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From “Things” to Structures: A Dialectical Phenomenological Perspective to Mental Health

ARTIGO

De “Coisas” a Estruturas: Uma Perspectiva Fenomenológica Dialética para a Saúde Mental

Guilherme Messas
Francesca Brencio

Abstract

The general aim of this contribution is to discuss a dilemma which lies in the conception and exercise of psychiatry. This dilemma lies in the recognition that, on one hand the reified model for describing and understanding mental health is not sufficient for overcoming a Kraepelinian paradigm still influent in psychiatry; on the other hand, that despite this recognition we are still stuck with this theoretical model. To overcome this aporia, we propose a theoretical hypothesis which may contribute to abandon the reified paradigm in favor of a different approach for which what is at the stake in mental health conditions are not “things” happening in the brain, rather variations of subjective and intersubjective structures. Put it differently, “mental diseases” may not be seen as brain disorders, as the naturalist reductionism proposes, and as consequence, localized in the brain. Drawing on resources from classical phenomenological literature and its recent dialogue with enactivism, we propose a dialectic model of phenomenology, the use of which may contribute to the understanding of these variations and pave the route to a different consideration of mental health conditions. To explain our proposal, this paper is divided into three sections: in the first section, we appraise critically the epistemological model in psychiatry starting from the legacy of the Kraepelinian heritage still influent in this specialty and moving toward a more fine-grained model for describing and understanding mental health conditions. In the second section, we provide a theoretical hypothesis, namely the dialectic model of phenomenology, able to elicit the variations of the subjective and intersubjective structures that are at the core of mental health condition. In doing so, we examine four cardinal elements: ambiguity, reciprocity, negativity and betweenness, which dialectically shape the fundamental structures of subjectivity and intersubjectivity. In the last section, we present some of the characteristics that phenomenological psychopathology assumes from a dialectical perspective in the paradigmatic case of schizophrenia.

Keywords: Psychiatric epistemology; Phenomenology; Phenomenological psychopathology; Ecology; Schizophrenia.

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Resumo

O objetivo geral desta contribuição é discutir um dilema presente na concepção e no exercício da psiquiatria. Esse dilema consiste no reconhecimento de que, por um lado, o modelo reificado de descrição e compreensão da saúde mental não é suficiente para superar um paradigma kraepeliniano ainda influente na psiquiatria; por outro lado, apesar desse reconhecimento, continuamos presos a esse modelo teórico. Para superar essa aporia, propomos uma hipótese teórica que pode contribuir para o abandono do paradigma reificado em favor de uma abordagem diferente, na qual o que está em jogo nas condições patológicas de saúde mental não são “coisas” que acontecem no cérebro, mas sim variações das estruturas subjetivas e intersubjetivas. Em outras palavras, as “doenças mentais” não devem ser vistas como transtornos cerebrais, como propõe o reducionismo naturalista, e, consequentemente, não devem ser localizadas apenas no cérebro. A partir dos recursos da literatura fenomenológica clássica e de seu diálogo recente com o enativismo, propomos um modelo dialético de fenomenologia, cujo uso pode contribuir para a compreensão dessas variações e abrir caminho para uma consideração diferente das condições patológicas de saúde mental. Para explicar nossa proposta, este artigo divide-se em três seções: na primeira, avaliamos criticamente o modelo epistemológico da psiquiatria, partindo do legado da herança kraepeliniana ainda influente nessa especialidade, avançando em direção a um modelo mais refinado de descrição e compreensão das condições patológicas de saúde mental. Na segunda seção, apresentamos uma hipótese teórica — o modelo dialético de fenomenologia — capaz de elucidar as variações das estruturas subjetivas e intersubjetivas que estão no cerne das condições patológicas de saúde mental. Ao fazê-lo, examinamos quatro elementos cardinais: ambiguidade, reciprocidade, negatividade e o estar-entre (betweenness), que dialeticamente moldam as estruturas fundamentais da subjetividade e da intersubjetividade. Na última seção, apresentamos algumas das características que a psicopatologia fenomenológica assume, a partir de uma perspectiva dialética, no caso paradigmático da esquizofrenia.

Palavras-chave: Epistemologia psiquiátrica; Fenomenologia; Psicopatologia fenomenológica; Ecologia; Esquizofrenia.

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"The crude psychopathological categories which we use to classify and apprehend our subject-matter do not penetrate to human fundamentals. The individual has an original source from which he takes his start and which enables him to detach himself from all that happens to him or overcomes him, or that, in so far as he detaches himself from it, is not he"

Karl Jaspers, *General Psychopathology*, p.426

"But explaining what I've come to call "disorganization" is a different challenge altogether.
Consciousness gradually loses its coherence.
One's center gives way. The center cannot hold.
The "me" becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal."

Elyn R. Saks, *The Center Cannot Hold: My Journey Through Madness*

INTRODUCTION

Recent times have been testifying a renewal on the use of phenomenology in psychiatry and a critical approach to mental health conceived as a whole. Editorials in first ranked journals, distinct special issues on the topics published both in academic journals and books, and even globally aimed funded projects are the most conspicuous face of this new renaissance. Born at the very beginning of the XX century and welcomed since its dawn in psychiatry, phenomenology is a classical current in philosophy. It seems worthwhile to briefly examine the characteristics of this new wave of renaissance of phenomenology in mental health, both in terms of the reasons for its occurrence and the features of this. Concerning the first aspect, we could say that in general the call for more phenomenology in mental health follows the widely recognized failure of the still dominant epistemological model, with its neuroscientific characteristics, which has dominated models of treatment and practice of care since the beginning of modernity. Failure not only in terms of results, but also of epistemological foundation, mainly grounded on an abstract dualism typical of the Cartesian heritage. In the words of the World Health Organization's 2022 report, "Business as usual for mental health will simply not do" (p. xiii). Phenomenological psychiatry, based on other epistemological foundations already tested over more than a hundred years, would thus be entitled to hold out the best hopes for offering an epistemological model more in tune with the global mental health needs of the population, as understood by the WHO. This model, led by central notions such as personalization of care and shared decision-making, belongs to the core of the phenomenological agenda.

