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WORDS MATTER. A HERMENEUTICAL-PHENOMENOLOGICAL ACCOUNT TO MENTAL HEALTH

abstract

The problem of names of illnesses is both a problem of words and values that should address not only the classification of disorders, but also a fundamental question both for medical sciences and humanities: can psychiatric nosology and classifications fit with the ontological constitution of human beings? This paper aims to discuss the so-called "psychiatric object" and its language and it intends to provide a hermeneutical-phenomenological account to mental health. In doing so, the paper will firstly examine the "psychiatric object" and its language; secondly, it will show the difference between taxonomy and ontology, both of interest for the psychiatric object; third, it will insist on the critique of the epistemological status of psychiatry conceived from a natural point of view following three main paths: a metaphysical one (Heidegger, Jaspers), a social one (Szasz, Foucault, Basaglia), and an ethical one (Laing). Finally, it will clarify why phenomenology and in particular hermeneutical-phenomenology can illuminate the understanding of the psychiatric object and its implications in a cultural context, in order to achieve a more humanistic psychiatry.

keywords

language, experience, phenomenology, hermeneutics, society

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1. Introduction

In his novel entitled *Wittgenstein's nephew*, Thomas Bernhard writes:

> The so-called psychiatric specialists gave my friend's illness first this name and then that, without having the courage to admit that there was no correct name for this disease, or indeed for any other, but only incorrect and misleading names; like all other doctors, they made life easy for themselves - and in the end murderously easy - by continually giving incorrect names to diseases. (Bernhard 1988, p. 16)

The problem of the name of an illness is not merely the problem of diagnosis, but it is also a problem of words and values that raises many complicated questions: how can words define and express something of which the borders and patterns are quite mysterious, undefined, and sometimes not accessible by people who experience the illness itself? Can the use of clinical definitions provided by statistic systems of evaluation and diagnosis really grasp the inner experiences of people who suffer from mental health issues? Can psychiatric nosology and classifications fit with the ontological constitution of human beings? What values are at the core of every diagnostic system?

With the title *Words matter* we aim to provide a phenomenological account of mental health starting from the assumption that the problem of language used in the field of mental health is a problem of epistemological constructions that needs to be re-discussed in the light of a deeper understanding of human beings and their suffering. Philosophically speaking, words are not merely signs that we employ in our ordinary way of using language, rather they signify something: objects and moreover relations. Words are the tools that open the path to relations and disclose alterity to us. Our ability to speak and to listen is the fundamental feature of being able to not only simply talk to each other but to get in dialogue with each other and moreover to be a dialogue. This becomes of paramount importance in the clinical encounter, since words introduce each practitioner and clinician to the patient's world, as an experience of displaying different forms of existence (G. Stanghellini, 2016). The issue of language is of interest for both psychiatry and philosophy, because it is through language that we have access to the world, and also to patients' inner world. In this respect, clinical language is far removed from ordinary and philosophical language but shares with them the need to understand, assess and define illness. Starting precisely from this common ground we think that the expression "words matter" aims to draw attention to 3 important points:

1. The problem of names of illnesses is a problem of words and values, and beyond words there are clinical definitions, philosophical concepts and social values; "words matter" means to discuss the central issue of diagnosis as well as the contemporary diagnostic systems (i.e. the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5); the International Classification of Diagnostics, tenth edition (ICD-10); the Research Domain Criteria (RDoC) initiative and the Psychodynamic Diagnostic Manual (PDM-2;).
2. The gap between psychiatric nosology and classifications and the ontological constitution of a human being as such, in its fragility, mortality, linguistic ability, in its desires, fears, concerns; in its personal history, that is not only the history of his/her illness. In other words, the incongruity between the medicalized classifications and the more nuanced complexity of human suffering witnessed in practice.
3. The meaning of patients' suffering and the words that he/she is going to use, the special value of the use of metaphors in the context of the psychiatric interview, the patient's self-narrative.

