Phenomenology of Temporality and Dimensional Psychopathology

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10.1 Introduction

The dimensional approach to diagnosis, as discussed in this book, can provide an individual profile of a patient's psychopathology. However, it still operates within a third-person framework. According to this approach, a subject (the clinician) observes an object (the patient), under the assumption that the mind is ultimately a product of brain activities. In contrast to the categorical perspective, the dimensional approach cuts across categorical boundaries, offering a more complex and refined view of the patient's psychopathological condition. It may thus lead to a more specific psychopharmacological or psychotherapeutic intervention. For example, a broad general category such as major depression can be differentiated into multiple forms of depression, each displaying relatively distinct symptomatological dimensions, which can then be treated accordingly.

The combination of categorical and dimensional diagnostics can thus convey a very accurate view of the patient. However, since both these diagnostic approaches have their foundations in a third-person perspective, they appear to lack a holistic comprehension of the different symptoms. As described in depth in the previous chapter, an approach that disregards the subjective experience underlying a symptomatological assessment risks not conveying a picture of the person in his or her totality. Moreover, it can lead to an incomplete understanding of the patient's way of *being-in-the-world* [1, 2], through which it might be possible to identify a *trouble générateur* on the basis of the various manifestations of the illness. In other words, "there is a lack of a suitable psychopathological framework that could integrate

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single symptoms and neuropsychological dysfunction into a coherent whole of altered conscious experience" [3].

In contrast, the identification of a basic disturbance by means of an in-depth description of the patient's subjectivity could indeed be highly significant for diagnosis, for research, as well as for treatment purposes. Some scholars have pointed out that subjectivity and intersubjectivity are basic categories of *being-in-the-world* and thus represent intrinsic aspects of a thorough psychiatric assessment [3–5]. Phenomenology in the Husserlian tradition seems ideally suited as a conceptual framework for a precise description including the integration of single anomalous experiences into more encompassing intentional structures. It "helps to define mental disorders on the basis of their structural features, linking apparently disconnected phenomena together" [6]. Hence, its contribution to psychopathological analysis could essentially enrich the objectifying perspective of categorical and dimensional studies, giving depth and substance to clinical observations based on these two paradigms.

Phenomenology can be defined as a descriptive and analytical science of consciously lived experiences and the objects of these experiences. Classical phenomenologists investigate consciousness by putting aside causal explanations and focusing on the way it shows itself in subjective experience. "Consciousness manifests itself as a 'becoming', a temporal 'streaming' of a unity of intertwined experiences. This streaming is not an amorphous mass of contents, but is organized into a field of consciousness, which exhibits certain structures involving intentionality, temporality, embodiment, self-awareness, and intersubjectivity" [7].

Classical psychopathology has been profoundly influenced by phenomenological analysis, and many authors, such as Jaspers, Minkowski, Binswanger, Tellenbach, and Blankenburg, have adopted the phenomenological method to explore the alteration of consciousness in mental illness. Indeed, their attempts to comprehend the lived experience of affected people have also played a role in better understanding the normal functioning of consciousness, providing philosophical contributions to the general theory of lived experience: "core features of subjectivity, including fundamental aspects of self-experience, can be sharply illuminated through a study of their pathological distortions" [8].

The basic structures investigated in psychopathology have been mainly the same ones as those of phenomenology in general: notions of self, self-awareness, temporality, intersubjectivity, and embodiment. Modern psychiatrists such as Parnas, Stanghellini, Callieri, and others have carried forward this exploration, in an ongoing debate with philosophers both in the phenomenological field and, more recently, in the cognitive sciences [9]. In the previous chapter, some issues about intersubjectivity, and how its disruption may be analysed in order to achieve a breakthrough in the exploration of mental pathology, were discussed. In particular, the potential of an overall clinical view that takes into account both a standardised diagnostic approach and an examination of subjective experience has been considered.

In this chapter, we aim to describe and investigate another core notion through which phenomenology can substantially contribute to psychopathological progress: the notion of temporality. Temporality is indeed one of the most central and

complex topics in phenomenological psychopathology. Many authors such as Straus [10], Minkowski [11], von Gebsattel [12], Binswanger [13], Tellenbach [14], Blankenburg [15], and Kimura [16] have focused their research on the altered experience of time in different clinical contexts. Temporality has also been considered an essential element of schizophrenia. Even the well-known Minkowskian concepts of *schizoidy* and *syntony* are grounded on a temporal concept of rhythmic modalities, namely, a subject's synchronisation and desynchronisation with his environment.