The general aim of this contribution is to discuss a dilemma which lies in the conception and exercise of psychiatry. This dilemma lies in the recognition that, on one hand the reified model for describing and understanding mental health is not sufficient for overcoming a Kraepelinian paradigm still influent in psychiatry; on the other hand, that

despite this recognition we are still stuck with this theoretical model. To overcome this dilemma, we propose a theoretical hypothesis which may contribute to abandon the reified paradigm in favor of a different approach for which what is at the stake in mental health conditions are not “things” happening in the brain, rather variations of subjective and intersubjective structures. Put it differently, “mental diseases” may not be seen as brain disorders, as the naturalist reductionism proposes, and as consequence, localized in the brain. Drawing on resources from classical phenomenological literature and its recent dialogue with enactivism, we propose a dialectic model of phenomenology, the use of which may contribute to the understanding of these variations and pave the route to a different consideration of mental health conditions. To explain our proposal, this paper is divided into three sections: in the first section, we appraise critically the epistemological model in psychiatry starting from the legacy of the Kraepelinian heritage still influent in this specialty and moving toward a more fine-grained model for describing and understanding mental health conditions. In the second section, we provide a theoretical hypothesis, namely the dialectic model of phenomenology, able to elicit the variations of the subjective and intersubjective structures that are at the core of mental health condition. In doing so, we examine the ontological proportions and disproportions of four cardinal elements: ambiguity, reciprocity, negativity and betweenness, which dialectically shape the fundamental structures of subjectivity and intersubjectivity. In the last section, we present some of the characteristics that phenomenological psychopathology assumes from a dialectical perspective in the paradigmatic case of schizophrenia.

In traveling along such an arduous pathway, a valuable help comes from philosophy, cognitive science, social sciences and cultural studies, whose speculative and ethnographic categories will help us in the conceptual definition of many passages and provide systematicity to the ponderings that follow. At the core of these ideas there is the belief that in every psychopathological experience what is at stake is not merely a semeiological definition or a nosological entity based on a set of third-person grounded elements, rather a fundamental modification of those fundamental structures that characterized the person as such, and provide significance to her experiences, putting her in relation with her environments and intersubjective space.

Another element cardinal to our meditation is that every experience – not only psychopathological one – is culturally determined, historically rooted to a certain context and values based. It would be a coarse mistake to overlook all these elements in favor of an uncovered approach to mental health which does not consider all those features that

forge a category *as a* category. Every language is theory landed (Putnam 1987) and rooted to socio-cultural factors (Englander 2018). We believe that the issue of description in psychiatry remains an inescapable matter in the landscape of psychopathological experiences; what descriptions share with diagnosis is the attempt to depict and understand the content of such experiences, but in doing so the gap between diagnostic tools and theoretical presuppositions remains unsolved. If clarifying the methods of description is the first step, moving towards the interpretation of these descriptions is the second step.

Therefore, for a minimum understanding of the internal logic of current psychiatric nosology, it is necessary to at least briefly investigate the epistemological conditions of possibility that have informed it - from Kraepelin's legacy to descriptive operationalism, and which continue to be its dominant philosophical inspiration. One cannot naturally assume that the unthinking assumption of nosological categories (and their dynamics) in phenomenology's venture into psychiatry did not have damaging effects on the magnitude of phenomenology's influence on psychiatry. It seems reasonable to assume that, by operating its worldview on the central concepts of another worldview, at the very least some hinderances to the full expressions of the phenomenological epistemology might have occurred. It was taken for granted that there was no radical incompatibility between the Krapelinian-operationalist and the phenomenological models. i.e., that the diagnostic categories created by the Kraepelinian model could be examined on equal terms by an epistemological model that differed from it in its general outlines. This assumption cannot be seen as uncontroversial (Morley, 2002).

The authors of this contribution are aware of the difficulties of such navigation: it will challenge the readers' patience and probably will make feel them uncomfortable in the philosophical landscape; however, they are also aware that genuine curiosity and passionate commitment to improve clinical practice may serve as a compass in pursuing the route we would like to explore.

That "thing" called mental health. Re-questioning the Kraepelinian model

The fundamental position of Kraepelinian epistemology, which underpins psychiatric nosology to this day, reproduces the general understanding of the so-called medical model. A diagnosis is established that reproduces a pathological reality; its distinctive characteristics are fixed, adding a name that allows it to be easily communicated

to the community of interest. Validity (existence in reality) and reliability (the ability of this reality to be shared by everyone as having the same meaning) are the main beams from which the main interest of the entire medical model can operate: the identification of the material causes of the production of this pathological event, the identification and study of the natural evolution of this pathology and, above all, based on this knowledge, the intervention to exclude this pathological event. Cure is the primary object of the medical model and surely the root of its undeniable success in today's societies.

> There are several reasons why Kraepelin's psychiatry became so influential, especially when it comes to nosological issues. Two of them shall be mentioned: first, his approach gained credibility by being grounded in clinical observations, and it proved to be applicable in practical psychiatric work since the question of prognosis had always been a major issue in describing and understanding mental illness. Second, it had been developed by a self-confident author who focused on straightforward quantitative and naturalistic research methods. He claimed to abandon speculative aspects of psychiatry as far as possible. However, he, albeit unintentionally, "imported" implicit theoretical and, in part, speculative aspects into his concept (Hoff, 2015 p. 37).

The Kraepelinian idea that the existence and scientific accessibility of "natural disease entities" may be reached through diagnostic criteria is still widely used today:

> There is a strong link between "Neo-Kraepelinianism" and operationalized diagnostic manuals (...). The question of whether there are "natural kinds" in psychiatric nosology or not, is of minor relevance in this context. The main intention is to improve the reliability of psychiatric diagnoses by establishing and continuously developing clear diagnostic criteria and algorithms. Describing what is observable on the behavioral level becomes the most important method (...). Such a position is very close to Emil Kraepelin's view of the diagnostic process in psychiatry (Hoff 2015, p. 38).

