Phenomenological Psychopathology and Care. From Person-Centered Dialectical Psychopathology to the PHD Method for Psychotherapy

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20.1 Introduction

We are a dialogue of the person with herself and with other persons. The crisis of the dialogue of the person with the alterity that inhabits her and with the alterity incarnated in the other person (through which we strive to build and maintain our personal identity and our position in the world) is at the heart of mental disorders. Schizophrenia is an exemplary case study of this interrupted dialogue between the person and herself in the general framework of dialectic person-centered psychopathology.

Central to human existence is a yearning for meaning, unity and identity. Yet, this attempt is unfulfilled in the encounter with alterity, that is, with all the powers of the involuntary: perplexing experiences, unwitting drives, uncontrolled passions and automatic habits leading to unintended actions, as well as needs, desires, impulses and dreams. And finally, one may encounter alterity in one's body, the impersonal and pre-individual element that is to each of us the closest and the remotest at the same time (Agamben 2005). One may feel forced to live in intimacy with an extraneous being—one's own body, that is, the a priori determined *What-ness* of *Who* we are. One may feel stuck with one's sheer biological body, its facticity, the raw material that constitutes the unchosen and sedimented part of one's being and sets the boundaries of one's freedom. *Who* one is stems from the fragile, complex and obscure dynamics of the voluntary efforts to make sense of the involuntary *What* inherent in human personhood.

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All this generates feelings of estrangement. Mental symptoms can be read as miscarried attempts to struggle for a sense of reconciliation, to heal the wounds of disunion. Only when I recognize the alterity that inhabits me as an incoercible datum can I begin to use it in my service. Care is an attempt to re-establish such a fragile dialogue of the soul with herself and with others. Such an attempt is based on one pillar: a dialectic, person-centered understanding of mental disorders. Its aim is to improve both our understanding of mental symptoms and syndromes and our therapeutic practice in mental health care.

20.2 Person-Centered Dialectic Psychopathology

The dialectic understanding of mental disorders acknowledges the vulnerability constitutive of human personhood. It assumes that the person is engaged in trying to cope, solve and make sense of new, disturbing, puzzling experiences stemming from her encounter with alterity. Each patient, urged by the drive for the intelligible unity of her life-construction, with her unique strengths and resources, plays an active role in interacting with these experiences. The product of this yearning for meaning can be establishing a new identity, or producing psychopathological symptoms. These are the outcome of a miscarried attempt to make sense of one's disturbing experiences (Stanghellini and Rosfort 2013). Psychopathological symptoms are not simply the direct outcome of some kind of dysfunction or of a 'broken brain'. A person's symptom is not generated as such—as it was the case with Minerva, who sprang fully armed from Jupiter's head. Rather, it is the outcome of the need for self-interpretation that each person has with respect to her encounter with alterity, that is, with challenging, unusual or abnormal experiences.

The psychopathological configurations that human existence takes on in the clinic are the outcome of a disproportion between the person and her encounter with alterity, including the disturbing experiences that stem from this encounter. Alterity is made manifest as a kind of estrangement from oneself and alienation from one's social environment. Faced with new, puzzling experiences, the person tries to make sense of them. The attempt to achieve a self-interpretation of her perplexing experiences characterizes the person's attitude, alongside a comprehending appropriation, that is, the constant search for personal meaning.

The encounter with alterity may offer the vantage from which a person can see herself from another, often radically different and new, perspective. Thus, otherness kindles the progressive dialectics of personal identity. Narratives are the principal means of integrating alterity into autobiographical memory, providing temporal and goal structure, combining personal experiences into a coherent story related to the Self. Yet, the encounter with alterity is also the origin of mental symptoms. The

production of a symptom is the *extrema ratio* for alterity to become discernible. The symptom is the last chance for the person to recognize alterity in herself. The patient, as a self-interpreting agent who interacts with her anomalous experiences, 'works through' them in such a way that they become symptoms. Psychopathological symptoms are the outcome of miscarried attempts to give a meaning to distressing experiences, to explain and to cope with them. Psychopathological symptoms arise when one's tacit background preconceptions and ways of interpreting the world fail to incorporate some kind of anomalous experiences, i.e. to make them into something that makes sense. Preconceptions (in the sense of Gadamer's *Vorurteil*, which can be translated prejudgments, presuppositions and prejudices) 'are conditions whereby we experience something—whereby what we encounter says something to us' (Gadamer 2008, p. 9; Fernandez submitted, Fernandez and Stanghellini, in press). In response to anomalous experiences, new preconceptions are enacted. This results in a fundamentally different conception of the world, in whose framework anomalous experiences are no longer 'anomaly' to the experiencing person—as it is typically the case with people who develop psychotic symptoms.

The main difference between this person-centered dialectic understanding of mental disorders and a reductionist model is that in the latter the patient is conceived as a passive victim of her symptoms, whereas the former attributes to the patient an active role in shaping her symptoms, course and outcome. Urged by the painful tension that derives from the drive for the intelligible unity of life-construction (Mayer-Gross 1920), each patient, as a 'goal-directed being', plays an active role and stamps her autograph onto the raw material of her basic abnormal experiences.