Temporality is thus not only an essential way of investigating consciousness and the self but also has relevance for studying subjectivity in people who are affected by mental disorders. Similar to intersubjectivity (see Chap. 9), subjectivity is a basic feature of the self, and it can be regarded as belonging to a more fundamental level of explanation, underlying the different symptom manifestations. For this reason, in this chapter we will first discuss its relevance in the evaluation of psychopathological conditions and then the convenience of complementing the positivistic third-person approach with such a perspective rooted in phenomenology.

10.2 Temporality from a Phenomenological Perspective

Mental illness not only interrupts the continuity of normal life but can also be accompanied by a radical change in subjective temporality, even to the point of a fragmentation of the experience of the self in time.

The phenomenological analysis of lived time, carried out by psychopathologists such as Jaspers [17], Minkowski [11], Binswanger [13], and Tatossian [18], deals with this crucial problem. These authors attempted to develop a systematic framework for the investigation of conscious experience in mental disorders, giving particular attention to the problem of altered lived experience of time. As stated by Tatossian, the impairment of lived time should not be considered as simply one symptom among others. On the contrary, it expresses a fundamentally altered mode of existence which cannot be reduced to brain dysfunctions. Indeed, a lack of attention to this aspect implies the loss of the possibility to articulate the subjectivity of the affected person in a comprehensive way, leading to a flawed psychopathological understanding.

Phenomenological philosophy has explored the concept of time as a basic structure of the human self. According to its perspective, human beings are *time-producing* organisms, and their awareness of being is imbued with the sense of a lived duration of experience. In the phenomenological model, in fact, the flow of consciousness proceeds, on a pre-reflective level, along with a specific sense of *for-me-ness* or *mineness*. In other words, every experience that appears in the stream of consciousness belongs to the experiencing subject in a unique way, even in the pre-linguistic phase of development. This sense of *mineness*, which is considered as the essential feature of the *minimal* or *experiential self* [8], entails the intrinsic capacity of experiencing the *block of duration*, that is, the continuity bridging discrete experiences. Without it, we would have an infinite sequence of single moments, which means that there would not be any *experience* at all; for as Zahavi [19] writes, "every experience is a temporally extended lived presence".

Husserl has examined the temporality of consciousness in depth, speaking of the *width* of the present as an interlacement of three elements: *retention*, *presentation,* and *protention* [20]. Each present moment with its primary impression (*presentation*) still maintains an awareness of the just-passed moments (*retention*), which inexorably fade from the consciousness, although they can be recollected as memories later on. At the same time, the present also contains a sort of expectation of the next possible future (*protention*), an implicit anticipation of what is going to happen in the flow. According to Husserl's classic example, when we hear a melody we experience it in its temporal duration, at each moment being still aware of the notes just heard and also prepared for the tones to come; we do not experience music as simply isolated tones that replace each other abruptly.

If *retention*, *presentation*, and *protention* describe the continuity of temporality, another concept grasps its energetic foundation, still at a pre-reflective or implicit level, namely, *conation* [21]. *Conation* is conceived as the basic energetic momentum of mental life, which can be expressed by such concepts as drive, striving, urge, or affect. It may also be regarded as an affective "energy", which is at the root of our spontaneity, directedness, attention, and tenacious pursuit of a goal and which also sustains what Merleau-Ponty called the *intentional arc* [22]. Through this concept, Merleau-Ponty describes a "unity of synthesis", which bridges sequential moments of consciousness by an intentional, dynamic, and affective directedness and which connects the lived body to an intended goal of action:

> Let us therefore say […] that the life of consciousness—cognitive life, the life of desire, or perceptual life—is subtended by an 'intentional arc', which projects round about us our past, our future, our human setting, our physical, ideological, and moral situation, or, rather, which results in our being situated in all these respects. It is this intentional arc which brings about the unity of the senses, of intelligence, of sensibility and motility.(Merleau-Ponty 1962, 120)

Thus, *conation* may be regarded as the result of the encounter between the potentialities of our body and the corresponding affective qualities of the environment.