The motto "descriptions, not interpretations" seems to guide the practice of psychiatry, silencing every voice that goes toward the opposite direction as "not scientific and not evidenced based". Reification, namely the fact that the so-called mental illness is a thing, is the predominant paradigm and, as consequence, it leads to a form of somatic reductionism, for which in the structure of the brain we should expect to find the structure of our psychic life:

> It seems as if the further neurology advances, the further the psyche recedes; psychopathology (...) explores the psyche to the limits of consciousness but finds at these limits no somatic process directly associated with such phenomena as delusional ideas, spontaneous affects and hallucinations (Jaspers, 1997, p. 4).

This is mainly how the education and training of psychiatrists still proceeds in medical schools and shapes the practice of physicians. However, the idea of a disease-entity at work in brain networks should be considered "an idea in Kant's sense of the world" (Jaspers, 1997, p. 569) and not as an existing:

> There has been no fulfillment of the hope that clinical observation of psychic phenomena, of the life-history and of the outcome might yield characteristic groupings which would subsequently be confirmed in the cerebral findings, and thus pave the way for the brain-anatomists (...) The original question: are there only stages and variants of one unitary psychosis or is there a series of disease-entities which we

> can delineate, now finds its answer: there are neither. The latter view is right in so far that the idea of disease-entities has become a fruitful orientation for the investigations of special psychiatry. The former view is right in so far that no actual disease-entities exist in scientific psychiatry (Jaspers 1997, pp. 568–570).

One route to overcome these limits has been offered by the ecological perspective in psychology. Gregory Bateson's *Steps to an Ecology of Mind* (1972) suggests that ecology transcends the conventional understanding of environmental science. For him, ecology is fundamentally about understanding the *patterns of relationships* and *interconnections* that constitute both mind and nature, what he calls "the pattern which connects". He sees ecology as an epistemological concept rather than merely a biological one. When Bateson speaks of an "ecology of mind", he's describing a system where mental characteristics (ideas, purpose, emotion, experience) are not confined to individual human consciousness but are immanent in the larger circuits of the natural world. This understanding of ecology emphasizes that ideas are never merely abstract concepts but are always embedded in material contexts and relationships. In his view, Western thinking deals with an epistemological fallacy where it fails to recognize that the mind is not contained within the individual but exists in the circuits and relationships that connect organisms with their environments. Therefore, Bateson's ecology is simultaneously a theory of knowledge, a theory of life, and a theory of mind that emphasizes the fundamental unity and interdependence of these domains. This ecological vision suggests that true understanding requires attention to context, relationship, and pattern rather than isolated facts or linear causation.

More recently, in his *Ecology of the Brain* (2018), Thomas Fuchs makes an explicit reference to Bateson's work and to the problem of the 'mind'. Fuchs develops an "ecological-enactive" conception of the brain that challenges both reductionist neuroscience and cognitivist approaches. His central argument is that the brain should be understood not as the creator or seat of consciousness, but as an organ of mediation between organism and environment. As such, the brain acts as a 'resonance organ' rather than as a creator of experience. Consciousness emerges from the living organism's relationship with its environment, and its main characteristic is to be fundamentally embodied, not just brain based. This means to recognize the role of the lived body *(Leib*) as the primary subject of experience. In this framework, implications for psychiatry are to consider mental disorders as disturbances of person-environment relationships, before which purely neurobiological approaches to mental illness are considered reductive.

The risk of considering mental health conditions considering a naturalist

reductionism, for which subjective experience and its structures are emptied and reduced only to neural processes, means to make an equation between the mental and the neuronal, for which the so-called "mental diseases" are seen as brain disorders. As it is recently highlighted,

> since the first 'decade of the brain', inaugurated in 1990, great hopes were placed on this biological turn of psychiatry. As a natural science discipline, psychiatry would soon be able to explain mental disorders such as malfunctioning brain circuits and make objective diagnoses by means of neuroimaging and other biomarkers. On this basis, highly specific drugs could then be developed, and even persons at risk for mental disorders could be identified by genetic screenings for preventive treatment" (Fuchs, 2018, p. 252).

This tendency leads to an increasing interest and practice of psychiatry redesigned as neuropsychiatry and mental health conditions as seen as characterized by reductionism, reification, and isolation. However, in consideration to the first element, reductionism, the risk is to regard and reduce "subjectivity as a product or epiphenomenon of the brain's activity. All mental processes take place in brain tissue, therefore mental disorders must be brain disorders" (Fuchs, 2018, p. 253). This leads to reification:

> mental states seem to be localizable in the brain; consequently, a mental disorder must be more or less equivalent to either too high circuit activation, reduced metabolic activity, or some other dysfunction in certain areas of the brain (Fuchs, 2018, p. 253).

Finally, isolation seems to be the plausible consequence of this view, which

> tends to isolate the individual patient and to consider his disorder separate from the current interconnections with his environment—even if it is conceded that the brain is epigenetically influenced by certain conditions such as early life trauma or disturbed attachment relations (Fuchs, 2018, p. 253).

However, psychic processes may not be reduced to the brain or to localized neural activities: "they are embodied, inherently intentional, and context related; and they are inseparable from the intersubjective world of shared meanings and interactions" (Fuchs, 2018, p. 253).

It would be beneficial both in the diagnostic phase and during the treatment to recognize the predominant role that experience, joint interactions and social behaviors play in the development of the person and of her psychic life. The circular interaction between the brain and the environment in which the person is embedded is central in the understanding of the content of experience, especially if we deal with psychopathological ones:

> These interactions should be considered as circular processes, including horizontal as well as vertical causality. Horizontal circularity characterizes the macro- and meso-levels of social and organism–environment interactions, whereas vertical causality is effective between higher and lower levels within the organism. Nevertheless, there are also circular (top-down and bottom-up) relations between the macro and micro-levels. Thus, a psychotherapeutic treatment, as an interactive, intentional process on the macro-level, involves neuronal processes on the micro-level, which result in a modification of the

> patient's brain structures—top-down. The modified neuronal structure, in turn, enables the patient to change his interactions with the environment—bottom-up, and so on. Over time, this leads to a mutual influence of superordinate psychosocial interactions and neuronal substrate, or of process and structure (Fuchs 2018, pp. 255-256).

