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Phenomenology and Dimensional Approaches to Psychiatric Research and Classification

Abstract:

The classification of mental illness—enshrined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)—has historically followed a categorial model of disorder. However, in light of psychiatry’s failure to validate the DSM categories, psychiatrists have developed dimensional models for understanding and classifying disorders, such as the National Institute of Mental Health’s Research Domain Criteria initiative (RDoC). While some philosophers have recently contributed to the literature on dimensional approaches to psychiatric research and classification, no sustained engagement has yet been offered by continental phenomenologists. In this article, I argue that phenomenological research can benefit from a broadly dimensional orientation—albeit one that differs in many respects from the RDoC. Developing this argument, I motivate, outline, and illustrate a phenomenological-dimensional approach. In so doing, I show how a dimensional orientation can circumvent problems stemming from the use of current diagnostic categories as a guide to psychiatric research. In addition, I argue that a dimensional orientation need not conflict with more traditional phenomenological approaches, such as the core gestalt model, and can even complement and support such approaches.

Keywords: Phenomenological Psychopathology; Research Domain Criteria (RDoC); Nosology; Existentials; Heidegger; Merleau-Ponty

Introduction: The Crisis of Contemporary Psychiatry

Contemporary psychiatry finds itself in the midst of a crisis of classification. The developments begun in the 1980s—with the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III)—successfully increased inter-rater reliability (i.e. the likelihood of two or more clinicians arriving at the same diagnosis for the same patient). However, these developments have done little to increase the predictive validity of our categories of disorder. A diagnosis based on DSM categories and criteria often fails to accurately anticipate course of illness or treatment response. In addition, there is little evidence that the DSM categories link up with genetic findings, and even less evidence that they correlate with distinct neurobiological states (St. Stoyanov, Borgwardt, & Varga, 2015).

Some argue that the lack of neurobiological correlates is evidence that psychiatric disorders are not brain disorders, but are instead problems of living (Szasz, 1960). Others argue that the lack of validity is evidence that these particular categories are poorly delineated—if we carved up the categories of mental disorder differently, we might make more accurate predictions and discover distinct biomarkers (Malhi, Parker, & Greenwood, 2005).

While both of these approaches have received attention in the psychiatric literature, much of the current debate hinges not on whether our current categories are valid, but on whether a categorial approach in general is capable of accurately articulating the domain of mental illness. Prominent figures at the National Institute of Mental Health (NIMH), such as Insel and Cuthbert, argue that the best way to approach current problems in psychiatric classification—at least from a research perspective—is to give up categories and turn toward dimensions (Cuthbert & Insel, 2013; Cuthbert & Kozak, 2013). Rather than beginning from distinct kinds of illness, we should begin from distinct features of human behavior, experience, and brain circuitry. From these core

features, we can study the full range of normal to abnormal phenomena, without being beholden to the still unjustified belief that mental disorders group into more or less distinct categories.

Philosophers have made considerable contributions to our understanding of the classification of mental disorders (Kincaid & Sullivan, 2014; Zachar, Stoyanov, Aragona, & Jablensky, 2015), including dimensional approaches to classification (Murphy, 2015; Schaffner, 2012). The contribution that I make here also concerns these developments. However, unlike most contributors to the current literature on the topic, my concern is with the role of *continental phenomenology* in dimensional approaches to psychiatric classification. I argue that, in spite of phenomenology's historical alignment with categorial approaches to the understanding and classification of psychiatric disorders, it is well suited to developing research programs along dimensional lines.

My project is developed in four parts. First, I distinguish categorial from dimensional models of disorder and I clarify the sense of dimensionality that I am concerned with. Second, I outline the phenomenological contributions to the philosophical literature on psychiatric classification and argue that this work does not adequately address dimensional approaches because of phenomenology's traditional orientation toward typification. Third, I motivate, outline, and illustrate a phenomenological-dimensional approach to psychiatric research and classification (drawing inspiration from the NIMH's Research Domain Criteria initiative (RDoC)). Fourth, and finally, I argue that a dimensional approach to phenomenological research can complement the *trouble générateur* or core gestalt approach employed by contemporary phenomenological psychopathologists such as Parnas and Sass.

