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TRACING THE PHENOMENOLOGICAL PSYCHOPATHOLOGICAL ANALYSIS TO ITS SOURCE IN THE SUBJECTIVE EXPERIENCE OF A PSYCHIATRIST*

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The paper explores the guiding motif of psychopathological phenomenological investigation. In other words, it investigates when, how and why the phenomenological method is applied to that, which represents the sole object of study in psychopathology. The exploration begins with a reappraisal of a famous case of melancholia presented by one of the founders of phenomenological psychiatry, Ludwig Binswanger. In critical reading of Binswanger's analysis I give, I argue that we should shift the focus from a patient to a phenomenologizing psychiatrist, to his or her own experience of the situation and the role it plays in application of the phenomenological approach to the analysis of this situation. Surprisingly, the personality of a psychiatrist has never been regarded as the ultimate object of phenomenological and psychopathological study per se neither by Binswanger, nor by other phenomenologizing psychiatrists, although a certain amount of attention has been paid to the relationship between a clinician and a patient by researchers. Moreover, to date, no one has questioned the relationship between the psychiatrist's subjective experience, characterized by a strong emotional input, and the process of establishing a phenomenological attitude. In this paper, I reveal how feelings of a psychiatrist encountering psychosis and, in particular, the malaise of a psychiatrist relate directly to applying the phenomenological method in order to understand of the clinical situation. This, in turn, allows me to revise the role of the phenomenological approach, as providing a psychiatrist with the tools for acknowledging the singular relationship, which his or her psychiatric knowledge has with his or her own experience of the clinical encounter.

Key words: Phenomenology, psychopathology, phenomenological psychiatry, phenomenological psychopathology, phenomenological method, phenomenological attitude, psychiatrist's experience, Ludwig Binswanger.

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ИСТОК ФЕНОМЕНОЛОГИЧЕСКОГО ПСИХОПАТОЛОГИЧЕСКОГО АНАЛИЗА В СУБЪЕКТИВНОМ ОПЫТЕ ПСИХИАТРА

СВЕТЛАНА ШОЛОХОВА

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В статье рассматривается вопрос о том, что является движущим мотивом психопатологического феноменологического исследования. Другими словами, речь идет о том, когда, как и почему феноменологический метод применяется в отношении того, что является единственным объектом изучения в психопатологии. Это исследование начинается с пересмотра знаменитого случая меланхолии, представленного одним из основателей феноменологической психиатрии Людвигом Бинсвангером. В своем критическом прочтении анализа Бинсвангера я утверждаю, что наше внимание должно быть перенесено с пациента на феноменологически мыслящего психиатра, на его собственный опыт переживания ситуации и его роль в применении феноменологического подхода к анализу этой ситуации. Удивительным образом личность психиатра никогда не рассматривалась в качестве конечного объекта феноменологическо-психопатологического исследования как такового ни самим Бинсвангером, ни другими феноменологически мыслящими психиатрами, хотя отношениям между клиницистом и пациентом и уделялось со стороны исследователей определенное внимание. Более того, никто до сих пор не ставил под сомнение связь между субъективным, характеризующимся сильным эмоциональным вкладом, опытом психиатра, и процессом установления феноменологического отношения. В этой статье я покажу, как ощущения психиатра, имеющего дело с психозом, и, в частности, *malaise* психиатра имеют непосредственное отношение к применению феноменологического метода для понимания клинической ситуации. Это, в свою очередь, позволяет мне пересмотреть роль феноменологического подхода, предоставляющего психиатру инструменты для признания особых отношений, которые его или ее психиатрические знания имеют с его или ее собственным клиническим опытом.

Ключевые слова: Феноменология, психопатология, феноменологическая психиатрия, феноменологическая психопатология, феноменологический метод, феноменологическая установка, опыт психиатра, Людвиг Бинсвангер.

INTRODUCTION

Today, the concept of phenomenological psychopathology has gained recognition among mental health professionals and philosophers alike, who see the advantages of combining phenomenology and psychopathology in order to address the question of what mental illness is from different, but ultimately compatible points of view. One of the main differences between phenomenological and psychopatho-

logical perspectives lies in the fact that whereas psychopathology's ultimate goal is to decide whether certain phenomena belong to the normal or pathological realm, phenomenological discourse is presented as non-normative. This does not, however, appear to be problematic since, according to the founding fathers of phenomenological psychopathology, Binswanger, Jaspers, and others, the relationship between the two discourses is a hierarchical one: the phenomenological perspective on the problem of mental illness is usually seen as laying the ground for the psychopathological one. The difference is perceived, therefore, as a source of complementarity: phenomenological analysis provides an understanding of the conditions of the possibility of mental illness, that is the understanding of the fundamental structure of the patient's experience underlying the phenomena apprehended as symptoms of mental illness (Parnas & Zahavi, 2000).

But how, in this perspective, could we account for the practical aspect of the alliance between phenomenology and psychopathology? How can a dialogue between these two discourses be realized in practice? In what language and on what territory should the passage from one discourse to the other take place? How can phenomenological psychopathological study be defined? In this paper, I explore the hypothesis that, in order to answer these questions and have a better understanding of what makes phenomenological psychopathology possible, we should follow it to its source and clarify what drives the psychopathological phenomenological investigation by analyzing how such an investigation unfolds itself. In other words, we should show when, how and why the phenomenological method is employed in what could otherwise be solely a study in psychopathology.

The usefulness of phenomenological analysis usually becomes clear only *après-coup*, after the clinical encounter takes place and during the case's analysis[1]. This does not mean, of course, that phenomenological analysis could not have repercussions for psychiatric and psychotherapeutic practice. Nevertheless, it is clear that phenomenological psychopathology and the definition of its object and method emerges primarily at the stage of research. In this context, it will come as no surprise that the analysis of texts will be the starting point for the argument presented in this paper.

