroused in me, the above-mentioned criteria seem to lack their schizophrenic character and their quality of being "very definite" […] ([44]; p. 332)

Rümke particularly stresses the idea that, even though this experience arises as a basic human perception of empathic failure, the ability to use it "as an instrument of guidance" should be nurtured and trained. Also, on this subject he agrees with his known (Binswanger) and unknown (Southard) predecessors, although he was the first to explicitly exhort psychiatrists to *learn* to recognize and use their own subjective experience.

The reliability of *praecox feeling* was a major concern for Rümke, and his reflection about its possible misinterpretations is probably one of the most original contributions coming from his proposal. On the one hand, the author makes it clear that *praecox feeling* is a highly specific tool, but it is not equally sensitive: "[…] however, while one no doubt can be sure that the patient suffers from schizophrenia whenever the praecox experience is there, the reverse, I must admit, is not true." ([44]; p. 332). What we would call *false negatives*, in fact, can occur when the

clinician has "rich and highly developed empathic capacities" and establishes a mutual contact with the patient even beyond the latter's limited possibilities: "a pseudo-rapport may be mistaken for a real one" ([42]; p. 341). On the other hand, Rümke acknowledges that a clinician might exhibit an "unjustified rejection of the diagnosis of schizophrenia" due to the development of a feeling of sympathy toward the patient, falling into a diagnostic mistake. For this reason, it is always recommended to integrate the prereflective impression with a properly detailed interview.

In addition, in Rümke's view, the occurrence of *praecox feeling* can be affected by the current condition of the patient. In a late essay about older schizophrenic patients, the author indeed acknowledges that this experience should be considered *reversible* and *state dependent*, as it may change or fade over the course of the illness:

> As I have considered the 'praecox feeling' [*Praecoxgefühl*] or the 'schizophrenia feeling' [*Schizophreniegefühl]*, or even better, the 'schizophrenia experience' [*Schizophrenie-Erleben*], as of great importance for the diagnosis of schizophrenia, I have described it several times. It turned out to be completely unexpected that in the encounter with these older schizophrenic patients, this feeling did not emerge in me. […] The above-mentioned insecurity does not arise, because a certain reciprocity has been built with the patient. While the doctor may feel something alien with the patient, this alienation faces him/her in another way; a way I wish to call 'almost pleasant'. Empathy [Einfühlung] fails here too; but in this now quiet personality there is still a lot to empathize with. (…) This has become possible because the distance between the patient's ego and his/her delusional world [Wahnwelt] is much greater than at the onset of schizophrenia. ([45]; p. 220–221, our translation)

In other words, it becomes even more clear that Rümke attributes a crucial importance, for the development of *praecox feeling*, to the lack of reciprocity embedded in the crumbled experience of the patient and in her inability to affectively partake in the encounter. On the contrary, the chronic patient's "restored" personality seems to enable the clinician to more easily approach him or her, mitigating the disturbing or alienating impression, which induces the *praecox feeling*.

Finally, while Rümke evidently focused his attention on the interpersonal phenomena implied in the relationship with schizophrenics, he claimed that psychiatrists should assume that their subjective experience is always a fundamental element for understanding and diagnosing, as "the importance of two-sidedness in interpersonal relations not only shows itself in the case of schizophrenia; it is important for the understanding of other illnesses as well" ([42]; p. 337).

1.2.6 Jakob Wyrsch

Jakob Wyrsch (1892–1980) was a Swiss psychiatrist, well-known for his studies on schizophrenia and close in theoretical alignment to the psychopathological positions of Bleuler and Binswanger. It was Wyrsch who suggested to Binswanger the use of the term *Daseinsanalyse* and, even though his essays were primarily derived from clinical practice, he was definitely influenced by the phenomenological perspective.

Inspired by the *Gefühlsdiagnose* concept, Wyrsch reaffirmed in 1946 the idea that the clinician's intuitive impressions are relevant and useful data for diagnosis [46]. Indeed, the clinician's sensations are related, according to Wyrsch, to an "intersubjective," shared dimension that directly refers to the patient's interior state, and they reach the highest sharpness when the patients describe their personal history or their thoughts and emotional states. Even in the case of a different person describing the patient's clinical history, we could theoretically experience typical relevant feelings. However, only a direct exchange with the patient is considered to function as a generative moment of clinical intuition (*Anschauung*). In Wyrsch's opinion, a careful recognition of the clinician's intuition also requires prolonged contact with the patient, and this contact should be free from theoretical influences and distant from the objectifying paradigm of medicine; rather, it should preserve a reciprocity dimension (*Mitmenschen*). This disposition implies in fact not only the technical aspects of the psychiatric practice, but also, and especially, all the nuances and patterns that are normally present in every human interaction.

Wyrsch, like his predecessors, rejects the potential criticism about the lack of objectivity and trustworthiness of the clinician's intuitive impression, emphasizing its nature as a methodologically rigorous knowledge tool. In fact, the discriminating power of intuition in the relationship with schizophrenic patients is rooted in the fundamental characteristics of the schizophrenic way of being, which are fully expressed in interpersonal interactions.

> This is what we see in schizophrenic patients through intuition, and what brings us to the right diagnosis, because we do not catch symptoms but a way of being which is peculiar to schizophrenics and to no one else. In the sense here used, intuition has nothing to do with magic, suggestion, or guessing, but is a sober method. Basically, we do nothing different from what a judge of men does when he experiences being together with another man [..] ([46]; p. 1173, our translation)

The feeling of facing a "strange" and "crazy" (*verrückt*) presence is indeed elicited in the clinician by the patient's emerging detachment from the shared world of common sense (*volkstümlichen Sinne*). Wyrsch refers to a deep disconnection between the patient and other human beings, as well as from the surrounding environment and from the cultural background in which the patient grew up. In other words, the schizophrenic patient lacks what the author calls the "living unity of the person," and for this reason, he or she appears to us as distant, hollow, a sort of "mere shape."

The effect of this core characteristic is that we immediately perceive a "deficiency," an "absence" of something that is fundamental and deeply human, and this perception gives a special meaning to the observable symptomatology. Hence, the schizophrenic existential structure can be holistically grasped only through intuition, not being susceptible to analytic dissection. Indeed, neither the individual symptoms nor the sum of these symptoms can exhaustively characterize schizophrenia as a whole; something always remains beyond this sum, and this is precisely what allows us to make an *intuitive* diagnosis. Diagnosis by intuition is, then, not a judgement based on deductive conclusions drawn from certain manifestations nor a method of

guessing or supposing; it is a real form of knowledge grounded in a subjective and reliable perceptual act. In Wyrsch's conclusive words: "The fact is that [schizophrenia] often precedes the tangible symptoms, and it cannot be dissected through analysis, but can be seen only through intuition" ([46]; p. 1176, our translation).

1.3 From 1950 to the Early 2000s: Atmosphere and Intersubjectivity

1.3.1 Hubertus Tellenbach

The German psychiatrist and philosopher Hubertus Tellenbach (1914–1994) was one of the first to account for the "intersubjective turn" of the paradigm of intuitive diagnosis, giving a notable contribution through the concepts of *atmosphere* and *atmospheric diagnosis*. His thoughts, expressed in the essay *Geschmack und Atmosphäre* [Taste and Atmosphere] [47], has been influential in both psychopathology and philosophy[48, 49], contributing to the advancement in perspective on the nature of human exchanges.

In his work, Tellenbach presents the idea that there exists a prelogical, immediate, and close communication between human beings engaged in social interaction, and that the senses of taste and olfaction are primarily involved in this form of communication, as we develop—since early childhood—the ability to "smell" the *atmosphere* of others.

> More than any other sensory experience, our sense of smell reveals that, beyond the mere fact of sensory reception, something enters into perception that tells us about the inherent nature of the thing, thus received. But *in every objective as in every personal experience there is a surplus that is not expressed. This surplus, which lies beyond the actual fact of the experience, but which we sense as belonging to it, is what we call atmosphere* […] An individual *has* atmosphere in that the [*sic*] radiates the nature of his personality - "like a delicate cloud, which emanates from his person" (E.Minkowski). But he also has the ability to discern the atmosphere of other people, a *sensitivity for atmosphere*, which is an inherent component of the oral sense. My sensing the atmosphere of another person reveals to me forces at work within him that reach my own disposition in the shortest and most direct way and make me react positively or negatively to him by instinct. ([50]; p. 227)

Tellenbach draws a parallel between the *atmospheric* perception of the world and the real perceptive properties of taste and olfaction. These two senses, according to him, provide in fact a *qualitative* view of the world that affects the experience of the subject. First, they are always accompanied by a feeling of "good" or "bad," in contrast to the other senses, which are commonly "emotionally neutral." Further, taste and olfaction are deeply linked to vital functions (i.e., we cannot breathe without perceiving an odor and vice versa) and often provide direct and substantial information about the constitutive nature of the objects (i.e., the intrinsic dangerousness of a gas). Similarly, human beings are, since early sensorial interaction with their mother, accustomed to "smell" or "sense" the *atmosphere* of others, which can be pleasant or unpleasant, and then elicit consistent, prereflective, reactions.

The *atmospheric* feeling, hence, can be conceived, in Tellenbach's opinion, as an automatic, implicit, and founding activity that plays an essential role in many human processes. The building of relational basic trust (through the interaction with the pleasant fragrance of the mother), the constitution of one's own "sense of self" (through the reciprocal phenomena of *atmospheric* resonance), and the creation of shared—cultural—*atmospheric* "envelopes" are just a few examples of such human processes. "Now, within this radiating and discerning encounter among individuals, a *common* atmosphere is also being constituted, which can be experienced as a certain *coloration* of interpersonal relations. This atmospheric composite fills that area, which M. Buber calls the "among" (or, "between") and K. Löwith the "one another"". ([50]; p. 228)

These *atmospheric* phenomena elude the possibility of an objective (i.e., third-person) approach, as it is not possible to "divide the atmospheric feeling from its *object*, since it coincides with its *presence*" ([51]; p. 54, our translation). Researchers should, then, give up on treating the *atmospheric* data from a traditional "scientific" point of view, and accept that we live immersed in *atmospheric* influences that we can grasp only through our natural—but trained through careful practice—sensorial attitude.

This particular mode of knowing is no doubt crucial in every human relationship, but it becomes even more critical in psychiatry. The irreducible, not objectifiable, *atmospheric* sense lays in fact the foundations for the formulation of the *atmospheric diagnosis*. Indeed, Tellenbach refers to the concepts previously introduced by Rümke and Wyrsch, explicitly sharing their claim about the validity of an intuitive criterion for psychiatric diagnosis:

> It is not justified to erase such a criterion from the *scientific* debate following the rationale that we are dealing with a "skill" that cannot be considered equal to the knowledge of facts in their objectivity. By doing so, we would attribute to this skill a vagueness that actually does not pertain to it. […] It seems to us beyond doubt that the coherence between the sense and the atmospheric radiation represents the most important element of the world of *comprehending* […]. If, therefore, an atmospheric element is not objectifiable, either in an explanatory or in a descriptive-phenomenological (à la Jaspers) sense, it still remains *qualifiable*, especially in those situations in which it can be perceived as a medium of intersubjectivity. ([51]; pp. 55–56, our translation)

Psychiatrists, therefore, should rely on "taste" to guide their diagnostic reasoning, since the deviance, the "extravagance" of the patient, can be implicitly acknowledged through this sense. This sense of taste, in fact, confers the ability to grasp the incoherence between the patient's behaviors and thoughts, on one side, and his or her being embedded in the shared cultural world, on the other. Once the psychiatrist has sensed the deviance, he or she should compare this impression with the symptoms and signs collected through an objective observation, and it is indeed from this comparison that a thorough diagnosis can arise. Hence, like his predecessors, Tellenbach highlights the need for an integration between a first intuitive moment and the following analytical and rational ones. Similarly, he claims that the ability to sense the patient's "inadequacy" is a trainable skill, and that often young trainees are not fully aware of and confident in using this way of knowing.

Even though Tellenbach focuses on schizophrenia as the most clear example of an intersubjective dissonance resulting in the possibility of an *atmospheric diagnosis*, he posits that such an understanding can be true for the "experience of fading or loss of freshness detectable also in mild endogenous depressive alterations" ([51]; p. 55, our translation). In fact, Tellenbach devotes a sizable part of his essay to the specific relation between *atmospheric* changes and the nature of psychopathological (or existential) crises. For instance, the perplexity and derealization seen in schizophrenia, which often precede or accompany the development of delusions, are keenly perceivable as an originally *atmospheric* phenomenon. Indeed, the psychotic transformations are by their nature embedded in deep sensorial distortions (e.g., unusual smell or taste perceptions), which can be experienced by both the patient and the clinician who interacts with him. Also, the mild melancholic conditions, or the very early stages of the severe ones, are related to an *atmospheric* change. Since in these cases, the sensorial perceptions lose their "emotional resonance," they are no longer suitable for facilitating an affective contact, a "syntony" with the world. Thus, melancholic patients cannot "feel" in agreement with their sensorium and the psychiatrist perceives this *atmospheric* disconnection as the absence of the vital "tone" of the *atmosphere* radiating from them.

Through these examples, thus, Tellenbach makes clear that it is the patient's *atmospheric* disruption that becomes part of the whole *atmosphere* of the dyadic interaction, providing a definition of the intersubjective perspective that was to be further developed by authors like Kimura and Blankenburg.

1.3.2 Bin Kimura

Bin Kimura (1931–) is a Japanese psychiatrist and scholar of phenomenology, who proposed a very original approach to the field of psychopathology: he is the first psychiatrist to clearly define schizophrenia as primarily a disorder of intersubjectivity. Kimura integrates ideas from traditional Japanese culture and philosophy (especially from Kitaro Nishida) with theoretical concepts borrowed from European phenomenological psychopathology, and enriches such perspectives through music practice and listening. His positions are close to those of Tellenbach and Blankenburg, with whom he began a personal relationship during his European studies.

In describing the human intersubjective dimension, Kimura takes inspiration from the Japanese concept of *aïda*, which to some extent recalls Buber's concept of *Zwischen*, that is, the "between" in which the *I-Thou* dialogue lies [2]. According to Japanese culture, *aïda* is the "between" of human presence, the (virtual) space in which the Self meets both oneself and the other, and it represents the essence of the identity of the subject. It represents at the same time an *inter*subjective and an *intra*-subjective experiential dimension. Kimura attempts to illustrate this in his 1988 dedicated essay [52], through a musical metaphor, describing the experience of musicians engaged in an orchestral performance. When the musical execution has reached—after a preparatory study—the stage of harmonization, any musician experiences himself or herself individually playing music while simultaneously

participating in the flow of the collective execution. From a subjective perspective, it is indistinguishable whether the musician independently *creates* the sounds that constitute the music or *is guided* by an autonomously living melody: the two moments coexist and interact with each other. *Aïda* is this place, which is neither internal nor external, neither detached nor subjective to the other.

> Intersubjective *aïda* is experienced as intrasubjective *aïda*. Intrasubjective *aïda* is nothing other than the scene of the encounter with the noematic sound world by virtue of the noetic playing act of each musician. Thus, *aïda* is between noetic and noematic, but its very essence is the noetic act of encountering the world. The noetic aspect of each subject generates, in the form of the internal *aïda*, a relationship between the self and the noematic aspect. ([52]; p. 43, our translation)

Kimura refers to the Husserlian terms of *noesis* and *noema*, according to which *noesis* is the act of being conscious of an object (intentionality), while *noema* is the object in the conscious act. However, these concepts are mixed with and enriched by Japanese philosophical tradition and by Kimura's thinking, yielding a very complex picture of the human intersubjective dimension. Yet, two issues seem to be fundamental to understanding Kimura's position on the relationship between intersubjectivity and psychopathology: First, Kimura does not consider intersubjectivity as the end product of the encounter between detached and fully formed subjects; rather, this dimension is continuously developed by—but also constitutive of—the interacting subjects: indeed, Self both *arises* and *resides* in the interpersonal field of interaction. Second, by virtue of its both *intra*subjective and *inter*subjective nature, *aïda* operates as a sort of *meta-noetic* principle, able to integrate the *aïda* of different individuals, anchoring them to a shared lifeworld, that is, the so-called *sensus communis* [52].

It is then not surprising that Kimura attributes a notable role to the clinician's subjective experience in the diagnostic moment of the clinical encounter, especially with regards to schizophrenic patients. Since early in his clinical experiences, in fact, Kimura has made observations on the interaction with schizophrenic patients, as is clear in this 1965 contribution:

> As Japanese, we attempt to go beyond individuality through immersing ourselves in the depth of our Self to find the common *aïda*. It is in this way that I meet the schizophrenic in my *jikaku* […] I look for the key essence of schizophrenia in my own inner world, where schizophrenia induces an abnormal noetic atmosphere that derives from the attempt to avoid contact with the other at a noetic level. The modification produced in the *aïda* by this mode of encountering—typical of the schizophrenic—makes difficult my habitual self-awareness. ([53]; p. 142, our translation)

The concept of *jikaku*, which Kimura uses following Nishida, can be translated as "self-awareness" or "self-consciousness." In other words, since intrasubjective *aïda* reflects the intersubjective experience (and vice versa), the encounter with the patient inevitably induces a change in the clinician's self-experience (*jikaku*), and this is particularly noticeable with schizophrenic patients. Interestingly, this concept calls to mind the particular expression used by Rümke about the *praecox*

feeling: the psychiatrist "notices something out of order within himself; he cannot find the patient." In fact, in a number of passages, Kimura explicitly refers to Rümke, yet goes beyond his predecessor in the intersubjective explanation of the described phenomenon. According to Kimura, schizophrenic patients exhibit a typical constitutive fracture in their *arché-aïda*, that is, the primordial *aïda* [53]. A failed foundation of the Self prevents them from establishing a dynamic and well-balanced intrasubjective relationship with otherness, and this is perceived by the clinician as an obstacle to the development of an authentic intersubjective mutual exchange. Again, as previous psychopathologists have claimed, the "absence of contact" is conceived as a specific marker of this peculiar human encounter:

> The inadequacy of *aïda* between the patient's own self and the self of the other entails a rupture in the interpersonal relationality that is characteristic of schizophrenia. The most clear sign of the peculiar interpersonal relationality of the schizophrenics is their specific lack of spontaneity: an absence of emotional exchange during interaction, a particularly cold or lifeless facial expressions, inappropriate social behaviour, bizarre or impulsive reactions, strange negativistic manifestations, or poor resistance in interpersonal relationships ([53]; p. 8, our translation).

1.3.3 Wolfgang Blankenburg

Wolfgang Blankenburg (1928–2002) was a German psychiatrist who was especially known for his 1971 work about the "loss of natural self-evidence" [54], which still represents an essential contribution to phenomenological reflection on the psychopathology of schizophrenia. Blankenburg studied both philosophy and medicine, drawing inspiration from scholars like Heidegger, Husserl, von Weizsaecker, and Binswanger. His view of mental illness was in line with the dasein-analytical tradition, which promoted an approach aimed at understanding the existential path of the individual rather than collecting her symptoms and signs.

Blankenburg proposed a view on schizophrenia focused on the failure of the intersubjective constituent of *common sense*, the implicit "givenness of things" or naturalness of everyday life that allows the individual to effortlessly attune to the world and to others, feeling in a prereflective way that she is taking part in a shared reality. His position is quite close to that of Kimura (who was also one of his Japanese translators), as they both assign to the alterations of the intersubjective field of experience a capital role in the development—as well as in the peculiar *presence*—of schizophrenia. Both authors acknowledge that this presence can be intuitively felt by those who encounter a schizophrenic patient, even in the absence of apparent manifestations (i.e., in symptom-poor schizophrenia). This perception is often sensed, according to Blankenburg, in the form of a feeling of *strangeness*, which mirrors the *alienation* experienced by the patient:

> Our feeling of alienness (*Befremdung*) and his or her [i.e. the schizophrenic's] feeling of estrangement (*Entfremdung*) are specular, and they refer to one another. ([55]; p. 28, our translation)

> For psychopathology, the failure of comprehension is a fundamental criterion. […] The consciousness of the psychiatrist (the "alienist", as Straus emphasizes) becomes, so to speak, a "sensitive reagent", and acquires a sort of hypersensitivity to the "incomprehensible". Such hypersensitivity allows one to more easily single out the schizophrenic element. ([55]; p. 82, our translation)

Blankenburg makes a number of explicit references to Rümke's *praecox feeling*, which he considers as the most subjectivist interpretation of the concept of "failure of comprehension" described from Jaspers onward. In accordance with other researchers in the field of intersubjectivity, in fact, Blankenburg calls into question the mere diagnostic use of the psychiatrist's interpersonal perceptions, recommending that the use of this approach move beyond the epistemological perspective. In his opinion, an exclusively diagnostic use of such "feeling" risks indeed leaving the psychiatrist in the position of *defining* the "abnormal" *from the outside*, while it should be essential to *place* the abnormal *within* a broader overview of the possibilities of human existence. The author's philosophical studies have had no doubt a role in this need to problematize the nature of the *praecox feeling* and to reject the idea of its uncritical application. In fact, it may be said that his or her essay represents itself an effort in the direction of addressing the ineffability of this experience.

Regardless of the divergences, however, Blankenburg agrees with Rümke about the crucial role of *praecox feeling* for differential diagnostics and about the significance of the first moments of the clinical encounter as a prime opportunity for its occurrence:

> The whole of what we meet (e.g. the whole of an ill individual) is not a sum of isolated details, but is already, necessarily, a co-experience. The fact that, within what we define as the "first impression"—for example the "praecox feeling" (Rümke) which represents a prototype of a phenomenological experience within the natural attitude—more can often be revealed than in further deeper interactions, is clearly connected to that minimal level of "empirical amputation" which indeed characterizes the first impression. This means that the first impression does not yet imply an already organized or defined categorical attitude, but a more basic capacity of experience which primarily gives meaning to categories. ([55]; p. 17, our translation)

Highlighting the phenomenological quality of *praecox feeling*, even when it occurs in the absence of an intentional act of *epochè*, Blankenburg reaffirms, in continuity with his predecessors, the universal nature of such an attitude, placing the "first impression" within the category of the basic human skillset. However, according to him, a competent use of this skill not only implies diagnostic expertise but also provides a therapeutic instrument that has the ability to give meaning to the patient's "alienated" experience.

1.3.4 Bruno Callieri

Bruno Callieri (1923–2012) was an Italian psychiatrist and psychopathologist. As a founder of the Italian phenomenological school, he favored the rejection of any

form of psychiatric reductionism and introduced a clinical praxis rooted in the intersubjective significance of the encounter [56]. Inspired in particular by the philosophical thought of Husserl, Stein, Scheler, and Buber, Callieri was in contact with many scholars in psychopathology (i.e., Jaspers, Schneider, Straus, Minkowski), and especially emphasized the therapeutic value of the phenomenological approach in clinical settings. His original contributions were indeed characterized by a perspicuous view on the double nature—*comprehensive* and *therapeutic*—of the clinical encounter, grounded in the idea that mental illness is a substantially intersubjective disorder (see also Chap. 13) [57].

Callieri placed the phenomenological attitude, which lies beyond the preformed or doctrinal theories, at the basis of any authentic and therapeutic interaction with the patient. Only an honest, direct, and spontaneous encounter can promote the possibility of a true *reciprocity*, whereas the naturalistic approaches, including psychoanalysis, risk encouraging an overly mechanistic model of psychotherapy.

> Thus it is necessary (and in the last years it has become for me almost an ethical need) to release the concept of *transference* from its narrow naturalistic and almost mechanistic framework, opening it to the encounter, that is to the *We* […] And so we might consider psychiatry as not only the investigation of the *distortions of inter-human communication* but also, and perhaps primarily, as the study of the *anthropological distortions* of the encounter. ([57]; p. 32, our translation)

In other words, according to Callieri, mental illness is the ultimate expression of a profound distortion in the possibility of interhuman dialogue. This distortion can, as in the case of schizophrenic patients, be present to such an extent that the *defeat of the interpersonal encounter* can be considered as the distinctive trait of the disease. In these cases, the normal *I-Thou* dialectic, according to which the Other is not given *to me* as an *object*, but arises *in me* as a *subject* to relate with, seems to be lost. As a consequence, the encounter with the patient is characterized by the psychiatrist's perception of facing a barely graspable subject. Callieri describes this experience as a feeling of disorientation and uncertainty, which reflects the impossibility of identifying the patient as a subject who is open to enter into a mutual interaction with another person. Through this feeling, the clinician directly grasps the implicit structure of the patient's *being-in-the-world*.

This kind of comprehension, which spontaneously emerges during the encounter, is not otherwise achievable, and therefore represents a valuable guide for the clinician's clinical thinking. The different atmospheres related to encountering not only schizophrenic patients, but also depressed, manic, paranoid, or borderline ones, enable the clinician to differentiate them along a common inability to develop a *We*.

> It remains in any case the vast desert of the fall of the encounter, of its defeat, of its failure into the "schizophrenic land", the paranoid steppe, the obsessive swamp, the melancholic fog; already von Gebsattel and then von Baeyer (1955) gave us memorable pages about the *failed encounter* (the *Vergegnung*) with the schizophrenic, about the impossibility to build the *we*, typical of the paranoid, the delusional, the manic and also of many patients with *personality disorders*, more or less characterized by elements of antisociality and/or perversion. ([57]; p. 32, our translation).

Callieri's position is rather close to that of Blankenburg, since both authors place the intuitive and understanding element inherent to the patient's evaluation into a larger reflection about the significance of the human and clinical relationship. Adopting an open (phenomenological) attitude toward the patient's experience, in fact, seems to be not only an epistemological issue, but is the means by which the psychiatrist can grasp the aberrant and disorienting presence of the patient and start the therapeutic restoration of the possibility of an authentic relationship with the other.

1.4 Conclusions

Over the years, a rich psychopathological and clinical tradition has been established regarding the role of the clinician's subjective experience in the process of understanding in psychiatry. As shown in this chapter, a number of eminent psychopathologists have attempted to describe and examine the core nature of the so-called diagnostic feeling, pointing out its clinical implications and potential usefulness. Phenomenological and, in some cases, psychoanalytic influences have contributed to this particular interest in the distortions of the implicit interpersonal dialectic.

Interestingly, taken together, the proposals collected here converge into a few main issues, which we can summarize in the following key points:

- Most of the authors highlighted in this chapter have pointed out that feeling, intuition, atmospheric sense, etc., represent a kind of immediate comprehension of the other's way of being that should be always complemented with clinical data gathered through an analytical and rational investigation. Empathic knowledge, in fact, should be considered mostly as a *guide*, rather than as a final judgement.
- Almost all of the authors have explicitly distinguished intuitive perception from sympathetic resonance, especially when the potentially confounding term "feeling" has been used. It has been generally acknowledged, in fact, that the clinician's receptivity to these kinds of sensations has nothing to do with affective involvement with the patient or with emotional feelings like sympathy or aversion. Rather, a pure perceptual act is at stake.
- A number of authors have claimed that a certain expertise is needed to usefully manage the intersubjective perceptions spontaneously emerging during the clinical encounter. According to these authors, if the ability to empathically grasp the other should be considered as a basic human skill, the ability to identify and correctly interpret one's own feelings needs to be valued and cultivated throughout the development of the psychiatric practice.
- From the "intersubjective turn" that occurred in psychiatry around the 1950s, almost all of the authors highlighted here have placed the clinician's sensitivity to the patient at the center of an overall reflection about the general significance of the clinical relationship in terms of developing a convenient framework for therapeutic alliance and intervention.

The convergence of the highlighted authors on these points is of particular relevance, not only since they came from different—sometimes culturally distant—biographical and theoretical backgrounds (consider in particular the case of Southard), but also, and especially, because their hypotheses were grounded in rigorous and systematic clinical observations. In this sense, their reflections should not be regarded as theoretical conjectures or anecdotal reports; rather, they represent a significant body of clinical observation and conclusions worthy of being expanded and tested using modern methodologies.

References

1. Parnas J, Zahavi D. The role of phenomenology in psychiatric diagnosis and classification. In: Maj M, Gaebel W, López-Ibor JJ, Sartorius N, editors. Psychiatric diagnosis and classification. Hoboken, NJ: John Wiley and Sons; 2002. p. 137–61.
2. Buber M. Ich und Du [I and Thou]. Leipzig: Insel-Verlag; 1923.
3. Gadamer HG. Wahrheit und Methode [Truth and Method]. Tübingen: JCB Mohr (Paul Siebeck); 1960.
4. Fuchs T. Subjectivity and intersubjectivity in psychiatric diagnosis. Psychopathology. 2010;43(4):268–74.
5. Van Duppen Z. The intersubjective dimension of schizophrenia. Philos Psychiatr Psychol. 2017;24(4):399–418.
6. Gupta M, Potter N, Goyer S. Diagnostic reasoning in psychiatry: acknowledging an explicit role for intersubjective knowing. Philos Psychiatr Psychol. 2019;26(1):49–64.
7. Sholokhova S. Benefits and challenges of the phenomenological approach to the psychiatrist's subjective experience: impassivity, neutrality, and embodied awareness in the clinical encounter. Philos Psychiatr Psychol. 2019;26(4):E83–96.
8. Jaspers K. Allgemeine psychopathologie. Berlin: Springer; 1913.
9. Jaspers K. General psychopathology. Baltimore and London: The John Hopkins University Press; 1959. p. 1997.
10. Eifersuchtswahn JK. Einer Beitrag zur Frage: «Ent-wicklung einer Persönlichkeit» oder «Prozess»? (1910). In: Jaspers K, editor. Gesammelte Schriften zur Psychopathologie. Berlin: Springer; 1963. p. 85–141.
11. Stanghellini G, Rosfort R. Empathy as a sense of autonomy. Psychopathology. 2013;46:337–44.
12. Luft S, Schlimme JE. The phenomenology of intersubjectivity in Jaspers and Husserl: on the capacities and limits of empathy and communication in psychiatric praxis. Psychopathology. 2013;46:345–54.
13. Southard EE, Noll R. Non-dementia non-praecox: note on the advantages to mental hygiene of extirpating a term, by E.E. Southard [1919]. Hist Psychiatry. 2007;18(4):483–502.
14. Southard EE. The empathic index in the diagnosis of mental diseases. J Abnorm Psychol. 1918;13(4):199–214.
15. Titchener EB. (1909) Introspection and empathy. Dial Phil Ment Neuro Sci. 2014;7(1):25–30.
16. Lanzoni S. An epistemology of the clinic: Ludwig Binswanger's phenomenology of the other. Crit Inq. 2003;30(1):160–86.
17. Binswanger L. Einführung in Die Probleme Der Allgemeinen Psychologie [Introduction to the general problems of psychology]. Berlin: Springer; 1922.
18. Binswanger L. Welche Aufgabenergebensich für die Psychiatrie aus den Fortschritten der neueren Psychologie? Z Gesamte Neurol Psychiatr. 1924;91:402–36.
19. Bleuler E. Affectivity, Suggestibility, Paranoia. Utica, NY: State Hospitals Press; 1906. p. 1912.
20. Binswanger L. Über Phänomenologie (1923), in: Ausgewählte Vorträge und Aufsätze. Bern: Francke; 1923. p. 1955.

21. Binswanger L. Quali compiti sono prospettati alla psichiatria dai progressi della psicologia più recenti? [Which tasks are presented to psychiatry from the most recent developments of psychology?]. In: Giacanelli F, editor. Per un'antropologia fenomenologica. Saggi e conferenze psichiatriche. Milano: Giangiacomo Feltrinelli Editore; 1924. p. 1989.
22. Binswanger L. Letter to Eugène Minkowski. In: Binswanger Archive 443/24. Tübingen: Tübingen University Archive; 1926.
23. Scheler M. Zur Phänomenologie und Theorie der Sympathiegefühle und von Liebe und Hass. Halle: M. Niemeyer; 1913.
24. Husserl E. The shorter logical investigations. London: Routledge; 1901. p. 2001.
25. Binswanger L. Drei Formen Missglückten Daseins [Three forms of failed existence]. Tübingen: M. Niemeyer; 1956.
26. Fichtner G. The Sigmund Freud-Ludwig Binswanger Correspondence 1908-1938. New York, NY, US: Other Press; 2003.
27. Binswanger L. Letter from Ludwig Binswanger to Freud, February 15, 1925. In: Fichtner G, editor. The Sigmund Freud-Ludwig Binswanger correspondence 1908-1938. New York, NY: Other Press; 2003. p. 175–8.
28. Urfer A. Phenomenology and psychopathology of schizophrenia: the views of Eugene Minkowski. Philos Psychiatr Psychol. 2001;8(4):279–89.
29. Bergson H. L'Évolution créatrice [Creative evolution]. Paris: Félix Alcan; 1907.
30. Minkowski E. La schizophrénie. Psychopathologie des schizoïdes et des schizophrènes [Schizophrenia. The psychopathology of schizoids and schizophrenics]. Paris: Payot; 1927.
31. Minkowski E. (1927). La schizofrenia. Psicopatologia degli schizoidi e degli schizofrenici [Schizophrenia. The psychopathology of schizoid and schizophrenics]. Torino: Einaudi; 1998.
32. Minkowski E. Letters to Ludwig Binswanger 2 Sept. 1924 and 15 Mar. 1926. In: Binswanger archive 443/24. Tübingen: Tübingen University Archive.
33. Minkowski E. Le Temps Vécu: Études Phénoménologiques et Psychopathologiques [Lived time: phenomenological and psychopathological studies]. Paris: Collection de l'Évolution Psychiatrique; 1933.
34. Minkowski E. (1933). Lived time. Phenomenological and psychopathological studies. Evanston (Illinois): Northwestern University Press; 2019.
35. Minkowski E. Phénoménologie et analyse existentielle en psychopathologie. Evol Psychiatr. 1948;11:137–85.
36. Grube M. Towards an empirically based validation of intuitive diagnostic: Rümke's 'Praecox Feeling' across the schizophrenia spectrum: preliminary results. Psychopathology. 2006;39:209–17.
37. Ungvari GS, Xiang Y, Hong Y, Leung HCM, Chiu HFK. Diagnosis of schizophrenia: reliability of an operationalized approach to 'Praecox feeling'. Psychopathology. 2010;43:292–9.
38. Gozé T, Moskalewicz M, Schwartz MA, Naudin J, Micoulaud-Franchi JA, Cermolacce M. Is "Praecox Feeling" a phenomenological fossil? A preliminary study on diagnostic decision making in schizophrenia. Schizophr Res. 2019;204:413–4.
39. Pallagrosi M, Fonzi L. On the concept of Praecox Feeling. Psychopathology. 2018;51(6):353–61.
40. Gozé T, Moskalewicz M, Schwartz MA, Naudin J, Micoulaud-Franchi JA, Cermolacce M. Reassessing "Praecox Feeling" in diagnostic decision making in schizophrenia: a critical review. Schizophr Bull. 2019;45(5):966–70.
41. Rümke HC. Das Kernsymptom der Schizophrenie und das 'Praecox Gefühl'. Z gesamte Neurol Psychiatr. 1941;102:168–75.
42. Rümke HC, Neeleman J. The nuclear symptom of schizophrenia and the praecoxfeeling. Hist Psychiatry. 1990;1(3 Pt 3):331–41.
43. Rümke HC. Die klinische Differenzierung innerhalb der Gruppe der Schizophrenien. Nervenarzt. 1958;29(2):49–53.
44. Rümke HC. Contradictions in the concepts of schizophrenia. Compr Psychiatry. 1960;1:331–7.
45. Rümke HC. (1963). Über alte Schizophrene. In: Eine blühende Psychiatrie in Gefahr [A flourishing psychiatry in danger]. Berlin, Heidelberg, New York: Springer Verlag; 1967.

46. Wyrsch J. Über die Intuition bei der Erkennung der Schizophrenen. Schweiz Med Wochenschr. 1946;46:1173–6.
47. Tellenbach H. Geschmack und Atmosphäre [Taste and atmosphere]. Salzburg: Otto Müller Verlag; 1968.
48. Costa C, Carmenates S, Madeira L, Stanghellini G. Phenomenology of atmospheres. The felt meanings of clinical encounters. J Psychopathol. 2014;20:351–7.
49. Francesetti G, Griffero T. Psychopathology and atmospheres: neither inside nor outside. Newcastle on Tyne, UK: Cambridge Scholars Publishing; 2019.
50. Tellenbach H. Tasting and smelling—taste and atmosphere—atmosphere and trust. J Phenomenol Psychol. 1981;12(2):221–30.
51. Tellenbach H (1968). L'aroma del mondo. Gusto, olfatto e atmosfere. Milano: Christian Martinotti Edizioni; 2013.
52. Kimura B (1988). Tra [Between]. Trapani: Il Pozzo di Giacobbe; 2013.
53. Kimura B (1992). Scritti di psicopatologia fenomenologica [Essays on phenomenological psychopathology]. Roma: Giovanni Fioriti Editore; 2005.
54. Blankenburg W. Der Verlust der natürlichen Selbstverständlichkeit. Ein Beitrag zur Psychopathologie symptomarmer Schizophrenien. Stuttgart: Enke; 1971.
55. Blankenburg W (1971). La perdita dell'evidenza naturale: un contributo alla psicopatologia delle schizofrenie pauci-sintomatiche [The loss of natural self-evidence: a contribution to the study of symptom-poor schizophrenics]. Milano: Raffaello Cortina Editore; 1998.
56. Callieri B. Percorsi di uno psichiatra [Paths of a psychiatrist]. Roma: Edizioni Universitarie Romane; 1993.
57. Callieri B. Appunti per una psicopatologia della reciprocità [Notes for a psychopathology of reciprocity]. In: Di Petta G, editor. Io e Tu. Fenomenologia dell'incontro. Roma: Edizioni Universitarie Romane; 2008.

The Psychiatric Assessment: First Person, Second Person, and Third Person Perspectives

2

Thomas Fuchs and Eugenio Dalpane

2.1 Introduction

The establishment of criteriological and manualized systems of diagnosis since the 1980s has led to a valuable increase in the precision and reliability of psychiatric diagnosis. On the other hand, the limits of this approach for clinicians and researchers are becoming increasingly apparent. Editorials of major psychiatric journals have deplored a decline of psychopathological expertise and capacity for individualizing, person-centered assessment [1–3]. DSM-5 and ICD-10, with their epistemological roots in logical positivism, are mainly conceived for purposes of reliability, and therefore characterized by rather simple psychopathological concepts compatible with easily applicable data collection techniques. Consciousness and subjectivity, however, are virtually excluded on the theoretical level and undervalued on the pragmatic level, with serious consequences for the validity of psychiatric diagnosis, for empirical research, and, above all, for therapeutic purposes.

In the following, the arguments that a thorough assessment and typology of subjective and intersubjective experience, included in our future diagnostic systems, will be indispensable for clinical, therapeutic as well as research purposes. It might even be essential for the identity of psychiatry as a discipline, which at present is

This chapter is a revised and expanded version of the article that appeared as: Fuchs T. Subjectivity and Intersubjectivity in Psychiatric Diagnosis. Psychopathology 2010;43:268–274. (https://doi.org/10.1159/000315126). Reprinted with permission from Karger AG, Basel.

T. Fuchs (✉)
Clinic of General Psychiatry, Center of Psychosocial Medicine, University of Heidelberg, Heidelberg, Germany
e-mail: thomas.fuchs@urz.uni-heidelberg.de

E. Dalpane
North Baden Psychiatric Center, Wiesloch, Germany
e-mail: eugenio@dalpane.com

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_2

about to become but a part of "clinical neuroscience" [4] and to neglect its historical roots in the humanities. Recently, there have been approaches toward a "person-centered psychiatry" aiming at a more holistic assessment of the patient's condition by including positive aspects of health, protective factors, values, and aspirations of the person as well as social and cultural contexts [5–7]. However, these ecological and biographical aspects should be based on a methodologically guided assessment of subjectivity and intersubjectivity as indispensable premises of a person-centered approach to diagnosis and classification.

In order to further support this claim, three major approaches to the assessment of mental illness may be distinguished:

1. The positivistic, objectifying, or third person approach as endorsed by DSM-5 and ICD-10, focusing mainly on observable behavioral symptoms
2. The phenomenological, subject-oriented, or first person approach, focusing on the patient's conscious self-experience and exploring its basic, often implicit structures
3. The hermeneutic, intersubjective, or second person approach, mainly aiming at the co-construction of shared narratives or interpretations regarding the patient's self-concept, conflicts, and relationships, as in psychodynamic approaches

The following is a brief presentation of the essential features of each approach, with arguments for a need to complement our diagnostic systems by the methodical, phenomenological, and hermeneutic assessment of the patient's altered self-experience and dysfunctional relationships.

2.2 Positivistic or Third Person Approach

The positivistic or third person approach, often taken as a standard of scientific discourse, emphasizes objectivity, subject-independent reliability, and quantification. The operationalism guiding this approach follows the Hempel-Oppenheim schema of explanation first introduced into psychiatry by DSM-III [8]. It links the definition of a term to a certain operation that may be executed or observed in a standardized way. Accordingly, the operational approach is mainly confined to the assessment of single symptoms and behaviors, since these are considered more reliably assessable features than personal experiences. The aim is not to understand human subjectivity as a coherent whole but to classify circumscribed abnormal human behaviors, with the final goal to explain them by reduction to subpersonal causes, that is, brain dysfunctions. The approach is thus mainly based on the medical model of psychiatry, which regards psychopathological conditions as resulting from some underlying pathophysiology. It is also connected to a modular theory of the mind as being composed of single functional units that may each be disturbed separately. This concept offers advantages for experimental neuropsychology and functional psychopathology [9], but it misses the integrative level of self-experience that is affected in most mental disorders.

The advantages of the positivistic approach are thus gained at the price of systematically neglecting the patient's subjective and intersubjective experience. As

Parnas and Zahavi have criticized [10], vast domains of mental life (e.g., notions of the person, self, identity, varieties of delusional experience, or subtle changes of perceptual, cognitive, and existential experience, for example, in prodromal stages of psychosis) have been deleted from the diagnostic manuals, because they are not describable in lay vocabulary. This leads not only to an increasing loss of psychopathological expertise, but is also bound to compromise neurobiological research, which is left without sufficient descriptions of what it attempts to explain. There is a lack of a suitable psychopathological framework that could integrate single symptoms and neuropsychological dysfunctions into a coherent whole of altered conscious experience. This results in a short-circuit between the level of rather superficially described symptoms, on the one hand, and the level of putative neurophysiological correlates on the other, often expressed in neophrenological claims such as "obsessive-compulsive disorder is caused by a dysfunction of the caudate nucleus."

In the last analysis, the current approach to assessment does not really bridge, but rather widens the "explanatory gap" between subjective experience and underlying brain dysfunctions. If psychopathology is reduced to a list of commonsensically derived and simplified operational features, further progress of pathogenetic research will be seriously impeded. What is needed is a complex psychopathology capable of mediating between symptom level and process level, and of developing models of the inherent structure and possible disturbances of conscious experience. Similarly, the modularity approach to brain functions should be complemented by integrative concepts in terms of parallel distributed processing, network interconnection, and, above all, brain–environment interaction [11, 12].

However, not only researchers and clinicians, but also psychotherapists face major difficulties with their particular needs for assessment when they use criteriological manuals such as ICD or DSM [13]. The Hempel-Oppenheim schema is applicable to the factual aspects of psychiatric diseases such as deviations of brain morphology or epidemiology, but it is inappropriate for the intersubjective level where patient and therapist are directed toward hermeneutic understanding and common construction of narrative meaning. Whereas subjectivity should be blinded in the one case, it becomes the very instrument of exploration and understanding in the other case [13]. Moreover, psychotherapy is largely based on concepts of psychosocial crisis as the result of a situation perceived and reacted upon in a particular, subjective, or idiosyncratic way. This stands in contrast to the medical model of an underlying biological pathology that is only triggered by life events. Therefore, what is needed for psychotherapy is an assessment of the narrative, idiographic and psychodynamic dimension of the patient's condition and biographical situation.

2.3 Phenomenological or First Person Approach

The phenomenological approach is primarily aimed at empathically understanding, describing, and analyzing the patient's subjective experience. Jaspers used the term of "intuitively representing" the other's psychic states (*anschauliche*

Vergegenwärtigung) by an act of inner recreation or "imaginative actualising" [14]. Phenomenology does not consider subjectivity as just an object to be described but as a medium allowing the world to manifest itself. Therefore phenomenology aims at grasping not the content or object, but rather the form and structure of conscious experience, a task for which it has developed suitable methodologies. Symptoms are not identified in isolation, but always in relation to the subject and the whole of consciousness in which these symptoms emerge. On the one hand, this means to understand the conscious and explicit perspective of the patient itself in the way envisaged by Jaspers. On the other hand, going beyond Jaspers' descriptive approach, present phenomenology also includes analyzing the prereflexive (subliminal, embodied, interpersonal, and situational) structures of experience, which are the antecedent basis of the patient's explicit perspective. It is only on this basis that the meaning of his verbal expressions may be adequately understood and interpreted.

To take an example given by Stanghellini [15]: What exactly does a patient mean, for example, when he says "I feel depressed?" – Some patients may use the word "depressed" to describe themselves as feeling sad and downhearted, discouraged by a setback or another adversity. That means, they are depressed by or because of something, their feeling is intentionally directed—corresponding to the diagnosis of reactive depression. Others may use it to mean that they feel dull, empty, bored, and dysphoric, as is often the case in Borderline patients. Others may denote that they are unable to feel anything at all, that they have lost the affective resonance with others, like being petrified – corresponding to the "feeling of loss of feeling" in endogenous depression. Some patients may also try to convey their sense of an inner void, a lack of inner nucleus or identity, feelings of being anonymous or nonexistent, as occurring in the prodromal phases of schizophrenia. Finally, some patients may use it to describe a blunting of affect, loss of drive, initiative and goal-directedness, corresponding to the phenomenon of aboulia in chronic schizophrenic states.

This example illustrates that a symptom such as depressiveness is far too unspecific to be valid as such, as it is assumed by the criteriologic approach of DSM-5 or ICD-10. The depressed mood of the neurotic, melancholic, schizophrenic, or Borderline patient displays a very differential quality. It is only within the context of the patient's situation, his or her overall relation to the world and to himself or herself that the feature gains its specific value. This even holds true for more circumscribed phenomena such as audible thoughts: They are not characterized by their content or by a presumed acoustic intensity, but rather by a dissociation of inner speech, leading the patient to attend to his or her thoughts in order to grasp what he or she is thinking of [16]. Similarly, not the probably "wrong" content of a delusion is decisive for its diagnosis, but rather the patient's specific attitude toward his or her convictions, namely, refusing to expose them to open communication and possible doubt, thus ultimately excluding intersubjectivity. Therefore, the reduction of experiential phenomena to mere single symptoms may lead to an illusionary reliability and validity: Often apples and pears are, as it were, treated alike, the extraordinary content is confused with the altered form of pathological experience, and the

disorders are put together from single symptoms that would suit just as well to another disorder—this explains the explosion of comorbid disorders. Phenomenological diagnostics, on the contrary, tries to grasp the patient's relation to himself or herself and the world, and this is more than the sum of single features.

Phenomenology offers an access to subjective experience as a meaningful and coherent structure. This structure can be formalized and arranged into a typology according to basic phenomenological categories such as minimal and higher level self-awareness, embodiment and agency, spatiality, temporality, intentionality, and intersubjectivity. In order to explore the essential structures of anomalous experience and existence, the psychiatrist must be familiar with this basic organization of consciousness. Typical phenomenological questions will be, among others:

- What is it like to be in a certain mental state (e.g., to feel depressed or to hear voices)? What is the personal meaning of that certain state?
- How does the patient experience his or her world? How does he or she express, move, and define space as embodied subject?
- Does the patient feel effective as an agent in the world, or rather as being only passively exposed to the world?
- Is there a sense of continuity over time, or are there breaks or fadings of self-awareness? What is the subject's experience of existential time?
- Is there a tendency to take an external perspective to one's body, actions, and self? Do the knowing and the feeling subject coincide or diverge?
- In how far is the patient able to empathize with others, to take their perspective? How does he or she experience his or her relationships?

Now one might ask how the findings gained by this kind of in-depth exploration are further processed. Subjective experience, by its very nature, does not lend itself to statistical analysis. The clustering of symptoms hardly arrives at a meaningful and coherent whole of interrelations between the phenomenal features. What phenomenology is looking for instead are the "psychopathological organizers" or fundamental patterns that connect the single features—for example, affective depersonalization in melancholic depression or autism in schizophrenia. To this aim, phenomenology first emphasizes the importance of single case studies serving as characteristic prototypes for categories and taxonomies of mental disorders. Second, it aims at the typification, that is, the recognition of prototypes of mental disturbances [17].

Experienced clinicians do not diagnose and practice by checking off the diagnostic criteria of the manuals. They work with the prototypal approach to diagnosis, for instance, with a general idea and experience of Borderline Personality Disorder, which is readily fleshed out into a variety of possible story lines, with a range of possible etiologic factors and of possible presentations. Prototypes are characteristic exemplars that help to grasp the essence of a phenomenon as an organizing and meaningful "Gestalt" over particular details—for instance, the "typus melancholicus" found by Tellenbach in patients with endogenous depression [18]. The recognition of prototypes is founded upon a "family resemblance" [19], a network of

similarities and analogies between the individual members of a group. The phenomenological approach is precisely concerned with bringing forth the typical, the ideally necessary features of experiences, expresions, and behaviors in a group of individuals [15].

Once captured by phenomenological analysis, these typical features may finally serve as a basis for the development of more standardized assessment instruments. Examples are the *Examination of Anomalous Self-Experience* (EASE) [20] and the *Examination of Anomalous World Experience* (EAWE) [21], extensive, phenomenologically based interviews developed for disturbances of basic self- and external world-awareness in prodromal stages of schizophrenia.

These instruments are the result of the observation that the majority of schizophrenia spectrum patients reported subtle alterations and disturbances regarding self- and body awareness, agency and identity, time-flow, use of habits in everyday performance as well as understanding and being with others [22].

Typification and analysis of these experiences supports the phenomenological theory of schizophrenia as involving a particular kind of disturbance both of the self and the external world [23–25]. There is a diminishment of the normally immediate sense of identity and self-affection, a feeling of a pervasive inner void or lack, an increasing anonymity of the field of awareness ("depersonalization"), characteristically associated with a hyperreflexive and self-conscious stance. The patients report feeling isolated and detached, unable to grasp the "natural," everyday significations or meanings in the world and in relations to others. Thus, phenomenological psychiatry locates the disturbance of subjective experience in schizophrenia in the prereflective and practical immersion of the self in the world—a dimension that may now be thoroughly explored by the EASE and EAWE interviews. In the meantime, larger-scale studies could demonstrate that self-disorders assessed by these instruments aggregate in ICD-10 schizophrenia and schizotypy but not in other, "non-spectrum" diagnoses such as bipolar illness; that is, self-disorders occur selectively in the schizophrenia spectrum disorders [26–28]. Thus, disturbances of basic self-awareness not only confer on schizophrenia its distinctive phenomenological typicality, but may also ground its conceptual validity.

Comparing this approach with the objective dysfunctions observed by experimental neuropsychology of deteriorated working memory, executive control functions, and attention in schizophrenia patients, the phenomenological approach is capable of integrating these microdysfunctions into a coherent whole of altered self-experience. Thorough assessment of subjective experience thus creates an intermediate level necessary to connect the level of molecular neuropsychological dysfunctions and the molar level of nosological syndromes [29]. At the same time, it helps the patients to express their experiences in a way that makes them understandable to themselves and to others. This leads to an empowerment of the patient's intentionality, that is, his or her capacity to take a reflexive stance toward his or her primary experiences [15, 29]. Thus reinforcing the patient's self-perception, phenomenological assessment may also prepare the therapeutic work of re-establishing his or her self-coherence.

2.4 Hermeneutic or Second Person Approach

The third approach to be described here is based on a hermeneutic or second-person perspective. Its guiding principles are the assumptions that

1. The patient as a person in his or her lifeworld can only be adequately understood through the medium of the interpersonal relationship, which already unfolds during the first encounter of patient and psychiatrist.
2. A major part of psychopathology, but also personality features relevant for diagnosis may only be grasped during and through the interaction.

These assumptions are opposed to the positivistic approach aimed at grasping the subject-independent aspects of psychiatric diseases by objectifiable methods. In psychotherapy, on the contrary, the negotiation of a shared focus of attention and the joint interpretation of relevant desires, motives, and conflicts are the hallmarks of a successful relationship as well as predictors of a good outcome. The model for this intersubjective construction of a shared reality is the interpretation of texts: it is based on the hermeneutic circle as an iterative and creative process of pre-understanding, questioning, and response in which two different horizons of meanings are bridged [30, 31]. This circular model of interpretation also emphasizes that meaning can only be constituted within a given cultural and historical context, which is of particular importance for psychiatric diagnosis [32].

As already pointed out, psychotherapy in general deviates from the medical model of an underlying biological pathology. The medical model of a one-way brain-to-mind causality may be suitable for circumscribed phenomena such as hallucinations or prosopagnosia but not, for example, for a depressive illness following loss or separation. In this case, the disorder should rather be regarded as a person's reaction that is meaningfully related to his or her biography and life situation. But even if the medical approach takes the patient's situation into account, it regards life events as objective facts working as causal agents in the precipitation of illness. On the contrary, from a hermeneutic point of view, there is a circular interdependence between life events and the individual perception and reaction patterns, in particular regarding the patient's way of relating to others [13]. The therapist's aim is to follow this hermeneutic circle in order to help the patient understand his or her way of cocreating these situations. In its psychodynamic form, the hermeneutic approach attempts to develop complex models for understanding the conscious and unconscious dynamics that underlie and sustain the patient's disorder.

Compared to the first-person approach, hermeneutic understanding is less unidirectional: it implies the co-construction of meaning and narratives in the course of the interactive process. The underlying idea is that humans are self-interpreting beings, and that self-interpretation is mainly practiced by telling stories to others [33]. Thus, already in the initial diagnostic phase, the contents and motives of experience, the life themes and narratives gain more importance, thus preparing the ground for the further psychotherapeutic process of self-clarification and self-actualization. Moreover, the diagnostic encounter is not restricted to the assessment

of symptoms and biographical facts, but also aims at the detection of the patient's particular way of relating to others, which is made visible on the foil of the therapeutic relationship. For this, it is necessary to explore the experiential perspectives of both the patient and the interviewer.

With regard to the perspective of the patient, hermeneutic or psychodynamic approaches to diagnosis have been operationalized in different ways and have therefore gained empirical reliability without being reduced to a collection of separate symptoms. An example of a multiaxial instrument that has been developed on a psychodynamic basis is the "Operationalized Psychodynamic Diagnostics System'"(OPD) [2]. The current version is the 2nd edition (OPD-2) [34] and consists of five major axes, the first four of which relate to the patient's psychodynamic perspective:

1. Illness experience and presuppositions for treatment, including subjective degree of suffering, individual disease model, secondary gain, treatment motivation, coping capacities, personal and environmental resources, social support
2. Characteristic patterns of relationships as experienced from the perspectives of both the patient (e.g. 'in his relations to others, the patient experiences himself often as …') and the interviewer (e.g. 'in his relation to the patient, the interviewer often experiences …'); these patterns are determined as a mixture of two orthogonal dimensions, namely, control (controlling vs. submissive) and affiliation (affectionate vs. hostile/distant)
3. Central intra- and interpersonal conflicts, as manifested repeatedly or constantly in different areas of life (bonding behavior, partnership, family life, work life, etc.)
4. Structure of personality, described in terms of capacities of self-reflection, self-determination, defenses and coping styles, interpersonal communication, attachment style, and level of integration

A particular advantage of this system as compared to former psychoanalytic approaches is the inclusion of severe personality disorder and dissociative syndromes made possible by an extended concept of personality structure. Although a recent meta-analysis of studies on OPD has shown that the number of publications on the subject is still relatively small [35], other studies show good reliability in research contexts and acceptable reliability for clinical purposes [36–38].

However, the hermeneutical approach is not to be intended as a monopoly of psychodynamics. As for the experiential perspective of the interviewer, a specific tool is the *Assessment of Clinician's Subjective Experience* (ACSE), which consists of a self-administered test for the psychiatrist or psychotherapist [39–41]. The holistic and gestaltic approach of this tool refers to classical psychopathology [42–44] and allows to evaluate, from the clinician's perspective, the subtle aspects of intersubjective experience that develop during the interview with the patient.

Through factor analysis, 5 scales were derived from this instrument, with high internal consistency and stability [39]:

1. The *Tension scale* contains items indicating physical tension and clumsiness, reduced spontaneity, and feelings of worry, nervousness, and alarm; greater scores indicate higher tension during the visit.
2. The *Difficulty in Attunement scale* includes items describing difficulty in establishing emotional contact, being empathic, understanding the patient's experience, and communicating with the patient; higher scores reflect greater difficulties in attunement to the patient.
3. The *Engagement scale* describes the degree of the psychiatrist's involvement with the patient, such as feelings of boredom, indifference, detachment, and, conversely, desire to take care of the patient, and feelings of deep involvement.
4. The *Disconfirmation scale* points to a failure to establish an authentic relationship with the patient, and to feelings of being manipulated and devalued.
5. The *Impotence scale* indicates feelings of helplessness, frustration, desolation, emptiness, and loneliness.

The ACSE showed a consistent relationship between the therapist's subjective experience pattern and the patient's psychiatric diagnosis [40].The available data signify the importance of reintroducing the concept of intersubjectivity at the core of the diagnostic process.

2.5 Conclusion

This was a brief presentation of three major approaches to diagnosis and assessment:

1. The positivistic or third person approach, dealing mainly with observable behavioral symptoms
2. The phenomenological or first person approach, focusing on self-experience and its basic structures
3. The hermeneutic or second person approach, aiming at understanding the narrative construction of self, identity, and personal history

From (1) to (3) there is an increasing involvement of the psychiatrist as subject:

1. The positivistic approach is based on the subject-object split and the assumption of a subject-independent, "objective" reality.
2. The phenomenological approach is based on the descriptive and imaginative reconstruction of the patient's world by means of empathy and eidetic variation.
3. The hermeneutic approach is based on the co-construction of intersubjectively shared narratives; here the psychiatrist's own subjective experience or countertransference functions as a complement to the patient's habitual way of relating to others.

Hence, from the first to the third approach, the psychiatrist as a person is increasingly involved in the diagnostic process as a dynamic interaction and co-construction

of meaning. And yet there is not less, but only another kind of objectivity operating in approaches (2) and (3); for if the subject is regarded as a being that relates to the world and to others, then it can only be adequately explored and understood by another subject. In this sense, as Nemiah has pointed out, as psychiatrists "… we are ourselves the instrument that sounds the depth of the patient's being, reverberates with his emotions, detects his hidden conflicts, and perceives the Gestalt of his recurring patterns of behavior" [45].

Taken this into account, subjectivity and intersubjectivity remain intrinsic aspects of a thorough psychiatric assessment and of a valid psychiatric classification. Therefore, the aim for criteriological manuals should be to implement a combined system of first and second person assessment, diagnosis, and classification, which complements the positivistic approach. The latter is valuable, for example, for epidemiological research, but insufficient for exploring the intricacies of disordered self-experience, of interaction and transference, and for preparing the ground for an intense therapeutic relationship. On one side, the EASE and the EAWE, on the other side, the OPD and the ACSE interviews, represent types of first and second person approaches that are needed to enrich the mainstream psychopathology, which is focused on objectivism, behavioral and decontextualized symptoms, biological causation, and modular theories of mind that are not translatable into the patient's subjective experience [29]. Assuming a combination of diagnostic procedures, unforeseen advances could result from recording subjective and idiographic data and bringing them into statistical covariation with factors on other axes. The resulting data and questions could redirect the clinician's or researcher's thematic concerns to new aspects of mental disorders.

In sum, subject-oriented approaches for psychiatric diagnosis and classification are strongly needed in order to pursue the following goals:

1. To reopen and enrich the dimension, which is the essence of psychiatry, namely, the methodically guided understanding of the patient's subjective experience
2. to re-establish psychopathology as a fundamental science of subjectivity, which is capable of integrating specialized approaches into overarching theoretical concepts
3. To prepare the ground for psychotherapy as a hermeneutic reinterpretation of meanings, motives, and strivings
4. Last but not least, to maintain the connections of psychiatry to the social sciences and the humanities with their longstanding tradition of understanding the human mind.

References

1. Andreasen NC. DSM and the death of phenomenology in America: an example of unintended consequences. Schiz Bull. 2007;33:108–12.
2. Cierpka M, Grande T, Rudolf G, von der Tann M, Stasch M, the OPD Task Force. The operationalized psychodynamic diagnostics system: clinical relevance, reliability and validity. Psychopathology. 2007;40:209–20.

3. Hojaij CR. Reappraisal of dementia praecox: focus on clinical psychopathology. World J Biol Psychiatry. 2000;1:43–54.
4. Insel TR, Quirion R. Psychiatry as a clinical neuroscience discipline. JAMA. 2005;294(17):2221–4.
5. Mezzich JE. Institutional consolidation and global impact: towards a psychiatry of the person. World Psychiatry. 2006;5:65–6.
6. Mezzich JE. Psychiatry for the person: articulating medicine's science and humanism. World Psychiatry. 2007;6:1–3.
7. Musalek M, Scheibenhagen O. From categorical to dimensional diagnostics. Deficiency-oriented versus person-centred diagnostics. Eur Arch Psychiatry Clin Neurosci. 2008;258(Suppl 5):18–21.
8. Hempel CG, Oppenheim P. Studies in the logic of explanation. Philos Sci. 1948;15:135–75.
9. van Praag HM. Two-tier diagnosing in psychiatry. Psychiatry Res. 1990;34:1–11.
10. Parnas J, Zahavi D. The role of phenomenology in psychiatric diagnosis and classification. In: Maj M, Gaebel W, López-Ibor JJ, Sartorius N, editors. Psychiatric diagnosis and classification. London: John Wiley; 2002. p. 137–62.
11. Fuchs T. Embodied cognitive neuroscience and its consequences for psychiatry. Poiesis Prax. 2009;6:219–33.
12. Umiltà C. Modularity in neural systems and localization of function. In: Nadel L, editor. Encyclopedia of cognitive science, vol. 3. London: Nature/Macmillan; 2003. p. 71–4.
13. Mundt C, Backenstrass M. Psychotherapy and classification: psychological, psychodynamic, and cognitive aspects. Psychopathology. 2005;38:219–22.
14. Jaspers K. General psychopathology. Manchester: Manchester University Press; 1963.
15. Stanghellini G. The grammar of the psychiatric interview. Psychopathology. 2007;40:69–74.
16. Parnas J, Sass L. Varieties of "Phenomenology". On description, understanding, and explanation in psychiatry. In: Kendler K, Parnas J, editors. Philosophical issues in psychiatry: explanation, phenomenology and nosology. New York: Johns Hopkins University Press; 2008. p. 239–77.
17. Kraus A. How can the phenomenological-anthropological approach contribute to diagnosis and classification in psychiatry? In: Fulford KWM, Morris KJ, Sadler JZ, editors. Nature and narrative. Oxford: Oxford University Press; 2003. p. 199–216.
18. Melancholy TH. History of the problem, endogeneity, typology, pathogenesis, clinical considerations. Pittsburgh: Duquesne University Press; 1980.
19. Wittgenstein L. Tractatus logico-philosophicus. London; Routledge & Kegan Paul: 1961.
20. Parnas J, Moeller P, Kircher T, Thalbitzer J, Jannson L, Handest P, Zahavi D. EASE: Examination of anomalous self-experience. Psychopathology. 2005;38:236–58.
21. Sass L, Pienkos E, Skodlar B, et al. EAWE: examination of anomalous world experience. Psychopathology. 2017;50(1):10–54.
22. Parnas J, Henriksen MG. Disordered self in the schizophrenia spectrum: a clinical and research perspective. Harv Rev Psychiatry. 2014;22(5):251–65.
23. Parnas J. Self and schizophrenia: a phenomenological perspective. In: Kircher T, David A, editors. The self in neuroscience and psychiatry. Cambridge: Cambridge University Press; 2003. p. 127–41.
24. Sass LA, Parnas J. Schizophrenia, consciousness, and the self. Schiz Bull. 2003;29:427–44.
25. Merleau-Ponty M. Phenomenology of perception. London: Routledge; 2012.
26. Handest P, Parnas J. Clinical characteristics of 50 first-admitted ICD-10 schizotypal patients. Br J Psychiatry. 2005;187(suppl):49–54.
27. Parnas J, Handest P, Sæbye D, Jansson L. Anomalies of subjective experience in schizophrenia and psychotic bipolar illness. Acta Psychiatr Scand. 2003;108:126–33.
28. Parnas J, Handest P. Phenomenology of anomalous self-experience in early schizophrenia. Compr Psychiatry. 2003;44:121–34.
29. Mundt C. Anomalous self-experience: a plea for phenomenology. Psychopathology. 2005;38:231–5.
30. Fuchs T. Psychotherapy of the lived space. A phenomenological and ecological concept. Am J Psychother. 2007;61:432–9.

31. Gadamer HG. Truth and method. 2nd ed. New York; Crossroad: Trans J Weinsheimer and DG. Marshall; 1989.
32. Kirmayer LJ. Culture, context and experience in psychiatric diagnosis. Psychopathology. 2005;38:192–6.
33. Glas G. Person, personality, self, and identity: a philosophically informed conceptual analysis. J Pers Disord. 2006;20:126–38.
34. Grupo de Trabajo OPD. Diagnóstico Psicodinámico Operacionalizado (OPD-2): manual para el diagnóstico, indicación y planificación de la psicoterapia. Barcelona: Herder; 2008.
35. Both LM, Bastos AG, Freitas LHM. Operationalized psychodynamic diagnosis: a systematic review of the literature. Trends Psychiatry Psychother. 2019;41(2):201–10.
36. Krieger DV. Operationalized psychodynamic diagnosis 2: apresentação da versão brasileira e estudos preliminares de validade e confiabilidade [dissertação]. Porto Alegre: Universidade Federal do Rio Grande do Sul; 2013.
37. Doering S, Burgmer M, Heuft G, Menke D, Bäumer B, Lübking M, et al. Assessment of personality functioning: validity of the Operationalized Psychodynamic Diagnosis Axis IV (Structure). Psychopathology. 2014;47:185–93.
38. Gordon R, Stoffey R. Operationalizing the psychodynamic diagnostic manual: a preliminary study of the psychodiagnostic chart. Bull Menninger Clin. 2014;78:1–15.
39. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Assessing clinician's subjective experience during interaction with patients. Psychopathology. 2014;47:111–8.
40. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Association between clinician's subjective experience during patient evaluation and psychiatric diagnosis. Psychopathology. 2016;49(2):83–94.
41. Fonzi L, Pallagrosi J, Picardi A, Biondi M, Pallagrosi M. Exploring how the psychiatrist experiences the patient during the diagnostic evaluation: the Assessment of Clinician's Subjective Experience (ACSE). Phen Cogn Sci. 2021; https://doi.org/10.1007/s11097-021-09729-y.
42. Binswanger L. Welche Aufgaben ergeben sich für die Psychiatrie aus den Fortschritten der neueren Psychologie? Zeitschr Gesamt Neurol Psychiatr. 1924;91:402–36.
43. Minkowski E. Le temps vécu. Etudes phénoménologiques et psychopathologiques. Paris: Collection de l'Evolution Psychiatrique; 1933.
44. Rümke HC. Das Kernsymptom der Schizophrenie und das 'Praecox Gefühl'. Z Gesamt Neurol Psychiatr. 1941;102:168–75.
45. Nemiah JC. The varieties of human experience. Br J Psychiatry. 1989;154:459–66.

A Cookbook Recipe for the Clinical and Phenomenologically Informed, Semi-structured Diagnostic Interview

3

Mads Gram Henriksen, Lennart Bertil Jansson, and Julie Nordgaard

3.1 Introduction

Diagnostic disagreement has always haunted psychiatry. In the 1970s, the problem came to the fore when international studies demonstrated markedly diverging diagnostic habits [1]. The subsequent *Diagnostic and Statistical Manual of Mental Disorders, third edition* [2] was fundamentally transformed, "operationalized" as it is called, now defining mental disorders on sets of polythetic diagnostic criteria. This approach was later adopted in ICD-10 [3]. The diagnostic criteria consist of psychopathological phenomena (symptoms and signs) that were well known in clinical work and research. These phenomena were elevated to the status of diagnostic criteria and clustered together on a consensus-based agreement with the explicit aim of increasing diagnostic reliability ([1], p. 3).