As Jaspers stated:

> Psychic life as such is not an object. It becomes an object to us through that which makes it perceptible in the world, the accompanying somatic phenomena, meaningful gestures, behavior and actions (...). We can try to objectify the psychic life through symbol and analogy but it remains simply the encompassing of existence, a comprehension which in itself can never be comprehended as an object (Jaspers, 1997, p. 9).

As it has been already argued (Ghaemi 2009), Jaspers has been the first one to move a critique toward the Kraepelinian paradigm:

> Kraepelin was responsible for one of the most fruitful lines of research, the investigation of the whole life-history of the patient (...) But Kraepelin's basic conceptual world remained a somatic one which in the company of the majority of doctors he held as the only important one for medicine, not only as a matter of preference but in an absolute sense. The psychological discussions in his Textbook are brilliant in parts and he succeeded with them as it were unwittingly. He himself regards them as temporary stopgaps until experiment, microscope and test-tube permitted objective investigation (Jaspers 1997, pp. 853-855).

As it has been said, conceptualizing mental illness is a 'stumbling block' for psychiatry, especially since it is concerned with the prevention, recognition, and treatment of an illness (Hoff, 2024).

Describing an experience is not the same as describing a disorder: while in the first case the subjective component is primary, in the second case generalization, reliability and prediction must be the fundamental elements in reaching a diagnosis. For these reasons during the 1980's the introduction of operationalism in diagnostic procedures, heralded particularly by the third edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (1980), seemed to be the only possible solution to find a general diagnostic agreement among clinicians to have the lowest possible level of inference. Operationalism and generalizations are at the core of classifications and, while generalizations may be useful to group conditions, operationalism leads to an increased level of inaccuracy, the simplicity of which is not of any help for psychopathology (Kendler & Parnas, 2012).

The criticisms of operationalism do not impact merely the poverty of language used in the diagnostic process, rather call into question the very notion of validity required by a diagnosis.

> Rooted in the domain of logic and grounded on the principle of coherence between formal and material validity, the shift from this field of knowledge to psychiatry and clinical psychology is very complicated. Reliability and validity (...) were introduced to measure inferred psychological attributes. Only later, were

> they used to distinguish between measuring a psychological attribute consistently (reliability) from measuring it accurately (validity). The problem was, and to a certain extent still is, how to use a category thought to measure theoretical constructs, whereas in psychiatry what is required is to confirm a disorder or not (Brencio, 2023, p. 326).

Beyond the use of diagnostic criteria lie philosophical issues often ignored by mental health professionals and mental health users. Among those philosophical issues there is the inescapable one to exclude theoretical principles from every system of diagnostic classification. Put it differently, what was aimed at being thrown out of the door, re-entered through the window and affected the practice of psychiatry from its very starting point: the diagnosis.

As we will explore below, one of the most hideous consequences of this exclusion of theoretical principles is the ontological unification of psychiatric disorders. Following the epistemology of the strict medical model, all altered experiences are assumed to be similar in terms of what they represent as a modification for the whole person, being distinct among themselves only by their symptoms. For instance, a schizophrenic disorder is ontologically tantamount to a generalized anxiety disorder, being distinct from the latter only for being more severe, as it portrays psychotic experiences, often assuming a devastating and chronic evolution. In addition, a schizophrenic disorder is supposed to be similar within its very definition: all people with schizophrenia share the same disorder, owing the differences among them to distinct symptoms and severity of evolution. In the end of this paper, we will sketch a distinct ontology for schizophrenic experiences, based on a dialectical vantage point, putting forward some consequences of this approach.

Another element which needs to be considered in this complex scenario is the social and political weight that a diagnosis has. We must recognize that the very idea of "conformity", namely the tendency to align one's attitudes, beliefs, and behaviors with those of the people around, is historically and socially determined. In other words, the construction of a diagnosis involves not only physiology, chemistry, and anatomy but also

> class, race, gender, language, technology, culture, the political economy, and institutional and professional structures and norms in shaping the knowledge base which produces our assumptions about the prevalence, incidence, treatment and meaning of disease (Brown, 1995, p. 34).

What we call "illness" and "health" are always determined socially, culturally and racially anchored to a predominant set of values and often are the result of epistemological breaks (Foucault, 1988): it contributes to increasing inclusivity or, on the contrary, to reducing it in favor of discrimination and segregation, ultimately reinforcing social stigma (Bizzari & Brencio, 2024).

The above-mentioned elements contribute to depicting a very complex scenario which does not consider the content of the experience that people with diagnosis in mental health often have. On one hand, we find the use of a third-person perspective as framework for classifying and explaining symptoms and signs which improve the reliability of psychiatric diagnoses, but on the other hand it impoverishes both the practice of psychiatry, reducing it to a kind of phrenology, and the role of the person, considered as passive vehicle of a disease that needs to be fixed quickly through the use of drugs, or any sort of somatic-based intervention[1]. We may observe an aporia on two distinct yet intertwined levels: on one hand, we continue to use diagnostic tools the limits of which are pretty evident and recognized by the scientific community; on the other hand, the verticality and hierarchical way of shaping practices of care underestimates the concrete and cardinal contribution that people with mental health issues may provide. The voice of those who experience psychopathological conditions often is silenced in the name of a disembodied science that tends to ignore the flesh and blood of those who suffer a mental health condition.

In this scenario, the phenomenological approach has its own role to play: not only as a resource for a shift of paradigm, but also showing its weakness in proposing different pathways. One may object that phenomenology is not born as a diagnostic resource, rather as descriptive psychology and, as such, its principal aim is not to ascertain a condition. We believe that a more fine-grained model for ascertaining diagnosis in psychiatry is possible precisely through the contribution of phenomenology, which is requested not simply to be critical, but rather to be dialectical (Messas & Fulford, 2021).

The dialectical pathway of phenomenological psychopathology: ambiguity, reciprocity, negativity and betweenness

> In our view psychic life is an infinite whole, a totality that resists any consistent attempt to systematize it; much like the sea, we may coast along the shore, go far out into the deeps but still only traverse the surface waters. If we try to reduce psychic life to a few universal principles and seek comprehensive laws, we beg a question that cannot be answered. Where our theories may seem to have some kinship with the natural sciences, it is in the forming of tentative hypotheses, which we make for limited research ends only and which have no application to the psyche as a whole (Jaspers, 1997, p. 17).