This person-centered, dialectic approach helps us to see the patient as meaning-making entity rather than passive individual (Stanghellini et al. 2013). The patient 'can see himself, judge himself, and mould himself' (Jaspers 1997). His attempts at self-understanding are not necessarily pathological and are potentially adaptive.

This approach contains a theoretical framework and practical resources for understanding the diversity of psychopathological structures, including symptom presentation, course and outcome as a consequence of the different ways patients seek to make sense of and value the basic changes in self and world experiences. It also contains a framework for engaging with human fragility by means of a person-centered, dialectic therapy.

The person-centered, dialectic approach involves two fundamental attitudes to mental illness:

- It is a therapeutic approach that acknowledges the subjective fragility constitutive of human personhood.
- It also insists, however, on our responsibility to care for this fragility for becoming the person that we are.

To become the person that we are, we must become aware of what we care about—or our own values—because being a person is to take upon oneself the responsibility involved in what one cares about. This approach is sensitive to the constitutional fragility of Who and What we are and thus conceives psychopathological structures as the result of a normative vulnerability intrinsic to being a human person. It insists that to help a suffering person is to help that person to responsibly deal with the obscure entanglement of freedom and necessity, the voluntary and involuntary, and with her sufferings as the result of the collapse of the dialectic of selfhood and otherness.

20.3 What Is a Symptom?

Handbooks usually present a list of phenomena that should be assessed and treated. By doing so, they establish a system of relevance concerning what should attract the clinician's attention. These relevant phenomena are called 'symptoms'.

Of course, there are different psychopathological paradigms (among which the biomedical, the psychodynamic, the phenomenological, etc.), and each paradigm has its own hierarchy of priorities (what should be the clinician's focus of attention) as well as its own concept of symptom. As a consequence, the concept of symptom covers a vast array of indexicalities (Stanghellini 2013a). In biological medicine, a symptom is the epiphenomenon of an underlying pathology. Red, itchy and watery eyes, congestion, runny nose and sneezing, sometimes accompanied by itchy ears and a buzzing sound, itchy and sore throat, cough and postnasal dripping are known to be the manifestations of an inflammation of the respiratory apparatus.

But long before we discovered the cause of these disturbing phenomena (namely, rhinovirus infection), we all knew that they were the symptoms of a mild, although distressing and untreatable, disorder called the common 'cold'. Within the biomedical paradigm, a symptom is first of all an index for diagnosis, i.e. it is used by clinicians to establish that the person who manifests that symptom is sick (rather that healthy) and that he or she is affected by a particular illness or disease.

The principal utility of any system of medical taxonomy relies on 'its capacity to identify specific entities to allow prediction of natural history and response to therapeutic intervention' (Bell 2010, p. 1). The biomedical understanding of 'symptom' is clearly coherent with this. Biomedical research aims to sharpen its tools to establish increasingly more reliable and valid diagnostic criteria. Its real ambition is not simply to establish a diagnosis through the assessment of clinical manifestations (i.e. symptoms), but to discover the causes of these symptoms (aetiology) and the pathway that leads from aetiology to symptoms (pathogenesis). 'Ultimately, disease specification should be related to events related to causality rather than simply clinical phenotype' (Bell 2010, p. 1). It is assumed that progress

in medicine is dependent on defining pathological entities as diseases based on aetiology and pathogenetic mechanisms—rather than as clinical syndromes based on symptom recognition. In the biomedical paradigm, the truth about a symptom is its cause. The main, more or less explicit, assumptions in the biomedical paradigm are the following: (1) Each symptom must have at least one cause, (2) this cause lies in some (endogenous or exogenous) *noxa* affecting the living organism, and (3) the presence of a symptom causes some kind of dysfunction (cause → symptom → dysfunction). Also, (4) if we want to eliminate a symptom, we should eliminate its cause or interrupt the pathogenetic chain that connects its putative aetiology with the symptom itself. Thus, the biomedical paradigm is a knowledge device based on the concept of 'causality'. In general, causality (in the biomedical paradigm) goes from aetiology (in our example, the presence of a virus), to symptom(s) (breathing difficulties), to dysfunction (poor physical performance due to blood hypo-oxygenation and thus reduced adaptation of the person to his or her environment).

An important, implicit assumption is also that symptoms are considered accidental—i.e. non-essential to the living organism—whereas the absence of symptoms is considered essential—i.e. normal to living organisms. In other terms, health is considered normal, whereas disease is considered abnormal.

Many of these assumptions—if we apply this paradigm to the field of mental pathology—are at least controversial or even counterfactual. What is of utmost interest here is the fact that in the biomedical paradigm, symptoms have causes, not meanings. Also, we can assume that a symptom is not an accident to that person; rather, it displays his true essence. As such, it is the contingent opportunity of a possible encounter between the person and alterity. Symptoms are the via *regia* to recognition as they express the person's vulnerability. Someone's *vulnus* displays what is most personal and intimate to him. 'Come inside—says Eumaeus to Ulysses when he arrives at his hut—and when you have had your fill of bread and wine, tell me where you come from, and *all about your misfortunes*' (Homer 2005, XIV, p. 47). Only after Odysseus had a hearty meal of pork does Eumaeus ask about his story: 'And now, old man, tell me your own story; tell me also, for I want to know, who you are and where you come from. Tell me of your town and parents, what manner of ship you came in, how crew brought you to Ithaca, and from what country they professed to come-for you cannot have come by land'.