Yet, several authors have voiced serious concerns about unintended consequences of the operationalization of the diagnostic manuals, which, in their view, have led to a state of differential diagnostic confusion and decreasing psychopathological knowledge [4–8]. In a seminal article, Andreasen argued that the

M. G. Henriksen (✉)
Center for Subjectivity Research, Department of Communication, University of Copenhagen, Copenhagen, Denmark

Mental Health Center Amager, Copenhagen, Denmark

Mental Health Center Glostrup, Brøndby, Denmark
e-mail: mgh@hum.ku.dk

L. B. Jansson
Mental Health Center Glostrup, Brøndby, Denmark

Faculty of Health and Medical Science, University of Copenhagen, Copenhagen, Denmark

J. Nordgaard
Mental Health Center Amager, Copenhagen, Denmark

Faculty of Health and Medical Sciences, University of Copenhagen, Copenhagen, Denmark

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_3

diagnostic criteria have come to be viewed as exhaustive of the psychopathology of the different disorders, although the criteria only were intended to function as "gatekeepers," a sort of minimum requirements, for making diagnoses ([4], p. 111), which always should be informed by clinical judgment ([9], p. 21; cf. [3], p. 8). Andreasen further argued that "validity has been sacrificed to achieve reliability. DSM diagnoses have given researchers a common nomenclature—but probably the wrong one" ([4], p. 111). In the construction of DSM-III, psychopathological phenomena considered central to a disorder were not included, if they did not exhibit a high degree of interrater reliability. Moreover, psychopathological phenomena spanning several diagnostic categories were generally omitted to strengthen the distinctiveness of the categories. As a result, knowledge of the simple fact that many psychopathological phenomena (e.g., anxiety and affective symptoms) are shared across disorders and thus are diagnostically nonspecific [10] as well as knowledge of the multitude of psychopathological phenomena not listed as diagnostic criteria disappeared from clinical awareness or were deemed irrelevant for diagnostic assessment.

Another psychiatric capacity, which has been negatively impacted by operational psychiatry and its widespread use of structured diagnostic interviews, is the semi-structured, clinical diagnostic interview. In this chapter, we will try to revive the clinical and phenomenologically informed, semi-structured interview for psychopathological and differential-diagnostic assessment, which we consider the only adequate method for allocating diagnoses in psychiatry [11–13].[1] How to properly conduct such an interview remains, however, largely unaddressed in the current literature ([12], p. 257–259). This is an important issue not least because fundamental interviewing skills and psychopathological knowledge, which are instrumental to the proper performance of the clinical diagnostic interview, have been left unnurtured for decades in the era of operational psychiatry and structured interviews.

The purpose of this chapter is to present the ingredients of the clinical diagnostic interview and describe how it ideally should be conducted. In other words, we will here present something akin to a cookbook recipe for the clinical diagnostic interview, explicating important epistemological, psychopathological, and phenomenological issues as we go along. It merits attention that psychiatric interviews take place in various contexts (e.g., emergency rooms, psychiatric assessment of patients with somatic conditions, etc.) and the interviews vary depending on the context (for interviews with patients that are suspicious, guarded, aggressive, exalted, or suicidal, see ([12], p. 45–49)). In this chapter, we exclusively focus on the psychiatric interview for a comprehensive differential-diagnostic assessment. We have divided it into three parts: First, we present the style of the clinical diagnostic interview. Second, we discuss how the interview should be conducted. Finally, we discuss how to synthesize the collected information and make a comprehensive differential-diagnostic decision.

[1] In the following, we simply refer to this interview as the clinical diagnostic interview.

3.2 The Style of the Clinical Diagnostic Interview

Below, we describe characteristics of the clinical diagnostic interview and offer some basic reflections on the chosen diagnostic manual.

3.2.1 The Empathic Attitude

One of the most decisive factors for the quality of the semi-structured interview and the psychopathological information it may bring to light is the rapport between the clinician and the patient. To establish a good rapport, the clinician must convey to the patient that she genuinely wants to hear him describe his experiences and understand the significance he attaches to them.[2] In our experience, it is not uncommon that patients have not told others about some of their symptoms, including their intimates. Thus, a certain degree of trust is required if the patient is to disclose the kind of experiences that are at stake in a diagnostic interview. In their famous book *Sexual Behavior in the Human Male* (1948), Kinsey, Pomeroy, and Martin made a similar observation about interviewing subjects about delicate matters: "One is not likely to win the sort of rapport which brings a full and frank confession from a human subject unless he can convince the subject that he is desperately anxious to comprehend what his experience has meant to him" ([14], p. 42). Striving to understand another person, in our case a psychiatric patient, is, phenomenologically speaking, an act of empathy. Crucially, empathy, in this specific sense of the term, is not a matter of projecting oneself onto the other, simulating, imitating, or theorizing what it would be like for *me* to be the patient, but of understanding what it is like for the *patient* to be himself and to experience himself, others, and the world the way he does [13]. Thus, empathy is not an acquired technique to make the patient (or the interviewer) feel at ease during the interview, and it is certainly not something that is expressed through a few sympathizing remarks (e.g., "that must have been difficult for you"). Rather, empathy is an overall attitude, a specific way of relating to the other person, which creates an atmosphere that permeates the entire clinical encounter and in which the interviewer, through her presence, gestures, mimics, and questions signals her strong intention to understand the patient's experiences [15]. The interviewer is responsible for adopting the empathic attitude, which concretely entails responding appropriately to the patient's answers and descriptions, knowing when and how to ask questions, and also knowing when not to ask certain questions.

[2] For the sake of textual simplicity, we portray the clinician as female and the patient as male throughout the chapter.

3.2.2 The Format of the Interview

In the clinical diagnostic interview, which must be conducted in a semi-structured way, the clinician has no list with preformulated questions but a set of basic psychopathological topics (e.g., specified in a checklist) that must be explored in order to perform a comprehensive psychopathological and differential-diagnostic evaluation of the patient. In other words, the "structure" of the interview relies on the clinician's obligation to faithfully cover these topics. The interview provides the clinician with an opportunity to hear the patient talk about aspects of his life and experience. The questions function as triggers that encourage the patient to talk. In the ideal situation, the semi-structured interview consists of a patient–clinician mutually interactive reflection. The practical conduct of the semistructured interview is dictated by the dynamics and context of the clinical encounter, that is, the interview style is free, dynamic, and conversational. The patient should be encouraged to speak freely, rarely be interrupted, and given time for reflection and recollection. For this reason, the questions should generally be open-ended, which better allows the patient to elaborate on his experiences. However, close-ended question may occasionally be useful, for example, when trying to clarify specific aspects of the patient's experience. The clinician must listen carefully to the patient's narrative and ask for elaboration and clarification when appropriate, that is, the questions must be contextually adapted and follow the logic of the patient's narrative and self-descriptions. Through comments and further questions, the clinician steers the interview to obtain the relevant information. It is noteworthy that it should be the patient that does the majority of talking and not the interviewer as it is the patient, who has the relevant information.

Not only does the semi-structured interview put high demands on the interviewer in terms of clinical experience, psychopathological knowledge, and interviewing skills, the interview itself is also more time consuming than a structured interview. Although it is more time consuming, conducting a comprehensive differential-diagnostic assessment and basing treatment decisions on it is of immense value for the patient, who otherwise risks being misdiagnosed and thus offered ineffective treatment (often with side effects from pharmacological treatment) and potentially not getting better. Patients, who are incorrectly diagnosed and thus inadequately treated, are frequently readmitted and diagnostically reassessed, often receiving different and sometimes even incompatible diagnoses. In the end, the time spent on a comprehensive, semi-structured interview, reaching a comprehensive differential-diagnostic decision, is easily gained in terms of time and resources spent. In this context, it must be pointed out that the clinical diagnostic interview often has different levels of purpose, for example, allocating an official diagnosis, mapping areas of psychopathology with respect to potential psychopharmacological treatment, and considering the possibility of psychotherapeutic intervention.

Finally, the semi-structured interview generally generates far more data than a structured interview. To avoid the interview turning into an enormous, yet barren data collection, the clinician must have a plan, that is, an idea of what data she must collect in order to make a comprehensive differential-diagnostic evaluation. In

research, it is important to use a checklist of psychopathological topics to make sure that all topics are explored in all participants. For clinical purposes, a checklist is not necessary, but it can be used to as a memo in case the clinician finds it difficult to remember all the psychopathological topics she must explore during the interview. In this case, the *Present State Examination* or the *Structured Clinical Interview for DSM* can be used as a memo, but they must not be applied in a structured manner.

3.2.3 Diagnoses, Diagnostic Manuals, and Comorbidity

It is important to emphasize that any diagnostic decision involves a differential-diagnostic assessment. In other words, to make a diagnosis, it is not enough that a patient fulfils diagnostic criteria for a certain mental disorder. If an ICD-10 diagnosis is to be made, one must keep in mind that ICD-10 entails an implicit diagnostic hierarchy, implying that if a patient fulfils criteria for several mental disorders, then the disorder placed highest in the diagnostic hierarchy generally outranks lower placed disorders (substance use [F1] is an exception to this rule). Thus, to diagnose a patient with an affective disorder (in F3), one must first make sure that the patient does not fulfil criteria for an organic disorder (in F0) or schizophrenia (in F2), which both are placed higher in the diagnostic hierarchy than affective disorders. By contrast, if a DSM-5 diagnosis is to be made, the situation is different, because DSM-5 does not operate with a similar diagnostic hierarchy. Consequently, DSM-5 allows for much more comorbidity than ICD-10. The issue of comorbidity also deserves a comment. Comorbidity, sensu stricto, implies the *co-occurring* of *independent* disorders (e.g., asthma and a sprained ankle). DSM-5, like ICD-10, encourages the clinician to make as many diagnoses as necessary to cover the full clinical picture. In ICD-10, however, it is assumed in the implicit diagnostic hierarchy that higher placed diagnoses may contain symptomatology of lower placed diagnoses: for example, depressive-like symptoms, anxiety, and changes to personality are common features of organic disorder and schizophrenia. Thus, DSM-5 and ICD-10 have to some extent divergent views on what constitutes comorbidity, and it does not boil down to a question of DSM-5 favoring full information versus ICD-10 prioritizing parsimony – that would miss the point. Rather, the point is that whereas additional fulfilment of diagnostic criteria for lower ranked mental disorders generally is considered *psychopathological aspect of* higher ranked disorders in ICD-10 (and does therefore not automatically enable diagnosing comorbidities), fulfilment of criteria for several mental disorders more often allows diagnosing *comorbidities* in DSM-5 (e.g., some patients meet criteria for 3–5 different personality disorders [16], which all should be diagnosed according to DSM guidelines). However, in order to recognize various symptoms (e.g., depressive-like experiences, anxiety, obsessions, compulsions, self-harm) as *psychopathological aspects* of a hierarchically higher ranked and thus primary mental disorder (e.g., schizophrenia) in ICD-10, the clinician must be knowledgeable about psychopathology beyond the criteria listed in the ICD-10. Before commencing a diagnostic interview, one must familiarize oneself with the relevant diagnostic manual and make sure that one abides to the principles of that manual.

3.3 Conducting the Clinical Diagnostic Interview

In this section, we sketch a stepwise format for the clinical diagnostic interview, which is not to be regarded as a firmly structured procedure.

3.3.1 The Presenting Complaint(s)

A natural point of departure of the interview is to explore the patient's presenting complaint(s). Not only does this provide an understanding of what the patient himself considers his key problem(s), either at admission or on a lifetime basis, it also provides an initial grasp of the patient's global mental health and his motivation to seek help. Detailed assessment of the patient's complaint (e.g., feeling depressed) and other symptoms should, however, be preserved for later in the interview, when trust and rapport have been properly established, and we have obtained an understanding of the patient and the context in which the potential symptoms must be evaluated. This context is primarily established through the chronological, psychosocial history.

3.3.2 The Chronological, Psychosocial History

Following exploration of the presenting complaint(s), the interview should always begin with a detailed and chronological, psychosocial history. This is fairly easy, because it is factual and usually "safe" for the patient to talk about, but also because most people actually like to talk about themselves. Here, we explore potential complications during pregnancy, perinatal complications, early developmental delays or disorders, the patient's upbringing and family constellation (parents, siblings, the emotional "climate" in the family while growing up), somatic and psychiatric conditions in the family, kindergarten years, school years, high school years, further educational achievements, jobs up till current time, spare time interests, and current social network. The chronological, psychosocial history helps identify "silent periods" (e.g., due to unemployment or social isolation), which otherwise often go undetected. Most importantly, the chronological, psychosocial history is not a mere listing of biographical facts. By contrast, this part of the interview serves a *psychiatric* purpose, that is, it serves to disclose important *patterns* indifferent domains of the patient's life, which have differential-diagnostic importance:

1. *Sociality*. Here, we acquire information about the patient's social relations throughout his life such as friendships, partners/spouses, contact with relatives and colleagues, the closeness, dynamics, and stability of the social relationships, sexual orientation and behavior, etc. Exploring the patient's social life (in connection with the areas described below) may reveal certain characteristic patterns. For example, incoherence of actions, thinking, and emotional life suggests

a pattern of disorganization, which would be compatible with a schizophrenia spectrum disorder such as hebephrenia or a disorganized form of schizotypal disorder but rare in other disorders such as OCD. A recurrent tendency to act rashly on impulses suggests a pattern of impulsivity, which could point to borderline personality disorder or schizophrenia spectrum disorders. Life-long personality problems (in the absence of psychosis), persisting since childhood or adolescence, could be reflective of a personality disorder, whereas a later occurring personality change could have an organic or traumatic basis. Social difficulties of a few months' duration in an adult, who has not previously had such difficulties, would be more indicative of depression than of schizophrenia spectrum disorders. Identification of such a pattern is of course not sufficient to make a diagnosis, but the pattern offers information that has differential-diagnostic relevance.

2. *Socioeconomic stability.* Here, we get information about jobs, housing, finances, periods of unemployment, and general functioning, which jointly testify to the patient's ability to structure his life. Recurrent instability in this area may be indicative of impulsivity, disorganization, or negative symptoms.
3. *Academic achievement*. Here, we obtain insight into the patient's highest education, level of grading, accomplishments, intellectual interests, etc., which jointly reflect the level of intelligence. Gradual reduction of cognitive capacities alongside personality change could point to dementia or pseudodementia.
4. *Spare-time interests*. Information about the form (e.g., social or solitary) and content (e.g., philosophical, technical, athletic, artistic, etc.) of spare-time interests is very helpful in grasping the patient's worldview. For example, persistent preoccupation with technical issues (e.g., the inner workings of a camera) could be indicative of a "special interest" as seen in autism (the notion of "special interest" should be used very conservatively; otherwise, any major interest risk being considered "special"). By contrast, a socially withdrawn patient's intense preoccupation with the meaning of existence or of his role in the cosmos could be reflective of the altered self-world relation in schizophrenia spectrum disorders.
5. *Basic functioning*. Estimated from basic skills such as cleanliness, grooming, cooking, etc. For example, significant drop or loss of basic functioning may be reflective of incipient dementia, of episodic loss of energy and psychomotor inhibition in depression, or of more trait-like negative symptoms in schizophrenia spectrum disorders.
6. *Breaks in the functional curve* ("Knick in der Lebenslinie" [17]). One or more episodes of functional decline, which are not readily connected to external stressors, substance use, or changes in living conditions, could be a prodromal sign. Such breaks may be detected in different domains such as school performance or social relations, sometimes preceding the emergence of symptoms listed as diagnostic criteria.
7. *Existential change*. A sudden, fundamental change of interest in ideas or life goals (e.g., toward philosophical or religious issues) may be indicative of a prodromal change [18].

8. *Medical history and substance use*. It is always important to explore the patient's medical history, especially illness that may affect the central-nervous system, and potential use/abuse of psychoactive substances. Here, we seek information about the relation between the substance abuse and psychopathology. Are substances used to "self-medicate" a pre-existing mental health problem? Or, by contrast, if a substance-induced psychosis is expected, it is important to explore potential psychopathology before the onset of the abuse as well as in substance-free intervals.

Furthermore, the psychosocial history should be complemented with case records (e.g., from prior admissions or outpatient treatment) and conversations with relatives. Relatives may contribute with valuable information about complications during pregnancy or birth and early childhood development, which often is unavailable for the patient. Moreover, relatives can inform us about a possible family history of mental illness (in case the patient does not know this) and they can describe potential changes in the patient's behavior (e.g., a patient with depression may state that things always have been this bad, whereas his relatives may report that this is not the case but an expression of the current illness). Finally, the assessment may, when relevant, be completed with psychological tests, physical examination, and paraclinical tests. Finally, discussing the patient's diary entries, letters, artwork, etc. may also shed light on the patient's lifeworld.

3.3.3 Exploring Psychopathology

By now, it should be clear that the chronological, psychosocial history itself yields important psychopathological information. It also provides the necessary context that all potential symptoms must be evaluated in. Moreover, since the psychosocial history usually is loosely structured, it provides a good opportunity to note how well the patient is able to structure the description of his life history and responses to questions. The rather loose structure also offers an excellent opportunity for observing thought disorders (e.g., disturbances of the speed or flow of thoughts may be seen in affective disorders, whereas *formal* thought disorders [e.g., various kinds of disorganization, semantic disturbances, autistic logic, etc.] are characteristic of schizophrenia spectrum disorders or, to some extent, organic disorders) ([12], p. 74–84) as well as other expressive features of psychopathology (e.g., emotional rapport, mood, affect, eye contact and gaze, facial expression, compulsions, catatonic features, etc.). Naturally, observation of expressive features of psychopathology should be made throughout the interview as this information forms an indispensable part of any differential-diagnostic assessment. If the patient is admitted, the mental state observation should be complemented with observations from the ward, for example, about functional skills, sleep patterns, etc.

The chronological, psychosocial history typically reveals periods of difficulty in the patient's life, certain drops of functioning, or other mental health or social problems, which can now serve as a natural point of departure for the more specific

psychopathological exploration by asking for elaboration and clarification of, say, previously reported social difficulties or anxiety. It cannot be overemphasized that psychopathology must be explored and evaluated within the context of the patient's life history and phases of the illness. For example, when did the symptoms first appear? Did they appear episodically, or do they rather exhibit a more trait-like status? Do they persist across time and different social situations or are they situationally bound? Is there a progression of psychopathology? For example, a chronological, psychosocial history with well-demarcated episodes of illness and with recovery of normal functioning in-between episodes should make us consider an affective disorder. By contrast, a life history marked by a more trait-like condition, fluctuating in intensity but never being really absent, should, depending on onset and symptomatology, make us consider a schizophrenia spectrum disorder, a personality disorder or a developmental disorder. If the life history indicates progression of psychopathology, we should ponder the possibility of an organic disorder or schizophrenia, etc.

During this part of interview, psychopathological topics are gradually explored in a conversational style and as far as possible adapted to the patient's narrative. Occasionally, it may be helpful to propose an example of a symptom to the patient. Notably, an affirmative answer ("yes") to a question about a symptom is never enough to rate this symptom as present. The patient should always be invited to describe in his own words at least one concrete example of the symptom, and only if his concrete example fulfills the definition of a relevant symptom, may this symptom be rated as "present." Likewise, a "no" to a question about a symptom is also not sufficient to rate it as absent, if the patient elsewhere in the interview offers a concrete example of an experience that corresponds to this particular symptom. There may be various reasons for such "incorrect" answers, for example, the patient may not recall the particular experience at the moment he is asked about it but may recall it when describing related experiences, or he may not recognize the experience as it is formulated in the question, etc.

Throughout the psychopathological exploration, it is of paramount importance to resist premature interpretation of the patient's experiences and instead "stay with" these experiences, exploring "how" they are experienced by the patient himself [19–22]. Of course, it is also often relevant to explore the "why" of experience (e.g., why do you believe that your neighbor is spying on you?), which also can yield important psychopathological information. However, we should try to resist the urge to jump to the "why" of experience and instead "stay with" them a bit longer, clarifying "how" they are experienced, before clinically judging them. To illustrate the issue of "staying with" the patient's experiences, we refer to an example that we have reported elsewhere ([22], p. 943). A young female patient with schizophrenia was asked how she experienced her own body. She replied, "I feel I have this void inside. I try to fill it with food but that isn't working well." When asked to clarify, she stated, "I think the void is a feeling of inadequacy, loneliness, a feeling of not being sufficient, and lack of meaning. I really don't know who I am, what I'm supposed to do, and what I'm here for." The new description shed some additional light on the initial complaint, now pointing to experiences of lack of meaning and a frail

identity. To further explore her experience, she was asked a concrete, closed question: "Does the void have a specific location?". The question may seem surprising, but in the context of the interview it was not. The patient had already described that she physically could feel her thoughts move around in her head and that she felt divided into parts that were spatially located in the left and right side of her body, respectively. Thus, the concrete question above was intended to explore if her experience of the void also had such a spatial quality. The patient replied, "Yes, I actually feel that it's right in the solar plexus. I feel it's gigantic, larger than my body. Like a big Pilates ball perhaps. There, I'm missing something. Some meaning is missing. I can physically feel the void. I have had it for many years. There is a space that is not filled out with anything. There's just a black void." The example illustrates how "staying with" the patient's experience, withholding interpretation until the symptom is fully grasped, can result in a more precise clinical judgment of the psychopathological phenomenon. What first seemed like a fairly nonspecific complaint (feeling a void and trying to fill it with food) turned out to be an expression of a fundamental uncertainty about her own identity and a long-lasting, concrete, physical feeling of having a real void inside her stomach. In phenomenological terms, "staying with" the experience and resisting premature interpretation can be described as a "bracketing" or "suspending" of one's own assumptions and in that regard be considered an effectuation of the phenomenological epoché.

The example also illustrates another important aspect of the interview. To grasp the nature of the patient's experience, the interviewer performs a kind of psychopathological eidetic reduction ([23], p. 157) in which the psychopathological phenomenon is stripped off its accidental features and its essence laid bare. Practically, the psychopathological eidetic reduction is carried out through additional questioning, asking for clarifications and more examples, and by proposing alternative examples of pathological experiences to the patient in which certain aspects of the experience are changed and others retained. Only when all that may vary in the particular psychopathological experience has been identified (its accidental features) is its invariant feature, its essence, laid bare, and we can make proper clinical judgment about what symptom it is. Performing the psychopathological eidetic reduction is what allows us to distinguish seemingly similar symptoms from each other, for example, thought pressure from rumination, primary from secondary self-reference, delusions from overvalued ideas, etc. and to discover similarity or even a unifying ground between apparently different phenomena.

3.4 Synthesizing the Information: Making a Comprehensive Diagnostic Decision

Although the diagnostic decision is made only at the end, diagnostic reasoning is an inherent and ongoing part of any psychopathological exploration. During the interview, the clinician uses her clinical experience and psychopathological knowledge to explore psychopathological phenomena and groups of phenomena that frequently go together (e.g., guilt feelings and self-blame in depression, or common sense

problems and hyperreflection in schizophrenia spectrum disorders). Occasionally, the presence of an expressive feature, a symptom, or even just a patient's wording of a seemingly nonspecific complaint may spark a diagnostic intuition. The clinician then uses her intuition and knowledge to steer the interview and key in on psychopathology characteristic of the intuited mental disorder to test her diagnostic hypothesis. For example, a patient's complaint about social anxiety may, upon questioning, turn out to be social anxiety due to an experience of his thoughts being so loud that others can hear them (i.e., thoughts aloud as a first-rank symptom of schizophrenia) or it may turn out to be a fear that others are out to get him (without any transitivistic background or psychotic elaboration). At a theoretical level, what happens when the skilled clinician gets such a diagnostic intuition is that she notices a potential manifestation of a characteristic psychopathological Gestalt (i.e., pattern recognition), and goes on to explore if other aspects of the Gestalt may be present (i.e., pattern completion).

It is important to note here that psychiatric patients rarely manifest a series of isolated, independent symptoms and signs. Rather, psychopathological phenomena are generally interdependent aspects of a whole (Gestalt). A psychopathological Gestalt can be described as a characteristic pattern, that is, a certain unifying structure of experiential, expressive, and behavioral phenomena, which transpires through, connects, shapes, and colors the symptoms and signs that may occur within a given mental disorder [22, 24]. To put it differently, the Gestalt is "the glue that allows the clinician to grasp in conjunction the disparate elements of the clinical picture" [24]. Different mental disorders have different psychopathological Gestalts, and all psychopathological phenomena bear an imprint of the Gestalt they are a part of. Detecting these subtle, gestaltic imprints is key in distinguishing seemingly similar symptoms and signs from each other and in grasping the Gestalt they partake in. In other words, to grasp a psychopathological Gestalt, an ongoing, interpretative oscillation between parts (symptoms and signs) and the whole is required, and through this process, the Gestalt from which the parts originate is laid bare. This interpretation requires clinical experience and knowledge of the different psychopathological Gestalts in their synchronic and diachronic unfolding.

Closely related to the notion of Gestalt is the notion of prototype. A prototype is a characteristic exemplar of a category – for example, a sparrow would be a good prototype of the category "bird," whereas a penguin or an ostrich would not be, since they do not look like most other birds and cannot fly [25]. Now, a psychopathological Gestalt is organized around prototypical cases (the "sparrows") with a diminishing typicality toward the boundary of the Gestalt (where the "penguins" and "ostriches" are located), and where they may overlap cases of low typicality from other Gestalts. In other words, psychopathological Gestalts, which are organized around different prototypes, usually come in form of diagnostic spectra. It is worth pointing out that prototypes and typification already are operative in ordinary human cognition, related to our seeing something *as* something, and thus also naturally embedded in the clinical encounter ([12], p. 18f.). A study on the diagnostic process itself [26] and theoretical studies on categorization [27, 28] suggest that during a diagnostic interview, the experiences reported by the patient in

combination with his expressivity and chronological, psychosocial history leads to a first typification, that is, the clinician begins to see the patient as resembling a certain prototype. This typification may be modulated or changed as the interview unfolds. It is important to emphasize that even if the clinician recognizes a certain psychopathological Gestalt, it does not in itself suffice for making a diagnosis. Thorough examination of other potentially relevant psychopathology must always be conducted.

Once we have obtained a full clinical picture, we must synthesize all the information and perform a differential-diagnostic evaluation. On the basis of contextual evaluation of all information (i.e., onset and course of the illness, patterns identified in the chronological, psychosocial history, symptoms, expressive features, behavior, etc.), the diagnosis is *first* made prototypically, that is, in terms of psychopathological Gestalts, at least as a spectrum diagnosis (e.g., a schizophrenia spectrum disorder). Here, we must decide if we are confronted with a trait-like or more episodic mental disorder? Is the patient psychotic or not, etc.? *Second*, and only at this point, do we make an ICD-10 or DSM-5 diagnosis, following the principles of the relevant diagnostic manual. Here, it is important to reiterate what is stated in the introduction to ICD-10, namely that the diagnostic guidelines are considered "a reasonable basis for defining the limits of categories in the classification of mental disorders" ([3], p. 9) – that is, the diagnostic criteria serve to *delimit*, not *describe*, the different mental disorders. Preferably, all psychopathological phenomena should be explained by a single diagnosis [29]—a principle also honored in somatic medicine. Multiple diagnoses should always cause suspicion of a common psychopathological process, underlying the heterogenous clinical picture, and which is better explained by a single diagnosis. In our view, the philosophical principle known as "Ockham's razor" is here particularly useful: if several explanations for a certain occurrence exist, the explanation requiring the least number of assumptions is usually correct.

Finally, lets us, in a somewhat staccato way, highlight some typical pitfalls that the clinician must be attentive to when conducting the clinical diagnostic interview. First, one must be aware of what may be termed "pars pro toto diagnosing" in which one, by focusing too narrowly on one particular part of the clinical picture (e.g., socially difficulty), explains away other relevant parts (e.g., psychosis). Second, beware of erroneous private or local prototypes (e.g., an intelligent, young man, occasionally psychotic, with long-lasting social difficulties must have Asperger's Syndrome). Third, beware of the "principle of charity," which refers to interpreting another's statements in the most rational way possible. While charitable interpretation is a virtue in academia and many other aspects of life, it does pose a potential problem in psychopathological evaluations. By way of this principle, much psychopathology can be played down, psychologized or normalized, and thus explained away. Figuratively speaking, we should register the bumps on the road (as aspects of the clinical picture) instead of evening them out. Fourth, psychotic or micropsychotic episodes are, by definition, not part of personality disorders and should not be accepted as such ([30], p. 69). Finally, patients generally do not lie, fake symptoms, pretend to be ill or imitate other patients' symptoms ([12], p. 159; [31, 32])—the situation may of course be more complex in forensic psychiatry.

References

1. Cooper J, Kendell R, Gurland B, Sharpe L, Copeland J. Psychiatric diagnosis in New York and London. London: Oxford University Press; 1972.
2. APA: American Psychiatric Association. Diagnostic and statistical manual of mental disorders, third edition (DSM-III). Washington, DC: APA; 1980.
3. WHO: World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: WHO; 1992.
4. Andreasen NC. DSM and the death of phenomenology in America: an example of unintended consequences. Schizophr Bull. 2007;33(1):108–12.
5. Hyman SE. The diagnosis of mental disorders: the problem of reification. Ann Rev Clin Psychol. 2010;6:155–79.
6. Hyman SE. Diagnosing the DSM: diagnostic classification needs fundamental reform. Cerebrum. 2011;Mar-Apr:6.
7. Parnas J. A disappearing heritage: The clinical core of schizophrenia. Schizophr Bull. 2011;37(6):1121–30.
8. Parnas J. Differential diagnosis and current polythetic classification. World Psychiatry. 2015;14(3):284–7.
9. APA: American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5). Arlington, VA: APA; 2013.
10. Mølstrøm IM, Henriksen MG, Nordgaard J. Differential-diagnostic confusion and non-specificity of affective symptoms and anxiety: an empirical study of first-admission patients. Psychiatry Res. 2020; https://doi.org/10.1016/j.psychres.2020.113302.
11. Nordgaard J, Sass L, Parnas J. The psychiatric interview: validity, structure and subjectivity. Eur Arch Psychiatry Clin Neurosci. 2013;263(4):353–64.
12. Jansson L, Nordgaard J. The psychiatric interview for differential diagnosis. Switzerland: Springer; 2016.
13. Henriksen MG, Englander M, Nordgaard J. Methods of data collection in psychopathology: the role of semi-structured, phenomenological interviews. Phenom Cogn Sci. 2021. https://doi.org/10.1007/s11097-021-09776-5.
14. Kinsey A, Pomeroy W, Martin C. Sexual behavior in the human male. Philadelphia: WB Saunders Company; 1948.
15. Stanghellini G. Philosophical resources for the psychiatric interview. In: Fulford KWM, Davis M, Gipps RGT, Graham G, Sadler JZ, Stanghellini G, Thornton T, editors. The Oxford handbook of philosophy and psychiatry. Oxford: Oxford University Press; 2013. p. 321–56.
16. Widiger TA, Frances AJ, Pincus HA, et al., editors. DSM-IV sourcebook, vol. 4. Washington: American Psychiatric Press; 1992.
17. Kahn E. Schizoid und Schizophrenie im Erbgang. In: Rüdin E, editor. Studien über Vererbung und Entstehung geistiger Störungen, vol. IV. Berlin/Heidelberg: Springer; 1923.
18. Møller P, Husby R. The initial prodrome in schizophrenia: searching for naturalistic core dimensions of experience and behavior. Schizophr Bull. 2000;26(1):217–32.
19. Friedlander ML, Phillips SD. Preventing anchoring errors in clinical judgment. J Consult Clin Psychol. 1984;52(3):366–71.
20. Voytovich AE, Rippey RM, Suffredini A. Premature conclusions in diagnostic reasoning. Med Educ. 1985;60(4):302–7.
21. Skodlar B, Henriksen MG. Toward a phenomenological psychotherapy for schizophrenia. Psychopathology. 2019;52:117–25.
22. Nordgaard J, Henriksen MG. Phenomenological psychopathology and quantitative research. In: Stanghellini G, Broome M, Fernandez A, FusarPoli P, Raballo A, Rosfort R, editors. The Oxford handbook of phenomenological psychopathology. Oxford: Oxford University Press; 2019. p. 941–51.
23. Parnas J, Zahavi D. The role of phenomenology in psychiatric classification and diagnosis. In: Maj M, Gaebel W, Lopez-Ibor JJ, Sartorius N, editors. Psychiatric diagnosis and classification.

World Psychiatric Association's Series on Evidence and Experience in Psychiatry. Chichester: Wiley; 2002. p. 137–62.
24. Zandersen M, Henriksen MG, Parnas J. A recurrent question: what is borderline? J Pers Disord. 2019;33(3):341–69.
25. Parnas J. The core Gestalt of schizophrenia. World Psychiatry. 2012;11(2):67–9.
26. Kendell R. The role of diagnosis in psychiatry. Oxford: Blackwell; 1975.
27. Rosch E. Natural categories. Cogn Psychol. 1973;4:238–50.
28. Rosch E, Mervis C. Family resemblance. Cogn Psychol. 1975;7:238–50.
29. Jaspers K. General psychopathology, trans. Hoenig, J., & Hamilton, M. W. London: Johns Hopkins University Press; 1997.
30. Jansson L. Near-psychotic phenomena in a clinical context. In: Waters F, Stephane M, editors. The assessment of psychosis. New York: Routledge; 2015. p. 55–74.
31. Hay GG. Feigned psychosis—a review of simulation of mental illness. Br J Psychiatry. 1983;143:8–10.
32. Humphreys M, Ogilvie A. Feigned psychosis revisited—a 20 year follow up of 10 patients. Psychiatr Bull. 1996;20:666–9.

4 The Distinction Between Second-Person and Third-Person Relations and Its Relevance for the Psychiatric Diagnostic Interview

Felipe León, Maja Zandersen, Patricia Meindl, and Dan Zahavi

4.1 Introduction

As a branch of medicine, psychiatry has been heavily influenced by the so-called medical model of somatic diseases [1, 2], which in a simplified version defines and categorizes disease entities according to their pathophysiological etiology. In this model, symptoms and signs refer exclusively to their biological cause and do not possess any meaning in themselves [3]. Although psychiatry, since its very establishment as a medical discipline, has sought for extraclinical markers to detect and explain diagnoses, it is an open question whether this will ever be achieved. Diagnosis in psychiatry is still based mainly on clinical descriptions of psychopathology, and the diagnostic interview is therefore the most important assessment tool of the psychiatrist or psychologist [4]. While the importance of the diagnostic interview is undeniable in the actual clinical practice, its peculiarities as a specific kind of interpersonal phenomenon have not attracted much attention in the literature (see, however, [5–7]).

F. León (✉) · P. Meindl
Center for Subjectivity Research, Department of Communication, University of Copenhagen, Copenhagen, Denmark
e-mail: felipe.leon@hum.ku.dk

M. Zandersen
Center for Subjectivity Research, Department of Communication, University of Copenhagen, Copenhagen, Denmark

Department of Psychology, University of Copenhagen, Copenhagen, Denmark

Mental Health Centre Glostrup, University Hospital of Copenhagen, Broendby, Denmark

D. Zahavi
Center for Subjectivity Research, Department of Communication, University of Copenhagen, Copenhagen, Denmark

Faculty of Philosophy, University of Oxford, Oxford, UK

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_4

What goes on in the diagnostic interview, when considered not only as a clinical tool but also as a specific kind of interpersonal encounter? Might research on interpersonal understanding shed any light on the diagnostic interview? In the following, we address these questions by drawing on recent discussions about *second-person* and *third-person* relations. The chapter is structured as follows. In Sect. 4.2, we describe some peculiarities of the diagnostic interview and highlight how it involves a complex interplay between different sources of diagnostically relevant information. In Sect. 4.3, we turn to research on interpersonal understanding. We reconstruct and critically assess some recent discussions about second-person relations, and present our own take on this notion. In Sect. 4.4, we elaborate on a conceptualization of second-person relations which foregrounds the roles of reciprocity and communication. In Sect. 4.5, we return to the diagnostic interview and assess the implications of our discussion.

4.2 The Psychiatric Diagnostic Interview

Since the publication of DSM-III, psychiatric disorders have been defined by criteria, that is, symptoms and signs. Basically, diagnosis in current diagnostic manuals of DSM-5 and ICD-10 is a matter of checking whether a sufficient number of criteria are met. It is worth noting that the very concepts of symptom and sign have been adopted from somatic medicine, where they are considered to be epiphenomenal with respect to the true illness, which is typically some sort of biological abnormality. With criteria-based diagnosis, structured clinical interviews have become the golden standard of psychiatric interviewing [8]. They consist in preformed questions asked in a fixed order. Although many interview instruments often claim to be "semistructured" (e.g. [9]), they are usually administered in a highly structured way. The purpose of such a "quasiexperimental" [10] approach is to minimize "subjectivism" in psychiatry and thus to optimize interrater reliability.

However, the main object of psychiatry is not blood pressure, body temperature, or a limb, but an entire and unique *person*. The nature of the psychiatric "object" is thus different from that of most other medical disciplines. Just as one will never find consciousness by looking through a microscope at brain cells, one will never find persons by studying them as though they were mere objects ([11], p. 20). In fact, the idea that an unbiased scientific understanding of the other requires one to be objective in the sense of depersonalizing the person into an "object" of study is a fallacy that, as Laing remarked, has nothing to do with proper science ([12], p. 24). Persons are centers of experience and origins of actions that exist in social fields of reciprocal influence and interaction, and the clinician inevitably has to deal with the experiences of another person and also with his or her own experiences of that person. The establishment of good rapport in the diagnostic assessment is consequently crucial to facilitate a joint exploration of the patient's lifeworld and psychopathology. In other words, the interviewer cannot be a "passive receptacle" [10] of phenomenological information. In this sense, the diagnostic process requires that "the

subjectivity of the patient and the subjectivity of the psychiatrist are in an intimate relation" ([13], p. 108). As Binswanger puts it:

> you examine the mental patient by putting *yourself*, as personality, into a relation *with him*, as personality. Here the patient is first of all very different from an *object* of investigation; he is not a direct object of perceiving and judging, but *partner* in a relation with a fellow man, a communication relationship. ([14], p. 197)

At the same time, however, the psychiatrist or clinical psychologist has to be attentive to different sources of diagnostically relevant information, which makes this communicative relationship different from other, perhaps more informal, relations. Most obviously, the psychiatrist must attend cautiously to the *content* of the patient's speech, that is, his or her description of subjective complaints (symptoms). Importantly, psychiatric symptoms don't have an object-like quality as, say, a broken bone. They are not well-demarcated "things," located "inside" a person, devoid of meaning and independent from one another [15]. For example, feeling anxious when walking down a crowded street is not a single "anxiety symptom" independent from having an experience of one's own thoughts as being accessible to bypassers. Rather, a psychiatric symptom emerges as individuated only in the context of other experiences and the biography of the patient [16]. It is therefore crucial to emphasize that the immediate complaints of the patient must not lead strictly to diagnosis, since the psychosocial history of the patient and the psychopathological whole or Gestalt is a necessary background and context for evaluation of the single symptom. The complaints of the patient, his or her experiences, feelings, actions, etc., are not defined by some underlying substrate but are part of a whole and permeated by biographical detail [3].

Another source of diagnostic information are the *expressive features* (signs), for example, the appearance of the patient, his or her mood, formal aspects of his or her thinking[1] and speech, his or her gestures, gaze, emotional expressions, and so forth—what is usually included in the so-called mental status examination [17]. As with symptoms, psychopathological signs are not individuated and context-independent features located on the "surface," independent of "inner" subjective experience. Rather, both symptoms and signs are manifestations of an overall psychopathological Gestalt. They become symptoms and signs not only in virtue of their content, but also in virtue of their structure and the experiential whole of which they are manifestations [see Chap. 3].

To exemplify, consider schizophrenia research. The core Gestalt of schizophrenia, historically conceptualized as, for example, autism [18], loss of vital contact with reality [19], crisis of common sense [20], and in more recent research as

[1] Thought processes are obviously hard to detect if the patient does not communicate linguistically, and one may argue that they do not belong to the expressive features. This issue involves a long debate about the relation between thinking and speech that we will leave out here. Formal thought disorders are here included as an expressive feature showing itself in the speech of the patient, but often without semantic disturbances, e.g., by responding with an answer that is only slightly related to the main topic of the question being asked (tangentiality).

self-disorders [21], is an example of a core psychopathology resisting a simple medical symptom/sign definition [16]. The core Gestalt of schizophrenia manifests itself as disturbances in subjective, expressive, existential, intersubjective, and behavioral domains. It cannot be reduced to single symptoms or signs. Rather, it reflects an altered being-in-the-world of the patient.

A further source of diagnostic information concerns the cognitive, perceptual, and emotional response or *resonance* occurring in the clinician himself or herself. Rümke, who coined the term "Praecox Gefühl," referring to the early label of schizophrenia as "Dementia Praecox" [22], stated that "the doctor's internal attitude induced by the patient is a very sensitive diagnostic tool, and it would be helpful if we were more skilled in recognizing changes in our own internal attitude" ([23], p. 194). A clinician always apprehends the patient's psychopathology against a background of certain prototypes developed through clinical experience and psychopathological knowledge. This *typification* refers to the ability of an experienced clinician to categorize patients in a preconceptual manner, usually at a stage of assessment earlier than formal diagnosis [24]. In connection with this typification, the clinician may have an intuition and/or a "resonance" that offers diagnostically relevant information. Such "internal attitude," as Rümke labels it, is often considered unreliable "subjective" information potentially obscuring the "objective data." It is obvious that a psychiatric diagnosis cannot be determined purely on the basis of the clinician's intuition and that the initial typification of the patient can prove erroneous. Yet, it is naïve to believe that the clinician can evade his or her own subjectivity and first-person perspective, and rather than letting his or her subjective resonance passively and prereflectively influence the diagnosis, he or she should actively reflect upon his or her perceptions, and cognitive and emotional reactions. Being aware of such reactions may inform the diagnostic process with diagnostic hypotheses that can be examined more explicitly during the interview with the patient.

The picture of the diagnostic interview that we have canvassed so far highlights that diagnosis is not a simple and linear process with a single, clearly identifiable input and output. Rather, it involves different factors that the clinician has to take into account and that may influence one another in complex ways. Because of the very nature of the psychiatric subject matter, and because of the aim of the interview, the clinician has to draw on different sources of diagnostically relevant information. Communication with the patient, observation of expressive features, and the clinician's own responses to the interaction with the patient are all key factors that come into play in the diagnostic interview. While they might not exhaust the relevant sources of diagnostic information—consider, for example, knowledge about the patient that the clinician may gather from third parties, such as the patient's relatives or hospital staff—and while there might be considerable variability between concrete clinical encounters, the psychiatric diagnostic assessment does not consist in a simple collection of single symptoms and signs.

How to parse out the relation between these different factors? We propose to do so by approaching the diagnostic interview as a phenomenon of interpersonal understanding. Under the heading of "social cognition," research on interpersonal

understanding has flourished in the last decades (for overviews, see [25, 26]). One distinction that has gotten traction in that context is the distinction between *second-person* and *third-person* relations. Although a consensus on how to understand these notions is still lacking, they can be traced back to the work of Martin Buber. According to Buber, a third-person or *I-it* relation and a second-person or *I-thou* relation are fundamentally different ways of engaging with the world. A third-person relation is characterized by a sharp divide between an active cognizing subject and a passive object that the subject seeks to determine. In contrast, in a second-person relation, both relata are active and passive, and relate reciprocally and openly to one another. Whereas the former type of relation can be thought of as a monologue, the latter can be compared to a dialogue ([27]; see [28]).

The relevance of the distinction between second-person and third-person relations has not gone unnoticed in the psychopathological literature.[2] For example, as part of a "Plea for the Second-Person Mode of Understanding," Stanghellini has argued that

> [t]he phenomenological perspective, and specially the second-person mode, advocates that the context of the clinical encounter should be one of co-presence (and not of dominance) with the aim of understanding (and not labelling), i.e. negotiating intersubjective constructs, and looking for meaningfulness through the bridging of two different horizons of meanings ([5], p. 70).

This proposal can be interpreted as standing in contrast to a more orthodox and (once) mainstream understanding of the clinical encounter, according to which the clinician relates third-personally to the patient, who, strictly speaking, remains an object of diagnosis. On this view, the more impersonal and the more detached the clinical encounter is, the less interference there will be with nonclinical factors, and the more fruitful and accurate the assessment may be.[3]

[2] See [6] for a critical review.

[3] A phenomenological characterization of the clinical encounter along these lines can be found in the work of Gurwitsch. Although Gurwitsch's work didn't focus on psychiatry, his view captures a traditional picture: "when the doctor *confronts* a mental patient whose condition he wishes to diagnose. […] there is *no common situation* at all obtaining between doctor and patient, in the sense that with respect to this situation they would do something with one another. We only say, however, that a common situation obtains where people do something with one another and, accordingly, live as situational partners. The doctor, however, has before him an object that he investigates—everything that he does and says to and with the patient is guided by this intention. For his part, the patient lives in *his* world, which we call a pathological world; from and on the basis of this world the patient speaks to the doctor. For the doctor, the patient is not a situational partner together with whom he does something in and according to the sense of a common situation—as his colleague would be when he gives advice about the case. The patient is, instead, an *object* which the doctor will know and define. To the same extent as the patient, the doctor also has his own situation, the sense of which is to penetrate into the world of the patient but which is not shared as something in common with the patient. As a consequence, the language of the doctor also does not possess the structure of 'speaking together' [...], because doctor and patient are by no means 'together with each other' in the genuine sense." ([29], p. 17).

It would be implausible to claim that there is a methodological dichotomy between understanding the diagnostic interview as either second-personal or third-personal, at least in the general terms in which we have characterized these notions. While the interview is not just *any* interpersonal encounter that may be captured by Stanghellini's description—such as an encounter between, say, two friends—there would be something missing if one interprets it in an overly medicalized way. In fact, some authors are inclined to adopt and recommend some sort of methodological pluralism about the role of the second-person and the third-person in the clinical encounter, taking them to be not mutually exclusive but rather complementary ([6], pp. 2, 9; [7], p. 56). Yet, an important question that remains open is what kind of pluralism is needed to make justice to the diagnostic interview. Although everyone would agree that a genuine pluralism cannot be a mere juxtaposition, one open challenge is how to articulate the relation between the different elements. We return to this question in Sect. 4.5, after exploring in some detail recent discussions in social cognition about the difference between second-person and third-person relations.

4.3 Spectatorial Observation, Engagement, and Openness: "Where Has 'You' Gone?"[4]

Research on social cognition has been primarily concerned with the question of how we go about understanding others by attributing to them mental states such as beliefs, intentions, and emotions. Traditional positions understand mental-state attribution in terms of "mindreading" (see [25]). In brief, Theory-theory approaches maintain that our capacity for mindreading relies on the possession of a relevant theory of mind, understood as a body of folk-psychological knowledge that allows us to infer that another person is undergoing a certain mental state [31–34]. In contrast to Theory-theory, Simulation Theory approaches to social cognition hold that mindreading does not rely on a body of theoretical knowledge and law-like generalizations, but rather on the attributor's use of his or her own mind as a model for the attribution of mental states to others [35–37].

In an influential 2013 article, Schilbach and colleagues argued that, in spite of all their differences, both Theory-theory and Simulation Theory approaches are "spectator theories of other minds" ([38], p. 394). By this they mean that those approaches would be concerned with social cognition in abstraction from the context of social interaction. In a nutshell, Theory-theory and Simulation Theory would construe social cognition as something that, in principle, could happen through a one-way mirror ([38], p. 396). A construal of social cognition in terms of the unilateral attribution of mental states need not incorporate in any way how the target of the attribution might be affected by it, react or respond to it. Although Schilbach and colleagues do not deny that social cognition may happen from what they characterize as a "spectatorial" stance ([38], p. 394), their central claim is that there is a fundamental difference between spectatorial and nonspectatorial social cognition. As they put it,

[4] The title of this section is partly indebted to [30].

> social cognition is fundamentally different when […] we are emotionally engaged with someone as compared to adopting an attitude of detachment, and when […] we are in interaction with someone as compared to merely observing her. ([38], p. 396)

One way of interpreting this emphasis on the fundamental difference between second-person interaction and third-person detached observation is that these would be two different *kinds* of social cognition. A second claim advanced by Schilbach et al. is that second-person social cognition is *primary* with respect to third-person social cognition. Although it is plausible that in a wide range of situations, we understand others by participating in social interaction with them—instead of observing them detachedly—Schilbach et al. make clear that their claim about the primacy of second-person interaction over third-person observation is not best understood as pertaining to the frequency or pervasiveness of the former, but rather as a developmental claim ([38], pp. 441–442).

Schilbach et al. propose that a second-person relation has two central constituents: emotional engagement and social interaction. First, a second-person relation requires a feeling of engagement and emotional responsiveness to the other ([38], p. 396). Second, it requires actual interaction with someone. Social interactions are characterized as involving reciprocal relations, different roles for the interactors, emerging properties that affect the continuation of the interaction, and a dimension of temporality and historicity ([38], p. 397). Importantly, emotional engagement and social interaction are not taken to be individually sufficient for a second-person relation. For example, watching a scene, or—with a slight modification of the example they use—a character in an emotionally intense movie scene may prompt feelings of engagement and involvement, even though the perceived character does not respond to one's feelings ([38], p. 397). Likewise, while an interacting subject may be conceptualized as being engaged simply in virtue of interacting, there are forms of interactions that lack affective engagement, as when one is, for example, hastily buying a bus ticket from a cashier ([38], p. 397). In light of cases like these, one reasonable way of interpreting Schilbach et al.'s proposal is that emotional engagement and social interaction are individually necessary and jointly sufficient conditions for a second-person relation. In a nutshell, on Schilbach et al.'s view, second-person relations are emotionally engaged social interactions. For one to successfully adopt a second-person stance toward another, it is not sufficient that one feels emotionally engaged with that person or that one interacts with him or her. Rather, on their account, both things are needed.

How should this proposal be assessed? Some authors have warned against a too simplified conception of observation as passive and disengaged [39]. For example, some studies have shown that the perception of another's facial expression such as smiling already elicits, at least on the level of muscular activity, an automatic response to smile back, independently of whether one is addressed or not (see [40]). As de Bruin et al. suggest, this has important consequences for accounts that spell out the difference between a second- and third person stance as a clear-cut distinction between active engagement and passive observation. Since an observing subject would never be completely passive, but in some sense actively engaged while

perceiving, the difference between second- and third-person relations would be better construed as one of *degree*, rather than in *kind* ([39], p. 4). Furthermore, if such difference is gradual rather than categorical, claims concerning the primacy of second-person social cognition would come under pressure ([39], p. 4).

In a recent contribution, Reddy takes issue with this criticism, which she dubs the "graded difference" objection" ([41], p. 437). In what appears to be a modification of the view put forward in the paper coauthored with Schilbach et al., she maintains that the difference between second-person and third-person relations is not categorical, but graded ([41], p. 435). And she attempts to respond to the "graded objection" by noting that "the fact of their graded distinction does not negate the fact of the different effects from different parts of the grading" ([41], p. 438). Reddy's line of response can be interpreted as follows: even if one takes second-person and third-person relations to be located on a continuum of social cognition, even if there is no clear-cut demarcation between them, different points within that continuum may still have different "effects" on the involved subjects. However, this line of response doesn't seem a convincing rebuttal of de Bruin et al.'s criticism. Their point was that it is hard to make sense of the claim concerning the *primacy* of second-person over third-person social cognition, if both varieties of social cognition are located within the very *same* continuum. Reddy's line of response doesn't provide resources to vindicate the primacy claim, although it might support a weaker claim concerning "different effects" that second-person and third-person relations might have on the involved subjects.

Before exploring one way in which the categorical distinction between second-person and third-person relations can be retained, it is worth considering another aspect of Reddy's most recent account of these notions. While she appears to hold on to the idea that reciprocity or mutuality is necessary for a second-person relation[5], she also allows for the possibility that observing a person without interacting with her, yes even observing someone in a movie, could qualify as second-personal. She suggests that a second-person relation is exemplified by cases in which one sees "the other(s) *as if* they were speaking to oneself and feel involved with responsive sympathy or hate or anger or adoration toward them," and notes that "[t]he key difference between relating in the second person and relating in the third person is not one of the structure of the situation, but one of the openness or closed-ness with which one faces (and is faced by) the other" ([41], p. 437, emphasis added).

This is problematic for various reasons. First, the relational component of second-person relations, hinted at in the notion of social interaction and suggested by the notions of reciprocity and mutuality, is considerably downplayed. This relational aspect is captured by the idea that in order for a subject to stand in a second-person relation to another, the second subject must also stand in a second-person relation toward the first subject [42]. But, following Reddy, this feature turns out to be inessential for the second person (see [43]). In fact, since the character observed

[5] "At its heart, a second-person relation involves the experience of being addressed by another, of being seen as a You by another person, and of the mutuality that is generated in seeing the other as a You in turn." ([41], p. 437).

in a movie is obviously not reciprocating the spectator's engagement, Reddy's suggestion runs the risk of collapsing the very distinction between spectatorial and second-person relations.

Secondly, Reddy now gives center stage to the notion of "openness," as distinguished from the notion of "closed-ness" ([41], p. 437). As Reddy explicates the latter notion, "closed-ness" to another can occur in different situations, for example, when one categorizes or objectifies the other, more particularly when one sees him or her "through the filter of a label, a group category, or a dismissive analysis (she is just a student, he is an immigrant, she is autistic)" ([41], p. 437). One difficulty with these suggestions is that we typically and quite inescapably navigate the world in terms of filters and categorizations of various sorts [44]. Given the examples that she uses, it might be that the categorizations that Reddy has in mind are the morally reproachable and questionable ones, whereas not reproachable categorizations would still be consistent with being "open" to the other. However, were one to take that route, it seems that the latter kind of categorizations can very well happen without any interaction with the categorized person.

Ultimately, Reddy's most recent characterization of the second person appears to vacillate between a thick version that attempts to capture some salient and distinctive elements of it with respect to third-person relations, and a thin version, which strongly emphasizes the continuities between the two. Perhaps she would retort that such ambivalence and, more generally, the vagueness of the notion of the second person is, like the vagueness of the notion of engagement, a constitutive feature of it, one that one should somehow make room for. Consider that, commenting on the notion of engagement, she writes as follows:

> Like all those other terms that we use—mind, culture, emotion, love—engagement is a vague and multifaceted term. One could argue that this is an essential vagueness—an indeterminacy that encompasses the possibility of as yet unknown manifestations. ([41], p. 448)

Yet, whether or not one takes the notions of mind, culture, emotion, and love as essentially vague, there would be something quite unsatisfactory in extending this appraisal to the notion of the second person. The reason is that, differently from those other notions, the concept of second-person relations is supposed to play an explanatory role in how we understand others, and not just add to the presumed indeterminacy and vagueness of the other notions. A further difficulty that looms large is whether it is feasible to account for the notion of second-person relation in terms of other, seemingly vague notions, such as "openness."

4.4 Reciprocity and Communication

In light of the foregoing discussion, we suggest that a better way forward is to unambiguously retain the relational character of the second person, by placing a starker emphasis than Schilbach et al. do on the *reciprocal* character of second-person relations. On the present proposal, to adopt a second-person stance or

perspective toward someone is to participate in an actual, real relation in which both persons are second-personally related toward one another. We propose that a second-person interaction is one, which, minimally, satisfies this requirement:

> the second-person perspective involves a relation between you and me, where the unique feature of relating to you as you is that you also have a second-person perspective on me, that is, you take me as your you. To that extent, there cannot be a single you: there always has to be at least two. ([42], p. 246)

Although this requirement is quite general, taking it on board immediately excludes the case of engagingly observing someone in a movie as a case of a second-person relation. It also excludes relations toward inanimate objects as second-personal, at least in a proper sense, since an inanimate object related to obviously lacks a second-person perspective on the engaging subject.[6] At the same time, needless to say, an emphasis on reciprocity as a mark of second-person relations doesn't settle the question of just how such reciprocity ought to be understood. How to flesh out in more detail this reciprocity requirement? There are different options one might consider.

A first option is suggested by de Bruin and colleagues, who propose that a social interaction is reciprocal if the involved subjects "coordinate their actions with one another—what is sometimes called 'attunement'" ([39], p. 5). The kind of coordination that de Bruin et al. have in mind is behavioral co-ordination, enabled by shared representations, action anticipations, and perspective-taking. As mentioned earlier, according to them, the difference between second-person and third-person relations is of degree, and not of kind. They suggest that the same cognitive capacities recruited in third-person social cognition may also be involved in second-person social cognition. This proposal has the advantage of doing justice to the fact that observation and interaction can be very closely interrelated (see [46]). However, one weakness of de Bruin et al.'s proposal is that their conceptualization of reciprocal coordination and attunement might be too thin. Consider that if two agents share representations about objects and events (i.e., have representations with overlapping content), anticipate each other's actions, and take each other's perspectives, then they appear to fulfil de Bruin et al.'s criteria of reciprocal coordination. So two persons walking in a busy corridor from opposite directions, and who quickly and surreptitiously notice each other's movements and efficiently avoid collision with each other would appear to satisfy these requirements of reciprocal behavioral coordination. Yet there is an intuitive difference between such a situation and one in which the two persons address one another with the "you" pronoun.

A more robust conceptualization of the reciprocity requirement can be found in work by Naomi Eilan. On her view, a second-person relation requires that one stands in a communicative relationship with another subject and achieves a "communicative connectedness" with her or him ([47], p. 8). According to Eilan, such a

[6] This goes against Brinck and Reddy's more radical rendering of the second-person perspective as one that may be applicable to the inanimate world. One central example in their discussion is the engagement between potter and clay ([45], p. 25).

connection is reached when subjects adopt "attitudes of mutual address" toward one another" ([47], p. 14). One consequence of this account is that no second-person relation is established if one's act of communication is not reciprocated. As Eilan illustrates:

> [O]n this account, A shouting out to B in the supermarket that he is spilling sugar doesn't put him in a communicative relation with B unless B responds to A in a way that involves his adopting an attitude of address towards A". ([48], p. 23)

This account avoids the difficulty just identified in de Bruin et al.'s account, since a relation of communicative connection enabled by mutual address is arguably more than behavioral co-ordination. At the same time, Eilan's account improves on the ambivalence identified above in the analysis of Reddy's most recent account. Yet, Eilan's account leaves several key issues unaddressed: What really changes in one's relation to another when one's communicative act is reciprocated? And what are the experiential aspects of participating in a communicative relation with someone else?

Resources to address these questions can be found in Husserl's writings on the "I-thou relation," which bear significant similarities with Eilan's account. Like Eilan, Husserl emphasizes the importance of communication in relating to another as a "you." Two subjects might be reciprocally aware of one another, as in the case of mere behavioral co-ordination illustrated above, but this does not yet amount to an I-thou relation. What is lacking in such situations of "reciprocal empathy" is the act of communication:

> What now that reciprocal, active empathy is established? Thereby no social unity, no communicative [unity], no actual I-thou nexus is established […] What is still missing is the intention and will of manifestation [*Kundgebung*] – the specific act of communication, which, in establishing a community, is called *communicatio* in Latin. ([49], pp. 472–473)

The aspect of communication highlighted by Husserl is not the transfer of information from one subject to another, but rather that, through communication, a specific kind of connectedness emerges between "I" and "thou." When I address someone, he writes, "I am not only carrying out certain acts, and I am not only understood by the other as someone carrying out these acts." What is essential is that "my act-accomplishment [*Aktvollzug*] motivates a certain co-accomplishment [*Mitvollzug*] in the other", i.e., the act of uptake ([49], p. 476). Similarly to Eilan's account, Husserl argues that once one's act of address is taken up by the addressee, a connection is formed between the communicating subjects, and an "I-thou-community" is brought about ([49], p. 476).

What does it mean for subjects to stand in such a communicative relation, in an "I-thou-community" with another? Two points seem to be of particular relevance in this regard. Based on Husserl's writings, Zahavi has recently argued that engaging in an I-thou relation has a *self-transformative* effect upon the communicating subjects. Being addressed by another is fundamentally different from merely being attended to, because the former can give rise to a specific "socially mediated externalized self-apprehension" ([50], p. 255). By means of communicative acts, one

comes to experience oneself as perceived and addressed by others and one attains "personal self-consciousness" ([50], p. 255). But communication not only leads to an enriched form of self-experience. A second point highlighted by Husserl, particularly in *Ideas II*, is that communication creates relations of "mutual understanding," which play a crucial role in the constitution of a common surrounding world:

> In this way *relations of mutual understanding* are formed: speaking elicits response; the theoretical, valuing, or practical appeal, addressed by the one to the other, elicits, as it were, a response coming back, assent (agreement) or refusal (disagreement) and perhaps a counter proposal, etc. In these relations of mutual understanding, there is produced a conscious *mutual relation* of persons and at the same time a unitary relation of them to a common surrounding world. ([51], pp. 202–203)

What emerges through relations of mutual understanding, and acts of agreement in particular, is a common surrounding world, which Husserl describes as the "communicative surrounding world [*kommunikative Umwelt*]" ([51], p. 203). On this account, for the surrounding world to become a *common* world, it is not sufficient that subjects merely understand each other's expressive behavior, or that they successfully co-ordinate their behavior and actions ([52], p. 136). What is further needed are communicative acts through which subjects co-refer to a shared world, and potentially motivate each other to perform certain acts. Only then does it become possible to relate to objects and other living beings in one's surroundings in the same way, such that the other "sees what I see and hears what I hear, or at least he *can* do so." ([51], p. 208).

The Husserlian conception of the I-thou relation as a communicative relation, which obtains when two subjects address one another and take up each other's acts of address, helps to flesh out the reciprocity requirement in a way that foregrounds the relational character of second-person relations. Moreover, Husserl suggests that an I-thou relation is qualitatively different from situations in which two subjects observe one another, as they could happen in simultaneous or reciprocal empathy. The idea that "something momentous happens the moment I turn toward and start to address the other as a you" ([53], p. 746) converges with Schilbach et al.'s suggestion that the difference between second-person interaction and third-person observation is a difference in kind, and not merely in degree.

We propose that the core of second-person relations is communication. More specifically, mutual communicative address between two subjects is both a necessary and sufficient condition for them to be second-personally related to one another. To be sure, such communicative relation doesn't have to be always linguistically articulated. But conceptualizing second-person relations as essentially communicative relations helps to capture a significant phenomenon that a successful account of social cognition should be sensitive to. If research on social cognition is primarily concerned with the question of how we go about understanding others by attributing mental states to them, according to the approach to second-person relations outlined here, understanding others by communicating with them is a distinctive kind of social understanding that deserves to be singled out in its own right. Such

understanding stands in contrast with the third-person social understanding that can be achieved from a purely observational and detached stance, and that is best exemplified by the one-way mirror situation.

What about the component of emotional involvement that, on Schilbach et al.'s proposal, is also part of a second-person relation? One tentative way of dealing with this question is by noting that while it might be plausible to hold that many communicative relations are affectively loaded, it would be too quick to exclude the possibility of affectively neutral communicative interactions in which subjects are nonetheless in a situation of mutual address. Needless to say, much depends on how broad or narrow one takes the notions of affectivity and emotions to be. On a liberal construal, if all engagements with the world are to some extent permeated by affectivity, then communicative relations would be no exception.

4.5 Back to the Diagnostic Interview: What Kind of Methodological Pluralism?

The domain of investigation of social cognition is obviously very broad. It concerns the foundations of our understanding of others. As hinted at above, there are a number of questions that have been discussed in the social cognition literature, including whether there is a developmentally primary way of understanding others, and how to understand the roles of reciprocity and affectivity in interpersonal understanding. Abstracting from such discussions, the issue to be considered in this section is whether research on social cognition, as presented and discussed in the two previous sections, can shed light on the psychiatric diagnostic interview.

Recall Stanghellini's characterization of the diagnostic interview as one that should not be of dominance and that should foster a co-construction of meaning [5]. One feature somewhat implicit in that characterization is that such co-construction of meaning is achieved via communication between the clinician and the patient. Dialogue between the two provides the space for a joint exploration of the patient's mental life. One should not assume that the patient is from the outset able to verbalize and conceptualize his or her own existential situation. Rather, one might consider the diagnostic interview a collaborative process where the clinician works with the patient in order to co-generate knowledge about what it means to live with the affliction in question. To some extent, one might see the approach of the clinician as being somewhat akin to the Socratic method, that is, it is also a question of helping the patient to obtain new insights of his or her own. This, one might add, is partly captured by the Husserlian idea of a socially mediated self-apprehension enabled by participation in an I-thou relation. After all, by means of communicative acts, one can come to experience another's perspective upon oneself, enabling one to discover aspects of oneself hitherto unknown. In order for a mutual exploration of the patient's mental life to be possible, a relation of trust must be established between the clinician and patient, and this in turn presupposes that a second-person relation is in place.

This approach to the diagnostic interview as an exploration of the patient's psychopathology "in an intersubjective (you and I) setting" seeks to stay clear from a situation in which "the patient's experiences and meanings" are overwritten by the psychiatrist or psychologist ([54], p. 172). Moreover, it opens the way for appreciating the role of narrative understanding in the clinical setting [55]. The view of second-person relations that we have developed in the previous sections, centered on the notion of communication, is consistent with Stanghellini's observations—which, however, also point to a thicker notion of the second person than the one we have endorsed above.

At the same time, it is important not to miss out on what a third-person way of relating to the patient can bring to the diagnostic interview. A too narrow focus on the joint co-construction of meaning in the clinical setting might risk missing the point that, on the one hand, labeling and approaching the patient's experiences from a third-person stance, and, on the other hand, engaging in a communicative relation with the patient, need not be mutually incompatible. The skilled clinician has to cultivate and make use of both. Part of the difficulty of the clinical interview, and part of the qualifications that the clinician has to acquire concern how to smoothly shift between two different and complementary ways of relating to the patient: as a partner in conversation and as a target of diagnosis. Importantly, as noted by Larry Davidson in the context of schizophrenia research, to include the patient as a partner in the research enterprise doesn't mean to include him or her "as a fellow scientist," but rather "as *the* expert on the domain of his or her everyday life" ([56], p. 62). Thus, both a second-person relation and a detached observational stance may well co-occur in the diagnostic interview. The clinician has to adopt and nurture a reciprocal communicative stance toward the patient, which is accompanied with observation and classification of any relevant symptoms and signs discerned from a third-person stance.

The factual co-occurrence and the intertwinement between these two ways of relating to the patient doesn't mean that there isn't a relevant *conceptual* distinction between them. In order for the clinician to be related both second-personally and third-personally to the patient, the distinction between a communicative stance and a non-communicative "spectatorial" stance is better appraised as one between two *kinds* of relations, and not merely as a matter of degree. Husserl's distinction between the I-thou relation and relations of reciprocal empathy supports this point from a phenomenological perspective. Whether one participates in a communicative relation with another subject or whether one adopts a spectatorial stance toward her, communication and detached observation are, phenomenologically, distinct sources of our understanding of others. This point can be further elaborated by considering that, whereas knowledge gained from observation of another is epistemically based on evidence about states of affairs, knowledge gained from interpersonal communication builds on what speakers tell and, more generally, communicate to one another. This feature is arguably absent when the other is taken merely as a source of information. To employ a distinction by Edward Craig, there is a relevant difference between taking the other as an *informant* and as a *source of information* ([57], p. 35; see [58]). Taken together, these phenomenological and epistemic considerations support the point that reciprocal communication is a relevant marker to take into

account when motivating a difference in kind between second-person and third-person relations, and that such difference can play a fruitful role in the investigation of the diagnostic interview.

The current proposal differs from some views advanced in the literature about the relevance of the distinction between second-person and third-person relations for psychopathology and the clinical encounter. As mentioned earlier, it is fairly obvious that a plausible methodological pluralism cannot simply amount to a mere juxtaposition of different methodologies. Rather, it has to delineate how these different methodologies are related. Consider one of the available proposals.

Galbusera and Fellin express sympathies toward methodological pluralism ([6], pp. 2, 3, 9, 12), and, as they argue, the second-person has primacy as an overarching integrative framework ([6], p. 13). One motivation for this view is that the second-person perspective "best accounts for the validity of our claims about the other" ([6], p. 12), insofar as it wouldn't be affected by general problems that third-person and first-person methodologies would run into. In brief, the former would seek to be based on immediate sensory experience while at the same time making our knowledge of other minds an inferential achievement ([6], pp. 3, 12). And the latter would be prone to neglect the alterity of the other, by modeling the understanding of the other on self-understanding ([6], pp. 5, 12). Drawing on enactive and phenomenological theories of social cognition, Galbusera and Fellin characterize the second-person methodology as non-spectatorial, embodied, and interactive, and as providing the basis for our understanding of others ([6], pp. 5, 6, 13). Although their proposal concerns psychopathological research at large, it would also apply to the specific kind of interaction that they are interested in, namely, "the relation between a researcher and a person presenting with a psychopathology" ([6], p. 7).

There is much of interest in Galbusera and Fellin's discussion, but their bold construal of the second person as an overarching framework for psychopathological research differs from the present proposal. The reason is that we don't believe it necessary to advance claims about the primacy of second-person over third-person relations in order to vindicate the more specific idea that they are different stances toward the patient that the clinician can adopt, and that can mutually inform one another. Another difficulty with their proposal is that it risks mischaracterizing the third-person perspective as being mainly exemplified by "checklists" ([6], p. 9) and as a view from nowhere seeking an "illusory objectivity" ([6], p. 13). But we suggest that as much as it is important to vindicate the role of the second-person perspective, it is also relevant not to endorse an overly scientistic understanding of the third-person perspective. The latter can also be construed as firmly anchored in the subjectivity of the clinician who adopts a reflective and theoretical stance toward the patient. At the same time, it is worth emphasizing that although some (the most severe) expressive features may be detectable without relating to the patient second-personally, they only gain their diagnostic significance in the context of the overall psychopathological picture/Gestalt and, most importantly, the psychosocial history of the patient.