This paper aims to discuss the so-called "psychiatric object" and its language and it intends to provide a hermeneutical-phenomenological account for mental health. This paper will first examine the psychiatric object and the language used to understand, clarify and grasp this object; secondly, it will show the difference between taxonomy and ontology, both of interest for the psychiatric object; third, it will provide a critique of the epistemological status of psychiatry conceived from a natural point of view following three main paths: a metaphysical one (Heidegger, Jaspers), a social one (Szasz, Foucault, Basaglia), and an ethical one (Laing). Finally, it will intend to clarify why phenomenology and in particular hermeneutical-phenomenology can illuminate the understanding of psychiatric object and its implications in a cultural context.
Despite the challenges in reaching these goals, this contribution offers a critical moment of reflection on the epistemological status of psychiatry from a philosophical point of view: rather than feeding the ambition of "shewing the fly the way out of the fly bottle" (Wittgenstein), it will offer critical reflections on medical science and philosophy.

2. The psychiatric object and its language

Psychiatry is a very young field, which in its 150 years has undergone many changes and difficulties – and is still developing, adjusting and modifying, both in theory and practice (Daly & Gallagher, 2019) . In its young history, this field of medicine moved from alienism (between the end of XIX century and the beginning of XX) in terms of medicalization of mental afflictions to a science "putatively dedicated to the understanding and management of 'mental afflictions' reconceptualized as 'mental symptoms and disorders'" (Berrios & Markova, 2015). Psychiatry has faced at least four important challenges: first, defining the so-called 'psychiatric object' and its implications in all the aspects of human life; second, finding its own language, able to understand, clarify, grasp, classify and communicate its object in a way that is valid for the scientific community; third, defining its practices in terms clinical interventions and, finally, its relation with society and the cultural context.
The 'psychiatric object' cannot only be defined in terms of illness, diagnosis, symptoms and methodologies able to capture valid phenomenal distinctions concerning the patient's experience. At the same time, it cannot be reduced to the human organism or some parts of it. The 'psychiatric object' is more complex and has to do with existence and specifically with some forms of existence that are characterized by phenomena that do not allow people to have an ordinary (or extraordinary) life. If existence has to do with the way through which human being has to be (Heidegger, 1962), it means that this *modus essendi* has a precise way to manifest itself also among people affected by mental health issues. Psychopathological

phenomena can be conceived not as something negative compared to the ordinary way of being but as variations (*Abwandlungen*) of the only and original ontological structure that characterizes existence in all its expressions (Binswanger, 1956; 1963).
The 'psychiatric object' also deals with the encounter between the patient and the practitioner, a personal encounter between two existences that must communicate and enter in a relationship with each other. For this reason, psychiatry requires the understanding of human being in its entirety, a good ability to empathize as well as to not project, attention to multiple sources of knowledge, each with its own epistemology and methods of inquiry (Kirmayer, Lemelson & Cummings, 2015). Therapeutic encounters involve many levels of confrontation: there is the encounter between the patient and the therapist, but also the encounter between the patient and his/her own condition, in which patients start to recognize what is disturbing their ordinary way of life.
In these encounters, there is the issue of language, both the language used to communicate, and the clinical language used by the doctor to formulate a diagnosis. Our original ability to speak and to listen is the fundamental feature of being able not only to simply enter in dialogue with each other, but *to be* a dialogue. Each of us is able to enter a dialogue with everybody but *being* a dialogue is something more: it is not simply a verbal exchange of information, or a conversation, or a discussion, rather, it is a transcendental experience that reminds us of the transcendental constitution of each of us. Put in Gadamer's words, «dialogue is what we are» (Gadamer, 1996). Through dialogue each form of existence we embody comes into the light together with the particular world we live in. Dialogue is what situates us in a world inhabited by alterity in a particular time, it is what allows us to tell our personal story. Being a dialogue allows patients to talk about their personal stories – which are not simply the stories of their illness but also the stories of their lives –, to frame their narratives providing significant contribution to so-called narrative medicine. Words introduce each practitioner and clinician to the patient's world, not merely as a study of the disturbance of language, but rather as an experience of a *way of thinking* in which existence shows itself. Considering all these issues, the so called 'psychiatric object' cannot be reduced to the human body and its relations with the mind (or vice versa), neither to a nomenclature of diagnosis or practices. Rather, we have to consider human being in all its complexity and contexts.
Starting from this common ground, we can start to compare taxonomy and ontology, trying to understand to which extent the use of clinical definitions based on statistical systems of evaluation and diagnosis can really grasp the inner experiences of people who suffer from mental health issues.