The recognition of Ulysses in the episode of Eurycleia—Ulysses' wet nurse—comes with the recognition of his scar. As Eurycleia is putting Ulysses' feet in a basin of water, she notices a scar on one of his feet. She immediately recognizes it as the scar that he received when he went boar hunting with his grandfather Autolycus: 'As soon as Eurycleia had got the scarred limb in her hands and had well hold of it, she recognized it and dropped the foot at once. The leg fell into the bath, which rang out and was overturned, so that all the water was spilt on the ground; Eurycleia's eyes between her joy and her grief filled with tears, and she could not speak, but she caught Ulysses by the beard and said, "My dear child, I am sure you must be Ulysses himself, only I did not know you till I had actually touched and handled you"' (ibid., XIX, p. 392).

This myth has a clear correspondence in Karl Jaspers' concept of 'cypher' (Jaspers 2003). 'Cypher-reading is the primary requisite of manhood' (Jaspers 2003, p. 50). Cypher reading is an essential character of the human being. Cyphers show what without them would remain implicit for us. Symptoms are a special category of cyphers: through them alterity, that is, the hidden yet operative (and perplexing or disturbing) dimension of our existence, is made manifest. Like a patient's symptom, which is not accidental to that patient but is rather the manifestation of his or her true identity, cyphers are the contingent opportunity of recognition, that is, of a possible encounter between the person and the encompassing dimension of her existence.

The cypher must keep on an inexhaustible signification with which no definite interpretation is commensurate (Jaspers 2003, p. 42). If the cypher 'becomes fixed and definite and turns into an object, then it loses its essential force. It collapses into a sign' (Jaspers 2003, p. 49). Cyphers must not be crystallized into a kind of definite, categorical concept. The meaning(s) of the cypher must be kept 'in suspension' (Jaspers 2003, p. 38), i.e. remain *unsaturated*. The defection from the cypher to the pure concept (as occurs when the cypher grows a single meaning), as well as the interpretation of a cypher as if it were a symbol (such as when the cypher is interpreted through an 'other'), destroys the force of the cypher.

20.4 Symptoms in Phenomenological Psychopathology

Phenomenology is essentially concerned with laying bare the structure of the lifeworld inhabited by a person (Stanghellini and Rossi 2014). A symptom is a feature of a person's lifeworld whose meaning will be enlightened by grasping the deep architecture of the lifeworld itself and the person's invisible transcendental structure that projects it. The lifeworld is the original domain, the obvious and unquestioned foundation of our everyday acting and thinking. In its concrete manifestations, it exists as the 'realm of immediate evidence'. Although the majority of people are situated within a shared lifeworld, there are several other frameworks of experience—for example, fantasy worlds, dream worlds and 'psychopathological worlds' (Schutz and Luckmann 1989). Abnormal mental phenomena are the expression of a 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 (Stanghellini and Rossi 2014). The experience of time, space, body, self and others, and their modifications, are indexes of the patient's basic structures of subjectivity within which each single abnormal experience is situated. We can rephrase and extend all this as follows: the non-experienced ontological disturbances of the basic structures of subjectivity, i.e. selfhood, produce anomalous experiences. In response to these alterations of experience, generated by a variation at the ontological level, a new set of preconceptions are enacted. These anomalous experiences act as a catalyst for the shift of the person's background preconceptions about the world since these

preconceptions are not sufficient to make sense of the person's experiences. In the framework of this new set of preconceptions, anomalous experiences are 'normalized', become meaningful to the experiencing person and are integrated as part of his personal identity.

Before we proceed in this direction, I need to clear the ground of a possible misunderstanding. To consider phenomenology as a purely descriptive science of the way the world appears to the experiencing subject is a serious mistake, although it is true that phenomenology sponsors a kind of seeing that relates to something already there, rather than to what stands before, beyond or behind what is existent. 'Making the invisible visible' can instead be taken as the motto of phenomenology, just as it was the passion that possessed many of the artists of the twentieth century and the intellectual motor of the major scientists of the 'invisible century', including Einstein and Freud, in their search for hidden universes.

The symptom is conceived as a part of a discourse, to be deployed and analyzed as a text. The issue, then, is how to rescue its invisible and unintended meaning. All human deeds can be produced or reproduced as a text. The text—be it oral or written—is a work of discourse that is produced by an act of intentional exteriorization. One of the main characteristics of a text is that once it is produced, it is no more a private affaire, but is of the public domain. It still belongs to the author, but it also stands independent of the intentions of the author.

The externalization of one's actions, experiences and beliefs via the production of a text implies their objectification; this objectification entails a distantiation from the person herself and an automatization of the significance of the text from the intentions of the author. Once produced, the text becomes a matter for public interpretation. Now, the author's meanings and intentions do not exist simply for himself, but also for another.