4.6 Concluding Remarks

We began our chapter by expressing reservations about an understanding of the diagnostic interview as a linear and simple process with a single input and output. We endorsed a different picture, according to which the clinician has to draw on multiple sources of diagnostically relevant information. This picture motivated the question of how to approach the complexity of the interview, and the role that the distinction between second-person and third-person relations might play for a better understanding of it. The notion of second-person engagement that we have delineated above allowed us to elaborate on the complex interplay between different factors that the clinician has to be attentive to. Our focus on communication allows us to consider second- and third-person relations as complementary methodological tools in the clinical practice, by means of which the clinician seeks to gain a better understanding of the patient. Moreover, at a more general level, our discussion suggests that the second-person relation does not necessarily need to go hand-in-hand with emotional engagement or with adopting a sympathetic, or compassionate stance toward the other. At the same time, relating to another third-personally does not necessarily imply that one dominates the situation, or that one engages in problematic forms of labeling. On the view we have presented, the psychiatric diagnostic assessment does not consist in a third-person collection of single symptoms and signs but is a complex process encompassing, from the clinician's perspective, both a second-person and a third-person stance. As mentioned earlier, a fuller account of the diagnostic interview would have to take into account other factors, such as the clinician's first-person resonance, typification, and/or intuition when interacting with the patient. In the present contribution, however, we have focused on the relevance of the distinction between second-person and third-person relations for understanding the diagnostic interview.

Acknowledgments Felipe León and Dan Zahavi received funding from the European Research Council (ERC) under the European Union's Horizon 2020 research and innovation programme (grant agreement No. 832940). Maja Zandersen and Dan Zahavi acknowledge funding from the Carlsberg Foundation (grant ID: CF18-1107), and Patricia Meindl from the Independent Research Fund Denmark (grant ID: DFF-7013- 00032).

References

1. Millon T. Classification in psychopathology: rationale, alternatives, and standards. J Abnorm Psychol. 1991;100(3):245–61.
2. Sánchez O, Brownlee-Duffeck M. Medical model. In: Kreutzer JS, DeLuca J, Caplan B, editors. Encyclopedia of clinical neuropsychology. Cham: Springer International Publishing; 2018. p. 2107.
3. Parnas J, Sass LA, Zahavi D. Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object. Schizophr Bull. 2013;39(2):270–7.
4. Parnas J. Differential diagnosis and current polythetic classification. World Psychiatry. 2015;14(3):284–7.
5. Stanghellini G. The grammar of the psychiatric interview. Psychopathology. 2007;40(2):69–74.

6. Galbusera L, Fellin L. The intersubjective endeavor of psychopathology research: methodological reflections on a second-person perspective approach. Front Psychol. 2014;5:1150.
7. Gupta M, Potter N, Goyer S. Diagnostic reasoning in psychiatry: acknowledging an explicit role for intersubjective knowing. Philos Psychiatr Psychol. 2019;26(1):49–64.
8. Nordgaard J, Revsbech R, Saebye D, Parnas J. Assessing the diagnostic validity of a structured psychiatric interview in a first-admission hospital sample. World Psychiatry. 2012;11(3):181–5.
9. Spitzer RL, Williams JB, Gibbon M, First MB. The structured clinical interview for DSM-III-R (SCID): I: history, rationale, and description. Arch Gen Psychiatry. 1992;49(8):624–9.
10. Nordgaard J, Sass LA, Parnas J. The psychiatric interview: validity, structure, and subjectivity. Eur Arch Psychiatry Clin Neurosci. 2013;263(4):353–64.
11. Laing RD. The politics of experience and the bird of paradise. Harmondsworth: Penguin; 1967.
12. Laing RD. The divided self. Harmondsworth: Penguin; 1990.
13. Urfer-Parnas A. Eugène Minkowski. In: Stanghellini G, Broome M, Raballo A, Fernandez AV, Fusar-Poli P, Rosfort R, editors. The Oxford handbook of phenomenological psychopathology. Oxford University Press; 2019. p. 104–110.
14. Binswanger L. On the manic mode of being-in-the-world. In: Broome MR, Harland R, Owen GS, Stringaris A, editors. The Maudsley reader in phenomenological psychiatry. Cambridge and New York: Cambridge University Press; 2012. p. 197–203.
15. Parnas J, Urfer-Parnas A. The ontology and epistemology of symptoms: the case of auditory verbal hallucinations in schizophrenia. In: Kendler KS, Parnas J, editors. Philosophical issues in psychiatry IV: classification of psychiatric illness. Oxford: Oxford University Press; 2017. p. 201–16.
16. Parnas J. A disappearing heritage: the clinical core of schizophrenia. Schizophr Bull. 2011;37(6):1121–30.
17. Trzepacz PT, Baker RW. The psychiatric mental status examination. New York: Oxford University Press; 1993.
18. Bleuler E. Dementia praecox oder Gruppe der Schizophrenien. Psychosozial-Verl: Gießen; 1911/2014.
19. Minkowski E. La schizophrénie. Psychopathologie des schizoides et des schizophrènes. Paris: Petite Bibliothèque Payot; 1927.
20. Blankenburg W. Der Verlust der natürlichen Selbstverständlichkeit. Ein Beitrag zur Psychopathologie symptomarmer Schizophrenien. 1971.
21. Sass LA, Parnas J. Schizophrenia, consciousness, and the Self. Schizophr Bull. 2003;29(3):427–44.
22. Kraepelin E. Lehrbuch der Psychiatrie. 6. Auflage. Johann Ambrosius Barth; 1899.
23. Rümke H. The nuclear symptom of schizophrenia and the praecox feeling (1948). In: Broome MR, Harland R, Owen GS, Stringaris A, editors. The Maudsley reader in phenomenological psychiatry. Cambridge and New York: Cambridge University Press; 2012. p. 193–6.
24. Schwartz MA, Wiggins OP. Typifications: the first step for clinical diagnosis in psychiatry. J Nerv Ment Dis. 1987;175(2):65–77.
25. Goldman AI. Theory of mind. In: Margoilis E, Samuels R, Stich S, editors. The Oxford handbook of philosophy and the cognitive sciences. Oxford: Oxford University Press; 2012. p. 402–24.
26. Michael J, De Bruin L. How direct is social perception? Conscious Cogn. 2015;36:373–5.
27. Buber M. I and Thou. Mansfield Centre, CT: Martino Publishing; 2010.
28. Meindl P, León F, Zahavi D. Buber, Levinas, and the I-Thou relation. In: Fagenblat M, Erdur M, editors. Levinas and analytic philosophy: second-person normativity and the moral life. New York: Routledge; 2020. p. 80–100.
29. Gurwitsch A. Human encounters in the social world. Pittsburgh: Duquesne University Press; 1979.
30. Lavin D. Other wills: the second-person in ethics. Philos Explor. 2014;17(3):279–88.
31. Baron-Cohen S. Mind blindness. An essay on autism and theory of mind. Cambridge, MA: MIT Press; 1995.

32. Scholl BJ, Leslie. Modularity, development and 'Theory of Mind'. Mind Lang. 1999;14(1):131–53.
33. Carruthers P. Simulation and self-knowledge: a defense of theory-theory. In: Carruthers P, Smith K, editors. Theories of theories of mind. Cambridge University Press; 1996. p. 22-38.
34. Gopnik A, Wellman HM. Why the child's theory of mind really is a theory. In: Davies M, Stone T, editors. Folk psychology: the theory of mind debate. Oxford: Blackwell; 1995. p. 232–58.
35. Gallese V. The roots of empathy: the shared manifold hypothesis and the neural basis of intersubjectivity. Psychopathology. 2003;36(4):171–80.
36. Goldman AI. Interpretation psychologized. In: Davies M, Stone T, editors. Folk psychology: the theory of mind debate. Oxford: Blackwell; 1995. p. 74–99.
37. Gordon R. Radical simulation. In: Carruthers P, Smith PK, editors. Theories of theories of mind. Cambridge: Cambridge University Press; 1996.
38. Schilbach L, Timmermans B, Reddy V, Costall A, Bente G, Schlicht T, et al. Toward a second-person neuroscience. Behav Brain Sci. 2013;36(04):393–414.
39. de Bruin L, van Elk M, Newen A. Reconceptualizing second-person interaction. Front Hum Neurosci. 2012;6:1–14.
40. Dimberg U, Thunberg M, Elmehed K. Unconscious facial reactions to emotional facial expressions. Psychol Sci. 2000;11(1):86–9.
41. Reddy V. Why engagement? A second-person take on social cognition. In: Newen A, De Bruin L, Gallagher S, editors. Oxford handbook of 4E cognition. New York, NY: Oxford University Press; 2018. p. 433–52.
42. Zahavi D. Self and other: exploring subjectivity, empathy, and shame. New York: Oxford University Press; 2014.
43. Herschbach M. Critical note. How revisionary are 4E accounts of social cognition? In: Newen A, De Bruin L, Gallagher S, editors. Oxford handbook of 4E cognition. 1st ed. New York, NY: Oxford University Press; 2018. p. 513–25.
44. Taipale J. From types to tokens. Empathy and typification. In: Szanto T, Moran D, editors. Phenomenology of sociality: discovering the we. New York: Routledge, Taylor & Francis Group; 2016. p. 143–58.
45. Brinck I, Reddy V. Dialogue in the making: emotional engagement with materials. Phenom Cogn Sci. 2020;19(1):23–45.
46. Overgaard S, Michael J. The interactive turn in social cognition research: a critique. Philos Psychol. 2015;28(2):160–83.
47. Eilan N. Other I's, communication, and the second person. Inquiry. 2020:1–23.
48. Eilan N. Knowing and understanding other minds: on the role of communication. https://warwick.ac.uk/fac/soc/philosophy/news/seminars/consciousness/wmagrads_.pdf. Accessed 18 Jan 2022.
49. Husserl E. Zur Phänomenologie der Intersubjektivität III. Texte aus dem Nachlass. Dritter Teil. 1929-35. Kern I, editor. Den Haag: Martinus Nijhoff; 1973.
50. Zahavi D. Second-person engagement, self-alienation, and group-identification. Topoi. 2019;38(1):251–60.
51. Husserl E. Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. Second book: studies in the phenomenology of constitution. Dordrecht: Kluwer Academic Publishers; 1989.
52. Caminada E. Vom Gemeingeist zum Habitus: Husserls Ideen II. Sozialphilosophische Implikationen der Phänomenologie. Cham: Springer International Publishing; 2019.
53. Zahavi D. Intersubjectivity, sociality, community. In: Zahavi D, editor. The Oxford handbook of the history of phenomenology. Oxford University Press; 2018. p. 734–752.
54. Stanghellini G, Lysaker PH. The psychotherapy of schizophrenia through the lens of phenomenology: intersubjectivity and the search for the recovery of first- and second-person awareness. APT. 2007;61(2):163–79.
55. Stanghellini G. The puzzle of the psychiatric interview. J Phenomenol Psychol. 2004;35(2):173–95.

56. Davidson L. Living outside mental illness: qualitative studies of recovery in schizophrenia. New York: New York University Press; 2003.
57. Craig E. Knowledge and the state of nature: an essay in conceptual synthesis. Oxford: New York: Clarendon Press; Oxford University Press; 1990.
58. Moran R. The exchange of words: speech, testimony, and intersubjectivity. New York: Oxford University Press; 2018.

Understanding Other Persons. A Guide for the Perplexed

5

Giovanni Stanghellini

5.1 Introduction

> I must not dwell upon the fearful repast, which immediately ensued. Such things may be imagined, but words have no power to impress the mind with the exquisite horror of their reality. Let it suffice to say that, having in some measure appeased the raging thirst, which consumed us by the blood of the victim, and having by common consent taken off the hands, feet, and head throwing them together with the entrails, into the sea, we devoured the rest of the body, piecemeal, during the four ever memorable days of the seventeenth, eighteenth, nineteenth, and twentieth of the month [1].

This description is taken from Edgar Poe's *The Narratives of A. Gordon Pym from Nantucket*—a shipwreck tale of survivor cannibalism. We can, indeed, hardly imagine the horror, guilt, or shame that mariners may have felt while consuming human flesh and after they did so. Words, as Poe says, "have no power to impress the mind" with the horror of reality.

It would not make such a difference if, instead of Poe's novel, I mentioned the opening of Kafka's *The Metamorphosis*:

> One morning, as Gregor Samsa was waking up from anxious dreams, he discovered that in bed, he had been changed into a monstrous verminous bug. He lay on his armour-hard back and saw, as he lifted his head up a little, his brown, arched abdomen divided up into rigid bow-like sections. From this height, the blanket, just about ready to slide off completely, could hardly stay in place. His numerous legs, pitifully thin in comparison to the rest of his circumference, flickered helplessly before his eyes. "What's happened to me," he thought [2].

G. Stanghellini (✉)
Department of Psychological, Humanistic and Territorial Sciences, 'G. d'Annunzio' University, Chieti, Italy

'D. Portales' University, Santiago, Chile
e-mail: giostan@libero.it

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_5

Some sort of *disjunctive experience* between ourselves and the protagonist of the narrative would have arisen even if my examples were taken from the overture of Melville's masterpiece *Moby Dick*:

> Call me Ishmael. Some years ago—never mind how long precisely—having little or no money in my purse, and nothing particular to interest me on shore, I thought I would sail about a little and see the watery part of the world. It is a way I have of driving off the spleen, and regulating the circulation. Whenever I find myself growing grim about the mouth; whenever it is a damp, drizzly November in my soul; whenever I find myself involuntarily pausing before coffin warehouses, and bringing up the rear of every funeral I meet; and especially whenever my hypos get such an upper hand of me, that it requires a strong moral principle to prevent me from deliberately stepping into the street, and methodically knocking people's hats off – then, I account it high time to get to sea as soon as I can. This is my substitute for pistol and ball [3].

Uncivilized practices like cannibalism, oneiroid metamorphosis into a nonhuman body, and even a rather familiar mood like spleen are all good examples of narratives that defy—in part or totally—our capacity to intuitively understand someone's actions, expressions, and experiences. Something hardly intelligible is described by the other person; and, in addition to that, our emotions—including disgust, repulsion, astonishment, irritation, contempt, etc.—hinder our capacity to feel and make sense of what the other is trying to tell us. This is obviously a feeling we may have not only when we are confronted with a fictional tale, but even more so when we hear stories like these from a flesh-and-blood person, as it is the case when we listen to a friend asking our help, or to a patient in our everyday clinical work. Understanding other persons—in short: understanding others, as I shall call it here—is not an easy task when we are faced with such radical form of otherness, but perhaps, paradoxically, it may become even more tricky if we find some correspondence between the other's narrative and our personal experiences, since the latter may surreptitiously overwrite the story told by the other.

Which are the conditions of possibility for understanding others? Let us start from the beginning, that is, from ordinary occurrences of face-to-face encounters in the human life-world, before we pass to more sophisticated forms of understanding as the ones that take place in the clinical setting.

5.2 A Priori Understanding Others in a Shared Life-World

First and foremost, we understand each other—or at least we have the *feeling* that we understand each other. The cognitive sciences have generally adopted a mentalistic, strictly representational approach to this phenomenon, in which the understanding of others is attributed to the possession of a theory of mind, conceptualized as an ability to perform inferential or imaginative-simulative routines in order to account for or predict the mental states subtending the other's behavior [4, 5]. By contrast, phenomenology maintains that the basic process of understanding others involves a quasi-perceptual, unmediated access to the mental states of others as displayed in their expressive behavior [6].

There are several features involved in this basic form of understanding others. Under normal circumstances, we have the feeling that we understand each other well enough thanks to our *shared engagement* in a shared world. Our relationships are given in a world that is, from the beginning, a shared world of action. We feel embedded in a world of praxis or practical engagements that we feel we share with others. For each of us, a knife is a utensil to cut and a pen a different kind of utensil to be used for writing. This entails that when two or more persons are in front of a knife or a pen they prereflectively share the same attitude about the use and thus about the meaning of that instrument—that is, how to put it to use. We do not need to use cognitive concepts in order to comprehend and respond to others. The majority of everyday relations are based on immediate and prereflective face-to-face encounters with other persons, whose emotions, beliefs intentions, and desires are expressed directly in their actions and are typically grasped as meaningful in an emergent, pragmatic context.

Not only do we feel embedded in a shared world of practical engagements, we also feel embedded in a *shared world of symbols*. A second reason why we have the feeling that we understand each other is that we share linguistic conventions rooted in social traditions. For instance, in abecedaries, which are used to teach children the alphabet, a given word is coupled through its initial letter with a corresponding thing or animal (*A like ant, B like bee, C like cat,* etc.) and each word is paired with the image of the corresponding thing or animal. This conveys the correspondence between the world of symbols and that of worldly entities. The word "knife" *means* (symbolizes) the utensil knife. The coupling between a word and a thing conveys a feeling of reciprocal understanding when we speak to each other. We take it for granted that if another person says "knife," he means a utensil made for cutting and nothing else. These linguistic conventions are reiterated and all anomalies are discouraged and stigmatized—with the exception of art or poetry or other forms of creativity.

A third feature of our feeling of understanding others is that the others' *actions* have for us an intuitive meaning. From birth, understanding others is a sensorimotor and proprioceptive apprehension of others grounded in early relations with the caregiver, as the infant and caregiver are able to create a preverbal communication context. This implicit code—which develops hand in hand with a basic sense of Self—is procedural, nonsymbolic, and prereflexive [7]. We are in touch with each other through a fine prethematic understanding of the expressive behavior of other people. Behavior (postures, gestures, expressed emotions, gazes, and goal-oriented actions) intrinsically possesses an expressive unity and meaningfulness that we can directly grasp during our encounters with others, without any reflexive/introspective mediation. This basic form of understanding others is a particular kind of perception, thought to be innate. Understanding others is based on the resonance between my body and the other's body, with the other given in his expressive bodily presence. Intersubjectivity is basically *intercorporeality* [8]. What the others do is meaningful to me because of two reasons: first, the others are *embodied like myself* and they move as I—as any other animal being—would move in the same circumstances; second, because these behaviors are handed down by culture. Let us make an

example of the first case: "[w]hen young lady is faced with the problem of an undesirable marriage she has two choices. She may proceed calmly and deliberately to take advantage of her adversary's weakness, now resisting him energetically and now cleverly eluding him—with the result that by selecting words and actions appropriate to every new development, she finally reaches her goal. Or she may suddenly breakdown, tremble and quiver convulsively, roll and toss and work herself up into a frenzied state; she will behave in this way until she frees herself from the unwanted suitor" ([9]; p. 3). The second behavior is an example of *instinctive flurry*, a typical reaction to situations that threaten or interfere with someone's existence. It is a built-in mechanism with a biological function. This behavior is embodied in *every* animal including humans and thus intuitively understandable by anyone who is observing it.

There are other behaviors whose meaning is culturally dependent. Some of our *corporeal habits* are embedded in a given culture and are implicitly handed down to all its members. For instance, in our culture, we all use forks, knives, and spoons to eat; thus, we feel that a person who is using these utensils is engaged in feeding himself or herself. Pierre Bourdieu [10] provides an excellent example of these: our arms and legs are full of silent imperatives. These imperatives include "Sit up straight!" and "Don't put your knife in the mouth." They select the range of affordable perceptions and actions. These corporeal orientations, which people acquire through their rearing in a given culture, constitute the track of our action and perception. In particular, they orientate our social relations. They are nonconceptual in nature: embodied schemas that are out of one's voluntary control and are difficult to be made explicit. Habits *qua* incorporated social schemas shared by a given community play a fundamental role in intuitively understanding the behavior of other members of this community.

Last but not least, in principle, we are *attuned* to other persons: *interpersonal prereflexive attunement* is a further aspect of the *a priori* form of other-understanding we are exploring. A fundamental feature of intersubjectivity *qua* intercorporeality is *intertemporality* or *synchronization*, that is the prereflective intertwining of lived and living bodies that mutually resonate with one another, or the reciprocal bodily synchrony that allows two or more persons to share a given experience through their lived bodies [11]. Prereflexive attunement is an entanglement between persons based on a silent mode of relating, a nonpropositional flow of communication between persons embedded in a given situation. Attunement is thus based on a prereflexive receptivity, enabling one to feel a situation and to adjust to it—the spontaneous capacity to orchestrate one's own feeling state according to the feeling state of the other [12]. It is like playing music together [13] where one musician coordinates and synchronizes his personal *tempo* (which in music indicates a mood, e.g., allegro, vivace, etc.) with the tempo of the other without the external help of a metronome.

Shared pragmatic engagement, linguistic conventions, embodiment, habits, and attunement are the columns of our a priori feeling of understanding others, that is, the ability to grasp or assess the meaningfulness of their actions and expressions. The understanding of others is enacted and fully embodied in the sense that it

unfolds in a pragmatic and semantically meaningful, situational context that is a constitutive part of the encounter itself.

5.3 Second-Order Understanding

What I tried to describe in the previous section are the modes of our primary and spontaneous engagement in the world, which allows a form of understanding of the other persons' actions and expressions. If we compare these with more sophisticated forms of understanding others, such as the ones required to have feelings in response to and to make sense of Poe's, Kafka's, or Melville's narratives, we may establish the following distinction: on one side, we have first-order or nonconative forms of understanding others, and, on the other, second-order or conative ones. While we experience the limitations of the first-order mode of understanding others, we may deliberately put forward all our efforts to thematically understand the other person. Whereas nonconative understanding mainly involves shared pragmatic engagement, linguistic conventions, embodiment, habits, and prereflexive attunement, and in general an unprompted and implicit resonance between me and the other, conative understanding others requires something more than this [14]. Conative understanding others, then, is a more reflexive and mediated task than nonconative understanding. Here I *actively* look inside myself for stored experiences to make them resonate with those of the other.

Thus, the most basic form of understanding others does not require any voluntary and explicit effort. Nonconative understanding others is basically a kind of spontaneous and involuntary phenomenon through which we implicitly make sense of the other's behavior. But, as we have seen, in some cases, the other person's behaviors and expressions become elusive: while performing this act of imaginative self-transposal, we experience the radical un-understandability of the other. In some cases—maybe the most relevant, at least in clinical practice—we do not feel immediately in touch with the other, we do not immediately grasp the reason and meaning of his actions, and, as a consequence, we purposively and knowingly attempt to put ourselves in his place. While attempting to transpose ourselves into the other, we experience the radical otherness of the other. In this vein, early clinical phenomenologists (like Jaspers) and early psychoanalysts (like Freud) rejected *Einfühlung* (usually translated with 'empathy') as an adequate tool for understanding the subjectivity of patients affected by severe mental illnesses like psychoses [15].

An important epistemological concern arises here: How do I know that when I am "empathizing" with someone I am not projecting my own experiences onto the other? Also, a perhaps even more important ethical concern is: How do I know that the other wants to be understood by me, that is, assimilated to my own experience?

Understanding severe aberrations of experience such as those that can be met with in schizophrenic, melancholic, or manic forms of existence requires a kind of training that goes beyond spontaneous nonconative empathic skills, and at the same time avoids the pitfalls of conative empathy based on the clinician's personal experiences and commonsense categories. To achieve second-order understanding is a

complex process [16]. First of all, I need to acknowledge the autonomy of the other person, and consequently that the life-world[1]—the province of reality inhabited by a given person, having its own meaning structure and a "style" of subjective experience and action determined by a "pragmatic motive"—of the other person is not like my own. Second, I must learn to neutralize my natural attitude that would make me try to understand the other's experience as if it took place in a world like my own. Third, I must try to reconstruct the existential structures of the world the other lives in. Fourth, I can finally attempt to understand the other's experience as meaningfully situated in a world that is indeed similar to my own, but also constantly and indelibly marked by the other person's particular existence, and by that person's endeavor to become who she or he is.

[1] The life-world is the original domain, the obvious and unquestioned foundation both of all types of everyday acting and thinking and of all scientific theorizing and philosophizing. In its concrete manifestations, it exists as the "realm of immediate evidence." The concept of *life-world* was introduced by Edmund Husserl in his *The Crisis of European Sciences and Transcendental Phenomenology* [17]: *In whatever way we may be conscious of the world as universal horizon, as coherent universe of existing objects, we, each "I-the-man" and all of us together, belong to the world as living with one another in the world; and the world is our world, valid for our consciousness as existing precisely through this 'living together.' We, as living in wakeful world-consciousness, are constantly active on the basis of our passive having of the world... Obviously this is true not only for me, the individual ego; rather we, in living together, have the world pre-given in this together, belong, the world as world for all, pre-given with this ontic meaning… The we-subjectivity… [is] constantly functioning"*.

The lifeworld is a grand theatre of objects variously arranged in space and time relative to perceiving subjects. It is already-always there, and is the "ground" for all shared human experience. Husserl's formulation of the lifeworld was influenced by Wilhelm Dilthey's "life-nexus" (*Lebenszusammenhang*) and Martin Heidegger's Being-in-the-world (*In-der-Welt-Sein*). The concept was further developed by students of Husserl such as Maurice Merleau-Ponty, Jan Patočka, and Alfred Schutz. The lifeworld can be thought of as the horizon of all our experiences, in the sense that it is that background on which all things appear as themselves and meaningful. The lifeworld cannot, however, be understood in a purely static manner. It isn't an unchangeable background, but rather a dynamic horizon in which we *live*, and which "lives with us" in the sense that nothing can appear in our lifeworld except as *lived*.

The most relevant variant of life-world phenomenology was developed by Alfred Schutz [18]: "The reality which seems self-evident to men remaining within the natural attitude (…) is the everyday life-world. The region of reality in which man can engage himself and which can change while he operates in it by means of his animate organism. The object and events which are already found in this realm limit his free possibility of action. Only within this realm can one be understood by his fellow-men, and only in it can he work together with them."

A life-world is the province of reality inhabited by a given person, having its own meaning structure and a "style" of subjective experience and action determined by a "pragmatic motive."

Although the majority of people are situated within a shared life-world, there are several other frameworks of experience—for example, fantasy worlds, dream world, and psychopathological worlds. Abnormal mental phenomena are the expression of a more or less pronounced modification of the ontological framework within which experience is generated. The overall change in the ontological framework of experience transpires through the single symptoms, but the specificity of the core is only graspable at a more comprehensive structural level. The experience of time, space, body, self and others, and their modifications are the principal indexes of the patient's basic structures of subjectivity within which each single experience is situated [19].

The supposition that the other lives in a world just like my own—that is, he or she experiences time, space, his or her own body, others, the materiality of objects, etc., just as I do—is often the source of serious misunderstandings. Take the example of lived time: existential time cannot be detached from the life and history of the individual. One day for a young man can be lived as growth and fulfilment, whereas an old man may live it as consumption and decline. An anxious person may be afflicted by a feeling that time vanishes, inexorably passes away, that the time that separates him or her from death is intolerably shortened. Another patient in an early stage of schizophrenia may experience time as the dawn of a new reality, an eternally pregnant "now" in which what is most important is not present, what is really relevant is not already there, but is forever about to happen.

In order to understand these persons, I need to acknowledge the *existential difference*, the particular autonomy, which separates me from the way of being in the world that characterizes each of them. Any forgetting of this difference, for instance, between my own world and that of an anxious or a schizophrenic person (but we would say, also, *mutatis mutandis* between my own and an adolescent's or an old man's world), will be an obstacle to understanding, since these people live in a life-world whose structure is (at least in part) different from my own. Achieving second-order understanding thus requires me to set aside my own prereflexive, natural attitude (in which my first-order understanding capacities are rooted), and to approach the other's world as I would do while exploring an unknown and alien country.

5.4 Understanding Others in the Psychotherapeutic Setting

In this last section, I will concisely discuss five apparatuses that seem to be relevant to develop understanding others in the context of psychotherapeutic care: "dialogue," "attunement," "recognition," "intimacy," and "tact." My analyses will be not much more than a list of topics, building on and extending my previous contributions. If the reader's interest is attracted by this sketchy review, I may suggest her or him to read the following [12, 14–16, 19, 20].

Dialogue is the overall framework within which other-understanding unfolds as we belong together in a human shared world, since we can dialogue. Dialogue is the essential happening of language. It is about communication about concepts, personal experiences, and meanings, but not only about that. Dialogue is not mere exchange of information. In dialogue, "meanings-effects" are always accompanied by "presence-effects" [21] as genuine dialogue points to what is irrevocably non-conceptual in our lives. Dialogue is the possibility to listen to each other, and listening is the opportunity to be touched by what the other says. In dialogue, words have a semantic content, which conveys meanings, but dialogue is also a performance that has a nonsemantic dimension, that is, the *Volumen* [22] or *materiality* of the voice of the speaker through which a resonance between the speaker's and the listener's bodies is established. A genuine dialogue is a genuinely social act. In it, at a given moment, the interlocutors themselves become the subject matter. As a

consequence of that, in dialogue, subjectivity is displaced. One enters into dialogue, but one does not control its progression and outcome. In dialogue, something new about the interlocutors is revealed [14].

Attunement, as we have seen, is the modulation of the emotional field in-between oneself and the other. I am attuned to the world and other persons through my emotional feelings. Attunement, as we have seen, is based on a prereflexive spontaneous receptivity, enabling me to feel situated in a given place or relationship. Yet attunement is also the capacity to actively and purposefully coordinate my tempo with that of the other. It is also the reflexive capacity to orchestrate my emotions according to the other's emotions and adjust to it—a modulation of the emotional field in-between myself and the other. Attunement is thus inter-emotionality and also inter-temporality. My feeling of being in sync with nature, of belonging to a world shared with other human beings, and of being recognized by the other person are all based on attunement.

Recognition is the epistemic and ethical capacity to acknowledge the alterity in myself and of the other person. Both these forms of recognition—self- and other-recognition—take place in the context of dialogue and supported by attunement. Self-recognition is the acknowledgement of the preindividual elements not yet appropriated by myself, my involuntary drives, emotions, and habits. Other-recognition is the acknowledgement of the other person as a fellow man to whom I attribute value, life, and consciousness like my own. Other-recognition has a spontaneous emotional side grounded in attunement (nonconative other-understanding), and a more intellectual nonspontaneous side fueled by my attempt to understand the other's experience as meaningfully situated in a world that is similar to my own (conative other-understanding), but also indelibly marked by the other person's particular existence. Thus, recognition has an epistemic as well as an ethical value.

Intimacy is an atmospheric experience of aloneness-togetherness, self-recognition, and other-recognition. The recognition of belonging to a common destiny of fragility and solitude. My sense of being a self emerges in the experience of resonance with another person—often a mute or wordless resonance. This experience is embedded in an atmosphere—the elusive and often almost indefinable "air," "mood," or "ambience" that envelops a given situation in which you and I are sited. An atmosphere is based on a feeling that is neither private nor internal, but spatially spread out and tinges the situation in which two or more persons happen to be involved. Enveloped in an atmosphere of intimacy, I *get in touch* with myself via getting in touch with the other person. This is often the climax of friendship or love, or of a psychotherapeutic encounter: an aesthetic happening enveloped in an atmosphere and leading to an experience of intimacy. It brings about a prereflexive feeling of shared meaningfulness, a preconceptual assemblage of the assortment of all sensorial inputs available to both partners. The sharing an atmosphere of intimacy may happen spontaneously, yet it usually needs that the persons involved actively clear the ground from memories, representations, desires, and all sort of prejudices. This clearing is what phenomenology calls *epochè*.

Tact is the capacity to feel and attune with the other within an atmosphere. Tact is the dexterity not to intrude into the other's sphere, to avoid instrumental relationships, to let the other manifest his or her uniqueness. Tact touches upon the very origin of the moral law. It is a form of connection released from prejudices and from instrumental relationship. It expresses a kind of contact that is not that of possession, physical (e.g., to take hold of the other in order to force him or her to do something), or intellectual (e.g., to grasp the significance of the other's behavior). Tact is a kind of grace, an implicit promise, and the capacity to wait until the moment is ripe for making explicit what I sensed.

5.5 Why Understanding?

Understanding other persons is a complex phenomenon that mingles the voluntary with the involuntary, conative with nonconative postures, cognitive with pathic forms of *cogito*, nature with culture, meaning-effects with presence-effects—in an unstable state of tension or oscillation between the two. Perhaps, genuine understanding is a dialectic situation that involves these conflicting attitudes without a synthesis and this is one of the reasons why it remains open to a process of infinite approximation to the other whose emblem is the feeling of aloneness-togetherness, that is, the more I feel in touch with the other, the more I acknowledge the distance from the other.

Understanding other is thus not merely a kind of accurate knowledge about the other, a concept that grasps the states of mind motivating the other's behaviors and expressions. Rather, it is a *gesture*—the commitment to cross the space that separates me from the other, the act of tending to the other, purified from its goal. Yet, unlike a Kantian or religious virtue, understanding others is not its own reward. What good do we get from this kind of "virtue"?

This brings us to the final question: why should I try to understand the other? Especially if I have become aware that grasping his states of mind, reasons, and motivations is on the edge of being an epistemologically impossible task (the essence of the other is its otherness), if not an unethical one (understanding others should not be a kind of "grasping," that is of physical or intellectual possession). Why should I condemn myself to such a frustrating effort? The reason is that without an effort to understand the other, I am at risk at imploding into myself. The other is the counterweight that avoids my collapsing into myself. Also, the other, without my effort to understand him or her, and more exactly without my effort to *recognize* him or her, is at risk of imploding into himself or herself. Mental pathologies can be defined as the sinking of the Self into itself that takes place when the dialectic with otherness – the dialectic of recognition – comes to a stop. Understanding other persons is not an act of pure generosity, but a necessity inscribed in the fragile condition of being a human Self. The effort to understand others is not only a way to care for the other, but an essential part of the *techne tou biou*, that is of the care for myself.

References

1. Poe EA. The narratives of A. Gordon Pym from Nantucket. Oxford: Oxford University Press; 1998.
2. Kafka F. The metamorphosis. Scotts Valley, CA: Create Space Publishing Platform; 2013.
3. Melville H. Moby Dick. Penguin Classics: Westminster (EN); 2012.
4. Gopnik A, Wellman H. Why the child's theory of mind really is a theory. Mind Lang. 1992;7:145–71.
5. Gordon R. Folk psychology as simulation. Mind Lang. 1986;1:158–71.
6. Stanghellini G, Ballerini M, Mancini M. Other persons: on the phenomenology of interpersonal experience in schizophrenia (ancillary article to EAWE domain 3). Psychopathology. 2017;50:75–82.
7. Ammaniti M, Gallese V. The birth of intersubjectivity. New York/London: Norton; 2014.
8. Merleau-Ponty M. The phenomenology of perception. London: Routledge & Kegan Paul; 1962.
9. Kretschmer E. Hysteria, instinct and reflex. New York: Philosophical Library; 1960.
10. Bourdieu P. Le sens pratique. Paris: Editions de Minuit; 1980.
11. Fuchs T. Intercorporeality and interaffectivity. In: Meyer C, Streek J, Jordan S, editors. Intercorporeality: emerging socialities in interaction. Oxford: Oxford University Press; 2017. p. 3–24.
12. Stanghellini G. Disembodied spirits and deanimated bodies. The psychopathology of common sense. Oxford/New York: Oxford University Press; 2004.
13. Schütz A. Making music together. In: Brodersen A, editor. Collected papers II: studies in social theory. The Hague: Nijhoff; 1976. p. 159–78.
14. Stanghellini G. Lost in dialogue. Anthropology, psychopathology, and care. Oxford/New York: Oxford University Press; 2017.
15. Stanghellini G. The ethics of incomprehensibility. In: Stanghellini G, Fuchs T, editors. One Century of Karl Jaspers' General Psychopathology. Oxford/New York: Oxford University Press; 2013. p. 166–81.
16. Stanghellini G. Philosophical resources for the psychiatric interview. In: Fulford KWM, Davies M, Gipps RGT, Graham G, Sadler JZ, Stanghellini G, Thornton T, editors. Oxford handbook of philosophy and psychiatry, vol. 2013. Oxford: Oxford University Press; 2013b. p. 321–56.
17. Husserl E. The crisis of European sciences and transcendental phenomenology. Northwestern: Evanston, IL; 1970.
18. Schütz A, Luckman T. The structures of the life-world. Evanston, IL: Northwestern University Press; 1989.
19. Stanghellini G, Mancini M. The therapeutic Interview. Cambridge: Cambridge University Press; 2017.
20. Stanghellini G. Phenomenological-hermeneutic resources for an ethics of psychotherapeutic care. In: Trachsel M, Gaab J, Biller-Andorno N, Tekin S, Sadler JZ, editors. The Oxford handbook of psychotherapy ethics. Oxford/New York: Oxford University Press; 2021. https://doi.org/10.1093/oxfordhb/9780198817338.013.18.
21. Gumbrecht A. Production of presence: what meaning cannot convey. Stanford, CA: Stanford University Press; 2004.
22. Gadamer HG. Hermeneutik, Aesthetic, Praktische Philosophie. Heidelberg: Carsten Dutt; 2000.

Intersubjectivity and Neuroscience in the Diagnostic Process

6

Massimiliano Aragona

6.1 Attempts at Neurobiological Explanation of "Objective" Psychiatric Disorders and Symptoms

Since Pinel's foundation of modern psychiatry (the classic 'alienism'), the basic idea was that psychiatric diagnoses reflected medical diseases: real, natural conditions presenting with specific characteristics [1]. Accordingly, one of the first tasks for psychiatrists was to observe naturalistically the signs and symptoms of the disease and their evolution over time, in order to identify and distinguish the various mental diseases occurring in human beings. This early nineteenth century "botanic" idea accompanied psychiatry through the entire twentieth century, from Kraepelin's textbook to the neo-Kraepelinian DSM-III and subsequent editions, and continues also today [2].

If mental symptoms were natural, objective signs that could be observed by the clinician, as is implicitly believed by current models of psychiatric diagnosis, the interviewer should be able to simply elicit observable behaviors that can be easily captured in rating scales that differentiate their formal features. This objective basis would then serve as a sufficient foundation to begin carrying out correlational analyses between symptoms and underlying brain activity.

This is exactly what the reductionist/eliminative materialism approach pursues. In this philosophical view, with the advancement of research, mental phenomena are reduced to their underlying biological causes (the neurobiological dysfunctions responsible for the phenomena), without residuum. Once discovered, the physiopathological mechanisms will replace the phenomenal description, which will be consequently eliminated as no longer necessary. As a general stance, this view has been long held in psychiatry: *Somatiker*, organicists, biological psychiatrists, and the like, all tacitly adopted it in the form allowed by the technical devices available

M. Aragona (✉)
The Roman Circle of Psychopathology, Rome, Italy
e-mail: email.aragona@gmail.com

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_6

at their times. Translated into psychiatry, the aim is to find the brain mechanisms, which, being altered, are responsible for the psychopathological symptom(s) under study. For example, the reduction of auditory hallucinations to dysfunctions of the temporal lobe, or the reduction of delusions to excessive brain levels of dopamine. As already noted by Jaspers, similar ideas are not contradictory, and these research programs are legitimate. However, they usually fail in two ways: first, because mental symptoms are rarely reducible to underlying dysfunctions, and second, because they neglect what is most important in psychiatry: the motivations for a person's behavior, feelings, etc. [3]. We will see below that it is exactly this last issue that is important in the diagnostic process when we try to make sense of what the patient is doing or saying.

First, however, we have to consider the main reason that, despite the rise of neuroimaging techniques and other relevant investments in neo-Kraepelinian programs over the last forty years, the neurobiological dysfunctions underlying mental disorders have remained elusive. Elsewhere [4], I suggested that it is the way the psychiatric classification was conceived that is responsible for this; that is, some key problems are intrinsic features of the system, including high internal diagnostic heterogeneity (i.e., different individuals, with possible different brain functioning, receiving the same diagnosis) and high comorbidity (i.e., several diagnoses in the same individual, so two individuals receiving the same diagnosis can still be different, because they have different comorbidity profiles). These problematic features increase complexity and reduce specificity, loosening the possible relationship (if one indeed exists) between a diagnosis and a corresponding neurobiological etiology. Said differently, a study sample of people with a given diagnosis would be too heterogeneous to allow the identification of a common causal factor.

One possible way to address this is to focus on single symptoms instead of general diagnoses. However, collecting samples of persons with, for example, hallucinations does not increase the desired specificity, considering that hallucinations are present in different mental disorders and there is no reason to believe that "hallucination" is a unique phenomenon, independent of the condition in which it is found. If there are several forms of hallucination, then a unique neurobiological dysfunction explaining all of them is unlikely.

To escape the philosophical difficulties intrinsic to reductionist/eliminative materialism, a more recent proposal of translational cross-validation has been advanced [5]. In this perspective, neuroimaging data are used to study brain activity *while* the experimental subject is filling out psychopathological questionnaires. According to Stoyanov [6], this approach avoids problematic reductionism to embrace a form of supervenience theory, which is philosophically more acceptable (for reasons of space, the reader is referred to the author's article for details.)

However, there is a fundamental methodological issue in this approach. It is not the symptom, but its representation, in form of an item's response, that is entered into the correlation analysis. How shall we interpret the resulting score? Let's take a simple example, such as a neuroimaging study of brain activity, while the patient is answering "almost always" to the item of a self-administered scale asking how often he or she feels sad. What is the mental proxy recorded here? In replying to the

question, is the subject re-enacting sadness, or evaluating his or her sadness, or remembering how it was like, or thinking about the possible reaction of the reader? In other words, even in a very simple act such as answering a simple question, several levels are involved (as we will see in the next section, where the semantic construction of mental symptoms will be discussed).

To sum up, modern mainstream psychiatry has held for more than two centuries (and still does) the basic belief that mental disorders are medical diseases that can be classified into discrete biological categories, as botanists classify plants. In this view, psychiatric disorders are natural objects that can be explained as the output of underlying brain dysfunctions. However, the efforts of reductionist materialism to directly correlate psychiatric disorders and brain mechanisms have not been successful. More recently, translational psychiatry has tried to escape the limitations of the reductionist models and has proposed an in vivo correlation between mental symptoms objectified as scores from rating scales and neuroimaging data. However, the problem is that quantification of mental symptoms in the form of items' scores conceals their semantic nature, so at a closer look, the problem of interpreting what a given score effectively means remains open [7].

Before discussing the neuroscientific issues concerning intersubjective features in the diagnostic process, we shall consider the shift from a psychiatry targeting the "objectification" of symptoms to psychopathological models considering the subjective and intersubjective nature of the majority of mental symptoms.

6.2 The Intersubjective Construction of Mental Symptoms in Clinical Practice

Mainstream psychiatry has tried to objectify mental symptoms, believing that in this way, it would be possible to treat them in a scientifically validated way and discover the brain dysfunctions responsible for them. Accordingly, although diagnostic systems like the DSM-III (and subsequent versions) were supposed to be "atheoretical," in truth, they are based on neo-positivist and neo-Kraepelinian theories fostering biological psychiatry [8]. A real-world interview is much more complex than this model, because usually, mental symptoms are not preformed objects but the product of personal and interpersonal activity of semantic construction that requires interpretative skills by both the patient and the psychopathologist.

To acknowledge this complexity, the Cambridge School developed a model of symptom formation that highlights the importance of the interplay between neurobiological activity and hermeneutic construction occurring in the dialogical encounter characteristic of psychiatric interviews [9–11]. Four pathways of symptom formation have been postulated: nature, personal capacities and narratives, familial and social idioms of distress, and *interpersonal* negotiation of meaning. These pathways are all operative and intertwined at different levels. Depending on the way symptoms arise and are configured, their structures will vary in terms of the extents to which the biological and semantic factors mentioned above will contribute to their formation.

In other words, in order to complain about an experienced mental symptom, patients first need to identify, differentiate, and denominate such an experience. Cultural ways to perform this "configuring" activity are apprehended during personal development, with some degree of variability even within the same cultural or familial context. Thus, personal, familial, and sociocultural factors co-operate to act together in shaping the so-called idioms of distress. For example, some patients report their distress in the symptomatic form that is more usual and "expected" in their sociocultural context. Other patients may configure similar experiences in a more idiosyncratic modality. In both cases, the same original experience is shaped according to personal and sociocultural factors.

In a second hermeneutic step, interactional and intersubjective influences are involved. For example, the clinician may play a fundamental role, influencing the formation of the articulated symptom. Particularly where it is perhaps difficult for an individual to define or make sense of a particular experience, the interlocutor may strongly contribute to this shaping of experience, both through direct suggestion as well as by a process of joint construction/negotiation. This is particularly relevant when clinical interviewing may actively help the subject to disambiguate complex subjective experiences. Accordingly, working diagnostic hypotheses may introduce important biases in the way in which the clinical interviewer helps the subject to reconfigure the final version of the mental symptom. Finally, it should be stressed that such influences are not only cognitive/theoretical (e.g., having a preformed diagnostic hypothesis) but also, and significantly, emotional, that is, the entire subjective resonance of the clinician confronted with his patient is part of the interview.

Of course, there are symptoms that bypass consciousness and its secondary elaboration, that is, that are the direct expression of basic neurobiological activity. In this case, the search for a direct correlation between symptom and neurobiological mechanism makes sense. However, for the most part, mental symptoms start as described above; that is, with something arising in the consciousness field, some first-person experience, which, to be grasped by the subject and communicated, needs to be enveloped in semantic structures. Accordingly, in the majority of cases, there is not a direct correspondence between mental symptom and neurobiological events [12].

To sum up, the diagnostic act is not a neutral description of a natural object, but the complex result of active semantic construction by the patient (first-person experience) and of co-construction within the dialogical encounter with the psychopathologist (intersubjectivity). It was stressed elsewhere that, as a consequence, in psychopathology, the subjective sphere is fundamental and cannot be excluded from research projects on mental symptoms [13].

6.3 The Neuroscientific Study of First-Person, "Lived" Experience

If many mental symptoms are not objects but personal experiences, are they suitable for neuroscientific study? As already noted, the reductivist mechanistic perspective has serious limitations in this field. Limitations have also been noted when considering the transformation of personal experience into scores derived from answers to

psychiatric questionnaires. To my knowledge, the movement that has most conscientiously designed neuroscientific studies of first-person experience is neurophenomenology. Based on the insights of the phenomenological movement regarding the analysis of the field and acts of consciousness, neurophenomenologists try to correlate lived experience and neuroscientific data. The basic claim is that instead of being subjective "noise," first-person accounts should be taken "seriously as valid domain of phenomena" ([14], p. 346) that enrich the experimental setting. For example, in a perceptive task experiment, the basic and variable electroencephalographic (EEG) activity (unrelated to the perceptive task) was not considered as *noise* but rather as related to different experiential states of the subject (some subjects were focused on the task, others were distracted, and so on) [15].

Being aware of the methodological risks involved in directly correlating brain areas and mental phenomena, the neurophenomenologists added complexity: on the neuroscientific side, it was claimed that the relevant neural processes measured in neurophenomenological studies weren't single neural processes, but highly integrated, differentiated, and transient dynamic links in a distributed neural population [15]. Moreover, to reduce the explanatory gap between the two poles of the correlation (i.e., phenomenological and neuroscientific evidence), a third domain was introduced: "Formal models and analytical tools from dynamical systems theory, grounded on an embodied-enactive approach to cognition" ([15], p. 34). Finally, recent studies have tried to extend the field of application of neurophenomenology from free experience (as in the experiment described above) to the interpretation of phenomena, which are relevant for psychopathology; for example, mood in major depression [16] or "minimal self-disturbances" (fragility in implicit first-person perspective, presence, and agency) in early psychosis [17].

However, there are some limitations to the neurophenomenological approach. Theoretically, I have argued elsewhere [18] that neurophenomenologists often use phenomenology as a mere descriptive psychopathology (and not as a study of intentionality) and that, above all, their model is at risk of concealed reductionism. Particularly risky is Petitot's proposal of naturalization of neurophenomenology [19]. However, I also showed that Varela's requirement for mutual constraints between biophysical data and data produced by accounts of subjective experience [14] was developed in a similar vein.

The body of research studies of psychopathological phenomena using a neurophenomenological method is limited to a few instances (e.g., [17, 20]). If this is the state of the art for neuroscientific studies of subjective experiences, what is the level reached by neuroscientific studies of intersubjective phenomena? Surprisingly, there are plenty of studies on a few interpersonal phenomena, as we will see in the next section.

6.4 The Neuroscientific Study of Intersubjective Experience: The Case of Empathy

The discovery of mirror neurons [21] fostered an upsurge in interest in empathy, that is, the phenomenon of putting oneself in another's shoes. This phenomenon, which is at the basis of intersubjectivity, has been lengthily debated in philosophy

and psychology. A version of this phenomenon (i.e., having an idea of what the other person believes) was already discussed in cognitive science (labelled as "theory of mind" or "theory-theory") before mirror neurons were detected in monkeys observing a conspecific making intentional movements. After their discovery, hundreds of studies explored the existence and features of mirror-like activity in humans, and the so-called simulation theory was proposed as an alternative to the "theory of mind." It seemed that the neurobiological mechanism responsible for empathy had finally been discovered.

However, a few years ago, two of the major neuroscientists in this field wrote that there are probably as many definitions of empathy as people working on it [22]. This served to highlight the fact that researchers tended to use the definition of empathy, which fit best into their research design, without an agreement on a common definition. However, there was something deeper as well: the implicit recognition that empathy is a concept that is intrinsically polysemic. Indeed, there is not a single definition of empathy; its meaning depends on the basic scientific/clinical/philosophical questions being asked. For example, in previous writings, our group showed that there are several levels to be considered, and while one possibility is to ask how intersubjectivity is possible (the argument against solipsism), another is to ask, provided that, *de facto,* we live in an intersubjective world, how we grasp and understand what the other person is experiencing [23]. More recently, I suggested that in human psychic development, these two levels are different but sequential: "Once a subjectivity and a clear self-other distinction are developed, then we have the pre-conditions necessary for empathy: i.e. the capability of understanding what the other is feeling by putting oneself in the other's shoes, contemporarily being conscious that we are two different persons. I can feel something similar to what you are feeling (Type) but not exactly what you are actually feeling (Token)" ([24], p. 76).

These conceptual distinctions were not valued enough in early neuroscientific research, although it had to be already clear that, provided that the explanandum is heterogeneous, we could not expect to discover a common mechanism explaining it. In fact, in early interpretations, the activity of mirror neurons was believed to be *the* mechanism underlying empathy. Furthermore, empathy being a broad concept, interpretations were alternatively directed to empathy as a basis for intersubjectivity [25] or empathy as putting oneself in the other's shoes [26], without a clear understanding of the conceptual difference. We will see that this basic assumption of empathy as a unique phenomenon to be explained is now rejected also by the neuroscientists, whose studies revealed more complexity than previously thought.

To highlight this point, it is useful to concentrate on one portion of the studies on empathy in neuroscience; that is, those focused on empathy for the other's physical pain. I choose empathy for pain, because it is the empathy-related phenomenon with the most research in the era of neuroscience, so we can avoid problems derived from insufficient data. Moreover, since pain is a well-determined phenomenon, we can also avoid problems of insufficient phenomenal characterization. Finally, the neurobiological activity underlying the experience of pain (the so-called pain matrix) is better understood than that of any other psychic phenomenon.

Neuroscientific research has investigated empathy for pain by comparing the brain function of a person suffering from pain to that of the same person while empathizing with another person in pain. For example, in a seminal paper, Tania Singer and her colleagues [27] used functional magnetic resonance imaging (fMRI) to assess activated brain areas during actual painful stimulus perception versus areas activated when the painful stimulus was delivered to a significant other. The experimental subjects were women directly receiving painful hand stimulation, and believing that pain was also delivered to their partners when a light was flashing. The pattern of brain activation of the two conditions grossly overlapped, particularly for the "emotional" areas involved in usual pain perception. Since then, several studies have added evidence to this early report of a mirror-like activation of pain areas. The following are some examples of this progressive integration and enrichment of the initial evidence. It was found that the somatosensory areas were also involved [28]. A "simpler" empathy, related to the mapping of an external sensory stimulus, was distinguished from a "complex" form of empathy associated with affective tuning [29]. Women and men showed differences in their empathic reactions, which were modulated by the perceived fairness of others [30]. Empathic brain activation differed depending on the basic empathic capacities of the experimental subjects [31] as well as on pain previously experienced in person [32], thus underlying the importance of first-hand experience and personal features. Psychopathic traits in youths decreased the empathic brain activation in some areas [33]. The empathic response was different when pain was observed in a person with a different color of the skin [34], but this effect was reduced by social integration [35]. The automatic part of the empathic response was modulated by self/other distinction and valence attribution areas [36]. A component related to the self/other distinction was activated when pain was inflicted on a stranger and deactivated in the case of pain felt by themselves or loved ones. Meanwhile, the bottom-up, automatic component of empathy was activated in all cases, as expected, but was significantly stronger for self and loved ones than for strangers, suggesting a modulatory role of the former areas [37]. Another study underlined the importance of the context of the painful event to the elicitation of an empathic response, showing that top-down mechanisms independently generated in the cortex modulated the basic automatic process of somatic and motor resonance. In this case, mirror-like activity was modulated by the expectation of a beneficial or negative effect of pain stimuli inflicted on supposedly ill subjects [38]. A temporal dynamic was also detected, with an early, bottom-up component of empathy, linked to emotional sharing and self-distress in response to viewing a conspecific suffering, and another late, top-down component, related to cognitive evaluation [39].

These are only a few examples from the widespread literature on this issue, but are sufficient to show that with the advancement of research, experimental neuroscientific research results have revised early assumptions about brain function during empathy, progressively integrating the simplistic implicit, automatic, bottom-up model of mirror neurons directly activated by the stimulus, with a more complex one. The latter considers the automatic part only as a first, early basic component of the empathic phenomenon, which in its full phenomenal expression involves finer

top-down influences and a temporal differentiation of several subcomponents [23]. Echoes of this complexity are also present in a more recent theoretical model, which, on the basis of experimental findings, suggests that a "mirror neurons system" is active at early stages of social information processing (involved in the "detection" of spatial or bodily signals), whereas a "mentalizing system" would be recruited during late stages of social information processing (related to the "evaluation" of the other's emotional and psychological states) [40]. Probably, the reduction of the complexity to two distinct "social brains" maintains a simplistic tendency to reductionism. The acknowledgment that mirror neurons alone are insufficient to explain complex intersubjective interactions, however, is significant. As shown elsewhere, the recognition of the neurobiological complexity of the dynamics related to empathic processes does not answer all the clinical and philosophical questions posed by psychologists and philosophers. Nevertheless, the attempts by researchers to address certain problems through neuroscientific theories are important, because they retroactively influence the debate on other levels, fostering a *cross-talk* between different disciplines that benefits all participants [41].

6.5 Discussion

With technical and theoretical advancements in the neurosciences, the question of primary importance that has emerged is how to use the new possibilities opened by these advancements to foster psychopathological research. Several models, with bases in different philosophical views about the mind-body problem, are addressing this challenge.

In the psychiatric diagnostic process, the interviewer needs to identify, define, and denominate the formal features of the mental symptoms presented by the patient, in order to arrive at a diagnostic judgment about the mental disorder(s) detected. Although psychiatric diagnostic manuals are based on the view that mental symptoms are objects that the interviewer detects and describes, I have emphasized that in diagnosing a mental disorder, the clinician must not restrict himself or herself to a measurement of behaviors, their frequency, and the like. The subjective experience of the patient is an essential part of the mental condition under examination. Accordingly, the interviewer needs to grasp what the patient is experiencing, to define and denominate its formal features, to test whether and how it resonates with his or her own experience of similar phenomena, to become aware of his or her own emotional reactions elicited by the patient's interpersonal communication, and so on. All this is based on empathic capabilities, which need to be technically modulated to reach therapeutic goals [24].

Therefore, provided that intersubjective dynamics have diagnostic relevance, the question posed in this chapter is whether neuroscience can help in better conceiving these (largely implicit) processes.

Empathy for pain was used as a concrete example of how neuroscience has explored an intersubjective phenomenon. It has been shown that, with the advancement of research, past early research models of automatic bottom-up activity have

been replaced by more complex ones. These newer models include multiple areas involved in the network, a top-down modulation structure, and a temporal dynamic of activation. At the same time, the image reflected back to conceptual studies by neuroscientific research acknowledged the phenomenological insight that empathy is not a unitary phenomenon and that mirror neurons are not its explanation, but a mechanism involved in one of its components. In turn, conceptual research was solicited by the new findings to reconsider previous phenomenal distinctions to include the arising temporal dynamic (an ongoing conceptual work).

The example of empathy for pain was therefore used (a) to show that research on intersubjective phenomena is feasible; (b) to discard as inadequate the reductionist model looking for one common mechanism underlying a unitary empathy; (c) to exemplify a model of interdisciplinary research in which phenomenological analyses might suggest to the experimenter possible variations to the experimental design, in order to consider some phenomenal issues or details of which he or she was unaware. Conversely, the phenomenologist could be solicited by some experimental findings to reconsider his or her phenomenological analysis to see if the phenomenon addressed could be more complex than previously thought.

Considering that this was possible in the case of empathy for pain, what might be possible for the other overlapping intersubjective features we are used to considering during a psychiatric interview? For example, how can the cognitive and emotional reactions of the clinician to the patient's "communication" be studied? How can the reaction of the patient himself or herself to the encounter with the clinician be studied? To my knowledge, these intersubjective levels have sometimes been explored indirectly; for example, by studying joint attention by means of eye-tracking instruments. This shows that it is possible to make inferences about subjective experience in interpersonal exchanges starting from behavioral observations. It is more difficult, however, to design studies directly exploring the intersubjective experience characterizing the psychiatric encounter in relation to neurobiological activity. This is because the personal experiences of both patient and clinician involve semantic/hermeneutic shaping. However, it is not an impossible task.

Regarding the patient's first-person experience occasioned by the encounter with the clinician, some inferences can be made from studies about the empathic abilities of patients with various diagnoses (*in primis* autistic spectrum disorders) and about the patients' competency in "social cognition" (another name currently used to explore this area). However, to my knowledge, studies directly addressing the neurobiological correlates of the personal experience of the patient during the diagnostic interview are not available.

Regarding the clinician's first-person experience occasioned by the encounter with the patient, for many years, the scientific community refused to make use of interrelated concepts such as intersubjective resonance, reciprocal attunement, countertransference, understanding, atmospheric perception, praecox feeling, etc. In fact, they were considered too subjective and vague to be used in scientific research, although they continued to be used in clinical settings where they maintained their usefulness (indirectly attested by evidence of the importance of nonspecific factors like patient–clinician alliance and empathy for the efficacy of

psychotherapies [42]). However, things are changing. For example, recent psychopathological research developed new assessment instruments to measure the clinician's subjective experience with the patient [43], leading to a renewed interest in classical concepts like that of praecox feeling [44], now formulated in terms acceptable for scientific research. Together with psychopathological studies constructing and validating assessment instruments for other phenomena (e.g., anomalous self-experiences, anomalous experience of the lived world, anomalous bodily phenomena, etc.), this is part of the present-day advancement of European psychopathology, which is not afraid to confront itself in the arena of empirical research. Nevertheless, despite this progress, the question remains similar to that already shown in the case of the translational programs seeking correlations between scores from psychiatric questionnaires and neurobiological proxies. What phenomenon is represented by a score on a given set of items in a scale measuring the subjective experience of a clinician during the diagnostic interview? Is he or she still feeling it? Is he or she remembering? Is he or she reliving? Is he or she judging? The limitations are of the same kind, rendering unsatisfactory a reductionist program of direct correlation between items' scores and neurobiological proxies.

In my view, research pointing to better ways to correlate mental and neurocognitive phenomena occurring in the intersubjective sphere might be useful if aimed at increasing the dialogue between the two sides in ways similar to those exemplified above in the case of the cross-talk about empathy for another's pain. It is immediately clear that, despite the complexity shown in the previous section, empathy for pain remains a quite simple phenomenon compared with the multiple intertwined levels involved in a psychiatric interview. Nevertheless, if the possibility exists, it shall be in this direction. As in other fields, even in the case of intersubjectivity in diagnostic processes, researchers should firstly work on phenomena; that is, their first task would be that of differentiating the several components involved in the intersubjective relationship in order to single out the elements that could be suitable (that is to say, simple enough) to be subjected to experimental research. Then, researchers could conceive a possible experimental setting capable of representing a part of the intersubjective dynamic occurring during a psychiatric interview. Finally, paralleling what happened with empathy for pain, the experimental results could then send back information about unobserved complexities of the phenomenon, allowing for a recursive revision of the first phenomenal characterization, and so on.

This recursive activity of breaking down complex phenomena into parts suitable for experimental research, and then trying to put together results to return an image of the whole, is probably unavoidable but risky. In fact, it is exposed to the same limitations and criticism encountered by Wundt at the dawn of the nascent field of experimental psychology. If history teaches us anything, it is that such "elementalist" research projects need to be complemented by the search for gestaltic general rules, because it is predictable that psychological phenomena will resist complete reduction to their parts. Nevertheless, an elementalist approach is initially necessary to conceive simple experiments testing minor components of the complex

intersubjective dynamic occurring in a diagnostic process. Other limitations such as the reduction to brief happenings of a process occurring over time, and disconnection from the ecological dynamic, are also relevant. Nevertheless, they can be considered later, after a few initial experiments have proven that the project of studying the neurobiological correlations of the intersubjective dynamics occurring in a diagnostic setting makes sense and is technically feasible.

There is a long way to go, but for the first time in psychiatric history, these types of studies can be conceived as projects in the realm of the realistic and of the achievable.

References

1. Pinel P. Traité médico-philosophique sur l'aliénation mentale ou la manie. Paris: Caille&Ravier; 1801.
2. Aragona M. La malattia mentale come disfunzione neurobiologica. Storia delle idee, problemi e proposte. In: Guerini R, Marraffa M, editors. Psicopatologia e scienze della mente. Dalla psichiatria organicistica alla neuroscienza cognitiva clinica. Rome: Carocci Editore; 2019. p. 21–36.
3. Jaspers K. Allgemeine Psychopathologie. Berlin: Springer Verlag; 1913.
4. Aragona M. Aspettando la rivoluzione. Oltre il DSM-V: Le nuove idee sulla diagnosi tra filosofia della scienza e psicopatologia. Editori Riuniti: Roma; 2006.
5. Stoyanov DS. The cross-validation in the dialogue of mental and neuroscience. Dial Phil Ment Neuro Sci. 2009;2:24–8.
6. Stoyanov DS. Methodological challenges before translation from psychopathology to neuroscience: top-down or bottom-up models? Dial Phil Ment Neuro Sci. 2020;13:1–7.
7. Marková IS. Translational neuroscience and psychiatry: a conceptual analysis. J Eval Clin Pract. 2018;24:791–6.
8. Aragona M. Neopositivism and the DSM psychiatric classification. An epistemological history. Part 1: theoretical comparison. Hist Psychiatry. 2013;24:166–79.
9. Berrios GE. Formation and meaning of mental symptoms: history and epistemology. Dial Phil Ment Neuro Sci. 2013;6:39–48.
10. Aragona M, Marková IS. The hermeneutics of mental symptoms in the Cambridge School. Rev Latinoam Psicopatol Fundam. 2015;18:599–618.
11. Marková IS, Chen E. The hybrid structure of psychiatry. Dial Phil Ment Neuro Sci. 2020;13:36–42.
12. Marková IS, Berrios GE. Neuroimaging in psychiatry: epistemological considerations. In: Zachar P, Stoyanov DS, Aragona M, Jablensky A, editors. Alternative perspectives on psychiatric validation. DSM, ICD, RDoC, and beyond. Oxford: Oxford University Press; 2015. p. 112–27.
13. Aragona M. The study of subjective experience as a scientific task for psychopathology. J Eval Clin Pract. 2012;18:155–6.
14. Varela FJ. Neurophenomenology. A methodological remedy for the hard problem. J Conscious Stud. 1996;3:330–49.
15. Lutz A, Thompson E. Neurophenomenology. J Conscious Stud. 2003;10:31–52.
16. Kiverstein J, Mark Miller M, Rietveld E. How mood tunes prediction: a neurophenomenological account of mood and its disturbance in major depression. Neurosci Conscious. 2020;6:niaa003.
17. Nelson B, Lavoie S, Gawęda Ł, Li E, Sass LA, Koren D, et al. The neurophenomenology of early psychosis: an integrative empirical study. Conscious Cogn. 2020;77:102,845.

18. Aragona M. Phenomenology, naturalism, and the neurosciences. In: Stanghellini G, Broome M, Raballo A, Fernandez AV, Fusar-Poli P, Rosfort R, editors. The Oxford handbook of phenomenological psychopathology. Oxford: Oxford University Press; 2018. p. 273–83.
19. Petitot J. La réorientation naturaliste de la phénoménologie. Archives de Philosophie. 1995;58:631–58.
20. Facco E, Casiglia E, Al Khafaji BE, Finatti F, Duma GM, Mento G, Pederzoli L, Tressoldi P. The neurophenomenology of out-of-body experiences induced by hypnotic suggestions. Int J Clin Exp Hypn. 2019;67:39–68.
21. Rizzolatti G, Sinigaglia C. So quel che fai. Il cervello che agisce e i neuroni specchio. Raffaello Cortina: Milano; 2006.
22. de Vignemont F, Singer T. The empathic brain: how, when and why? Trend Cogn Sci. 2006;10:435–41.
23. Aragona M, Kotzalidis G, Puzella A. The many faces of empathy: between phenomenology and neuroscience. Arch Psychiatry Psychother. 2013;4:5–12.
24. Aragona M. The hermeneutic complexity of therapeutic empathy. Dial Phil Ment Neuro Sci. 2019;12:75–6.
25. Gallese V. The roots of empathy: the shared manifold hypothesis and the neural basis of intersubjectivity. Psychopathology. 2003;36:171–80.
26. Gallese V, Goldman A. Mirror neurons and the simulation theory of mind-reading. Trends Cogn Sci. 1998;2:493–501.
27. Singer T, Seymour B, O'Doherty J, Kaube H, Dolan RJ, Frith CD. Empathy for pain involves the affective but not sensory components of pain. Science. 2004;303:1157–62.
28. Avenanti A, Bueti D, Galati G, Aglioti SM. Transcranial magnetic stimulation highlights the sensorimotor side of empathy for pain. Nat Neurosci. 2005;8:955–60.
29. Avenanti A, Minio-Paluello I, Bufalari I, Aglioti SM. Stimulus driven modulation of motor-evoked potentials during observation of others' pain. Neuroimage. 2006;32:316–24.
30. Singer T, Seymour B, O'Doherty JP, Stephan KE, Dolan RJ, Frith CD. Empathic neural responses are modulated by the perceived fairness of others. Nature. 2006;439:466–9.
31. Avenanti A, Minio-Paluello I, Bufalari I, Aglioti SM. The pain of a model in the personality of an onlooker: influence of state-reactivity and personality traits on embodied empathy for pain. Neuroimage. 2009;44:275–83.
32. Valeriani M, Betti V, Le Pera D, De Armas L, Miliucci R, Restuccia D, et al. Seeing the pain of others while being in pain: a laser-evoked potentials study. Neuroimage. 2008;40:1419–28.
33. Marsh AA, Finger EC, Fowler KA, Adalio CJ, Jurkowitz IT, Schechter JC, et al. Empathic responsiveness in amygdala and anterior cingulate cortex in youths with psychopathic traits. J Child Psychol Psychiatry. 2013;54:900–10.
34. Azevedo RT, Macaluso E, Avenanti A, Santangelo V, Cazzato V, Aglioti SM. Their pain is not our pain: brain and autonomic correlates of empathic resonance with the pain of same and different race individuals. Hum Brain Mapp. 2013;34:3168–81.
35. Sheng F, Han S. Manipulations of cognitive strategies and intergroup relationships reduce the racial bias in empathic neural responses. Neuroimage. 2012;61:786–97.
36. Lamm C, Nusbaum HC, Meltzoff AN, Decety J. What are you feeling? Using functional magnetic resonance imaging to assess the modulation of sensory and affective responses during empathy for pain. PLoS One. 2007;2:e1292.
37. Cheng Y, Chen C, Lin CP, Chou KH, Decety J. Love hurts: an fMRI study. Neuroimage. 2010;51:923–9.
38. Lamm C, Batson CD, Decety J. The neural substrate of human empathy: effects of perspective-taking and cognitive appraisal. J Cogn Neurosci. 2007;19:42–58.
39. Fan Y, Han S. Temporal dynamic of neural mechanisms involved in empathy for pain: an event-related brain potential study. Neuropsychologia. 2008;46:160–73.
40. Vogeley K. Two social brains: neural mechanisms of intersubjectivity. Phil Trans R Soc B. 2017;372:20160245.

41. Aragona M, Kotzalidis G, Puzella A. Empathy: the crosstalk between humanistic disciplines and neuroscience. In: Stoyanov D, editor. Psychopathology: theory, perspectives and future approaches. New York: Nova Publishers; 2013. p. 151–80.
42. Wampold BE. How important are the common factors in psychotherapy? An update. World Psychiatry. 2015;14:270–7.
43. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Assessing clinician's subjective experience during interaction with patients. Psychopathology. 2014;47:111–8.
44. Pallagrosi M, Fonzi L. On the concept of praecox feeling. Psychopathology. 2018;51:353–61.

7 Origin and Development of the *Assessment of Clinician's Subjective Experience* (ACSE)

Mauro Pallagrosi, Angelo Picardi, Laura Fonzi, and Massimo Biondi

7.1 Introduction

It has been thoroughly illustrated in previous chapters how emerging epistemological issues in psychiatry have been addressed—in history and in current times—by phenomenological psychopathology, cognitive science, psychoanalysis, and neuroscience. A crucial point of convergence among such proposals is no doubt represented by the specific attention paid to the role of intersubjective phenomena in the process of understanding and diagnosis during the clinical encounter.