Categorial and Dimensional Approaches to Psychiatric Classification

Before considering the possibility of a phenomenological-dimensional approach to classifying mental disorders, it will be helpful to clarify the kind of dimensional approach that I am concerned with, and how it differs from more traditional categorial approaches. The major diagnostic manuals assume that the kinds of phenomena studied and treated by psychiatrists are amenable to discrimination—that is, more or less definite lines can be drawn not only between normality and psychopathology, but also among the various kinds of psychopathological conditions (Tabb, 2015). This assumption is not necessarily essentialist; it does not require that absolutely clear boundaries can be drawn in all cases (Kincaid & Sullivan, 2014). However, it at least requires that we have more or less discrete entities, even if these entities have fuzzy boundaries or are better categorized through family resemblances (e.g. shared property clusters) rather than absolutely essential features (Haslam, 2014; Zachar, 2014).

Proponents of “dimensional” approaches have recently challenged categorial dominance. However, there are two fundamentally different kinds of dimensional approaches that are not always disambiguated in the literature. One dimensional approach—a major topic of discussion in the decade preceding the publication of the DSM-5 (2013)—aims to supplement (rather than undermine and replace) categories with dimensions (see Helzer et al., 2008). This approach was taken up in the DSM-5, leading to broad and explicitly heterogeneous categories such as autism spectrum disorder.

Another dimensional approach that recently entered into scientific and philosophical discourse aims to undermine and replace (rather than supplement) categories with dimensions. On this new dimensional approach, the phenomena that vary in degree, or exist along a continuum, are core features of human beings—behavioral, experiential, or neurobiological. Such features might include attention, visual perception, agency, or even the understanding of

others' mental states (Cuthbert & Insel, 2013; Cuthbert & Kozak, 2013; "Research domain criteria matrix," n.d.).

The distinction between these approaches hinges on the kind of phenomena the dimensions belong to. The former approach focuses on *dimensions of categories of disorder*. It posits that the domain of mental disorder is amenable to categorization, but concedes that there are no hard boundaries between health and illness, or between various disordered conditions. The latter approach focuses on *dimensions of human behavior, experience, and neurobiology*. It therefore dispenses with categories of mental disorder entirely.

I reserve the term "dimensional" for this latter approach, which is the one I am concerned with here. I refer to the former approach as "spectral," drawing on its use in the development of broad categories such as autism spectrum disorder.

Contemporary Phenomenological Approaches to Psychiatric Classification

Most phenomenological psychopathologists are critical of the diagnostic criteria as well as the categories of disorder currently in use. Parnas and Bovet criticize the superficiality of operationalism, which is the diagnostic approach employed since the DSM-III (Parnas & Bovet, 2015). Stanghellini argues that many of the diagnostic criteria are poorly defined, offering us vague and problematically heterogeneous accounts of what actually constitutes each disorder (Stanghellini, 2004). Ratcliffe and his colleagues have pointed out that some of the categories are so broad that they include somatic disorders, such as inflammation (Ratcliffe, Broome, Smith, & Bowden, 2013). However, in spite of the critical stance toward both the diagnostic criteria and the particular diagnostic categories currently in use, phenomenologists tend to be sympathetic toward—if not overtly supportive of—a categorial approach to classification.

The phenomenological orientation toward categorial approaches to research and classification has a long history, but its contemporary manifestation owes much to Schwartz and Wiggins' early work on typification (1985, 1987). Drawing on the work of Husserl (1973), Schutz (1966), and Polanyi (1966), they argue that our everyday manner of understanding and perceiving objects within the world (including other embodied subjects) is grounded in a process of typification. That is, we experience things as belonging to a certain *type*, or *kind*. These types need not be explicitly defined or clearly delineated; they constitute a tacit, passive background through which we perceive and understand our world.¹

In light of this account of sense-making, phenomenologists tend to be critical of classificatory systems that ignore this intuitive mode of understanding. Operationalism receives the brunt of this criticism because it not only dispenses with any kind of intuitive understanding, but also seeks to replace this understanding with superficial lists of easily observable symptoms that do not hang together in any meaningful structure. The operational approach fails to acknowledge how psychiatrists (and human beings in general) understand, classify, and make sense of their world. These phenomenologists argue that when classifying a new domain, we would do well to make our system of classification mirror or mimic our everyday ways of understanding phenomena. Psychiatric classification and diagnosis should be developed through an enhanced or scientifically supplemented process of typification that we already employ in everyday life (Wiggins & Schwartz, 1994).