The fundamental structure of *implicit time* is thus established by a synthesis of two components, which are only conceptually distinguishable: on the one hand, the *protention*, *presentation*, and *retention* system and, on the other hand, the "energetic" moment or *conation.* At the same time, these components are the conditions for a basic (or minimal) *sense of coherent self*, which is essentially temporal and inherent in the stream of consciousness. According to Merleau-Ponty, "we must understand time as the subject and the subject as time" [22]. In the same respect, Zahavi proposes the notion of *minimal* or *experiential self*, which is not socially constituted but is instead inherent in any experience as such. He defines the minimal self as "the very subjectivity of experience and [...] not something that exists independently of the experiential flow" [8].

Since Zahavi does not speak about "energy", our proposal is to complement the notion of *experiential self* with that of a bodily and affective drive that "energises" the flow of consciousness. Moreover, we propose that implicit time is also related to *the others* with whom we share a basic "contemporality" [21]. Since their very

birth, infants experience the presence of others, mainly through interbodily resonance, coordination of utterances, and affect attunement. Thus, implicit time starts with the shared rhythms and dynamics of early interactions or with *primary intersubjectivity* [23]. Even the conative-affective momentum of conscious life is not only an individual, monadic force; it is always embedded in social relationships. Infants move forward into a promising future because they feel contemporal with caring adults who structure the world to be an inviting place.

So far, we have described time experience as it is implicitly lived, i.e. thoroughly intertwined with the concept of the pre-reflective self. However, phenomenological analysis describes the self as a complex, multilayered phenomenon. The pre-reflective self is considered as a basic prerequisite for a more complex sense of self. Similarly, a different kind of intersubjectivity, which is experienced at a reflective level and consciously shared (i.e. the *secondary intersubjectivity* according to Trevarthen [24]), implies a different mode of living time.

Based on a primary sense of self-awareness, which probably starts in prenatal stages, humans develop a more complex form of self that depends on interactions with others in the intersubjective field. As a result of a long developmental process, particularly including the acquisition of language, there unfolds a *narrative self* related to autobiographical temporality. Whereas the *minimal self* is connected with the lived experience of implicit time, the emerging *narrative self* is connected to the explicit dimension of temporality. *Explicit time* superimposes itself on the implicit one when the tacit undercurrent of experience becomes consciously or reflectively lived. For example, when we look at a child obliviously absorbed in his play, we can assume that he does not reflectively experience the passing of time: time is lived at an implicit level, as an unimpeded flow. However, if we ask the child to tell a story about his play, we lead him to interrupt that flow and to share with us a narrative sequence, with a beginning, a circumscribed duration, and a "historical" reference. This is a sequence of explicit time, which indeed seems to be produced primarily through a disturbance or negation of the implicit time of pure becoming. In fact, explicit temporality frequently arises in states of desynchronisation, produced by a retardation or an acceleration of inner time in relation to external or social processes—a desynchronisation that is frequently perceived as unpleasant [21].

Explicit time can be divided into the three dimensions of *present*, *past*, and *future*, which, unlike the *presentation*, *retention*, and *protention* system, are actively reflected and synthesised by the subject. This is why they require an extended personal, or *narrative*, self, which is capable of engaging in a reflective relationship towards itself and is thus in the position, on the one hand, to project itself into the future and, on the other hand, to appropriate its own life story in the form of autobiographical narratives.

To summarise, we can distinguish between:

- **Implicit, pre-reflective, passive temporality**, based on the threefold structure of time consciousness (*retention*, *presentation*, *protention*) and on *conation*. Together, these dimensions of implicit time form the structure of the *intentional*

arc. Included in this level is a component of basic intersubjectivity or contemporality.

- **Explicit, conscious, or reflected temporality**, actively constructed by the reflective or *narrative self*. This is substantially, but not entirely, intersubjectively constituted. The *narrative self* connects *past*, *present*, and *future* through an active synthesis, according to one's autobiographical or narrative identity.

10.3 Psychopathology of Temporality

Here we present a brief account of temporality in schizophrenia, melancholic depression, and borderline personality disorder, as paradigmatic cases for a psychopathology of temporality. We have chosen to focus on these three disorders in order to give an account of the phenomenological method and to illustrate how major symptoms of these disorders may be regarded as manifesting a disturbance of the synthesis of different levels of time consciousness.