As a matter of fact, the unshakable faith in the power of *objectivity* and *reliability* in psychiatric assessment has not been supported, over the years, by an equally satisfactory picture of the diagnosable illnesses [1–3]. The *scientific* evidence provided by neurobiology, neuroimaging, and genetics has not yielded patterns that clearly match up with the current diagnostic categories, and this prevents researchers from establishing their real validity [4, 5]. Without a biological validation, the modern diagnostic categories have become a sort of group of empty containers, only

M. Pallagrosi (✉)
Community Service for Prevention and Early Intervention in Mental Health, Rome 1 Local Health Unit, Rome, Italy
e-mail: mauro.pallagrosi@uniroma1.it

A. Picardi
Centre for Behavioural Sciences and Mental Health, Italian National Institute of Health, Rome, Italy
e-mail: angelo.picardi@iss.it

L. Fonzi
National Institute of Training, Italian Psychoanalytic Society, Rome, Italy
e-mail: laura.fonzi@hotmail.it

M. Biondi
Department of Human Neurosciences, Sapienza University of Rome, Rome, Italy
e-mail: massimo.biondi@uniroma1.it

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_7

definable through criteriological algorithms based on a statistical co-occurrence criterion. Conversely, several in-depth psychopathological and phenomenological *prototypical* descriptions have offered over the years the possibility to deal with meaningful psychopathological entities, identified through a process of immersion in the patients' *subjective* experience. These entities, however, require investigation by means of the psychiatrist's relational and diagnostic expertise, since they mostly elude *objective* and *reliable* diagnostic interviews.

In substance, despite the amount of evidence collected through the decades, psychiatry still faces an open question: *How can we effectively classify and properly investigate the structures of the human psychopathological experience*? [6–9].

The line of research described in this chapter places itself into the epistemological debate, aiming in particular at empirically supporting the claim of a role for intersubjectivity as a privileged means to explore the patient's experience. Its ultimate scope is in fact to scientifically restore the role of *reciprocity* as a core dimension for both the diagnostic process and therapeutic intervention.

This research relies on the development of a psychometric instrument purposely designed to grasp the clinician's subjective experience during the clinical encounter, which can be considered as a meaningful reflection of the latter's intersubjective dynamics. The construction and validation of this instrument, named the *Assessment of Clinician's Subjective Experience* (ACSE), are the main object of this chapter, while its clinical applications will be presented in the following one.

7.2 Background and Development

7.2.1 Clinical and Theoretical Foundations

The idea of quantitatively assessing the clinician's subjective experience through a psychometric instrument primarily stemmed from our everyday clinical practice and was theoretically informed by the phenomenological literature [10]. From a "real world" perspective, we know that a psychiatrist deals with the human dimension of the encounter almost every day, being continuously permeated by its emotional, resonant, and meaningful atmosphere (see Sholokhova [11] for an acute reflection on this subject). This intersubjective immersion cannot be eluded, especially during the early stages of the acquaintance with the patient, when a substantial exploratory effort is required from the clinician.

In truth, it is not infrequently that the intersubjective immersion itself provides the psychiatrist with a number of implicit suggestions about the patient's condition or personality. For example, it is a common experience among clinicians that they can *sense* the bizarreness of a patient even without or before the recognition of his or her psychotic symptoms, or that they can *feel* an idiosyncratic struggle when facing patients with certain personality organizations. These perceptions are often subtle and tacit, and can receive more or less credit depending on the theoretical and personal attitude of the clinician himself.

However, personal impressions are mostly considered, within the modern scientific community, as an insidious source of unreliable judgments, to the point that their exclusion has been often presented as a necessary step to improve the quality of diagnostic practice. Indeed, the widespread use of algorithmic models and rating scales has been substantially promoted with the goal of limiting any subjective influence [12].

From an epistemological perspective, nevertheless, it could be questioned whether an approach based on interviews seeking *predetermined* symptoms and signs, suitable to be arranged in *preformed* diagnostic categories, carries the risk of being tautological [13]. In this way, in fact, all the dimensions of the patient's psychopathological experience that are not explicitly targeted by the algorithm are simply neglected, resulting in an impoverished assessment. Moreover, the unnatural marginalization of the subjective character of the clinical encounter, which is inherent to the human situation of two people interacting with each other, entails the denial of the dialogical, exploratory—and prospectively therapeutic—value of the assessment, reducing it to an inert collection of symptoms and signs.

In previous chapters, it has been discussed how a substantial body of thought has provided well-supported credit to the epistemological significance of intersubjective experience. Phenomenology, psychoanalysis, cognitive sciences, and even neuroscience have acknowledged—albeit differently—the relevance of the clinician's subjective perceptions to understanding the patient, and have integrated these apparently arbitrary experiences into meaningful conceptual frameworks. In particular, phenomenologically oriented scholars have introduced paradigms such as *empathy* and *second-person understanding*, in order to clarify how the clinician's subjectivity can work as a probe of the patient's disturbances in the dynamic and mutual process of interacting [6, 8, 14–16].

Classical psychopathologists, for their part, were already familiar with the importance of interpersonal perceptions in guiding the expert psychiatrist toward an accurate diagnosis. They grasped what we now call "intersubjective comprehension" through expressions such as *empathic*, *intuitive*, *penetrating,* and *atmospheric* understanding (see Chap. 1 for a thorough review). Also, in their view, the patient's way of *being-with-others* in fact reverberates—in a pre-reflective way—in the clinician's experience, and this reverberation can be translated into a useful diagnostic feeling.

However, in the era of operationalization, both clinical prompts and well-established bodies of knowledge risk being discarded in the absence of solid empirical evidence to corroborate them. This is the reason why we decided to investigate the everyday clinician's subjective experience *through a standardized process of description and quantification*, accepting the challenge of exploring intersubjective phenomena by means of an objective method. It allowed us, in fact, to address both a scientific and an ethical need.

On the one hand, we followed the view expounded by the phenomenologist Dan Zahavi, who has repeatedly fostered the fruitfulness of a thoughtful integration between the phenomenological theoretical formulations and the investigations of empirical sciences [17, 18]. In particular, we adopted his proposal of

using phenomenologically derived concepts to carry out "local regional-ontological investigations," in an effort to fill the gap between the first-person understandability of subjective experience and the third-person objectifying method of natural science. This integration has indeed proven to be effective and profitable for the so-called phenomenological scales, which operationally describe, in a clinically meaningful way, different kinds of patients' subtle subjective experiences [19–21].

On the other hand, we pursued the ambition to substantially contribute to a renewed attention to the relational nature of the psychiatric encounter, which may prompt clinicians to return to a more thoughtful and comprehensive approach to assessment. The abandonment of a (presumed) neutral and "technical" disposition, in fact, not only might promote a deeper understanding of the patient's psychopathological world, but also might encourage an openness toward such a world, which in itself could help the patient to emerge from her pathological seclusion, starting a therapeutic process.

7.2.2 Current Empirical Evidence About the Clinician's Subjective Experience

Despite the amount of clinical and theoretical suggestions on the key role of the psychiatrist's subjective experience in comprehending the patient's psychopathological world, relevant empirical investigations are scarce. Probably, this is one of the reasons why mainstream psychiatry neglects this dimension of the assessment, assuming *de facto* its unreliability.

A few researchers have attempted, nonetheless, to provide scientific integrity to the domain of the clinician's feelings and subjective reactions to the patient, pursuing different but contiguous aims.

7.2.2.1 The *Praecox Feeling* in the Diagnosis of Schizophrenia

The effort to empirically test the validity and reliability of Rümke's *Praecox Feeling* in the diagnosis of schizophrenia has been encouraged not only by the classical psychopathologists, but also by a number of surveys showing the extent to which many psychiatrists still consider the "poor rapport" with the patient [22] and the feeling of "alienity" [23] as important guides to identify schizophrenia.

However, only two studies have dealt with a detailed analysis of the diagnostic potential of the *Praecox Feeling*. The first [24] provided data about the perception of *Praecox Feeling* by one experienced psychiatrist who evaluated 67 patients with paranoid hallucinatory syndromes. When compared with the diagnosis made according to ICD-10 and DSM-IV criteria, the clinician's "feeling," which was rated on a scale ranging from "not present" to "high," showed high sensitivity and high positive predictive value. In addition, it was found to be significantly correlated with the degree of "affective disturbance" observed in the patients, which corroborated Rümke's original claim.

The other study, by Ungvari and colleagues [25], considered the presence/absence of *Praecox Feeling* in five clinicians who evaluated 102 patients admitted

to an acute psychiatric unit. In contrast to the high sensitivity and positive predictive value shown in the Grube et al. study [24], when compared with the DSM-IV standard diagnosis, the clinicians' feelings in the Ungvari et al. study [25] showed largely inconsistent sensitivity, and generally low positive predictive values, whereas the negative predictive ones were acceptable. The agreement between the clinicians was also poor, although this finding was probably affected by the situation, as the participants only attended the visits and did not personally interact with the patients.

The sparse and inconsistent results of these kinds of studies have so far prevented researchers from drawing solid conclusions about the real weight and trustworthiness of *Praecox Feeling* in the clinical practice. The aforementioned conflicting evidence, however, has contributed to the raising of critical questions about the appropriateness of the methods to be used in studying such an ineffable subjective experience.

The first of two such questions is a matter of reliability. In order to gain confidence in the discriminating power of a subjective perception, we should bear in mind that the recruitment of a proper number of heterogeneous clinicians, the clinicians' direct involvement in the interaction with patients, and the use of validated tools to explore their feelings are pivotal.

The second is a matter of epistemology. *Praecox Feeling*, as well as other described modes of "subjective" diagnostics, entails a multifaceted experience that is not reducible to a single one-dimensional sensation [26]. The presence/absence criterion, thus, sounds inadequate to effectively identify it. A thorough investigation of the emotional, perceptual, and bodily nuances of this kind of experience requires, instead, an almost equally sophisticated assessment tool, capable also of accounting for its articulated relation with a number of clinical variables.

7.2.2.2 Psychometric Scales Measuring the Therapist's *Countertransference*

The empirical interest regarding the therapist's emotional response to the patient is not rooted in the psychopathological tradition, but arises mainly from the psychoanalytic discourse on the phenomenon of *countertransference* (see Chap. 10 for a complete review). The body of evidence regarding this phenomenon mostly relies upon the application of two assessment tools: the *Therapist Response Questionnaire* (TRQ) [27] and the *Feeling Word Checklist* (FWC) [28].

The TRQ (originally *Countertransference Questionnaire*) was introduced in 2005 with the aim to describe the *countertransference* feelings experienced by psychotherapists during their work with patients. It was validated on a large sample of therapists (mostly clinical psychologists), who reported personal experiences related to long-lasting therapeutic relationships with nonpsychotic patients. The TRQ yields an eight-dimensional picture of the therapist's subjective experience and is effective in exploring many aspects of *countertransference*. It has been used to investigate the relationship between several patients' characteristics, such as personality and symptomatology, and its dimensions have been found to be consistently related to patient's personality (both disorders and styles) [27, 29–31], symptom severity [32], and also suicidality [33], regardless of the clinician's attitude and theoretical background.

Conversely, the FWC, the first version of which was presented in 1986 [34], was conceived for psychiatric settings, and was designed to be used by any mental health worker (e.g., clinicians, nurses, social workers, etc.). The questionnaire collects a number (ranging from 16 to 58 depending on the version) of emotional responses elicited by psychiatric patients in whoever takes care of them, independently of the nature of the relationship. Over the years, the FWC has been used by two main research groups to explore, respectively, the relation between staff feelings and patient's gender, self-image, or diagnosis [35–37], and between staff feelings and patient's personality or symptoms [38–40].

Overall, the findings from TRQ studies have corroborated the hypothesis of a connection between the patient's condition and the clinician's subjective experience, at least for long-lasting clinical contacts with patients with personality disorders or with neurotic ones. Similarly, a clear association between staff feelings and patients' personality organization has been confirmed by all FWC studies, whereas only the severity and the psychotic or neurotic quality of psychiatric symptoms has been found to substantially affect staff feelings, regardless of categorical diagnosis. None of the studies have specifically examined the connection between the psychiatrist's subjective experience and the process of assessment or diagnosis.

7.2.3 Development of the Preliminary Questionnaire

As mentioned above, our project relies on the basic assumption that the clinician's subjective experience during the encounter is imbued with his or her emotional, prereflective, and cognitive reactions to the patient's way of relating with others. Such reactions are particularly meaningful during the first diagnostic encounter, when the clinician shows a high receptive attitude and is scarcely influenced by preconceptions derived from previous knowledge of the patient.

Accordingly, our instrument has been conceived as a self-report questionnaire to be completed immediately after the first encounter with an unknown patient.

First, we collected a large number of psychiatrists' experiences related to the clinical encounter, expressed in the form of simple self-descriptive sentences (e.g., "I felt unease during the encounter," "I felt I lacked spontaneity," "I had difficulties in identifying myself with the patient"). These sentences (hereafter the *items*) were formulated using everyday language and avoiding theoretical terms and metaphorical or ambiguous expressions. The clarity of the items was, in fact, a major concern, since the questionnaire was intended to be used by all clinicians, regardless of their degree of clinical experience or their expertise in phenomenological concepts.

The considered experiences came from two main sources: on the one hand, the descriptions of classical psychopathologists; on the other hand, the everyday practice of a large number of psychiatrists and psychiatry residents. During the collection, we paid specific attention to the inclusion of various kinds of subjective experience (e.g. bodily sensations, thoughts, emotions, etc.), in an effort to explore through the questionnaire both the cognitive, reflective aspects and the embodied, prereflective aspects of the subjective experience.

We aimed to develop an instrument that was suitable for probing a wide range of human experiences, just as reported by clinicians, without the need for training or changing their usual attitude and praxis. Equally, we chose not to define *a priori* discrete domains of investigation—for example, "affectivity," "bodily reactions," etc.—preferring to explore the experiential field with several different descriptors, and to study their pattern of aggregation as it naturally emerges.

First, we created an initial list of 104 items. Subsequently, this list was further examined by a group of fifteen experienced clinicians, who were asked to thoroughly review each item for understandability and clarity, and possibly to suggest further ones. A number of items were judged to be redundant, unclear, irrelevant, or inappropriate, and these were excluded or substituted, yielding a refined list of 65 items, each one to be rated on a 5-point Likert scale.

In submitting the questionnaire to a large number of psychiatrists, we faced the inherently problematic nature of self-reporting. We observed, in fact, to what extent the act of verbally describing the lived experience of the encounter implies, for the clinician, a reflective process that entails also elements exceeding the pure nature of the experience itself. The time-lag, the need for a semantic translation, and the worries about the coders' opinion were significant examples of these influences. Nevertheless, we had to accept that the risk of hiding, forgetting, overinterpreting, or unconsciously distorting the perceptions by the rater, as well as the risk of misunderstanding some items, could not be completely avoided. After all, this problem is common to all self-completed instruments exploring subjectivity, and the best practice in these cases is to follow an appropriate validation process, bearing in mind this limitation when interpreting the empirical results [12].

Still, in order to minimize the risk of biases, we decided to preface the questionnaire with the following instructions: "*Please complete this questionnaire at the end of the visit. The questions aim at exploring some subjective elements that psychiatrists may experience during their first interaction with a patient. The items describe behaviours, thoughts and feelings that may emerge within the specific relationship with the patient at different moments during the visit. The questionnaire aims to assess subjective and emotional aspects, and by no means aims to assess clinical practice*."

7.3 The Assessment of Clinician's Subjective Experience (ACSE)

7.3.1 Validation of the Preliminary Questionnaire

The preliminary 65-item version of the questionnaire underwent a rigorous validation process [41]. It was indeed mandatory that the selected items were found to be truly informative about the clinician's experience, showing a fair range of responses and a good stability over time, as well as a coherent factor structure.

7.3.1.1 Methods

The validation study involved a convenience sample of 13 psychiatrists, heterogeneous for age (39.6 ± 8.8), sex (6 F, 7 M), years of experience (9.1 ± 8.2), and

theoretical background. The clinicians were asked to complete our preliminary questionnaire when they met with a previously unknown patient for the first time. No exclusion criteria regarding the patient's characteristics or the setting in which the assessment took place (outpatient clinic, acute inpatient ward, or emergency room) were applied.

Before and after each clinical examination, the clinicians also completed the "right now form" of the *Profile of Mood States* (POMS), which explores the subject's mood state through 58 adjectives rated on a 5-point scale [42–44]. The POMS yields an emotional profile based on six dimensions (Tension/Anxiety, Depression/Dejection, Anger/Hostility, Fatigue/Inertia, Confusion/Bewilderment, Vigor/Activity). The change in the six scores through the encounter was taken as a measure of the clinicians' emotional reaction to the encounter itself.

After the examination, finally, clinicians were required to assess the patient's psychopathological condition using the 24-item version of the *Brief Psychiatric Rating Scale* (BPRS) [45, 46]. In order to collect data on the stability over time of the ACSE, the clinicians were asked to complete, for a subsample of patients, the ACSE and the BPRS at the end of a subsequent examination as well. The second encounter should have taken place within a few days after the first one, and the change in BPRS total score was used to test the stability of the patient's clinical state.

7.3.1.2 Results

A total of 527 patients, seeing the clinician for their first visit, were included in the study. Both outpatient and inpatient settings were well represented (N = 268 and N = 217, respectively), with a smaller number of patients being assessed in emergency rooms (N = 41).

The patient sample was equally distributed between males (N = 228) and females (N = 299), with a mean age of 42.8 ± 14.5 years. The main diagnostic categories, identified by DSM-IV criteria [47], were all represented: schizophrenia and other psychoses (N = 133), mood disorders (N = 148), cluster B personality disorders (N = 74), anxiety disorders (N = 58), and other disorders (N = 114).

Sixty subsequent encounters with patients whose BPRS score had not changed by more than 5 points between the two assessments were included in the analysis. These were equally distributed between outpatient (N = 24) and inpatient (N = 28) settings, with a small number of reassessments of patients initially seen in emergency rooms (N = 8).

As a first step, descriptive analyses were performed to examine the distribution of responses to all items of the ACSE. Then, the *intraclass correlation coefficient* (ICC) between scores on the first and the second administration was calculated for each item as a measure of temporal stability. Then, an exploratory principal component analysis was performed. At this early stage, nine items showing a narrow range of responses, poor test-retest reliability, or low communality estimates were dropped. A new principal component analysis was then performed on the remaining 56 items, in order to examine the factor structure and to further refine the item composition of the ACSE.

Factor Structure

The number of factors to be extracted was determined according to the scree-plot method [48]. Five factors were extracted, accounting for 57.4% of total variance. After orthogonal rotation, a fairly simple structure emerged, as most items loaded strongly on one factor, and much more weakly on the other four factors. Communality values were fairly high, which suggests that most variables were well defined by this factor solution.

The item composition of the instrument was further refined by dropping 8 items that did not show at least a .32 loading on any factor (corresponding to 10% shared variance between variable and factor) or that ambiguously loaded on different factors. Therefore, the final version of the instrument included 46 items, divided into 5 factorially derived scales.

Factor I, interpreted as "**Tension**," explained 15.1% of variance after rotation and was loaded by items indicating physical tension and awkwardness; reduced spontaneity; and feelings of worry, nervousness, and alarm.

Factor II, interpreted as "**Difficulty in Attunement**," accounted for 11.7% of variance and was defined by items describing difficulty in establishing emotional contact, being empathic, understanding the patient's experience, and communicating with the patient.

Factor III explained 11.5% of variance and was interpreted as "**Engagement**" as it was loaded by items describing the degree of the psychiatrist's involvement with the patient, such as feelings of boredom, indifference, detachment, lack of attention and, conversely, desire to take care of the patient, and feelings of deep involvement in the patient–physician relationship, emotional closeness, and tenderness.

Factor IV, accounting for 10.1% of variance, was defined by items describing a failure to establish an authentic relationship with the patient, and feelings of being manipulated, rejected, criticized, or devalued by the patient; thus, it was interpreted as "**Disconfirmation**."

Factor V explained 8.9% of variance and was interpreted as "**Impotence**" as it was loaded by items indicating feelings of helplessness, frustration, desolation, emptiness, loneliness, and being drained.

Reliability and Convergent Validity of the Scales

The reliability of the identified scales was tested in terms of both internal consistency, as measured by *coefficient alpha*, and test-retest stability, as measured by the ICC between scores on the first and on the second administration. All the scales displayed high reliability (see Table 7.1).

Convergent validity was assessed by examining the correlation between the ACSE scales and the change in scores on POMS scales throughout the clinician–patient interaction. Overall, all ACSE scales, except for Engagement, were found to be positively correlated with the change in scores on the "negative" scales of the POMS (Tension/Anxiety, Depression/Dejection, Anger/Hostility, Fatigue/Inertia, Confusion/Bewilderment) and negatively correlated with the change in the only "positive" scale of the POMS (Vigor/Activity). The Engagement scale showed the opposite pattern of correlations.

Table 7.1 Reliability and convergent validity of the ACSE scales

	Internal consistency	Relative stability (95% CI)	POMS scale with strongest correlation
Tension (11 items)	0.91	0.83 (0.72–0.90)	Tension/Anxiety (positive)
Difficulty in Attunement (10 items)	0.90	0.90 (0.80–0.95)	Fatigue/Inertia (positive)
Engagement (8 items)	0.85	0.82 (0.72–0.89)	Fatigue/Inertia (negative)
Disconfirmation (9 items)	0.88	0.91 (0.86–0.95)	Anger/Hostility (positive)
Impotence (8 items)	0.86	0.87 (0.80–0.92)	Depression/Dejection (positive)

The pattern of significant correlations was consistent with expectations based on the similarities and analogies between the constructs measured by the two instruments. The strongest correlations are reported in Table 7.1.

7.3.2 A Five-Dimensional Profile of the Clinician's Subjective Experience

The final version of the ACSE is a 46-item self-completed questionnaire, which yields a valid and reliable picture of the clinician's subjective experience during psychiatric assessment. This picture is characterized by five well-defined dimensions, which we named—according to their composition—*Tension*, *Difficulty in Attunement*, *Engagement*, *Disconfirmation*, and *Impotence*.

Our first result was, thus, that the clinician's experience related to the clinical encounter can be represented through a unique profile consisting of five experiential domains, each describing a different nuance of the relational challenge. Most of the domains indeed characterize the potential difficulties in establishing an effective contact with the patient, with the exception of *Engagement*, which conversely illustrates also the possibility of a syntonic feeling.

But what do the ACSE dimensions exactly capture?

The first factor, which we named *Tension*, describes an experience characterized by a general concern about possible sudden changes in the temperature of the interaction, and in particular about possible patient's unexpected outbursts. This condition of alertness, which prevents the clinician from feeling completely natural, safe, and relaxed during the encounter, reveals itself also in a set of bodily perceptions, mostly marked by stiffness and awkwardness. Eye contact becomes difficult, the posture is rigid, and a general sympathetic activation of the autonomic nervous system seems to indicate that the clinician is ready to respond to an alleged threat.

It cannot be ascertained at this point whether the sense of pending collision is attributable to the patient's actual aggressiveness or to the clinician's reactivity itself. Nonetheless, even though it does not necessarily mean that a concrete danger is at stake, this scale expresses the potentiality of a symmetrical confrontation. It might be said that the *spatial* dimension of the encounter is implied, since the

concrete sharing of a common space and the need for a fair safety distance are emphasized.

The second factor, namely, *Difficulty in Attunement*, gathers all the items that refer to sharing, mirroring, and communicability of the experiences within the clinician–patient dyad. The clinician's described struggle in establishing contact with the patient seems to rest, in fact, on the difficulty in recognizing himself or herself in the patient's way of experiencing (*being in the world*), a difficulty that in extreme cases results in a feeling of alienation. Exceptional care in the choice of words and tone of voice on the part of the clinician, which reveal an unusual degree of effort exerted to effectively reach the patient, represents the behavioral equivalent of this experience.

In essence, *Difficulty in Attunement* seems to pertain to the domain of human identification and *empathy*, intended as the ability to feel the other's presence as a familiar and understandable one, graspable with a prereflective, mostly effortless and immediate act of perception. Due to these characteristics, this dimension calls to mind the descriptions made by classical psychopathologists about the feeling of strangeness or alienation experienced by clinicians when they encounter schizophrenic patients (see Chap. 1).

The third factor refers to a rather different level of contact, being focused on the clinician's emerging affective involvement with the patient: accordingly, it has been called *Engagement*. Differently from the other scales, *Engagement* is characterized by items illustrating both poles of the experience, which goes from detachment and indifference to emotional participation and caring. It is mostly an emotional dimension, and it makes sense to the claim that the clinical encounter is rarely a "neutral" situation, for both clinician and patient. Rather, *Engagement* seems to grasp the *pathic* element inherent to the interaction, just as it was traditionally conceptualized by phenomenologists with the name of *feeling-with* or *sympathy* [49].

Naturally, even though this dimension illuminates the extent of the clinician's affective investment in the relationship, it does not characterize a specific emotional content, capturing both "troubled" and "straightforward" engagements.

The fourth factor, on the contrary, reports an emotionally well-defined experience, which is quite familiar to psychiatrists, even if it has received the most attention in psychotherapeutic settings. With the term *Disconfirmation*, we have in fact indicated a set of common feelings and thoughts that are dominated by a perceived relational unwillingness of the patient, often accompanied by an emotional nuance of anger. This dimension seems, in contrast with the others, to describe the impression of an *active*—even when not conscious—rejection by the patient, which reverberates in the clinician as a feeling of being judged, devalued, or manipulated, resulting in poor confidence in the clinical relationship. Such an interpersonal dynamic is imbued with a mood of aggressiveness; however, it is not an overt or physical aggressiveness, but rather a subtle denial of the clinician's professional or, in extreme cases, personal identity. Indeed, the clinician's feelings of "being nonexistent" and anger seem to represent the effect of the patient's act of "nullifying", and this is why we have borrowed the term "disconfirmation" from the reflection of

R. D. Laing [50] about this devaluing and disowning form of pathological communication.

The fifth factor, finally, defines an experiential field in which the painful perception of a stasis in the interaction prevails and has gained the name of *Impotence*. It is characterized, on the one hand, by feelings of sadness, loneliness, and emptiness, and, on the other hand, by the perception of poor therapeutic success. Impotence and frustration at the end of the encounter come up as the final result of this persistent sense of frozen possibilities, to the point of seeming that the clinician experiences a sort of "depressive reaction."

This aspect of the clinician's subjective experience seems to refer to the *temporal* dimension of the encounter, which shows an impaired dynamism and a limited potential of transformations. Interestingly, indeed, *Impotence* focuses on the experiential domain that most clearly moves away from the *hic et nunc* of the encounter, projecting the clinical interaction in a diachronic dimension.

Hence, the five factors of the ACSE emerge as different receptors of a single probe, each detecting a specific "portion" of the clinician's subjective experience related to the encounter. In essence, this probe can give a synthetic depiction of the intersubjective areas of spatial confrontation, empathic attunement, sympathy, interpersonal rejection, and therapeutic potentiality.

Although the ACSE cannot be considered as an exhaustive depiction of the whole intersubjective experience, it nonetheless accounts for a number of substantial, well-defined, and theoretically convincing modes of *feeling the other* experienced by clinicians. Their "bottom-up" emergence from a large, heterogeneous, and untrained sample of psychiatrists, in addition, provides indirect proof of the real existence of such intersubjective domains in the "real world" practice, and not only in refined phenomenological descriptions.

7.4 Final Reflections

The ACSE is a new instrument that contributes in an original way to the exploration of the field of diagnostic evaluation, integrating the intersubjective perspective into the clinician's operational toolkit.

Basically, the ACSE enables the collection and arrangement of key, relevant aspects of the clinician's subjective experience in a synthetic formal structure, making these elements available for research, and prospectively for clinical reasoning. In addition to representing the first step toward a comprehensive evaluation of the importance of intersubjectivity during the clinical encounter, its successful development suggests in itself some preliminary reflections.

We have seen that the lack of a scientific tool suitable for reliably exploring the intersubjective phenomena inherent to assessment has supported the exclusion of these phenomena from questions worthy of being investigated. Unfortunately, most researchers have not sought an instrument capable of improving knowledge about

those phenomena, but rather have continued to rely on epistemological means tailored to detect only "acceptable" objective data. The construction of a valid and reliable "objective" instrument such as the ACSE may help break this circle, since it provides the proof that intersubjectivity is a real domain that can be explored and described.

Naturally, to achieve the goal of translating the subjective experience into an operational and quantifiable grid, we had to reduce its living complexity to a finite number of countable descriptors. This reduction may raise concerns about a possible overobjectifying approach to intersubjectivity, or about the risk of a detachment from the vital dynamic of the clinical encounter. However, the ACSE dimensions are not thought of as algorithmic variables to be used for assigning the patient to one category or to another, or irrevocably qualifying the nature of the encounter. Rather, they are conceived as a means to synthetically shed light on the emerging intersubjective dynamics, drawing the clinician's attention to his or her own subjective world as a source of knowledge about the ongoing interactive process. Thinking about his or her own living participation in the encounter, in fact, may help the clinician to broaden his or her perspective on the patient, introducing epistemologically different elements and, at the same time, promoting a more open (and, likely, therapeutic) disposition toward the patient.

Appendix

Here we show the English version of the ACSE. While it has yet to be formally validated, it has been developed through a rigorous process. We did not perform a formal iterative back-translation procedure and preferred to concentrate on making a good translation, because several scholars have argued persuasively against back-translation for theoretical and practical reasons [51]. Specifically, back-translation has been characterized as merely a suboptimal procedure for checking translations that achieves linguistic and conceptual equivalence, but does not devote attention to clarity and understandability and does not take adequate account of context and milieu [52, 53]. In order to produce a good translation, we followed well-known paths in the cross-cultural adaptation of psychosocial measures [54]. First, an initial translation was produced by two independent translators, who were fluent in both Italian and English. Then, each translator independently reviewed the other version and provided comments and suggestions. Then, each translator included those suggestions judged to be relevant in a second version. This process was repeated one more time, until consensus was reached. Then, the translation was further reviewed by a native English speaker who provided a number of suggestions that further improved clarity and acceptability, and finally, an overall consensus was reached. We are deeply grateful to Dr. Nicoletta Gentili and Dr. Neil Owens for their help with this process.

ASSESSMENT OF CLINICIAN'S SUBJECTIVE EXPERIENCE (ACSE)

(Pallagrosi M, Fonzi L, Picardi A, Biondi M. *Psychopathology* 2014;47:111-118)

English version by Nicoletta Gentili and Angelo Picardi

The following questions aim to explore some aspects of the clinician's subjective experience when meeting a patient. The items describe behaviours, thoughts, or personal experiences arising from within the specific relationship with the patient.

WARNING: *The questionnaire must be completed at the end of the interview with the patient. Answers are based on the evaluation of the assessor's own subjective experience. Thus, you are asked to refer exclusively to your own subjective experience within the context of your relationship with the patient, leaving out any inference on the patient's emotional state or psychopathological condition. There are no right or wrong answers: the object of the assessment is how the clinician felt whilst interviewing the patient. Therefore, in no way should the answers given be taken as a judgement on the clinical work of the assessor*

1) At the beginning of the interview I felt tense

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Extremely

2) At the beginning of the interview I struggled to establish an emotional connection with the patient

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Extremely

3) I simplified my communication by modifying my usual language (e.g., I used simpler words, I avoided the use of metaphors)

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

4) I tempered the tone of my voice in relation to the patient's state

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

5) I carefully chose my words in order not to scare the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

6) I carefully chose my words in order to be easily understood by the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

7) I avoided eye contact with the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

8) I felt I lacked spontaneity

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

9) I felt insecure

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

10) I felt tense in moments of silence

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

11) I was bored

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

12) I was distracted

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

13) I found it difficult to follow the train of thoughts expressed by the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

14) There were times when I felt the way in which the patient gave sense to his/her own experiences was alien to me *(feeling of alienation towards specific aspects of the experience reported by the patient in terms of experience, expressed beliefs, meaning attributed to events)*

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

15) I perceived a sense of inauthenticity in the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

16) I felt that I did not exist for the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

17) I was afraid that the patient could act unpredictably

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

18) I felt a sense of alienation from the patient *(feeling of general alienation from the patient in his personal wholeness)*

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

19) I felt distant from the patient *(feeling of emotional distance from the patient)*

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

20) I had difficulties in identifying myself with the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

21) I felt a sense of anger towards the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

22) I felt rejected by the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

23) I felt depreciated by the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

24) I felt judged by the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

(continued)

25) I sensed the patient was trying to manipulate me

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

26) I felt indifference towards the topics introduced by the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

27) I experienced a feeling of tenderness towards the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

28) I experienced the desire to care for the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

29) I felt a sense of emptiness

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

30) I felt anguish

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

31) I felt a sense of loneliness

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

32) I felt sadness

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

33) I felt emotionally close to the patient

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

34) I felt a sense of desolation (feeling of despondency)

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

35) I perceived a discordance between the way in which the patient experienced some of his/her life events and the way in which I would have experienced them *(difficulty in sharing the patient's point of view in relation to experiences, expressed beliefs, meaning attributed to individual events)*

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

36) I felt emotionally involved with the patient *(feeling of intense emotional participation in the relationship)*

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

37) I experienced physical tension

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

(continued)

38) I felt awkward in my movements

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

39) I maintained a rigid posture

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

40) I experienced neurovegetative sensations *(e.g., shivering, cold/hot sensation, sweating, etc.)*

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

41) At the end of the interview I felt physically tired

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Extremely

42) At the end of the interview I felt physically and mentally drained

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Extremely

43) At the end of the interview I sensed that the relationship established with the patient was fragile and precarious

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Extremely

44) At the end of the interview I felt compelled to establish very clear boundaries with the patient

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Extremely

45) At the end of the interview I felt a sense of frustration

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Extremely

46) At the end of the interview I felt a sense of impotence

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Extremely

References

1. Parnas J. Differential diagnosis and current polythetic classification. World Psychiatry. 2015;14:3.
2. Jablensky A. Psychiatric classifications: validity and utility. World Psychiatry. 2016;15(1):26–31.
3. Kendler K. DSM disorders and their criteria: how should they inter-relate? Psychol Med. 2017;47(12):2054–60.
4. Kendell R, Jablensky A. Distinguishing between the validity and utility of psychiatric diagnoses. Am J Psychiatry. 2003;160(1):4–12.
5. Cohen BM. Embracing complexity in psychiatric diagnosis, treatment, and research. JAMA Psychiatry. 2016;73:1211–2.
6. Stanghellini G. The grammar of the psychiatric interview. Psychopathology. 2007;40:69–74.
7. Gallagher S, Zahavi D. The phenomenological mind: an introduction to philosophy of mind and cognitive science. New York: Routledge; 2008.
8. Fuchs T. Subjectivity and intersubjectivity in psychiatric diagnosis. Psychopathology. 2010;43:268–74.
9. Fuchs T. Pathologies of intersubjectivity in autism and schizophrenia. J Conscious Stud. 2015;22(1-2):191–214.
10. Fonzi L, Pallagrosi J, Picardi A, Biondi M, Pallagrosi M. Exploring how the psychiatrist experiences the patient during the diagnostic evaluation: the Assessment of Clinician's Subjective Experience (ACSE). Phenomenol Cogn Sci. 2021; https://doi.org/10.1007/s11097-021-09729-y.
11. Sholokhova S. Benefits and challenges of the phenomenological approach to the psychiatrist's subjective experience: impassivity, neutrality, and embodied awareness in the clinical encounter. Philos Psychiatr Psychol. 2019;26(4):E-83–96.
12. Berrios GE. Per una nuova epistemologia della psichiatria [Towards a new epistemology of psychiatry]. Rome: Giovanni Fioriti Editore; 2013.
13. Stanghellini G, Mancini M. Mondi psicopatologici. Teoria e pratica dell'intervista psicoterapeutica [Psychopathological worlds. Theory and practice of the psychotherapeutic interview]. Edra: Milan; 2018.
14. Varga S. Vulnerability to psychosis, I-thou intersubjectivity and the praecox-feeling. Phenomenol Cogn Sci. 2013;12(1):131–43.
15. Galbusera L, Fellin L. The intersubjective endeavor of psychopathology research: methodological reflections on a second-person perspective approach. Front Psychol. 2014;5:1150.
16. Gupta M, Potter N, Goyer S. Diagnostic reasoning in psychiatry: acknowledging an explicit role for intersubjective knowing. Philos Psychiatr Psychol. 2019;26(1):49–64.
17. Zahavi D. Phenomenology and the project of naturalization. Phenomenol Cogn Sci. 2004;3:331–47.
18. Zahavi D. Phenomenology: the basics. New York, NY: Routledge; 2019.
19. Parnas J, Møller P, Kircher T, Thalbitzer J, Jansson L, Handest P, Zahavi D. EASE: examination of anomalous self-experience. Psychopathology. 2005;38:236–58.
20. Sass L, Pienkos E, Skodlar B, Stanghellini G, Fuchs T, Parnas J, Jones N. EAWE: examination of anomalous world experience. Psychopathology. 2017;50:10–54.
21. Rasmussen AR, Stephensen H, Parnas J. EAFI: examination of anomalous fantasy and imagination. Psychopathology. 2018;51(3):216–26.
22. Carpenter WT, Strauss JS, Bartko JJ. Flexible system for the diagnosis of schizophrenia: report from the WHO International Pilot Study of Schizophrenia. Science. 1973;182(4118):1275–8.
23. Moskalewicz M, Kordel P, Brejwo A, Schwartz MA, Gozè T. Psychiatrists report praecox feeling and find it reliable. A cross-cultural comparison. Front Psychiatry. 2021;12:642322.
24. Grube M. Towards an empirically based validation of intuitive diagnostic: Rümke's 'Praecox feeling' across the schizophrenia spectrum: preliminary results. Psychopathology. 2006;39:209–17.

25. Ungvari GS, Xiang Y, Hong Y, Leung HCM, Chiu HFK. Diagnosis of Schizophrenia: reliability of an operationalized approach to 'Praecox-Feeling'. Psychopathology. 2010;43:292–9.
26. Pallagrosi M, Fonzi L. On the concept of Praecox Feeling. Psychopathology. 2018;51(6):353–61.
27. Betan E, Heim AK, Conklin CZ, Westen D. Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. Am J Psychiatry. 2005;162:890–8.
28. Holmqvist R, Armelius B-Å. Emotional reactions to psychiatric patients. Analysis of a feeling checklist. Acta Psychiatr Scand. 1994;90:204–9.
29. Colli A, Tanzilli A, Dimaggio G, Lingiardi V. Patient personality and therapist response: an empirical investigation. Am J Psychiatry. 2014;171:102–8.
30. Knaus S, Grassl R, Seidman C, Seitz T, Karwauts A, Löffler-Stastka H. Psychiatrists' emotional reactions: useful for precise diagnosis in adolescence? Bull Menninger Clinic. 2016;80(4):316–25.
31. Genova F, Gazzillo F. Personality organization, personality styles, and the emotional reactions of treating clinicians. Psychodyn Psychiatry. 2018;46(3):357–92.
32. Tanzilli A, Colli A, Del Corno F, Lingiardi V. Factor structure, reliability, and validity of the Therapist Response Questionnaire. Pers Disord: Theory Res Treat. 2016;7(2):147–58.
33. Yaseen ZS, Galynker II, Cohen LJ, Briggs J. Clinicians' conflicting emotional responses to high suicide-risk patients—association with short-term suicide behaviors: a prospective pilot study. Compr Psychiatry. 2017;76(69-78).
34. Colson DB, Allen JG, Coyne L, Dexter N, Jehl N, Mayer CA, et al. An anatomy of countertransference: staff reactions to difficult psychiatric patients. Hosp Community Psychiatry. 1986;37:923–8.
35. Holmqvist R. The influence of patient diagnosis and self-image on clinicians' feelings. J Nerv Ment Dis. 1998;186:455–61.
36. Holmqvist R. Staff feelings and patient diagnosis. Can J Psychiatry. 2000;45:349–56.
37. Armelius K, Holmqvist R. Staff members' feelings towards psychiatric patients related to their own and the patient's self-image and gender. Scand J Psychol. 2003;44(2):69–77.
38. Rossberg JI, Friis S. Staff members' emotional reactions to aggressive and suicidal behaviour of inpatients. Psychiatr Serv. 2003;54(10):1388–94.
39. Rossberg JI, Karterud S, Pedersen G, Friis S. Specific personality traits evoke different countertransference reactions. An empirical study. J Nerv Ment Dis. 2008;196:702–8.
40. Rossberg JI, Karterud S, Pedersen G, Friis S. Psychiatric Symptoms and countertransference feelings: an empirical investigation. Psychiatry Res. 2010;178(1):191–5.
41. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Assessing clinician's subjective experience during interaction with patients. Psychopathology. 2014;47(2):111–8.
42. McNair DM, Heuchert JP, Shilony E. Profile of mood states: bibliography 1964-2002. Multi-Health Systems: Toronto, Ontario; 2003.
43. McNair DM, Lorr M, Droppleman LF. Manual for the profile of mood states. Educational and Industrial Testing Service: San Diego, CA; 1971.
44. McNair DM, Lorr M, Droppleman LF. POMS, Profile of Mood States. Adattamento italiano a cura di M. Farnè, A. Sebellico, D. Gnugnoli, A. Corallo. Firenze: O. S. Organizzazioni Speciali; 1991.
45. Overall JE, Gorham DR. The brief psychiatric rating scale. Psychol Rep. 1962;10:799–812.
46. Morosini PL, Casacchia M. Traduzione italiana della Brief Psychiatric Rating Scale, versione 4.0 ampliata (BPRS 4.0). Riv Riabil Psichiat Psicosoc. 1995;3:199–228.
47. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision (DSM-IV-TR). Washington DC: American Psychiatric Association; 2000.
48. Cattell RB. The scree test for the number of factors. Multivariate Behav Res. 1966;1:245–76.
49. Scheler M. Essenze e forme della simpatia [The nature of Sympathy]. Rome: Franco Angeli; 1923. p. 2010.

50. Laing RD. The self and others. London: Tavistock Publications; 1961.
51. Harkness J. In pursuit of quality: issues for cross-national survey research. Int J Soc Res Methodol. 1999;2:125–40.
52. Bulmer M. The problem of exporting social survey research. Am Behav Sci. 1998;42:153–67.
53. Hambleton RK, Merenda PF, Spielberger CD, editors. Adapting educational and psychological tests for cross-cultural assessment. New Jersey: Erlbaum; 2005.
54. Guillemin F, Bombardier C, Beaton D. Cross-cultural adaptation of health-related quality of life measures: literature review and proposed guidelines. J Clin Epidemiol. 1993;46:1417–32.

8 Evidence Supporting a Role for the Intersubjective Dimension in the Clinical Encounter: Empirical Findings from ACSE Research

Laura Fonzi, Mauro Pallagrosi, Angelo Picardi, and Massimo Biondi

8.1 Introduction

The *Assessment of Clinician's Subjective Experience* (ACSE), the development of which has been described in detail in the previous chapter, is a psychometric tool that provides a five-dimensional profile of the clinician's lived experience during an interview with an unknown patient. It has been validated on a heterogeneous sample of psychiatrists seeing adult patients suffering from different psychiatric disorders. It has also recently been extended to child and adolescent psychiatrists evaluating young patients, aged 12–17 years [1].

The ACSE has been primarily conceived to be used for research purposes, and in particular to study the complex and fine relations between the clinician's subjective experience and many relevant aspects of the psychiatric interview: the patient's personal and psychopathological characteristics, the clinician's attitude, the setting of the encounter, and the interactions between these elements.

L. Fonzi (✉)
National Institute of Training, Italian Psychoanalytic Society, Rome, Italy
e-mail: laura.fonzi@hotmail.it

M. Pallagrosi
Community Service for Prevention and Early Intervention in Mental Health, Rome 1 Local Health Unit, Rome, Italy
e-mail: mauro.pallagrosi@uniroma1.it

A. Picardi
Centre for Behavioural Sciences and Mental Health, Italian National Institute of Health, Rome, Italy
e-mail: angelo.picardi@iss.it

M. Biondi
Department of Human Neurosciences, Sapienza University of Rome, Rome, Italy
e-mail: massimo.biondi@uniroma1.it

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_8

In this chapter, we illustrate the findings coming from a number of studies based on the ACSE and its connection with both clinical and non-clinical variables in psychiatric settings. To maximise clarity, the findings are first summarised according to each 'single-dimension' criterion and then discussed as aggregate profiles. The main clinical implications of these findings are highlighted, and a number of possible useful applications of the ACSE are proposed.

8.2 ACSE Dimensions and the Clinical Encounter: A Detailed Review

As we have seen, the ACSE yields a profile of clinician's subjective experience that consists of five main domains: *Tension*, *Difficulty in Attunement*, *Engagement*, *Disconfirmation,* and *Impotence*. These domains are internally consistent and reflect some common experiences related to psychiatric practice, the clinical value of which has been investigated through a number of studies. Each domain has been tested for its specific relation with several variables, revealing a characteristic pattern of associations and gaining as a consequence a unique contour.

8.2.1 *Tension*

Tension is an 11-item subscale that describes feelings of nervousness and alarm together with a set of bodily sensations such as clumsiness, stiffness, and autonomic activation. Overall, it depicts a sort of preparedness in anticipation of an aggressive outburst, which might arise from the clinician's and/or the patient's confrontational attitude.

According to the findings from our studies, *Tension* exhibits a pattern of associations characterised by a prominent role for variables that may affect the perceived quietness and safety of the developing clinical relationship, whether they are psychopathological or not (see Table 8.1).

As Table 8.1 shows, clinical severity and a specific psychopathological profile, both measured through the *Brief Psychiatric Rating Scale* (BPRS), were found to be the factors most associated with *Tension*.

In particular, *Activation* on the BPRS has emerged as the strongest independent predictor of *Tension* in a multiple regression analysis performed on 754 interviews made by 45 different clinicians [2]. Both *Positive* and *Negative Symptoms* dimensions on the BPRS also showed a significant, though less marked, association with *Tension* while no association was seen for *Affect* and *Disorganisation*. The clinician's *Tension* did not display, on the contrary, any significant association with specific patient's diagnosis, with the exception of a significantly lower mean score for clinicians engaged in the assessment of patients affected by depressive or anxiety disorders in comparison with those affected by schizophrenia, manic or mixed episode in bipolar I disorder, or cluster B personality disorder [3].

Table 8.1 Association between *Tension* and demographic/clinical variables

	Association	Notes
Clinician age	Yes	Mild correlation ($\beta = -0.17$, $p < 0.001$) in multiple regression[a]
Clinician gender	Yes	Mild correlation with male gender ($\beta = 0.18$, $p < 0.001$) in multiple regression[c], further confirmed in general linear model ($p < 0.05$)[b]
Clinician expertise	No	
Patient age	Yes	Mild correlation ($\beta = -0.13$, $p < 0.001$) in multiple regression[a]
Patient gender	Unclear	No correlation in multiple regression[a], but significant correlation with male gender in general linear model controlling for clinical severity ($p < 0.001$)[b]
Patient education	No	
Patient nationality	No	
Setting of the clinical examination	No	
Duration of the clinical examination	Yes	Mild correlation ($\beta = 0.17$, $p < 0.01$) in multiple regression[a]
Patient diagnosis	Yes	Mean score in the depression/anxiety group significantly lower than all other groups ($p < 0.05$), confirmed by general linear model[c]
Patient clinical severity	Yes	Moderate correlation with BPRS total score ($r = 0.42$, $p < 0.001$)[a], further confirmed in general linear model ($p < 0.001$)[b]
Patient symptom pattern	Yes	Moderate correlation with BPRS *Activation* ($\beta = 0.33$, $p < 0.001$) and mild correlation with BPRS *Positive* ($\beta = 0.18$, $p < 0.001$) and *Negative Symptoms* ($\beta = 0.19$, $p < 0.001$) in multiple regression[a]

BPRS Brief Psychiatric Rating Scale
[a]Picardi et al. (2017) [2]
[b]Unpublished data
[c]Pallagrosi et al. (2016) [3]

Tension, in other words, seems to be a dimension of the clinician's subjective experience not specifically related to the patient's psychopathological *structure*, but instead seems 'reactive' to a set of symptoms (mainly hyperactivity, excitement, and mood elevation) that cut across the most severe disorders.

Consistently, this emotional reaction is more intense when the clinician and/or the patient are younger and when they are males as a recent, yet not published, investigation carried out by our group on 960 first interviews has also revealed. Both these findings, in fact, strengthen the idea that an issue of potential conflict is at stake, and that the more dangerous and unstable the patient is perceived to be, the higher the level of *Tension* felt by the clinician.

8.2.2 *Difficulty in Attunement*

Difficulty in Attunement is a 10-item subscale that consists of statements essentially illustrating the clinician's struggle in establishing a valid connection with the patient, which appears in the form of troubled communication and a perceived failure of empathic understanding. Bodily involvement is less evident, though this subscale includes manifest behaviours such as heightened care in choosing words and perceived effort in keeping eye contact.

As Table 8.2 shows, *Difficulty in Attunement* displays a pattern of associations in which clinical factors are the most relevant ones.

Although it might seem counterintuitive, neither cultural differences nor age or gender heterogeneity seem to significantly influence the clinician's ability to feel connected with the patient or to immediately understand his experience and suffering.

Table 8.2 Association between *Difficulty in Attunement* and demographic/clinical variables

	Association	Notes
Clinician age	No	
Clinician gender	Yes	Weak, though significant, correlation with female gender ($\beta = -0.06$, $p < 0.05$) in multiple regression[a], further confirmed in general linear model ($p < 0.001$)[b]
Clinician expertise	No	
Patient age	No	
Patient gender	No	
Patient education	Yes	Modest correlation ($\beta = -0.10$, $p < 0.001$) in multiple regression[a]
Patient nationality	No	
Setting of visit	No	
Duration of visit	No	
Patient diagnosis	Yes	Mean score in schizophrenia group significantly higher than all other groups ($p < 0.001$), confirmed by general linear model[c]
Patient clinical severity	Yes	High correlation with BPRS total score ($r = 0.60$, $p < 0.001$)[a], further confirmed in general linear model ($p < 0.001$)[b]
Patient symptom pattern	Yes	Moderate correlation with BPRS *Positive* ($\beta = 0.34$, $p < 0.001$) and *Negative Symptoms* ($\beta = 0.29$, $p < 0.001$), and modest correlation with *Activation* ($\beta = 0.17$, $p < 0.001$) in multiple regression[a]

BPRS Brief Psychiatric Rating Scale
[a]Picardi et al. (2017) [2]
[b]Unpublished data
[c]Pallagrosi et al. (2016) [3]

Concerning the role of cultural differences, a recent study matching a total of 84 intracultural and intercultural psychiatric interviews [4] revealed that—age, gender, clinical diagnosis, and severity of the two patient groups being equal—the difference in clinician's *Difficulty in Attunement* mean score was modest (Cohen's $d = -0.34$) and did not reach statistical significance ($p = 0.12$). Similarly, clinician's gender has shown only a weak relationship with *Difficulty in Attunement*, with female clinicians seeming to feel the empathic hindrance a bit more [2]; this result was confirmed by the aforementioned unpublished study by our group.

In contrast, the association with the patient's clinical variables seems to be clear and well-defined. In fact, *Difficulty in Attunement* was found to be the ACSE dimension most specifically linked to a patient's diagnosis of schizophrenia, with a large effect size (Cohen's $f = 0.57$) and a high significance, which was confirmed in multivariate analysis controlling for clinical severity and demographic variables ($p < 0.001$) [3]. In accordance with this result, the BPRS *Positive* and *Negative Symptoms* dimensions were identified as the strongest predictors of higher scores in *Difficulty in Attunement* while the association with *Activation* and *Disorganisation* was smaller in size, and *Affect* showed no association [2].

Overall, this indicates that—even though an empathic struggle can be perceived in several clinical situations—this impression has a pronounced link with the interaction with schizophrenic patients, even as compared with other patients of similar clinical severity and possibly experiencing psychotic symptoms. It may be hypothesised that it is the 'autistic' core of schizophrenia that accounts for such an intense inability, on the part of the clinician, to easily attune with the patient. In fact, whereas other substantial differences between clinician and patient (i.e. ethnocultural differences) do not seem to seriously prevent the clinician from feeling the patient as a comprehensible fellow human being, the schizophrenic way of being poses a greater challenge to this possibility.

8.2.3 *Engagement*

Engagement is an eight-item subscale that describes the clinician's emotional involvement with the patient along a gradient that goes from indifference to lively participation. It provides a measure of closeness to the patient, in the sense of *pathic* resonance, regardless of its pleasant or disturbing character.

The most striking evidence from our findings is that *Engagement* is not markedly associated with any of the clinical or demographic variables considered so far (see Table 8.3).

There was a significant but modest association with clinician's female gender in the recent unpublished study by our group, though this association was not detectable in a multiple regression analysis performed on a different sample [2]. As might be expected, there was also a modest independent association with younger patient age.

At the same time, the patient's psychopathology was only weakly linked with *Engagement*; a regression model explaining a relatively low proportion of the

Table 8.3 Association between *Engagement* and demographic/clinical variables

	Association	Notes
Clinician age	No	
Clinician gender	Unclear	No correlation in multiple regression[a], but significant association with female gender in general linear model controlling for clinical severity ($p < 0.001$)[b]
Clinician expertise	No	
Patient age	Yes	Modest correlation ($\beta = -0.12$, $p < 0.05$) in multiple regression[a]
Patient gender	Yes	
Patient education	No	
Patient nationality	No	
Setting of visit	No	
Duration of visit	Yes	Weak correlation ($\beta = 0.10$, $p < 0.05$) in multiple regression[a]
Patient diagnosis	Yes	Mean score in cluster B personality group significantly lower than all other groups ($p < 0.01$), confirmed by general linear model[c]
Patient clinical severity	No	
Patient symptom pattern	Yes	Modest correlation with BPRS *Affect* ($\beta = 0.15$, $p < 0.001$), *Positive* ($\beta = 0.17$, $p < 0.001$), and *Negative Symptoms* ($\beta = -0.12$, $p < 0.05$) in multiple regression[a]

BPRS Brief Psychiatric Rating Scale
[a]Picardi et al. (2017) [2]
[b]Unpublished data
[c]Pallagrosi et al. (2016) [3]

variance has identified the BPRS *Affect* and *Positive Symptoms* dimensions as modest predictors, with an even lower negative contribution of the *Negative Symptoms* dimension [2]. From a diagnostic point of view, *Engagement* did not emerge as a specific marker of the clinical encounter, though it displayed a negative association with the diagnosis of cluster B personality disorder, with a modest effect size (Cohen's $d = 0.24$) [3].

It may then be speculated that, differently from the other ACSE dimensions, *Engagement* represents an intersubjective phenomenon that is idiosyncratically linked to the unique clinician–patient dyad, which is scarcely affected by generalisable characteristics, although a dismissing attitude on the part of the patient may contribute to impairing it.

8.2.4 *Disconfirmation*

Disconfirmation is a nine-item subscale that accounts for the experience of being rejected, devalued, and manipulated, with related feelings of anger and a distressful sense of 'non-existence'. Overall, this scale measures the need for substantial

Table 8.4 Association between *Disconfirmation* and demographic/clinical variables

	Association	Notes
Clinician age	No	
Clinician gender	Unclear	No correlation in multiple regression[a], but significant correlation with male gender in general linear model controlling for clinical severity ($p < 0.001$)[b]
Clinician expertise	No	
Patient age	Yes	Modest correlation ($\beta = -0.12$, $p < 0.01$) in multiple regression[a]
Patient gender	No	
Patient education	Yes	Modest correlation ($\beta = 0.11$, $p < 0.01$) in multiple regression[a]
Patient nationality	No	
Setting of visit	No	
Duration of visit	No	
Patient diagnosis	Yes	Mean score in cluster B personality group and in depression/anxiety group significantly higher ($p < 0.05$) and significantly lower ($p < 0.001$) than all other groups, respectively, as confirmed by general linear model[c]
Patient clinical severity	Yes	Moderate correlation with BPRS total score ($r = 0.34$, $p < 0.001$)[a], further confirmed in general linear model ($p < 0.001$)[b]
Patient symptom pattern	Yes	Moderate correlation with BPRS *Activation* ($\beta = 0.27$, $p < 0.001$) and weak correlation with *Negative Symptoms* ($\beta = 0.10$, $p < 0.05$) in multiple regression[a]

BPRS Brief Psychiatric Rating Scale
[a]Picardi et al. (2017) [2]
[b]Unpublished data
[c]Pallagrosi et al. (2016) [3]

effort to develop and keep a respectful, cooperative, and stable alliance with the patient.

Disconfirmation emerges as a rather 'clinical' intersubjective dimension. Indeed, it has shown only a modest association with demographic variables, but a notable and peculiar pattern of association with clinical ones (Table 8.4). On the one hand, it resembles the pattern of *Difficulty in Attunement*, for its pronounced link with a given diagnostic category (in this case, the cluster B personality disorder). On the other hand, it diverges from that dimension, for its weak relation to the patient's symptom pattern.

Indeed, a regression model accounting for a relatively low proportion of variance in *Disconfirmation* revealed only a moderate association with the BPRS *Activation* dimension, a modest association with the *Negative Symptoms* dimension, and no significant relationship with the *Affect*, *Positive Symptoms,* and *Disorganisation* dimensions [2]. In other words, the patient's elevated mood, excitement, and

hyperactivity explain a significant but small proportion of scores on the *Disconfirmation* subscale.

On the contrary, the relationship between *Disconfirmation* and the diagnosis of cluster B personality disorder seems to be substantial as mean scores on the *Disconfirmation* subscale were found to be higher for the cluster B personality disorder group than for all the other diagnostic groups [3]. The effect size of this finding was large (Cohen's $f = 0.46$), and its significance was retained in multivariate analysis ($p < 0.001$). Conversely, the lowest mean scores on the *Disconfirmation* subscale were observed in the group of patients with depressive or anxiety disorders.

These findings suggest that the patient's psychopathological structure has a remarkable effect on this facet of the clinician's subjective experience, though in a way that is only marginally linked with the symptom pattern, at least as measured by the BPRS. Probably, subtler (though powerful) interpersonal dynamics are involved, which mostly pertain to the area of mutual recognition and alliance. In fact, while depressed or anxious patients generally present themselves as mostly collaborative and trusting, genuinely seeking the clinician's help, patients with cluster B personality disorder are often chaotic and demanding, oscillating between an almost overwhelming request for help and a dramatic rejection. Under this pressure, the clinician, too, may oscillate between feeling moved but drowned and feeling attacked in her personal and professional identity.

The modest associations between *Disconfirmation* and some demographic variables can also be seen in this perspective. In fact, even though the association with the clinician's male gender was found to be inconsistent, the patient's younger age and higher education were found to be modestly associated with *Disconfirmation* in a large regression model [2]. This suggests that the more challenging the patient, as a young and educated individual is more likely to be, the more acute the clinician's perception of being cornered.

8.2.5 *Impotence*

Impotence is an eight-item subscale that explores an area of the clinician's experience characterised by feelings of sadness and dejection, embedded in an overall mood of frustration and poor confidence in the patient's improvement. It represents the most temporality-linked dimension of the ACSE profile as it goes beyond the *hic et nunc* of the encounter and refers also to the evolving course of the relationship.

The pattern illustrated in Table 8.5 points out a significant connection between *Impotence* and a peculiar psychopathological profile.

As a matter of fact, *Impotence* does not seem to be related to the patient's diagnosis as its association with severe disorders such as schizophrenia loses significance when controlled for demographic variables and clinical severity as measured by the BPRS total score [3]. Rather, this dimension displays a moderate independent correlation with the BPRS *Negative Symptoms* dimension, which explains 7% of its unique variance [2]; this suggests that symptoms such as blunted affect, emotional withdrawal, and motor retardation are particularly implicated in generating a 'depressed' climate of the encounter. The association with the *Activation*, *Positive*

Table 8.5 Association between *Impotence* and demographic/clinical variables

	Association	Notes
Clinician age	Yes	Weak correlation ($\beta = -0.10$, $p < 0.01$) in multiple regression[a]
Clinician gender	Yes	Weak correlation with female gender ($\beta = -0.09$, $p < 0.05$) in multiple regression[a], further confirmed in general linear model ($p < 0.01$)[b]
Clinician expertise	No	
Patient age	No	
Patient gender	No	
Patient education	No	
Patient nationality	No	
Setting of visit	No	
Duration of visit	No	
Patient diagnosis	No	
Patient clinical severity	Yes	Moderate correlation with BPRS total score ($r = 0.42$, $p < 0.001$)[c], further confirmed in general linear model ($p < 0.001$)[b]
Patient symptom pattern	Yes	Moderate correlation with BPRS *Negative Symptoms* ($\beta = 0.35$, $p < 0.001$) and modest correlation with *Activation* ($\beta = 0.13$, $p < 0.01$), *Positive Symptoms* ($\beta = 0.12$, $p < 0.01$), and *Affect* ($\beta = 0.10$, $p < 0.01$) in multiple regression[a]

BPRS Brief Psychiatric Rating Scale
[a]Picardi et al. (2017) [2]
[b]Unpublished data
[c]Pallagrosi et al. (2016) [3]

Symptoms, and *Affect* dimensions is less strong, whereas no association was found with the *Disorganisation* dimension.

Younger and female clinicians seem to be more vulnerable to this kind of reaction as if they more acutely experienced the stasis of the clinical situation or as if they had less confidence in their therapeutic potential. The experience described by the *Impotence* subscale, indeed, can involve both a perceived non-transformability of the patient's pathological nucleus (inferred from the patient's 'unmovable' attitude) and a poor trust in one's own ability to really affect the patient's clinical course and outcome.

8.3 Clinical Significance of the ACSE Profiles

In the studies performed so far, the ACSE dimensions have displayed a distinctive pattern of association with several clinical and demographic variables related to psychiatric assessment. Interestingly, for almost all subscales, the most strongly associated factors are the clinical ones.

This finding, besides supporting the original idea that the clinician's subjective experience is notably affected by the patient's psychopathological characteristics through the medium of intersubjectivity, may have clinical implications worthy of being discussed.

8.3.1 ACSE Profiles as a Potential Contribution to Differential Diagnosis

One of the most striking findings from our studies has been that patients belonging to the main diagnostic categories tend to elicit distinctive 'reaction patterns' in the clinicians. In fact, even though not all ACSE subscales were singly capable of differentiating between diagnostic groups—especially *Tension*, *Engagement,* and *Impotence*, which basically distinguished only depressed/anxious patients from the others—the overall profile of mean scores on ACSE subscales (from now on, 'ACSE profile') was unique for each group (Fig. 8.1).

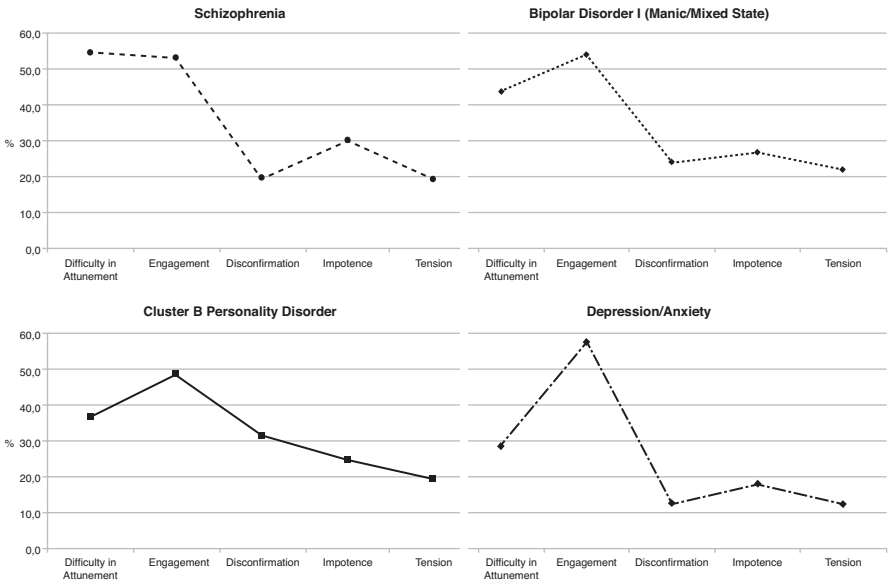

Fig. 8.1 ACSE profiles and patient diagnostic groups. The ACSE scores were converted to a common metric (i.e. the percentage of the maximum possible score on each scale). The subscales were ordered to make the differences between groups most visible

In other words, it seems that the clinician implicitly grasps a difference between patients that is 'relational' in nature, and this distinction is reflected by unique patterns of feelings, thoughts, and bodily perceptions. This is intriguing and suggests that clinicians might be able to differentiate patients with overlapping symptoms not only via the common objective and standardised approach to evaluation, but also by means of an 'intersubjective' criterion.

Not infrequently, in fact, psychiatrists engaged in clinical assessment face the problem of grasping subtle differences that can be significant for diagnosis but go beyond the mere evaluation of observable symptoms and signs. What has been called 'intuitive diagnosis', as we know from previous chapters, rests indeed on 'atmospheric' elements that elude explicit description and quantifiable evidence. Rendering these elements into a comprehensible pattern may help clinicians to take advantage of them.

For instance, we have noted that patients suffering from manic or mixed episodes elicit a typical reaction on the part of the clinician that is similar to the one elicited by patients with schizophrenia, except for *Difficulty in Attunement*, the level of which is significantly different between the two diagnostic categories (Fig. 8.2). Our findings suggest that it is neither the global severity nor the possible psychotic expression that accounts for this difference; rather, it seems to imply a core difference between the two interactions.

Our hypothesis is that the pre-reflective perception of a 'typical' empathic failure, which shapes the ACSE profile in a form that emphasises *Difficulty in Attunement* among all dimensions, characterises the encounter with schizophrenic patients in a way that stands apart from the impact of the psychopathological expression, even when it is bizarre or chaotic, as can occur in severe manic episodes. It appears that something that 'goes beyond the sum of symptoms and signs' is implicated. Apart from being of potential significance for differential diagnosis, such an

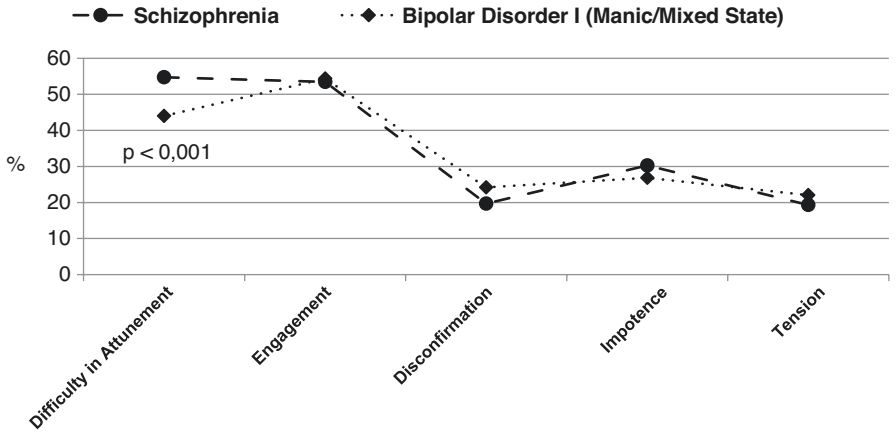

Fig. 8.2 ACSE profiles for schizophrenia and bipolar I disorder groups

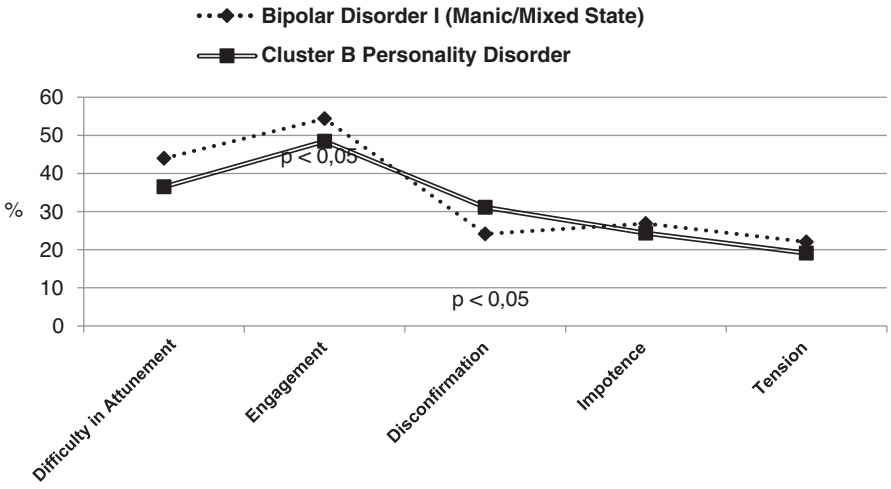

Fig. 8.3 ACSE profiles for bipolar I disorder and cluster B personality disorder groups

intersubjective 'typicality' is of particular interest for a large body of reflection about diagnostic feeling and schizophrenia, which will be illustrated in detail later.

Another example of intersubjective hue that might be significant for differential diagnosis concerns the comparison between patients with manic or mixed state and patients with cluster B personality disorders (Fig. 8.3). It is known that in some cases making a clear distinction between these patients is not straightforward, particularly when they exhibit similar patterns of dysphoric mood, emotional dysregulation, and impulsivity. This can be particularly true during acute phases and when dealing with bipolar patients with rapid cycling or marked residual symptoms.