This process of objectification and of automatization is nicely described in Hegel's theory of action (Berthold-Bond 1995). Indeed, there is a parallel between a text and an action. Just as every action involves a recoil of unintended implications back upon the actor, every text—including symptoms—implies a recoil of unintended meanings back upon its author.

Whenever we act, via the externalization of our intentions, we experience a kind of alienation and estrangement from ourselves. We discover alterity within ourselves. The symptom deployed as a text exposes its author to this very destiny. A text is the product of an action—a linguistic action. Like all actions, once produced the text shows the disparity between the author's conscious intentions and unintended consequences. The symptom exposed like a text recoils back upon its author, displaying the discrepancy between the private intended sense and its public tangible result. The text, as the tangible result of a linguistic act with its unintended consequences, reflects—in the sense of making visible—the 'mind' of the author much more faithfully than a simple act of self-reflection. To paraphrase Hegel, the 'mind' cannot see itself until it produces a text objectifying itself in a social act. Because all conscious intentions are incomplete, self-reflection is just an incomplete form of self-knowledge. A person cannot discern alterity within himself until

he has made of himself an external reality by producing a text and after reflecting upon it.

The production of a symptom is simply a particular case of this general rule. Just as in a text, in the symptom alterity becomes manifest. A symptom is the outcome of an interrupted dialogue between the person and alterity. The symptom is nothing but a text by which an unrecognized alterity is made manifest. When alterity is no more integrated into the narrative the person fabricates about herself, a symptom is produced as an *extrema ratio* for alterity to become discernible. The symptom is the last chance for the person to recognize herself.

This is a kind of understanding that 'seeks to find the logos of the phenomena in themselves, not in underlying subpersonal mechanisms' (Fuchs 2008). The symptom, then, is an anomaly, but not an abnormal, aberrant or insane phenomenon in a strict sense. Rather, it is a salience, a knot in the texture of a person's lifeworld, like a tear in the matrix. It is a place that attracts someone's attention, catches one's eyes and awakens one's care for oneself—as we will see in great detail in the section on the person-centred dialectical (PCD) model. The symptom reflects and reveals alterity in oneself—in it alterity becomes conspicuous. From the vantage offered by the symptom, one can see oneself from another, often radically different and new, perspective.

20.5 Selfhood and Personhood in Schizophrenia

In recent years, schizophrenia has been conceptualized as a disorder of the minimal Self. The self-disorder hypothesis conceives schizophrenia as a basic disturbance of the sense of self. The notion 'selfhood' serves to investigate the pre-reflective structures and dynamics of experience. The Self is the subject of his perceptions, feelings, thoughts, volitions and actions. The phenomenological notion of the Self serves to explore the fact that we live our conscious life in the first-person perspective, as an embodied, self-present, single, temporally persistent and demarcated being. This basic form of self-experience is implicitly, pre-reflexively and non-observationally manifest. It is usually called 'minimal' self or 'core' self, referring to a minimum of what must be the case for an experience to be considered 'subjective' at all and which must be in place in order for an experience to be someone's experience, rather than existing in a free-floating state and only appropriated post hoc by the subject in the act of reflection. The minimal self is the pre-reflective sense of existing as a vital and self-identical subject of experience, which serves as a necessary foundation for the articulation of a richer reflective and narrative representation.

It was noted already at the outset of the modern notion of schizophrenia that these basic aspects of the structure of subjectivity (and not merely a change in the *contents* of experience and action) may become altered in this illness. The complaints of persons affected by schizophrenia point to the disruptions of formal or structural aspects of the minimal self. Abnormal self-experiences in schizophrenia can be divided into three main domains:

Self-presence: This includes a troubled sense of self (e.g. 'I don't feel myself', 'I am losing contact with myself') and an alienated sense of self (e.g. 'I am almost nonexistent'; 'I have a strange ghostly feeling as if I were belonging to another planet').

Perspective: This is mainly the loss of first-person perspective (e.g. 'I have thoughts rather than being thoughts (...) having thoughts [means that] the thoughts are delimited; you can hear or see them').

Phenomenality: This includes loss of 'immersion' in the world (e.g. 'I live only in the head') and hyper-reflexivity (e.g. 'I'm always in the mode of simultaneous introspection', 'Whenever I see something I also think of myself seeing it').

An extended account on this, including the main references, is given by Henriksen and Nordgaard in this book as well as by Sass and his colleagues.

The self-disorder hypothesis provides a very rich and detailed account of the experiential dimension of the schizophrenic condition. Yet one may wonder what is the role of the person who is affected by these abnormal experiences in *reacting* to the experiences themselves.