10.3.1 Temporality in Schizophrenia

In schizophrenia, we encounter a weakening and temporal fragmentation of self-experience, which, according to phenomenological concepts, should be considered as a generative disturbance of the illness. Especially symptoms like thought disorder, thought withdrawal, or thought insertion, passivity experiences or the more basic "loss of natural self-evidence" [15] may be regarded as resulting from a fragmentation of the *intentional arc*, which is essential to all our perceiving, thinking, and acting. This disturbance of self-coherence affects intersubjective synchronisation as well, so that schizophrenia always appears as a disturbance of basic intersubjectivity or contemporality.

The continuity of the *intentional arc* disintegrates, arguably due to an impairment of the *protentional* function, thus creating gaps in the flow of consciousness, which in severe cases are experienced as thought blockages or thought withdrawal. Generally, *protention* presents a vaguely determined expectation or openness towards the future. It opens up a "cone of probability" [25]. This cone originates in the present and continuously moves forward. If the *protentional*, and thus preparatory or anticipatory, process now fails to function, events will start coming too rapidly for conscious apperception. The *protentional* function will be "overwhelmed", and perplexity results when patients try to interpret the meaning of what intrudes on them. This model resembles the concept of aberrant assignment of salience to the elements of one's experience, as proposed by Kapur [26].

The subject then loses the ability to be actively directed towards the future and is instead left with focusing on what just turned up in his consciousness or on the sensory feedback of his just-passed movement. This *transcendental delay* may be regarded as the essence of major schizophrenic self-disturbances. Acts or thoughts are no longer embedded in the continuity of basic self-experience but appear as

being inserted or—if further externalised—as auditory hallucinations. The temporal disintegration of the *intentional arc* thus results in an externalisation of the fragments [21].

The synthesis of inner time consciousness is also bound up with an implicit self-awareness. If this synthesis is disturbed, the patient not only loses the feeling that particular conscious events belong to herself, but the continuity of her self-experience is affected as well. The continuity of the sense of self depends, in fact, on the constant linking of the primal impression with protention and retention. If this linkage is disturbed, the sense of self can no longer be recovered by a subsequent recording of what has been experienced.

In sum, from a phenomenological point of view, key schizophrenic symptoms such as thought disorder, thought insertion, auditory hallucinations, and passivity experiences may be described as disturbances of transcendental constitution of inner time consciousness or of the microstructure of temporality. There is increasing evidence for a structural homology between phenomenological and cognitive neuroscience views of schizophrenia with regard to the temporal order of mental life [25, 27, 28]. Several authors have pointed out the parallel between Husserl's tripartite concept of time consciousness and Fuster's analysis of the cognitive functions of the prefrontal cortex, where integration across time plays a cardinal role in the temporal organisation of behaviour [29]. This integration is served by working memory, selective attention, and preparatory set. The dorsolateral prefrontal and the anterior cingulate cortex seem to play essential roles in the neural network underlying these functions [27]. Although Husserl would have certainly opposed a neuropsychological explanation of consciousness, the fact that he attributed the intentional structure of time consciousness to passive syntheses, i.e. to functions not performed by the subject, indicates that it is reasonable to look for their possible neurobiological correlates.

In the basic stages of the illness, however, subtler disturbances in self-coherence can be found which do not yet have the character of breaks in the *intentional arc* but rather indicate a weakness of the self-awareness or *ipseity* (basic sense of self) inherent in it [30]. Patients can no longer trust the continuity and identity of their experience, which is undermined by the loss of implicit *mineness* and familiarity. Moreover, the disintegration and alienation of routine units of activity often force patients to produce every single movement intentionally in a way that one could call a Cartesian effect of the mind on the body: the body's implicit knowledge is lost and has to be substituted by "hyper-reflexive" self-observation and self-control. As Sass and Parnas have put it, the patient's mental processes "are no longer permeated with the sense of selfhood but have become more like introspected objects, with increased reified, spatialized and externalized qualities" [30].

The weakening of basic self-coherence affects intersubjective temporality in every phase of the illness. Patients do not develop a certainty of contemporality, the unquestioned assurance of living with others in a shared time of emotional resonance and synchrony. Considering this, autistic withdrawal can also be understood as an attempt to reduce the complexity of the social sphere and to compensate for the lack of ability to synchronise, namely, by avoiding overstimulating and potentially overwhelming interactions.