Indeed, due to the degree of overlap in these symptom domains, even the validity of a clear-cut distinction between the two disorders has been questioned, at least in the *mainstream* psychiatry debate. Nevertheless, a growing number of researchers have put this overlap in perspective [5, 6], pointing out that 'similarities between the two conditions […] are superficial, while differences are profound' [7].

Interestingly, from the 'clinician's side', the interaction with patients affected by cluster B personality disorder is quite different from the one with patients experiencing a manic or mixed episode, with differences in *Engagement* and *Disconfirmation* that mirror each other. In essence, a clinician who interacts with a patient with cluster B personality disorder feels, on average, less engaged and more annoyed, even though she does not experience a different degree of *Tension*, *Difficulty in Attunement*, and/or *Impotence*.

It might be said that the clinician implicitly *smells* the interpersonal rejecting and confusing attitude that is the background of many symptomatic behaviours of patients with a borderline personality organisation, regardless of the impact of mood swings or behavioural activation.

Such a view is further corroborated by the marked difference observed between the latter profile of clinician's subjective experience and the one related to the

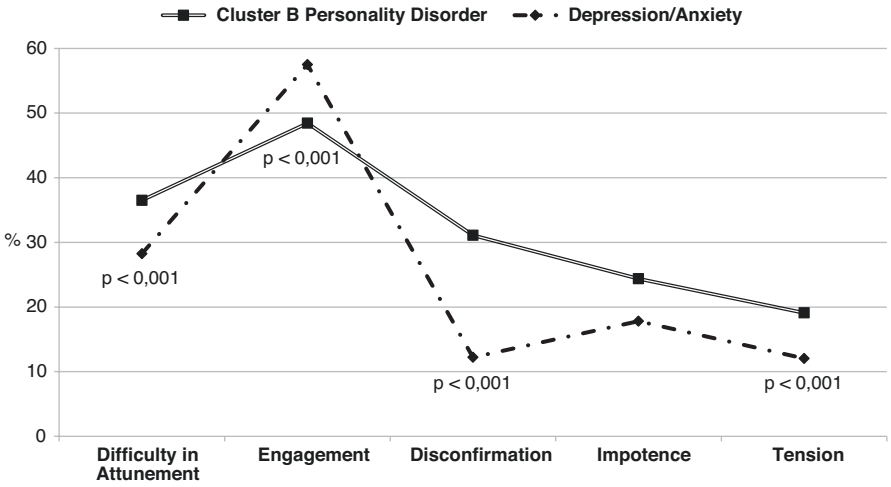

Fig. 8.4 ACSE profiles for cluster B personality disorder and depressive or anxiety disorder groups

encounter with patients suffering from unipolar depression or anxiety (Fig. 8.4). In this case, the two situations significantly differ from each other in the mean score on all ACSE subscales.

The patients with depressive or anxiety disorders without comorbid Axis II diagnoses tend, in fact, to elicit less *Tension*, *Difficulty in Attunement*, *Disconfirmation*, and *Impotence*, and more *Engagement* than patients with cluster B personality disorder. Provided that the former patients are generally experienced by clinicians as the least challenging and the most favourably disposed, it is interesting that, once again, a 'relational' difference emerges between a patient suffering from a mood disorder and a patient suffering from a personality disorder, independent of clinical severity.

In fact, in everyday practice, it is sometimes hard to clearly identify an underlying personality disorder when a patient comes to the clinician presenting a marked depressive suffering or a generalised anxiety state. A quick and correct distinction between a basic mood alteration and the feelings of emptiness or dejection that develop in the context of a specific personality attitude, however, can make the difference between an effective treatment and a therapeutic failure. Therefore, the relative specificity of the relational pattern grasped by the clinician may turn out to be particularly helpful during these early stages of acquaintance.

8.3.2 The Paradigm of *Praecox Feeling* Examined Through the ACSE Lens

In this book, the paradigm of *Praecox Feeling* has been discussed from several points of view. Different authors have outlined its historical development, its connection with similar concepts, and its peculiar nature, which implies at the same time a gestaltic character and an intersubjective nuclear origin.

In addition, we have seen that a number of studies were carried out to explore, on the one hand, the 'real-world popularity' of the *Praecox Feeling* among psychiatrists, and, on the other, the in vivo diagnostic reliability of this construct. Nevertheless, to date, a valid and reliable measure of the *Praecox Feeling* has not been developed, and the research about its clinical significance relies upon qualitative methods or non-validated instruments.

The ACSE project explicitly acknowledges the concept of *Praecox Feeling* among its sources of inspiration, and, possibly not surprisingly, one of the factorially derived ACSE subscales, namely, *Difficulty in Attunement*, closely resembles Rümke's description. Indeed, if we compare this subscale with Rümke's concept, they have several points in common. *Difficulty in Attunement* describes a perceived difficulty in recognising oneself in the experience of the other as if there existed a substantial difference in the way of giving meaning to the experience itself. The subscale also measures a sense of alienation, and uneasiness in interacting and communicating with the other. Furthermore, it includes an explicit reference to the field of 'emotional contact', encompassing also an affective element of the sharing.

In his pivotal essay [8], Rümke in fact speaks about the clinician's subjective perception of general discomfort as if something is going wrong in the interaction, and he relates this feeling to a barrier hindering the clinician/patient intercourse. In his view, the patient's lack of the so-called 'rapprochement instinct' produces in the clinician an effect of estrangement, which involves, besides a more reflective experiential level (i.e. the impossibility to identify oneself in the other's way of experiencing), an implicit feeling of an impossible participation in a shared situation. In this context, Rümke explicitly refers to the concept of 'affective exchange'.

In both the *Praecox Feeling* concept and the ACSE *Difficulty in Attunement* dimension, therefore, an empathic struggle is at stake. Nevertheless, this similarity does not entail a complete overlap of these two entities as they differ significantly in terms of development and epistemological meaning.

The *Praecox Feeling* is a complex construct that includes at least two poles: an intersubjective experiential pole and a descriptive gestaltic one. Also, it has been conceptualised as a diagnostic tool, the presence or absence of which can be critical for identifying well-defined clinical conditions. The *Difficulty in Attunement* dimension, on the contrary, represents a certain nuance of a multidimensional subjective impression, derived through a large empirical observation and not solely pertaining to determined clinical situations.

One may venture that *Difficulty in Attunement* captures the intersubjective nuclear part of the *Praecox Feeling*, around which elements such as gestaltic impressions and trained abilities structure a diagnostic sense. In this light, the clinical intertwinings of *Difficulty in Attunement* may help shed light on some aspects of the *Praecox Feeling* itself and provide new empirical insights about this experience.

For instance, we have seen that *Difficulty in Attunement* is the ACSE dimension most linked with the diagnosis of schizophrenia, to such an extent that we consider this connection as one of the most clinically relevant findings from the ACSE studies. However, such an experience was not found to specifically characterise the encounters with schizophrenic patients. Rather, it seems to be present in all clinical

encounters, being less or more intense depending on the patient's psychiatric condition (Fig. 8.5).

Hence, it seems that what matters is not the presence or absence of this experience, but its relative prominence into the wholeness of the clinician's own subjective experience. In fact, every clinical encounter with an unknown patient entails a portion of 'incomprehensibility', which requires an empathic endeavour that has to do with both the patient's individual alterity and his elusive pathological condition. This struggle tends to increase as the psychopathological 'alienity' progresses and reaches the highest and most distinguishable sharpness when interacting with schizophrenic patients.

Schizophrenia is indeed the condition of otherness *par excellence*, and our studies corroborated the intersubjective extremeness of this otherness. In fact, differently from the interaction with schizophrenic patients, the ethnocultural difference between clinician and patient—which can be presumed to appreciably affect the clinician's empathic ability—has shown only a negligible association with *Difficulty in Attunement*. This finding suggests that *geographical alterity* and *psychopathological alienity* differ in terms of empathic challenge. A possible explanation is that there is a basic level of empathy that is preserved even when the cultural difference alters the shared world of language and narratives (see Chap. 5).

The *Difficulty in Attunement* dimension, thus, seems to capture the disruption of a very basic level of empathic connection; possibly, it is this characteristic that accounts for its relative 'diagnostic' specificity for schizophrenia.

Concerning this diagnostic specificity, the absence of a significant relationship between *Difficulty in Attunement* and clinician's age and expertise is a finding that, while on the surface seems secondary, is quite important. Within the psychopathological debate, indeed, the idea that intuitive understanding is favoured by a rich

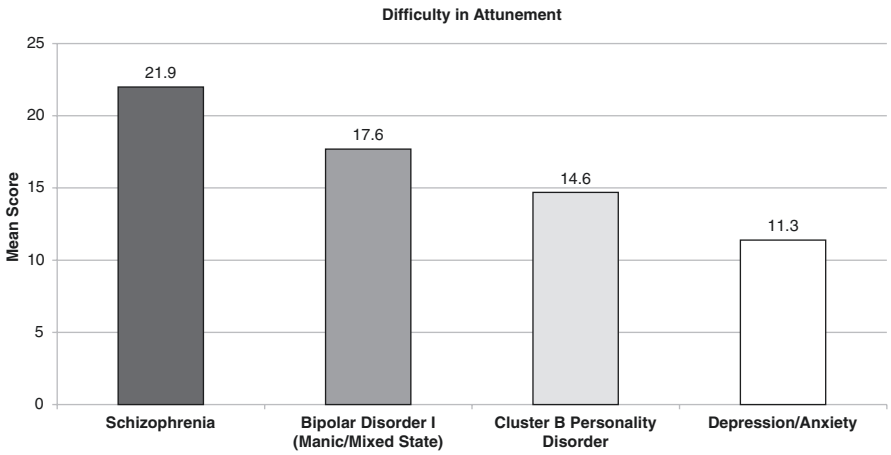

Fig. 8.5 *Difficulty in Attunement* and patient diagnostic groups. The mean score difference was significant for all the comparisons, with the exception of the bipolar disorder I vs. cluster B personality disorder match

background of clinical experience has been repeatedly stressed (see Chap. 1). Nevertheless, in our studies we did not find a difference in terms of perceived *Difficulty in Attunement* between young psychiatrists or psychiatry residents and experienced psychiatrists [1–3]. This finding indicates that, other variables being equal, the clinician's expertise does not change the pre-reflective perception of an empathic hindrance. It suggests that *Difficulty in Attunement* describes an experience that is fundamentally human, belonging to all clinicians, despite their acquired skills. It is, rather, the ability to recognise and thoughtfully use this experience that distinguishes a beginning clinician from a seasoned one. What is inherently available to all human beings, in other words, becomes a sharp instrument of knowledge in the hands of a well-trained psychiatrist.

In conclusion, what can the ACSE studies tell us about the nature of the *Praecox Feeling* and its clinical implications?

First, they suggest that empathic attunement (and its fate) is a clinically relevant dimension of the clinician's subjective experience, and that it is related to the patient's diagnosis of schizophrenia in psychiatric settings. Second, they support the notion that *Difficulty in Attunement*, which seems to represent the basic empathic struggle on which the *Praecox Feeling* relies, is an experience that transcends cultural differences and professional knowledge, and does not need to be specifically trained. What needs to be practised, instead, seems to be the clinician's ability to discriminate such feelings and perceptions, and to make them available for understanding and clinical judgement.

8.3.3 The ACSE in Psychotherapeutic Settings

In the field of psychotherapy, the use of the therapist's feelings is a quite-discussed issue. Historically, this topic is linked to psychoanalysis and the concept of *countertransference*, which in its *totalistic* meaning can be defined as all the attitudes and feelings that therapists experience towards patients.

A strong connection between the therapist's *countertransference* and the patient's inner dynamics has been claimed over the years, and the use of *countertransference* is still recommended in psychoanalytic practice to more thoroughly understand the patient's inner world and to work more optimally during sessions (see Chap. 10 for a thorough discussion).

Even though the psychoanalytic discourse about *countertransference* has some common points with the phenomenological reflection about the emotional and intuitive elements involved in the psychiatrist's clinical impression [9], the two conceptualisations differ significantly with regard to historical development, epistemological framework, and practical application. Delving deeply into this distinction goes beyond the scope of the present section, but it can nevertheless be useful to briefly account for the most relevant aspects.

Countertransference has historically grown into the study of the unconscious dynamics entailed by the psychoanalytic rapport. Initially conceived as the therapist's response to the patient's *transference*, it has been in time enlarged to

encompass elements such as *projective identification*, *empathic resonance,* and *therapist's transference*. All these elements lie in the domain of the unconscious plot of the therapeutic relationship, the gradual interpretation of which is a major tool for the psychodynamically oriented therapist. *Countertransference* is seen then as a compass for the therapeutic process, working from the early stages of the therapeutic relationship.

The empirical research about *countertransference* mainly rests on the *Therapist's Response Questionnaire* (TRQ), which has been designed for psychotherapists engaged in long-lasting relationships. As we have seen in the previous chapter, studies using the TRQ mostly address questions relevant to the care of patients affected by personality and 'neurotic' disorders.

On the other hand, the phenomenological account for the clinician's feelings within psychiatric settings, which is the subject of our work, emphasises the *hic et nunc* experiential dimension of the clinical encounter, and renounces an hermeneutic approach. The clinician's feeling is indeed regarded as an active player of the actual intersubjective interaction, capable of promoting an intuitive diagnostic understanding as well as a consistent therapeutic attitude. Differently from *countertransference*, it lies in the realm of an extended, non-technical dimension of the interpersonal exchange, which can be successfully exploited in clinical practice.

However, in the phenomenological perspective, too, the clinician's subjective experience can be considered as a significant element capable of shaping the fate of a psychotherapeutic relationship. Regarding this issue, we recently carried out a study about short-term psychodynamic psychotherapy [10], exploring the relationship between the clinician's subjective experience as measured by the ACSE, *countertransference* as measured by the TRQ, therapeutic alliance and psychopathological outcome in a sample of 32 outpatients treated by 20 clinicians.

Predictably, the clinician's subjective experience of the first interaction showed many significant correlations with the early therapeutic alliance. We found a strong correlation for *Engagement* ($r = 0.77$, $p < 0.001$), *Difficulty in Attunement* ($r = -0.60$, $p < 0.001$), and *Disconfirmation* ($r = -0.58$, $p < 0.001$); a moderate correlation for *Tension* ($r = -0.42$, $p < 0.05$); and no correlation for *Impotence*. The clinician's immediate perception of the interpersonal dynamics seemed then to be mostly consistent with the outcome of the alliance, so that an overall positive 'starting engagement' predicted a good collaboration with the patient and vice versa.

Conversely, a different picture emerged concerning clinical outcome. In fact, only the level of *Difficulty in Attunement* experienced by the clinician during the first encounter was shown to be significantly associated with the patient's clinical change at the end of the psychotherapeutic intervention, with a moderate inverse correlation ($r = -0.47$, $p < 0.01$).

Such a deviation from the pattern exhibited by therapeutic alliance is intriguing as it seems to suggest that the connection between the early clinician's subjective experience and the patient's clinical improvement was not mediated by the alliance itself. Otherwise, the two trends should have been similar.

Hence, if a number of clinician's disturbing emotions at the beginning of the relationship may impair the therapeutic alliance (especially in the short term), their

association with the patient's psychopathological change is more complex. Indeed, neither a positive engagement with the patient nor a relational annoyance seems to affect short-term clinical outcome as if the latter depended more on the patient's resources than on the clinician's affection, hopes, or aversions.

Nevertheless, when a clinician's early experience includes an empathic hindrance, this seems to be inversely linked to the patient's subsequent improvement. Our experience with the ACSE suggests that in these cases the clinician grasps an experiential distance that can be related to both the therapeutic dyad's lack of syntony and the patient's withdrawn attitude. This subtle intersubjective alteration, quickly perceived by the clinician, possibly prevents the development of the implicit interpersonal *milieu* that supports an effective therapeutic intervention. According to this interpretation, a high early level of *Difficulty in Attunement* may indeed predict a poor short-term outcome, which suggests that this dimension deserves careful consideration from the very beginning of the psychotherapeutic work.

8.4 Conclusions

Around 2010, when we started our work on the clinician's subjective experience, we faced the reality of a world where mainstream psychiatry ignored the clinician's subjectivity altogether while a small professional niche deeply rooted in the phenomenological tradition believed in the diagnostic value of the clinician's feelings despite the absence of solid empirical support for this notion and actually the impossibility of providing such support, given the lack of validated measures of the clinician's subjectivity. It was a daunting task, but we decided to attempt to develop and validate such a measure, and use it to test whether the great phenomenological psychopathologists of the twentieth century were on a reasonably right path. We succeeded, despite the limitations that any quantitative measure implies, in developing a valid and reliable measure of the clinician's subjective experience that could be used in scientific studies. Although this line of research is still in its infancy and much work is still needed to elaborate on our findings, the ACSE filled a research vacuum that had lasted for almost a century.

At the end of the overview presented in this chapter, in fact, we can conclude that the ACSE holds promise to be an original lens through which to investigate a number of clinical issues. In particular, our findings have so far allowed us to identify the involvement of the clinician's subjective experience in both diagnostic evaluation and therapeutic intervention. In contrast to what a strictly objectivist perspective would suggest, such involvement did not emerge as the volatile and idiosyncratic reactions of single clinicians, but as a consistent pattern of experiences that can be at least partially characterised.

Recent unpublished data about the inter-rater reliability of the ACSE subscales provide further evidence of the consistency of the experiences measured by the ACSE. In 189 pairs of clinicians seeing the same patient within a few days, we found a statistically significant agreement between raters as measured by the intraclass correlation coefficient (ICC) when the patient's clinical state as measured by

the BPRS did not substantially change across the two clinical examinations. The ICC values indicate a negligible agreement for *Tension* (0.17), a modest, though significant, agreement for *Engagement* (0.31) and *Disconfirmation* (0.32), and a moderate agreement for *Impotence* (0.40) and *Difficulty in Attunement* (0.57). The higher the agreement, the bigger the proportion of variance which can be reasonably attributed to the specificity of the encounter with *that* patient.

So, if the clinician's subjective experience has such a significant potential role for assessment, a number of clinical applications can be imagined for the ACSE.

First, it may represent a valuable integrative tool for the traditional third-person approach to the psychiatric interview and diagnostic reasoning. As we have seen, in fact, it may contribute to differential diagnosis for those conditions that present themselves with a high degree of overlapping symptoms. In addition, it may help clinicians to identify 'ultra-high-risk' patients across the schizophrenia spectrum disorders, allowing the detection of intersubjective disturbances even when pre-psychotic symptoms are absent or very difficult to identify.

As it promotes the act of focusing on one's own subjective experience, the use of the ACSE may also play a major role in helping clinicians to get acquainted with their feelings and better trained in recognising and managing them. This is indeed a critical issue for both therapeutic and technical aims. On the one hand, the clinician's self-awareness represents a significant step towards the establishing of an authentic and effective therapeutic alliance, from the early stages of the relationship with the patient. On the other hand, it can assist the clinician in limiting the overwhelming emotional load that is often elicited by contact with patients (especially those with severe mental disorders), and that can lead, in the long term, to professional burnout [11].

In this regard, it has been a common observation among clinicians participating in the ACSE studies that the time spent in completing the instrument was beneficial, facilitating a better focus on some clinical issues. They often reported that during the 5–10 min needed to complete the ACSE they were able to better reflect on the dynamics of the encounter, which enabled them both to refine the clinical reasoning and to discharge the most disturbing emotions.

It follows that, due to these potentialities, the use of the ACSE may also have a role in training programmes. Its incorporation in such programmes seems to be particularly relevant in the current *zeitgeist*, where a mostly impersonal approach to the patient is encouraged, to the detriment of the young psychiatrists' subjective and relational skills.

It should be kept in mind that several issues are still in need of investigation regarding the clinician's subjective experience as measured by the ACSE and its links with the clinical encounter. For instance, it would be interesting to investigate the relationship between ACSE scores and a standardised, independent diagnosis made by another psychiatrist. Also, cut-off scores for the subscales might be at least tentatively identified, to complement profile-based interpretation. An extension beyond the Italian culture through validation of the ACSE in other languages would also be useful to test the generalisability of our results.

While further studies are needed, the data collected so far in studies involving more than a hundred clinicians and about 2000 patients seem solid enough to take intersubjectivity and the clinician's subjective experience out of the realm of randomness and unfathomability, and suggest a careful reflection about the epistemological attitude of current mainstream psychiatry.

We would like to conclude, borrowing from Rümke, that '*the doctor's internal attitude induced by the patient is a very sensitive diagnostic tool, and it would be helpful if we were more skilled in recognizing changes in our own internal attitude; it would certainly make us more self-confident in making diagnoses'* ([7], p. 337).

References

1. Picardi A, Panunzi S, Misuraca S, Di Maggio C, Maugeri A, Fonzi L, Biondi M, Ferrara M, Pallagrosi M. The clinician's subjective experience during the interaction with adolescent psychiatric patients: validity and reliability of the Assessment of Clinician's Subjective Experience (ACSE). Psychopathology. 2021; https://doi.org/10.1159/000513769.
2. Picardi A, Pallagrosi M, Fonzi L, Biondi M. Psychopathological dimensions and the clinician's subjective experience. Psychiatry Res. 2017;258:407–14.
3. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Association between clinician's subjective experience during patient evaluation and psychiatric diagnosis. Psychopathology. 2016;49(2):83–94.
4. Fonzi L, Picardi A, Monaco V, Buonarroti M, Prevete E, Biondi M, Pallagrosi M. Clinician's subjective experience in the cross-cultural psychiatric encounter. Psychopathology. 2020;53(5-6):282–90.
5. Bayes A, Parker G, Paris J. Differential diagnosis of Bipolar II Disorder and Borderline Personality Disorder. Curr Psychiatry Rep. 2019;21(12):125.
6. Sanches M. The limits between Bipolar Disorder and Borderline Personality Disorder: a review of the evidence. Diseases. 2019;7(3):49.
7. Ghaemi SN, Dalley S, Catania C, Barroilhet S. Bipolar or Borderline: a clinical overview. Acta Psychiatr Scand. 2014;130(2):99–108.
8. Rümke HC, Neeleman J. The nuclear symptom of schizophrenia and the praecox feeling. Hist Psychiatry. 1990 Sep;1(3 Pt 3):331–41.
9. Rossi Monti M. Psicoanalisi e psicopatologia. Controtransfert e sentimento precoce di schizofrenia. Comprendre. 2008(16–17–18):325–345.
10. Tanzilli A, Majorana M, Fonzi L, Pallagrosi M, Picardi A, Coccanari de' Fornari MA, Biondi M, Lingiardi V. Relational variables in short-term psychodynamic psychotherapy: an effectiveness study. Res Psychotherapy. 2018;21(3):327.
11. Maslach C, Leiter MP. Understanding the burnout experience: recent research and its implications for psychiatry. World Psychiatry. 2016;15:103–11.

9 Clinical Judgment of Schizophrenia: Praecox Feeling and the Bizarreness of Contact—Open Controversies

Marcin Moskalewicz and Tudi Gozé

The sensing is to knowing as a cry is to words.

Erwin Straus (1963, p. 312)

9.1 Praecox Feeling as an Expert Judgment

Schizophrenia is one of the most invaliding mental conditions that affects 0.7% of the world population. Since there is no valid biomarker of schizophrenia, clinical expertise remains referential for diagnostic decision-making. The Praecox Feeling (PF) is a specific experience that arises in a psychiatrist during an encounter with a person with schizophrenia. It is classically described as an atmospheric feeling of strangeness and unease. Several studies in different cultural contexts have shown that psychiatrists take this experience seriously into consideration in diagnosis. There are also a few studies attempting to explain the PF's causes and assess validity (see below). However, this phenomenon is still relatively poorly understood, which might lead to clinicians' mistrust of their subjective experiences.

In his seminal description from 1941, the Dutch psychiatrist Henricus Cornelius Rümke defined the PF as a feeling of strangeness experienced by a clinician in the

M. Moskalewicz (✉)
Philosophy of Mental Health Unit, Department of Social Sciences and the Humanities, Poznan University of Medical Sciences, Poznan, Poland
e-mail: moskalewicz@gmail.com

T. Gozé
Department of Psychiatry, Psychotherapies and Art-therapy, Toulouse University Hospital, Toulouse, France

Equipe de Recherche sur les Rationalités Philosophiques et les Savoirs—EA3051, Université de Toulouse—Jean Jaurès, Toulouse, France
e-mail: dr.tudigoze@gmail.com

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_9

first minutes of the encounter with a patient. Rümke claimed that the diagnosis of schizophrenia is often fairly quickly reached through a passive and indescribable intuition. Taken individually, the symptoms of schizophrenia are unspecific, but taken together they appear as having something of a "schizophrenic tint." That is why the PF appears less in the manner of object perception than as a kind of atmospheric strangeness surrounding the encounter in which particular symptoms are immersed. Rümke also noted that despite its rapidness the diagnosis of schizophrenia is often challenging to account for by the psychiatrist.

> In the encounter with the schizophrenic patient, the investigator feels a curious hesitation and a feeling of strangeness, which refer to the rupture of the normal mutual relationship of two people meeting. What is called the instinct of rapprochement and its expressions are disturbed on one side only. The investigator's rapprochement is hampered by the lack of rapprochement on the other side. ([1], p. 162)

Rümke suggests that the PF could be explained by the fundamental inaccessibility of the patient to empathic understanding. No matter how well one knows the patient's biography and psychopathology, there is something that resists the effort of comprehension.

Some researchers claimed that the backbone of the PF could be expanded into other disorders that also have a particular "color," analogically to the "schizophrenic color" ([2], p. 195). For example, Hans Asperger, who invoked and reconceptualized Bleuler's idea of schizophrenic autism, wrote that "autistic behaviour has its own particular flavour which is unmistakable for the experienced" ([3], p. 50). Others spoke of analogical "hysteria feeling" [4], and some clinical psychologists speak of their "borderline feeling"—the ability to recognize a patient with borderline personality disorder immediately. Indeed, rapid impressions may play a role in medical diagnosis, and, probably, all these phenomena are somehow related to what is metaphorically termed the "gut feeling." Today, psychometric tools such as the *Assessment of Clinician's Subjective Experience* are designed to explore the psychiatrists' feelings toward their patients with different disorders [5]. In this chapter, however, we focus on the PF only and maintain its specificity.

How is such "feeling" supposed to lead to valid and reliable diagnosis? The legitimate doubts led to the relegation of the PF from diagnostic decision-making in the last quarter of the twentieth century. One of the reasons was severe consequences of schizophrenia diagnosis in the form of involuntary confinement and associated stigma. If the clinical diagnosis was based merely on psychiatrists' feelings, then Thomas Szasz could be right in claiming that schizophrenia is just a derogatory label put onto people whose disturbing behaviors psychiatrists disvalue [6]. Thanks to experimental evidence, we are now aware of unconscious cognitive biases in expert judgments based on intuitive reasoning. As the proponents of the heuristics and biases approach to decision-making underline, professional judgments suffer from inherent validity flaws despite the subjective conviction that it is otherwise [7]. The PF, therefore, could be just another exemplification of the illusion of validity accompanied with a sense of accuracy, to which even sophisticated scientists and clinicians are not immune.

Nevertheless, while a great deal of skepticism is warranted, there are equally strong arguments for the accuracy and validity of expert intuitions, such as those presented by the proponents of the naturalistic decision-making model. The examples are master chess players, firefighting commanders, or neonatal nurses, all capable of making adequate decisions within seconds without being fully aware of their rationale. Therefore, it is possible to demystify expert intuitions and feelings as ultimately relying on cues, which are difficult to articulate, but that, in the right hands, lead to accurate decisions. Is this the case of the PF?

9.2 The Conceptual History of the Praecox Feeling

While Rümke was the first to use the term Praecox Feeling, his conception belonged to a much longer discussion taking place in continental psychopathology. Speaking in terms of conceptual history, the idea of intuitive and immediate diagnosis of schizophrenia evolved and took several related forms, of which the notion of the PF was just one (even if ultimately the most popular) expression. The history of the PF is thus intimately linked to the conceptual history of schizophrenia [8] (Berrios, Lugue & Vilagran, 2003).

The relevant step in this history was taken by Eugen Bleuler, who did not simply change the name of Emil Kraepelin's notion of *Dementia Praecox* nor refined its preexisting sense. It was a more radical change in the very way of thinking about this nosographic category and nothing less than a Copernican revolution, a transformation of the epistemological paradigm. In his *Dementia Praecox and the group of schizophrenias* (1911), Bleuler argued that these disorders should not be grouped according to their hereditary nature and unfavorable evolution (like in Kraepelin's "Dementia Praecox"), but according to their common psychopathological determinant (clinical core) [9]. This core was the "intra-psychic *Spaltung*" resulting, on the one hand, in the slackening of associations and, on the other hand, in withdrawal to a fantasy life and detachment from reality (schizophrenic autism). For Bleuler, the clinical core was more encompassing than the sum of symptoms described by Kraepelin, and it was supposed to transpire through particular manifestations of illness. The notion of clinical core, taken from the French psychologists Binet and Simon, was further developed by one of Bleuler's most eminent students, Eugene Minkowski (1885–1972).

Minkowski was a Polish-French psychiatrist of Jewish origin, born in St. Petersburg, educated in Warsaw, Breslau, Gottingen, and Munich. During the First World War, he worked under Bleuler at the Burghölzli. After the war, he settled in France, obtained citizenship, and contributed significantly to the introduction of the concept of schizophrenia in France. Initially inspired by Henri Bergson and Max Scheler, Minkowski substantially modified the Bleulerian conception by exploring its phenomenological foundations [10]. Minkowski's contribution to the debate consisted in clarifying the idea of direct recognition of the clinical core, for which he coined the term "diagnostic by penetration." According to Minkowski, Bleuler did not go far enough in his conceptualization of schizophrenic autism. Focusing on

mental contents, he missed the key to understanding schizophrenia, which is the connection between a person and his/her world.

The actual clinical core in Minkowski's view is a "loss of vital contact with reality" or an imbalance between syntony and schizoidia, the two dimensions of vital contact that are normally in equilibrium. The patient loses the passive "ability to move forward harmoniously with the ambient becoming penetrating us and making feel one with it" ([11], p. 59). It is the anthropological "principle of penetration" between the subject of experience and the surrounding world. In schizophrenia, a disproportionate tendency of schizoidia results in a loss of "resonance" with the world. As a consequence, the patient attempts to cognitively (explicitly) but vainly reconstruct what is normally implicitly felt through affective contact (a process Minkowski calls "morbid rationalism" or "morbid geometrism"). The "diagnostic by penetration" refers to the clinician's ability to recognize (through syntony) the clinical core somehow passively. The clinician may feel that the patient is cut off from harmony with the world. It should be added that for Minkowski the diagnosis by penetration does not always appear immediately; it can take place after years of psychotherapy. As he later put it:

> At a given moment, sometimes in connection with a single sentence, suddenly, without my knowing exactly how, the light comes on: I have the certainty of having grasped the whole, of finding myself in the presence of the fundamental disorder, the generating disorder which, like a cornerstone, carries all the others as they spread out on the surface and can be the object of a description. We can speak there of a phenomenological intuition very close to the Bergsonian intuition. ([12], p. 162)

Already in 1924 Ludwig Binswanger, the founder of Daseinsanalyse, highlighted the possibility of diagnosing schizophrenia "intuitively" through face-to-face interaction. He argued that the relationship between a doctor and a patient operates at a fundamentally different level than the objective perception of symptoms. What is presented to the psychiatrists are not partial symptoms but the whole person:

> This is often referred to as a "feeling diagnosis" (*Gefühlsdiagnose*), but it is not clear whether this is something different from the case where, for example, a general practitioner confronted with a patient who has no other symptoms than a high fever has the feeling (*Gefühl*) or the instinctive conviction (Instinkt) that it is a case of typhus and not pneumonia…. In contrast, when we diagnose schizophrenia "by feeling" (*nach dem Gefühl*), "feeling" is here exclusively a more vague general expression, it is the act of perception of a foreign psychic reality (*seelischen Fremdwahrnehmung*). …] In this case, we do not diagnose exactly according to the feeling but through the feeling (*nicht nach, sondern mit dem Gefühl*). ([13], p. 136)

Here, Binswanger points out that the psychiatrist beholds the essence (*Wesenserschauung*) and perceives through feeling the lack of rapport between the patient and oneself. The general practitioner could also find the origin of fever thanks to his feeling based on clinical experience. The difference is, however, that

> A schizophrenic patient can be very sympathetic to me as a human being, and yet he always repels me inwardly (*pralle ich innerlichimmerzurück*), I always have the impression that there is a barrier that prevents me from uniting myself deeply with him. [13] (Binswanger, 1955, p. 136)

So far, we have spoken of two notions, penetration and feeling, both preceding Rümke's PF. Other terms have been used as well, often involving some shifts of meaning. Jakob Wyrsch used the notion of intuition and spoke about diagnosis through intuition [14]. Carp, on the other hand, preferred the term sensation (*Empfindung*) [4]. As the author of the first and the most comprehensive survey of the PF among German psychiatrists rightly put it: "the term 'feeling' used in the concept that is supposed to serve diagnostic clarification is suspicious" ([15], p. 385). In his later work, Rümke himself says explicitly that the PF is not a feeling (*Gefühl*), but an experience (*Erlebnis*) [16]. This latter term is usually translated as lived experience and not simply the experience of an external object. Considering the comprehensive character of the PF reaching beyond particular symptoms, Swiss psychiatrist Theodor Spoerri (1924–1973) suggested not to speak of a feeling, but instead of "impression" (*Eindruck*) of the totality of schizophrenic expression (*Ausdruck*) ([17], p. 62). Much later on, Schwartz and Wiggins presented the PF as a typification, a tacit and preconceptual skill [18].

We have seen how the epistemic roots of Rümke's concept of the PF are embedded in the conceptual history of schizophrenia. It is also for this reason that the concept is ideologically charged and must be phenomenologically purified. Rümke considered the PF the ultimate sign of "real schizophrenia" [16]. This concept referred to degenerative and incurable Dementia Praecox conceptualized by Kraepelin as Rümke did not follow Bleuler. The reasons for this conservatism are unclear. Rümke found Bleuler's description too extensive and assembling heterogeneous etiopathological conditions. He even justified the poor results of recovery in his clinic by the fact that he selected patients with this famous "real schizophrenia." Therefore, there is an epistemological link between Rümke's view of schizophrenia and the heredity/degeneration paradigm, reaching back to Bénédict Augustin Morel (1809–1873), and still very much in operation in the first half of the twentieth century. The second noteworthy fact is Rümke's rejection of the very possibility of an intra-psychic *Spaltung* (dissociation) being the core of schizophrenia. Although Rümke came from an agnostic background, he seems to have been influenced by the Calvinist conception of his professor, Leendert Bouman (1869–1936) from the University of Amsterdam [19], who rejected the idea of divisibility of the human soul [20].

Therefore, we must attempt to distinguish the historical, contextual, and ideological aspects of the phenomenon of the PF from the naked phenomenon itself. This is possible thanks to phenomenological épochè or reduction that enables bracketing any doxic position to study the phenomenon's phenomenalization, that is, the dynamics of its appearing. We shall term the core of the PF's appearance as different from its clinical, social, and political layers, the bizarreness of contact. We shall come back to this point after a detour through empirical data on the PF.

9.3 Empirical Evidence

From the clinical–empirical perspective, the two most important problems associated with the PF are: (1) Is it merely a purely subjective impression that must lack any scientific validity and reliability? [21] (2) How often does it take place and

guide the diagnosis of schizophrenia today given the "operational revolution" [22] and the widely recognized "death of phenomenology" in clinical decision-making [23]? Only a few empirical studies explore PF-like experiences systematically. There is nevertheless some evidence that the PF has at least some clinical validity and reliability and that it still plays a role in diagnostic decision-making in schizophrenia. The first type of evidence comes from experimental studies, and the second type of evidence concerns the prevalence and content of PF-like experiences in reports of clinical interviews.

Regarding experimental evidence, two studies investigated the sensitivity and specificity of the PF compared to standardized diagnostic classifications (ICD 10 and DSM-IV). Grube [24] included 67 patients with acute positive psychotic symptoms and measured the intensity of the PF in a single experienced clinician during a few minutes-long interview. The degree of correlation with the final diagnosis was high. Using a different protocol, Ungvari et al. [25] have nuanced these results on a population of 102 recently admitted patients. The PF was rated by five psychiatrists with different levels of professional experience. This study brought inconsistent results regarding reliability and showed poor sensitivity and specificity of the PF.

Unfortunately, we cannot conclude much from these results, and new studies must be conducted in the future. As Pallagrosi and Fonzi stated, it is methodologically crucial that the evaluators have direct contact with the patients since the PF is a highly intersubjective phenomenon [26]. It should be noted here that the assessment of the validity of the PF as a diagnostic tool for schizophrenia is very delicate insofar as there is no gold standard against which to compare it. Furthermore, as is well known, there is no consensus on the definition of schizophrenia and its nosographic boundaries [27]. As far as psychiatrists' reports are concerned, our comparative studies, described in detail elsewhere [28, 29] and aimed at assessing the self-reported prevalence of the feelings suggestive of the diagnosis of schizophrenia, indicate that these feelings are relatively stable across countries and times. This is despite distinct nosological frameworks used in the 1960s Germany, the 1980s United States (DSM-III era), and the 2010s France and Poland (DSM-5 era), and despite the widely accepted implementation of operationalized diagnostic tools. It appears that the teaching of criteriological methods as cardinal diagnostic skills did not lead to any significant relegation of the PF from diagnostic decision-making (Fig. 9.1).

The problem with reported reliability is that subjective confidence is itself an unreliable indicator of the reliability of intuitive judgments such as those based on the PF [30]. Overconfidence appears among clinical experts as among other professions, and it is a genuine problem in medicine. Reliance on subjective confidence (such as a belief in reliability) may lead to diagnostic inaccuracy. Nevertheless, a potential theoretical argument in favor of the PF is that the uncertainty of diagnosis is much lower in specialty disciplines than in general medical settings [31].

With regard to the phenomenal content of the PF-like experiences, little is known as to what it is like to have them. It is likely that the pre-reflective quality of the PF is a barrier to its verbal expression. Our unpublished surveys on small convenience samples conducted in New York City in 2016 ($n = 38$) and in the United Kingdom

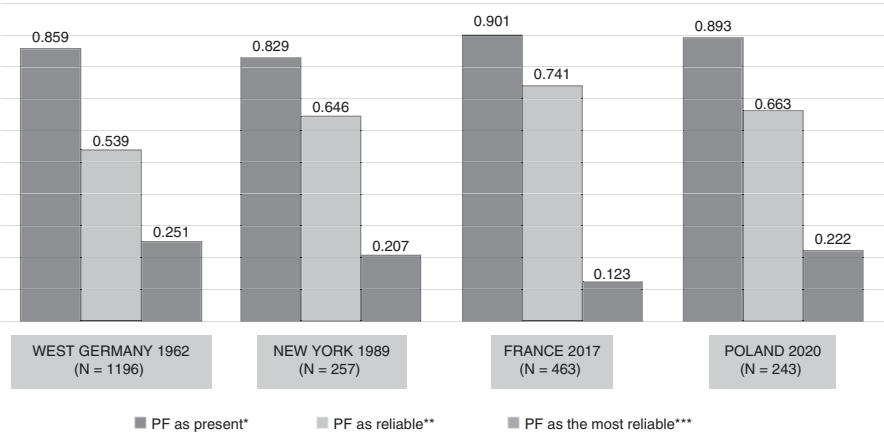

Fig. 9.1 Presence and reported reliability of PF-like experiences in different countries. $^{*}p < 0.02$; $V = 0.068$; $^{**}p < 0.001$; $V = 0.17$; $^{***}p < 0.001$; $V = 0.123$ [29] Despite statistically significant differences regarding these feelings' considered presence and reliability, the low Cramér's V measuring the strength of the associations warrants the conclusion that the differences are negligible

in 2017 ($n = 93$) asked the psychiatrists who reported having "feelings suggestive of the diagnosis of schizophrenia" and were capable of articulating them in words (the majority of both samples; $n = 24$ and $n = 49$, respectively) to give a brief description. Interestingly, many of them referred to metaphors to break down the barrier of expression. In the mode of exemplification only (as this chapter does not allow for a detailed qualitative interpretation), most of the psychiatrists speak about something being wrong with the patient when asked about their feelings. However, some (9.5% in the NY sample and 35.7% in the UK sample) define these feelings in terms of a break in the relation with the patient (see Table 9.1). This is consistent with those conceptions of the PF that emphasize its intersubjective, and not subjective and patient-oriented qualities. For example, Hubertus Tellenbach spoke about "atmospheric diagnosis" pertaining to the whole atmosphere shared by the two subjects [32]. Alfred Kraus (1999, 2007) described the PF in Heideggerian categories as deformation of affective tonality (*Stimmung*) between a patient and a psychiatrist, which is neither "here" nor "there" [33, 34]. Somogy Varga wrote about disturbed I-Thou intersubjectivity [35], while Bin Kimura of the intersubjective in-betweenness (*Aida*) [36].

Finally, only a few (9.5% in the UK sample) described these feelings as self-referential and neither object nor relation-based. These descriptions point to the PF's subjective dimension and how mental illness, and schizophrenic bizarreness in particular, resonates in clinicians. Speaking in such existential terms, a prominent Dutch psychiatrist Eugène Carp (1895–1983) interpreted the PF as a defense mechanism against otherness that is evoked by the existential possibility of radical loneliness that everyone carries within oneself [4]. Carp observed that the PF contains an element of "bad faith," and its function is to preserve the illusion of being different and "normal." It might be that this aspect of the PF is not so evident since, as Bruni

Table 9.1 Exemplary descriptions of the PF

Intentional object	Exemplary descriptions
Patient	P1 (NY): "The patient's mood is often 'empty' which is readily differentiated from an anxious, depressed, irritable or manic mood" P2 (UK): "A level of distractibility and cognitive impairment similar to executive function impairment but stranger, combined with perplexed or flat affect"
Relation	P3 (NY): "Experience a flatness, almost like a wall is up between me and the person" P4 (UK): "I can best describe it as myself and the patient's sense of the world being two circles of a Venn Diagram, and the feelings relate to how little our circles intersect"
Physician	P5 (UK): "Often I experience sadness mixed with a mild bewilderment of the 'reality' and experiences described by patients" P6 (UK): "Feeling similar to when having a conversation (for instance, at a party) with someone who is cleverer than I am—that I should be able to follow the conversation but can't keep up"

et al. have argued, to become more sensitive to the effects of schizophrenia in oneself requires someself-training [2]. Both the relation- and the self-based descriptions of the PF point to the non-individualistic structure of existence, mental illness being neither in the brain nor simply in the body, but at the intersection of two (or more) interconnected selves.

9.4 On the Phenomenological Givenness of the Praecox Feeling

We have noticed earlier several shifts of the meaning of the PF-like experiences. Is the PF best described in terms of sensation, feeling, experience, intuition, impression, or typification? Before we proceed further, let us mention an analogy between PF-based diagnostic decision-making and aesthetic judgment [37]. This analogy presents a psychiatrist as a skilled art connoisseur who does not need to follow a checklist of qualities that a person should exhibit in order to be judged as schizophrenic. Instead, a clinician has an *immediate* sense of dealing with an interpersonal encounter of a particular *Gestalt*. It is no coincidence that the sense of taste became the metaphor of aesthetic judgment in the European aesthetics tradition. Art affects one like a flavor; it is immediate and indisputable—*de gustibus non disputandum est*. Despite this quasi-sensual immediacy, the judgments of taste lay claims to universal validity [38]. An analogical paradox pervades the phenomenological evidence of the PF. How the indisputable but ineffable atmosphere of bizarreness becomes a clinically perceptible and universal sign?

We have seen with Rümke and the phenomenological tradition in psychiatry that the PF's departure point is paradoxical. On the one hand, the PF is described as intuitive evidence and a basis of diagnostic certainty capable of defining the clinical

core of the nosological entity. On the other hand, the PF is given in a vague way as an atmosphere that cannot be perceived as an intentional objects sensu stricto. The problem of the phenomenal givenness (*how* is it given as an experience) of the PF has already been the subject of much debate. The majority of contemporary psychiatric literature follows the concept of typification developed by Schwartz and Wiggins [18], which so far has been only mentioned. Typification is a tacit perception of the other as a particular gestalt under conditions of incomplete information. In early Husserl, the concept of typification refers to every object perception; it is not limited to intersubjective situations. For example, we do not need to have an overall view of a building to recognize it because the partial perception of one of its facets immediately send us back to the idea (*eidos*) of the building. Schwartz and Wiggins have argued that thanks to typification a trained clinician can recognize in the first minutes of the encounter that a patient presents a specific prototype. Relying on Jaspers, they claimed that typification reveals the ideal-typical connections and not a set of virtually independent signs [39, 40]. The initial typification evolves along the interviewing process from a mainly tacit and elusive feeling to a more nuanced and specific impression. The scientific use of typifications requires that psychiatrists also doubt and reflect on their typifications, as we have argued earlier [37]. They need to repeatedly test their interpretations by looking for additional components to prove or correct their typifications. Typification processes are scientific only to the extent that they are based upon this dynamic circle of recognition and verification by evidence-based criteria. The PF understood as a typification ultimately leads to a predicative judgment. It is admittedly partly tacit to consciousness, but well within the perceptual intentional process's scope—intentional in the phenomenological sense of being directed at something.

This conceptualization certainly helped to legitimize the PF as a medically valid experience. Nevertheless, it also brings about an inevitable theoretical impasse. The critique of typification comes from Husserl himself and his arguments against analogization. The most well-known argument is presented in the famous fifth *Cartesian meditation* [41]. In this text, Husserl questions the idea that the experience of others proceeds analogically to the perception of an object typified as a whole, even though only some of its "shading" (*Abschattung*) is perceived. Every object can be perceived from several perspectives, each anticipating its possible forms, so the world remains continuous and reliable. With regard to the other, Husserl notes, there is an unfathomable reserve of otherness. One cannot "go around" the other to reveal all his/her facets. In every other, there is an insurmountable otherness that one cannot fully grasp (an argument largely extended by Emmanuel Levinas as the foundation of his ethics [42]). If one can understand the Other, it is through apperception, where the gap of otherness is somehow crossed by analogy with one's own body. On this point, Husserl is very cautious. He had discussed earlier his contemporary psychology of empathy of Lipps [43] and Erdmann [44], and pointed out that it is not simply a question of attaching an "image" of one's body to the appearing body of others to experience the other body as an embodied presence [45]. If this were the case, one would see in others only avatars of oneself, the look-alikes responding to one's intentions. This may perhaps correspond to the psychotic experience, but it does not

account for the ordinary encounter. The givenness of the Other is possible because one's corporeality is the matrix of appearance that itself contains a fundamental otherness (transcendence) [46]. Because one makes the experience of exteriority (the surrounding world) through one's living corporality and according to the habitus of one's body schema, the appearing body of others is not taken for that of a disembodied puppet, but as another self. Despite the insurmountable otherness of the other, one can recognize this other as another self from the position of one's own otherness.

The experience of the PF legitimizes a critique of typification insofar as it is described as perceptive and intentional, even if preconceptual. Indeed, we have seen that PF is most often described as a vague, nonpositional, and nonthematic atmosphere, and corresponds (in Husserlian terms) to the ante-predicative level of experience. Moreover, Husserl's typification aims at perceiving the world in a continuous, unified, and predictable way even though we most often perceive it in incomplete fragments. In other words, typification aims to attach the known to the unknown in order to limit surprise. On the contrary, what characterizes the PF's experiential level is its dimension of surprise and strangeness, which, precisely, seems to thwart the usual perceptual processes of familiarity and recognition of the other.

As far as the schizophrenic encounter is concerned, a kind of redoubling of the otherness takes place. In his General Psychopathology, Jaspers has emphasized the radical incomprehensibility of schizophrenic delusional experience and the lack of empathic interaction [47]. If the PF's phenomenological analysis remained at this level of incomprehensibility, it would be an impasse. The paradox of the PF as indescribable and, at the same time, self-evident is unsolvable if one remains at the level of direct apprehension of the lived phenomenon (what Husserl called the *static phenomenological analysis*). We must therefore abandon the level of PF's what-is-it-like-ness, and move toward its unfolding (what Husserl called the *genetic phenomenological analysis*). We focus on the PF's temporal deployment, from the pre-givenness of passive syntheses to intentional shaping of lived experience.

Such a view of the PF's phenomenal givenness as an unintentional or pre-intentional mode of grasping has been recently backed up by the distinction between the PF and the bizarreness of contact (BC) [48, 49]. The concept of the PF is embedded in a vast historical, ideological, diagnostic, and prognostic context. The BC, in contrast, is about naïve sensing that a layperson might have when coming into contact with a person with schizophrenia, without even being explicitly aware of it. The bizarre is a pure phenomenon free from theoretical and scientific constructions.

We posit that in the clinical encounter with a schizophrenic person a psychiatrist does not simply deal with Jasper's incomprehensibility of delusions. Neither he deals with Rümke's definite un-understandability of the patient and the resulting lack of affective exchange. A true radical incomprehensibility would prevent any affective exchange with the patient. Here, one feels affected, touched, and embarrassed, but this feeling is not a result of synthetic and conscious theorizing. Instead, it happens underneath as a "gut feeling" or rises in the atmosphere, to use another metaphor. The metaphor of taste can be applied to schizophrenic bizarreness as well. Bizarreness is difficult, if not impossible, to describe, but it is simultaneously

indisputable *as if* it was "tasted." Even if every diagnosis of mental illness is (at least partly) a social construct, bizarreness is not. It is somewhat wild and basic.

Relying on Erwin Straus, we would like to call this mode of givenness aesthetic sensing. The German neurologist proposed the distinction between two levels of apprehending exteriority (the world or the Others)—the sensing (*Empfinden*) and the knowing. "The sensing is to knowing as a cry is to words," Straus wrote in his masterpiece *The Sense of the Senses* ([50], p. 312). The cry is a sound that reaches the one who hears it at a particular moment in space and time. It is an immediate and nonconceptual "living-with." Sensing is also more basic than perception—"the space of the sensory world stands to that of perception as the landscape to geography" ([50], p. 312). On the other hand, the word conveys a meaning whose sensual form (written or phonic) is secondary. Knowing seeks the objective nature of things beyond a singular appearance. In order to know, "I must step forth, as it were, from the center into which I am placed and become a stranger to myself" ([50], p. 315). Straus' distinction of sensing and knowing allows us to understand how the aesthetic sensing and the perceptive typification cooperate with each other in the experience that leads from the BC to the PF. We shall argue that the two modes, the pre-intentional sensing and intentional typification, are not opposed but account for two moments or two levels of phenomenological apprehension of the other.

To describe the BC's mode of givenness is a theoretical phenomenological challenge. As Gozé has shown, the BC's givenness cannot be accounted for from the perspective of perception only insofar as it is rather a quality of the atmosphere of a situation or encounter [49]. A perception of an object (a sign or a symptom) is always already immersed in an affective atmosphere that is tinted with a certain aesthetic quality. According to Husserl, the atmosphere surrounding perception belongs to the ante-predicative sphere of the passive syntheses of consciousness [51]. This argument is helpful to understand that the BC would not appear when looked for. It would rather tend to disappear. The BC manifests itself when one does not expect it. It takes perception and judgment by surprise.

Merleau-Ponty extended Husserl's analysis by indicating that the ante-predictive sphere is structured on the most unconscious transcendental stratum (the Flesh), which is the matrix of phenomenalization of object perception (the invisible is the matrix of visibility) [52]. The constitutive stratum in which the PF is embedded is involved in any interpersonal and intercorporeal encounter. This does not imply that the BC or PF is present in every encounter. Nevertheless, the pre-reflexive stratum of passive synthesis activates before every perception of verbal content or motor or emotional expression. This phenomenological statement has epistemological consequences. Any intentional act of object perception is possible only from a stratum that is itself nonpositional and pre-reflective, the stratum of aesthetic sensing. Consequently, any perception of a given symptom (perceived according to a typification scheme) is immersed in a wider or deeper sensitive atmosphere. In other words, if one can perceive a clinical sign as a diagnostic criterion, it is only to the extent that already, without even thinking about it, one senses the atmosphere of the encounter. A symptom is a figure in the atmospheric background. This atmosphere penetrates and guides, more or less explicitly, the search for clinical signs. To

become a safe and sensitive tool for the clinician, the grasp of this indefinite atmosphere must be trained. There is a back-and-forth movement between sensing and perceiving that allows the clinician to make his way through the clinical encounter and understand what the patient is going through. It integrates the scattered and discrete symptoms into the field of a unified presence.

The BC's temporal deployment into the PF, a consciously lived experience, may further follow a reflective path. While Rümke defined the PF in terms of definite un-understandability of the patient, a German psychiatrist Hemmo von Müller-Suur (1911–2001) corrected his view and argued that the PF is primarily noticed as an indefinite un-understandability (the bizarreness of the affective exchange) [53]. It is only a further search for disconfirming evidence that ultimately strengthens the validity of the initial experience. This process is reflective and critical, and it is through this process that the PF develops into a diagnosis. Only then can the incomprehensibility of the patient that initially struck the psychiatrist become relatively (but never fully) definite as a reliable clinical sign.

It follows that in our view the PF does not stand in flagrant contradiction to operationalism. It is not, we maintain, the famous "art of medicine" or an empathic version of making a diagnosis that could be added to operational "scientific" diagnosis for humanistic reasons. If we interpret the PF following Parnas as merely a Gestalt or pattern recognition, a passive and rapid change in the perception of the whole structure of schizophrenic subjectivity that transpires through particular symptoms, then, indeed, we cannot but agree that it is "obvious that praecox-feeling, for several reasons, cannot belong to the diagnostic tools in clinical psychiatry" [22]. The PF would remain epistemologically valid but with no use for reliable clinical diagnosis.

9.5 Conclusions

Despite operational revolution, the PF plays a role in diagnostic decision-making. But it should not be trivialized as a rapid diagnosis. The results of existing studies (experimental and qualitative) warrant a moderate skepticism regarding the PF's accuracy as it may lead to a false-positive and false-negative diagnosis (e.g., when it is lacking). However, even if the PF cannot be immune to biases, it must be underlined that the clinical setting, in which it usually takes place, provides an institutional backbone potentially increasing its validity and reliability. In their attempt to overcome the differences between the natural decision-making model and heuristic biases model, Kahneman and Klein enumerate a set of conditions to be met to develop expert skills and increase the accuracy of judgments [30]. One is high-validity environments that have sufficient regularity to provide cues adequate to the situation. Another is an adequate opportunity to learn these cues and develop expert skills. The modern clinical psychiatry setting fulfills both conditions as it provides regularity together with learning opportunities and feedback.

The reflective verification of the PF can be read in a limited analogy to how the so-called System 1 (automatic and involuntary) and System 2 (controlled and

deliberate) as utilized in the psychology of decision-making and research on expertise operate [7]. The temporal unfolding of the initial BC ultimately becomes knowledge thanks to System 2 reflective validation. From the perspective of further reflective operations, it is not easy to go back to those earliest sensual stages, which might explain why psychiatrists find it difficult (though probably not as difficult as Rümke originally proposed) to give an account of that earliest "feeling." From the last stage's perspective, indeed, the diagnostic operation may look like a typification of a familiar object.

The PF is neither a feeling, experience, intuition, nor simply an automated typification, but a complex cognitive and embodied process based upon pre-reflective and ante-predicative aesthetic sensing (the bizarreness of contact), which is secondly apprehended as perceptible evidence thanks to clinical experience. It is not so much an impossibility of affective exchange as its bizarreness. Otherwise, it would not be disturbing, would not beg for an explanation, and could be easily forgotten. In this sense, the PF is not subjective, but interactive and spatial. It is not a change in the perception of an object (patient) by a subject (clinician), for structures of I-world relation, unlike particular gestures or facial expressions, are not "objects." Finally, the PF is not rapid but extended in time, and it requires conscious, reflective operations for its validation, a critical attitude toward one's "feelings" through operationalized confrontation with evidence.

Hence, the importance of the PF for the education of mental health professionals. Firstly, the PF is a perfect example to show the clinician-in-training how their lived experience is always involved in the clinical process. Second, it exemplifies how clinical judgment is always embedded in the complex historical and social context that has to be epistemologically analyzed. Finally, it illustrates how crucial it is to identify, describe, and criticize one's "feelings" to use them as a reliable diagnostic tool. In this respect, phenomenology is precious.

Nevertheless, we should remember that phenomenological theory is not to be "applied" to clinical psychiatry. Rather, it is "implicated" in clinical psychiatry, to quote Tatossian [54]. The philosophical method must always respect the complexity and otherness of the clinical encounter and must withhold its conceptual powers not to explain the phenomena in advance. Therefore, the phenomenological clinician must be aware of the epistemological limits of the phenomenological method in psychiatry to avoid dangerous generalizations.

References

1. Rümke HC. Signification de la phénoménologie dans l'étude clinique des délirants. Congrès international de psychiatrie. 1950;1
2. Bruni P, Suppa M, Scarpellini MG, Aguglia F. Praecox gefuhl in medicina. Minerva Psichiatrica. 1994;35(3):193–5.
3. Asperger H. Problems of Infantile Autism. Communication. 1979;13:45–52.
4. Carp EA. Über das Praecox- und Hysteriegefühl. Psychotherapy and Psychosomatics. 1971;19(4):232–9.

5. Fonzi L, Pallagrosi J, Picardi A, et al. Exploring how the psychiatrist experiences the patient during the diagnostic evaluation: the Assessment of Clinician's Subjective Experience (ACSE). Phenom Cogn Sci. 2021; https://doi.org/10.1007/s11097-021-09729-y.
6. Szasz TS. Schizophrenia: the sacred symbol of psychiatry. Br J Psychiatry. 1976;129(4):308–16.
7. Kahneman D. Thinking, fast and slow. New York: Farrar, Straus and Giroux; 2011.
8. Berrios G, Lugue R, Vilagran J. Schizophrenia: A Conceptual History. Int J Psychol Psychol Ther. 2003;3(2):111–40.
9. Bleuler E. Dementia Praecox oder Gruppe der Schizophrenien. Leipzig: Deuticke; 1911.
10. Minkowski E. La schizophrénie. Paris: Payot; 1927.
11. Minkowski E. Le tempsvécu. Paris: Presses Universitaires de France; 1933.
12. Minkowski E. Phénoménologie et analyse existentielle en psychopathologie. L'Évolution psychiatrique. 1948;13
13. Binswanger L. Welche Aufgaben ergeben sich für die Psychiatrie aus den Forschungen der neueren Psychologie? Berne: Ausgewählte Vorträge und Aufsätze, II; 1955.
14. Wyrsch J. Über die Intuition bei der Erkennung des Schizophrenen. Schweizerische Medizinische Wochenschrift. 1946;46:1173–6.
15. Irle G. Das 'PraecoxgefÜhl' in der diagnostik der schizophrenie. Arch Psychiat Ztschr Ges Neurol. 1962;203:385–406.
16. RÜmke HC. Der klinische Differenzierung innerhalb der Gruppe der Schizophrenien. Nervenarzt. 1958;29:40–53.
17. Spoerri T. Schizophreniediagnose und "Praecoxgefuehl". Confinia Psychiatrica. 1963;6:53–63.
18. Schwartz MA, Wiggins OP. Typifications the first step for clinical diagnosis in psychiatry. J Nerv Ment Dis. 1987;175:65–77.
19. Belzen JA. An early effort in the psychology of belied and unbelief. Critical reflexion on a dutch classic in psychology of religion. In: Conveleyn J, Hutsebaut J, editors. Belief and unbelief: psychological perspectives. Special series in the psychology of religion. Amsterdam: Rodopi; 1994.
20. Neeleman J. The legacy of Dutch psychiatry. Psychiatrie Bull. 1990;14:222–3.
21. Hempel CG. Aspects of scientific explanation. New York: Free Press; 1965.
22. Parnas J. A disappearing heritage: the clinical core of schizophrenia. Schizophr Bull. 2011;37(6):1121–30.
23. Andreasen NC. DSM and the death of phenomenology in America: an example of unintended consequences. Schizophr Bull. 2007;33:108–12.
24. Grube M. Towards an empirically based validation of intuitive diagnostic: RÜmke's "praecox feeling" across the schizophrenia spectrum: Preliminary results. Psychopathology. 2006;39(5):209–17.
25. Ungvari GS, Xiang YT, Hong Y, Leung HC, Chiu HF. Diagnosis of schizophrenia: reliability of an operationalized approach to 'praecox-feeling'. Psychopathology. 2010;43(5):292–9.
26. Pallagrosi M, Fonzi L. On the concept of praecox feeling. Psychopathology. 2018;51(6):353–61.
27. Tandon R, Gaebel W, Barch DM, Bustillo J, Gur RE, Heckers S, Malaspina D, Owen MJ, Schultz S, Tsuang M, Van Os J, Carpenter W. Definition and description of schizophrenia in the DSM-5. Schizophr Res. 2013;150(1):3–10.
28. Gozé T, Moskalewicz M, Schwartz MA, Naudin J, Micoulaud-Franchi JA, Cermolacce M. Is "praecox feeling" a phenomenological fossil? A preliminary study on diagnostic decision making in schizophrenia. Schizophr Res. 2019;204:413–4.
29. Moskalewicz M, Kordel P, Brejwo A, Schwartz MA, Gozé T. Psychiatrists report praecox feeling and find it reliable. A cross-cultural comparison. Front Psychiatry. 2021;12:642322.
30. Kahneman D, Klein G. Conditions for intuitive expertise: a failure to disagree. Am Psychol. 2009;64(6):515–26.
31. Croskerry P, Norman G. Overconfidence in clinical decision making. Am J Med. 2008;121(5):24–9.
32. Tellenbach H. Geschmack und Atmosphäre. Salzburg: Otto Müller Verlag; 1968.
33. Krauss A. The significance of intuition for the diagnosis of schizophrenia. In: Maj M, Sartorius N, editors. Schizophrenia. Chichester: John Wiley& Sons; 1999.

34. Kraus, A. Schizophrenic delusion and hallucination as the expression and consequence of an alternation of the existential a prioris. In Cheung M.C. Fulford K. W. M. Graham G (Eds.), Reconveiving schizophrenia. Oxford: Oxford University Press; 2007: 97-111.
35. Varga S. Vulnerability to psychosis, I-thou intersubjectivity and the praecox-feeling. Phenomenol Cogn Sci. 2013;12(1):131–43.
36. L'Entre KB. Une approche phénoménologique de la schizophrénie. Grenoble: Millon; 2000.
37. Moskalewicz M, Schwartz MA, Gozé T. Phenomenology of intuitive judgment: praecox-feeling in the diagnosis of schizophrenia. AVANT. 2018;9:63–74.
38. Kant I. Critique of judgment. New York: Hafner; 1951.
39. Fernandez AV. Phenomenology, typification, and ideal types in psychiatric diagnosis and classification. In: Bluhm R, editor. Knowing and acting in medicine. Lanham: Rowman & Littlefield International; 2016. p. 39–58.
40. Schwartz MA, Wiggins OP. Diagnosis and ideal types: a contribution to psychiatric classification. Compr Psychiatry. 1987;28:277–91.
41. Husserl E. Méditations cartésiennes: Introduction à la phénoménologie (Hua I). Paris: Vrin; 1931.
42. Levinas E. Totality and infinity: an essay on exteriority. Dordrecht: Kluwer; 1991.
43. Lipps T. Leitfaden der Psychologie. Leipzig: Wilhelm Engelmann; 1909.
44. Erdmann B. Wissenschaftliche Hypothesen über Leib und Seele. Köln: Dumont-Schauberg; 1907.
45. Husserl E. Zur Phänomenologie der Intersubjektivität: 1905-1920 (Hua XIII), 1921-1928 (Hua XIV), 1929-1935 (Hua XV). Den Haag: M. Nijhoff; 1973.
46. Depraz N. Transcendance et incarnation. Le statut de l'intersubjectivité comme altérité à soi chez Husserl. Paris: Vrin; 1995.
47. Jaspers K. General psychopathology. London: John Hopkins; 1997.
48. Gozé T, Moskalewicz M, Schwartz MA, Naudin J, Micoulaud-Franchi JA, Cermolacce M. Reassessing "Praecox Feeling" in diagnostic decision making in schizophrenia: a critical review. Schizophr Bull. 2019;45(5):966–70.
49. Gozé T. Expérience de la rencontre schizophrénique: de la bizarrerie de contact. Paris: Hermann; 2020.
50. Straus E. The primary world of senses: a vindication of sensory experience. New York: Free Press; 1963.
51. Husserl E. Experience and judgement. Evanston: Northwestern University Press; 1975.
52. Merleau-Ponty M. The visible and the invisible: followed by working notes. Evanston: Northwestern University Press; 1969.
53. Müller-Suur H. Das sogenannte Praecoxgefuehl. Fortschritte Der Neurologie-Psychiatrie. 1961;29:145–52.
54. Tatossian A. La phénoménologie des psychoses. Paris: Cercle Herméneutique; 2002.

The Diagnostic Use of Countertransference in Psychodynamic Practice

10

Annalisa Tanzilli and Vittorio Lingiardi

10.1 The Origins of Countertransference

The therapeutic relationship has been shown to be one of the most important mutative factors able to promote good treatment outcomes [1, 2]. Countertransference is a crucial component of the therapeutic relationship, and it is strongly related to multifaceted processes involved in producing the patient's change not only in the context of psychoanalytic/psychodynamic psychotherapies but also, in general, in all approaches of different persuasions [3–5]. Over recent years, it has become increasingly clear to clinicians of various theoretical orientations that recognizing and working through countertransference may help inform a more sensitive diagnostic process, generate accurate and clinically meaningful case formulations, and facilitate planning effective therapeutic interventions [6–10].

Historically, the roots of countertransference must be traced within the confines of classical psychoanalysis. The credit of its discovery is acknowledged to belong to Freud, who first described and discussed this clinical phenomenon in *The Future Prospects of Psycho-Analytic Therapy* at the Second International Nuremberg Congress in 1910 as follows:

> We have become aware of the *counter-transference*, which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it. (…) We have noticed that no psycho-analyst goes further than his own complexes and internal resistances permit; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients. Anyone who fails to produce results in a self-analysis of this kind may at once give up any idea of being able to treat patients by analysis. [11, p. 144–145]

A. Tanzilli · V. Lingiardi (✉)
Department of Dynamic and Clinical Psychology, and Health Studies, Faculty of Medicine and Psychology, SAPIENZA University of Rome, Rome, Italy
e-mail: annalisa.tanzilli@uniroma1.it; vittorio.lingiardi@uniroma1.it

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_10

According to the Freudian perspective, countertransference represents an obstacle to the treatment progress, being the result of the patient's influence on the analyst's unconscious feelings or, in other words, the analyst's transference to the patient [12]. Deriving from the analyst's resistances and unresolved neurotic conflicts originating in early childhood, countertransference reactions create "blind spots" or severe distortions in the clinician's perception of the patient, hindering the treatment; therefore, they have to be eliminated through rigorous psychoanalysis [13]. Freud states:

> [the analyst] must bend his own unconscious like a receptive organ towards the emerging unconscious of the patient, be as the receiver of the telephone to the disc. As the receiver transmutes the electric vibrations induced by the sound-waves back again into sound-waves, so is the physician's unconscious mind able to reconstruct the patient's unconscious, which has directed his associations, for the communications derived from it. [13, p. 115–116]

If the analyst's mind is a powerful and effective tool able to attune to patient and capture the unconscious meanings in his or her communications, countertransference clearly provokes interferences that perturb the therapeutic process. Indeed, the quickly changing, fluctuating, and confusing nature of countertransference reactions severely threatens the analyst's neutrality and may lead him or her to act in antitherapeutic ways.

As is known, neutrality is one of the three structural rules that define the analyst's mental stance in technical or theoretical Freudian writings. The figure of the analyst is compared to that of a surgeon who remains unaffected by his or her emotions. The clinician should serve as a mirror or a "blank screen" to allow the projection of the patient's internal structure. According to Freud's transference theory, indeed, patients displace onto the analyst strong feelings and conflicts associated with significant figures of childhood through unconscious processes, repeating and re-actualizing their dysfunctional patterns of relatedness in therapy [14, 15]. Despite the controversies about the conceptualization of neutrality, which is often misunderstood as the clinician's indifference and detachment [cf., 16], the role of this technique is to promote a deeper understanding of the patient's intrapsychic conflict. Freud highlights the centrality of neutrality to point out that the analyst should reflect the patient's conflicts without conflating them with his or her own emotions and conflicts [17]. In this perspective, it is crucial that the analyst resolves his or her problems and any psychological vulnerabilities that may cause countertransference reactions and impede a neutral attitude toward the patient, irreversibly compromising the therapeutic process [18, 19].

Although Freud's observations on countertransference are not systematized in a more rigorous and accomplished way and his suggestions sometimes seem contradictory, this classical and overly "narrow" perspective, which views this phenomenon as a disturbing factor, predominated for many decades in psychoanalysis with a few exceptions. For example, Sàndor Ferenczi's [20, 21] distances himself from Freudian "orthodoxy" by developing a concept of countertransference as a useful therapeutic tool rather than as an obstacle to the cure. In his theory of

countertransference, he shifts the focus from the patient's individual and intrapsychic dimension to the intersubjective field of the analyst–patient dyad. Ferenczi's ideas and clinical emphasis on mutuality (intimacy) and intersubjectivity in the therapeutic relationship did not have a great response among his contemporaries, but his legacy will influence future generations of analysts, especially by laying the groundwork for the relational turn in psychoanalysis (see later in this chapter) and promoting the radical revision in the theory and technique of countertransference around the 1950s [22].