This outlook has been developed along two different lines, referred to as the ideal type approach and the prototype approach. Schwartz, Wiggins, and Norko (1989, 1995) propose an ideal types approach to diagnosis and classification. An ideal type (as defined in the work of Weber (2011) and Jaspers (1997)), is a heuristic concept that outlines the basic features of the

phenomenon in question. Much like the relation between geometric concepts and their material manifestations, there need not be any real instances of the type in its ideal form. Nevertheless, the ideal type offers a clear starting point whereby a community of researchers and clinicians can orient their investigations. Because it is understood that a pure instance of the type may not exist, the concept casts a wide net, allowing researchers and clinicians to categorize a subject's condition while also stipulating how this particular manifestation diverges from the ideal type in question.

Parnas and Gallagher, by contrast, have most recently advocated a prototype approach to psychiatric classification (2015).² Much like ideal types, prototyping acknowledges the inherent fuzziness in the boundaries between psychiatric disorders. Rather than offering essential criteria for diagnosis, the prototype approach begins with an exemplar—one that stands as the best representative of a certain class. They use the analogy of taking a sparrow, rather than a penguin or an ostrich, as the prototype for the category “bird.” While penguins and ostriches are certainly birds, they fail to exhibit a number of features typically associated with birds (e.g. flying), while exhibiting a number of features not typically associated with birds (e.g. efficient locomotion in water or on land). As a result, these birds are poor prototypical representatives of the class “birds”—in many respects they are the exception rather than the rule. Parnas and Gallagher argue that we should approach the classification of mental disorders in much the same way, carefully selecting the prototypical representatives of each category (2015, pp. 75–76). The primary point of differentiation between the ideal type and prototype approaches is that the former anchors its concept in an ideal (and not necessarily real) phenomenon, while the latter anchors its concept in an actual instance of the condition in question.

These approaches offer a corrective to the operational program in which psychiatrists diagnose through structured interviews and symptom checklists—which, as the above authors have pointed out, are not followed by most clinicians. However, insofar as these phenomenological approaches are founded on the process of typification, they are necessarily aligned with categorial classifications, and it remains unclear whether and how phenomenology can engage in dimensionally oriented research and classification. In the following two sections I develop an initial outline of a phenomenological-dimensional approach and argue that this kind of approach need not conflict with more traditional approaches to phenomenological psychopathology.

A Phenomenological-Dimensional Approach to Psychiatric Research and Classification

In light of phenomenology's traditional orientation toward typification and categorial classification, I need to justify my aim of articulating a phenomenological-dimensional approach. The most compelling reason for developing a dimensional outlook hinges on the distinction between *diagnostic* and *research* classifications. The DSM, originally developed for use in diagnosis, became the de facto standard by which subjects are selected for research. As a result, it became nearly impossible to design studies that test and challenge the validity of current diagnostic categories; the legitimacy of the DSM categories is necessarily presumed in the construction of the study, producing a vicious circularity at the heart of psychiatric research.

The negative consequences of employing the same categorial classification in both diagnosis and research prompted dimensional approaches, such as the Research Domain Criteria initiative (RDoC). This kind of approach relieves the question-begging constraints that arise when preliminary diagnostic categories delimit the populations employed in research studies. Current diagnostic categories are bracketed or put out of play, and psychopathological research is

oriented through basic features of human existence. A dimensional approach supplies a fundamentally different orientation by which to explore mental health and illness—one that cuts across current diagnostic boundaries and spans the health-illness spectrum.

In the following subsections, I 1) introduce the NIMH’s RDoC initiative as an example of a dimensional framework, 2) outline a phenomenological-dimensional approach, and 3) illustrate this approach by drawing on recent work by Sass and Pienkos (2013) and Ratcliffe (2012).