The question of how one develops a phenomenologically informed psychopathological analysis and where one should start such an analysis has, however, remained looming in phenomenologico-psychopathological literature. To raise such

[1] See, for example, the interview with the Belgian psychiatrist Jacques Schotte, where he highlights the fact that Binswanger "considered the *Daseinsanalysis* primarily as a research method, including a new way of presenting the 'analyses' of pathological cases and that it is through the latter that it might have an effect on the psychopathology" (Schotte, 1995).

questions demands, indeed, shifting our attention away from the patient to phenomenologizing psychiatrist. It may appear surprising that throughout phenomenological psychiatry's history, clinicians have not paid close attention to their own experience of the situation and its role in the application of the phenomenological approach to the analysis of the clinical encounter.

Needless to say, the phenomenologico-psychopathological approach does not blithely ignore the experience of the psychiatrist and the relationship between the latter and that of the patient in the process of psychiatric study. In his major contribution to phenomenological psychiatry, W. Blankenburg draws a clear distinction between two meanings of the experience of the patient during the clinical encounter modeled on the two meanings of *genitivus* (experience *of* mental illness): the first refers to the experience of the patient (*genitivus subjectivus*) and the second to that of the psychiatrist (*genitivus objectivus*) (Blankenburg, 1971, 21). But, even for Blankenburg, the twofold character of the situation of the encounter with mental illness seems, in the final analysis, to be secondary, since the psychiatrist's experience is never put forward as an eventual object of study *per se*. This approach is still common in contemporary phenomenological writings on psychiatry and psychopathology: even though researchers increasingly highlight the intersubjective nature of the clinical relationship (Laing, 1964; Tatossian, 2002; Fuchs, 2010; Parnas & Gallagher, 2015), the patient's experience is still largely considered to be the only object worthy of being studied, as if it were the only condition that constituted the patient as a subject. In this article, I argue that, however counterintuitive it may appear at first, it is only by acknowledging that there is another subject at stake in the clinical encounter — a subject that also deserves to become an object of study — that the patient can truly emerge from the encounter as a subject. In order to fully understand the implications of this apparent paradox, we need to reconsider the role of the process of the phenomenological attitude.

In this paper, I argue that the understanding of phenomenology's contribution to psychiatry, dominant in psychopathological literature, does not reflect the fact that the implementation of the phenomenological approach in psychiatry requires an adoption of a phenomenological *attitude*: the psychiatrist has to become a phenomenologist[2]. To consider the psychiatrist solely as an observer, means, indeed, to neglect

[2] Of course, not only a psychiatrist, but every practitioner, could become a phenomenologist. We could also think, for example, of a kind of interdisciplinary study where the phenomenologist would be a philosopher that would come to work together with the psychiatrist and/or a member of the clinical staff. In any case, we have to assume that there is a point where the psychiatric, and phenomenological points of view converge, allowing a dialogue between psychopathology, psychiatry

the active role that the psychiatrist's experience plays in the analysis as well as the effect that the adoption of the phenomenological method may have on it. Consequently, in order to achieve a comprehensive understanding of how phenomenological psychopathological analysis unfolds itself and its effects, one has to take into account not only the 'object' of phenomenological analysis (the patient's experience), but also the experience of its subject, i.e. the experience of the one who is conducting the analysis.

The lack of attention to the experience of the phenomenologizing psychiatrist is connected to the distrust towards the person of the psychiatrist in psychiatry in general. This distrust can stem from the fact that somatic medicine has long been considered the model with which the development of psychiatry should be aligned. Contemporary psychiatric diagnostic systems inherited the idea of objectivity as it is presented in medicine, i.e., as something that can be achieved only by adopting a 'point of view from nowhere'. From this perspective, the psychiatrist's impressions and feelings should be discarded because they tend to interfere with the results of psychiatric expertise. Only a perfectly neutral attitude is considered appropriate for an accurate diagnosis.

This approach to mental illness remains, however, very narrow. Firstly, the specificity of the psychiatric 'object' lies precisely in the fact that it is not observable in the same way as the objects of somatic medicine. Mental illness is subjective by definition since it affects not simply the person's behavior or capacities for adaptation to a given situation, but also her everyday relationship to the world, to others and herself. The fact that mental illness alters a person's subjective life is, therefore, what compels her (or her entourage) to seek the help of a psychiatrist. Secondly, it is only possible to have access to the subjective experience of the patient through a relationship. In this

and phenomenology to take place. To analyze the idea of a psychiatrist becoming a phenomenologist is therefore one possible way to address the possibility of such a dialogue and, more precisely, to question the perspective that should be adopted in order to address such a question. Another possible way to address this issue would be from a patient's perspective. In their recent article, Høffding and Martiny (2015) develop the idea of a phenomenological interview that would offer the patient (or any other person whose experience we would like to analyze) phenomenological tools that would help him or her to develop, by his or her own means, a phenomenological analysis of his or her own experience. Whereas the authors emphasize the difference between such a phenomenological kind of interview and an explicitation kind of interview developed by Vermersch (1994), Petitmengin (2006) and others, both of these approaches share the idea that phenomenological analysis should be delivered first-hand, i.e. by the person whose experience becomes the object of the study. I also share this concern. So, if we understand the phenomenological approach as grounded in a first-hand description, the development of a psychiatrist-oriented perspective becomes indeed a necessity in such cases where the psychiatrist explicitly adopts the role of the initiator of phenomenological analysis.