Gradually, the conceptualization of countertransference indeed evolves away from the classical position and broadens to encompass all the feelings, thoughts, attitudes, and behaviors clinicians experience in treating patients [23]. Consistent with the so-called "totalistic" approach [24], this clinical dimension becomes a valuable source of knowledge about patients, providing insight into their dysfunctional interpersonal and intrapsychic dynamics in the context of their significant relationships. According to this expanded view, if properly used and managed, countertransference can benefit all of the treatments (of various approaches) rather than hinder them.

10.2 The Rediscovery of Countertransference

In the 1950s, the relevant contributions on countertransference of Donald Winnicott [25], Paula Heimann [23], and Heinrich Racker [26] favor the rediscovery of this phenomenon. Emphasizing the deeper nature of analytic situation that implies the (intersubjective) encounter between two individuals, Heimann [23] proposes evolutionary innovations of countertransference theory that extended its conceptual limits. Consistent with her perspective, all the emotional responses expressed by clinicians toward patient help them shed light on patient's unconscious conflicts and defenses. Heimann [23, p. 82] posits that "often the emotions roused in him are much nearer to the heart of the matter than his reasoning," which suggests that therapists may better understand their patients using their subjectivity and emotional sensitivity. Moreover, she provides a different reformulation of the Freudian technical precepts: "In my view Freud's demand that the analyst must 'recognize and master' his counter-transference does not lead to the conclusion that the countertransference is a disturbing factor and that the analyst should become unfeeling and detached, but that he must use his emotional response as a key to the patient's unconscious" [23, p. 83].

At a similar time, in line with Heimann and, in general, with a broader view of countertransference, Winnicott [25] distinguishes an objective form of this phenomenon reflecting the "normal" therapist's reactions to the patient's personality and behavior from a subjective form; the latter—in accordance with the classical perspective—is based on the analyst's unresolved issues or sensitivities. Borrowing from his experience as a pediatrician, Winnicott focuses on the mother–infant dyad and draws an analogy with the therapist–patient relationship. Thanks to his illuminating clinical observations on the early stages of childhood development and the

environmental failures, the author stresses the developmental relevance of hate in the mother–child relationship. Similarly, he normalizes and universalizes the analyst's negative reactions toward the patients and discusses the hate in countertransference toward severe psychotic patients. According to Winnicott [25], the objective and negative countertransference consists of intense and realistic responses evoked in the analyst by patients with more primitive levels of mental functioning, which in turn were based on the patient's early object experiences (or experiences of significant others).

In line with Heimann and Winnicott, Racker [27] develops the idea of countertransference as the combination of all feelings, thoughts, motivation, and behaviors experienced by the analyst toward the patients and introduces the psychodynamic concepts of concordant and complementary countertransference. Through the observations of the relational dynamics between patient and analyst, the author defines concordant countertransference as the process by which the analyst identifies his ego with the patient's ego and, similarly, with the other parts of the personality (i.e., id and superego). Conversely, following Deutsch's [28] model of identification, complementary countertransference is the result of all the psychological processes by which the analyst's ego identifies with the patient's internal objects.

These two forms of countertransference are highly complex and intimately relate to other relevant and clinically meaningful psychoanalytic constructs. Racker establishes a strong relationship between *empathy* and the first form of countertransference, given that the underlying *concordant identification* is very close to the processes that allows the empathic and positive understanding of patient. Many authors disagree with this point of view and make a firm distinction between these concepts [17]. Contrary to Racker's perspective, they speculate that empathy might refer back to the primary processes of psychic life, and they express concerns on the full correspondence between what goes on in the analyst and what goes on in the patient [cf. 29]. This topic is beyond the scope of this work, but, essentially, these controversies depend on how each author intends to expand the conceptual confines of countertransference (for a deeper discussion, see [19]).

Regarding the *complementary countertransference* (based on this specific kind of identification), Racker [30] also refers to it as the analyst's response by which she or he takes on the role "assigned" to him or her by the patient. For example, a patient projects his introjected father onto the analyst and treats him or her as such. The clinician may identify with the patient's internal object, that is, the introjected father, and experience feelings (e.g., anger, irritation, or resentment) that are consistent to the introjected father. If the clinician is not able to understand what is going on in the relationship with the patients, he or she might act in treatment like the introjected father and repeat an experience "that helped establish the patient's neurosis" [30, p. 138]. The process that Racker describes in this clinical vignette is defined in different ways by many analysts, but it is very close to the view of *projective identification* [31–35], *role responsiveness* [36], or *countertransference enactment* [37, 38].

The concept of projective identification has considerably contributed to countertransference's theoretical–clinical (r)evolution. This term is first introduced in

"Notes on some schizoid mechanisms" by Melanie Klein [33], who describes it as results from the patient unconsciously disowning or splitting off certain affects or parts of the self and projecting them into the therapist, exercising their omnipotent control. The therapist unconsciously internalizes these affects and experiences the impulse to act them out; for example, clinician can be the hyperaggressive object that is projected into him or her [22].

According to Klein [33], the projective identification is an unconscious phantasy that plays a pivotal role in structuring the mental life of the child influencing and, in turn, being influenced by the complex relationship between the infant's inner world and the surrounding reality. In other words, in her model of mental functioning, "fantasy is the primary content of unconscious mental processes" [39, p. 82], and the child's inner world is populated with good or bad, total or partial "internal objects," which not only derive from early relational experiences with real human figures, but also are the result, in varying degrees, of his unconscious destructive or constructive fantasies [33].

The Kleinian concept of projective identification essentially refers to an intrapsychic process; thus, the theoretical–clinical framework remains intrinsically related to a monopersonal psychology. Although Klein introduces the concept of the "internal objects" showing a certain interest in the reality, she does not recognize or emphasize the relevance of interpersonal dimension in this mechanism. Overall, her speculation's main focus is always directed on the nature of the phantasmatic processes that characterize the patients' state of mind, and in this perspective, countertransference continues to be read and interpreted in the classical and narrow key as a sign of the analyst's vulnerability that requires further analysis [cf. 40]. It is not surprising that Klein develops a strong argument with Heimann, clarifying her disagreement on the totalistic view of countertransference that would imply the wrong attribution to the patient of the analyst's problems and conflicts.

Looking at the subsequent contributions on projective identification and their implications to the patient–therapist relationship, it is important to discuss the innovative theories of Wilfred Bion [31] and Thomas Ogden [41, 35], who elaborate an interpersonal view of this mechanism reformulating the characteristics and dynamics of countertransference. Bion [42] believes that the projective identification is not only an unconscious phantasy. Consistent with his model of *maternal rêverie* and the *container-contained model* of the mother–infant relationship, the analyst considers the crucial importance of projective identification in the process of a child's growth and learning from experience [31, 43]. According to his theory, the mother should show the ability to contain the infant's unpleasant and intolerable affects, linked to his or her needs' frustration, and to transform these negative emotional experiences into a more tolerable form permitting the infant to reinternalize them as "detoxified" and modified elements.

Ogden [34] develops Bion's conceptualization incorporating the projective identification in his dialectical model of therapist–patient interaction. He considers this process as a complex phenomenon through which (a) specific aspects of the patient's self or internal objects are projectively disavowed by unconsciously displacing it in the clinician (because these aspects threaten to damage the self or, conversely, risk

being attacked by the self's other aggressive and disruptive parties and have to be protected within the therapist); (b) the patient actually exerts an interpersonal pressure to coerce the clinician to experience, unconsciously identify with or behave according with that which has been projected; and (c) the clinician contains and processes the projected contents and, if she or he is capable of "metabolizing" and managing them, allows the reintrojection by the patient in a transformed and more tolerable form [37].

Overall, Bion and Ogden elevate the projective identification to a mental process that allows interpersonal interaction and human communication. The authors recognize that clinicians' exploring and metabolizing of their countertransference experiences from the patients' projective identifications may permit them to integrate aspects of self that originally are intolerable and to develop a more cohesive and stable sense of self. To promote this relevant change in patients, a clinician must resist interpersonal pressures from the patients that, through largely unconscious verbal and nonverbal maneuvers, try to draw the clinician into dysfunctional interactions in which s/he has to play a particular role, provoking the so-called countertransference enactment (for a deeper discussion, see [37, 38, 36]). If appropriately managed, countertransference improves clinical work across a wide array of treatments, reducing detrimental interventions and bridging impasses in the psychotherapy process [5].

10.3 The Relational and Intersubjective Turn of Countertransference

A radical revision of countertransference theory is strongly related to the perspective change in psychoanalysis from a classical monopersonal versus bipersonal approach, which seeks to understand psychological phenomena as products of patient and clinician subjectivities that interact with each other in reciprocal and mutual influence within a dynamic field [e.g., 44–47]. This new metapsychology points out the impact of the clinician and his or her participation on the unfolding of the therapeutic process rejecting the notion of the "blank screen" analyst. Overall, relational and intersubjective analysts question the *myth of the isolated individual mind* [48], which attributes to the individual mind an existence separate from the world of nature and social bonds, denying the dependence on the interpersonal environment and reifying the image of an illusory human self-sufficiency.

This new paradigm favors the shift from the classical psychoanalytic model to the intersubjective and relational perspective of therapeutic relationship based on the contributions of many authors such as Stephen Mitchell [49], Lewis Aron [50], and George Atwood and Robert Stolorow [51]. These theorists stress that the analyst's actual behavior influences the patient's transference to the analyst. Hence, the concepts of transference and countertransference are rethought in the light of the intersubjective experience developed in the context of the psychoanalytic relationship. These clinical dimensions continually oscillate between the experiential foreground and background of the transference in concert with perceptions of the

analyst's varying attunement to the patient's emotional states and needs [52]. Thus, transference and countertransference are inextricably linked and jointly co-constructed depending on the mutual interplay of two subjects [50].

Notably, Mitchell [53] recognizes in Ogden's perspective of projective identification an "interpersonalization" of the countertransference concept. Ogden [54] conceives of projective identification as a form of the "analytic third," in which the individual subjectivities of analyst and patient are subjugated to a co-created third subject of analysis. Good analytic work involves a superseding of the subjugating third by means of mutual recognition of analyst and patient as separate subjects and a reappropriation of their (transformed) individual subjectivities [55]. The figure of the analyst or therapist as completely neutral or aloof is no longer appropriate. According to relational and intersubjective perspectives, the analyst is "embedded" within the relational matrix of analytical interactions [49].

10.4 Countertransference and Psychodynamic Diagnosis

The psychodynamic diagnosis aims at promoting an accurate case formulation and fostering patient-tailored treatments. The diagnostic process develops within a relational matrix derived from the encounter and interaction between the subjectivities of patient and clinician. The therapeutic relationship is an essential source of information about the unfolding patient–clinician interaction in the here and now of clinical situations, and psychological and interpersonal characteristics of the patient and the therapist [9, 56].

Notably, according to the post-Freudian contributions reviewed in the previous sections of this chapter [especially, 24, 25, 27], countertransference represents a useful and clinically relevant diagnostic tool to shed light on specific features of patient's personality and mental functioning. Personality disorders are characterized by pervasive and dysfunctional interpersonal styles; thus, personality-disordered patients tend to "reactualize" their relational difficulties in the context of a therapeutic relationship, drawing the clinician into interactions that reflect these enduring and maladaptive schemas of the self, others, and relational interactions [35, 36]. In these terms, therapist's recognition of his or her emotional responses and experiences (i.e., countertransference according to the totalistic view; [24]) is an important vehicle for assessing and understanding patients' personality functioning and their peculiar ways of adapting to environmental contexts.

When considering countertransference as a diagnostic tool, the clinician should always remember to maintain a tension between the idiographic and nomothetic approaches that is inherent in every diagnostic process [57]. Notably, it is crucial to capture the unique and unrepeatable aspects (*idiographic perspective*) that emerge in the here and now of the relational encounter between patient and therapist, and at the same time, the patient's relational patterns that she or he tends to repeat and show in a stable form in all interpersonal situations and that she or he shapes with other similar individuals (*nomothetic perspective*). In other words, examining countertransference reactions toward patients with specific personality disorders by

adopting a nomothetic and idiographic view allows the clinician to identify specific relational models occurring in "coherent and predictable ways" in these patients' treatment, without losing focus on individual relational aspects [58–59].

Not surprisingly, the *Psychodynamic Diagnostic Manual-Second Edition* (PDM-2; [9]) is the first international nosography that "legitimates" the use of the clinician's (but also of the patients') subjectivity in the diagnostic and therapeutic process. Aspiring to be a "taxonomy of people" rather than a "taxonomy of disorders," the PDM-2 offers a theoretical–clinical framework that reflects an individual's full range of functioning—the depth, as well as the surface, of emotional, cognitive, interpersonal, and social patterns. It intends to promote a deeper and accurate knowledge of patient's functioning for case formulation and treatment planning, taking into account individual variations and commonalities.

The diagnostic approach of the PDM-2 is multiaxial and proposes a systematic description of *personality syndromes* (P Axis), including essential characteristics of transference and countertransference patterns that are typical in the treatment of each disorder; profiles of *mental functioning* (including 12 specific capacities, e.g., patterns of relating to others, comprehending and expressing feelings, coping with stress and anxiety, regulating impulses, observing one's own emotions and behaviors, and forming moral judgments) (M Axis); and *symptom patterns* (S Axis), including differences in each individual's personal, subjective experience of psychopathological presentations, as well as the emotional responses and experiences of treating clinicians [cf. 60, 61]. The importance of considering the quality of the therapeutic relationship emphasized by the PDM-2 is supported by some studies showing strong associations between countertransference (or, in this context, therapist emotional responses) and personality pathologies across different treatment approaches [58, 59, 62–68].

Research in the field to date is still limited, but the findings are clinically meaningful and empirically robust. Overall, evidence shows that patients with cluster A and B personality disorders tend to evoke more negative therapist reactions than cluster C patients, and that cluster B patients elicit more intense and heterogeneous feelings in their therapists [58, 65, 66]. Moreover, among cluster B disorders, borderline patients seem to arouse stronger and more mixed reactions in clinicians [69–72].

A relevant and comprehensive study [59] has examined the relationships between therapist's responses (evaluated using the Therapist Response Questionnaire; [58, 72]) and all the patients' personality disorders (assessed using the Shedler–Westen Assessment Procedure-200; [73–75]). Research has found that specific countertransference configurations reflect particular patterns of relatedness that are ubiquitous in the patient's life [cf. 37, 76]. For example, schizoid patients tend to elicit a sense of helpless and inadequate in therapists. Clinicians report difficulties establishing a comfortable relationship with, being more attuned with, and developing a sense of intimate connections with a schizoid patient who show a pervasive pattern of detachment from social relationships and have a very restricted range of expression of emotions in interpersonal contexts [77]. Patients with antisocial personality

disorder tend to provoke countertransference reactions combining anger and irritation, which are strongly related to their reckless disregard for others, the lack the empathy and tendency to manipulate and lie without remorse, as well as insensibility and callous unemotional traits [9, 74]. Notably, borderline patients may "pull" therapists to experience countertransference reactions characterized by strong feelings of anxiety, concern, and frustration in therapy. Clinicians treating these patients report feeling incompetent or inadequate and experiencing a sense of confusion in sessions. These reactions likely reflect the patients' fragmented and incoherent sense of self and others; severe difficulties regulating emotions and impulses and developing and maintaining stable, intimate relationships; prevalent use of primitive defense mechanisms, such as splitting and projective identification; and some problems in reality testing [e.g., 78]. Conversely, clinicians report protective and positive feelings toward avoidant patients, perhaps experiencing a wish to repair some deficiencies or failures in their patients' relationships with parents or significant others [9, 74].

Another recent study [79; see also 80] has examined clinician emotional responses in psychotherapy with patients presenting with narcissistic personality disorder (NPD), one of the most common and challenging clinical syndromes to treat. This empirical investigation has indicated that NPD was positively associated with hostile, criticized, helpless, and disengaged countertransference, and negatively associated with a positive response to the patient. Clinicians treating NPD patients experience intense feelings of being unappreciated, denigrated, and belittled, as well as rage and resentment due to the contemptuous and devaluing attitudes expressed by these patients or their manipulative and defiant behaviors [81, 82]. These therapists' reactions may be related to the most common defensive strategy of narcissistic patients who devalue others (including therapists) to protect their grandiosity and deny feelings of inadequacy associated with difficulties in regulating their vacillating self-esteem [76, 83]. Moreover, these patients are difficult to engage in a therapeutic relationship characterized by reciprocity, trust, and close connection, evoking frustration and disengagement in clinicians [84]. Thus, clinicians' understanding of their own countertransference reactions to NPD patients and of the quality of mutual collaboration and connection with them is helpful when making a thorough and accurate diagnosis and planning individualized interventions or treatments.

Overall, research in this field seems to show that, despite the uniqueness of each patient–therapist dyad, distinct dimensions of countertransference are associated with specific personality disorders in a clinically meaningful and systematically predictable manner. In other words, all patients can not only stimulate *idiosyncratic countertransference responses* in clinicians (that borrow from the clinician's personal dynamics and are based on his or her life history, personality and psychological functioning, anxieties, and unresolved conflicts) but they also evoke *average expected countertransference reactions*, which likely resemble the typical responses activated in significant others in the patient's life, similar to Winnicott's concept of "objective countertransference."

10.5 Conclusion

Countertransference has evolved from a narrow conceptualization of obstacle to therapeutic progress and become a ubiquitous, pervasive, and potentially useful phenomenon for practitioners of various backgrounds and experiences, in all therapeutic situations and settings. It reflects a broad spectrum of clinicians' emotional and interpersonal experiences with patients and is intrinsically linked to the complex combination of the therapist's own dynamics, responses evoked by the patient, and the interaction of patient and therapist.

The clinical and empirical literature seems to support the view that countertransference responses is a useful source of knowledge for better understanding the patients' psychological functioning, and in particular all the relational dynamics that tend to repeat in significant relationships of their life, which are strongly associated with their relatively stable patterns of thinking, feeling, behaving, and regulating emotions and impulses.

References

1. Norcross JC, Lambert MJ. Psychotherapy relationships that work III. Psychotherapy (Chic). 2018;55(4):303–15. https://doi.org/10.1037/pst0000193.
2. Wampold BE. How important are the common factors in psychotherapy? An update World Psychiatry. 2015;14(3):270–7. https://doi.org/10.1002/wps.20238.
3. Gabbard GO. Countertransference: the emerging common ground. Int J Psychoanal. 1995;76(3):475–85.
4. Gabbard GO, Westen D. Rethinking therapeutic action. Int J Psychoanal. 2003;84(4):823–41. https://doi.org/10.1516/0020757037682846O5.
5. Hayes JA, Gelso CJ, Goldberg S, Kivlighan DM. Countertransference management and effective psychotherapy: meta-analytic findings. Psychotherapy (Chic). 2018;55(4):496–507. https://doi.org/10.1037/pst0000189.
6. Bateman AW, Fonagy P. Mentalization based treatment for borderline personality disorder: a practical guide. Oxford, UK: Oxford University Press; 2006.
7. Beck AT, Davis DD, Freeman A. Cognitive therapy of personality disorders. 2nd ed. New York, NY: Guilford Press; 2004.
8. Gabbard GO, editor. Textbook of psychotherapeutic treatments. Washington, DC: American Psychiatric Publishing; 2009a.
9. Lingiardi V, McWilliams N, editors. Psychodynamic diagnostic manual, 2nd ed. (PDM-2). New York, NY: Guilford Press; 2017.
10. Yeomans FE, Clarkin JF, Kernberg OF. Transference focused psychotherapy for borderline personality disorder: a clinical guide. Washington, DC: American Psychiatric Publishing; 2015.
11. Freud S. The future prospects of psychoanalytic therapy. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 11. London, UK: Hogarth Press; 1910. p. 139–51.
12. Laplanche J, Pontalis JB. Vocabulaire de la psychanalyse. Paris: Les Presses Universitaire de France; 1967.
13. Freud S. Recommendations to physicians practicing psychoanalysis. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 12. London, UK: Hogarth Press; 1912b. p. 111–20.
14. Freud S. The dynamics of transference. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 12. London, UK: Hogarth Press; 1912a. p. 97–108.

15. Freud S. Introductory lectures on psychoanalysis: part III. General theory of neurosis. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 16. London, UK: Hogarth Press; 1917. p. 243–436.
16. Hoffer A. Toward a definition of psychoanalytic neutrality. J Am Psychoanal Assoc. 1985;33(4):771–95. https://doi.org/10.1177/000306518503300402.
17. Eagle MN. From classical to contemporary psychoanalysis: a critique and integration. New York, NY: Routledge; 2011.
18. Epstein L, Feiner AH. Countertransference: the therapist's contribution to treatment. Contemp Psychoanal. 1979;15(4):489–513. https://doi.org/10.1080/00107530.1979.10745593.
19. Etchegoyen RH. The fundamentals of psychoanalytic technique. London: Karnac Books; 1986.
20. Ferenczi SL. On the technique of psychoanalysis. In: Richman J, editor. Further contributions to the theory and technique of psychoanalysis. Karnac: London, UK; 1919. p. 177–89.
21. Ferenczi S. Child-analysis in the analysis of adults. Int J Psychoanal. 1931;12:468–82.
22. Gelso CJ, Hayes JA. Countertransference and the therapist's inner experience: perils and possibilities. Mahwah, NJ: Erlbaum; 2007.
23. Heimann P. On counter-transference. Int J Psychoanal. 1950;31:81–4.
24. Kernberg O. Notes on counter-transference. J Am Psychoanal Assoc. 1965;13(1):38–56. https://doi.org/10.1177/000306516501300102.
25. Winnicott DW. Hate in the countertransference. Int J Psychoanal. 1949;30:69–75.
26. Racker H. A contribution to the problem of counter-transference. Int J Psychoanal. 1953;34(4):313–24.
27. Racker H. The meanings and uses of countertransference. Psychoanal Q. 1957;26(3):303–57. https://doi.org/10.1080/21674086.1957.11926061.
28. Deutsch H. Occult processes occurring during psychoanalysis. In: Devereux G, editor. Psychoanalysis and the occult. New York, NY: International University Press; 1926. p. 133–46.
29. Sandler J. On communication from patient to analyst: not everything is projective identification. Int J Psychoanal. 1993;74(6):1097–107.
30. Racker H. Transference and countertransference. London, UK: Hogarth Press; 1968.
31. Bion WR. Learning from experience. London: William Heinemann; 1962.
32. Joseph B. In: Feldman M, Spillius EB, editors. Psychic equilibrium and psychic change: selected papers of Betty Joseph. London, UK: Taylor & Frances/Routledge; 1989.
33. Klein M. Notes on some schizoid mechanisms. J Psychother Pract Res. 1996;5(2):164–79.
34. Ogden TH. Projective identification and psychotherapeutic technique. New York, NY: Jason Aronson; 1982.
35. Ogden TH. The analytic third: working with intersubjective clinical facts. Int J Psychoanal. 1994;75:3–19.
36. Sandler J. Countertransference and role-responsiveness. Int Rev Psychoanal. 1976;3(1):43–7.
37. Gabbard GO. A contemporary psychoanalytic model of countertransference. J Clin Psychol. 2001;57(8):983–91. https://doi.org/10.1002/jclp.1065.
38. Jacobs TJ. On countertransference enactments. J Am Psychoanal Assoc. 1986;34(2):289–307. https://doi.org/10.1177/000306518603400203.
39. Isaacs S. The nature and function of phantasy. Int J Psychoanal. 1948;29:73–97.
40. Klein M. The psychoanalytic play technique. Am J Orthopsychiatry. 1955;25(2):223–37.
41. Ogden TH. On projective identification. Int J Psychoanal. 1979;60(3):357–73.
42. Bion WR. Development of schizophrenic thought. Int J Psychoanal. 1956;37:344–6.
43. Bion WR. Attention and interpretation. London: Tavistock Publications; 1970.
44. Baranger M, Baranger W. Insight in the analytic situation. In: Litman RE, editor. Psychoanalysis in the Americas. New York, NY: International Universities Press; 1966. p. 56–72.
45. Gill MM. Psychoanalysis in transition: a personal view. Hillsdale, NJ: Analytic Press; 1994.
46. Langs R. The bipersonal field. New York, NY: Jason Aronson; 1976.
47. Sullivan HS. The interpersonal theory of psychiatry. New York, NY: WW Norton & Co; 1953.
48. Stolorow R, Atwood G, Brandchaft B, editors. The intersubjective perspective. Northvale, NJ: Jason Aronson; 1994.

49. Mitchell SA. Relational concepts in psychoanalysis: an integration. Harvard University Press; 1988.
50. Aron L. A meeting of minds: mutuality in psychoanalysis. Hillsdale: The Analytic Press; 1996.
51. Atwood G, Stolorow R. Structures of subjectivity: explorations in psychoanalytic phenomenology. Hillsdale, NJ: The Analytic Press; 1984.
52. Stolorow R, Atwood G. Contexts of being: the intersubjective foundations of psychological life. Hillsdale, NJ: The Analytic Press; 1992. p. 1992.
53. Mitchell SA. Interaction in the Kleinian and interpersonal traditions. Contemp Psychoanal. 1995;31(1):65–91. https://doi.org/10.1080/00107530.1995.10746896.
54. Ogden TH. Reverie and interpretation. Psychoanal Q. 1997;66(4):567–95. https://doi.org/10.1080/21674086.1997.11927546.
55. Ogden TH. This art of psychoanalysis. Dreaming undreamt dreams and interrupted cries. Int J Psychoanal. 2004;85:857–77. https://doi.org/10.1516/0020757041557575.
56. Lingiardi V, Holmqvist R, Safran JD. Relational turn and psychotherapy research. Contemp Psychoanal. 2016;52(2):275–312. https://doi.org/10.1080/00107530.2015.1137177.
57. Lingiardi V, McWilliams N. Introduction to the special issue on the Psychodynamic Diagnostic Manual, 2nd Edition (PDM-2). The PDM: yesterday, today, tomorrow. Psychoanal Psychol. 2018;35(3):289–93. https://doi.org/10.1037/pap0000188.
58. Betan E, Heim AK, Zittel Conklin C, Westen D. Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. Am J Psychiatry. 2005;162(5):890–8. https://doi.org/10.1176/appi.ajp.162.5.890.
59. Colli A, Tanzilli A, Dimaggio G, Lingiardi V. Patient personality and therapist response: an empirical investigation. Am J Psychiatry. 2014;171(1):102–8. https://doi.org/10.1176/appi.ajp.2013.13020224.
60. Hilsenroth MJ, Katz M, Tanzilli A. Psychotherapy research and the Psychodynamic Diagnostic Manual (PDM–2). Psychoanal Psychol. 2018;35(3):320–7. https://doi.org/10.1037/pap0000207.
61. Tanzilli A, Majorana M, Fonzi L, Pallagrosi M, Picardi A, Coccanari De Fornari MA, Biondi M, Lingiardi V. Relational variables in short-term psychodynamic psychotherapy: an effectiveness study. Res Psychother. 2018;21(3):327. https://doi.org/10.4081/ripppo.2018.327.
62. Dahl HJ, Høglend P, Ulberg R, Amlo S, Gabbard GO, Perry JC, et al. Does therapists' disengaged feelings influence the effect of transference work? A study on countertransference. Clin Psychol Psychother. 2017;24(2):462–74. https://doi.org/10.1002/cpp.2015.
63. Dahl H-S, Røssberg J, Bøgwald K, Gabbard G, Høglend P. Countertransference feelings in one year of individual therapy: an evaluation of the factor structure in the Feeling Word Checklist-58. Psychother Res. 2012;22(1):12–25. https://doi.org/10.1080/10503307.2011.622312.
64. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Assessing clinician's subjective experience during interaction with patients. Psychopathology. 2014;47(2):111–8. https://doi.org/10.1159/000351589.
65. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Association between Clinician's Subjective Experience during Patient Evaluation and Psychiatric Diagnosis. Psychopathology. 2016;49(2):83–94. https://doi.org/10.1159/000444506.
66. Røssberg JI, Karterud S, Pedersen G, Friis S. An empirical study of countertransference reactions toward patients with personality disorders. Compr Psychiatry. 2007;48(3):225–30. https://doi.org/10.1016/j.comppsych.2007.02.002.
67. Tanzilli A, Gualco I, Baiocco R, Lingiardi V. Clinician reactions when working with adolescent patients: the therapist response questionnaire for adolescents. J Pers Assess. 2020;102(5):616–27. https://doi.org/10.1080/00223891.2019.1674318.
68. Tanzilli A, Lingiardi V, Hilsenroth M. Patient SWAP-200 personality dimensions and FFM traits: do they predict therapist responses? Personal Disord. 2018;9(3):250–62. https://doi.org/10.1037/per0000260.
69. Brody EM, Farber BA. The effects of therapist experience and patient diagnosis on countertransference. Psychotherapy. 1996;33(3):372–80. https://doi.org/10.1037/0033-3204.33.3.372.

70. McIntyre SM, Schwartz RC. Therapists' differential countertransference reactions toward clients with major depression or borderline personality disorder. J Clin Psychol. 1998;54(7):923–31. https://doi.org/10.1002/(sici)1097-4679(199811)54:7<923::aid-jclp6>3.0.co;2-f.
71. Schwartz RC, Smith SD, Chopko B. Psychotherapists' countertransference reactions toward clients with antisocial personality disorder and schizophrenia: an empirical test of theory. Am J Psychother. 2007;61(4):375–93. https://doi.org/10.1176/appi.psychotherapy.2007.61.4.375.
72. Tanzilli A, Colli A, Del Corno F, Lingiardi V. Factor structure, reliability, and validity of the Therapist Response Questionnaire. Personal Disord. 2016;7(2):147–58. https://doi.org/10.1037/per0000146.
73. Shedler J, Westen D, Lingiardi V. The evaluation of personality with the SWAP-200. Milan, Italy: Raffaello Cortina Publisher; 2014.
74. Westen D, Shedler J. Revising and assessing axis II, Part I: developing a clinically and empirically valid assessment method. Am J Psychiatry. 1999;156(2):258–72. https://doi.org/10.1176/ajp.156.2.258.
75. Westen D, Shedler J. Revising and assessing axis II, Part II: toward an empirically based and clinically useful classification of personality disorders. Am J Psychiatry. 1999;156(2):273–85. https://doi.org/10.1176/ajp.156.2.273.
76. Gabbard GO. Transference and countertransference: developments in the treatment of narcissistic personality disorder. Psychiatr Ann. 2009;39(3):129–36. https://doi.org/10.1037/pst0000111.
77. McWilliams N. Psychoanalytic diagnosis: understanding personality structure in the clinical process. 2nd ed. New York, NY: Guilford Press; 2011.
78. Kernberg OF. Severe personality disorders: psychotherapeutic strategies. New Haven, CT: Yale University Press; 1984.
79. Tanzilli A, Muzi L, Ronningstam E, Lingiardi V. Countertransference when working with narcissistic personality disorder: an empirical investigation. Psychotherapy (Chic). 2017;54(2):184–94. https://doi.org/10.1037/pst0000111.
80. Tanzilli A, Gualco I. Clinician emotional responses and therapeutic alliance when treating adolescent patients with narcissistic personality disorder subtypes: a clinically meaningful empirical investigation. J Personal Disord. 2020;34(Suppl):42–62. https://doi.org/10.1521/pedi.2020.34.supp.42.
81. Gabbard GO, Crisp H. Narcissism and its discontents: diagnostic dilemmas and treatment strategies with narcissistic patients. Washington, DC: American Psychological Association; 2018.
82. Ogrodniczuk JS, Kealy D. Interpersonal problems of narcissistic patients. In: Ogrodniczuk JS, editor. Understanding and treating pathological narcissism. Washington, DC: American Psychological Association; 2013. p. 113–27.
83. Ogrodniczuk JS, editor. Understanding and treating pathological narcissism. Washington, DC: American Psychological Association; 2013.
84. Ronningstam E. Alliance building and narcissistic personality disorder. J Clin Psychol. 2012;68(8):943–53. https://doi.org/10.1002/jclp.21898.

A Cognitive Therapy Perspective on Therapists' Feelings and Interpersonal Processes

11

Paola Gaetano, Angelo Picardi, and Antonino Carcione

11.1 Introduction

Historically, psychotherapies can be distinguished into two main categories based on their general approach. On the one hand are psychodynamic and humanistic therapies, which are based on dialogue and introspection; on the other are behavioural and cognitive therapies, which are (or were, originally) based on action [1].

Behavioural therapies (BTs) are grounded in scientific, experimental models developed for the analysis of automatic mechanisms. Therapies derived from these models were mainly developed in the 1950s and are considered as the first generation of psychotherapies based on experimental data. Subsequently, in the 1970s, experimental analysis, enabled by technology, was extended to automatic information processing, which gave birth to a new field, cognitive psychology, and a new generation of interventions, called cognitive-behavioural therapies (CBTs). Over time, new models of assessment and treatment that reconsidered the relationship between thoughts and emotions and between mental states and context were developed. This led to a third generation, or 'third wave', of CBT, which includes a number of integrated cognitive therapies that incorporate humanistic, existential, scientific, and/or strategic elements and practices from other approaches, and that

P. Gaetano (✉)
Italian Association for Behavioural and Cognitive Therapy (SITCC), Rome, Italy
e-mail: paolagaetano@gmail.com

A. Picardi
Centre for Behavioural Sciences and Mental Health, Italian National Institute of Health, Rome, Italy
e-mail: angelo.picardi@iss.it

A. Carcione
Third Centre of Cognitive Psychotherapy, Italian School of Clinical Cognitivism (SICC), Rome, Italy
e-mail: carcione@terzocentro.it

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_11

take into account the mind–body unit and the spiritual aspects of the individual. Some of these approaches incorporate mindfulness exercises [2], while others put emphasis on emotion regulation and communication techniques [3], or evolutionary models [4, 5]. Many of these approaches emphasise the importance of accepting the suffering intrinsic to life [6] while others, such as constructivist and metacognitive therapies, focus on the analysis of experience and the understanding of mental events [7–9]. The efficacy of these recent approaches is supported by a large number of randomised clinical trials [10, 11], though evidence of their superiority over traditional BT and CBT is limited [12, 13].

As detailed in other chapters of this book, throughout history many scholars in mental health disciplines have underscored the importance of the clinician's subjectivity. Phenomenological psychopathology has classically suggested that the clinician's feelings play a role in the diagnostic assessment, a view that has been corroborated by a number of recent empirical studies. Also, psychoanalysis has elaborated sophisticated concepts such as countertransference and projective identification to address the intersubjective phenomena of the therapeutic encounter as perceived by the therapist.

Until relatively recently, the literature on cognitive therapy did not devote much attention to the therapist's subjective experience. However, in the past few decades the literature on cognitive therapy has started to highlight the role of the therapist's emotions as useful indicators of the patient's emotional and cognitive processes [15], and to emphasise that the therapist's ability to feel, identify, accept, and monitor her own emotions is instrumental in keeping the right distance during the therapeutic process [16]. Although precisely which interventions can be considered as 'new wave' and which are simply extensions of CBT is a matter of debate [14], it can be stated that, independent of their categorisation as 'third wave' or not, these recent approaches, as compared with their predecessors, place much more emphasis on the therapeutic relationship and on the role of the therapist's emotions in the process of effecting change.

The importance of making contact with one's own 'negative' feelings and accepting them had already been underscored in psychoanalysis [17], which places emphasis on making unconscious conflicts conscious and recognising uncomfortable feelings as vital aspects of one's own experience. In a similar vein, humanistic therapies, such as client-centred therapy [18] and Gestalt therapy [19], underscore the importance of accepting every aspect of one's own experience. In this respect, third-generation cognitive therapies, while maintaining a focus on empirical evaluation of effectiveness, overcome some of the barriers that divided scientifically based approaches from humanistic and hermeneutic approaches.

While further research on therapy processes and outcomes is needed, it nevertheless seems clear that over the last century both clinical practice and the study of mental phenomena have shown a common tendency towards a growing recognition of the importance of the emotional experience, the relational and sociocultural context, and the spiritual dimension of existence.

This chapter will mainly focus on constructivist and metacognitive interpersonal therapies. These therapies give primacy to the interaction between emotions,

behaviours, and thoughts, the degree of coherence between the pre-reflective and reflective level of the manifestation and organisation of experience, current life situation, network of personal relationships, and historical and cultural context. As far as constructivist therapies are concerned, we will focus on the so-called post-rationalist cognitive therapy model that was pioneered by Vittorio Guidano in the 1980s, and in particular on one of its elaborations, known as experience-centred post-rationalist cognitive psychotherapy (EPCP) [20]. Similarly to a few other approaches, such as phenomenological psychotherapy [21–24], EPCP is informed by phenomenological philosophy. In this first section, we will examine how the therapist's subjective experience during early psychotherapy sessions may help build the therapeutic alliance and guide the clinician in the assessment of the patient's personal meaning organisation (PMO). In the second section, we will focus on more advanced stages of therapy and examine the value of the clinician's subjective experience in the context of the therapeutic relationship and of the cycles in the therapeutic alliance, which is a topic more specifically addressed by the meta-cognitive interpersonal therapy approach [25].

11.2 Experience-Centred Post-rationalist Cognitive Psychotherapy

EPCP is grounded in the distinction between reflective and pre-reflective consciousness, and aims at exploring the manifestations of experience at the pre-reflective level [26], where the processes of passive synthesis that do not require the subject's active intervention occur [27]. This approach relies on a phenomenological model that examines the links between the context, emotions, thoughts, and actions of the subject as related to his emotional situation [28]. The EPCP approach aims at increasing the coherence between the intuitive understanding of experience, its explicit verbal expression, and its symbolic-linguistic explanation at the reflective level [29, 30]. This, in turn, should improve emotion regulation and give patients the opportunity to freely choose their actions so that they can fully adhere to their decisions and be proud of themselves and able to collaborate empathically and actively with others [31].

Building on previous theoretical work on cognitive-behavioural schemata [32], Guidano conceived the notion of PMO to identify and describe a number of developmental pathways of personality and existential themes that stem from early attachment experiences. The notion of PMO refers to patterns of self-referential semantic representations that are consistently linked to self-organised patterns of the emotional domain which are structured depending on different developmental pathways [29]. In this framework, personal meaning represents the link that connects, in an internally consistent way, significant life events with their corresponding lived experiences, the thoughts and behaviours related to these experiences, and the personal explanations that provide a unified and shareable sense for the experiences. As used here, the term 'lived experiences' does not refer to what emerges from a simple introspective exploration translated in subjective, often idiosyncratic

accounts; rather, it refers to the product of a guided exploration and critical analysis of experience. Lived experience in this sense brings out the links between the embodied emotional situation (plans, expectations, feelings, quality of affective relationships, socio-economic and cultural possibilities, interpretive criteria, health state, time of life, etc.) and what is happening in life (significant facts, meaningful events), the related psychic acts (perceptions, emotions, memories, etc.), and the development over time of all these connections.

The fundamental phenomenological concept used to explore the subjective experience is Heidegger's *Befindlichkeit*, which is inherently interrelated with the other two basic parameters of human existence: *understanding* and *speech*. *Befindlichkeit* refers to the specific kind of being that humans are: we are always situated in the world, in a context, living in a certain way with others, trying to achieve this and avoid that. We find ourselves how we already are, amidst the circumstances of our living, in a particular mood, trying to understand what we feel and how we behave in that situation, projected towards the future, aware of having a limited life time, trying to make sense of it all, always engaged in an eternal dialogue with others [28].

To perform the analysis of experience, Guidano developed the 'moviola' technique, which enables the therapist to guide patients in the exploration and understanding of their experience [33]. This technique consists of identifying and examining in fine detail a significant episode in the patient's life that elicited unsettling emotions. The latter are defined as states of mind and behaviours that the patient herself judges to be excessive in intensity or duration, or inappropriate to the situation. When the patient gains an understanding of the life situation and the contingencies of the moment in which the episode occurred, the therapist extracts the fragment of experience that he wants to focus on and guides the patient to recall in detail the facts in their chronological order. Subsequently, the therapist reconstructs the 'scenic design' of each significant step in the interaction with others and, using this reconstruction, examines the patient's corresponding lived experiences and guides the patient to formulate hypotheses about the lived experiences of other people by putting herself in their shoes, evaluate the event according to socially and culturally shared criteria, and distinguish the self-referential interpretations she has made from the meaning that can be seen through the emotions and behaviours that have been manifested.

Finally, the event is reconfigured and reinserted into the patient's current life situation, and the sense of the examined experience, with the links between facts, emotions, actions, and evaluations, is made explicit. In order to carry out a *moviola* perfectly, the therapist should follow a phenomenologically oriented approach to the experience, have good expertise in psychopathology and adequate understanding of the relationship between behaviours and states of mind, and be able to recognise the 'cliché explanations' that all people in a given historical and cultural community tend to give for their lived experiences that are not well-understood. In other words, the therapist should have the skill and ability required to identify the discrepancy between how a person interprets the phenomena related to the manifestation of herself, to herself, and how these phenomena originally present themselves to consciousness at the pre-reflective level. Being familiar with PMOs may therefore be of great help to the therapist.

The ability to distinguish explanations from genuine experience requires substantial practice. The patient's accounts at the explicit, reflective level, are, in general, poorly reliable because they tend to ascribe their behaviours to causes or aims that actually have little to do with the real reasons underlying those behaviours. The more the person has difficulty understanding his own immediate experience at the tacit or pre-reflective level, the greater the degree of discordance. Although it is impossible to completely eliminate every kind of inference in trying to reach the original and authentic experience, a solid foundation of expertise in psychopathology and phenomenology may greatly help reduce the margin of error to a minimum. First, the knowledge of physiological and pathological mechanisms makes it possible to fairly easily distinguish functional from organic mental processes. Second, a good understanding of the coherent relationship that exists between trigger events, emotional reactions, and the emotional situation allows the clinician to grasp the reasons for a given behaviour, independent of any narrative. To the experienced psychotherapist, every emotional reaction shows itself as an 'internally coherent' configuration of somatovisceral changes, facial expressions, behaviours, thoughts, and automatic images. Such a reaction is triggered by a specific kind of external stimulus, a reference object for that emotion. In order to induce a reaction, this stimulus should present itself as a 'new event' in a given situation [34]. There is an intrinsically legitimate link between subjective responses, external stimuli, and lived experiences related to a person's life situation. Through its occurrence, a given emotion reveals to a person the value of a given event for her in that particular emotional situation. Third, it is possible to distinguish explanations of human actions based on interpretive reasoning from descriptions of actions grounded in intuitive understanding of motives. On the one hand, an explanation replaces a motivational link with a causal link, and often expresses a judgement, be it of blame or justification, or it is accompanied by scepticism, incoherence, or incompleteness. On the other hand, understanding, which is intuitive in nature, links in a stable, clear, and coherent way all the aspects of thinking, feeling, and acting related to certain events in a given context.

Though PMOs do not refer to mental health conditions, their names draw on clinical observations and relate to some of the main diagnostic categories that most often arise when an individual whose understanding of herself is inadequate to the situation faces particularly meaningful events that put to the test her emotion regulation abilities. At its core, the post-rationalist cognitive therapy approach consists of the accurate exploration and critical analysis of experience. During treatment, the work on the present experience is intertwined with working on experiences related to past events identified as having high emotional content and seen as related to the current distress. If necessary, the analysis can be extended to the whole personal and family history. In fact, although lived experiences flow smoothly, are intertwined, bind together in a unified way, and give rise to mutually consistent emotional, behavioural and ideational manifestations, an individual may find himself imprisoned in the ongoing experience without understanding its origin. Such a psychological imprisonment may continue until he concludes that what he feels is part of an unavoidable fate, or he may become trapped in his own explanations and lose the

ability to grasp the original meaning of his experience. Historicising a way of feeling and of behaving with others promotes understanding, which is already a positive change, in the form of orientation, recovery, acceptance, and freedom of choice [35]. In the EPCP approach [20], the exploratory work is carried out following the phenomenological method, with particular reference to three foundations of philosophical thought: the intentional theory of emotions mainly formulated by Husserl [36], the contributions of Heidegger and Ricoeur on language functions [37, 38], and the observations of Heidegger on *Befindlichkeit*; in other words on the fundamentals of existence [28].

Establishing the therapeutic relationship is of the utmost importance to being able to proceed gently and incisively with the exploration of experience. If the clinical condition allows, it is mandatory to build a collaborative relationship right from the start. To this purpose, it is vital for the therapist to create an atmosphere of mutual respect and to be constantly in tune with the patients in order to allow them to explore their experience under her guidance, while being careful to avoid unwarranted interpretations or inferences, as this can lead patients to delegate their decisions and understanding to the therapist.

The preliminary aim of psychotherapeutic treatment should be to reach conditions in which the patient can communicate the sorts of needs expressed in statements such as 'I do not like this way of feeling', 'I do not like this way of behaving', or 'I do not recognise myself in my own feelings or behaviours, and I would like to understand why I cannot rule myself and be the person that I would like to be'. With such a request, the patient authorises the therapist to put herself on the patient's side. Then, they can search together for the reasons underlying his difficulties through working on his relationship with himself, between his reflective and pre-reflective consciousness. The therapist should thus be genuine, empathic, and clear in her manner of relating to the patient.

Guidano defined the therapist who uses this method of experience analysis as a 'strategically oriented perturber' [29]. Our interpretation of this definition is that such an exploration, aimed at revealing the original sense of experience that has been obscured by self-narrative accounts that are at odds with this sense, has the 'strategic' objective of eliminating every prejudice and guiding the patient towards a greater understanding of her and other people's motives, thus allowing her to be ever more herself, genuine, and free. In the present context, the term 'motive' refers to emotions and drives that induce a person to act. A person's understanding of her own motives and of their links with her ongoing life events and emotional state allows her to choose the action that most fits with how she would like to be. Other people's motives cannot be known, but they can at least be hypothesised by putting ourselves in their shoes based on our knowledge of the events occurring to them and their emotional situation.

The therapist who manages to build a collaborative relationship and to share the patient's perspective in order to understand his flow of lived experiences, while refraining from doctrinal interpretations, has the advantage of not taking the patient's attitudes and feelings as referring to herself. Instead, these attitudes and feelings should be taken as manifestations of the meaning that events assume for the

therapist in relation to the patient's lived world. In fact, right from the start, the therapist should take care to recognise the patient's emotional situation, his life context, and his most important actions, which allows her to grasp the meaning of his lived experiences, the motives for his actions, and the object to which his feelings refer. For instance, it may soon be evident to the therapist that the patient's frustration relates to feelings of impotence associated with his experience, or that his feelings of inadequacy and guilt refer to the inability to understand and validate his lived experiences and thus to see his actions as part of a coherent whole. The more the therapist is attuned to the patient's original worries and difficulties, the more she will feel at ease with the patient, and the patient will immediately feel comforted and relieved as well. On the other hand, being attuned to a patient's feelings that are linked to appraisals based on inconsistent interpretations of his experience would be misleading for the therapist. This is because she would be focusing on the patient's explanations, which in fact serve to distance him from himself even more, thus contributing to the maintenance of distress. A cultivation of self-awareness on the part of the therapist through phenomenological study and meditation will allow her to identify with sufficient clarity every automatic countertransference of the feelings that arise in the relationship with the patient by understanding how these feelings refer to her own life experiences. She will thus be able to use this understanding to gain access to the patient's life experiences with greater speed and lucidity. For instance, the therapist may feel too activated by a request for help and realise that her excessive involvement is linked to her need for approval. Through this understanding, she can transcend herself and focus instead on the meaning of the patient's request. For example, she may grasp that it refers to his fear of failure, if the phenomena converge in this direction. Conversely, she may recognise that her intense involvement is consistent with the patient's needs; she would thus assess her own fears and limits, and then meet the patient's request as far as possible by choosing the behaviour that is most adequate and safe for the patient. In other words, self-awareness is indispensable to maintain a clear and permeable border between self and other.

11.3 Clinical Aspects of Personal Meaning Organisations

In order to explore more deeply the meaning of the therapist's emotional resonance and how it may be used in therapy, it seems useful to delve into certain aspects of PMOs, as developed by Guidano. His theory describes the possible developmental trajectories of personality from early attachment experiences. It is based on the integration of several concepts from developmental and cognitive psychology, phenomenological psychology and psychopathology, constructivist epistemology, and complex systems theory [29, 33].

During the development of primary attachment relationships, the child repeatedly feels in certain ways in the presence of the caregiver, which depend on the kind of emotional and physical reciprocity that characterises the relationship in various life contexts. These experiences can yield mental 'sediment', in the sense of

emotional or cognitive fallout or precipitation, and these sediments can autonomously organise themselves, according to rules that express the correspondence between mental activity and the interpersonal context. In fact, our mind is intentionally open to the world and is receptive to the structural order of both our world and the other worlds in whose references we live [35]. In their continuous sedimentation, life experiences gradually influence subsequent life experiences by affecting expectations and ways of relating to others. They also bias development towards routes that are tightly linked with personal history and a number of subjective variables.

Guidano has distinguished four main PMOs, which may in turn be divided into further categories. In actuality, these categories have blurred borders and several points of contact between them. While the interested reader is referred to Guidano's work for a comprehensive description of them, here we will illustrate some of the most typical ways PMOs present themselves to the clinician. Classically, the majority of people who request psychotherapy have a personal history characterised by painful events that they found hard to cope with; therefore, they will most likely fit into the category of those who have suffered from dysfunctional attachment relationships. However, it should be kept in mind that, although PMOs are named after mental health conditions, these constructs are larger in scope and have gradually come to relate more to personality theories than to studies of psychopathology [39]. Indeed, PMOs can be balanced and functional, even in the presence of life paths full of obstacles, as difficulties can be overcome through adequate support or earned self-awareness.

Some patients have a tendency to stubbornly adhere to their own point of view and to discard or underestimate perspectives other than their own. They also display little fear of new experiences and anger or indifference towards criticism; they feel embarrassed about and tend to downplay their painful feelings related to rejection or abandonment; and they show feelings of self-reliance and reluctance to build collaborative relationships. Above all, no matter how they try to regulate their emotions through cognitive rationalisation processes or distancing behavioural strategies, they display intense and well-defined emotions with marked somatovisceral involvement. These characteristics are typical of the PMO that is prone to depressive disorders ('Dep-prone'). This PMO is theorised to stem from recurrent early experiences of neglect and solitude, as typically happens to children with an avoidant attachment pattern [40]. Such life conditions force the child to deal with her emotions by herself. The main feeling that arises is one of loss, and thus of anger and sadness, sometimes accompanied by a feeling of self-reliance. While developmental routes vary widely, depending on the characteristics of their situations and the intensity of their emotions, they share a common need to prevent and reduce the pain resulting from perceptions of rejection and loss. Responses to meet this need may vary from avoiding or devaluing romantic relationships to constantly searching for an ideal place where they could finally be happy and rewarded for their efforts. The predictable failure of these strategies, and the difficulty to recognise the plot of lived experiences that over time may have caused this failure, may lead to a vulnerability to mental health problems. In people with such life paths, mood and anxiety disorders,

particularly depressive disorders, and personality disorders like antisocial or narcissistic disorder, are frequently observed. Typically, the therapist may find herself facing patients who show a variety of attitudes ranging from impenetrable to dissimulating, devaluing, desperate, angry, helpless, indifferent, nervous, hostile, or with 'all or nothing' expectations.

Those patients who tend to explicitly define relationship rules, are very focused on the physical manifestations of their emotions, seem to demand attention and direct it towards the aspects they hold most dear, may rapidly oscillate between collaborative or seductive attitudes and vindictive attitudes or requests for help, display intense emotional reactions, and validate their own needs and feelings, are often characterised by a PMO prone to phobic disorders ('Phob-prone'). This PMO is postulated to be linked to recurrent early experiences with an unreliable caregiver that lead to ambivalent attachment [40]. In order to keep himself safe, the child shall constantly require attention and maintain a controlling attitude towards the other, which will lead to an inability to regulate his emotions independently. Over time, he will tend towards feelings of anxiety, particularly when alone, will be prone to express anger and protest if his significant other is unavailable or has an ambiguous attitude, and will be almost constantly worried for his own stability. In this case, too, the developmental routes vary greatly according to each person's situation; nevertheless, those with this PMO share a common tendency to monitor the intensity of their emotional reactions and the predictability of circumstances and situations. Their emotional reactions are typically vivid and well-defined. On the one hand, they search for stimulation and challenge; on the other hand, they show a need for regulation, stability, safety, and independence. They most often present with anxiety disorders, particularly panic disorder and agoraphobia, and may also develop hypochondriasis, impulse control disorders, mood disorders, eating disorders, and personality disorders such as borderline, histrionic, and dependent personality. The therapist will often have to deal with behaviours such as requests for reassurance and attitudes of dependency possibly alternating with controlling and intolerant behaviours. Other alternating sets of behaviour can also manifest, including idealisation and devaluation, arrogance and weakness, impudence and timidity, seduction and indifference, and respect and condescension. Indeed, the ease with which these patients can swing from one extreme to another in their attitudes is quite extraordinary, and they have some tolerance for their own apparent verbal and behavioural incoherence. What links these contrasting behaviours is the need to control the relationship and to have their necessities met, as well as to prevent the unavailability of others.

Other patients, while displaying behaviours that are similar to those mentioned above, either on the ambivalent or the avoidant side of the attachment spectrum, have the peculiar characteristic of not validating their own experience and of feeling vague and indistinct emotions. In this case, we are more likely to be dealing with people having a PMO prone to obsessive disorders ('Obs-prone') or a PMO prone to eating disorders ('ED-prone'). Differently from the two PMOs described above, their developmental path is mainly characterised by repetitive devaluation and invalidation of their experience by the caregiver, together with neglect or unpredictable caregiving behaviour, usually marked by ambiguous emotional disposition.

Since childhood, patients with a PMO prone to obsessive disorders have faced situations where they had to meet demands for behaviours deemed as 'coherent and sensible' by their caregiver. Therefore, they have a heightened need to consider their states of mind as 'right and desirable' in terms of quality and intensity according to their evaluation of the situation. As a consequence, they often completely ignore spontaneous emotional reactions to contextual stimuli and regard every state of mind as a product of the intellect, rather than as the natural response of an organism to the value of certain stimuli in a given context. In other words, they tend to miss the point that emotional reactions are initially grounded in passive synthesis processes and, as such, are not amenable to conscious control when they emerge into consciousness. Each effort they make to rationally examine the events, from ongoing events to those in the near and distant past, to control their own behaviour, and to prevent or modify the contextual elements that elicit emotions, imposes a substantial cognitive load and leads them to distance themselves further from the original experience. They do this because information about the value of contextual stimuli that is contained in emotional reactions is neglected rather than being recognised and integrated into reasoning processes to lead to a fully informed action. On the one hand, those who rely more on avoidant attachment strategies develop a series of dogmatic principles that lead them to analyse situations in detail and make rigid judgements. When they are in doubt, they show a tendency to rumination or a need for close discussion with significant others. On the other hand, those higher in attachment anxiety preferably focus on preventing upsetting situations that may elicit indecipherable emotions that are difficult to manage. The patients with this PMO most often develop obsessive-compulsive and related disorders, depressive or anxiety disorders, eating disorders, or personality disorders such as paranoid, narcissistic, or antisocial, as well as avoidant or dependent personality. They may experience serious difficulties in intimate relationships, both in forming affective bonds and in sexual life. On the one hand, these difficulties are associated with a tendency to postpone decisions, which stems from ambition for perfection or absolute certainty; on the other hand, they are related to the difficulty of recognising and validating their own emotions and the resulting need to avoid situations that may trigger state of minds that are contrary to expectations or hard to identify and rationalise. In the eyes of an observer, a patient with this PMO seems inauthentic, very attentive to the details of conversations and situations, and frequently prejudiced against or cautious towards others. When not upset, such a patient is usually a brilliant and engaging talker, and is sometimes coercive in her requests for explanations or reassurance. The patient takes her time to sift through the various options, and she shows difficulties in making decisions. Sometimes, it seems that time passes at a different speed for these patients, with a peculiar slowness, almost as if they felt the need to stop time in order not to make mistakes. They express feelings rather than emotions, with the possible exception of tormenting fear concerning perceived threats to their physical or moral integrity. The most frequent feelings experienced by these patients when they are distressed are guilt, unworthiness, contempt, revenge, resentment, indignation, perplexity, repugnance, anguish, doubt, and disorientation.

Patients with an ED-prone PMO often have an inclination towards reflection, and they, too, may show avoidant or anxious attachment traits. They experience

variegated state of minds that are quite unclear and that they themselves find it difficult to decipher. This gives them the characteristic of being vague and ill-defined, so much so that they may give the impression of going to great length to avoid being defined or judged by others. In reality, the problem is intrinsically linked to their peculiar difficulty validating their own experience and, thus, their perspective. It follows that, for such a patient, all judgements made by others about her and the world are perceived as potentially more valid than hers and guided by superior understanding based on direct personal experience that the ED-prone patient feels she lacks. On the one hand, this entails the need to turn to others to find her bearings in the world and to cope with the sense of emptiness and bewilderment that may arise; on the other hand, it involves the perception of others as intrusive and dominating. In the course of their development, these individuals experienced a caregiver who gave much more importance to their performances than to their needs. This does not necessarily prevent them from validating their emotions, but it may impair their ability to validate a sequence of emotions, thoughts, and actions in a given context, particularly if the outcome of their efforts is not fully satisfactory. Moreover, the criterion for high satisfaction is often an unreasonably ideal one that does not conform to the embodied and contextualised character of the normal human condition. The result is a pervasive sense of inadequacy, which increases fear of judgement and, paradoxically, also the need for an external opinion. These patients find it difficult to express evaluations that are sensible in their own eyes, and they often put effort into a continuous examination of events or people from multiple points of view, with an incessant state of mental work that almost never comes to a conclusion. Their difficulty in making decisions translates sometimes into impulsivity, and other times into constant postponement or fatalism, with frequent changes of course. These patients can present with depressive disorders, particularly after an unexpected romantic break-up experienced as received rather than as chosen, or after failures and disappointments. Besides mood disorders, they may also present with anxiety disorders and personality disorders, particularly avoidant personality. Eating disorders, which inspired the first clinical observations, may often occur in patients who are strongly tuned to approval from others; typically, disordered eating patterns range from restrictive behaviours in those who suffered disappointment to uncontrolled eating in those in whom frustration predominates. To an observer, the patient may appear particularly vague and ill-defined, touchy, embarrassed, evasive, inaccessible, or ambiguous.

11.4 Building the Therapeutic Alliance and Working with Emotions in Experience-Centred Post-rationalist Cognitive Psychotherapy

Feelings and behaviours displayed by patients help the therapist to understand the reason for their request for help, as well as their difficulty in regulating emotions and accessing their original experience. If we consider therapy to be a process of understanding the vital connections in the flow of subjective experience, it clearly follows that the patient should be guided to discover the connections between life

events and the initial emotions that these events elicited in the emotional situation at the time of the event. These emotions can be the very motives for key automatic behaviours on the part of a patient.

To facilitate the patient's learning of the necessary skills to understand and regulate her emotions, it is mandatory to setup a trusting, non-judgemental therapeutic relationship. Such a relationship allows the patient to set aside her interpretive accounts and explore her genuine experience. The therapist can also much more easily steer the patient through the critical examination of her experience and support the patient in her choices, guided by a sense of pride and coherence. The therapist should modulate the intensity of the patient's emotional reaction, so that it is neither too low nor too high, and provide the right amount of energy for effective action after appropriate reflection. Working with 'depressive-prone' patients, it is particularly important for the therapist to highlight the relationship between the motive for the symptomatic behaviour, which in our view is an emotion that was poorly regulated, and the event that triggered it. Then, all this can be connected with the underlying state of mind and the background emotional situation that amplified the poorly regulated emotional reaction. With 'phobic-prone' patients, it is essential to identify the nature of past destabilising events that gave rise to shorter or longer periods of emotional hyperactivity that led to the current experience of emotional dysregulation. Throughout this work, the therapist should refrain from the temptation to draw any kind of inferences. When working with 'obsessive-prone' patients, it is of prime importance to recognise and validate emotional states by identifying the stimuli that naturally elicit them without any cognitive mediation (passive synthesis). With 'ED-prone' patients, the exploration will focus on reconstructing links between the emotional situation, events, emotional reactions, and behaviours. This allows the recognition and corroboration of automatic evaluations of the value of events (passive synthesis) and the attainment of a freely expressed conscious judgement that allows choice in accordance with one's own motivations.

During the initial phases of therapy, when the syntonic relationship between the clinician and the patient is not yet having its modulating effect on the intensity of the patient's states of mind [41], the patient will tend to reproduce the emotional behaviours corresponding to the uncomfortable situation that he is facing. We have previously touched upon the most common PMO manifestations that guide diagnosis and are the first hurdle to overcome. The therapist should regulate her emotional reaction to such problematic behaviours, in order to use her understanding for the purpose of caring for the patient. As mentioned above, it is important that the therapist does not relate the patient's attitudes to herself. This is necessary to maximise empathic skills and allow the patient to place his trust in her during the exploration of his lived experiences, while being sure not to suffer any judgement or interpretive manipulation.

To examine the value of the therapist's subjective experience, we carried out a pilot study aimed at identifying characteristic patterns of therapists' reactions to core features of a patient's PMO. Gaining knowledge of such patterns may aid in clinical assessment and establishment of the therapeutic relationship.

11.5 A Pilot Study of the Therapist's Emotional Reaction to Features of Personal Meaning Organisation During the Early Phase of Therapy

11.5.1 Methods

This pilot study was performed in two private practices located in central Rome. To be considered for inclusion in the study, patients were required to meet the following criteria: (1) age between 18 and 60 years; (2) treatment started no more than 3 months prior to enrolment; (3) no psychotic disorder or syndrome with psychotic symptoms; and (4) no mental retardation or substantial cognitive impairment as clinically determined. Each clinician provided data on two or more patients. All clinicians participated in this research on a voluntary basis, with no remuneration.

A total of five therapists contributed data for the study. Three of them were male, and two were female, with a mean age of 49.4 years (SD = 6.5 years). Their average length of clinical experience as psychotherapists was 18.4 years (SD = 2.5), and they were each performing at least 30 h of direct patient care per week at the time of the study. Their main clinical–theoretical approach was cognitive-behavioural ($N = 4$) and phenomenological ($N = 1$).

The therapists provided data for a total of 24 patients (two therapists provided data for six patients, two others for five patients, and one for two patients), of whom 17 were women. The patients' mean age was 36 years (SD = 9.4). Overall, their education level was high as one-third of the patients had a high school education and two-thirds had attained a university degree. Most of the patients presented with a DSM-IV [42] diagnosis of depressive ($N = 8$) or anxiety ($N = 10$) disorder, in some cases associated with a personality disorder ($N = 9$).

While in the waiting room patients completed the 18-item version of the Brief Symptom Inventory (BSI-18) and the Personal Meaning Questionnaire (PMQ). The BSI-18 [43] is a self-report symptom checklist measure derived from the 53-item Brief Symptom Inventory, which itself is a shortened form of the 90-item Symptom Checklist-90-Revised. The BSI-18 consists of 18 items, each rated on a 5-point Likert scale. The instrument provides scores on three symptom scales, that is, Somatisation, Depression, and Anxiety.

The PMQ is a self-report questionnaire that has been developed to measure the construct of 'personal meaning organisation', which plays a key role in Guidano's model of the Self. The PMQ items, which were designed in accordance with the theoretical descriptions of the organisations, describe a person's general way of feeling, thinking and acting, with no reference to psychopathological symptoms. Each PMQ item is rated on a 5-point Likert scale. The answers for these items are then used to provide scores for four 17-item scales, one for each PMO (depressive-prone, phobic-prone, obsessive-prone, and ED-prone). The PMQ has been validated, with evidence of internal consistency, test–retest reliability, low correlation with the level of depression and anxiety, and criterion validity against measures of personality, emotion regulation, and attachment style [39].

In order to assess the change in the therapist's mood state throughout the visit, the therapists were asked to complete the 'right now form' of the Profile of Mood States (POMS) just before seeing each patient and immediately after the therapy session. The POMS is a validated, self-administered measure of the subject's affective mood states [44, 45]. It consists of 58 adjectives rated on a 5-point scale, ranging from 'not at all' to 'extremely'. It yields scores on six subscales, that is, tension-anxiety, depression-dejection, anger-hostility, fatigue-inertia, vigour-activity, and confusion-bewilderment.

All statistical analyses were performed using SPSS for Windows, version 22.0 (SPSS Inc., Chicago, IL). All tests were two-tailed, with alpha set at 5%. Partial correlation analysis was used to examine the relationship between changes in the therapist's mood state during the session as measured by the therapist's POMS scores and patient's PMQ scores, while controlling for the patient's level of depression and anxiety as measured by the relevant BSI-18 scales.

11.5.2 Results

There were only a few noteworthy correlations between changes in the therapist's POMS scores during the session and the patient's cognitive-emotional organisation as measured by the PMQ. Higher patient scores on the 'phobic' scale were correlated with a greater increase in depression-dejection ($r = 0.43$; $p = 0.04$) and anger-hostility ($r = 0.46$; $p = 0.03$) and tended to be correlated with a greater increase in tension in the therapist ($r = 0.37$; $p = 0.08$). Higher patient scores on the 'eating disorder' scale tended to be correlated with a greater increase in anger-hostility ($r = 0.35$; $p = 0.10$) in the therapist. Higher patient scores on the 'depressed' PMQ scale tended to be correlated with a greater increase in vigour-activity ($r = 0.40$; $p = 0.06$) and a greater decrease in confusion-bewilderment ($r = -0.39$; $p = 0.08$) in the therapist.

Of greater interest was the pattern of partial correlations between individual PMQ items and changes in the therapist's POMS scores during the session. Higher scores on item 1, 'I know how to recognise danger and the people I can trust', were correlated with a greater decrease in scores on the POMS tension ($r = -0.43$; $p = 0.04$), depression-dejection ($r = -0.52$; $p = 0.01$), and anger-hostility ($r = -0.48$; $p = 0.03$) subscales. Higher scores on item 15, 'One can feel angry with somebody but only for an extremely good reason', were correlated with a greater increase in scores on the POMS tension ($r = 0.54$; $p = 0.01$), depression-dejection ($r = 0.48$; $p = 0.02$), and anger-hostility ($r = 0.45$; $p = 0.03$) subscales. Higher scores on item 19, 'When I find myself in trouble, I realise I cannot rely on others', were correlated with a greater increase in scores on the POMS tension ($r = 0.75$; $p < 0.001$), depression-dejection ($r = 0.55$; $p < 0.01$), anger-hostility ($r = 0.58$; $p < 0.01$), and fatigue-inertia ($r = 0.48$; $p = 0.02$) subscales. Higher scores on item 20, 'I think that it is better to be alone rather than to meet the unavoidable and repeated disappointments that every relationship involves', were correlated with a greater increase in scores on the POMS tension ($r = 0.59$; $p < 0.01$), depression-dejection ($r = 0.61$;

$p < 0.01$), anger-hostility ($r = 0.69$; $p < 0.001$), and fatigue-inertia ($r = 0.45$; $p = 0.03$) subscales. Higher scores on item 24, 'I often fear that my point of view will be undermined by others', displayed a borderline correlation with a greater increase in scores on the POMS anger-hostility subscale ($r = 0.41$; $p = 0.06$). Higher scores on item 36, 'I am always afraid that others know more than I do', were correlated with a greater increase in scores on the POMS anger-hostility subscale ($r = 0.53$; $p = 0.01$). Higher scores on item 37, 'I need to feel that I can get out of a situation or come back to it, at any time', were correlated with a greater decrease in scores on the POMS tension ($r = 0.44$; $p = 0.04$), depression-dejection ($r = 0.46$; $p = 0.03$), and anger-hostility ($r = 0.59$; $p < 0.01$) subscales. Higher scores on item 43, 'I take a long time to make decisions, but once I have decided, I act without further delay', were correlated with a greater decrease in scores on the POMS depression-dejection ($r = -0.43$; $p = 0.04$) and confusion-bewilderment ($r = -0.44$; $p = 0.04$) subscales. Higher scores on item 51, 'I think it is better to lose one's dignity than one's health', were correlated with a greater increase in scores on the POMS vigour-activity subscale ($r = 0.47$; $p = 0.03$) and a greater decrease in scores on the POMS fatigue-inertia ($r = -0.50$; $p = 0.02$) and confusion-bewilderment ($r = -0.57$; $p < 0.01$) subscales. Higher scores on item 56, 'I think that to avoid growing attached to another person is a good way to avoid suffering', displayed a borderline correlation ($r = 0.41$; $p = 0.06$) with a greater increase in scores on the POMS anger-hostility subscale. Higher scores on item 58, 'In my opinion, there is an order to things that it is essential to understand', were correlated with a greater increase in scores on the POMS vigour-activity subscale ($r = 0.56$; $p < 0.01$). Higher scores on item 60, 'I go over situations when I feel I haven't behaved justly, and for a long time try to understand my responsibility in what happened', were correlated with a greater increase in scores on the POMS depression-dejection subscale ($r = 0.43$; $p = 0.04$) and showed a borderline correlation ($r = 0.41$; $p = 0.06$) with a greater increase in scores on the POMS tension subscale. Higher scores on item 61, 'It is essential for me to be able to contact at all times the persons I love', were correlated with a greater increase in scores on the POMS depression-dejection ($r = 0.52$; $p = 0.01$), and anger-hostility ($r = 0.49$; $p = 0.02$) subscales.