A Contemporary Dimensional Approach: The RDoC

While there are numerous ways to frame a phenomenological-dimensional approach, my proposal is roughly guided by the RDoC insofar as it begins from a set of domains, each containing dimensions, or constructs (the two terms are used interchangeably). The current version of the RDoC divides its domains into 1) Negative Valence Systems; 2) Positive Valence Systems; 3) Cognitive Systems; 4) Systems for Social Processes; and 5) Arousal/Regulatory Systems (for definitions, see “NIMH » Development and definitions of the RDoC domains and constructs,” n.d.). Each domain captures a broad range of human behavior, experience, and biology, which is refined through a set of constructs and sub-constructs. Systems for Social Processes, for example, include the constructs of 1) Affiliation and Attachment; 2) Social Communication; 3) Perception and Understanding of Self; and 4) Perception and Understanding of Others. Of these, all except the first include additional sub-constructs. Perception and Understanding of Self, for instance, includes the sub-constructs of 1) Agency and 2) Self-Knowledge. Perception and Understanding of Others, by contrast, includes the sub-constructs of 1) Animacy Perception, 2) Action Perception, and 3) Understanding Mental States. These divisions, however, are not set in stone—the NIMH encourages research proposals that investigate new constructs or refine current constructs.

When a new study is proposed within the RDoC framework, its primary orientation is defined by the construct or sub-construct in question (rather than a category of disorder). By orienting the study along these dimensional lines, researchers are able to study this particular dimension of human consciousness across various psychopathological conditions, or across the health-illness spectrum.

Outlining a Phenomenological-Dimensional Approach

In drawing on the RDoC I am not proposing that phenomenologists attempt to make their own approach consistent with the RDoC *matrix* (i.e. its set of domains, constructs, and sub-constructs). Rather, in appealing to the RDoC model as a fairly robust dimensional—rather than categorical—approach to psychiatric research and classification, I aim to adapt a broad domain/construct framework for use in phenomenological research.

To begin, it is immediately apparent that phenomenologists do not distinguish or delineate the constitutive features of human subjectivity in a manner analogous to the RDoC domains. However, most phenomenologists do rely on a shared set of conceptual distinctions to guide their investigations of human subjectivity. These concepts are what Heidegger refers to as “existentials” (1962), although they are also referred to as “transcendental,” “essential,” or “ontological” structures (Fernandez, 2014; forthcoming b). Each existential refers to a basic constitutive feature of human existence, including (but not limited to) selfhood, intersubjectivity, affectivity, understanding, temporality, spatiality, and intentionality.³

Because the distinctions among these existentials are largely uncontroversial, I propose that they stand as the *domains* of phenomenological-dimensional research. Selfhood, for example, can stand as a domain at the highest level, and might include the constructs of 1) Core Self and 2) Narrative Self. Within the Core Self, we can include a set of sub-constructs. Drawing

on the Examination of Anomalous Experience (EASE), these constructs might include 1) Cognition and Stream of Consciousness; 2) Self-Awareness and Presence; 3) Bodily Experiences; 4) Demarcation/Transitivism (of the self-world boundary); and 5) Existential Orientation (with respect to metaphysical worldview and/or hierarchy of values) (Parnas et al., 2005).

It is important that these dimensions are neutral with respect to health and illness. In order to provide phenomenologists with the tools to study the full range of healthy and psychopathological phenomena, the framework should not predetermine or otherwise limit the possibilities for these investigations. For this reason, the EASE does not in itself provide a dimensional framework of the kind I am proposing. The additional items and subtypes in the EASE are psychopathological phenomena, rather than basic features of human subjectivity. For example, Cognition and Stream of Consciousness includes items such as Thought Interference; Thought Pressure; and Perceptualization of Inner Speech or Thought. While these may be the kinds of psychopathological features that phenomenological psychopathologists investigate via a dimensional approach, the dimensional framework itself should not be oriented through these items. By limiting the domains and constructs to the basic features of human subjectivity, the framework remains applicable to broadest range of healthy and psychopathological conditions.