Finally, schizophrenic delusion can be understood as a failure to take the other's perspective: what is typical of delusions is the reinterpretation of all opposing evidence according to a rigid cognitive schema, at the price of a decoupling from intersubjective exchange. Delusions seem to permit the patient to reintegrate the irritating fragments generated by the basal disintegration of time into a coherent, though distorted framework. In other words, the intrusions, inserted thoughts, passivity phenomena, and other fragments of the broken *intentional arc* are "re-temporalised" at the explicit level, namely, reintegrated into a fixed delusional narrative. Using Heidegger's terminology, one could say that in schizophrenic delusions the "ontological" (existential) threat presented by the imminent loss of the self is replaced by the "ontic" (inner-worldly) threat posed by presumed persecutors. Thus, the frozen reality of delusion arrests the course of biographical and intersubjective time in order to compensate for the fragmentation of the more basic lived time.

To summarise: the fundamental disorder or *trouble générateur* of schizophrenia consists of a weakening and temporal fragmentation of basic self-experience. It appears in premorbid or chronic phases as a lack of a sense of self-coherence that undermines the habitual conduct of life and has to be compensated for through rational reconstruction at the explicit level of time. In acute phases, it manifests itself on the micro-level of time consciousness as an increasing fragmentation of the *intentional arc* and the self-coherence connected to it. This results in the appearance of major self-disturbances, such as thought withdrawal or thought insertion, hallucinations, and delusions of influence. In all phases, this disturbance of self-constitution is accompanied by a profound desynchronisation of intersubjective temporality, which culminates in delusion—a "frozen reality" detached from the ongoing intersubjective constitution of a shared world.

10.3.2 Temporality in Melancholic Depression

In melancholic depression, lived time becomes explicit or even object-like and turns into a constant burden of guilt. Time is reified to the point of becoming an irreversible facticity of the past on the one hand and an inevitable, predetermined future on the other. The psychotic culmination of this experience in delusions of indelible guilt or imminent death also indicates a basal disturbance of constitutive temporality. In contrast to schizophrenia, however, there is no fragmentation of the stream of consciousness, but rather a retardation or inhibition. The schizophrenic incoherence and blockade of thought to the point of thought withdrawal is fundamentally different from this inhibition, since in depression it is not the coherence of the stream of consciousness, but its *conative-affective dynamics* that is affected [21]. Moreover, we propose that in depression the intersubjective dimension of temporality, both at the basic level of the minimal self and at the level of the narrative self, undergoes a *desynchronisation*.

Tellenbach [14] characterised the *typus melancholicus* by the patient's inability to let go of the past (which also means an inability to grieve) and therefore a failure to live his own present. The hyper-conformism that characterises the melancholic

personality type could also be interpreted as an attempt to avoid or nullify former ruptures or desynchronisations early in life that were experienced as extremely painful by the subject. It could then be hypothesised that in his early affective interactions with others, the patient had experienced some painful loss of resonance. This would imply that later events of desynchronisation (i.e. falling short of goals, painful losses, or separations) strongly resonate with that experience, appearing as highly distressing breaks in the continuity of time. In such a situation, the *narrative self* will fail to perform the active synthesis of biographical time and to continuously integrate one's past with one's future. This process of active synthesis indeed includes the capacity for closure of the past, as a prerequisite for not falling victim to time and becoming dominated by it.

At this point, a depressive illness may occur, corresponding to a switch from an intersubjective or existential desynchronisation into a biological one (overall organismic stress reaction connected with various disturbances of biorhythms, sleep, appetite, etc.). With the resulting loss of drive and *conation,* the depressive psychopathology further increases the social desynchronisation. Temporality is affected at the level of the conative momentum, but the constitutive (protentional, presentational, retentional) synthesis of inner time consciousness remains intact. What is lacking is the affective tension and energy that carries the intentional arc forward. Since conation implies the affective interaction with others, this dimension is of an intrinsically intersubjective nature as well.

In terms of *explicit time*, in depression the past remains always present as a constant accusation. Future is experienced as a process leading to an irreversible and fatal end that is already known from the past. Complete desynchronisation from intersubjective time is marked by the transition to melancholic delusion. Its climax in nihilistic delusion—the idea that one has already died or the world does not exist any longer—comes close to the schizophrenic's depersonalisation; however, it is ultimately based on the loss of conative-affective dynamics instead of a breakdown of the transcendental synthesis of temporality.