11.5.3 Conclusions

To our knowledge, this is the first study to examine the relationship between the patient's PMO and the therapist's emotional reactions. Although other studies have examined the therapist's emotional reactions during post-rationalist cognitive therapy sessions, their findings cannot be compared with ours due to differences in focus and measurement. A previous study [46] used psychophysiological indices of the autonomic nervous system to measure emotional reactions and did not take into account the role of PMO. Another study [47] investigated the relationship between countertransference experience and PMO, but it focused on the therapist's, rather than the patient's, PMO.

Due to the number of significant or trend-level findings concerning PMOs that were observed, this pilot study suggests links between the patient's PMO and the

therapist's emotional reactions that are independent from the level of depression and anxiety. The higher level of traits typical of the depressive-prone PMO elicited activation in the clinician, possibly due to the sense of inescapability and impotence that they convey. On the other hand, the clarity of feelings and judgements intrinsic to these traits probably contributes to the observed reduction in the therapist's sense of bewilderment and confusion. The increased annoyance associated with higher levels of traits characteristic of the ED-prone PMO might be related to the vagueness and ambiguity inherent in these traits. The increase in therapist's dejection, annoyance, and tension associated with greater levels of traits typical of the phobic-prone PMO is likely linked with the expression of highly intense emotions intrinsic to these traits. No significant or nearly significant findings were observed concerning the traits typical of the obsessive-prone PMO, which suggests that the formal and respectful behaviours inherent in these traits do not trigger a substantial reaction.

While these findings suggest some degree of association between the therapist's emotional reactions and the patient's PMO, the strength of this association is modest. This is not surprising because, theoretically, PMOs are not conceived as pathological in nature. A client can have a well-defined PMO and display high levels of traits typical of that PMO without being mentally disordered and without eliciting any substantial reaction in the clinician. It is likely that whether the clinician's mood changes significantly or not mainly depends on the degree of inner harmony and self-regulating abilities of the client.

Things change, however, if we consider certain specific ways of feeling and thinking, rather than PMOs as a whole. We found a large number of significant correlations between the therapist's emotional reaction and individual PMQ items. This suggests that the therapist's emotional reactions correlate more with aspects concerning specific patient's attitudes than with the patient's PMO.

The belief that others cannot be relied upon for help (item 19) as well as the tendency to prefer being alone rather than risking disappointments (item 20) correlated with increased tension, dejection, anger, and fatigue in the therapist. Along a similar vein, the belief that interpersonal attachment can cause suffering (item 56) was associated with increased clinician's annoyance. On the other hand, the confidence of being able to recognise dangers and identify trustworthy people (item 1) seemed to have a positive effect on the therapists, who reported being more relaxed, confident, and calm, similarly to when the patient described a need to always feel free to choose her way and have an alternative option to the current situation (item 37). Probably, these attitudes reveal interpersonal and decision-making skills that were appreciated by the therapist. Even higher scores on item 51, which indicate considerable attention to one's own health, appeared to reduce therapist's fatigue and confusion and foster a sense of energy. On the contrary, dependency (item 61) correlated with increased dejection and anger by the therapist; the fear of being overwhelmed by other people's judgements (item 24) may have been irritating; and the sense of incompetence indicated by high scores on item 36 more clearly aroused anger in the therapists. Finally, the clinicians appeared to experience tension, dejection, and anger if the patient showed a tendency to suppress spontaneous emotional reactions and substitute them with cognitive evaluations (item 15). On the contrary,

a tendency towards reflection to help dispel doubts and promote decisions (item 43) seemed to be welcomed and to elicit relief and a pleasant sense of confidence.

In conclusion, the findings suggest that the therapist's reaction varies according to two main dimensions underlying the patient's attitude; namely, interpersonal distance versus warmth, and autonomy versus insecurity/dependence. Concerning the first aspect, those patients who appeared distant and detached (items 19, 20, and 56) or who did not seem genuine (item 15) seemed to elicit tension, depression, anger, and fatigue. Conversely, those patients who appeared capable of establishing trusting relationships (item 1) seemed to induce relief. Concerning the second aspect, higher levels of self-confidence and autonomy on the part of the patient (items 37 and 43) were associated with relief on the part of the therapist. On the contrary, those patients who showed excessive dependence on others (item 61) or complained of being incompetent (item 36) seemed to elicit anger and dejection. Finally, it is not surprising that higher levels of both interpersonal discomfort and incompetence (item 24) appear to induce anger in the therapist.

The relevance of these two dimensions is likely related to their key role in the context of the initial phase of therapy, during which the therapeutic relationship begins to take shape. The susceptibility of the therapist to variation in these dimensions can be understood in light of the dimensions' importance for the formation of a healthy, active, and effective therapeutic alliance. The increased distress observed in the therapist in the presence of higher levels of interpersonal distance, detachment, and distrust might be related to increased perceived difficulty in building the alliance. A similar perception of increased difficulty might be induced by higher levels of dependence and incompetence. Indeed, certain patient attitudes can interfere with the formation of the therapeutic alliance to an even greater degree than psychopathological symptoms.

These preliminary findings should be further explored in future larger studies using the POMS and also by studies using other assessment instruments to measure the therapist's experience. One example of such instruments is the Assessment of Clinician's Subjective Experience (ACSE), the scores of which display meaningful correlations with the changes in conceptually related POMS scales during the clinical examination, as reported in detail in Chap. 7.

In clinical practice, the therapist should not neglect the information provided by his own subjective reaction to the patient. Research on patients undergoing short-term psychodynamic psychotherapy suggests that some aspects of the therapist's subjective experience during the first session are correlated with both the quality of the working alliance and the clinical outcome [48]. The arising of feelings such as tension, fatigue, and irritation during the first sessions is an important signal that should not be underestimated. Such feelings, if perceived by the patient, may confirm her expectations of being rejected, abandoned, or overwhelmed, or may corroborate her sense of personal inadequacy and incompetence.

Some specific feelings should be given particular attention as they may serve as a wake-up call for the therapist. For instance, the feeling of understanding the patient very well may lead to being complacent, missing the opportunity to provide the patient with new perspectives, and becoming trapped with the patient within a

single conception of the problems. Other alarm bells that may ring in a more advanced stage of therapy are feelings of annoyance when the patient attributes an increase in insight to significant experiences outside therapy, such as reading a book or listening to a preacher, or hostile feelings towards the patient's relatives if they are seen as people who may jeopardise the therapeutic work [49].

In deciding how to proceed when noticing the arising in himself of negative feelings such as tension, fatigue, and irritation, a critical element is the therapist's judgement of whether or not his own attitude has played a significant part in causing the patient's behaviours that elicited those feelings.

If not, the key step is regulating these feelings. To this purpose, it is useful to relate them to the overall way of being in the world of the patient, rather than to her relationship with the clinician. The therapist's feelings about the patient may also provide a clue to how other people in the patient's life may feel, which in turn may later be useful for the therapist in helping the patient better understand the people around her and thus improve her relationship with them [49].

If yes, the therapist should not only regulate such feelings, but also further modulate his own behaviour in accordance with the patient's characteristics and needs. Then, the therapist should ask himself what the feelings he experiences during the session tell him about the patient's difficulties and problems. Of particular relevance are those patient's difficulties that may hinder the development and maintenance of a collaborative therapeutic relationship, which is essential for effective treatment. Addressing such difficulties in a timely manner is important not only in the early phases of therapy, but also in subsequent phases, as will be shown in the second part of this chapter.

11.6 Clinicians' Management of Their Own Emotions Throughout Therapy to Maintain Effective Working Alliances

In this second part of the chapter, we will discuss how the patient's difficulties can induce emotional reactions in the therapist that can compromise the alliance, and how to manage such problematic situations through Metacognitive Interpersonal Therapy [24]. Why the topic is relevant is clear: among the non-specific factors related to the effectiveness of psychotherapy, the alliance is considered one of the most reliable predictors, and problematic therapeutic relationships are associated with unsatisfactory outcomes [50]. We are not saying anything new; to highlight a few key examples from the literature on the topic, Freud was the first to highlight the importance of the relationship and of a collaborative attitude between patient and therapist [51]. The psychology of the ego brought attention to real aspects of the relationship [17]. Then, Greenson [52] expressed a more subtle idea: that in the therapeutic relationship, not only the transferal level but also the real one should be considered, with understanding in the clinical relationship being a real exchange of perceptions, emotions, and trust that are as completely authentic as those in a non-therapeutic relationship. Taking a temporal leap, we arrive at Mitchell [53] and relational theory, which insists on the therapist's participation and subjectivity,

describing it as more and more similar to a 'real' relationship that removes the distinction between transference and real aspects. In the cognitivist tradition, attention to the therapeutic relationship has been neglected, but the most recent literature and the so-called third wave of CBT, as mentioned above, is filling this gap. The authors to whom we mainly refer in this part of the chapter are Safran and Segal [54] with their construct of dysfunctional interpersonal cycles, which we will describe later. Therapist neutrality now seems to be a false myth. For this reason, although our focus is on the patient's experiences and how he reacts to the therapist's manner, here we would like to focus on the other side of the coin; that is, how the patient induces in the therapist thoughts and feelings that could induce him to act in ways that could (predictably) facilitate a rupture of the therapeutic alliance.

Bordin [55] defines an alliance as a client and a therapist in agreement on goals, tasks, and the quality of the interpersonal bond. Referring to this definition, it becomes evident how the therapeutic process provides for a continuous negotiation of this alliance, involving both explicit and tacit processes, which often touch the participants in the relationship on a deep human level. This deep emotional connection can lead to irritation, distrust, worry, and frustration, dangerously compromising a fundamental requirement for successful psychotherapy.

On the other hand, traditionally, CBT limits itself to the promotion of collaborative empiricism [56] and does not provide for specific technical interventions to manage difficulties in the therapeutic relationship. However, empirical research indicates that working on the relationship as well as addressing symptoms are mutually reinforcing actions. In fact, treatments focused on symptoms and interpersonal issues, including attention to the therapeutic relationship, appear to be more effective [57, 58]. If there are no dysfunctions in the relationship, the session does not require explicit interventions on the therapeutic relationship, and the therapist can use techniques to access the patient's mental states and regulate them in a functional and adaptive way through specific techniques [59].

The therapeutic alliance is, by definition, the relational context in which therapist and patient cooperate to achieve the goals of therapy. Maintaining and restoring the alliance therefore means, from the point of view of the relationship, maintaining and restoring a climate of interpersonal cooperation. Furthermore, the climate of cooperation is also the context within which the exploration of mental processes is facilitated and metacognitive abilities are improved [60, 61]. For all these reasons, the therapist must, as much as possible, maintain a relationship that is perceived as cooperative. Dysfunctional metacognitive processes can compromise the therapeutic relationship; therefore, the study of dysfunctional interpersonal cycles and metacognition can help us to understand relational difficulties.

11.7 Metacognition

In this chapter, we use the term *metacognition* to refer to a set of abilities that are crucial to (1) identify mental states and ascribe them to oneself and others on the basis of facial expressions, somatic states, behaviours, and actions; (2) reflect and

reason on mental states; and (3) use information about mental states to make decisions or solve problems, or to mitigate psychological and interpersonal conflicts and to cope with subjective suffering [25, 62].

Metacognition is composed of different and relatively independent subfunctions: monitoring, differentiation, integration, and decentration. Monitoring is the ability to identify and define the components that make up an inner state in terms of thoughts, images, and emotions, and the variables related to them. Differentiation refers to the ability to differentiate between different classes of representation (e.g. dreams, fantasies, beliefs) and between representations and reality, recognising their subjectivity. Integration is the ability to reflect on different mental states and give a complete and coherent description of their components, including their evolution over time. Integration also relates to the ability to form a coherent narrative. Decentration captures one's ability to define others' mental states by forming hypotheses independent of one's own perspective, mental functioning, or involvement in the relationship, recognising the subjectivity of these mental states.

The metacognitive functioning of the patient is relevant because specific metacognitive difficulties tend to induce corresponding mental states in the therapist. When encountering a patient with an identification impairment, the therapist will find it difficult to represent the patient's mind, perceiving only a wall that cannot be climbed over and that hinders the understanding of the patient's mental processes. However, it is important to remember that this is what the patient himself feels. The therapist may experience boredom and distraction when she is in the presence of patients who have difficulty in intersubjective representation, producing slow, empty pauses. If, on the other hand, the therapist is confronted with a patient with difficulty in decentration, the therapist may experience feelings of alarm or precariousness that can undermine the therapeutic relationship, possibly leading to a sudden breakdown. The impairment of integrative functions brings representations of chaos and confusion in stories and life history. A lack of differentiation, on the other hand, will produce in the therapist a sense of helplessness and uselessness in the therapeutic dialogue, and will cause the therapist to have defensive attitudes in the face of the patient's firm convictions. A patient with a poor mastery of his own emotions can generate ambivalent feelings that can range from the urge to care and the desire to take the patient's place in facing cognitive tasks that are unsuccessful, to feelings of frustration generated by the patient's lack of will. The therapist must be aware of this challenge and master it; primarily through an inner process of understanding and managing her own mental states, called an *inner discipline procedure*, as described below.

11.8 The Problematic Nature of Interpersonal Cycles

In any human relationship, it is possible that vicious circles may be created between the participants that undermine the relationship's quality, even leading to its interruption. Such events are frequent in particular in patients with personality disorders (PDs), in whom complicated, sometimes traumatic, family histories are associated

with an excessive rigidity of interpersonal patterns through which the patient interprets what happens in the relationship. In such patients, the roles of self and other are represented in a rigid way, with the patient making predictions that orient tacit expectations, memory, and selective attention, and can thereby lead to biases. On the other hand, PDs are described in the DSM5 in section III as disturbances of the Self functions and interpersonal relationships. It is therefore not surprising that this tendency to damage relationships also manifests itself in the therapeutic relationship. This tendency happens much more frequently in these pathologies than in other disorders of the neurotic area (anxiety, depression, etc.). In this relational dynamic, the central aspect linked to the focus of this part of the chapter is that such relational difficulties on the part of the patient tend to provoke emotional and cognitive reactions in the therapist that are associated with a marked tendency to act in an anti-therapeutic way. As an example, the therapist might want to escape the therapeutic commitment because of feelings of boredom or devitalisation or because he feels charged with excessive responsibility, or powerless to continue the treatment, or tormented by excessive demands. Alternatively, he may feel that he dislikes the patient or feels the urge to hurt or humiliate her. In other cases, he may feel overwhelmed in a pervasive way.

We can explain such dynamics through the construct of dysfunctional interpersonal cycles. The term was proposed by Safran and Segal [54] and taken up by Semerari [63]. According to Safran and Segal, the interpersonal cycle is the way in which the relationship with the other activates circuits that reinforce pathology due to mainly non-verbal, automatic, and emotional signals that patients exchange with their interacting partners [54]. In therapy, an interpersonal cycle is defined by the way in which patient and therapist perceive their respective roles during the process and by the emotions and action tendencies that are activated [9, 24, 64, 65].

However, this process, which appears on first glance to be purely negative, can in fact confer on the therapist a huge advantage as long as she is aware of the active process. This is due to the fact that, in an interpersonal cycle, for a moment, the patient makes the therapist feel as she feels, or as she is afraid to feel, in a relationship. This allows the therapist to grasp the possibility of reaching an understanding that is not only intellectual and cognitive, but also experiential, emotional, and empathic in terms of the patient's relational experience. It is clear that this kind of understanding can be extremely beneficial for therapy, for several reasons. First of all, some chronic interpersonal cycles are activated very early in therapy and allow one to get an idea of the patient's relational mental states well before it is possible to explore them explicitly through conversation and self-observation tasks. If a therapist feels like she is walking on eggshells and swings through fear and anger during a first phone contact, these are likely signs that the client has prominent paranoid features, signalling that the therapist needs to be ready to avoid withdrawing or counterattacking. A second advantage is that, by giving the therapist an emotional measure of the patient's difficulty, it also provides a fair measure of the treatment setting.

How can we be aware of being involved in an interpersonal cycle? In most cases, the signs are quite evident. Sometimes, the patients' acts are completely explicit and

the therapist's reactions are absolutely clear to himself. In cases where the patient acts in a less explicit way, the interpersonal cycle can be perceived when the therapist finds himself experiencing moments of intense relational discomfort, with accentuated emotions towards the patient and unusual thoughts, intentions, and behavioural tendencies that go beyond normal therapeutic intervention. The difficulty, in both cases, is not the recognition of the interpersonal cycle, but the challenge of how to refrain from acting on one's impulses. Often, it is precisely the awareness that we are striving not to act in an anti-therapeutic way that gives us the decisive information that we are in an interpersonal cycle. Once the therapist has become aware of his discomfort and has held back from action, he must turn his attention to his internal state and become aware of the thoughts, emotions, and impulses that, in that moment, he addresses towards the patient.

Interpersonal cycles that are activated in the therapeutic relationship can be divided into *acute* and *chronic*. Acute cycles are characterised by the intensity of the emotions, the power of the impulse to action, and the relatively short duration; when the cycle does not lead to the breaking of the relationship, it rarely exceeds two sessions.

Chronic cycles, on the other hand, are characterised by feelings of lower intensity and impulses to action that are more easily contained. However, they are also characterised by a longer duration. Especially at the beginning of therapy, they can extend for several sessions. Therefore, whereas in acute cycles the therapist may encounter serious difficulties in containing the emotional drive to carry out anti-therapeutic actions, in chronic cycles there is a tendency to action which is less intense. However, the therapist may find himself having to manage these impulses for a longer period of time, leading to the risk of turning towards interventions linked more to his emotional state than to clinical reasoning. It should be stressed here that, in these disorders, the effects of pathogenic interpersonal patterns and metacognitive impairments are mutually reinforcing. The former encourages patients to relate to attitudes that are, from time to time, aggressive, fearful, detached, distrustful, or avoidant. The latter prevents them from reflecting on their own relational attitude and from understanding the intentions of the other by hindering the correction of the predictions contained in the schemes. All this induces emotions in the therapist which, if acted upon, can reinforce the psychopathology.

However, the very regularity with which the problem presents itself has a potential therapeutic advantage. When dealing with countertransference reactions with borderline subjects, Clarkin, Yeomans, and Kernberg [66] observed how these are determined by three factors: the character of the patient, the character of the therapist, and the nature of the psychopathology. In acute cycles, the authors assert that the more serious the psychopathology, the less relevant the personal characteristics of both the therapist and the patient (personal characteristics that are not strictly related to the pathology). This assertion can be extended as a general rule. Psychopathology tends to cancel the contributions of individual characteristics of the patient and the therapist and to induce problematic cycles that manifest in the same way but are characteristic of certain types of disorders. Therefore, the fact that the onset of problematic cycles is deeply linked to the interpersonal pathology of

PDs means that the same type of cycle tends to repeat itself when a certain type of pathology is present, independent of the therapist's personal characteristics. In other words, similar patients tend to create similar cycles and this makes it possible to attempt a partial classification of the cycles. Above all, this provides the advantage of a learning opportunity to recognise and manage them.

11.9 Inner Discipline Procedures

Inner discipline procedures [24, 64, 65] can be simply considered empathic operations. However, this term stresses the discipline involved and emphasises the effort required by the therapist to control her mental state so that she is able to behave in a way that resists the spontaneous impulses that arise from the interaction with the patient. Such operations consist essentially of a double inner effort. At first, the therapist focuses on her own sensations, trying to identify her problematic mental state in order to grasp its essential cognitive, emotional, and relational aspects. In the second phase, the focus shifts to the patient and the therapist asks herself what, of her own experience, is shared with the patient and what is complementary to the patient's experience. The first phase allows the therapist to recognise her mental state. The second allows the therapist to recognise commonalities. When it succeeds, the operation of inner discipline in itself results in an exit from the cycle as it shifts the therapist from an anti-therapeutic perspective to an empathic perspective. From this empathic perspective, she can now understand both the patient's mental state and his role in determining and maintaining it. It should be stressed that these processes do not yet constitute a therapeutic act. Inner discipline is a private event of the therapist, a regulation of one's mental state with the goal of cessation of the tendency towards harmful action. Once successfully completed, however, the process of inner discipline places the therapist in an advantageous position to operate a therapeutic meta-communication [50]. However, if a problematic cycle is triggered, mastering it should be considered as a priority over any other type of intervention. For example, some patients with avoidant personality disorder present, among the relevant features, difficulties in metacognitive monitoring and interpersonal patterns centred on an image of the Self as different, inadequate, and inferior, which promotes the non-sharing of experience and tendency towards detachment. The combination of these two factors serves to make the mind of these patients opaque to the therapist, and dialogue with them difficult. For many sessions, the therapist may feel the weight of a stunted conversation with a stranger, who answers in monosyllables and silently waits for the next question to which he will give an equally laconic answer. The patient sometimes seems not to understand the intentions of the therapist's questions, and his answers do not provide information beyond what is strictly necessary. In these conditions the therapist may become bored and begin to mentally evade the work commitment. She may be surprised to find her mind wandering towards questions that have nothing to do with the patient, or to find herself peeking at the clock or asking questions for the sole purpose of passing the time.

Again, operations of inner discipline consist of two movements. The first one focuses on the therapist's internal state, leading to awareness of her progressive estrangement from the patient. In the second, by focusing on the patient, she can grasp how this sense of extraneousness is mirrored, pervasive, and chronic. At this point, the awareness of the shared dimension can be used for therapeutic purposes by communicating it to the patient using the techniques described below.

11.10 Sharing Interventions

Through interpersonal cycles, the therapist can directly experience what happens in the patient's relationships. In doing so, she becomes aware of how the patient contributes to creating interpersonal circuits that strengthen and maintain the patient's psychopathology. Transmission of this awareness (which has been acquired through direct experience) to the patient becomes one of the strategic objectives of therapy to be pursued over time and in the appropriate manner. Timing and modalities of communication and explanation of cycles are essential for the intervention to be effective. However, communication of key ideas that takes place too early in the relationship and/or in too pedagogical a tone can make the patient feel judged and completely responsible for his difficult relationships, excluding any contribution from other participants.

Finally, empathic and experiential understanding gives rise to a fairly precise idea of how the patient feels at that precise moment of the session. This understanding gives the therapist the opportunity to appropriately modulate the non-verbal aspects of communication. For example, if the therapist realises that he is in a cycle in which he is competing with the patient, he may feel that a sympathetic tone in which he shows solidarity with the patient's suffering may be shocking and offensive or be experienced as a move within a competitive logic.

Sharing consists of explicit interventions in which some aspects of the patient's experience are shared or can be shared by the therapist himself. Sharing interventions contain both validation and disclosure elements. With this technique, in fact, the therapist implicitly validates the patient's experience through the acceptance and recognition of the shared dimension and, in doing so, reveals aspects of his own mental states.

To promote a climate of cooperation, metacognitive interpersonal therapy suggests a particular conversational style based on two types of interventions: the use of the 'universal we' and transparency of the therapist's intentions. The use of the 'universal we' expresses the connotation that the patient's experience is an experience potentially shared by the whole of humanity, and therefore also by the therapist. An example of a typical expression is: 'Are you telling me that you have lived one of those moments in which you feel deprived of energy and you just want to be thrown on a bed?' The use of the 'universal we' has the advantage of underlining the potentially universal character of the patient's problem, implicitly suggesting that it is an experience at least potentially shared by the therapist. This can help the patient to find the best balance between aspects of acceptance and change. It also creates an

interpersonal context of security that reduces the fear of arousing negative judgements or rejection and sarcasm in the interlocutor.

The second intervention type, transparency of the therapist's intentions, consists of continuously offering brief explanations of why the therapist asks certain questions or makes specific requests of the patient. For example, 'Forgive me if I may appear insistent on asking you continuously what you think and what you feel in the various circumstances that you are describing to me, when you clearly are having difficulty identifying them. I am doing this because it is indispensable for me to understand your state of mind before I can understand the specific details that are preventing you from managing it autonomously.' Transparency has the particular advantage of reducing the risk of serious distortions by patients who may have extreme difficulties in understanding the minds of others. In addition, this intervention makes explicit the objectives of the therapy at that precise moment, thereby fostering a climate of collaboration.

The most important procedure for the management of problematic interpersonal cycles concerns the therapist's mental states. The first two therapeutic objectives to be set for the activation of a cycle are not to harm the patient and to use the therapist's inner experience to understand that of the patient. They are both pursued entirely through reflective procedures.

Once the therapist has achieved an empathic understanding of the patient, she will use that understanding to regulate her non-verbal communication to modulate the emotional tone of the relationship. Once the emotional climate has been adjusted, the therapist will try to guide the patient in exploring the mental state that underlies the activation of the cycle in order to establish an interpersonal climate in which patient and therapist reflect jointly on what has happened between them, promoting a metacognitive attitude.

Other sharing interventions suggested by metacognitive interpersonal therapy are discussion of topics of shared interest and narrations of episodes in the therapist's life. In discussion on topics of shared interest, the therapist spontaneously uses discourses on topics of common interest to create a climate of sharing and ease with delusional patients or those with serious interpersonal difficulties. This is particularly useful with patients with differentiation and decentralisation impairments. The therapist, starting from the discussion of a topic that arouses the interest of both (cinema, literature, sport, etc.), encourages the patient to emerge from a state of prevalent mental autarchy into a state of connection with the therapist. Within the discussion of the shared topic, the patient is invited to consider different points of view from his own in order to favour decentration operations.

Narrations of episodes in the therapist's life, like the use of the universal we, bring the interaction into the realm of common and general experiences. As with all types of unveiling, the narration of episodes from the therapist's life has a positive effect when the patient perceives it as an attempt at normalisation [67].

Sharing operations have been proposed as a technique to obtain an increase, albeit transitory, in metacognitive functions in the treatment of PDs in several clinical and research works [24, 64, 65, 68]. In this context, we limit ourselves to some theoretical considerations on the relationship between states of sharing and metacognitive functions in psychotherapy.

It is intuitive that improved metacognitive functioning favours the construction of shared knowledge. During moments of better metacognitive functioning, the patient is able to access his mental states, to integrate them, and to communicate them to the therapist. Moreover, he is able to better understand the therapist's mental states; he is therefore more able to grasp the sense of what is communicated to him, to assimilate it, and to remember it. On this basis it becomes possible, through the emotional experience of the therapist, to help the patient to integrate his relational experience with the therapist with his general feelings in relationships.

11.11 Overall Conclusions

The clinician's subjectivity has long been a subject of interest in several mental health disciplines, and in the last decades cognitive psychotherapy has joined other psychotherapeutic approaches in recognising its relevance. Indeed, the therapist's emotions and feelings are quite important in the context of the therapeutic relationship as they work as indicators that inform the participation of the therapist in the interaction process through her own appraisal systems. However, the therapist must be careful not to act on her emotions and feelings in ways that would harm the therapeutic process. Rather, she should harness the awareness of her own mental states during the session and her accurate assessment of the patient's metacognitive functioning in order to make fruitful use of what happens in the therapeutic relationship.

During the first sessions, when the key aim is to set up a trusting, non-judgemental therapeutic relationship to help the patient learn the skills necessary for understanding herself and regulating her emotion, the patient typically tends to reproduce the emotional behaviours corresponding to the distressing situation she is in. In these initial sessions, the therapist should be particularly alert to feelings such as tension, fatigue, and irritation in himself. Our pilot study indicated that such feelings may arise when the patient shows high levels of interpersonal distance, detachment, and distrust, or of dependency and incompetence, which suggest difficulty in building an effective therapeutic alliance. If perceived by the patient, negative feelings on the part of the therapist, such as tension, annoyance, and fatigue, may confirm her expectations to be rejected, abandoned, or overwhelmed, or may corroborate her sense of personal inadequacy and incompetence. Rather than relating the patient's attitudes to himself, the therapist should regulate his emotional reaction to them and make use of his understanding and empathic skills to promote the patient's trust in him.

In the following stages of therapy, after the working alliance has been established, the therapist should continuously monitor the quality of the alliance and her own emotional reactions in order to recognise problems in the therapy relationship early on, to identify the problematic patterns invading the relationship, and to use inner discipline procedures to manage these problems.

The management of acute cycles during the session is achieved through the following steps:

(a) Tolerating relational discomfort
(b) Avoiding actions detrimental to therapy
(c) Using therapist's inner experience to understand the patient's experience
(d) Exploring the patient's mental state during the cycle

Once the cycle is over, the therapist should invite the patient to explore her state of mind, so that through a process of integration she recognises how this plays a key role in her relationships as it is a recurring pattern.

In chronic cycles the steps are

(a) Tolerating relational discomfort
(b) Using relational discomfort to understand the patient
(c) Consolidating the alliance through direct exploration of the patient's mental state in the relationship

A more advanced stage of therapy can be exploited later to induce the patient to understand his role in the genesis of his interpersonal processes [24].

Finally, it should be noted that not all therapist's emotions and feelings should be viewed as related to aspects of the patient. Indeed, it would not be justified to consider every mental state of the therapist and every push for anti-therapeutic action as indicative of an aspect of the patient, and to view every inner experience of the therapist as 'diagnostic'. The therapist's emotional reaction might be linked not only to the personality and psychopathological characteristics of the patient, but also to his own characteristics [66]. In other words, the reaction may also be related to mental states of the therapist that are related to his own character aspects (e.g. insecurity, arrogance, coldness, etc.) or psychophysical conditions (e.g. tiredness, discomfort, burnout, etc.).

A key therapist's skill is being able to observe her own mental state, recognise it, and ask herself more or less in real time how much it has to do with herself, and how much it is related to the patient or to what is currently happening in the relationship. Also, the therapist should attempt to honestly judge whether her own attitude has played a significant part in causing the patient's behaviours that elicited unpleasant feelings in her. If the therapist does not see a responsibility on her part, the key step is regulating these feelings. To this aim, it is useful to relate them to the patient's general way of being in the world, rather than to his relationship with the clinician. On the other hand, if the therapist recognises a responsibility, she should not only regulate these feelings, but also further modulate her own behaviour according to the patient's characteristics and needs. Only then should the therapist ask herself what the feelings she experiences during the session tell her about the patient's difficulties and problems. Neglecting one's own feelings and emotions, or always uncritically ascribing them to the patient's characteristics and problems, may seriously hinder the therapeutic process. On the contrary, knowing how to observe and manage one's own feelings is an important part of care and is a key technical aspect of the intervention on a relational level with dysfunctional patients such as those with severe personality disorders.

Acknowledgments The authors are grateful to the colleagues who made the pilot study possible by taking the time to complete the study instruments and sharing their subjective experience, namely Drs. Massimiliano Aragona, Massimo Esposito, Paolo Maselli, and Antonella Puzella.

References

1. Lambert MJ, editor. Bergin and Garfield's handbook of psychotherapy and behavior change 6th ed. New York: Wiley; 2013.
2. Segal ZV, Williams JMG, Teasdale JD. Mindfulness-based cognitive therapy for depression. New York: Guilford Press; 2002.
3. Elliott R, Greenberg LS, Watson JC, Timulak L, Freire E. Research on humanistic-experiential psychotherapies. In: Lambert MJ, editor. Bergin and Garfield's handbook of psychotherapy and behavior change. 6th ed. New York: John Wiley & Sons; 2013.
4. Adenzato M, Meini C. Psicologia evoluzionistica. Torino: Bollati Boringhieri; 2006.
5. Liotti G. Disorganized attachment, models of borderline states, and evolutionary psychotherapy. In: Gilbert P, Bailey K, editors. Genes on the couch: essays in evolutionary psychotherapy. Hove: Psychology Press; 2000.
6. Hayes SC, Strosahl KD, Wilson KG. Acceptance and commitment therapy: an experiential approach to behavior change. New York: Guilford Press; 2012.
7. Papageorgiou C. Metacognitive theory, therapy and techniques: introduction to the special issue. Cogn Ther Res. 2015;39:1–3.
8. Carcione A, Riccardi I, Bilotta E, Leone L, Pedone R, Conti L, Colle L, Fiore D, Nicolò G, Pellecchia G, Procacci M, Semerari A. Metacognition as a predictor of improvements in personality disorders. Front Psychol. 2019;10:170.
9. Dimaggio G, Montano A, Popolo R, Salvatore S. Metacognitive interpersonal therapy for personality disorder: a treatment manual. New York: Routledge; 2015.
10. Khoury B, Lecomte T, Fortin G, Masse M, Therien P, Bouchard V, Chapleau MA, Paquin K, Hofmann SG. Mindfulness-based therapy: a comprehensive meta-analysis. Clin Psychol Rev. 2013;33:763–71.
11. Bai Z, Luo S, Zhang L, Wu S, Chi I. Acceptance and Commitment Therapy (ACT) to reduce depression: a systematic review and meta-analysis. J Affect Disord. 2020;260:728–37.
12. Normann N, Morina N. The efficacy of metacognitive therapy: a systematic review and meta-analysis. Front Psychol. 2018;9:2211.
13. Lawlor ER, Islam N, Bates S, Griffin SJ, Hill AJ, Hughes CA, Sharp SJ, Ahern AL. Third-wave cognitive behaviour therapies for weight management: a systematic review and network meta-analysis. Obes Rev. 2020;21:e13013.
14. Hofmann SG, Sawyer AT, Fang A. The empirical status of the "new wave" of cognitive behavioral therapy. Psychiatr Clin North Am. 2010;33:701–10.
15. Liotti G. La dimensione interpersonale della coscienza. Roma: Nuova Italia Scientifica; 1994.
16. Ardito RB, Papa FB, Concas S, Necciai L, Rinaldi S, Ristori S, Rezzonico G. La dimensione soggettiva del terapeuta in psicoterapia: esperienze, strumenti e metodi d'indagine. Quaderni di Psicoterapia Cognitiva. 2008;22:60–70.
17. Freud A. The ego and the mechanisms of defense. Revised edition. New York: International Universities Press; 1966. (original German edition first published in 1936 under the title "Das Ich und die Abwehrmechanismen").
18. Rogers CR. Client-centered approach to therapy. In: Kutash IL, Wolf A, editors. Psychotherapist's casebook: theory and technique in practice. San Francisco: Jossey Bass; 1986. p. 197–208.
19. Perls S, Goodman P, Hefferline RF. Gestalt therapy: excitement and growth in the human personality. Houston: Frederick Julian Press; 1951.
20. Gaetano P, Maselli P, Meldolesi GN, Picardi A. Una psicoterapia cognitiva centrata sull'esperienza: verso una terapia fenomenologicamente orientata. Riv Psichiatr. 2015;50:51–60.

21. Arciero G, Bondolfi G, Mazzola V. The foundations of phenomenological psychotherapy. Berlin: Springer International; 2018.
22. Watson JC, Bohart A. Humanistic/existential/phenomenological psychotherapy. In: Cautin RL, Lilienfeld SO, editors. The encyclopaedia of clinical psychology. 5th ed. New York: John Wiley & Sons; 2015.
23. Stanghellini G. Phenomenological psychopathology and psychotherapy. In: Stanghellini G, Broome M, Raballo A, Fernandez AV, Fusar-Poli P, Rosfort R, editors. The Oxford handbook of phenomenological psychopathology. Oxford: Oxford University Press; 2018.
24. Young C. A phenomenological model in the practice of psychotherapy. Int J Psychother. 2010;14:36–53.
25. Carcione A, Nicolò G, Semerari A, editors. Curare i Casi Complessi. Laterza: La Terapia Metacognitiva Interpersonale dei Disturbi di Personalità. Bari; 2016.
26. Sartre JP. L'Être et le Néant. Paris: Edition Gallimard; 1943.
27. Analyses HE, Passive C, Synthesis A. Lectures on transcendental logic (1920–1926). Berlin: Springer Science & Business Media; 2001.
28. Heidegger M. Sein und Zeit. Halle: Verlag von Max Niemeyer; 1927. [Being and Time. Albany: State University of New York Press; 2010].
29. Guidano VF. The self in process: toward a post-rationalist cognitive therapy. New York: Guilford Press; 1991.
30. Ricoeur P. Du texte à l'action. Paris: Editions du Seuil; 1986. [From Text to Action. Evanston: Northwestern University Press; 1991].
31. Costa V. Distanti da Sé: Verso una Fenomenologia della Volontà. Milano: Jaca Book; 2011.
32. Guidano VF, Liotti G. Cognitive processes and emotional disorders. New York: Guilford Press; 1983.
33. Guidano VF. Complexity of the self. New York: Guilford Press; 1987.
34. Husserl E. Die Krisis der europäischen Wissenschaften und die transzendentale Phänomenologie. Halle: Verlag von Max Niemeyer; 1936. [The Crisis of European Sciences and Transcendental Phenomenology. Evanston: Northwestern University Press; 1970].
35. Costa V. Psicologia Fenomenologica. Forme dell'Esperienza e Strutture della Mente. Brescia: Morcelliana; 2018.
36. Hart J. Edmund Husserl, analyses concerning passive and active synthesis. Lectures on transcendental logic [Book Review]. Husserl Stud. 2004;20:135–59.
37. Costa V. Esperire e Parlare. Intepretazione di Heidegger. Milano: Jaca Book; 2006.
38. Ricoeur P. Du texte à l'action. Essais d'herméneutique, t. 2. Paris: Esprit/Seuil; 1969.
39. Picardi A. First steps in the assessment of cognitive-emotional organisation within the framework of Guidano's model of the Self. Psychother Psychosom. 2003;72:363–5.
40. Holmes J. John Bowlby and attachment theory. New York: Routledge; 1993.
41. Porges SW. The polyvagal theory: phylogenetic substrates of a social nervous system. Int J Psychophysiol. 2001;42:123–46.
42. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-IV. Washington, DC: American Psychiatric Association; 1994.
43. Derogatis LR. Brief symptoms inventory 18: administration, scoring, and procedures manual. Minneapolis: NCS Pearson; 2001.
44. McNair DM, Lorr M, Droppleman LF. Manual for the profile of mood states. San Diego: Educational and Industrial Testing Service; 1971.
45. McNair DM, Heuchert JP, Shilony E. Profile of mood states: bibliography 1964–2002. Toronto: Multi-Health Systems; 2003.
46. Canestri L, Donati Della Lunga S, Pilleri MF, Reda MA. Profili psicofisiologici in psicoterapia: implicazioni emozionali del paziente e del terapeuta. Quaderni di Psicoterapia Cognitiva. 2008;22:84–95.
47. Arimatea E, Blasi S, Capecci I, Nardi B. Studio preliminare sulla soggettività del terapeuta in relazione all'organizzazione di significato personale. Quaderni di Psicoterapia Cognitiva. 2008;22:96–123.

48. Tanzilli A, Majorana M, Fonzi L, Pallagrosi M, Picardi A, Coccanari de Fornari MA, Biondi M, Lingiardi V. Relational variables in short-term psychodynamic psychotherapy: an effectiveness study. Res Psychother. 2018;21:190–200.
49. Ortu MC. La persona del terapeuta entra nella stanza della terapia. Quaderni di Psicoterapia Cognitiva. 2008;22:72–83.
50. Safran JD, Muran JC. Negotiating the therapeutic alliance: a relational treatment guide. New York: Guilford Press; 2000.
51. Freud S. (1912). The Dynamics of Transference. The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911–1913): The Case of Schreber, Papers on Technique and Other Works, pagg. 97–108. New York: W. W. Norton; 1976.
52. Greenson RR. The technique and practice of psychoanalysis. New York: International University Press; 1967.
53. Mitchell SA. Relational concepts in psychoanalysis. Cambridge: Harvard University Press; 1988.
54. Safran JD, Segal ZV. Interpersonal process in cognitive therapy. New York: Basic Books; 1990.
55. Bordin ES. The generalizability of psychoanalytic concept of working alliance. Psychotherapy. 1979;16:252–60.
56. Beck AT, Rush AI, Shaw BF, Emery G. Cognitive therapy of depression. New York: Guilford Press; 1979.
57. Leichsenring F, Salzer S, Jaeger U, Kächele H, Kreische R, Leweke F, Rüger U, Winkelbach C, Leibing E. Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized, controlled trial. Am J Psychiatry. 2009;166:875–81.
58. Castonguay LG, Constantino MJ, Holtforth MG. The working alliance: where are we and where should we go? Psychotherapy (Chic). 2006;43:271–9.
59. Dimaggio G, Carcione A, Salvatore G, Semerari A, Nicolo G. A rational model for maximizing the effects of therapeutic relationship regulation in personality disorders with poor metacognition and over-regulation of affects. Psychol Psychother. 2010;83:363–84.
60. Liotti G, Prunetti E. Metacognitive deficits in trauma-related disorders: contingent on interpersonal motivational contexts? In: Dimaggio G, Lysaker PH, editors. Metacognition and severe adult mental disorders: from research to treatment. London: Routledge; 2010.
61. Monticelli F, Imperatori C, Carcione A, Pedone R, Farina B. Cooperation in psychotherapy increases metacognitive abilities: a single-case study. Riv Psichiatr. 2018;53:336–40.
62. Carcione A, Dimaggio G, Conti L, Nicolò G, Fiore D, Procacci M, Semerari A. Metacognition Assessment Scale (MAS) V.4.0-manual. Unpublished manuscript. Roma: Terzocentro; 2010.
63. Semerari A. I processi cognitivi nella relazione terapeutica. Roma: Carocci; 1991.
64. Dimaggio G, Semerari A, Carcione A, Nicolo G, Procacci M. Psychotherapy of personality disorders: metacognition, states of mind, and interpersonal cycles. London: Routledge; 2007.
65. Semerari A, editor. Psicoterapia Cognitiva del Paziente Grave. Metacognizione e Relazione Terapeutica. Milano: Raffaello Cortina; 1999.
66. Clarkin JF, Yeomans FE, Kernberg OF. Psychotherapy for borderline personality. New York: Wiley; 1999.
67. Knox S, Hess SA, Petersen DA, Hill CE. A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. J Couns Psychol. 1997;44:274–83.
68. Conti L, Bosco FM, Bara B, Semerari A. Condivisione e funzioni metacognitive: analisi di sedute psicoterapeutiche attraverso L'Indice di Condivisione e la S.Va.M. Quaderni di Psicoterapia Cognitiva. 2001;4:6–24.

The Clinician and the Human Side of Mental Illness

12

John S. Strauss

What is the saying, "To see the obvious takes a little longer"? In this report, I will focus on how the clinician has the almost unique possibility of seeing beyond the usual narrow limits of what we consider relevant to severe mental illness, its course and improvement. The thesis is that the clinician, given the time and the interest, can find out and work with the many aspects of psychiatric disorder and related mental health that extend beyond the more traditional focus on symptoms, biology, and psychological process, often in spite of our training, theories, and practice that can prevent us from learning about and working with the broader range of relevant factors.

In the medical field, only the clinician sees the human side of mental illness. As important as it is, knowledge of features such as diagnostic criteria, genetic factors, brain structure, etc., does not replace or substitute for that human side. Strangely, even the term "subjectivity" objectifies many of the human aspects of the most severe instances of mental illness. These other "human" aspects are not trivial, incidental, or even "ancillary." In this report, I will focus on some of these "human" aspects, for want of a better adjective, to suggest their crucial role in even severe disorder, ways in which a variety of approaches are needed to elicit and understand them, the degree to which they are systematically ignored, and approaches to dealing with them that are more effective than those generally used (or neglected).

Susan Godschalx, who at the time was a nurse in Moab Utah studying people with severe mental illness, sent me a copy of her protocol [1] at my request. In the interview she used with patients, one question that had stood out for me was, "How has your illness affected your life?" This simple sounding question was so amazing to me because in all our research interviews, and in my clinical practice as well, it had never even occurred to us. And yet, once I saw it it seemed so obvious.

J. S. Strauss (✉)
Yale School of Medicine, New Haven, CT, USA
e-mail: john.strauss@yale.edu

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_12

When we started asking this question to subjects in our studies many of whom had been diagnosed as having schizophrenia, a frequent response was, "You are the first psychiatrist who has even noticed that I have a life." Encouraged by that response, we began attending to other related phenomena that patients described to us. In one report, for example [2], we noted how a young woman improving after a psychotic episode did so apparently aided by such "simple" things as the radio a nurse had brought her that allowed her to have the integrating experience following her psychotic break of having a desire (wanting to listen to music) and being able to act on the real world (the radio) to have the effect she sought.

To explore such phenomena further, we began changing our research protocols to leave more time open to listening to patients' reports of their experiences and to inquire into these in more depth. This change in our protocol seemed quite radical since although the broader focus is sometimes found in clinical practice it is relatively rare in "really scientific" research that is generally much more highly structured. We realized even from the start that it was going to be difficult and often impossible to utilize quantitative measures and such important tools as assessments of reliability and validity in this aspect of our work. Thus, reaching off in this way from the invaluable approaches to traditional science, we nevertheless felt it was essential to seek the range of patients' experience rather than limit ourselves to more usual methods. In so doing, we hoped we were following the implications of the physicist Heisenberg [3] that stated in essence, that what you are not looking for in your research you are unlikely to find, and that narrow methods as important as they are for some goals may actually prevent you from learning about other important things that your methods will systematically miss.

In the remainder of this report, I will describe some of the things we noted that are not often pursued by more traditional science in our field, in the belief that it is bad science to ignore these other things, frequently so difficult to document, to prove, or even sometimes to define. I think also that it is a potential disaster to doom these more elusive phenomena to the graveyard so often the end of "Qualitative Research" that is often viewed by "real scientists" as a rather negligible sideline to "real research" [4].

So where to start? Why not with some of the most difficult phenomena to determine? A patient with schizophrenia who has been discharged from inpatient status responds to the question, "Do you have some idea of why you started getting better?" with the response something like, "Oh yes, I looked around me at other patients on the ward and said to myself, 'I can do better than this, and so I started to try to pull myself together'" [5]. Can one actually "pull oneself together" from a psychotic episode? Well, we interviewed other people who described analogous phenomena, such as the middle-aged woman with schizophrenia who worked in a large very confusing office setting. One of her major problems was thinking clearly, so during the interview I was surprised that she told me that the confusion of the setting was important to her because working there meant she actually had to strive to organize her thinking there. Did I talk her into that? Not hardly, in fact she had to tell me about it across three successive interviews, "Dr. Strauss, as I've told you before ---" before it finally registered to me what she was describing.

Did I prove in these interviews that these reports actually had the described cause/effect relationship described? Not at all. Does that mean that such reports of helping oneself get better should be ignored because they're so difficult to prove? Talk about bad science. What kind of science is it that teaches, "When the data don't fit the method, just throw out the data"?

Frequently such efforts at self-improvement were aided by other people or situations. In one instance, a young woman troubled by auditory hallucinations began to be able to work in a small store. She reported to me that when the voices became troublesome she would ask her coworker with whom she had become friendly if she (the coworker) heard anything strange. And if the coworker said no, the young woman with hallucinations felt reassured and the hallucinations diminished.

In yet another example of getting help from another person was the woman (with the diagnosis of schizophrenia) who after discharge from the hospital had found a job working in a municipal office. She would become so disturbed that she would call her mother who would say, for example, "OK, stick with it until lunch-break, then if you have to, come home." The patient would do that and then decide to stay at work, but then in the afternoon she would become troubled again and again call her mother who would say to try to stay for the rest of the day and then tomorrow if she felt too bad she shouldn't go back. This continued on for an extended period, but gradually the patient found she didn't need to call her mother so often, then not at all. By the time I carried out our follow-up interview, the "patient" had been promoted and worked regularly in that office.

In another group of follow-up experiences, I was impressed how my orientation as psychiatrist talking to a patient led me to erroneous interpretations. One of the most striking for me was during a follow-up interview I carried out as part of a wonderful research project that some colleagues were carrying out in South Carolina. My minor part of this project was to go down to South Carolina periodically to carry out research interviews on some patients who had been discharged from a state hospital. During one such interview I was talking with this woman in her late forties who carried a diagnosis of schizo-affective disorder, I learned that she had been rehospitalized for a while since our previous interview. During the interview, I had asked one of our standardized questions about hospitalizations, and the woman told me that yes she had been in the hospital relatively briefly since I saw her last. I said something like "that's too bad," and she was quick to respond that no that wasn't serious at all ("Denial?" my psychiatrist brain asked me. But my error was quickly corrected). No she told me that it was not serious at all, the big news since we had met last was actually that she had gotten divorced from an abusive marriage and that her life had improved tremendously since that time.

In the example of another "psychiatric theory error," during a follow-up interview of a young woman discharged from the hospital following a psychotic diagnosis, I was distressed to see that she was still living at home and "doing nothing." Of course, as a good research interviewer, I didn't comment my distress. At the next interview 2 months later, she had started seeing friends and looking for a job. I asked her about this sequence, and she replied as though as a psychiatrist I already knew about such things, that of course she needed a rest and a period to recover after the

hospitalization and that now she was ready to have a more active life again. From that experience with her, we hypothesized that a resting period far from being a kind of "burning out" that I had imagined seemed to be a time for regaining strength before returning to a major reentry to the world. In writing this, I am embarrassed as with so many of these instances at my naivete in my understanding of how people, even psychiatric patients, have these various understandable needs in the course of their disorder. We did however write a paper about it, calling that woman's experience "woodshedding" from the term used by some jazz musicians who return to practice "in the woodshed" out of range of an audience, when they are learning new music.

As a kind of extension of this post-hospitalization need, I was impressed by another young woman who had been discharged from the hospital and found how hard the getting back into life during the reentry had been. Her friends had moved on with their lives, it was hard finding a job during this period of the economy, and she felt isolated. My impression during the interview was not that this was any lack in her as much as the expectable range of situational impediments in trying to get back into the "real world."

In another content area, I have less direct data but speculate on the possibility based on other experiences; this is the area of fear of return of disorder. People working with the so-called "Long Haul" cases of Covid 19 where the symptoms persist note the psychological effects of the "aftermath" of disorders such as the fear of recurrence that such illnesses have generated [6]. Have I just not looked enough in the psychiatric literature for these kinds of issue? I have not yet seen an article on what it is like to have had a mental illness. For example, with people who have been psychotic, do they often live with a mortal fear that it will return? I had a friend whom I first met outside of Gallup New Mexico when I was hitchhiking around the country many years ago who had been a bombardier in a B17 during World War II. His plane had been shot down over Germany, and he had been taken as a prisoner of war. We became friends; he and his wife bought a house in Connecticut several years after his becoming a physician, but now, about 10 years later, he had found it necessary to sleep in the cellar because the sound of a distant train in the middle of the night would otherwise awaken him in a cold sweat, reminding him as it did of allied bombers coming over his German prisoner of war camp in the middle of the night. I have an old nasty back injury that is no longer a frequent problem. But when I get that old familiar pain, "Is it coming back?" The possibility causes much fear.

Near the beginning of this report I cited the question "How has your illness affected your life?" used by Godschalx in her interviews with patients. I went on to describe several aspects of a patient's life that seem relevant, even central, to our understanding and interventions. I would now like to focus on another less obvious part of that question, the subjectivity of the professional who asks it. Clearly the question focuses on the patient, but less obviously it also focuses on the professional asking it. Implicit in the question is something like, "Even though I am here to learn about (or treat) your problems, I also recognize that you are a person and thus have a life as well as a problem." Even more concealed perhaps is the professional's

potential implicit message, "I am a human being too and want thus to be 'with you' in your struggles." Although this part of the message is not so obvious, still when the sentiment is there, the message of a person's "being with" is so often reported by patients as a major part of the improvement effort that it needs to be considered. It is these less obvious aspects of subjectivity, the professional's subjectivity, that I will address next.

In this report, I have rarely used the term subjectivity, but would like to do so here to discuss further our own subjectivity, that of professionals [7]. Here again I will use evidence that is indirect but that may help us become more aware of our subjectivity and the problems it may generate. This "evidence" will include experiences in the arts since it is these fields after all that deal with especial depth on understanding subjectivity, leaving more direct simple questions taught to be used by mental health professionals such as "Do you feel depressed" as important but seriously incomplete approaches to actually understanding subjectivity. I will focus on how much we professionals, especially in our theory and research, tend to be naive about patients' subjectivity and how much, except in some notable important efforts focused on structured approaches to assessment and diagnosis (e.g., [8]), we systematically ignore our own. In a follow-along research project during which we repeatedly interviewed patients over several years, things about my subjective sensitivity or the lack of it were taught to me as by the experience with one woman I was seeing. She came into my office for an interview, and I mentioned how great she looked. She replied that it was a problem for her. Often when she was going through one of her worst psychiatric periods, people would say how good she looked and it was so hard to get them to understand that in fact the opposite was true and that her symptoms were troubling her terribly.

In a relevant, though not clinical, experience several years ago, at the suggestion of a friend I was taking an acting class for the first time in my life. The teacher, the wonderful Doug Taylor, had us students pair up and then do an exercise in which one student would comment to the other something like "You have brown hair" and the other would reply, "I have brown hair." And the two would each repeat their sentence in response to the other. But Doug stopped me, "John, you're not listening to her!" And he was right. I was repeating my statement after she repeated hers, but as I realized I wasn't reacting to all the more subtle cues that both of us were reflecting in our changing tones and gestures.

So while we are discussing subjectivity, let's also take one more look at our own, the subjectivity of us the professionals. Not only may we miss strong evidence of someone else's subjectivity, but we may be amazingly limited in connecting to our own. Another experience in Doug Taylor's acting class was also startling to me. In spite of my impressive lack of talent, after several weeks, we students were asked to begin doing improvisations. Of course I had never done anything like that, but like the other students I paired up with someone in the class, in this instance a young man. We decided I was going to be the hardworking lawyer father and he was going to be my profligate son. I was finally planning to take a vacation and he once again had gotten himself in trouble and wanted me to stay home to help him. We started

the scene, and after a couple minutes Doug stopped us. “John, where did you go to law school?” Doug asked. I replied, “Doug, that’s not relevant, in this scenario I’ve been in practice for years”. Doug: “John, where did you go to law school”. Me: “Ok, Harvard.” Doug: “How many children do you have?” Me (having fully capitulated): “Three, Frank (my ‘son’ for the scene) is the youngest. Doug: “OK, you can continue.” We did, and my experience was a total shock, I now had a much more complete sense of myself than I had when Doug first stopped us. If one’s sense of self is so easily generated, and if one has been so poorly aware of its impact, what must it be in real life when we are “professionals, with all that training, experience and knowledge”? How does that affect our sense of self, our understanding of others, and our behavior?

It appears then that human beings with severe mental illness, unlike a defective machine, can be involved in a wide range of processes during their difficulties and their improvement. These processes often involve active efforts by the afflicted person to improve and an equally diverse and wide range of situational and environmental factors being part of the improvement process. An implication thus is that the clinician is in a unique position to learn about what and how the person might improve and that only the clinician has the potential flexibility and wide range of information and ability to speculate on these diverse interactions. As part of our follow-up studies, we had collected sequential data over several years on over 100 subjects. When I took these data to my friend the biostatistician John Hartigan, he showed me how, with even a much larger data set than we had, it would be difficult to demonstrate statistically significant sequences. I was of course extremely disappointed. On the other hand, that problem still left open the possibility for us, the clinician-researchers, to consider, for example, the apparent nonlinear processes of change following hospitalization that practically all our subjects had described. So we began to hypothesize about such nonlinear processes: “the low turning point” in which the person did not improve from a very deteriorated state until all of a sudden there was a change for the better, “woodshedding” during which the person appeared first to stagnate and then began to lead a more active and effective life, “mountain climbing” a process that was marked by successions of improvement followed by what seemed to be stagnation, followed then by more improvement followed by what appeared to be more stagnation. The existence of such hypothesized processes that was impossible to demonstrate statistically appeared to be supported by the subjective experiences of the patients who were living them out. Thus, I suggest, the flexibility of the clinician, and of the clinician-researcher, to notice such possibilities and work with them as hypotheses is a unique potentiality of the clinician and the clinician-researcher that is not possible for a more narrowly defined, traditionally statistical, research protocol. “Qualitative research,” often disregarded or even vilified for working with humans struggling with severe psychiatric disorder, is not only acceptable, it is in my view essential for our understanding of what is happening to our patients. We are only required to notice that such findings do not demonstrate proof, but, on the other hand, that they are extremely valuable to suggest crucial processes.

What are the implications for treatment? There are a multitude. One example is that after people in our studies began telling us the various things they did to manage their symptoms and expand their lives, we began to talk about these processes with patients with whom we were working in treatment. "I know you have had these troublesome voices. I know a lot of people who have similar experiences; some of these people have found ways to help manage or even deal with their voices. Would you like me to tell you what they have tried so that you could perhaps try them yourself to see if any of them are helpful?"

Strangely, or perhaps not so strangely, in other instances, patients in treatment often found it helpful merely that we would listen to them and try to recognize what they were going through. Often a change in venue for the interview was a major factor in helping us "be with" people more effectively and understand their lives in more depth and dimensions. Like so many of our findings, it may sound naive to relate some of our experiences and how it even took such experiences to show us more clearly the lives of our subjects. Especially common was the impact on us the research team when the site of a subsequent research interview shifted from seeing people in the hospital to our interviewing them in their homes. I recall with embarrassment how surprised I was when one person I had been interviewing in the hospital had been discharged so I now had to see her at a home visit. I arrived with my co-interviewer, rang the doorbell, and our "subject" opened the door for us. She was suddenly no longer a more or less passive patient on the ward but was now our host! This impact was further magnified when she asked if we would like to have some coffee before we started. Something in retrospect so obvious, but in actuality so astounding, we were seeing a major aspect of her we had never witnessed before.

In other instances, subjects from our follow-along research where we were seeing people repeatedly over time began to tell us that it had been useful for them to use some of our interview questions by posing them to themselves. Particularly popular was asking oneself the question we had posed about living situation, work, and social relationships, "Has that been helpful? Has it posed a problem in any way?" They began to ask these questions for various activities to themselves and then moderate their activities accordingly.

As professionals, we have often been taught a role about how to structure information, using the narrow focus of our knowledge and that of our field (the child with the hammer that treats everything like a nail). With our training and attention to illness and disorder, as important as all that is, it is crucial not to neglect the important aspects of a person's subjectivity including mental state, behavior, and surroundings that do not fall within the rubric of "illness," so that we can get a picture of the whole person, of that person's perception of the problem and ways to solve it or deal with the felt helplessness of the experience. There are many aspects to subjectivity beyond the type, "Do you hear voices when no one is there?' The experiential and situational aspects of subjectivity, the subjectivity of both the patient and the professional, and both the problematic and the helpful aspects, must be important parts of assessment, theory, and treatment.

References

1. Godschalx SM. Experiences and coping strategies of people with schizophrenia. Unpublished doctoral dissertation. School of Nursing; University of Utah; 1987.
2. Davidson L, Strauss JS. Sense of self in recovery from severe mental illness. Br J Med Psychol. 1992;65:131–45.
3. Heisenberg W. Physics and philosophy: the revolution in modern science. London: George Allen and Unwin; 1958.
4. Strauss JS, Hafez H. Clinical questions and "real" research. Am J Psychiatry. 1981;138(12):1592–7.
5. Strauss JS, Hafez H, Lieberman P, Harding CM. The course of psychiatric disorder: III. Longitudinal principles. Am J Psychiatry. 1985;142(3):289–96.
6. Lamas D. Pandemic Status: Almost 'Normal,' but not OK. NYT: Opinion. 2021 May 19.
7. Strauss J. To understand a person. Rhinebeck, NY: Epigraph Books; 2020.
8. Picardi A, Pallagrosi M, Fonzi L, Biondi M. Psychopathological dimensions and the clinician's subjective experience. Psychiatry Res. 2017;258:407–14.

Mental Illness as a Pathology of Intersubjectivity

13

Gilberto Di Petta, Danilo Tittarelli, and Raffaele Vanacore

13.1 Introduction

The crisis of the Neokraepelinian psychiatric model, which considers mental illness as an aggregate of signs and symptoms attributable to organic causes, is now unambiguously official. Even in a recent article appearing in the reference journal of international *mainstream* psychiatry, the *World Psychiatry Journal*, Pim Cuijpers states that "*it is not yet clear what mental disorders are*" [1]. This statement sounds like a declaration that over 40 years of reductionist research has failed to yield any significant results. In fact, two questions remain open. The first is methodological: *What is psychiatry?* The second is epistemological: *What is mental illness?* In other words, we wonder, again, on the nature of those experiences considered psychopathological and on the methods that can open the doors to their understanding and treatment.

The Neokraepelinian model (syndromic pictures as *natural entities of disease*), which was by nature statistical-nosographic—thus legitimizing the separation of the *insane* from the *sane* and managing social diversity and dangerousness—imposed itself as atheoretical, effectively excluding the psychopathological and philosophical reflection from studies on mental illness. This model, however, has not proved capable, under either empirical or epistemological tests, of offering support in the clinical treatment of mental illnesses. In other words, this categorical-taxonomic

G. Di Petta · D. Tittarelli (✉) · R. Vanacore
School of Phenomenological-Dynamic Psychotherapy in Florence, Mental Health Departments, Naples, Ancona, Modena, Italy
e-mail: gilberto.dipetta@aslnapoli2nord.it; danilo.tittarelli@sanita.marche.it; r.vanacore@ausl.mo.it

M. Biondi et al. (eds.), *The Clinician in the Psychiatric Diagnostic Process*,
https://doi.org/10.1007/978-3-030-90431-9_13

model has proved useful neither for the diagnosis nor for the therapy of mental illnesses. This lack of usefulness is particularly striking regarding what for a century has been called "schizophrenia," still considered the mental disease par excellence, and one that has become recklessly, in any ambit, synonymous with "madness." In short, we have reached a methodological and epistemological impasse.

What, then, can be relied upon for understanding and treating the complexity of mental illness? We could answer that what can be trusted is the common denominator of *humanity,* which inevitably forms the basis of the encounter between the clinician and the patient. We can, in fact, affirm that what we consider as *mental illness* is a *distortion of the structure of the existence of the human being*. However, in the following paragraphs, we shall ask ourselves how this structure of existence is constituted and which clinical orientation can allow us to understand it. In the meantime, as a premise, we want to remember that modern psychiatry was born out of the deeds of Pinel, who freed the madmen from their chains [2], and Basaglia, who laid the foundation for the destruction of the asylum institutions [3]. These reforms have been implemented in line with a certain idea about the human being—from a certain *philosophy of life*—and not from the results of neurobiological or statistical research or surveys. The main trace of their path—philosophical, clinical, and human—was, in fact, the gaze of the other. This gaze of the other was charged—in any case—with a right to life and freedom, thus escaping from that risk of anguish and disturbing de-humanization that Francis Bacon painted with such vigor in his works, from self-portraits to the screaming Pope. It is on this gaze that psychiatry has been able to establish as a *clinicalart* (escaping the need for surveillance and social hygiene) and as a *social* science (dealing with the right to live in a community, rather than the need to institute exclusion from the community). However, after decades of domination by a categorical and nosographic vision of such a clinical-social approach—that is, an *anthropological* and human approach—the need to reaffirm psychiatry as a science of life and freedom, in other words as the *science of humanity*, seems imperative.

We are declaring nothing new here. Indeed, as soon as 1957, Ludwig Binswanger had, without hesitation, stated that

> the foundation and ground on which psychiatry as a science endowed with its own autonomy can sink its roots, lie neither in the anatomy-physiology of the brain, nor in biology, nor in psychology, character study, or typology, not even in the science of the *person*, but *in the human*. This sounds like a very simple idea, yet it is still hardly accessible to our ears today. [4]

Yet this "very simple idea" is revolutionary in itself as it allows us to understand the human being—and therefore also ourselves—not as aggregates of atoms and molecules subjected to external forces, but as *living beings*, endowed with the possibility of freedom and autonomy. It is therefore from this different attitude toward life, and therefore toward humanity, that the understanding of the *conditions of possibility* of every experience and the treatment of those experiences, gagged by suffering and wrapped in pain, become possible. However, it is not a mere question of humanism in and of itself, but of the reaffirmation of psychiatry as a clinical

practice, which preserves and renews its clinical perspective in the encounter and exchange between human beings, and not between detached aggregates of elementary particles. If, in fact, it is from a basic bio-organic structure that life, *Leben,* begins—in an enactive, embodied, ecological, and embedded way (*4e Cognition Paradigm* [5])—it is in the conscious experience of this living, in the *Erleben*, that the existential structure of the human is defined and revealed as a *subjective experience endowed with meaning*. In this sense, mental pathology is tout court a human experience; indeed, an inter-human experience.

13.2 Psychiatry as Science of Humanity

We intend psychiatry as a science that studies the life of the human being, and in particular the forms of existence (*psyché*) that require therapeutic acts (*ìatreìa*). We consider here, as we will see more clearly later in the chapter, the *psyche* as what constitutes the possibility and the root of human living. The human being is characterized, on the one hand, by the possibility of experiencing his own life, and, on the other, by the continuous rooting of this experience in the vital background of his existence. In other words, at a level that has been defined as pre-reflective, tacit, or immediate, human life is immersed, from birth, in a natural and cultural world inhabited by other human beings.

It is in this continuous living in the world and with others that the structure of existence can develop, on that fulcrum of personal life that is one's *own body*. This body is born, grows, and dies in intimate relationship with other bodies, thus defining itself more properly as *intercorporeity* or *intersubjectivity*. In a dynamic and constant way, the human being lives this intercorporeal and intersubjective dimension as an *experience of meaning*. And it is this experience of meaning that can reveal itself as *psychopathological* when it cannot escape from suffering.

Once we have reiterated that the empiricist and reductionist model has done nothing but leave intact the question of what mental illness is, we would like to dwell on the importance of *psychopathology* in this attempt at understanding. But what is psychopathology? It could be said that this is a "knowledge" (*logos*) about the "suffering" (*pathos*) of the "mind" (*psyché*). This answer, however, appears to us still partial, reluctant to overcome that Cartesianism, which is sometimes still latent in an unaware way: as if psychiatry investigated only the "mind," and not—in fact—the totality of human experience (which in truth is the psychopathological one). An effort to penetrate this dimension, new to those who therefore approach psychiatry as the science of the "mind," of the "soul," or of a "psychic apparatus," can start from a careful etymological investigation. In fact, the *logos* finds its original meaning in the root *leg-*, which indicates the gathering, the putting together, of disparate components into a whole. This meaning is found not only in Homer, in which, for example, soldiers are "put together" to get prepared for battle and war, but also in Heraclitus, according to whom "all things happen according to the *logos*" [6, 7]. In other words, in Heraclitean thought—which we do not want to go into here—the *logos* was not so much a "knowledge" or a "rationality" as *that unifying*

principle, which precisely through this unification gives meaning to reality. For this reason, for Heraclitus, the *logos* is "common"; that is, it relates and connects the human with other humans and with nature. From this point of view, therefore, the *logos* is *what allows the parts of the whole to be put together, making a synthesis of them to assign a meaning that is comprehensible as a whole*. It is, in fact, on this basis that Karl Jaspers found his *General Psychopathology* [8] in an attempt to understand psychopathological experience as a significant expression of human subjectivity.

In this sense, the *logos* approaches us not so much as a detached experience of knowledge, but as that *event* that makes us part and partakers of the world in which we are; that is, to our *life*. The *logos*, in fact, introduces us into that way of being that is constituted through the *pathos*, etymologically understood not as "suffering," but as the *sensitive foundation of our experience of life*, as a sensory, corporeal, and common possibility of being. In other words, the *pathic moment* not only grounds the experience of suffering, but also, and much more generally, the very possibility of human and subjective experiencing, as Minkowski had already mentioned [9]. In this sense, for Viktor von Weizsäcker [10], the character of the *pathic* resides in his *passivity*. And this passivity consists of the *inevitability* of our *being-in-the-world-with-others* and our *being-tuned-to-the-world*. Here, however, we want to take up and overturn the concept of *pathos* as a *passage* from life to death, meaning it instead as a passage from death to life, or rather from the *no longer possible possibility of non-being-there* to the *possibility of being-there*. From this point of view, therefore, the pathic moment—in its being at the foundation of the very possibility of experience, corporeal and common, can disclose the *possibility of meaning* that frees the human from the steady psychopathological possibility and sets her on the path toward different experiences.