Illustrating Phenomenological-Dimensional Investigations

In order to better clarify the kinds of investigations that can be developed within a phenomenological-dimensional approach, I consider two examples. These studies are not explicitly developed along the dimensional lines that I have proposed, but they do employ a broadly dimensional outlook, investigating the boundaries *between* and *within* current diagnostic categories. The first example is Sass and Pienkos' (2013) study of selfhood across melancholia,

mania, and schizophrenia. The second is Ratcliffe's (2012) study of temporality in major depressive disorder. With the first example, I show how a broadly dimensional approach provides an effective framework for comparing (apparently) similar features across different psychopathological conditions. With the second example, I show how focusing on one phenomenological domain, or existential, provides an effective framework for teasing apart the conditions enveloped within a single diagnostic category.

Sass and Pienkos take up items from the EASE, designed primarily for studies of schizophrenia spectrum disorders, but employ these items across a variety of psychopathological conditions, including those typically classed as affective disorders. In adopting this orientation, they still take for granted certain categorial distinctions, but the investigation itself is oriented through basic dimensions of human subjectivity. This orientation illuminates subtle distinctions among the dimensions of human subjectivity and the psychopathological changes these dimensions can undergo.

Sass and Pienkos' investigation of the self-world boundary clearly illustrates their approach. They point out that the self-world boundary is sometimes increased in melancholia, while in mania (and especially psychotic mania) there can be a sense of mystic union with the world, severely diminishing "normal ego boundaries" (Sass & Pienkos, 2013, p. 124). This latter alteration of the self-world relation seems akin to conditions along the schizophrenia spectrum, where the boundary between self and world is also put into question. However, by attending to this specific dimension, they point out that subtle (yet important) differences remain. First, in mania the diminished self-world boundary is accompanied by an ecstatic or benign mood tone (the mood is neither frightening nor unpleasant) (Sass & Pienkos, 2013, p. 125). Second, the manic subject does not actually become confused about his own perspective or who he is, despite

his feeling of oneness with the world. In conditions on the schizophrenia spectrum, by contrast, the subject can become anxious about his own identity, feeling invaded by the outside world. In addition, the sense of unity is often accompanied by a kind of solipsism—the world is simply an extension of oneself, having no independent reality. Both cases involve a blurring of the self-world boundary, but the boundary is blurred in fundamentally different ways.

Sass and Pienkos' study, while preliminary and exploratory, offers substantial insight into both the similarities and differences across melancholic, manic, and schizophrenic experience. And it is precisely their dimensional orientation—beginning from core features of human existence rather than diagnostic categories (DSM or otherwise)—that allows them to explore these similarities and differences, drawing more fine-grained distinctions between psychopathological disturbances.

However, while Sass and Pienkos offer a careful analysis of dimensions of the Core Self across melancholia, mania, and schizophrenia, they do not use their approach to examine or tease apart the heterogeneity *within* current diagnostic categories. To see how a dimensional approach might highlight and tease apart the diverse conditions enveloped within a single diagnostic category, we can turn to Ratcliffe's study of temporality in major depression.

It is common to characterize temporal experience in depression as a slowing down of perceived temporal duration or velocity. However, as Ratcliffe points out, this is a fairly limited and superficial characterization, at least when considered in the light of robust and detailed phenomenological analyses of the structural features of temporality (Ratcliffe, 2012). These features include, but are not limited to, Conative Momentum; the Protentional-Retentional Structure; Teleological Orientation vs. Cyclical Orientation; and Intersubjective Synchronicity, or the sense that “our experiences and activities are ordinarily temporally synchronized with

those of others” (Fuchs, 2013; Ratcliffe, 2012). Examining these distinct structural elements, Ratcliffe shows that while many conditions classed as MDD include a disturbance of temporal experience, the changes are not the same across all subjects meeting the criteria for this diagnosis.

Some subjects, for instance, undergo a partial or total loss of conative drive/momentum; possibilities do not appear as enticing or worth pursuing. Others experience a loss of some or all of one’s futural projects. Still others undergo a more profound change in which the significance that futural projects presuppose is itself absent. Some subjects undergo multiple changes in temporality simultaneously—e.g. loss of conative drive accompanied by loss of futural projects—while others undergo a temporal disturbance along a single dimension.

Like Sass and Pienkos’ study, Ratcliffe’s investigation is oriented first and foremost through a single domain, or existential—in this case, temporality. This domain is then subdivided into its distinct structural elements, or what I have referred to as constructs and sub-constructs. In so doing, Ratcliffe not only illuminates the heterogeneity of conditions enveloped by the category of MDD, he also offers a preliminary set of disturbances that might guide research aimed at subtyping MDD or further mapping the dimensions of human subjectivity.