If we take into account Jaspers' ponderings of the risk of failing into systematize the psyche, since its very nature is far from being a Manichean constitution of black and white,

[1] This statement does not imply rejecting the use of these; rather, it should be seen as a call for renewing the guidelines and purposes of their use (see Lopes & Messas, 2023) and invite to explore the dialogue with phenomenology (Brencio 2024).

phenomenology has two alternatives in its relationship to the neokraepelinian models of diagnosing: either improving it by supplying adjunct instruments to it (Larsen et al., 2022) – or supplying elements for changing it accordingly to a transformative absorption of it, based on the dialectical model. In the first case, phenomenology appears as a supplementary layer to the dominant paradigm, an instrument capable of solving certain aporias of the medical-neuroscientific system, without changing it. A quick investigation of the most recent publications linked to phenomenology in mental health seems to indicate that phenomenology has mostly followed this pathway, particularly concerning psychiatric diagnosis (Stanghellini et al. 2019). Seen from this perspective, the new phenomenology would reproduce its function at the beginning of the 20th century, when it set out to improve the diagnoses of the time, with rather limited results in terms of influencing the dominant sociological model (Messas et al., 2023).

In the following, we wish to sketch the dialectical pathway. In doing that, we would like to demonstrate as the dialectical pathway was ever put forward in the psychopathological tradition (Messas, 2023), though have not reached its ultimate consequences. We could even say that proposing a dialectical account of phenomenological psychopathology could be considered the resumption of an interrupted psychopathological project, whose sociological reasons we cannot develop here. We are aware that using the expression “dialectic phenomenology” might sound as a contradiction, since on one hand we find the strive to essentialism typical of the phenomenological endeavor and, on the other, a movement of oppositions and reconciliations in which there is no room left for “the things themselves”, rather for their becoming. Nevertheless, a historical reading of phenomenological psychopathology shows that “it is possible (...) to be mutually fruitful action between the interest of phenomenology in essence and the interest of dialectics in transformation, consolidated in what is known as dialectical essentialism” (Messas & Tamelini, 2018, p. 96).

Dialectical phenomenology combines the clues of phenomenological method with dialectical thinking to understand experience and existence. It emerges primarily from the work of Binswanger, Minkowski and Maurice Merleau-Ponty with the aims not only stress the recognition of the interconnection of opposing terms, but moreover emphasizes the role of contradiction as productive, avoiding both dualism and reductive monism. Beginning with the analysis of lived experience and with the examination of phenomena as they appear, the emphasis on embodied perspective is cardinal in describing and understanding the structures of subjectivity and intersubjectivity. Starting from description

of phenomena, the dialectical phenomenology seeks to examine the dynamics of the *opposition among different conditions of possibility of experience/qualitie*s, arranged in terms of anthropological proportions (Nielsen, 2022), and to find a mediation in the developmental process. Under this perspective, the body is regarded as a site of experience and as the medium of world-engagement and shared reality. Moreover, the introduction of the investigation of the dynamics of the anthropological proportions/disproportions enables the psychopathologist to better understand the changing nature of personal development (Messas et al., 2017)

One of the first authors of the phenomenological approach to psychopathology to have used the dialectic as a fine-grained tool for understanding the contents of anomalous experiences was Wolfgang Blankenburg. He uses the dialectic approach in phenomenological psychopathology (1982) as a category of anthropological comprehension. Focusing on the dynamics of transformation by analyzing the positivity of negativity and the negativity of positivity, Blankenburg applied this model to the major existential disorders; only later it is extended to personality disorders in general (Dörr-Zegers 1990), addiction (Messas, 2021), and depressive experiences (Messas & Brencio, 2024). Fundamental in these attempts is the emphasis put on the role of ambiguities of psychological reality which bring an important contribution to treatment strategies in clinical encounters.

The notion of "ambiguity" has been often considered problematic in philosophy, and not only from a strict speculative perspective. It deals somehow with the origin of the discipline, rooted in the passage from mythos to logos, that is into the necessity to design a rational framework for understanding the world, human beings and their affects and actions, the rules of society and guarantees a good life. The Apollinean element typical of the *ratio philosophiae* has guided and still guides philosophical meditation, as a powerful resource to depict, describe and interpret who we are and our relationship with the world. However, in this rational and systematic philosophical narration, there is no room left for what has been and still is considered dissonant, ambiguous, disturbing: every element of opposition to the dominant rational paradigm has been absorbed into a broader speculative attempt to rationalize it. In other words, bringing the *kósmos* (order) into the *akósmia* (dis-order) remains the priority of the philosophical discourse, a *manoeuvre* which has metaphysical and pragmatic consequences not only in the way we conceive knowledge but also in the way we live. We can say that this is precisely Achilles' heel of western meditation: the difficulty to deal with ambiguity, negativity, overlapping spaces, disturbing

elements, as if the human soul – or what in origin was called the *psyche'* – cannot stand in front of dialectics. But behind the fascination that these elements may have in our times, lies an inescapable question: how can we include, translate and bring into mere physiological models what has a different nature? Going back to the very topic of this contribution, how can we conceive ontological differences among psychopathological experiences if the dominant paradigm does not consider the notion of ambiguity in relation to the psychological dialect at work in the life of the mind? One could reply: psychiatrists are physicians and as such their services are aimed to cure, not to philosophizing - a naïve consideration since what should be at the core of the clinical enterprise is also thinking, and not only ascertaining diagnosis and prescribing drugs. The risk to overlook the peculiarity of ambiguity in psychic life is to shape a "science of the psyche" without the psyche (Jaspers, 1968), in the name of a model of care which is disembodied and far from what people feel, experience and live. The recognition of the role played by concept of ambiguity is not a synonym of confusion but is an ontological feature in which multiple meanings appear as constitutive of the complexity of the subject and their relationship with the environment. This might be exemplified in the notion of chiasmic reversibility as it is offered in Merleau-Ponty's meditation (Merleau-Ponty, 1968, p. 155). The logic behind the chiasmatic structure mirrors a relational ontology nicely captured by Gallagher and Zahavi when they refer to "the notion of an embodied mind or a minded body" (Gallagher & Zahavi, 2012, p. 153).