Thus, on this journey, we come to the concept of *psyché.* In its ancient etymology, it designated that *vital breath* that makes life possible. It is the passage from passivity to *activity*: the human being is alive as active and active as living. It is therefore this dialectic between *pathos* and *psyché*, between passivity and activity, which is embraced by the unifying moment of the *logos*. This, in fact, is a dialectic that *includes* the possibility of the living being to live. In these terms, psychopathology offers itself as a founding method for the investigation of mental illnesses, precisely inasmuch as it is hidden, in the most lacerating experiences. The schizophrenic, for example, can be seen as a yielding of this dialectic between pathic foundation and, we could say in accord with Minkowski, *vital contact* [11]. In these terms, schizophrenia can be considered a *logic* alteration, in the sense of an *impairment of the moment in which the logos gives a sense to the subjective experience, which as such is established in the world and shared with others.* Obviously, the meaning of this statement is not that schizophrenia is characterized by a cognitive or meta-cognitive error in attributing meaning to experience, but that it is characterized by the *inability to establish a dialectic between the pathic and the vital*. The pathic moment—which is the foundation of the *logical* possibility of embracing life in its fullness, dynamism, and complexity—is rooted in *otherness*: it is with the other that feeling becomes possible. Further, it is for this fundamental character,

which we define *intersubjective*, that the pathic moment is a common and *communicative* moment: the *logos* embraces our subjective experience as the *possibility of experience of a human being who lives in a social and historical world*. Therefore, *the logic of* psychopathological experience is not enclosed in the "mind," in the "soul," or in a "psychic apparatus," but *extends to the intersubjective world in which it is expressed*. In the same way, the pathic foundation of feeling is not an internal characteristic, but a human peculiarity that becomes possible only in the encounter with otherness. In this sense, the psychopathological experience is an experience that is both common and communicative: the schizophrenic experience is expressed and stated in its *non-common communicability*, in the sense of not sharing, or rather an impossibility to share, the dialectic of the meaning of life. The logical moment thus escapes, as *the schizophrenic is unable to involve and embrace the other, to share his own experience with the other, and to communicate it to the other*. This can be the foundation not only of those experiences in which, once the pathic and intersubjective foundation of experience has fallen, the affirmation of logic is made possible with delusion and hallucination. But it can be also found in those experiences that, if delusion or hallucination has not yet crystallized, are lost in perplexity and in the search for the indefinite and indefinable. In these terms, *empathy is* not only a "putting oneself in the other's shoes"; it is offering the possibility of reconstituting a source of sharing and communication of experience with otherness. However, this requires the therapist to accept the possibility of *logical loss*; that is, plunging into a world where the moment of *logos* escapes and offers no understandable and common guarantees. However, dialectically, the therapist's return to logical possibility should form the basis for the reaffirmation of the *logos* in the patient. It is therefore precisely in *pathos*, in the pathic exchange, that the experience of the living can offer and show itself and that the phenomenon becomes possible. It is for this reason that the psychopathological moment is an *aesthetic* moment: it is in these phenomena that *meaning* shows itself and offers itself to understanding. Furthermore, the phenomenon, inasmuch as it is pathic and vital, is a *bodily* manifestation, or rather *intercorporeal* manifestation. The aesthetic moment, thus, is the moment in which the appearance of the world coincides with the emergence of the human presence as an opening to otherness.

Why should this psychopathological *method* be *clinical,* based on the clinic of the encounter, and not philosophical and speculative? When the *logic* of disease as a human possibility was not yet established, and therefore pathological experiences were believed to be caused by superhuman deities, an epistemological change began, which culminated in the founding of *medical methodology*. Starting with Hippocrates, the medical clinic set itself as a tool for understanding human experiences. This step is crucial because the doctor, no longer treated as an employee of the priesthood, had the task not of alleviating the ills from supernatural entities but of *caring* for a human experience; an experience that had been precisely defined as pathological. The *feeling*, in most cases physical, was a human experience, the understanding of which, however, did not yet rest on entities like defined diseases, but on the possibility of establishment of a method that would enable such understanding. This is perhaps the point at which psychopathology is today: not yet

granted a presumed knowledge of the entity of illness, it assigns itself the task of establishing a methodology that aims at understanding those human experiences that are as *uncommon* as they are in need of *communication*. The *logos* is no longer a naturalistic and rationalistic observation of *a res*, but a clinical participation in the foundation of a method of treatment leading to freedom from the pathology. In these terms, psychopathology offers itself as a clinical method.

13.3 The Italian School of Phenomenological Psychopathology

13.3.1 Aldo Masullo: The Contribution of the Philosophy of Life

During the twentieth century, one of the main sources of inspiration for Italian and European philosophy and psychopathology was the philosopher Aldo Masullo. In particular, his period of research in Freiburg in 1957–1958 allowed him to deepen the study of phenomenology and the thought of the German neuropsychiatrist and philosopher Viktor von Weizsäcker. Inspired by Freud and Scheler, in the galaxy of that "philosophy of life" (*Lebensphilosophie*), which saw many psychiatrists as protagonists, he had clarified, in philosophical and scientific language, the concept of "pathic," introduced in the 1930s by Erwin Straus [12]. In Freiburg, Masullo had frequented the Husserlian circles headed by Husserl's pupil, Eugen Fink, and, returning to Italy, he had translated and commented on some of Husserl's texts [13]. Masullo, therefore, elaborating on the stimuli of von Weizsäcker's medical anthropology, made the concept of "pathic" his own, connecting it to temporality, and finding, precisely in the construct of *pathicity-temporality*, a foundation of meaning for that fragmented being in the world that is the human with others [14]. The unusual terms "pathic" and "pathicity" have etymological origins in the Greek verbal root *path* (from which *pathos* is also derived, as we have noted earlier, and from which the semantic use of terms such as "suffering" and "passion" also stem). Although the terms "emotion," "feelings," and "affectivity" are not extraneous to the field of ideas gathered under the canopy of the Greek *paschein* and *pathos* and of the Latin *sentire* (and *sensus*), they are not comparable to these notions. The "pathic," in fact, is the condition of decisive possibility for which are given those dimensions such as human emotions, affections, and feelings, strongly imbued with lived corporeity, but also with exaggeration and excess, which burst into the existence in a *sudden* instant of time. Masullo comes to conceive that the "pathic feeling" is not *another way* of knowing, but the essence of authentic knowledge, the most proper and irreducible one, marked by the latent and irruptive emergence of worldly and vital events. Already, von Weizsäcker had warned that the notion of *pathic* is by no means only psychological, but rather it expresses the essence of the living, its own way of existing. He further expressed that it does not indicate being (the ontic) but, rather, suffering (*das Leiden)*; that is, the jolt of the living into laceration and crisis. In fact, dramatic experiences, such as expectation and surprise, danger and threat, will and freedom, decision and limitation, can be traced back to

the modality of the pathic (*Pathisch)*. It is the whole world that changes its significance if perceived through suffering.

The proper-corporeal area of the pathic therefore intersects, in a rich and complex way, with Calvi's concept of *Carne* [15], with Stanghellini's concept of *shapeless* [16], and with the whole area of pre-reflexivity of the bodily-self explored by Parnas and Fuchs [17].

Aldo Masullo—and here lies the centrality of his thought for the *Clinic of Intersubjectivity*—therefore radicalizes subjectivity as *sensus sui* or as *Arci-sensus* [18]. This is the dimension of the *lived experience*, or rather of the Italian neologism *vivenza* [19]. Therefore, the *sensus sui* stands as the original moment and foundation of all inter-feeling and, ultimately, community: if there was not an origin, in the foundational rather than in the chronological sense—and this origin is properly "me," my subjectivity—no individual sense would assume such feeling in the world. Therefore, the Arci-sense, the *Ursinn*, comes to constitute that cardinal moment in the life of a human; an "untouchable touch" or, in other words, "the original phenomenon with which the very possibility of appearing and without which no other phenomenon would be possible" [18]. However, it would be absurd to believe that this feeling can be revealed in everyday life because it is, due to its founding and original nature, "untouchable," and indeed "incommunicative." It is, in fact, in life that it manifests itself as *living existence with otherness*. It is therefore not the task of the clinician to guess the deep and archi-sensible essence of being, but to *grasp the manifestation of the presence in the encounter and in life*. It is only as living beings that humans can exist, and they do so through the mediation of the body and language. Therefore, the appearance of the human in the world is intercorporeal and intersubjective: it is in these dimensions that meaning, existing with the other, affirms itself. And here the thought of Aldo Masullo recognizes the debt to Ludwig Binswanger [18], whom the Italian master mentions several times (in particular, his work "*Traum und Existenz*" [20]). Psychopathological forms, therefore, cannot be considered as a withdrawal from the modality of being-with or as a communicative closure, but rather as a *particular modality of intersubjective and intercorporeal existence*. Thus, for example, for Binswanger [21], the forms of *missing existence* go *beyond* coexistence. They go beyond it, but they never ignore it, except in the development of the most advanced stages of psychopathology. On the contrary, in fact, the task of psychopathology seems to us to *recognize the particular and original forms of coexistence, or intersubjectivity, which come to the attention of the clinician*. The task of treatment and the clinical encounter is, as we will see more clearly later in the chapter, to lay the foundations for the implementation of a renewed and different way of existing with others.

13.3.2 Bruno Callieri: A Life for Psychopathology

Bruno Callieri was born in Rome in 1923. Called to arms while Rome was in the hands of the Nazi-fascists, Callieri decided to escape and take refuge in the mountains, near Tivoli, where he met Melania, the woman he had loved all his life. Thanks

to his contact with German and Polish Jews on the run who he met in hiding, he became familiar with the German language. In 1951, he was thus able to read Karl Jaspers directly from German. It was not until 1964 that Jaspers' *General Psychopathology* was translated into Italian, although it had been translated into French by Sartre in 1938 [8]. Callieri's life thus took the German path, where he met all the most influential psychiatrists, which drawing on scientific tools and psychopathological analyses in a way unknown at the time in Italy. Only Danilo Cargnello had begun to introduce this immense heritage to Italy, in 1947 [22]. Between 1943 and 1944, due to the war, Callieri had to interrupt his studies. Returning to Rome at the end of the war, he graduated in Medicine in 1948 at the Policlinic Hospital "Umberto I." In 1951, Mario Gozzano, cousin of the poet Guido, became rector of the prestigious Institute of Nervous and Mental Diseases, and in the same year Callieri specialized in Neuropsychiatry, with a thesis on the use of amphetamines in psychosis. He then began his career as an internal medicine doctor at the Clinic of Nervous and Mental Diseases. Italian psychiatry, at that time, was de facto a vassal of the French and German schools of thought; it had not contributed to the body of thought on psychopathological syndromes, as happened in France and Germany. The only well-known contribution was represented by Cerletti, regarding electroconvulsive therapy (ECT). Callieri had no foundation from which to start; he was told that deepening the general understanding of phenomenological psychopathology was a waste of time.

However, in 1947, Cargnello published *Alterità e Alienità*, thus introducing Binswanger's thought to Italy [23]. It was therefore in contact with the sick that Callieri began his passion for the encounter. Psychiatrists who were gifted intellectually were able to maintain the title of neurologist, and Callieri could have had an important neurological career; his training was in physiological/anatomical neurology. When he went down to the basement of the clinic, where the patients suffering from psychosis were housed, he approached people in fact wrapped in straitjackets when they were nothing more than *salt statues* [24] because they were catatonic. The purpose of hospitalization at the time was essentially custodial and not at all therapeutic. The Italian psychiatry practice was a *freniatria* that myopically avoided the term *psi*. Physicians chose to use it in their titles, if at all, in the context of their being *neuropsychiatrists,* to avoid the "shameful" term *psychiatrist*.

All of Jaspers' comprehensive psychology and the interpretative psychology of psychoanalysis was replaced by a sterile, anatomical approach. However, Callieri, rather than run aground in these anatomical shallows, realized and understood the importance of a phenomenological approach to psychopathology, to meeting the sick, and to the prospects for treatment. Among the few, at that time, in Italy, to deal with clinical phenomena—together with Danilo Cargnello and Franco Basaglia—he therefore began to lay the foundations of what can be considered the Italian school of phenomenological psychopathology.

In fact, in 1962, on the occasion of the publication of *Psicopatologia oggi*, a text dedicated to the birthday of Kurt Schneider, Callieri's mentor and who, in 1961, was in direct contact with him, he was the only Italian to be invited to make an Italian contribution to this collective text, together with Ey, Kranz (direct pupil of

Schneider), Lopez Ibor, Janzarick, Huber Matussek, Muller Suur, Pichot, and Weitbrecht [25]. Callieri can therefore be defined as the Italian representative of the Heidelberg school and the main exponent of the Italian school of the time. A letter from Professor Zutt on May 18, 1965, testifies that "Callieri is among the best and most successful psychiatry scholars in his generation." Although all the other great psychopathologists in this text were professors, Callieri would never become one. However, he obtained the freedom to teach in Psychiatry in 1954 with a master's lesson on dementia and in the Clinic of Nervous and Mental Diseases in 1956, discussing a lesson on epilepsy precipitated by thunderstorms. In 1966, moreover, Minkowski relied on Callieri for an entire issue of the magazine *L'evolution psychiatrique* dedicated to Italian psychiatry, with a preface by Ey, counter-preface by Gozzano, and contribution also from Basaglia. The text is characterized by a mix of medical semeiotics and phenomenological philosophy: this is not only the birth certificate of the Italian school of phenomenological psychopathology, but also a fundamental point of reference for what would become the reform of Italian psychiatry. The text includes the contributions of Bovi, Confrighi, De Martiis, Cargnello, Piro, Priori, Giberti, and Calvi.

Another important contribution by Callieri is *Quando vince l'ombra,* a text from 1982 (first edition) [26]; it is thanks to this text that Di Petta subsequently comes into contact with Callieri, becoming his pupil and trusted friend. Within this text, three essays are collected: *Stato d'animo delirante (Wahstimmung)*, from 1962, *The Experience of the End of the World (Weltundergangerlebnis),* from 1955, and *The Perplexity*, from 1977. In truth, it is in these essays that arises the foundation of Callieri's thinking on mental illness, and in particular, on schizophrenia. Twenty years later, in 2002, Arnaldo Ballerini, another leading proponent of the Italian school, wrote *Patologia di un eremitaggio* [27], and with this accomplishment, the path of this Italian school, with profound clinical implications, was completed. For both Callieri and Ballerini, the heart, the core of the schizophrenic disease is not, in fact, the visible and obvious aspects caused by positive and productive symptoms. Although madness has always been identified with psychomotor agitation, delusion, and hallucination, for Callieri and Ballerini, madness is different: it has to do with the *invisible* core. This core does not consist of positive symptoms, but has a rough face, a point of beginning, the *trouble generateur* of Minkowski, which nestles in silence, in a sort of ontological suspension, in a sort of rupture of a coexistence of the subject and the world, a disarticulation of the *being-in-the-world.*

In the Italian panorama, there were therefore very significant crossroads: the 1980s, when Callieri's book, *Quandovincel'ombra,* was published in 1982; and the 1990s, which were characterized by two important phenomena; namely, the appearance of Blankenburg's *The Loss of Natural Evidence* [28], translated by Ballerini, and the 1998 paper in the *British Journal* by Mario Maj, which defines schizophrenia as "a label devoid of meaning" [29].

What needs to be done, Callieri seems to admonish, is to learn to observe psychopathologically, to learn to ask questions, to analyze, and to learn to think. It is necessary to learn a method of investigation that is psychopathological: this

Jaspersian warning refers to the idea that one must not ossify or crystallize internal prejudices.

If the transcendental aspect somehow transcends and cannot interest the clinic, we use this term in an immediate, practical sense: the spirit does not ail, as Jaspers said; it is the passage between "alienity" and otherness that Callieri cared about. These existences, however, retain their meaning, and in fact these patients improve because there is something that works, there is essentially an extrapsychotic space, and it is in this space where the *we* precedes the *I* and the *you*. The patient removed from these environments can, however, collapse. This would take us to a change of position: drug treatments attack the productive symptoms but cannot address the root cause, and the subject will remain as one who wanders among others who do not resonate with his emotionality, and therefore become objects to him. In contrast to the symptomatic treatments conferred by pharmaceuticals, another would be a treatment based on transcendental phenomenology, which with the *epoché* manages to make the world of these subjects transparent. Therapy in a phenomenological sense brings out skills that must be found by firmly believing in the fact that they are there despite everything. The patient gets stuck in the non-natural evidence; therefore, it is necessary to detach oneself from the term of healing, to escape the concept of deficit, to break down the conviction that these patients cannot structure a world of values. *Dis-sociability* and *idionomy* are values that these patients possess.

Bruno Callieri died on February 9, 2012. He and Arnaldo Ballerini represent the two pillars of Italian psychiatry of the second half of the twentieth century, but they are also those who have established strong contact with European psychiatry outside Italy.

There was no European psychiatrist, and not many nonpsychiatric intellectuals, who approached Callieri with a cultural background conferring anywhere near the whole of his culture. This fact allowed him to immediately put the interlocutor at ease because he was convinced that he had not studied the author in vain since Callieri approved his choice. Callieri, further, showed him the ways to follow and to deepen this choice, showed him how one study could fertilize one experience and another one, a different experience [30].

Callieri was a torch providing light for all those who were mentored in his presence. Psychiatrists, psychologists, philosophers, and patients, more or less young, from all parts of the world, rebellious, escapist, irreducible, unable to recognize themselves in current clinical practice and in fashionable theoretical models. In this European landscape and climate, in which the Dutch school has gradually faded, the German school is substantially in great suffering, and the French one is just alive, it is the Italian phenomenological psychopathology school that, in spite of developing 50 years later than the others, is currently in the vanguard.

13.3.2.1 The Lived Experience of the Encounter: Body to Body

What sense is there in—now, here—addressing the theme of the encounter and of the clinical manifestations of psychopathological states? What sense is there, in today's world, where superficialization, speeding up, technification, and procedur-alization (guidelines and protocols), seem to have reached the maximum degree of

consensus among the operators, even to the idolatry of those who perceive them as an excellent defensive shield?

The crucial *punctum dolens* of the encounter with psychopathological states in the clinical setting is due to the fact that both the diagnosis and the therapy, as well as the continuation of the therapeutic relationship between the clinician and the patient, depend precisely on the "data" collected and gathered during the meeting, and nothing else. That is to say, in other words, that everything depends on the encounter. Sometimes, everything depends on a single encounter, as in acute clinical situations. The encounter between two human beings, one of whom by convention is called patient and the other clinician, is, however, a sum of exceptions and unpredictability, which occurs against the background of a common way of interacting. I would like to try, here, starting from some acute clinical situations, to describe this common text as the "living flesh" of the encounter. The encounter "with bare hands," or hand-to-hand. That is, an encounter that does not include other means, except that of characterizing a differential diagnosis in the "organic" sense, and that, in fact, in its procedural structure, is a mixture of "atmospheric" and "eidetic" elements [31]. By atmospheric elements, we mean, here, exquisitely "aesthetic" aspects, which can be grasped with a metaphorical extension of the senses; namely, the "gustatory," the "tactile," and the "olfactory." The atmosphere generated by two human beings who meet, and by the context in which they meet, is something that "is felt," or that "touches," or that comes "to the skin," or is something that you "smell," or something that you "taste" or "feel." When we use these "sensory" expressions, it must be made clear that they refer only nominally to specific pathways of senses. In other words, smelling, touching, tasting an atmosphere have nothing to do with the neuronal chains that start from the olfactory mucous membranes, or from the taste buds, or from the Pacini corpuscles in the layers of the epidermis and dermis, but, nevertheless, they represent immediate perspectives that give a very powerful knowledge ("immediate data of knowledge"). These cognitive modalities can be traced back to a "pathic feeling," which has its roots in our lived body, in the body-that-we-are, or in that vibrated and participatory extension of our being that maintains a continuous sympathetic relationship with the world.

But, returning to the encounter, who do we really meet when we meet someone? Are we sure we meet the patient in flesh and blood? In other words, who are the subjects of the encounter? Does the meeting take place between the two physical persons or rather between two side figures, transposed, who are completed as the meeting proceeds? We would like to try to propose here this representation not as the co-localization with the physical person in front of us, as an entity occupying space, and instead the dislocation, with respect to the physical space occupied by the body of the other, of the lived body of the other, and of ours. The same lived body, which fills the sphere of emptiness that apparently (visibly) is inside the setting of the encounter. While our bodies take a proxemic position toward each other and away, these same bodies have already established contact. They are the ones who regulate the distance, they are the ones who regulate the level of interaction. It is from their interaction that first-hand information comes. All this happens on a level that precedes language, thought, and reflection. Semiotics, as a science of

signs, induces us to meet what the body produces outside itself; the significant signs. Clinical phenomenology gives us the theoretical foundations to understand all this, to discern a reason for it, to represent that our living body, extension of our "mind," makes us meet another lived body, or the body that the patient is, his living body, through resonance and vibration and the involvement of our own living body. The advantage of the body-that-I-am is that it sinks and moves into an unsaturated, preverbal, pre-thematic horizon that is attuned to the world-of-life, and therefore draws essential, incontrovertible information from this dimension, which has to do with the rooting of the person in his own world-of-life, unmasking his truth. The operator therefore realizes a knowledge of the other on a human basis, and then becomes aware of it; that is to say, he removes himself from the whim of dislike, attraction, or repulsion, through a practice of awareness.

It's a January night, January 11 to be exact. There are 12 patients on the ward. My shift has just begun. As usual, I arrived early, and I saw the comings and goings of the nurses asking the colleague on duty to "meet" the patients, or, better, they made themselves carriers of the patients' desire to "meet" the doctor on duty. It is always an event when an acute hospitalized patient asks to see the doctor. Disgust is not just a basic emotion expressed by the patient with the cervicofacial grimace. He is disgusting in his whole being, with a seborrheic patina on the galea capitis, with his lopsided attitude, with his physical neglect, he gives the very idea of a wreck, of a consumed man, who fails to hold himself up in his standing. During his "fits of possession", the patient screams. Screams of damnation. During the night, he wanders the ward, not responding to drugs, terrorizing the other patients and nurses, with his eyeballs protruding from their hollowed sockets. He is too hyper-expressive a patient to be a chronic delusional patient; he is a sort of icon of the always-madman. Now this man claims to be possessed by a demon I named Lucifer. Is it a delusion? According to the superficialization of the DSM 5, since it is an obviously erroneous belief, yes. The fact is, this "symptom" does not respond to antipsychotic drugs. How should we view this non-response to both first- and second-generation antipsychotic drugs? As a non-responding example of the subject or his pathology? Or, rather, as an indicator of the fact that we are not facing a delusion? It is only by assuming the existence, or rather the embodied materialization, of this living body, that we can understand this story of "feeling by skin", of "having an ear", of "having an eye". That is, to notice the texture, color, warmth, thickness, rigidity, angularity, roundness, or softness of certain experiences. (Gilberto Di Petta)

Here, the foundations are laid for a clinic of the invisible, which strongly puts the clinic of standardized procedures in check. In fact, I am dealing with the encounter between two bodies-that-we-are who obviously feel each other, but which are not seen or physically touched. Nevertheless, those two lived bodies can be seen and touched on another level of sensitivity. Can a clinic of the invisible be compatible with the items of a rating scale or a psychodiagnostic test? This is a challenging question. However, it concerns more a research project and the attempt to "objectify" or "validate" the elements, rather than the experience of the encounter. In reality, beyond a crystallization or trapping of the data resulting from a clinical encounter, I would like to dwell again on the encounter in flesh and blood, the one experienced at the bedside, or in the emergency room, or at home, or even in an office or clinic. That is, on the "ground zero" encounter, made up of living, feeling, painful, hopeful, loving, anguished, hallucinating, delusional flesh. In all those

situations, the clinician must, in a reasonable time for a meeting, get out information and, more importantly, structure an interaction with the patient. In doing so, it is crucial to become familiar with these peculiar ways of vital contact with the other. It will be the task of a qualitative research approach, then, to develop an interview device capable of crystallizing these elements, which are in themselves elusive and invisible. This is exactly what Mauro Pallagrosi and his colleagues have defined in their ACSE project (Assessing Clinician's Subjective Experience) [32, 33].

> *It's almost two in the morning now. I returned from the ER. It's cold, the wind is cold. There was a man in cardiac arrest, in code red. The silence was deadly. The resuscitation team was around him. A colleague performed heart massage relentlessly. In code yellow, however, our patient was waiting for us. A lonely man, devoured by anguish: "Doctor I live alone. I have got no one. I woke up suddenly, I looked out on the balcony, I saw all the lights of the houses turned off. I felt the urge to get down. Tonight does not pass. My anguish has risen. I don't know how I did it, I called 911. I didn't have anyone who could give me a calming shot. My heart is beating. My heart bursts. It seems to me that it stops at any moment, so much so that it pulsates. Don't let me go. Keep me here tonight." I think, at that moment, of the man who is dying in the next room. Or rather, the man who died, whose heart stopped, who they are trying to bring back to life. Which heart is it? Evidently, as clinicians, my colleague and I are dealing with two hearts of verses. He of the suction and pressing muscle-pump, I of the "lived heart". The anguish of this man, for example, hits me. I feel a sense of agitation the closer I get to him, while I contemplated, coldly, the scene of the resuscitation from death, as if it didn't concern me anymore. On the other hand, this living man in front of me anguishes me. He speaks in a tremulous voice, his whole body is trembling. But it is another body, this one here, opposite that of the man who is dying. This is a lived body. That is a dying body, upon which life is suspended. This, here, is a lived body, steeped in anguish, like a sponge of water. Evidently his heart is not in his chest; this heart is in friction with the world. This heart is the pulse of his existence. It is the embodiment of his existence in the world. His heart engages mine in this panic fibrillation. It brings me back to my loneliness, to my fear of dying alone, to my anguish of having come into the world. The anguish I feel is physical. A real, vital distress nebulises between us. We walk, in silence, towards the ward. From there the resuscitation continues. My colleagues are colliding with his physical body. I could not even report my patient's cardiac trace, because the cardiologist is busy trying to save the other's life. My patient came with a cloth bag already. I think, to myself, that he has come home. That we both, tonight, are returning to a bed that tends to us and to a house where there is someone. As we leave, we take a final look at the resuscitation scene, but my patient is indifferent to the world, he is occupied only by his heart—and I, from "our heart". (Gilberto Di Petta)*

13.3.2.2 Understanding the Ineffable Failure of the Encounter

The psychopathological method attempts to propose an understanding of mental illness that is not based solely on the objectivity of reified data. For those reasons, it seems useful to recall to attention some contributions, many from classical psychopathology, others from contemporary researchers who have investigated these aspects of *the pathic* interaction between the clinician and the patient, which have much importance in the understanding of an experience like that of the schizophrenic.

Let's go back to the starting point: "how does a psychiatrist make a diagnosis of schizophrenia"? It is interesting to note how, before the decisive work of authors such as Griesinger and Kraepelin, what is now considered an "organic" disease, was in no way traced back to the corporeality of human existence. In contrast to neurotic

or melancholic conditions (*neurosis* = disease of the nerves; *melancholy* = disease of excess black bile), believed to have *corporeal correlates*, "madness" had no reference to the *body*, thus escaping every reference to the *naturalness of the human being*. In fact, the etymology of the term "madness" referred to an aerial condition, *follis* (balloon or pillow filled with air), a condition of detachment from the bodily mediation between the person, the other, and the world. Madness was a spiritual, diabolical condition, in any case considered *alien to the pathic foundation of human experience.* This alienation, in fact, denied all humanity to the person suffering from this condition, justifying the exclusion and confinement of the insane in places of abandonment, violence, and oppression, between criminals and vagabonds.

The world had to wait for Philippe Pinel for the affirmation of madness as *a clinical condition*: the clinician had to take an interest in the mad not only for hygienic-sanitary problems, but also for the *treatment* of this disease [2]. Having developed his own conception of insanity during the French Revolution, Pinel assured the insane of inalienable *human rights* that resulted in their liberation not only from the physical chains of the prisons in which they actually lived, but also from the ideological ones, that had caged them in a condition that was a nonhumane and noncorporeal one, which had nothing done but nourished the disease itself, until it had effectively become against the limits of the humanity.

Lollo is welcomed into our service accompanied by his father, sent by the attending physician, who recognized the clinical urgency, given the protracted and worsening clinical and psychopathological picture characterized by severe depressive syndrome, social isolation, and poor academic performance. It was decided to start a program of psychodiagnostic evaluation and multidisciplinary treatment within the "ArgentoVivo" clinic, made up of a team that deals with first psychopathological episodes in adolescents and young adults. At a first visit with the psychiatrist and subsequent psychometric and laboratory test evaluations, the patient showed a clinical picture characterized by difficulty in sleeping, depressed mood, loss of concentration, reduced pleasure and involvement in activities, including social activities and relationships, as well as a subjective sensation of being observed, of hearing and feeling things around him, ideas of reference, and a certain strangeness in thought and speech. The father with whom L. lives in his home together with his older sister also reported that L. would have a suspicious attitude towards his family, and with him in particular, as well as a tendency to argue more easily and spend more time on his own. The checklist for the assessment of psychotic onset showed a high score of 50 points.

L. then attended further encounters with psychiatrists for a longitudinal observation of his psychopathological picture. The mother was of Cuban origin and had two children with L.'s father, she separated from him, and then had two further relationships from which three other children were born. L. dropped out of school after having repeated an artistic high school for two consecutive years and then enrolled in the second year of a professional institute, from which he withdrew a few months before the beginning of the school year. The previous psychopathological history also revealed a specific learning disorder, with dyslexia, dysgraphia, and dyscalculia, which confirmed the onset of specific learning psychopathology (SLD) in childhood.

In this particular environment, a progressive "transformation of the surrounding world" would be expected to have arisen, with an increasingly threatening and persecutory atmosphere. The pre-delusional mood, with a strong distressing connotation, appeared compatible with an onset of psychotic schizophreniform disorder, with a prevalent syndrome characterized by anhedonia and depressive symptoms, as well as the pres-

ence of basic cognitive-perceptive symptoms, including inability to divide attention, interference of emotionally neutral thoughts, crowding or pressure of thoughts and flight of ideas, blockage of thoughts, receptive disturbance of visual and acoustic language, expressive language disorder, tendency towards self-referentiality, and tendency to fix attention on perceptual details. This picture, on the basis of the evaluation and clinical interviews, as confirmed both by the reported subjective experiences and by the objective findings of the psychological examination by the psychiatrist, indicated a prodromal phase of a schizophreniform onset with anticipated increasing symptomatological progress with the need for immediate intervention for prognostic purposes. The FBF scale was used to analyze the subjective experience of the patient in the first person. The resulting score was 85/98, with particular elevation of the scores regarding the loss of automatisms, anhedonia, anxiety, and expressive and receptive language abnormalities, as well as thinking and memory abnormalities. These elements were confirmed by the schizophrenia proneness instrument (SPI-CY), which was compiled during subsequent clinical audits with the psychiatrist [34].

In the delusional perception that L. experiences, especially at school in the classroom but also in the videos that he himself makes on his smartphone to immortalize what is happening to him, there is not only a conglomerate of data or sensory stimuli, but also the encounter with a reality "observed" with other eyes and lived intuitively, since it is a transformation of the Self-world relationship in its totality. The sensations take on new qualitative characteristics, in the form of a sudden, immediate, unforeseen mass, coming from afar, urgent, directed exclusively and personally. L. also dreams of a lighthouse that follows him and illuminates him as if he were at the center of a stage from which he cannot move, in the greyness that surrounds him. Alcohol and cannabis are the only elements that in some way are used in a recreational manner as a "sedative anti-anxiety binge". Even these, however, are no longer able to appease the sense of revelation that pervades the days "out of common sense" that L. relives without continuity between day and night, between the state of wakefulness; sleep and dream states that intersect with the high caused by cannabis that interpolates itself. L. began his existential journey with obvious failures in the possibility of a "basic trust" in early childhood, school failures, and reported experiences of being bullied as well as a sense of being "off-axis". (Danilo Tittarelli)

The world becomes *i-ico,* with an Italian neologism invented by Prof. Bruno Callieri to describe this transfer of the ego that makes the world become persecutory [26]. Huber raises the question of what precedes the symptoms, the sort of experiences that are basic phenomena, cenesthetic sensations referring to the construction of subjectivity and of presence, which are embryonic moments in this ontological deficiency, of the structure of the subject, which is in some way insufficient to make him find the key to the world of the relationship with the other. These are phenomena that could remain dormant. Life itself, however, makes them problematic in the sense that the German authors have of the term, the *Lebenskrise*, which is not necessarily exogenous events, such as war or great dramas, but also personal situations that one encounters in living. The question of psychosis arises precisely when the subject must somehow deal with the other, and with the world: an ontological inadequacy and an aspect of defensive ontic construction can occur as extreme flourishing, which conceals the core of inadequacy.

From an anthropo-analytic perspective, what is identified in the clinic as the beginning of psychosis (in our case the experience of centrality) in reality does not constitute a beginning at all, but rather the result of a long and systematic path characterized by a gradual and more or less intense failure of the process of affirmation

of the self toward the world, as the point of arrival of a more or less radical process of disorientation, and of absorption of the Self by the world.

In the beginning, there is therefore a transition stage of perplexity that remains so, and in this case the cure represents the thread that Ariann gives to Theseus in the labyrinth: immersed in the experience of the dream, there is only the actor-acting subject. It is with the awakening that the subject gains the awareness and ownership of being, or, rather, of having been the actor-protagonist of a dream, a character in a direction written elsewhere. This, then, is exactly the a priori structure of the dream: pre-reflective rather than conscientious. It is, in some ways, an experience analogous to delusion. These pre-reflexive devices function (badly) even in delusion, so much so that the delusional person has no reason to doubt the reality of his own delusion. The difference with delusion here is restored via recovery of the waking state. The delusional patient is able to establish that he has dreamed, that he has only dreamed, while he is unable to understand that he is delusional. From this point of view, phenomenological reflection on the ontological status of the dream can enlighten us on the constitution of reality and on the constitution of delusion, in the sense that not only the dream, but also reality and delusion are not exclusively the result of the activity of conscious reflection. It is in this "game" between reality, dream, and delusion wherein exists the possibility of leaving the canonical setting of the clinic, and of facing this moment of anguished suspension with L., accompanying him side by side on a path of possible co-constitution of another world.

Clinical experience with patients who live the experience of centrality in the phase of a nascent psychosis shows us that in some cases the subjects live in a space that is actually so small, narrow, and adverse that they are under the banner of the most painful receptivity and passivity. If this is true, it is also true that in other cases we still witness some possibility of "movement" on the part of the subject, testimony of a fundamental residual capacity to unfold in this space, orienting itself in it. At the very moment in which a subject is no longer able to decentralize himself from the position of the center of the world, a possibility typical of natural experience, "his perspective changes overwhelmingly; he is no longer able to meet others and things; he has the feeling that others and things are there for him, falling into an overflow situation: everything is too full; perceptions, sensations, feelings, the world of things … there is no more space for chance, there is no longer any neutral background in which people can move, but there is the anguished sensation of a world that speaks a single language: the physiognomic acquires a particular importance with constant fearful or persecutory declination and delusional themes highlighted with ever greater clarity" [4].

In one of the meetings, L. tells of having dreamed of a lighthouse: the referring nurse proposes to take a walk with the psychiatrist and the patient near the lighthouse, located in a suggestive place in the city. In this circumstance L. seems almost amazed that some people, and in this case, the health workers, could share a similar moment. The fire of anxiety still makes him a candidate for treatment despite the fact that we need to deal with his dissociability on the one hand (detachment from immediate and intuitive participation in evidence of the shared sense, pillar of shared sociality), and on the other with its idionomy (constitution of a personal context of idiosyncratic reference, articulate in an elusive,

enigmatic and paradoxical logic). The nascent psychoses are the most viable from a treatment point of view.

L. reports that he wants to continue along the path of care undertaken. He has resumed contact with friends and attention to some peers, and we are trying to respond to his desire to go back to school, in collaboration with the school. He reported having made use of cannabis on two occasions for recreational purposes; however, reporting an unpleasant effect and adequately critiquing that fact, he acknowledged the worsening of his overall psychophysical balance. He is "rewriting" his own history and his own "crazy experience", composing the lines of numerous songs, rediscovering his passion for rap and trap. He comes to the clinic twice a week. Together, we listen to his new beat, accompanying him in this renewed flow. (Danilo Tittarelli)

The trip to the lighthouse represents an effective "gimmick" of the nurse immediately caught by the doctor, to facilitate the start of psychotherapy. In 1935, Binswanger emphasized that psychotherapy acts as a "being-human-with another human" and "being-doctor." They are among themselves in a relationship of "dialectical reciprocity." This allows an existential communication fruit of trust that is capable of freeing and directing biological–psychological forces, indicating as a decisive factor an uninterrupted mutual communicative contact, a "being together."

The "trick" is the first condition of every psychotherapy and of every medical art, as indeed of every art in general; a "gimmick" is "artistic" and not amateurish when it derives from a rigorous, artistic, and scientific style, all at the same time. This has become normative for the personality of the doctor and, I would almost say, embodied in it [35].

When a psychotic breakdown occurs, the Self loses the ability to transform the past into a narrative, both because the schizophrenic mind loses the possibility of historicizing and therefore of integrating its mental representations and because the fracture becomes intolerably painful. Regarding the relationship that one has had with the past, this makes that relationship feel as if it were forever lost.

The onset of schizophrenia almost always occurs in adolescence, when something crucial prevents the transition from childhood to adulthood. Unlike what happens in other psychoses, schizophrenic almost always experience apocalyptic moments, preceded by an atmosphere that springs from delusion and experiences of perplexity, which change the life of the subject forever and can transform others into potential enemies. Because, inexplicably, they participate in, and indeed, they flaunt indifference, the subject experiences a threat that threatens to annihilate him in this descent into hell. From this point of view, in this gradient of becoming schizophrenic, with L., it was possible in some way to intervene early, by not being indifferent to his request for help (help seeking). The potential for empathic tuning offered by the sensitivity of the phenomenological method to subjective experience is particularly important in the construction of the therapeutic alliance in those with "at-risk mental states" that lead to profound experiences of alienation and interhuman alienation.

"What does psychopathology want?" asks Minkowski in his famous *Treatise* [9]. The obvious answer would be that it "studies the morbid manifestations," and in this sense it would belong to psychology and like pathology to physiology. However,

Minkowski's intent is to remove psychopathology from the role of "younger sister" and therefore from pathological deviance, and to instead move toward a definition of autonomy in a phenomenological and structural sense, in other words, toward a anthropologic psychopathology. Bringing the emphasis of caring back to the person, this view indicates that care is not declined as a simple aseptic technique but as an expression of an original intentionality based on the original "I-you" relationship. The relationship with the patient appears in this paradigm to be no longer centered on psychic functions and not even on structures, but on the concept of environment, atmosphere, and resonances (*Stimmungen*).

One aspect of psychiatry on which the phenomenologically oriented vision is directed is the encounter between doctor and patient. In it, psychiatric knowledge/doing is itself embodied, with its *eidos* as it appears and as it is constituted. Since psychiatry, in the past the subject of in-depth epistemological reflection, is currently conditioned by a neurologizing medical-positivist prejudice, this discourse is of the utmost interest. The neo-positivistic prejudice starts from the scientist's assumption of the radical and self-validating objectivity of the object, which in the case of psychiatry would be mental illnesses. The clinician's task in this view would consist of observation of the entities of nature with a neutral eye and description of how the various aspects of these entities, in a spontaneous and natural way, manifest themselves in the sick. That is, the clinician's task is to describe the symptoms that are present, cataloging them according to equally presumed natural categories of psychic faculties (attention, memory, sensory perception, mood, etc.). Psychopathology in this perspective would reveal itself as a kind of generalizing extrapolation of semeiology. Actually, the encounter between two human beings, who we describe, by convention, as a patient and a psychiatrist, is affected by all the complexity of their human nature, by the intertwining of their subjectivities and their stories. The encounter, of course, also constitutes a means of obtaining useful information for diagnosis and treatment. In this sense, we make Cargnello's intuition our own [23], according to which in the psychiatric interview one continually oscillates between "having something in front" (objectifying attitude) and "being-with someone" (subjectifying attitude). Despite *check lists* and *rating scales*, although structured interviews and psycho-diagnostic tests are more or less validated, nothing can replace, in the absence of instrumental and/or laboratory examinations, the contact between two human beings, the climate of the relationship that is established between them, the degree of mutual confidence, the sensitivity with which the interlocutor asks open questions and, alternately, manages to tighten on critical issues. All this derives from the psychiatrist as well as from experience and guided learning, from the development of an aesthetic sensitivity that is also nourished by a certain culture inherent in human history and events, outside of which the clinical data lose their significance.

When, at the end of the nineteenth century, modernity had already shown its technological value and some aesthetes such as Ruskin and Pater had denounced the incipient crisis of the sensitive relationship with the world, the notion of *Einfuhlung*, which translates quite closely to the Flaubert term *entrer,* as well as the term *intropatia* proposed by Paci, became a relevant one. This term has,

however, been supplanted by the term *empathy,* with all the misunderstandings that it brings, starting from the confusion with *sympathy*. The concept of empathy is one that everyone would like to possess, and that everyone uses with the most diverse intentions to conquer it. We think that bodily action, as enunciated by Husserl, and the consequent notion of *mimetic praxis* can help to define empathy, so that we can say "understanding by empathy means constituting intersubjectivity by operating in oneself the imperceptible mimesis of the other." Furthermore, intersubjectivity exists not only between people, but also in our relationship with things [36].

According to Calvi, in his latest work [37], which contains many of his contributions and his "phenomenological exercises," intersubjectivity has an aesthetic foundation. It is the state of bodily co-feeling, in which feeling itself can be "Eidetic vision or mimesis," in an intentional movement that welcomes within itself the voluntary and the involuntary, the aware and the unaware.

13.4 Intersubjectivity and Therapy

What can psychopathology tell us in this regard? According to our perspective, it is *in the intersubjective space of the therapeutic relationship* that the patient's experience can not only reveal itself, but can also *acquire the possibility of an experience that is not only psychopathological*. At this point, we should emphasize that *the encounter should be the inescapable focus of the cure.* Orienting the treatment in a phenomenological direction means re-establishing it on the basic assumption that it is possible only in the encounter between two or more subjects, in the possibility of creating an experience that is not psychopathological.

It was, in fact, starting from this assumption that Franco Basaglia, in Italy, in the 1960s and 1970s, initiated a radical transformation of public psychiatric practice [38]. In fact, starting from the degrading situation of the Italian asylums, which, evidently, were more similar to concentration and detention camps than to places of clinical assistance, he saw the debasement of the bodies exiled in asylums. He saw the patients as prisoners in inhuman conditions, and the psychiatric clinic as a garrison of concealment of those who are different, and of the leavening of suffering. Basaglia, himself detained in fascist prisons, had the courage to affirm, like Ludwig Binswanger, one of his mentors, an *obvious fact*. The condition of social exclusion and hygienic-sanitary degradation is anything but curative; it is itself part of the problem. It acts both as a factor that aggravates the pathology itself (contributing to the continuous dehumanization of the patient) and as *a direct expression of a distorted society; a society that produced both the disease and the places to hide it* (thus eliminating from view the distortions, gaps, and failures of a dysfunctional social system). Mental illness, therefore, was largely considered *an institutional illness*, in the sense of its being both a pathology that exploded in such inhuman places of alienation, and a disorder that emerged from the fabric of familial, political, and economic relationships. In other words, a disorder that emerged *from all that is instituted as an inter-human relationship*. The closure of the

asylums, with the consequent release of the madmen who were ejected from them, is associated with a still-fragile territorial psychiatry. This movement wanted to be something akin to the storming of the Bastille; the first act of liberation of a future social and political revolution. However, once the enormous *clinical* importance of the closure of asylums had been affirmed without a shadow of doubt, the point was precisely that, rather than continuing on the clinical path of encounter and treatment, the heirs of Franco Basaglia, who died prematurely only 2 years after the approval of the reform he inspired, followed a sociopolitical path: they believed that now—once the madmen were freed—*the social structure that looked at madmen as such* had to be *changed at the root*. This project has obviously been inconsistent. Just as the storming of the Bastille resulted in the Terror and the guillotines, and finally in the Napoleonic Empire, so the closure of the asylums—once Basaglia's strict foundational ideas of encounter and care were lost—left, in a few years, space for a biological and reductionist restoration, on the one hand, and for "mental health" approach, based on services and needs, on the other. In both cases, the subjective experience of the patient is placed in the margins. The path of the Basaglia reform and subsequent approaches agrees on one thing: *the unspeakable experience of inhumanity and suffering of the alienated in the asylums*. In both cases, the question of suffering and the pathic, sensitive, and bodily pulsation has been exorcised as a neurobiological-cerebral deficit or as a social–political artifact. In no case was the emergence of psychopathology traced back to that background that we have defined as "pathic," "intersubjective," or "intercorporeal." It is only from this background—as Husserl taught us in his "Logical Research" [39]—that a *sentient ego* can assert himself as such and live this experience. We have thus witnessed the restoration of a psychiatry that is once again inhumane and dehumanizing. The Italian experience, more than 40 years after Law 180, but only a few decades after the definitive closure of the asylums and the disappearance of the human residues that were still exiled there, has shown the inconsistency of a model based on pharmacological dispensation, on the provision of services, and on the development of psychotherapeutic techniques that are often redundant and deaf to the patient's suffering. There, in fact, the encounter—understood as an openness to understanding the sufferings of *that subject who manifests the psychopathological experience* and as *the therapist's transparency with respect to his own human experiences that emerged in that encounter*—is relegated to a romantic surplus and useless to a science considered "neuro-clinical." Where the encounter has been relegated to such a place, a cure for these experiences remains impossible. The path is inevitably that of a chronic disease: mental illness is understood as a sort of emotional hypertension or cognitive malfunction, to be modulated pharmacologically, with specific psychotherapeutic techniques, or with the provision of specific services to users. The psychiatrist, once again, is a *clinical specter*, unable to live his own experiences in clinical daily life. To all this, on the basis of Basaglia's thought and of what has been said previously, we have tried here to oppose a psychiatry as the science of encounter, of listening to what emerges from the space in which such an encounter takes place and of the freedom of possibility that every human being, as such, has within himself.

13.4.1 Being-Between: The *Human* as an Unexpected Encounter and Event

The aesthetic perception of clinical atmospheres and the grasping of shapes or suspended worlds do not represent a mere act of aestheticization of the clinic itself [40]. This phenomenological psychopathology has a great evocative power: in this sense, sensation-related and aesthetic. That is, it is a psychopathology that uses the channels of aesthetics and that shuns and in a certain way repels the prevailing naturalisms, empiricisms, pragmatisms, and reductionist positivisms. The intersubjectively lived clinical experience and the aesthetic experience have *in essence* a common denominator represented by the *pathic*. If an atmospheric element cannot be objectified (neither in an explanatory nor in a descriptive-phenomenological sense) from a Jaspersian perspective, it is nevertheless qualifiable, wherein it is perceived and suffered as a *medium* of intersubjectivity.

There is, probably, a primary atmospheric dimension, a feeling that is immediately perceptible, with respect to certain aspects of an encounter. Just as there is a first eidetic level, that of detail, anyone is able to grasp this atmospheric feeling. All of this coincides with what is commonly known as intuition or insight. This first level, or survival level, is ontic, accessible to all, characterized by psychological values. It is not so much anthropological; that is, it does not refer to the structure of the human being as *being-in-the-world*. The atmospheric feeling of the first level also has a mildly depersonalizing action, that is, it favors the *epochè*; it transports the subject out of the worldliness of origin. At this point, the prepared subject begins to grasp the details that allow him to structure the world in which he finds himself and to remember the world from which he comes. If the atmosphere of an event has turned out particularly well, it leaves a trace in the consciousness, like a dream. Then, the next day, we need to get in touch with whoever was there that evening, or that time, and share the memory of that event, whether "hot" or "cold," with another person. After that, for both dimensions, atmospheric and eidetic, the ontological leap is necessary. That is, the detachment from the world of worldliness to enter into contact with the *world-of-life*. This is a transcendental dimension, in which both the atmosphere and the eidetic image meet forms of constitution. That is, they must be constituted. This second level is accessible to phenomenological work, and is the only one that allows the work of re-founding otherness and intersubjectivity.

Feeling the cold is an intentional experience, but within this experience the *we* is already outside of us: what we do is observe our self emerging inside the cold itself. Even the structure of this "to come out," even before emerging in a "thing" like the cold wind exists thanks to its presentation within the self of others. This is not an intentional relationship, but *aidagara* or "interface." To discover the ego in the sensation of cold and originally the *ki* intended as *aidagara* [41].

One of the best explanations of *aidagara or inter-being* is that a human cannot be considered as a single individual, but as a relational being within a network of relationships in which the other actors are the other humans, nature, and the society to which he belongs. A human is therefore within the daily "hand to hand" relationship that takes place between human beings [42].

This discourse is evident in encounters in the clinic. The unexpected is disturbing in that it escapes perceptive intentionality and its usual office of constitution of reality. On the contrary, it shows, even without pushing into the well-known pathological excesses, the occult intentionality of an anonymous power ("the hidden"). In the context of a lived experience that has become solipsistic, however, it shows a mere fictional surface—as when one discovers that a face is only a mask, covered with indecipherable signals and for this very reason invariably "felt" as addressed to the perceiver [43]. A successful encounter, on the other hand, is one that ensures intersubjectivity. The Real, to which the Lacanian psychoanalytic conceptualization also refers [44], is what happens. It is the event, the openness, the opening of experience and meaning, the "it is what was not expected" and that is impossible to wait for. It is, therefore, neither possible, nor impossible, neither imaginable nor properly unimaginable; in a word, it is a figure of the *trans-possible*. In the inseparable tension of the *ici en deux* lies what Maldiney defines as *trans-passability* [45]. *Trans-passability* rediscovers the original relationship we have with the world and with others, a relationship that, once rediscovered, only enriches us, as if to make us reborn again. We ultimately believe that this is the cure.

The Eastern philosopher Watsuji Tetsuro, in his *The Meaning of Ethics as a Study of the Human Being* [41], uses the Japanese term *Ningen* in three declinations: human being understood as a single individual; human being socially involved in a vast network of social relationships; and, finally, as a synonym for the "space" existing between human beings where relationships unfold. Being-in-the-world means being fully in a space–time dimension, as in *care (Sorge)*, "being-for," "being-between," *aidagara*, and as a daily "body to body" relationship.

An existential understanding of the human being cannot be reached solely through the "transcendence" that structures the element of time. Transcendence must be transcendent first of all in the sense of the discovery of the self through the other, and then of the return to absolute negation through the unity of the self and the other. The realm of transcendence must therefore be the "interface" (*aidagara*) between individual and individual. In other words, the *aidagara* is that sphere in which we discover the self and the other, and must be in and of itself, originally, the scope of this "go outside" or *ex-sistere* [41].

Watsuji distinguishes two modes of embodied beings: we are hybrid entities that host, simultaneously, both subjective and objective dimensions. To use orthodox phenomenological language, Watsuji distinguishes two modes of *embodiment*: first, the body from an internal perspective, or the body as a subject; second, the body from the perspective of an outside observer, or the body as an object. For Watsuji, this hybrid nature of our "flesh" reflects our dialectical nature of being-between (*being-in-between-ness)* [15, 46].

We exist as a "subjective spatiality" perpetually intermediate between pure subjectivity and objectivity [47]. This embodied perspective derives from Watsuji's first critique of Heidegger. Despite his initial enthusiasm for *Being and Time*, Watsuji was one of the first commentators to offer substantial criticism of Heidegger's myopia for *embodiment*. He argues that Heidegger's excessive concentration on the temporal nature of *Dasein* leads him to overlook the essential role that spatiality plays

in constituting the structure of *Dasein*, which means that Heidegger ultimately has little to say about either embodiment or intersubjectivity.

13.4.2 The Pathic Way to Care: The We-ness-in-Loving

Can a way of looking, of being-with, a "simple" way a human meets himself with another human, in a room and through a *Stimmung* choral, configure a possible cure? We have elsewhere argued not only its actual feasibility, but we have valued and exalted its great transformative and therapeutic potential, for which phenomenology itself becomes therapy, or in other words: intuition is understanding, and to understand is to care, to meet authentically, existence to existence; to understand is to change. Studies and reflections on "new" psychotherapies, studies on communication, authenticity, mutual implication, and intimacy, move in this direction, in particular the *Dasein-Group Analysis,* a group device of a phenomenological nature, developed and "fine-tuned" in the approach to the world of drug addiction, *synthetic psychoses*, and borderline existences [48, 49]. The anguish of "being in tremendous disorientation," this structure of *Befindlichkeit* analyzed by Heidegger [50], is in this context uncovered, lived, verbalized, and rationalized. This includes finding eidetically in its essence emotional phenomena that cause suffering, endured and felt by a large part of the Group, that are located in a *suspended atmosphere of vertigo*, that are, in other words, aesthetically transfigured.

This idea of a plural phenomenology (*being-us-in-the-care*), Binswanger's realization of a *weness-which-loves*, in an emotional group composed of health workers and patients together, was the result of despair stemming from failed encounters with addicts and psychotics. The intention was to offer a common and intimate place, a new space, a new time, in which anyone could have the possibility to fully feel their existential condition—the possibility of feeling your own body and that of another one again, the possibility of feeling your own pain and that of others again, of feeling the support of others, the possibility of making your own heart cry. For some of these lost beings, this new phenomenological approach has become a kind of way out. Treatment with this approach can ultimately lead to freedom to truly be in the world.

13.4.2.1 Dasein-Group Analysis

The experience called Dasein-Group Analysis (*Gruppen Daseinsanalyse*) is made possible by extrapolating some tools from the phenomenologist's toolbox, as follows:

1. *Epochè*: The "conductor," the arranger, practices an initial radical *epochè,* even of his own asymmetric role. This allows a connection with the internal experience of that moment, which is then related to the external plural experience. The arranger makes an initial declaration, a real opening of his own world of life. He then asks the participants to do the same.

2. *Intentionality*: Every expression, from the crudest to the most elaborate, by each member of the group, is permeated by a directionality. Intentionality constitutes lived experiences, but it also influences the intentionality of other members through them.
3. *Co-constitution of the Erlebnisse*: Little by little, from the references to the *Erlebnisse* that are formed, a central group takes shape. Each person's experience changes everyone else's experience and is modified by the experience of everyone in the group.
4. *Encounter*: At the center of the group meetings, there are two people, face to face.
5. *Intercorporeity*: Taking hands, hugging, and putting a hand on someone are all examples of intercorporeity welcomed in the group.
6. *Atmosphere*: Atmosphere is gradually defined, and therefore is in turn an element of induction of *epochè*, in terms of its displacement and the pathic disorientation it induces in the participants.

The experience consists of a group of people who decide to pass from a natural interaction to a situation in which the transcendental structure of the world of life emerges and is felt in all its pathicity. The group's arranger starts from his personal experience. After a few minutes of silence, he brings forward what he feels. Then, he asks everyone to do the same. He starts by summoning group participants one by one. If necessary, he gives some references. When the first round is over, he invites those who feel like sitting in the center of the group to meet someone. These meetings can be repeated. When it is enough to get the right atmosphere, we proceed with a final cycle of experiences. The arranger concludes by recounting his own emotional experience, which is intimately connected with that of the others. The Dasein analytical group is freely formed, with a variable number of participants, a mixture of patients and therapists. It has a circular structure with two central chairs or *poufs,* a structure intended to facilitate interaction, face to face, hand in hand, and "supported" by the rest of the group. This group approach is centered on the search for an authentic intersubjective encounter, as an embodied crucial event, or as a *purple zone* [51] or *dual thirdness* [52]. The encounter zone or purple zone is described as the zone resulting from a mixture of red (patient) and blue (therapist) in terms of presence in the experience of the Other as another Subjectivity. The experiences represented by these two rays of light condense in a form that represents "the place where the therapy takes place." From an ontological point of view, the purple zone is defined as the totality of events, behaviors, and experiences, conscious and unconscious, recognized or not, that occur in the therapeutic room. From a psychological point of view, it is defined as quasi-spatial presence (a semi-thing, quasi-thing) in which there is a feeling of meeting someone or being met and which requires a sense or appreciation of a very different quality than encountering an inanimate object. Every relationship produces an affective resonance. This affective resonance occurs on a specific portion of the duality involved (or of the group, if more than two people are involved); that is, only some of the current experiences in the two dialoguing consciousnesses resonate. The parts of the consciousness of the

individuals that resonate as they relate to each other generate what we call interpersonal essence. This interpersonal essence is constituted, so to speak, of a dual thirdness because it is not only and exclusively the subjectivity of the patient, nor that of the psychopathologist. This condition, which occurs face to face between the two human beings in the middle of the group, is the necessary step for any subsequent cure. The phenomenological background is extremely useful, especially in the close encounter (face to face) with the patient who is during this experience respected more as a real person rather than yet another clinical case. The experience lived here (any lived experience, including delusional or hallucinatory experiences) has its intentionality (regarding the underlying truth). These experiences in the emotional context of the phenomenological group mix freely with each other, producing changes and transformations in all of the participants. The transition from initial negative emotions to final positive emotions in each group session is crucial. The tuning, the *attunement*, and the gradual attainment of empathy are key elements in the process. The "ground level" of the encounter is a definition that was created to describe this particular type of group therapy, after entering the intersubjective atmosphere, above and beyond the guidelines of the settings [53]. It is impossible to distinguish, in these encounters, between atmospheric *allure* and eidetic detail. The pattern here is not that of the interminable (infinite) chess game between a therapist and a patient, but that of a single *round*, after which one of the two is out of the game. We are talking about loading the single encounter with all possible intensity, working for hope against defeat, for life against death, and trying to pierce the screen of substance. The "elimination of roles" and the involvement of the clinician as fundamental for the evolution of lived experience make this a group experience that goes beyond traditional treatment. This atmosphere, in the public health service locations (day centers, prison, medical clinic) where it has been applied, has worked very well for the "containment" of multiprofessional work teams. It has facilitated the involvement of people who believe in demonstrating how much the human factor is a factor that cures, and has demonstrated the ability of phenomenological psychotherapy to understand the world of the whole person, who is all too often observed and treated only in fragments.

13.5 Conclusion: Toward a Psychiatry on a Human Scale

We started from that *great crisis* that reigns in the field of psychiatry. After 40 years of neuroimaging, electroencephalographic measurement, and neuropharmacological and socioepidemiological studies, little new has been discovered regarding the nature of "mental illness." We believe that this is an inevitable result of the starting point of a reductionist and categorical psychiatry; namely, the vision of a human being as an inert aggregate of molecules and at the mercy of external events. We could define it as an *inorganic science of the individual*. Instead, we have tried to redesign the horizon from which to start investigating psychopathological experiences according to a method that we could define as *organic science of the human being*. With this we want to indicate that perspective according to which every

person is a living being capable of experiencing his or her own living in a shared and common world, in a sensible way and starting from that rootedness in the world of life which is one's own body. It is this dimension—in turn formed of *intercorporeity* because it develops in the resonance between our bodies, and *intersubjectivity*, because it becomes possible in the encounter with otherness—that is the foundation of the opportunity to *gain experience of our lives*. In these terms, treatment of "mental illness," which we more properly define as psychopathological experience, includes the possibility of experiencing the life of a person: it is a *global* experience of the human being.

On the one hand, therefore, we shift the clinical paradigm from a detached observation aimed at a semeiological collection to an *understanding of the experiences that emerge from the encounter of a patient with a clinician*. In this way, the disposition of the latter, with its intersubjective and intercorporeal experience, becomes fundamental to diagnosis, as anticipated by Rümke in 1941 [54]. On the other hand, we want to free psychiatry from an implacable determinism, that of mental disease as an "unfortunate neurobiological accident." On the contrary, just as we consider the psychopathological experience to be *a possibility* of the human being, we equally consider *the dimension of care a possibility for every human being*. In this way, this psychiatry can claim its own epistemological-hermeneutical status, which recognizes part of its foundations within medicine and neurology (making use of neuroscience, but not flattening itself as being a type of neuroscience), while being willing to recognize part of its foundations in history and the humanities (hermeneutics, aesthetics, philosophy, and anthropology). The apparent fragility of psychiatry, which is not constituted as a monolithic science but, on the contrary, as a problematic and complex science, becomes an added value, in a world where the complexity of inter-human phenomena cannot be reduced to deterministic and stochastic simplifications. This status of psychiatry as a *science of the human*, that is, of her life in the world and of the conditions of her freedom, confers on it a centrality that is not only clinical but also *cosmological*, in the sense of the investigation and evolution of human and cultural worlds she inhabits. Every cosmos, every culture, every history, is such only because it is inhabited, felt, and experienced by a human [9].

Finally, we believe that bringing the question of the method back to the center of the psychiatric heartbeat raises the problem of training the psychiatrist, which cannot be limited to an organicist background and the uncritical application of nosographic categories, but must aim at educating his sensitivity, the taste, intuition, descriptive and linguistic ability, and, above all, ability to take care of humanity through specific training and maturation paths. Given that each of us as a human being is inclined and suited to the encounter with the other, and that such encounters happen through the type of immediate and embodied knowledge herein described, the real point of the question is the following: What kind of training is appropriate for giving the clinician the ability to read, precisely, the "embodied" score of a lived encounter? A musicologist or an oenologist can understand, by listening or tasting, the structure of a musical text or a wine. That is, they are able to reconstitute, by approaching the final product of an art, much of the

phenomenon or experience underlying these structures. There are no standardized machines or procedures to achieve this type of cognitive result. It is clear that it takes a predisposition, a vocation, a pleasure, and then an organoleptic exercise. However, the comparison between the inter-human encounter in the clinic and the phenomena of music and culinary arts does not hold up, since in music, or in the kitchen, or in visual art, we are dealing with sensorial processes; culturally refined, but sensorial. In contrast, in psychiatry, the encounter is with altered experience, it is a question of obtaining as rapidly, correctly, and usefully as possible, "data" from exquisitely "immaterial" experiences. Another conceptual step necessary to understand the clinical encounter through the notion of the lived body is the shifting of the center of gravity of the experience. Centuries of philosophy and psychology have confined the idea of mind or mental states within the boundary of the body or the skull, or the brain itself. The chest, the belly, the heart, the soul, the moods, the content of thought, and so on have always been placed inside. Here, however, it is a question of radically changing the perspective. We are faced with the outside. The phenomenon we want to understand is outside of us, and our "living" cognitive apparatus is also outside of us. If it were not outside of us, we could not use it. In the encounter with the patient, what we have thematized as mind is not placed or confined inside the patient, but outside; that is, in the lived space between us. In the encounter, the patient's mind and our mind are externalized, they interact in a *co-embodied* dimension that is outside, *trans-embodied*, evaginated by our two physical bodies, which keep their distance. Perhaps this is the hardest blow that brain-centric psychocentrism has to suffer.

References

1. Cuijpers P. Targets and outcomes of psychotherapies for mental disorders: an overview. World Psychiatry. 2019;18(3):276–85.
2. Pinel P. Traité Médico-philosophique sur l'aliénation mentale ou la manie. Paris. 1800;
3. Basaglia F. L'istituzione Negata. Milano: Baldini Castoldi Dalai; 1968.
4. Binswanger L. Der Mensch in der Psychiatrie. Pfullingen; 1957.
5. Newen A, De Bruin L, Gallagher S. The Oxford handbook of 4E cognition. Oxford: Oxford University Press; 2018.
6. Homer. The Iliad. Penguin Books; 1998.
7. Robinson TM. Heraclitus: fragments. University of Toronto Press; 1987. https://www.jstor.org/stable/10.3138/j.ctt1287wwg
8. Jaspers K. Allgemeine psychopathologie. Berlin: Springer; 1913.
9. Minkowski E. Traité de psychopathologie, 2 e éd. Paris: Le Plessis-Robinson; 1966.
10. von Weizsäcker V. Pathosophie. Göttingen: Vandenhoeck&Ruprecht; 1956.
11. La Schizophrénie ME. Psychopathologie des Schizoïdes et des Schizophrènes. Paris: Payot; 1927.
12. Vom SE. Sinn der Sinne: Ein BeitragzurGrundlegung der Psychologie. Berlin: Springer; 1930.
13. Masullo A. Logica, psicologia, filosofia. Un'introduzione Alla Fenomenologia. Napoli: Il Tripode; 1961.
14. Masullo A. Paticità e indifferenza. Milano: Il Melangolo; 2003.
15. Calvi L. Esercizi Fenomenologici D'uno Psichiatra Sulla carne, il sesso, la morte. Milano: Mimesis; 2007.

16. Stanghellini G. L'amore Che Cura. Milano: Feltrinelli; 2018.
17. Fuchs T. Ecology of the Brain: the phenomenology and biology of the embodied mind. Oxford: Oxford University Press; 2017.
18. Masullo A. L'Arcisenso Dialettica della solitudine. Macerata: Quodlibet; 2018.
19. Ales Bello An. Ontologia del femminile. Il pensare Rivista di filosofia. 2018;VII(7).
20. Binswanger L. Traum und Existenz. Einleitung von Michel Foucault. Bern/Berlin: Verlag Gachnang & Springer; 1992.
21. Binswanger L. DreiFormenmissglücktenDaseins: Verstiegenheit, Verschrobenheit, Manieriertheit. Tübingen; 1956.
22. Cargnello D. La schizofrenia come turbe della personalità. Archivio Psicologia Neurologia Psichiatrica. 1947;8(333).
23. Cargnello D. Alterità e alienità: introduzione alla fenomenologia antropoanalitica. Milano: Feltrinelli; 1966.
24. Del Pistoia L. Il giardino delle statue di sale. Lucca: PaciniFazzi; 1998.
25. Schneider K, Kranz H. PsychopathologieHeute: Professor Dr. med. Dr. phil Dr. jur. h.c. Kurt Schneider zum 75. GeburtstagGewidmet. Stuttgart: Thieme; 1962.
26. Quando CB, L'ombra V. Problemi di psicopatologia clinica. Roma: Edizioni Universitarie Romane; 1982.
27. Ballerini A. Patologia di un eremitaggio. Uno studio sull'autismo schizofrenico. Torino: Bollati Boringhieri; 2002.
28. Blankenburg W. Der Verlust der natürlichen Selbstverständlichkeit: Ein Beitrag zur Psychopathologie symptomarmer Schizophrenien. Stuttgart: Enke Verlag; 1971.
29. Maj M. Critique of the DSM–IV operational diagnostic criteria for schizophrenia. Br J Psychiatry. 1998;172(6):458–60.
30. Calvi L. Callieri e l'esperienza di fine del mondo. Comprendre. 2013;23:61–6.
31. Di Petta G, Tittarelli D. Atmos/Eidos. The life-world between form and formless. In: Psychopathology and atmospheres: neither inside nor outside. Cambridge Scholars Publishing; 2019.
32. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Assessing clinician's subjective experience during interaction with patients. Psychopathology. 2014;47(2):111–8.
33. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Association between Clinician's Subjective Experience during Patient Evaluation and Psychiatric Diagnosis. Psychopathology. 2016;49(2):83–94.
34. Fux L, Walger P, Schimmelmann BG, Schultze-Lutter F. The Schizophrenia Proneness Instrument, Child and Youth version (SPI-CY): practicability and discriminative validity. Schizophr Res. 2013;146(1–3):69–78.
35. Binswanger L. Wahn. Beiträge Zu seiner phänomenologischen und daseinsanalytische Erforschung. Pfullingen; 1965.
36. Calvi L. Empatia e relazionalità dopo Binswanger. Da Flaubert ai neuroni specchio. In: LudwigBinswangerEsperienza Della Soggettività e trascendenza dell'altro I margini di un'esplorazione fenomenologico-psichiatrica. Macerata: Quodlibet; 2006.
37. Calvi L. La coscienza paziente. Esercizi per una cura fenomenologica. Roma: Fioriti; 2013.
38. Basaglia F. Scritti 1953–1980. Milano: Il Saggiatore; 2017.
39. Husserl E. Logische Untersuchungen (1900). Hamburg: Felix Meiner Verlag. 2013.
40. Callieri B, Di Petta G, Maldonato M. Lineamenti di psicopatologia fenomenologica. Napoli: Guida; 1999.
41. WatsujiTetsuro. climate and culture: a philosophical study trans. from Fūdo (風土) by Geoffrey Bownas. Westport, CT: Greenwood Press; 1961.
42. Frattolillo O. Watsuji Tetsurō e l'etica dell'inter-essere: la costruzione di una relazionalità intersoggettiva. Milano: Mimesis; 2013.
43. Fuchs T. Das Unheimliche als Atmosphäre. In: Andermann K, Eberlein U, editors. Gefühle als Atmosphären. Neue Phänomenologie und philosophische Emotionstheorie. Berlin: Akademie Verlag; 2010. p. 167–82.

44. Lacan J. The ethics of psychoanalysis: the seminar of Jacques Lacan: Book VII: 7 (1959–1960). Routledge; 2007.
45. Maldiney H. Della transpassibilità, a cura di F. Leoni. Milano: Mimesis; 2004.
46. Tittarelli D. Io Matteo Il Fegato. In: Colavero P, editor. Storie Cliniche Fenomenologia e psicopatologia. Roma: Edizioni Universitarie Romane; 2014.
47. Krueger J. Watsuji's phenomenology of aidagara: an interpretation and application to psychopathology. In: Shigeru T, Altobrando A, editors. Tetsugaku Companion to Phenomenology and Japanese Philosophy, Tetsugaku Companions to Japanese Philosophy. Switzerland: Springer Nature; 2019. p. 165–81.
48. Di Petta G, Tittarelli D. Le psicosi sintetiche. Il contributo della psicopatologia fenomenologica italiana alle psicosi indotte da sostanze. Roma: Fioriti; 2016.
49. Di Petta G, Tittarelli D. The We-ness: a Dasein-analytical approach to group therapy. Phenomenological Approaches to Psychotherapy. In: T Fuchs, G Messas, G Stanghellini, Editors. Psychopathology International Journal of Descriptive and Experimental Psychopathology, Phenomenology and Psychiatric Diagnosis. Basel: Karger AG; 2019.
50. Heidegger M. Sein und Zeit. Halle; 1927.
51. Hersch E. From philosophy to psychotherapy: a phenomenological model for psychology, psychiatry, and psychoanalysis. Toronto: University of Toronto Press; 2003.
52. Messas G, Fukuda L. O diagnóstico psicopatológico fenomenológico da perspectiva dialético-essencialista. Revista Pesquisa Qualitativa. 2018;6(11):160–91.
53. Di Petta G. Il mondo tossicomane, fenomenologia e psicopatologia. Milano: Franco Angeli; 2004.
54. Rümke HC. Das Kernsymptom der Schizophrenie und das "Praecox-Gefühl". Z Gesamte Neurol Psychiatr. 1941;102:168–75.