These kinds of investigations, whether they ultimately challenge or support current diagnostic boundaries, are made possible by employing a dimensional research framework—one that does not presume the legitimacy of our current diagnostic categories, instead providing a fundamentally new orientation for phenomenological investigations.

Dimensions, *Trouble Générateur*, and the Core Gestalt

Having motivated, outlined, and illustrated a phenomenological-dimensional approach to psychiatric research and classification, my aim in this section is to clarify the relationship

between my proposal and a more traditional orientation of phenomenological research. The phenomenological psychopathologist, Minkowski, developed a phenomenological approach that uncovers the *trouble générateur*, or “generating disorder” (Minkowski, 1927). This genetic⁴ orientation investigates 1) the general theme or organization of the psychopathological condition, and 2) the fundamental disturbance at the heart of the disorder, or the alteration that brings about or otherwise influences other aspects of the condition (Sass, 2014, p. 367). More recently, Parnas has developed this notion into what he calls the “core gestalt.”

The notion of Gestalt refers to a *salient unity or intrinsic organization* of diverse phenomenal features, based on reciprocal part-whole interactions. In this framework, psychiatric symptoms and signs cannot be considered as mutually independent, atomic features that become individuated (i.e., identified as *this* or *that* particular symptom) “in themselves,” independently of their experiential context. (Parnas, 2012, p. 67)

In this clarification, Parnas contrasts the core gestalt approach with approaches that characterize psychiatric disorders through clusters of atomistic symptoms. His critique is aimed at the operational approach mentioned above (i.e. the system of classification and diagnosis employed in the DSM). However, my dimensional proposal may fall into his line of criticism as well, at least insofar as it proceeds by distinguishing the diverse elements of human subjectivity, and using these distinctions as a framework for phenomenological research.

I argue, however, that my dimensional proposal need not conflict with, and can even complement, the traditional core gestalt approach. The phenomenological psychiatrist, Ellenberger, distinguished three approaches to phenomenological studies of psychopathology. He referred to these as the descriptive, genetic-structural, and categorical approaches. The first refers to Jaspers’ version of phenomenological psychopathology, which offers clear and

systematic descriptions of lived experience. The second refers to the *trouble générateur* or core gestalt approach. And the third refers to the study of “categories of inner experience,” or what I refer to as existentials (Ellenberger, 1958, p. 101; Fernandez, forthcoming b). While Ellenberger portrays these as three distinct approaches, he does not claim that they are mutually exclusive. At different stages of investigation we may benefit from employing one kind of study or the other, and information we obtain in one kind of investigation may inform the conclusions of another. For example, while Minkowski employs the *trouble générateur* approach, Ellenberger points out that Minkowski also made headway by orienting some of his investigations through a specific existential, such as spatiality or temporality, exploring how this particular aspect of human experience is altered or disturbed in the condition in question (Ellenberger, 1958, pp. 101–108).

While Ellenberger does not fully explore the possibility of mutually informative investigations across these approaches, I here want to sketch some avenues for complementary research in phenomenological psychopathology. First, if phenomenologists aim to uncover the holistic organization of a psychopathological condition, an adequate understanding of the condition still requires detailed analyses of the structural features involved in the gestalt shift, or what Parnas refers to as part-whole interactions. Dimensional approaches distinguish these structural features, and can provide a framework of the various elements that should be considered when articulating and describing an overall gestalt shift. Reciprocally, clarifying the gestalt or organizing principle of a condition might supply hypotheses for further dimensional research. For example, if a subject’s condition seems to involve a general lowering or diminishing of affective intensity or attunement, a dimensionally oriented researcher might hypothesize similar kinds of changes in perception (e.g. lowered intensity of tactile sensation, or diminished response to stimuli), thereby guiding research into another domain of human

existence. Furthermore the results of such an investigation can confirm or disconfirm initial claims about the changes involved in a particular kind of gestalt shift.