sense, the phenomenon of mental illness should be considered not only in its subjective, but also its intersubjective dimension: "What is given [as Merleau-Ponty writes about a study of hallucinations] is not myself as opposed to the other […] sane consciousness with its *cogito* as opposed to consciousness afflicted with hallucinations, the former being the sole judge of the latter and limited, in relation to it, to its internal conjectures — it is the doctor *with* the patient, myself *with* others…" (Merleau-Ponty, 2005, 393–394). Consequently, it is not helpful to treat the subject of the study (the psychiatrist) as someone who provides a neutral gaze that only registers the object's features. Even if such neutrality were achievable, in the context of the clinical encounter, the psychiatrist's presence proves to be essential for the understanding of the mental illness. While dealing with the most tangled and complicated cases, instead of interfering with the diagnostic process, the psychiatrist's emotional response to the situation is often her main guide (Srivastava & Grube, 2009). Hence to acknowledge the psychiatrist's emotional involvement in the clinical situation does not mean admitting scientifically irrelevant information into the discussion (Pallagrosi, Fonzi, Picardi, & Biondi, 2014). In fact, what one considers relevant for producing objective knowledge depends on how one defines objectivity and its relation to social reality. Psychiatry has already made some important steps towards the model of 'participative science' by including the patients and their families and loved ones into the discussion about mental illness. Today it is becoming all the more important to put forward the figure of the psychiatrist as an active decision-making participant in this specific social situation. For this to be achievable, the psychiatrist needs to become aware of her feelings and impressions as they present a key to establishing reciprocal contact with the patient.

In this paper I argue that the application of the phenomenological approach is directly connected to the subjective experience of the psychiatrist. My thesis is that this experience is at the same time the very source of the phenomenological work and its object *par excellence*. This means, however, to reconsider the value of the phenomenological approach as proposing a new kind of framework that makes intelligible the phenomenon of mental illness. The phenomenology appears to be first and foremost a 'technique', in the Levinasian sense of term (Levinas, 2010), that allows the subject of the analysis (the psychiatrist) to shed new light on his or her own experience of the clinical encounter and to identify the singular relation that his or her psychiatric knowledge entertains with it. For this, we shall have a closer look at a phenomenologically informed psychiatric study.

I propose to investigate the starting point of the phenomenologically informed analysis of a mental illness case by going back to the beginning of the phenomeno-

logical psychopathology, to the writings of Ludwig Binswanger, one of the founding fathers of phenomenological psychopathology. Binswanger's position represents an important example of an attitude shared by many phenomenologizing psychiatrists, for whom the use of phenomenology amounts merely to a decision to adopt a certain theoretical perspective. They are motivated by the potential benefits of this perspective rather than by the possibility of any kind of special personal experience the clinical encounter may offer. Even though Binswanger ostensibly adopts this approach in his account of a clinical encounter, a close examination of his words makes it possible to detect the existence of an interconnection between the psychiatrist's experience and the phenomenological attitude. The phenomenological method distinguishes itself, indeed, from other types of philosophical approaches precisely by the way it engages the subject of analysis and affects subjective life as a whole. I argue that Binswanger's own account allows following the phenomenological psychopathological analysis to its source in the psychiatrist's subjective experience.

1. LUDWIG BINSWANGER'S PROJECT OF DASEINSANALYSIS

At the beginning of the twentieth century, progress in psychopathology and psychology showed that it was impossible to treat psychosis using existing medical methods, and more specifically the existing neurological model. But one question remained: if psychiatry abandoned the neurological model, would it still be a science? If the object of psychiatry is the problem of the *psyche* rather than that of the body, how could an objective study of the former be assessed (Lanzoni, 2003)? And, finally, would it be possible for psychiatry to take into account the subjective nature of psychic life while at the same time proposing a diagnosis and a treatment? Ludwig Binswanger, the young director of the Bellevue Clinic, attempts to find a solution to the problems expressed in these questions by bringing to psychiatry a new kind of philosophical investigation, the phenomenological method (Basso, 2012). This solution, which Binswanger designates as *Daseinsanalysis*, involved a new definition of the object and method of psychiatry[3].

[3] Binswanger's contribution to psychiatry and phenomenology is, of course, not limited to the *Daseinsanalysis*. Researchers usually distinguish between three periods in Binswanger's phenomenological writings: Husserlian, Heideggerian and the second Husserlian period. In this paper, my intention is, however, to discuss to the Daseinsanalytical period only, since my goal here is to show how a phenomenological methodology is brought into the psychopathological study. This process is best illustrated with the case of melancholia. The distinction between the Husserlian and Heideggerian periods in Binswanger's writings is left out of this discussion also because Binswanger's vision of the contribution of phenomenological description always followed the general idea of re-

In phenomenology, Binswanger sees a new way of understanding the process of investigation that deals with a person's *psyche*. As he understands them at the time, psychiatry, and also psychoanalysis, are both mostly based on an explanatory model since they are focused on finding a cause that would *explain* the patient's behavior, expressions or words perceived as pathological, by analyzing them as symptoms. This approach, however, disregards the fact that every symptom is an expression of the processes that take place within the totality of the person's experience. It is therefore necessary to go beyond looking for an explanation and to try to understand what is at stake in the patient's experience by grasping the structure of the global system that determines the conditions of the possibility of every mental state.

In order to achieve such an understanding, Binswanger turns to Heidegger's concept of *Dasein*, which denotes the person's subjective experience as it constitutes his or her being-in-the-world. According to Binswanger, the important advantage of *Dasein* lies in the fact that this concept (unlike those of life or consciousness, for example) displays a unity, 'a true structure' (Binswanger, 1992, 396). The crucial point of the daseinsanalytical approach is, indeed, the idea that every form of human experience unfolds within a certain singular framework. More importantly, to consider a human being as a structure of being-in-the-world means to see it as a structure that has within itself the laws of its structuration. Such a structure cannot be defined by referring to something other than the structure itself, i.e. to a norm that would be external to it (Binswanger, 1994a, 231).

