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Subjectivity and Intersubjectivity in Psychiatric Diagnosis

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Abstract
The establishment of criteriological diagnostic systems since the 1980s has increased the reliability of psychiatric diagnosis. On the other hand, the limits of this approach for clinicians and researchers are becoming increasingly apparent. In particular, the assessment of subjective experience is nearly excluded on the theoretical level and undervalued on the pragmatic level, with detrimental consequences for the validity of psychiatric diagnosis, empirical research and therapeutic purposes. To correct this unfavourable development, three major approaches to the assessment of mental illness should be equally taken into account: (1) the positivistic, objectifying or 3rd-person approach as endorsed by DSM-IV and ICD-10, focusing mainly on observable behavioural symptoms; (2) the phenomenological, subject-oriented or 1st-person approach, focusing on the patient's self-experience and exploring its basic structures, and (3) the hermeneutic, intersubjective or 2nd-person approach, mainly aiming at the co-construction of narratives and interpretations regarding the patient's self-concept, relationships and conflicts. These three approaches will be compared regarding their respective values for psychopathological description, diagnosis, research and therapeutic purposes.

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-centred assessment [1–3]. DSM-IV 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 what follows, I argue 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 about to become but a part of 'clinical neuroscience' [4] and to neglect its historical roots in the humanities. Recently, there have been approaches towards a 'person-centred psychia-

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try' 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-centred approach to diagnosis and classification.

In order to further support this claim, I will distinguish three major approaches to the assessment of mental illness:

(1) the *positivistic, objectifying or 3rd-person approach* as endorsed by DSM-IV and ICD-10, focusing mainly on observable behavioural symptoms;
(2) the *phenomenological, subject-oriented or 1st-person approach,* focusing on the patient's conscious self-experience and exploring its basic, often implicit structures, and
(3) the *hermeneutic, intersubjective or 2nd-person approach,* mainly aiming at the co-construction of shared narratives or interpretations regarding the patient's self-concept, conflicts and relationships, for example in psychodynamic approaches.

I will briefly present the essential features of each approach and then argue 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.

Positivistic or 3rd-Person Approach

The positivistic or 3rd-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 behaviours, 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 behaviours, with the final goal to explain them by reduction to subpersonal causes, i.e. 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 [10] have criticized, 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 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 towards 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.

Phenomenological or 1st-Person Approach

The phenomenological approach is primarily aimed at empathically understanding, describing and analyzing the patient's subjective experience. Jaspers [14] used the term of 'intuitively representing' the other's psychic states *(anschauliche Vergegenwärtigung)* by an act of inner recreation or 'imaginative actualizing'. 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 [14]. 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 criteriological approach of DSM-IV 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 overall relation to the world and to himself 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 thoughts in order to grasp what he is thinking of [16, p. 257]. Similarly, not the probably 'wrong' content of a delusion is decisive for its diagnosis, but rather the patient's *specific attitude* towards his 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 and the world, and this is more than the sum of single features.

Phenomenology offers 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 questions asked by the phenomenologist 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,* i.e. the recognition of *prototypes* of mental disturbances [17].

Experienced clinicians do not diagnose and practise by ticking 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 [18] in patients with endogenous depression. 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, expressions and behaviours 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. A recent example is the 'Examination of anomalous self-experience' (EASE), an extensive, phenomenologically based interview developed by Pamas et al. [20] for disturbances of basic self-awareness in prodromal stages of schizophrenia. It started from the observation that the majority of schizophrenia spectrum patients report subtle alterations and disturbances regarding self- and body awareness, agency and identity, time flow, use of habits in everyday performance as well as understanding others.

Typification and analysis of these experiences supports the phenomenological theory of schizophrenia as involving a particular kind of self-disturbance [21, 22]. 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 interview. In the meantime, larger-scale studies could demonstrate that self-disorders assessed by the EASE interview aggregate in ICD-10 schizophrenia and schizotypy but not in other, 'non-spectrum' diagnoses such as bipolar illness, i.e. self-disorders occur selectively in the schizophrenia spectrum disorders [23–25]. 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 micro-dysfunctions 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 [26]. At the same time, it helps the patients to express their experiences in a way that makes them understandable to themselves and to others. As Mundt [26] and Stanghellini [15] have emphasized, this leads to an empowerment of the patient's intentionality, i.e. his capacity to take a reflexive stance towards his primary experiences. Thus, reinforcing the patient's self-perception, phenomenological assessment may also prepare the therapeutic work of re-establishing his self-coherence.

Hermeneutic or 2nd-Person Approach

The third approach to be described here is based on a hermeneutic or 2nd-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, and
(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 [27, 28]. 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 [29].

Compared to the phenomenological 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 man is a self-interpreting being, and that self-interpretation is mainly practiced by telling stories to others [30]. 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.

As I have already pointed out before, 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 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 co-creating 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.

Hermeneutic or psychodynamic approaches to diagnosis have been operationalized in different ways and have thus gained empirical reliability without being reduced to a collection of separate symptoms. An example of a multi-axial instrument that has been developed on a psychodynamic basis is the 'Operationalized Psychodynamic Diagnostics System' (OPD) [2]. It consists of four major axes:

(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 behaviour, partnership, family life, work life, etc.);
(4) *structure of personality,* described in terms of capacities of self-reflection, self-determination, defences and coping styles, interpersonal communication, attachment style and level of integration.

The instrument has attained wide usage in German-speaking countries in the last decade. Studies show good reliability in research contexts and acceptable reliability for clinical purposes [2, 31]. 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.

Conclusion

I have briefly presented three major approaches to diagnosis and assessment:
(1) the positivistic or 3rd-person approach, dealing mainly with observable behavioural symptoms;
(2) the phenomenological or 1st-person approach, focusing on self-experience and its basic structures, and
(3) the hermeneutic or 2nd-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, and
(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 [32] 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'.

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 ICD-11 should be to develop a combined system of 1st- and 2nd-person assessment, diagnosis and classification which complements the manualized, criteriological approach. This approach 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. The EASE and the OPD interview represent two types of 1st- and 2nd-person approaches that are needed to enrich the mainstream psychopathology which is focused on objectivism, behavioural and decontextualized symptoms, biological causation, and modular theories of mind that are not translatable into the patient's subjective experience [26]. 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 re-interpretation of meanings, motives and strivings, and
(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.

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