3. Taxonomy vs ontology

> The DSM has had a dehumanizing impact on the practice of psychiatry. History taking the central evaluation tool in psychiatry has frequently been reduced to the use of DSM checklists. DSM discourages clinicians from getting to know the patient as an individual person [...] DSM diagnoses have given researchers a common nomenclature but probably the wrong one. (Andreasen, 2006)

This thoughtful yet provocative reflection by Nancy Andreasen shows the impact of the taxonomy used in the DSM on the way medicine is practiced. The issues she raises in her essay had (and still have) a strong resonance with those who practice psychiatry or cross borders between different disciplines. If it is true that from the DSM-III onwards (and through its successors) this diagnostic and statistical manual of mental disorders became universally and uncritically accepted as the ultimate authority on psychopathology and diagnosis, it is also true that it has a range of limits that have been underlined both by the scientific and philosophical community. Diagnosis is a medical concept which covers

both the process of identifying a disease, and the designation of that disease. Reaching a 'diagnosis' involves investigations and observations that help to identify the nature of the underlying disease that is thought to be causing the individual's symptoms. Having a diagnosis indicates that the nature of the underlying disease has been certainly or probably ascertained (Moncrieff, 2010). However, the issue of diagnosis, namely the issue of the name of an illness, is also a problem of words and values that are expressed by that diagnosis. It is not only a matter of selected symptoms in view of a nosographical diagnosis according to what medical-like diagnostic systems assess, but it is also a matter of the inner experience of each human being and their suffering and a matter of values (social, cultural and political) that ground not merely the name of illness but the epistemic model that establishes that name.

Biological approaches to mental health and practicing psychiatry are based on the principle of measurement. In order to measure, questionnaires and forms substitute people's own stories. The psychiatric assessment process is typically defined by the clinician's search for specific behaviors, described in the psychiatric lexicon as symptoms. These behaviors are given weight in terms of their contribution to the clinician's identification of a psychiatric disorder, as indicated by the recognition of symptoms (Bradfield, 2007). Behaviors identified as symptomatic of illness are given explanatory weight in terms of the individual's presentation. These behaviors are focused upon, emphasized, and given priority, while those behaviors not seen as symptomatic are given less consideration. This process may devalue and ignore non-symptomatic behaviors. It is thus evident that a more phenomenologically informed approach, which encourages equal priority of all emerging behavior, may facilitate a fuller and more accurate understanding and description of the individual.

It could be argued that this standardized way of diagnosing mental health issues actually robs people of their own words, language and narratives. Only a genuine and empathic dialogue can fit with the ontological constitution of human being, since *clinical meanings* and *existential ones* sometimes differ. As Jaspers reminds us at the very beginning of his monumental *General Psychopathology*, "the psychiatrist, as a practitioner deals with individuals" (Jaspers, 1997), and the gap between different levels of meaning must be carefully considered in order to be faithful to Jaspers' indication.

Human forms of existence are embodied (physically) and embedded (socially and culturally); among these forms, illness is a specific way of being in-the-world. This means that we cannot simply classify it as something that happens to an objective body, a purely physiological condition that is explainable entirely in causal or mechanistic terms (Gallagher, 2005).

> Mental symptoms are not 'things' that happen to have a content and also a meaning to the sufferer [...]. Mental symptoms have a wider, deeper, personal, and cultural sense and a fluidity that may not be amenable to the sort of techniques of capture that are used in relation to organic or biological dimensions of disorder or disease. (Berrios and Marková, 2015, p. 57)

From a theoretical point of view, a psychiatric symptom is not a clear demarcated thing, like an object, rather it is a certain configuration of consciousness that involves the phenomenal flow with its intentional content and form (structures). What manifests are not isolated symptoms but "certain wholes of interpenetrating experiences, feelings, beliefs, expressions, and actions, all of them permeated by the patient's dispositions and by biographical (and not just biological) detail" (Parnas & Gallagher, 2015).

A symptom is not an entity in itself that can be easily isolated from consciousness and objectified, defined, and described independently of its context. Perhaps, we could define it

as a *Gestalt* and as such, a descriptive approach is improper. Descriptive methods of present day psychiatry tend to perpetuate the problem of description, because these methods, mainly based on the third-person approach to symptoms, are not adequately tailored to the ontological nature of the 'psychiatric object', that is experientially a complete form of existence (Merleau-Ponty, 1963), a human being in a particular form of existence. Calibrating the method to the 'object' (that basically is a subject) means to question the method and its ability to grasp inner experiences of people affected by mental health diagnoses, but at the same time to maintain scientific validity and universal communicability (Sadler, 2005). Many psychiatric conditions may turn out to result from disturbances in evolved neurological processes, but this could be a merely contingent fact, and not stipulative of the very notion of mental health conditions (Broome, 2007).
How can we deal with this issue considering that, on one hand the scientific method and its validity cannot be changed, and a universally understandable and accurate nomenclature is required, while on the other hand, we should not lose sight of human being in its total complexity – and humanity?