This opens to the importance of a dialectic movement in understanding mental health conditions and psychopathological experiences. We use the notion of dialectic considering both the speculative and psychological meanings and implications: "Dialectics is the form in which a basic aspect of meaningful connections become accessible to us, namely, that these connections are not a simple sequence of events but show a constant reciprocity" (Jaspers, 1997, p. 345). There is no dialectic without a process of oppositions which in the best possible scenario allows a synthesis able to reconcile previous stands. In psychological terms this means that

> human development in the individual and in history is not only a passive transformation as with all other biological happenings, but it is an inward effort of mind and spirit working on its own, driving itself forward in the universal dialectic of opposition and transformation. (Jaspers, 1997, p. 131).

Life, and especially psychic life, proceeds through movements and oppositions that nourish the vivid flow and the changes, what we could call the *becoming*: "Mere sequences of events, mere willing and persisting in one direction only, bring limitation, rigidity and end

destructively" (Jaspers, 1997, p. 345), and this is particularly clear in self-reflection. With reciprocity Jaspers seems to point toward a strict relation between the form and the concrete of patients' experiences:

> The experiences of individual patients are infinitely manifold (...) and phenomenology only extracts from them some general feature which can be found equally in some other case and therefore can be called the same feature, whereas the infinity of individual experience continues to change. We therefore have the position that on the one hand phenomenology abstracts from an infinity of constantly changing constituents, and on the other hand is definitely orientated towards the perceptible and the concrete, not the abstract[2] (Jaspers 1968, p. 1320).

Experiences, perceptible and lived, are the themes of attention of the phenomenological enterprise, and how these experiences shape the relationship between the person and the world. How these phenomena are presented to one's consciousness must be scrutinized considering the internal tension, opposition and reciprocity that they share with each other

*Through oppositions life expands its meaning*s. When we talk about oppositions, especially in the field of speculative thinking and logic, we are not talking in terms of values; rather we use the logic of negation as the only possible tool which allows the dialectic movement to proceed: "From the point of view of classical logic, negativity is a logical connective, the use of which can only be a 'one-way path': the meaning of negation is to invert the truth value of a proposition to which it (the negation) is related" (Brencio 2021, p. 121). Oppositions show that *contradictio est regula veri* and assign a cardinal role to negativity, as "the energy" of unconditional thought. If we want to simplify the complexity of speculative thinking and see its (hidden) relevance for psychic life, we may say that

> biological events only provide an analogy for what is meaningful. In the field of the meaningful, we discover risk, fear of making the inescapable leap (always into the reciprocity of the whole), choice and creation (...) These meaningful reciprocal movements are of two opposing kinds, those that drive life upwards or those that drive it to destruction (Jaspers, 1997, p. 346).

It is in this space that the concept of betweenness enriches the internal dynamics between the interpersonal and intersubjective nature and space of subjectivity. The notion betweenness allows the overcoming of the dualistic approach typical of Cartesian meditation to subjectivity in general, and to mental health in particular.

That said, we will now present some of the characteristics that phenomenological psychopathology assumes from a dialectical perspective. We argue that the introduction of

[2] For a contemporary critique of some perspectives of Jaspers, please see Ferrarello & Brencio (2025); Fuchs, Breyer, Mundt (2014) and Stanghellini & Fuchs (2013).

dialectics allows psychopathology to better understand the development of the person, a perspective that is so relevant for the contemporary needs of mental health, by enriching the static structural comprehension still dominant in phenomenological psychopathology. We will explore this idea starting from the paradigmatic case of schizophrenia[3], by sketching some ideas for a comprehension of this condition under a dialectic perspective. Before moving on to the next step, a few words are warranted here. Overcoming a Kraepelinian diagnostic system doesn't mean abandoning it altogether; rather, we understand this concept from a Hegelian perspective, to which "overcoming" means incorporating some knowledge/event/category into a superior, i.e. more complex, Gestalt. In doing so, the characteristics of this knowledge are both kept and changed, being the latter due to this belonging to a new Gestalt. It is the new Gestalt that will define the meaning and importance of the knowledge acquired prior to overcoming. In this case, it means that the core Gestalt that defines the meaning of the schizophrenic symptoms is the person in her totality, i.e., not only as the bearer of a series of symptoms, but as the living unity that experiences and gives meaning to these symptoms. This perspective changes the focus from the symptoms to the integrity of the person, without reducing the value of their abnormal experiences, as we will see. Moreover, this is in line with recent calls to improve the names of mental health conditions (Cohen et al., 2022)[4].

From philosophy to clinical practice: towards a dialectical model in schizophrenia

We owe the study of schizophrenia to the very birth of psychopathology. The complexity of primary psychotic experiences (so-called functional or endogenous) and the impossibility of understanding them using the positivist categories of the early twentieth century gave rise to attempts to tackle them using more comprehensive epistemological models. It could be said that the moment when the contemporary concept of schizophrenia was created, coined by Eugen Bleuler in 1911 (1950), was guided by the acceptance of an existential complexity that the previous Kraepelinian model did not have as a central factor. Although Bleuler remained generally within the epistemological perspective of traditional nosology, his distinction between fundamental and accessory symptoms inaugurated a

[3] However, we believe that this procedure can and should be extended to all mental health diagnostic categories. A more detailed presentation of the extent and vitality of the use of dialectics as opposition of elements can be seen in Messas 2021.

[4] we could wonder if the concept of schizophrenia still makes sense after this dialectic comprehension: however, for the sake of simplicity, we will skip this discussion in this article

tradition of psychopathological understanding that would be inherited by structural phenomenological psychopathology. By using this distinction, Bleuler already sensed the insufficiency of investigating schizophrenia as a simple nosological unit, like others in neurology or medicine. Bleuler, maintaining his conviction of a cerebral cause for the disease, inaugurated the scientific search for the essential elements that would characterize it as such. Parallel to this tradition of searching for the essence of schizophrenic breakdown, another current has historically developed, which seeks to examine schizophrenic experiences from a dialectical perspective (Messas et al., 2017).