Let us consider, for example, how Binswanger analyzes a case of psychotic melancholia. In his text *Melancholia and Mania* (Binswanger, 1994b) Binswanger tells the story of a patient who lost her husband in a train accident and cannot stop blaming herself for what happened. Over and over again she keeps saying: "…if I had not proposed this trip, my husband would still be alive, I would still be happy, full of life, and I would have nothing to blame myself for, etc." (Binswanger, 1994b, 361). Up to a certain point, Binswanger writes, he is able to relate to this woman's experience. Her pain and her regrets expressed in these lamentations become an object of empathy: he can imagine, together with the patient, that everything could have been different, that she could have avoided taking the train with her husband or taking the train altogether, etc. And even though the psychiatrist's feelings do not have exactly the same object as his patient's feelings, the suffering can to a certain extent be shared (Binswanger, 1994b, 360–361).

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vealing the fundamental structure of human experience and its possible transformations (whether it should be described in terms of maturation of *Dasein*, in terms of the temporal structure of the stream of consciousness, or in terms of embodied and spatial experience).

The psychiatrist's empathy, however, has its limits. Binswanger observes that "even if we still can empathize with the self-reproach, we cannot do this regarding what is, in clinical terms, imposing itself here as melancholic" (Binswanger 1994b, 361)[4]. In other words, Binswanger notices that there is a breach, a gap in his ability to relate to such a patient's situation, there is something in the other person's experience that cannot be grasped through empathy. At the same time, this something demands to be explained and psychiatry is able to address the problem by theorizing it in terms of melancholia.

There is, however, Binswanger argues, another — phenomenological — way to address the problem of the limits of empathy. The phenomenological approach has the advantage of being able to show what kind of modification of the existential structure should take place in order for the patient to feel the way she feels. It is this modification that is then identified as melancholia in psychopathological terms. In the analyzed case, it is the capacity to project oneself into the future, onto the horizon of different possibilities of being in the world that is undermined. The reproaches that the patient continues to make to herself ('if only I had,' 'if only I had not') demonstrate that such possibilities became 'empty', (Binswanger 1994b, 361), because they are no longer projected into the future but remain trapped in the past. In phenomenological terms, the protentions got mixed up with the retentions thus altering the entire stream of consciousness.

The value of the phenomenological understanding of mental illness lies, therefore, in grasping the fundamental flexibility (or *Dasein*'s 'mobility' (Heidegger, 2010, §38)) of the structure of being-in-the-world: our ability to be in the world and with others does not take a fixed form, identical for everyone, but at the same time its fundamental structure is shared by everyone. The daseinsanalytical approach, then, allows to see a certain mental state as a "factual variation of the *a priori* structure"[5], as a "change in a form of being-in-the-world or life-style"[6]. This means that a variation in the mode of being is a product of factual circumstances, but it unfolds within given limits.

By grasping how the factual circumstances provoke modifications within an *a priori* structure of experience, one can determine what it means for a person to be affected by mental illness. From a daseinsanalytical perspective, a mental illness could be understood as a shrinking of the general framework of experience, as the

[4] „Auch in einen solchen Selbstvorwurf können wir uns zwar noch ‚einfühlen', nicht aber in das, was uns daran klinisch als melancholisch imponiert".

[5] „Faktische Abwandlungen dieser apriorischen Struktur" (Binswanger, 1992, 397).

[6] „Veränderung der gesamten Daseinsform oder des gesamten Lebensstils" (Binswanger, 1994a, 257).

subordination of the being in the world to one project of being, i.e., to a single way of relating to the world. In other words, everything that happens to a person acquires its meaning based on a single idea that produces the effect of a lens refracting light rays in such a way that they bend away from their initial direction. The ultimate goal of *Daseinsanalysis*, according to Binswanger, is to provide a 'scientifically accurate' study of the 'deviations from the norm' (*Abweichungen von der Norm)* (Binswanger, 1994a, 243) that *Dasein* can endure under the constraint of facticity. With a new definition of the object of psychiatry (as *Dasein*) and a new, appropriate type of analysis (phenomenological analysis) that tries to articulate factuality with normativity, psychiatry becomes, then, a 'science of the singular' (Basso, 2015), i.e., an approach that aims to provide a valid, objective, and thus scientific knowledge based on the understanding of singular cases.

2. TWO-LEVEL RELATIONSHIP BETWEEN PHENOMENOLOGY AND PSYCHOPATHOLOGY

The *Daseinsanalysis* played an important role in the dissemination of phenomenological ideas in psychiatric circles. Phenomenological psychopathology, in turn, contributed to the introduction in psychiatry of a patient-oriented perspective, as we call it today, and to the development of a positive vision of the patient's mental states as meaningful. This hermeneutic attitude made it possible for practitioners to start relating to their patients' experiences, now considered as essentially intelligible. As such a hermeneutic approach, the *Daseinsanalysis* is first and foremost descriptive and not explanatory (Binswanger, 1955, 288).

For Binswanger phenomenological description and psychiatric diagnosis are situated on two different levels. In the context of psychopathology, to adopt the phenomenological approach means "to gain a 'deeper' perspective" (Binswanger 1963, 328): the transcendental level of understanding that reveals the conditions of the possibility of a particular type of experience by grasping the basic existential structure of being-in-the-world as well as its vulnerable points. This transcendental understanding is the result of the procedure of phenomenological reduction that makes it possible to detach oneself from the existing explanatory model and thus brings the analysis of the clinical situation on a level independent from psychopathological knowledge. It is, then, precisely the *freedom* of phenomenological analysis, its autonomy from psychiatry that makes possible the description of the subjective experience of the patients, without assuming them mentally ill in advance.

Binswanger insists, however, that such *freedom*, which puts aside the normative psychopathological terminology, does not entail a rejection of psychiatric knowledge or an assumption that phenomenology's goal is simply to provide a substitute for psychopathology. As Binswanger puts it, existential analysis cannot 'replace' psychopathology with phenomenology (Binswanger, 1955, 288); instead, it provides psychiatry with strong theoretical foundation. Psychiatric knowledge is therefore not less reliable than the transcendental phenomenological understanding; however, it is by grasping the principle structuring the human experience that we can understand 'what is really happening'[7] in mental illness.