4. Putting psychiatry into discussion

The DSM is not independent of epistemology and metaphysics and a critique of this manual is firstly a critique to the epistemological and metaphysical structure on which it is based. Since the end of 1600, science has built a paradigm of truth in terms of measurability, calculations, and projections: only what can be proven through numbers is effective and, as such, true. For centuries, medicine had strong ties with the humanities, but in the last century became increasingly influenced by the exact sciences. For a long time, physicians have not questioned this prevailing view of medicine as applied biology because it is the customary method in which medical care and practices are done. Science is so concerned with the discovery of its power to invent, explore, cure, that along the way it has lost sight of its relationship with the human being. If modern science has changed the way we see the world today, it has also changed the way we see ourselves as human beings, as a "whole": we see ourselves more and more as made up of parts to be repaired, fixed or changed. This has been one of the most influential concepts that pushed thinkers such as Heidegger, Jaspers, Jonas, Marcuse to criticize the technological revolution of the 20th century and the improper use of science, medicine and mental health disciplines. Starting from the peculiarity of their approach to this criticism, they underlined the importance of our mortality and vulnerability in order to understand our ways of being.
The risk of an improper use of medical science grows the more we lose the idea of human being as such and it can irreversibly affect both our lives and life in general. As Jonas has shown (Jonas, 1984) it is not possible to confront the use of modern technology (such as the manipulation of DNA, cloning, alteration of the entire biosphere) without recalling the ethical responsibility that this use implies. This responsibility addresses mankind and its global control over an improper use of technological and material development since it affects life on our planet in its totality.
According to Heidegger, the scientific method initiated by modernity does not work with human beings, neither in its definition nor in considering what health and illness are: "How far can we get with a sick person [with this approach]? We fail totally!" (Heidegger, 2001). Forasmuch as science has no relationship with truth but only with exactness, the human being is ontologically different from the results that come from the accuracy of being measured or being objectified. It is precisely in recognizing the inadequacy of applying the scientific method to the human being, that Heidegger initiates a novel and provocative way of thinking, called meditative thinking, which will affect Binswanger's and Boss' work and practice.
In recent years, this critique of science has become an interdisciplinary dialogue aimed at discovering the benefits of understanding the human being in all its complexity. This

interdisciplinary dialogue began approximately at the beginning of XX century, when some branches of medicine and human sciences examined their practices and acknowledged the contributions of other intellectual and disciplinary resources. An example is offered by psychiatry, which for a long time was seen primarily as concerned with overcoming mental disorders, or broadly as interested in health and human fulfillment, but it is only in the last decades that it has located its specialization in relation to the whole of life and to other spheres of human life such as ethics, law, religion, arts, and so on. Many therapists and theorists became dissatisfied with the theoretical framework offered by traditional psychiatry – and traditional medical paradigms in general– they found alternative conceptual frameworks in philosophy. The general dissatisfaction of the therapies and results has two main reasons: 1) the method of applying natural sciences to mental illness loses sight of the human being as a whole beyond the diagnosis; 2) the method of applying natural sciences to mental illness is not concerned with the inner experience of a human being's consciousness, suffering and undergoing treatment. Mental illness starts to be understood in a variety of new ways, both among psychiatric services and in society. For example, models of mental illness are based on biomedical, cognitive, behavioral, psychodynamic and social perspectives. These new models lead to new and distinct approaches to classification, explanation, and treatment. They influence the focus and methods of research (for example, whether biological or social research is more likely to reveal the causes of schizophrenia) and the significance of symptoms. Some accounts of mental illness explicitly criticize psychiatric models: the notion of mental illness considered as a 'myth' (Szasz, 1960) based on a mistaken analogy between physical illness and psychological distress, or the notion that psychiatric categories (and their practices) are a product of interests of society at large (Basaglia, 1973, 1998; Foucault, 1971), or political and cultural (Laing, 1960; 1982). Mental distress is viewed as a burden or 'illness' to get rid of, as quickly as possible and without pain. Medication fits very well into this view, providing hopes of 'quick fixes', even if in many cases they can turn into chronicity and long term (dis)ability and the 'message' carried by the symptoms is ignored.
This critique of psychiatry provides a strong foundation to explore how a hermeneutic-phenomenological approach to mental health improve the understanding of the psychiatric object and achieve a more humanistic psychiatry.