Focusing on troubled selfhood brings to light the patients' immediate subjective experiences, e.g. their feeling ephemeral and lacking core identity, affected by a diminished sense of existing as a self-present subject. Self-disorders have been conceptualized as the core of the vulnerability to schizophrenia. What may remain out of focus in these descriptions, though, is the person's attitude towards these anomalous experiences. Taking into account the notion of personhood allows for an articulation of the way the suffering person *reflectively responds* to and makes sense of her troubled selfhood (Stanghellini and Rosfort 2015). This can help to develop a person-centred psychopathology of schizophrenia that is concerned not only with the phenomenological description of troubled selfhood, but also with how persons with schizophrenia understand themselves and interpret their own anomalous experiences. By bringing into focus the question of personhood (rather than only selfhood), we draw attention to the person's attitude towards her anomalous experiences and to the active role that the person, as a self-interpreting agent with her individual existential orientation (Stanghellini et al. 2013), has in interacting and coping with these experiences and in the shaping of psychopathological symptoms and syndromes.

In order to give a more comprehensive account of the schizophrenic condition, we must take into account the notion of 'personhood' in addition to the notion of 'selfhood'. The notion of personhood is markedly more comprehensive than the notion of selfhood. 'Selfhood' articulates the phenomenological dimension of our experience of being human. 'Personhood' requires a hermeneutical elaboration of the phenomenological method, bringing into account the *normative* dimensions of human experience. This hermeneutic qualification of phenomenology deals with the fact that first-person experience is not merely concerned with self-awareness and experiential objects but also with *how* the experienced objects and the sense of being a self are experienced as an integral part of a person's life. Hermeneutical phenomenology deals with *how* we respond to and interpret the questions that our

self-awareness and phenomenal consciousness give rise to. Whereas phenomenology deals with the *What* of experience, hermeneutical phenomenology deals with the way the *Who* takes care of the *What*.

20.6 A Case Study

An illustration of the vulnerable duplicity inherent in the human condition and of the emergence of symptoms as the cypher of a miscarried dialogue with alterity can be taken from the following case study:

A man in his twenties is very keen to describe the abnormal experiences affecting him:

> I had these strange energies inside. It all started like this. I felt as if my body was sending me messages from another place. I was different from all the others. Distinct from them. Separate from my body and from them. A funny funny feeling, although it made me feel very vulnerable in front of others as it in most cases happened when I was with others.

As one can see, his abnormal experiences include two main categories: abnormal bodily phenomena (coenesthopathies) and disorders of intersubjectivity (dissociality). He feels 'strange energies', a kind of force that to him is hard to explain and make sense of and even to express with an ordinary vocabulary. These energies are 'strange', perplexing and awkward. They are ambiguous as they are 'funny' but they also make him feel 'vulnerable'. They elude ordinary language as well as ordinary evaluation since they are neither good nor bad. One may say that he experiences a kind of bodily arousal, but contrary to what one normally would say about this he does not say that these feelings are part of one (or more) emotions that are elicited in a given situation. Another sense in which these feelings are 'strange' is that these 'energies' are located in some part of his body, but in a space that is outside his self-boundaries, 'as if' they came from without. He feels 'separate' from his body and 'distinct' from these. In short, his feelings are 'other' with respect to ordinary meaning (what are they?), function (what are they for?), language (how can one talk about them?), value judgment (are they good or bad?), origin (do they come from me or not?) and spatial location (are they inside or outside my Self?).

Also, these strange sensations are closely connected to abnormal interpersonal experiences. They mainly take place during social encounters. They make him feel 'different' from other persons and 'distinct' from them. By 'different' he may mean that he feels that he does not belong to the human community, and by 'distinct' he may mean that he feels a kind of separated when he is in social circumstances—a lack of grip or hold in situations that would otherwise involve interpersonal contact or attunement.

Obviously, for him this is all in need of some meaning and of some explanation. He needs to 'work through' these abnormal experiences and makes sense of them:

> At first, I thought someone was poisoning me. Then I realized that I lacked the internal wisdom that leads you in life. And all of sudden there came this intuition: that They had chosen me for the experiment.

In these sentences, there is a *Who* trying to make sense of the *What* of his uncanny experiences. His first 'interpretation' of his strange experiences is quite coarse: he thinks that someone is poisoning him. This explains his feeling of weakness and vulnerability. He feels bad because someone infected him with some toxic substance. He develops an explanation that leads him to a delusion of a paranoid kind. I would call this an 'ontic' (Stanghellini 2009) working-through as if there is really nothing unusual, odd or 'bizarre'. This kind of working-through expresses the rather common-sense, universal fear to be damaged by someone or something.

Later he develops a second kind of interpretation, far more out of touch with common sense than the previous one. His strange feelings derive from a quality that he possesses and the others don't. This quality is that he lacks the 'internal wisdom' that leads all the others in their lives and makes of them ordinary people. He considers this not as a deficit, but rather as a gift—or, as we may say, a *charisma*. Since he was gifted with this charisma, 'They' chose him for the experiment. Let's have a closer look at this gift. It is not the prey of common sense in the way as his other interpretations. Common sense is a kind of 'wisdom' that implies conformity. 'They' appreciate his nonconformity. This is why he has been *chosen*.

Although 'They' are conducting an 'experiment' on him, this is not meant to harm him (as was the case with the first paranoid interpretation). 'Their' intention is radically different from the one expressed in the ontic working-through (poisoning). What 'They' want to do with him is near to creating a 'new' man, a new kind of human being with a special destiny.