At this point, it would be useful to raise the question of whether this two-level explanation, which distinguishes the role of phenomenological description from the psychiatric approach within the general system of psychiatric knowledge, fully explains what is at stake in the project of phenomenological psychiatry. What seems to be missing here is an account of how this change in perspective occurs. In other words, what would motivate a psychiatrist in a given situation to look for a new perspective in the first place? In order to answer these questions, let us have a closer look at Binswanger's analysis of the case of psychotic melancholia presented earlier.

3. "…(W)HAT IS, IN CLINICAL TERMS, IMPOSING ITSELF HERE AS MELANCHOLIC"?

Binswanger's understanding of the value of phenomenology can be gleaned from his analysis of the case of melancholia: phenomenology allows the psychiatrist to further his understanding of the patient's persistent lamentations to which he has considerable difficulty to relate. Thanks to the phenomenological analysis, the psychiatrist gains the ability to grasp the reason for these expressions of grief and regret and better understand why he is not able to empathize with them. The psychiatrist now becomes aware that it is the deformation of the structure of temporality in the patient's experience that alters her whole being in the world to the point that it is difficult for him to connect with her through empathy. But since, the experience of the limits of empathy is what drives the psychiatrist to use the phenomenological approach, then it seems fair to conclude that, for the psychiatrist, phenomenology becomes, implicitly, a technique that allows to address, first of all, *his own experience* as a psychiatrist in a new and more satisfactory way, and only secondly, to provide a better understanding of the experience of the patient.

[7] „Was ist eigentlich geschehen" (Binswanger, 1994b, 359).

It is important indeed to underline the fact that it is as a phenomenologist, i.e. as he is conducting phenomenological analysis, that Binswanger identifies the intervention of psychiatric knowledge as one way to address the limits of empathy: this something which cannot be grasped through empathy is, as Binswanger puts it, '*imposing* itself *as* melancholic' (Binswanger, 1994b, 361). The choice of the verb 'to impose oneself' is absolutely crucial here. It demonstrates that what phenomenology does here is, firstly, *pinpointing a gap separating the psychiatrist's experience from that of the person that he encounters*, an interruption of empathy, and, secondly, *making explicit the role of the clinical concept* (melancholia) as filling in this gap: this incomprehensible element 'is imposing itself *as* melancholic', i.e., it presents itself in the *form* of or by way of a psychopathological concept such as melancholia. The concept of melancholia clearly appears to be used as a bridge that spans the gap in the experience and makes it intelligible.

Although Binswanger himself does not define the role of the clinical concept as that of filling in the gap, this idea follows his argument regarding phenomenological and psychiatric discourses being situated on two different levels of a hierarchy (where the former serves as the basis for the latter). The daseinanalytical approach is assigned a more fundamental position in the hierarchy because, according to Binswanger, it seeks to grasp something incomprehensible as 'what it really is' and not 'as something else'. We can see now that *Daseinsanalysis* allows to access to the true character of the phenomena or the things themselves that the psychopathological conceptual framework can only denote.

It seems fair to conclude, however, that, in final analysis, both the daseinsanalytical and psychiatric approaches identify the breach in communication as a problem that has to be solved and pursue the same goal: the gap should be filled in one way or another. Whereas psychopathology bridges the gap, the daseinsanalytical approach seeks to close or reduce the gap completely, since the aim of *Daseinsanalysis* is to provide a comprehensive understanding of the patient's condition. In a sense, the gap produced by the encounter is first phenomenologically perceived by the psychiatrist to be immediately filled in by the psychiatrist's knowledge and by phenomenology itself as a study of the patient's subjective structure.

But there is yet another way of interpreting the meaning of the adoption of the phenomenological attitude based on Binswanger's own remark. If we take the imposing character of the case of melancholia seriously, we will see that the psychopathological concept does not appear as simply external to and distant from the clinical experience. When Binswanger uses 'as' in 'imposing as melancholia', this is to be understood positively — the concept of melancholia appears to be *a way to deal with the peculiar*

clinical experience — rather than negatively — even if the concept only explains the phenomenon 'as something else' instead of 'as it really is'. In other words, phenomenology offers a *critical attitude* that is *prior* to the kind of knowledge of the object that the intervention of phenomenology would provide (the 'deeper perspective' offered by the understanding of the structural modifications endured by *Dasein*), phenomenology *reveals the ambition* of the psychiatric concept to make intelligible the peculiar experience of the encounter with the patient, an experience that clearly imposes limits to such a hermeneutic ambition.

4. A PSYCHIATRIST-ORIENTED PERSPECTIVE

What really happens when Binswanger engages in phenomenological analysis and what makes the phenomenological approach unique? As has been suggested earlier, the advantage of phenomenological analysis consists in revealing psychiatric knowledge as a certain system of knowledge, i.e. *a complex savoir-faire that the psychiatrist brings to the clinical encounter in order to face a particular experience*. Nevertheless, in order to see the contribution of the phenomenological approach this way, we have to change the perspective from which we analyze the clinical situation.

In fact, even though this is not made explicit in Binswanger's text, his commentary on the imposing character of the situation draws the reader's attention away from the patient's experience of mental illness and reorients it towards the *psychiatrist's experience of the clinical encounter*. The psychiatrist and his experience of the encounter with mental illness are brought to the forefront, relegating the questions of the nature of mental illness to the background. At the very moment when the psychiatrist's feeling is described as *imposing* itself, the psychiatrist appears indeed as the subject, as the one *on whom* something is imposing itself.