This seeks to examine the longitudinal intertwining between the pathological experience and the existential whole. This perspective was inaugurated by Karl Jaspers in 1910 by introducing the distinction between process and development (1910). Coined to give visibility to the distinction between schizophrenia and non-schizophrenic psychoses, the notion of process is the longitudinal synonym for schizophrenia. A process is, as Jaspers exhaustively demonstrates through lengthy analyses of clinical cases, the biographical result of the transformation of existence starting from a primary alteration, irreducible to any psychological understanding (also of possible biological origin, according to the author), which goes on to guide the psychologically understandable results. As the French historian of psychiatry Lantéri-Laura puts it, the notion of psychic process is “essentially dialectical” (1962, p.471), as it defines the most important disorder in psychiatry based on the principle of negativity. It is the impossibility of a psychological comprehension, i.e. of a positive experience, coherent to the development of the person, which brings to light the meaning of a disorder. Schizophrenic process is the paradoxical incorporation into a person's life of a negative rupture of the continuity of this very person, prompting necessarily a dialectical relationship between the experience and its secondary organization in the whole person.

However, the notion of process can also be understood under a dialectic of reciprocity. The dialectical way in which these negative experiences are processed in a person's life will henceforth appear as a scientific object, shaping the overall clinical condition that is called schizophrenia. In the words of Jaspers: “[the diseases] assail the individual like other illnesses but in this case the individual *becomes one with the illness* (p.608, our italics). It is the form of this “becoming one with” which still deserves attention in phenomenological psychopathology. It remains a challenge for historians of psychiatry to find the answer to why the concept of process waned in the last decades of psychiatry (along with the waning of the scientific value of detailed investigations of clinical cases),

even though its vitality was still widely recognized long after its original coining by Jaspers (Alonso-Fernández, 1976).

In any case, it is impossible to use the notion of the schizophrenic process without incorporating the dialectical dimension in the experience of the person living with schizophrenia, in their evolving biographical dynamism. In the following paragraphs, we would like to sketch a proposal of distinct situations in which a dialectical account might enlighten the comprehension of the schizophrenic process, which correspondingly determines specific ontologies of the disorders, i.e., global meanings of the disorder for the affected person, enabling a wider comprehension of distinct meanings for the person with schizophrenia and, hence, for schizophrenia as a disorder.

The negative discontinuity of the experiences which characterizes the schizophrenic process does not occur in a neutral way in relation to the existential totality. Except for extremely serious psychotic conditions, in which there is a dissolution of the personality, in most cases it establishes a dialectical relationship with the whole of existence. This dialectic, in turn, takes place on two levels, the pre-reflexive and the reflexive. The first level refers to the pre-reflective dialectic between the basic conditions of possibility of existence and the whole of personality. The second level addresses the value a schizophrenic person ascribes to her new altered state. For reason of space limitation, we will examine here only the pre-reflective level, stressing that, in real life, there is no such a clear-cut distinction between both[5].

The pre-reflective dimension (also called the conditions of possibility) of experience is the one that provides the general framework in which consciousness and the experience of self occur. When we are conscious, we pre-reflexively have, for example, a tacit notion of the continuity of our own identity and the world we are in. We are what our pre-reflexive dimension has allowed us to be. By disrupting this dimension, the schizophrenic experience causes the historical personality itself to undergo a distortion, so that the foundation of self and world on which the disorder occurs and which the person must react to it is also transformed. This situation was brilliantly summarized by Binswanger:

> [...]it is not `the schizophrenic` who 'understands' himself and his existential transformation and seeks to `guide himself` this way - has any schizophrenic ever reported something of this kind? - But it is the Dasein in his schizophrenic condition - who understands and orients himself and the world that way. In the first case, understanding means a psychological understanding; in the latter, a transcendental [pre-reflective] understanding (Binswanger, 1957, p. 455, our translation)

[5] Regarding the value attribution of the schizophrenic person, we refer the reader to Wirsch (1949), in classical times, and, more recently, Stanghellini & Ballerini, 2007

It is not, however, a question of excluding the person from their biographical unity in order to understand the schizophrenic processual experience, but of including a previous ontological layer that investigates the donation of the world that the disorder imposes on this person. Although the affected person simultaneously maintains her biographical unity, with their personal values and aspirations, she now must deal with a new parallel unity of meaning, with which they necessarily establish a dialectical relationship (the phenomenon of double bookkeeping, designed by Bleuler). It should be noted that, at this level, it is not a question of attributing value to the psychotic phenomenon, but of a primary experience of coexistence between two worlds in their pre-reflexive configuration.

We suggest that three dialectical forms can be observed here in decrescent degrees of preservation of the previous historical unity of the personality. We do not want to suggest that there are only three ways of organization but understand that they are sufficient for us to make our point. Neither do we want to suggest that these dialectics should mirror the classical nosological distinctions of schizophrenia (e.g., negative vs positive; or the simple, hebephrenic, paranoid and catatonic forms); our aim is to shed light on how new forms of existing emerge after a schizophrenic transformation.

A. The dialectic of resignation

This dialectic captures the so-called negative schizophrenic experiences, such as the classic Anne case studied by Blankenburg, about which the author coined the term of loss of natural evidence (1971/2012). In this condition, the historical person is faced with the fact that something central to her has disappeared or been cancelled out (“Doctor, they've stolen my soul”, as one of our patients put it). Now, the occurrence of this affective experience presupposes that there is sufficient historical continuity in the personality for a comparison to be made between a habitual state and a pathological one. Thus, a parallel trajectory of personality development occurs, in which the central pre-reflective dialogue of existence becomes the reduction of the capacity to experience meaning in life, while maintaining the notion that life is meaningful. The central experience of loss of self means that the way in which the other appears in the schizophrenic person's consciousness takes on the appearance of an ally. The other is the one who can either help the person overcome their annulment (in a more clinical dimension) or share with them the realization of their suffering.