Note that 'They' express an impersonal entity—whereas in the previous 'ontic' interpretation the others who poison him are other persons, ordinary people. 'They' are to be imagined as nonhuman, extraterrestrial entities. They are located in a non-time, non-space, that is, they are 'now', 'here' and 'now-here'. They possess extraordinary powers and act and affect reality by means that are not reducible to ordinary causality. In short, 'They' belong to another reality, that is, to a lifeworld or ontological dimension where space, time, body, causality, etc. are different from our own. This extraordinary structure or scaffolding is the 'bizarre' quality of the lifeworld to which 'They' and the patient himself belong.

Also note that this interpretation comes as a sudden intuition, as a kind of 'Ah-ah!' experience that enables the patient to make sense of all strangeness affecting him. It is not the effect of a deductive or inductive process. It is based in his abnormal experiences, but he does not present it as the outcome of reasoning. Rather, his 'new' understanding has the character of a *revelation*. Being for him a revelation, it does not need to be validated or corroborated by some 'facts'. He would not agree to call his understanding an 'interpretation', since his 'intuition' has to him the character of an absolute and indubitable truth, whereas an interpretation has the perspectival character of a subjective belief. Indeed, you cannot find a

real development from his first to his second working-through. Although he mentions a first and a second understanding of his abnormal experiences, these are not set in a historical context. History would make of his intuition a relative, rather than absolute truth. For an idea to be absolutely true, it has to be set out of history, and this is what revelation does: it discloses an unhistorical truth uncovering a fact that has always been there.

> I was chosen to incarnate myself in one body and to come to the Earth. This explained why I felt a stranger in my body. And a stranger on the Earth too. It was worthwhile. The Earth is a very élite place to go through to reach a planet that is higher in evolution. Here on planet Earth everything is a task, even drinking a cup of coffee. My destination after this is a place where everything is vibration, a pure state of consciousness, so elevated that everything is peace.

Once he realized that 'They' had chosen him because of his charisma, his abnormal sensations become all of a sudden meaningful to him. Especially his abnormal *bodily* sensations get a new meaning: the body in which he feels so uncomfortable is not his own body; rather, 'They' 'incarnated' him in one body. The body into which he was thrown is an impersonal body—that's why he feels a stranger in it. One can imagine that before 'They' incarnated him in that body he was living as a disembodied spirit. One can also visualize the scenario in which all this took place: his disembodied spirit was deposited by 'They' into one of the soulless bodies stored in some place in the universe. This is obviously reminiscent of Gnostic theories of being imprisoned in a body and being a stranger on the Earth. The important thing here is that after he had his 'intuition', everything—including bodily and world experiences, as well as the difficulties he has in performing everyday tasks ('drinking a cup of coffee')—became parts of a meaningful and coherent lifeworld. His explanation is *ontological* in nature (Stanghellini 2009) since he achieves an understanding of single experiences via framing them into a totally new set of prejudices that radically depart from common sense. Because of this ontological working-through, bizarre as they can be, his experiences are not insignificant to him—and they are not meaningless to us too. He believes he is not a human being that belongs to planet Earth, but a traveller who has to go through the 'lower world' in order to deserve a 'higher' place. The Earth is not his destination, but a stage in his personal evolution.

It's very important to note that his belief is framed within a positive and even euphoric emotional state ('It was worthwhile', 'the Earth is a very elite place'). Also, his understanding of his own condition is coherently embedded in a very well-defined value structure (Stanghellini and Rosfort 2015). What matters for him is reaching his 'destination', no matter how painful or difficult this can be. Disembodiment to him is destiny. He thinks of himself to be a disembodied Self: this is to him not only his point of departure but also his destination as a form of life characterized by being 'pure consciousness' in a planet where 'everything is vibration'.

> Well, I must admit that all this started when that girl refused my 'intentions'. . .

Abnormal experiences are embedded in the patient's life history. They began, or at least became more severe and distressing, when 'that' girl rejected his *advances*. This comes as a confession after his spontaneous long and detailed descriptions of his feelings and beliefs. This admission posits the whole story in a meaningful context. Although it may sound odd that a full-blown psychotic state develops out of one's love being rejected, the revelation of this traumatic experience sets it in a framework that includes some type of psychological continuity, motivation and meaningfulness. Traditional psychopathology has always been sceptical about pathogenic hypotheses linking traumatic events and severe psychopathological states like schizophrenia (Stanghellini 2013b). Jaspers (1997) insists that empathic understanding fails when it comes to certain kinds of abnormal phenomena like, for instance, delusion proper and maintains that the 'primary experiences', i.e. the background metamorphosis of consciousness underlying delusions proper, are beyond the reach of understanding. Yet our patient's 'confession' suggests that we can apply psychological understanding based on meaningful connections in order to shed some light on his uncanny experiences of self- and world transformation. Jaspers' ill-famed 'theorem of incomprehensibility' (Baeyer 1979) applies to the formal aspects of psychotic experiences, not to their contents and meanings (Fernandez and Stanghellini, in press). To make sense of a given phenomenon is finally to posit it in a meaningful context, trying to grasp how psychic phenomena 'emerge' out of each other in the context of the life history of a given person.