It is, then, by focusing on how the experience of the gap affects the psychiatrist and not simply on what it tells us about the patient that we can understand the significance of the phenomenological turn. We can see that the adoption of the phenomenological approach is *motivated* by the experience of a gap separating the psychiatrist's experience from that of the person that he encounters, and that it is, firstly, the effect of a desire to respond to the experience of the gap and, only secondly, a possible, concrete response to it (in our case, this response is the daseinsanalytical description of the modifications of the existential structure in the situation that psychopathology defines as melancholia).

The way Binswanger describes the articulation between the phenomenological and psychiatric approaches as the articulation between two levels remains, on the

contrary, patient-oriented and fails to take into account the psychiatrist's experience as the very source of the distinction between the two levels, that is of the adoption of the phenomenological attitude. It is possible, in my view, that Binswanger does not pay enough attention to the question of the reason for this change in attitude because he perceives the application of phenomenology in the field of psychiatry mainly as an act of will. Such an understanding of the process of the adoption of phenomenological attitude is, however, limited since the latter does not depend exclusively on the subject's decision or a choice that does not affect the integrity of the subject.

Already for Husserl, the change in attitude cannot be reduced to a pure act of judgment that would start with putting aside the assumptions that tend to be naturally adopted (whether it would be about the existence of the world, the basic scientific theorems that describe natural processes or shared social stereotypes). This 'technical' gesture does not exhaust the meaning of the transition to the phenomenological attitude, a transition that is implemented not only as a professional, but also as an existential transformation, comparable to a religious conversion (Husserl, 1970, 137). To understand the adoption of the phenomenological attitude as a matter of decision is, therefore, problematic, because it prevents us from seeing what it means for the psychiatrist to become a phenomenologist and the kind of existential transformation that this requires; a transformation that affects a person's way of life as a whole (Yampol'skaya, 2013, 22–23).

Our hypothesis is that, if the phenomenological attitude *does not* (as Binswanger suggests) seek to eliminate or replace psychiatric knowledge, it is because, from a psychiatrist-oriented perspective, it would be insufficient to consider becoming a phenomenologist as a *switch* from one attitude to another, from a naïve (in the Husserlian sense) vision of things to a more 'profound' one, as if the psychiatrist could simply become a phenomenologist by throwing away his or her white coat. So, instead of being liberation *from* psychopathology, an alternative to it, phenomenology is put into practice *with regards to* it.

Furthermore, if the transition to the phenomenological attitude is not a switch, it is precisely because the psychiatrist's clinical experience galvanizes the process of phenomenological analysis through which he or she may apprehend psychiatric knowledge in a new way. This process reflects the so-called 'motivational aporia' of the phenomenological attitude (Chernyakov, 2005). This aporia has been widely debated in phenomenological literature (Fink, 1995; Bernet, 1994; Luft, 2011) and can be summed up in the following way: on the one hand, since the goal of phenomenological analysis should be, to some extent, already clear for the ego that puts into practice the phenomenological approach, then it seems fair to conclude that the ego

should have already adopted the phenomenological attitude; on the other hand, the reduction is by definition only the way towards the phenomenological attitude, and its starting point should therefore be that of a natural and not of a phenomenological attitude. It is clear then that we have to acknowledge that the peculiar feeling of distance that the face-to-face encounter with a psychotic person produces in a psychiatrist leaves a mark on the phenomenological analysis of the clinical situation. This suggests, in my view, that in the same way as, instead of rejecting psychopathological concepts, phenomenology helps to reveal their functioning in psychiatric practice, it can be used in order to analyze the psychiatrist's experience of the clinical encounter. But where should such a description start?

5. THE MALAISE OF THE CLINICAL ENCOUNTER

The experience of something incomprehensible, when the words do not seem to be able to describe the situation, is not unknown in psychiatric literature. Binswanger, like many other psychiatrists, clearly indicates the peculiar character of the encounter with a psychotic person: this person appears to be strange. Estrangement is, therefore, one of the first feelings the psychiatrist has during a clinical encounter and, in this sense, it constitutes the basis of the psychiatric experience. In fact, this impression is considered to play an important role in the diagnosis (Jaspers, 1913; Minkowski, 1927, 71; Rümke, 1941). Such an account of the bizarreness of the face-to-face clinical encounter tends to remain one-dimensional, because the feeling of the bizarre is described primarily in a psychopathological perspective, i.e. as something that refers to the mental state of the other person. This is clearly the case in *Daseinsanalysis*. Binswanger explains the psychiatrist's feeling of estrangement by means of the description of the patient's condition: it is because the patient's being-in-the-world is undergoing an important modification that the psychiatrist feels a distance with regards to his patient.

In contrast, if estrangement felt towards the other person tells us something about this person, it also tells us something about the one who is confronted with such a person. Hence, rather than interpreting the psychiatrist's feeling as determined by the state of the other person, it is useful to look at this experience *per se*, and to reveal what this experience means *for* the psychiatrist.

When considering Binswanger's melancholia case, analyzed above, the term 'gap' was used to describe the psychiatrist's experience of a breach that appears in the psychiatrist's empathic understanding of the situation ("Even if we still can empathize with the self-reproach, we cannot do this with regards what is, in clinical terms, im-

posing itself here as melancholic") and to which the psychiatric and daseinsanalytical approaches propose their answers. The term gap (*décalage*) is borrowed from Eugène Minkowski who, while trying to identify the nature of the phenomenon of mental illness, poses the question of what creates the gap between the other person's psyche and his own (Minkowski, 1933, 173). In order to push such a questioning further, we need to focus our attention on the psychiatrist. In the psychiatrist-oriented perspective, it is the *opening* of the gap — the fact that something in the other person's experience appears to be unusual and extremely distant with regards to the psychiatrist's own experience — that becomes the object of study.