10.3.3 Temporality in Borderline Personality Disorder

In reactive, neurotic, or personality disorders, it is only the biographical level of temporalisation that is affected, whereas the fundamental dimension of implicit time is maintained. However, in severe cases this may well lead to a fragmentation of narrative identity [31].

As stated above, the self is a multifaceted and multilayered concept, and some of its most important features belong to the narrative domain, which is based on a temporally enduring *self-identity*. Such a self-identity "relies upon the ability to maintain memories, personality traits, goals, and values within a coherent narrative structure" [8]. In other words, it entails the capacity to articulate one's own historical continuity, thus unfolding the sense of a growing but stable identity. The French philosopher Paul Ricoeur places the very essence of the human being in the temporal relationship that we have towards ourselves through a narrative identity that

implies a process of integration, or at least a quest for coherence of the personal past, present, and future [32]. This process is basically social; it starts from the first relationships in our childhood and continues for the rest of our lives. Furthermore, personal identity is rooted in a complex interaction with others who are not only the implicit auditors and witnesses but in a sense also "co-authors" of our life stories.

In borderline personality disorder (BPD), we find marked disturbances of identity; indeed, a specific form of self-fragmentation is exhibited. Patients with BPD lack the strength to establish and maintain a coherent self-concept. They tend to switch from one present to the next, being totally identified with their momentary state of affect. This leads to a temporal splitting of the self, with a tendency to neglect or exclude past and future dimensions of relationships such as constancy, commitment, responsibility, and identity.

Affect dysregulation and impulsivity—highly represented clinical features in this disorder—express the patient's inability to contain and regulate overwhelming moods and affects. The patients undergo intense and abrupt mood changes, including anxiety, dysphoria, anger, shame, depression, or short-lived enthusiasm and euphoria. They are unable to draw on the experiences of the past in order to determine their own future through reflective decisions.

Thus, BPD individuals show a characteristic structure of temporality: they identify themselves with a short-lived, rather flat and empty present. They often describe lasting feelings of emptiness and boredom since their transitory present has no depth. It lacks the fulfilment that grows from the integration of past experience and anticipated future into the present. Bin Kimura speaks of a kind of absolute "now", which he calls the *intra festum* type of temporality [16]. In fact, for borderline individuals, the present moment loses its relation to the past or the future, lacking the continuity of coherent narratives and instead acquiring the features of inflated spontaneity, ecstasy, and oblivion. Others have defined borderline temporality as a cyclical movement without any historical progression [33].

This typical structure of temporality is deeply intertwined with the incoherence of autobiographical experiences and the fragmentation of identity seen in BPD patients. This fragmentation is increased by their tendency to dissociate as a result of traumatic experiences and adverse early environments. Whilst working as a defence mechanism against trauma-related distressing emotions, in the long term, dissociations can undermine the coherence of the life narrative. At the same time, regarding intersubjective relations, the patients do not succeed in integrating series of interactions to form a coherent concept of the other. BPD patients lack *object constancy* in the sense of being able to retain a positive image of important others in spite of temporary separation or rejection. Again, the result is a fragmentation of the *narrative self*: a shifting view of oneself and others, with sharp discontinuities, rapidly changing roles and relationships, and an underlying feeling of inner emptiness.

Since the patients' lack of a stable sense of self may be derived from deficits in early attunement and resulting attachment disorders, BPD may also be regarded as a disorder of intersubjective temporality. If experiences of stable, trusting relationships are missing, the child will not be able to establish the inner schemes of being with others that are necessary to form coherent narratives of oneself.

Both paradigmatic illnesses studied here—**schizophrenia** and **melancholic depression—**primarily **affect the basal level of lived time**. In schizophrenia, there is a weakening and fragmentation of temporal self-coherence rooted in *ipseity*, whereas we find a phasic inhibition of *conation* and *affectivity* in melancholic depression. Thus, in both of these disorders, the explicit dimension of time experience is not sufficient to capture the crucial temporal disturbance.

On the other hand, in **borderline personality disorder** and other neurotic spectrum disorders, it is mainly the level of **explicit temporality** and **narrative identity** that is affected, implying disturbances of the intersubjective dimension of time as well.