20.7 The Person-Centered Dialectical Model

The main characteristic of the PCD model of mental disorders is that it seeks to see clinical phenotypes and abnormal forms of existence as the outcomes of the interaction between the *Who* (the person) and the *What* (her experiences). It emphasizes the importance of the involuntary, a priori determined Whatness of Who we are. But also it emphasizes the importance of the role of the Who in trying to make sense of his experiences. A good way to approximate the meaning of the Whatness of an experience is to see it in the light of Ricoeur's (1966) notion of 'experienced necessity' or the experience of necessity—of what we did not and cannot choose. This notion comes close to that of sheer biological life (Agamben 2005), but also to what Heidegger (2010) called *Geworfenheit*, in the sense of being stuck with the particularity of one's situation. Notions like instinct, emotion, habit, character, unconscious, etc., belong to the circle of the involuntary.

The involuntary dimension of our being the person that we are includes *What* is a priori given in our existence, the raw material that constitutes the sedimented part of our being and sets the boundaries of our freedom: our past (e.g. a traumatic experience), our body (e.g. our emotions and drives) and the world (e.g. its rules and values) in which we are thrown. *Who* we are stems from the fragile, complex and obscure dynamics of the voluntary efforts to make sense of the involuntary *What* inherent in human personhood. Only as I recognize my involuntary as an incoercible datum can I begin to use it in my service.

When a clinical syndrome manifests, the line of the pathogenetic trajectory is the following:

1. An extreme disproportion of vulnerability and person, of experience and understanding, of emotions and rationality, of *pathos* and *logos* and of selfhood and otherness—that is, of the voluntary and involuntary aspects of being a person—bringing about an uncanny metamorphosis of the lifeworld
2. A miscarried auto-hermeneutics of one's abnormal experiences and of the transformations of the lifeworld that they bring about
3. The fixation in a psychopathological structure in which the dialectics between the person and her vulnerability gets lost

The PCD approach helps us to see the patient as meaning-making entity (as the involuntary becomes meaningful only *for* the voluntary), rather than passive individual. The patient 'can see himself, judge himself, and mould himself' (Jaspers 1997). The 'matter' of vulnerability receives explicit form from the intention of the person. His attempts at self-understanding are not necessarily pathological and are potentially adaptive. Pathology is not vulnerability itself. Rather, it is the loss of the dialectics between a person and her vulnerability, the voluntary and the involuntary.

20.8 Advantages of the PCD Model

In our case study, the PCD model provided a theoretical framework to explore self-disorders and the way our patient's position-taking generated his particular schizophrenic phenotype. The PCD model

1. Articulates the *dialectics* of the impersonal and personal aspects of illness
2. Provides a solid framework for the *narrative articulation* of the patient's position-taking to her abnormal experiences and her attempt to cope with those experiences by working through her troubled sense of identity
3. Brings out the fundamental role of *values* that inform and shape a person's attitudes to the disturbance of her sense of selfhood and identity

In this way, it secures the autonomy of the patient by evidencing the importance of the patient's interpretation of her suffering.

The PCD model involves two fundamental attitudes to mental illness:

– It is a therapeutic approach that acknowledges the subjective fragility constitutive of human personhood.
– It also insists, however, on our responsibility for being the person that we are.

To become the person that we are, we must become aware of what we care about because being a person is to take upon oneself the responsibility involved in what one cares about. Health is preserved through the dialectics of the involuntary and

the voluntary as the appropriation of the involuntary by the voluntary, as we do not choose our involuntary, but we can decide to appropriate it. This therapeutic approach is sensitive to the constitutional fragility of who and what we are and thus conceives psychopathological structures as the result of a normative vulnerability intrinsic to being a human person. It insists that to help a suffering person is to help that person to responsibly deal with the obscure entanglement of freedom and necessity, the voluntary and involuntary, and with her sufferings as the result of the collapse of the dialectic of selfhood and otherness.

The PCD model has important *diagnostic implications* since it serves to establish a two-tier diagnostics. It integrates the self-disorder model, as it helps to disentangle basic vulnerability (first tier) from personal 'reaction' and emotional tone (second tier). This approach contains a theoretical framework and practical resources for understanding the diversity of psychopathological phenotypes, including symptom presentation, course and outcome as a consequence of the different ways patients seek to make sense of the basic changes in self and world experiences.

The PCD model also has *therapeutic implications*. It enhances insight and awareness of illness by shifting their focus from full-blown symptoms (e.g. delusions and hallucinations) to more basic manifestations of vulnerability. It helps to take a reflective stance with respect to her vulnerability, that is, to articulate it in a better expressive and communicative format and to construe it as situated in a personal-historical as well as a relational-interpersonal context. It enhances efforts to modify position-taking and construing different and more effective narratives of illness and interpretation of anomalous experiences.

This approach, in building on patients' individual values and experiences as key aspects of their self-understanding of their suffering, supports recovery and development of self-management abilities. It also contains a framework for engaging with this fragility by means of a PC, dialectical therapy. The aim of such a therapy is to re-establish the dialectics of a person and vulnerability that will allow the suffering person to become who she is.