The term 'malaise' will help us grasp the way in which the psychiatrist experiences the gap in the clinical situation, without immediately shifting the analysis to a psychopathological (patient-oriented) perspective. As highlighted by H. Maldiney[8], during the clinician's encounter with a psychotic person, the "difficulty of being in the presence of the other person […] is indeed the difficulty of being (*difficulté d'être*), because it is immediately doubled by another difficulty that creates the malaise, i.e. the difficulty of being in the presence of oneself" (Maldiney, 2001, 37). Even if Maldiney continues to assume a patient-oriented perspective[9], the term malaise pinpoints the psychiatrist's feeling of the bizarre. The malaise tells us how destabilized the clinician could feel while feeling disconnected from the patient: the word 'malaise' describes, indeed, feeling 'mal à l'aise', that is, 'ill at ease'. More importantly, the concept of malaise perfectly conveys the intertwining of, on the one hand, the distance felt by the psychiatrist regarding the other person's experience (in the case of melancholia,

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[8] Henri Maldiney (1912–2013) was a French phenomenologist who remains largely unknown to English-speaking readers due to the absence of translations. A short article presenting the ensemble of Maldiney's philosophy can be found, however, in the recently published *Handbook of Phenomenological Aesthetics* (Escoubas, 2010)

[9] The "difficulty of being in the presence of the other person" refers here to the difficulty, experienced by a psychiatrist when attempting to make contact during a clinical encounter: the other person appears to be absent, as if the psychiatrist was confronted with the "void", where there is "no one to communicate with" (Maldiney, 2007, 67). The impression that the other person is not there does not imply, of course, that the person in front of the psychiatrist does not mean anything to him or her, or that this person is seen as non-existent; instead it signals the difficulty in communication that may occur in clinical practice, as has been seen for example in Binswanger's case of melancholia. I would like to avoid, however, embracing Maldiney's patient-oriented perspective that explains the psychiatrist's impressions through the analysis of the other person's experience, i.e., by referring to the peculiar character of the existence of the psychotic person, thus reproducing Binswanger's daseinsanalytical approach. For Maldiney, if the psychiatrist feels a malaise as if there were "no one to communicate with", it is indeed because the other person's structure of existence is altered to the point that he or she shuts out from the world, loses the ability to inhabit it, and prevents the psychiatrist from communicating with him or her.

the feeling of incomprehensibility, i.e. Binswanger's incapacity to empathize with the patient's self-reproach) and the distance with regard to psychiatric knowledge and, therefore, to him or herself as a trained psychiatrist (approaching an incomprehensible phenomenon *as* melancholia). Malaise refers, therefore, not only to those qualities of other person that make us feel uncomfortable, but also and most importantly, to the way in which this feeling *means to us*, how *our* own actions and thoughts are affected and animated by it.

A complex *feeling of alienation from the body of acquired knowledge*, the feeling of malaise can have a positive effect on the clinical encounter as it can give rise to a change in the psychiatrist's attitude. The malaise implies, indeed, a distancing, on the one hand, from the scientific psychiatric knowledge and, on the other, from the everyday knowledge of how to communicate with others and relate to their experience. These two elements, as has already been discussed, are crucial in the adoption of the phenomenological attitude.

6. PHENOMENOLOGIZING PSYCHIATRIST AS A WITNESS

The importance of the role played by the malaise of the clinical encounter in the adoption of the phenomenological attitude prompts us to question the possibility of talking about the phenomenological approach to psychiatry as a purely transcendental one. In my view, prior to revealing the conditions of the possibility of the patient's experience of mental illness, a revelation that would then form the basis for the complex knowledge of mental illness, the adoption of the phenomenological attitude underpins psychiatry in the sense that *it supports the subject of psychiatry* (the psychiatrist) in the process of the adoption of a theoretical approach in a given context. *The phenomenological attitude, because it begins with a feeling of malaise, creates a space where the subject of knowledge becomes aware of himself or herself as a subject and expects his or her knowledge to correspond to his or her lived experience*. But such a subject is clearly not a transcendental one, since its existence is no longer exhausted by the desire to have a comprehensive view of the world, of others or of himself or herself, as if from the outside. Instead, such a subject is constituted by the fact of being implicated in the analyzed situation, and is, therefore, constituted as affected by it. In introducing the concept of 'malaise' felt by a psychiatrist during the clinical encounter, my goal is to emphasize that the phenomenologizing psychiatrist *does not represent an absolute zero point*, the center of a perspective that would be imposed on the other. He or she *is not an invisible gaze, a perfect viewpoint, which makes the phenomena visible*, but

rather a place of phenomenalization, the place of the emergence of the phenomenon of mental illness.

Such a description of a psychiatric subject is yet to be provided. By way of conclusion, it will be useful to summarize the results of the analysis and outline the changes in our understanding of the psychiatric subject that such a description would require. First of all, we can see now that if we take into account the way in which the psychiatrist is affected by the encounter with mental illness we begin to view him or her as becoming a *witness*.

The term 'witness' can be used in three different ways. Firstly, a witness is someone who is simply present and aware during an event. In this case, such a person plays the role of the spectator who observes, but does not intervene. In this sense, even a technical device could be considered as a witness if it is used only to register the event and to eventually reproduce it. Secondly, being a witness could mean that, instead of indicating or referring to the event, the person claims to provide an insight into it. In this case, the witness claims to give direct access to the event without any mediation, as if his or her presence did not have any effect on the situation. This type of witnessing claims, therefore, to be absolutely accurate and even unique. With these two meanings of being a witness we can describe the situation of the phenomenologizing psychiatrist during his or her encounter with mental illness as it can be understood from a patient-oriented perspective; on the one hand, the biomedical approach can be compared to the attitude of a spectator and, on the other, the ambition of Binswanger's approach (shared by phenomenological psychopathology as a whole) to provide an understanding of the reality of mental illness corresponds to the idea of the witness as the one who has access to 'what is really happening'.