B. The dialectic of resistance

The so-called positive schizophrenias are characterized by the formation of a delusion. Seen from an existential point of view, delusion is a pre-reflexive organization of consciousness aimed at establishing a secondary unity in the face of the primary rupture of the shared experience of the world (Ritunnano et al., 2022). Thus, delusional formations have above all a restorative and stabilizing function for the integrity of existence (Tamelini & Messas, 2016). Although the delusional experience emerges as something external to the person's usual biographical development, their own integrity as a historical person comes to depend on the delusional formation. This condition gives delusion a gigantic influence on the person experiencing it. Psychologically, the person experiences it as an uncontrollable power acting on them. Their primary reaction is one of defense against the risk of annihilation in the face of such an uncontrollable power. This experience is called paranoia. Less than a feeling of persecution, paranoid delusion portrays the impotence of a self in the face of something that belongs to it, but which seems external to itself. Its basic attitude will be one of suspicion and, above all, of defense in the face of a continually imminent risk. From the point of view of biographical development, the defensive theme dominates, causing the person's life to gravitate towards protection strategies, restricting the breadth of existential possibilities. In the intersubjective sphere, the capture of the other oscillates between an auxiliary within the state of siege experienced by the person and the representative of continuous delusional harassment.

C. The dialectic of absorption

Rigorously speaking, we could say that this condition points to an almost exclusion of the dialectical dynamics between a pre-reflective experience and the person. Under this condition, the person experiences the new meanings supplied by the core pathological experience as a completely new and life-changing reason for their existence. The typical clinical example of this is the so-called religious delusion. The affected person is overwhelmed by an experience of being a saint or a god or chosen by a god to act following its determinations. There is a complete change in their existence, as this new meaning drives her behavior, making them, for example, bless unknown people in the streets. Distinctly from the two former conditions, the person does not experience the new emergence as a problem or as a thread, but as bliss for their existence. They did not claim any transformation, let alone a restoration in her new psychological state, and, as such, they don't understand the presence of the clinician as an instrument to help them. The only

access of the clinician to the patient under this dialectic is assuming a role of mediator between the person and the community, trying to expose to them that her behavior might be misunderstood by her context. Care should be understood as a mediating process between the person and the social context, as a diplomat in a foreign country seeks to make his culture better understood by another one. The main new interpretation of the other by the part of the patient – as someone to be saved by her – however, cannot be changed and cannot be the target of the care.

As we can see from the brief analyses above, the experience of schizophrenia, from the point of view of the wholeness of the person, cannot be understood as homogeneous. Rather than understanding these differences in terms of semeiological forms of schizophrenia (always disputed), - determined either by their distinctive symptoms or evolution - or even in terms of distinct value-based reactions of the person to a psychotic experience, it is arguable to defend that these differences reach the ontological level. These experiences constitute in fact distinct transformed worlds, which should not be unwarranted unified under the concept of schizophrenia *tout court*. Again, we can find in Ludwig Binswanger, the first essay of renewing the language of the mental disorders, by creating new names for schizoid experiences, names more related to the way they experience their world than to their symptomatic experiences, taken as pathological (1956/1992). In times like ours, eager for choosing a more appropriate language for reducing stigma in mental health (Volkow et al., 2021), and to do that depicting the real experience of real people, resuming this interrupted project of classical phenomenological psychopathology looks highly disruptive and cutting-edge[6]. As these experiences are ontologically diverse, the corresponding meaning of care should fit to each of them. Care, in the first case, means helping the person to cope with her sequelae of altered experiences attaining her field of experience. In the second case, care means adopting the harassed experience of the person as the aim of the clinical decision-making process, seeking to allow the affected person to live in a continuously harassed world. Finally, in the third case, care means guiding the person through a new world, inaccessible to her fellow people. In times like ours, when there are strong claims for putting the person as the center of mental health, it seems necessary to have an epistemological perspective which may illuminate the distinct experiences of the person.

[6] At this point, it is important to highlight that Bleuler, when coining the current concept, did it in its plural form: *the schizophrenias* (*die Schizophrenien*), pointing to this ontological difference though his epistemology could not develop this interpretation).

CONCLUSIONS

This paper tried to address a fundamental dilemma in psychiatry: while the recognition of the biological paradigm and the consequent reification is inadequate to understand mental health conditions, we haven't still managed to move beyond this framework. Our theoretical hypothesis, a dialectic approach to phenomenological psychopathology, examines how different aspects of the experience interact and influence each other.

Philosophically speaking, we are still at the crossroads of an epistemological choice between the need of a naturalistic paradigm for mental health conditions, more than often inclined to a form of reductionism the risk of which is to have a psychiatry without a psyche, and the need of a person-centered care which recognizes the constitutive fragility of the personhood in its ontological determination, "a "wounded Cogito—a Cogito that posits itself but does not possess itself; a Cogito that sees its original truth only in and through the avowal of the inadequacy, illusion, and lying of actual consciousness" (Ricouer 1970, p. 439) The wounded cogito (*cogito blessé*) unveils the need of a hermeneutics of existence able to recognize, understand and interpret the ontological proportions and disproportions which dialectically shape the fundamental structures of subjectivity and intersubjectivity.

Contemporary psychiatry is based on an illness-centered paradigm: this means that the question of diagnosis and its treatment is at the core of the therapeutic enterprise. The treatment and understanding of mental health conditions are strictly linked to the need of reevaluating models and roles in clinical practices, such as a drug prescription, a more careful attention to a person-centered approach, and a focus on treatments centered on patients' lived experiences and community-based interventions.

A psychopathological schizophrenic experience represents a tsunami that can overwhelm and devastate the patient's life; it can represent the moment of a deep and irremediable fracture with the attribution of meaning and value that the person gives to the world around her and represents an occasion of danger for herself. The pain of a schizophrenic person, for example, remains an experience comparable to a wound that crosses the soul, which is not merely in her head, but burns inside her chest. In this sense, it would be important that practices of care are not limited to "fixing" what remains after the storm, but also to consider the absence of what the storm has destroyed and carried away. The dialectical notions of ambiguity, reciprocity, negativity and betweenness, as we

explored them in this contribution, may serve to redesign the compass of a navigation along the borders of human suffering, dismantling the Kraepelinian heritage and pushing a phenomenological informed model to psychiatry one step ahead in the consideration of its novelty.

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