20.9 The PHD Method

Building on and extending these principles, the PCD therapeutic interview is based on the integration of three basic dispositives:

– *Phenomenological unfolding* (P): The basic purpose is to empower clinicians and patients with a systematic knowledge of the patient's experiences. This is done through a process of unfolding that aims to open up and lay bare the furrows and layers of the patient's experiences. What comes into sight is the *texture* that is immanent in the patient's style of experience and action, although it may remain prima facie invisible to or unnoticed by her. Unfolding enriches understanding by providing further resources in addition to those that are immediately visible. The aim of this process is sometimes referred to as 'thick description', in contrast to the explanations of causal analyses. It aspires to force

the tacit, implicit and opaque structure to the surface of awareness and to collect a range of phenomena that point to multiple facets of a potentially significant construct. The final purpose is to rescue the *logos* of the phenomena in themselves, that is, in the immanent intertwining of phenomena.

– *Hermeneutic analysis* of the person's position-taking towards her experience (H): The central idea of clinical hermeneutics is that there is an active interplay between the person and her basic abnormal experiences. If we assume that a given set of abnormal experiences are the *core Gestalt* of a given type of vulnerable structure, then we can assume that the manifold, fluctuating and state-like phenotypes are the consequence of the vulnerable person's individual position-taking in response to this state-like, structural core anomaly. As self-interpreting animals, we continuously strive to make a *logos* out of *pathos*. In psychotherapy, attention is paid to the active role that the person has in taking a position and interacting with her abnormal, distressing and dysfunctional experiences. Her attempt at self-understanding and coping are determined by her unique strengths and resources as well as needs and difficulties. Hermeneutic analyses aim at rescuing the patient's active role in shaping her symptoms, course and outcome. Although the patient's attempts may generate a miscarried self-understanding, they are not necessarily pathological and potentially resilient.
– *Dynamic analysis* of the life history in which abnormal experiences and position-taking are embedded (D): To make sense of a given phenomenon is finally to posit it in a meaningful context, and this context includes the personal history of the patient. The basic presuppositions of psychodynamics, endorsed by the PHD method, are psychological continuity and psychological determinism. The former assumes that the totality of a person's psychological events (including those that look inconsistent) is lawful and potentially meaningful in a particular way for that person. The latter presumes that all psychic events have at least as one of their 'causes' a psychological motivation and can thereby be understood on a psychological basis. Dynamic analysis tries to grasp how psychic phenomena 'emerge' out of each other in the context of the life history of a given person. More precisely, it tries to approximate how they stem from *involuntary* factors that restrict, enable and form our lives This involuntary dimension of our being the person that we are includes *what* is a priori given in our existence, the raw material that constitutes the sedimented part of our being and sets the boundaries of our freedom: our past (e.g. a traumatic experience), our body (e.g. our drives) and the world (e.g. its rules and values) in which we are thrown. *Who* we are stems from the fragile, complex and obscure dynamics of the voluntary efforts to make sense of the involuntary *What* inherent in human personhood. Through dynamic analysis, 'what sedimentation has contracted, narrative can redeploy' (Ricouer 1966).

20.10 Phenomenological Psychopathology and Care

The challenge facing the clinician is how to offer the patient an insight into her fragile personhood, that is, into the alterity she experiences in herself, as well as helping her to understand the way she tries to make sense of this and, moreover, to acquire the appropriate means to cope with her unease. Hermeneutical phenomenology is a resource when dealing with this challenge of therapy because of three basic features of this philosophical approach to human personhood.

First, the phenomenological character of the approach provides a theoretical framework to assess and explore the patient's experience of troubled personhood. This is an important methodological contribution to therapy, since it is open to an unusual extent in that it reveals aspects of experience that other approaches tend to overwrite or eclipse with their strong theoretical—and sometimes moralistic—claims. In this sense, we can say that the ethics of this approach is based on the principle of letting the patient have his or her say. This principle admonishes the clinician to bracket her own prejudices and let the features of a pathological condition emerge in their peculiar feel, meaning and value for the patient, thus making every effort to focus on the patient's suffering as experienced and narrated by her.

Second, the phenomenological articulation of the dialectics of selfhood and otherness gives the clinician an epistemic tool with which to understand how the struggle with one's involuntary dispositions makes personhood not just a fact but also a problem. The vulnerable character of personhood that is so dramatically expressed in mental disorders is closely connected with the problem of the fragility of human identity, that is, with the problem of our cares and concerns. Making sense of what we care about and how we care about being the particular person we are involves the responsibility for one's being so, that is, for one's vulnerable and troubled personhood. This responsibility implies how to respond to the challenges involved in discovering alterity in one's own Self, how to make sense of one's troubled personhood and how to become the person that one is.

Third, the hermeneutical character of this approach provides a framework by means of which the clinician can make sense of norms and values involved in a person's struggle with her involuntary dispositions. We care about being persons, and the hermeneutical emphasis on both the *What* and *Who* of the person that we care about being and becoming—that is, both the a-rational, biological values and the rational, personal values at work in our care—provides the clinician with a framework with room for the ethical problems involved in being a person.

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