The term 'witness' may, however, have a third meaning, which does not consist in providing information about or an insight into the event. This idea is borrowed from Levinas whose writings inspire many phenomenologizing psychiatrists today. For Levinas being a witness also means being the *place* where the event occurs as a phenomenon: the witness "is not, therefore, a 'being' among beings, a simple receiver of sublime information. He is simultaneously him to whom the word is said, but also him through whom there is Revelation" (Levinas, 1994, 145). While in this quote Levinas is talking about a religious event, being a witness as the structure of subjectivity, which he describes here, denotes the way to face something that cannot be approached in a customary manner, and notably through understanding. This definition of being a witness is based on the idea that the desire to grasp the other person's experience is a fundamentally violent and therefore questionable act as it conceals the otherness of the other person, an otherness that reveals itself in the ethical meaning

that the other person has for me. This meaning emerges independently of the consciousness that wants to understand it. As Levinas puts it, it is 'smuggled' (Levinas, 1991, 13), while the subject remains absolutely passive. This is why the otherness of the other person, unlike any other object, could not become intelligible and the only subjective attitude that would do justice to it is that of being a witness, of being the place of its revelation.

When analyzing the psychiatrist's experience as that of a witness in this third sense of the term, my goal is not to prescribe an ethical stance to the psychiatrist. It would be in fact improper to translate the passivity, which, according to Levinas, defines the relation to others into something like an unbounded respect or tolerance for the patient. As Alain Badiou has demonstrated, the interpretation that identifies Levinasian passivity with such qualities as respect or tolerance misrepresents his approach. For Levinas, the other person's otherness is not something that I could easily accept: "…the 'concern for the other' signifies that it is not a matter — that it is never a matter — of prescribing hitherto unexplored possibilities for *our* situation, and ultimately for ourselves" (Badiou, 2001, 33). In fact, it is this inconvenience of the other person that shows that his or her existence *means* something to me. This is what Levinas calls being affected by the other.

For Binswanger, phenomenology is an approach that offers a solution for this troubling character of the clinical encounter, but this solution risks obscuring the peculiar character of such an encounter by suturing the gap that characterizes it, which constitutes the very source of the adoption of the phenomenological attitude. Levinasian position, on the other hand, consists in rejecting the basic presupposition of such a hermeneutic project based on the idea that the possibility of intersubjective contact lies in the possibility of understanding the other (Heinimaa, 2002; Stanghellini, 2013). For Levinas, while it is true that the relation to the other person is largely animated by the desire to understand his or her experience, the interpersonal connection is grounded at a more fundamental level, i.e., the level of affectivity. In this case, the sense of being related to the other refers primarily to the significance that the presence of the other person has *for me*, to what the presence of the other person does to me, by affecting me, for example, in the case of a psychiatrist, by creating a strong emotional resonance to her patient's presence.

Consequently, for phenomenological psychiatry to adopt a Levinasian perspective would mean to grasp the potential of the phenomenological method as going beyond the quest to further our understanding of mental illness. This approach would not, however, involve abandoning the psychiatric system of knowledge and the intention of obtaining an objective scientific or transcendental understanding of the

clinical situation, but, instead, would lead to the transformation of the psychiatrist's relationship to his or her own psychiatric *savoir-faire*. To analyze the psychiatrist's experience as that of the one *through whom* the phenomenon of mental illness acquires meaning, means to analyze this process of phenomenalization of mental illness as it affects him or her as a psychiatrist. When this analysis is applied by the psychiatrist, it allows him or her to acknowledge the singular relation that his or her psychiatric knowledge entertains with his or her own experience of the clinical encounter.

CONCLUSION

The clinician-oriented approach to the clinical encounter opens a new perspective for the analysis of the process of psychiatric diagnosis and treatment. Instead of leading to neglecting the patient-oriented perspective, as it may appear at first, as if paying attention to the practitioner would necessarily mean forgetting the importance of the patient and the fact that it is his or her situation that constitutes the object of psychiatry, the elaboration of a psychiatrist-oriented analysis allows understanding the possibility of such neglecting. Taking a closer look at the practitioner enables us to discern the kind of attitude that would be implied by such a treatment. Moreover, for psychiatric knowledge to remain open to transformations that would respond to other people's needs, these transformations should not be considered exclusively as the extension of the knowledge about the object of study, because they start with the transformation of the way the psychiatrist understands his or her relationship to the patient *and* of the way the psychiatrist relates to his or her own experience and knowledge.

In the context of phenomenologically informed analysis of the clinical situation, without taking into consideration a psychiatrist-oriented perspective, the study also remains one-sided, incapable of grasping the complexity of the psychiatric field compared to other medical disciplines. However, more importantly, in this case, one also risks overlooking the particularity of the phenomenological approach and therefore its potential benefits for psychiatry.

It is true that, presented as a descriptive and qualitative operation, phenomenology gives us the means to counterbalance explanatory and quantitative medical methods. The value of phenomenological method cannot be, however, reduced to trying to resolve to a dilemma between normative and descriptive approaches. By putting the experience of psychiatrist at the center of the phenomenological investigation we can see now that the experience of the psychiatrist is a key for understanding the value and the process implementation of the phenomenological method in psychiatric

study. We see what it means for the psychiatrist to *practice* phenomenology as it is indeed his or her human behavior as a whole that is at stake in what in the phenomenological perspective is called a new *attitude* towards the world, the others and the self. As a production of a new attitude, the application of phenomenology does not result in a replacement of the classical psychiatric discourse with a new one. The phenomenological approach provides, instead, the psychiatrist with the tools to become aware of his or her own emotional response to the patient's situation and to acknowledge the singular relationship that his or her psychiatric knowledge entertains with his or her own experience of the clinical encounter.

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