Conclusions

The dimensional approach to patient evaluation, as discussed throughout the book, provides information about the most prominent target symptoms and the personal symptom profile of each patient. This approach can play a substantial role in targeting the specific needs of the patient, especially in terms of a psychopharmacologically tailored treatment. Indeed, a dimensional approach can be more sensitive to the different profiles of symptoms, allowing more individualised treatment, as well as subtler diagnostic differentiation among the overly broad categories of the DSM.

In addition, dimensionality, in terms of description of the psychopathologic experience, seems to support a less "labelling attitude" on the part of the clinician, reducing the risk of the "narrative traps" represented by categorical diagnosis. In fact, these can trap the clinician's mind in preformed narrative contents, which can discourage the effort to really get to know the patient as a unique individual.

In Chap. 9, the dimensional model has been related to a very different epistemological perspective, i.e. a phenomenological one. Exploring in particular the intersubjective experience during the clinical encounter, the authors have proposed an integration of different epistemologies and pointed out how this may enable a more comprehensive understanding of mental illness. This may also help to better address the patient's needs and further a stronger therapeutic alliance. As we have stated in our introduction, the phenomenological method is different from the objectifying or third-person approach to psychic suffering that is characteristic of both the categorical and dimensional perspective. In contrast, it is aimed at a holistic reconstruction of the experience of the mentally ill person in terms of his or her fundamental characteristics of *being-in-the-world*.

Temporal experience, which has been the object of our present discussion, may represent a similar "cornerstone" in a multifaceted overview of the psychiatric assessment. Similar to alterations of intersubjective experience, to which temporality is thoroughly related, the disruptions of lived time are not simply psychopathological symptoms. Rather, they represent a fundamental break in one of the most basic human functions, since temporal experience also structures the experience of self. Hence, we can assume that distortions of lived time are always involved in the core of psychic disturbances and give rise to different symptomatic manifestations. From this perspective, it follows that each psychopathological

symptom or dysfunction acquires its meaning in relation to the broader picture of an altered existence, and temporality is one of the main dimensions giving sense to that picture.

Further research on the relationships between the "subject-object" epistemology, particularly the dimensional one, and the phenomenological "subject-subject" epistemology seems very promising. Since every person affected by mental illness presents many needs, an intervention model that allows the clinician to design a systematically tailored treatment should be sought, without losing the sense of the patient's existential wholeness. Recently, a number of researchers have attempted to transfer some phenomenological concepts to standardised and operational instruments [34–36], including in one case a specific section dedicated to temporal experience [36]. This may be the first step towards an integrated psychopathological and psychotherapeutic approach.

Moreover, an empirical study of the distortions of lived time may improve the analytical understanding of such experiences and of how they evolve over the course of a pathological condition and its treatment. As we have seen, from a phenomenological point of view, significant desynchronisations and failures of attunement at different levels of temporality might produce a rupture in the process of temporal synthesis, both at the pre-reflective and reflective level.

We thus propose an integration of different approaches to diagnosis and treatment, as a necessary step towards more effective pharmacological and relational interventions. Ultimately, they should both help to re-establish interpersonal relatedness for and with the patient. If temporality represents a central dimension of subjectivity, its distortions are the implicit targets of interventions aimed to restore at least moments of synchronisation and mutual understanding in the therapeutic relationship.

Despite our research efforts, time could well represent a dimension of reality that we cannot change in terms of a *restitutio ad integrum*, since we are time-producing beings and our life story is stored irreversibly in our living body. Still, as clinicians, we should try to alleviate the suffering of patients by restoring, as much as possible, their ability to unfold their own time, both in terms of subjectivity and intersubjectivity. In this sense, it would be beneficial to investigate the therapeutic effects of establishing rhythmic patterns of interaction, not only in psychotherapeutic settings but in every clinical encounter, even during the initial diagnostic process [37, 38]. In fact, every clinical encounter entails this opportunity, and any kind of intervention, be it psychotherapeutic or psychopharmacological, should promote the lived relation with another human being, primarily in the form of a sharing of resonance and rhythmic time. This implies a recommendation of analysing the patient's mode of temporalisation and, last but not least, the consideration of the enormous value, in terms of therapeutic potential, of our personal time shared with them.

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