5. A hermeneutical-phenomenological account to mental health

Before becoming a subject of study in philosophy classes, phenomenology is the method that underpins all of science. Husserl conceived phenomenology as an a priori science of essences, but it has developed through other important authors during the beginning and first half of XX century (Gallagher & Zahavi, 2012; Moran, 2000; Zahavi, 2003). Phenomenology has recently contributed to illuminate psychiatry and psychopathology in setting up different theoretical frameworks (Sass, Parnas & Zahavi, 2011) and to define the subjective essence of the given experience more clearly. It would be a mistake to reduce the role of phenomenology to a purely descriptive science of the way the world appears to the experiencing subject.
The method of applying phenomenology to psychopathology implies a new understanding of psychopathological phenomena conceived as a coherent way of being in the world:

> The scope of clinical phenomenology is neither just to unfold the phenomena that are present in the experiential field of a specific person, nor to select symptoms in view of a nosographical diagnosis. These are the tasks of descriptive and clinical psychopathologies respectively. Rather, it aims to recover the underlying characteristic modification that keeps the manifold of phenomena meaningfully interconnected in the life-world of the person. (Stanghellini & Rosfort, 2013, p. 225)

Phenomenology is efficacious in understanding the human being without forgetting biological constraints: a vision of a person as a psycho-physical entity is very useful for not underestimating either the psyche or the natural organism. The advantages of adopting a phenomenological approach are both methodological (focusing on subjective experiences and not only on symptoms, considering the real object of psychopathology the person and her/his subjective experiences instead of biological symptoms) and practical (phenomenology is helpful in hypothesizing therapy, in modifying the relationship between the clinician and the patient providing a person-centered approach).
We do not suggest to get rid of diagnostic, and statistical categories, rather, we suggest that they be complemented by first-person data. Biomedical research on mental health should not focus only on the body or brain, but on the experience of people. Self-report questionnaires can never capture the full complexity and nuances and therefore, a more qualitative, phenomenological, approach is needed, both in research and medical practice. To achieve this, we suggest that several changes are needed, on different levels:

1. In medical training at universities, basic training in phenomenology could be implemented alongside statistics. Phenomenological training should also include methods of self-reflexivity. For medical students, this means not only learning how to communicate with patients (how to bring bad news for example), but it means to learn how to enter in true dialogue with patients, so that they can gain access to their experience of their inner world.
2. In medical research, especially on mental health, qualitative research should be improved to enrich diagnosis and therefore therapeutic approaches. Qualitative and mixed-methods approaches may bring to light different issues that cannot only be addressed with medication.
3. On institutional/governmental level, changes in the structure of care should be encouraged. Prescribing medication may appear quicker and more efficient in short-term, but in the long term, it may be more cost-efficient if there is more time to enter in relation with patients to really understand their needs, and address them adequately.

In this framework, the concept of sanity (and insanity) shows its fragility: “Sanity is not truth. Sanity is conformity to what is socially expected. Truth is sometimes in conformity, sometimes not” (Pirsig, 1992). From a phenomenological standpoint, a psychopathological syndrome is not simply a casual association of phenomena: the manifold of phenomena in a syndrome are meaningfully interconnected, that is, they form a structure. To have a phenomenological grasp on these phenomena is to grasp the structural nexus that lend coherence and continuity to them, because each phenomenon in a psychopathological structure carries the traces of the underlying formal alterations of subjectivity (Stanghellini, 2011).
It is a matter of words (narratives, patient-practitioner’s encounter, nomenclature) and pieces (alteration of subjectivity). Put in Pirsig words:

> the world comes to us in an endless stream of puzzle pieces that we would like to think all fit together somehow, but that in fact never do. There are always some pieces that don’t fit, and we can either ignore these pieces, or we can give them silly explanations, or we can take the whole puzzle apart and try other ways of assembling it that will include more of them. (Pirsig, 1992, p. 51)

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