Second, if phenomenologists aim to discover a core disturbance, or a fundamental alteration that brings about the other aspects of the condition, a dimensional approach can delineate and isolate possible candidates. A good example of this approach is found in Merleau-Ponty's study of Schneider, a World War I veteran who underwent dramatic changes in his perception and motility following a brain injury (Merleau-Ponty, 2012). In the course of his investigation, Merleau-Ponty seeks out a core disturbance that makes sense of the complex and varied layers of Schneider's condition, and he draws considerable influence from the gestalt psychologists. However, in order to make sense of this gestalt and isolate the core disturbance, he moves between discussions of the overall organization of Schneider's condition and detailed investigations of specific elements, such as motility, vision, touch, and projection. He begins by proposing a hypothesis, stipulating a core disturbance at the heart of Schneider's condition. He then investigates various aspects of Schneider's condition in order to assess whether their alteration might be explained by appealing to his earlier hypothesis. When this stipulated core disturbance cannot explain one or more aspects of Schneider's condition, he proposes a new hypothesis, stipulating a different core disturbance, and so on and so forth. Throughout his study, he moves between a core gestalt approach, seeking out a fundamental disturbance, and something not unlike a dimensional approach, investigating distinct structural elements of Schneider's condition in order to test whether these changes can be made sense of within the overall framework he has sketched.

While my own proposal may not require that a phenomenologist move between the core gestalt and dimensional approaches as freely as Merleau-Ponty, his method at least offers an

example of how such approaches might be complementary and mutually informative. When conducted on a larger scale, dimensionally orientated investigations can shed much needed light on specific facets of psychopathological conditions, providing resources for the phenomenological study of core gestalts.

In light of these examples, it is not only clear that a phenomenological-dimensional approach can complement and support a core gestalt approach—it is also clear that a phenomenological-dimensional approach need not subscribe to an atomistic characterization of the structural features of human subjectivity. Conceptually distinguishing domains and dimensions of human subjectivity as a guide for phenomenological research does not entail that these domains and dimensions are separate from each other, or otherwise unrelated to a holistically organized subjectivity.

Conclusion: The Future of Phenomenological Psychopathology

While the dominant approach to psychiatric diagnosis and classification remains categorial, the current DSM categories have not been validated. They do not supply adequate guides for predicting course of illness or treatment response, or guiding neurobiological research. In light of this crisis in contemporary psychiatry, dimensional approaches have been put forward as a viable alternative for psychiatric research and classification. Such approaches relieve certain question begging constraints imposed by the use of invalid diagnostic categories as a framework for cutting edge research. By orienting a research program through dimensions rather than preliminary categories, studies can address variations and disturbances across the full range of psychopathological conditions.

In following with these new developments in the field of psychiatry, I have considered the possibility of phenomenological psychopathologists orienting their own research through a

broadly dimensional framework. While the RDoC does not adequately accommodate a phenomenological approach, I have argued that phenomenologists organize their research along dimensional lines by relying on their own conceptual distinctions among the basic existentials, or constitutive features of human existence. In addition, I have drawn on recent phenomenological studies with broadly dimensional orientations in order to illustrate how such an approach can cut across diagnostic boundaries or tease apart the heterogeneity of conditions enveloped by a single category. Finally, I have argued that a phenomenological-dimensional approach need not conflict with the more traditional and currently dominant core gestalt approach. In fact, the two approaches are in many ways complementary and mutually supportive.

Whether psychiatry will ultimately adopt a dimensional system of classification remains to be seen. Nevertheless, dimensional approaches are already being employed in contemporary psychiatric research, and clearly offer a viable alternative to categorially oriented research programs. Insofar as phenomenologists are concerned with maintaining interdisciplinary dialogue and potentially collaborating with psychiatric researchers, it would be prudent to develop a broadly dimensional outlook—even if it differs in important respects from what is currently used in mainstream psychiatry. Employing similar approaches reduces the barriers to interdisciplinary dialogue and collaboration, increasing the potential for phenomenological research to make its way into mainstream psychiatry, ultimately influencing the course of psychiatric research and practice.

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¹ For an introduction and critical analysis of typification and ideal types in psychiatric diagnosis and classification, see Fernandez (forthcoming a).

² Parnas and Zahavi (2002) have also proposed an ideal types approach. However, their approach differs from the one proposed by Schwartz, Wiggins, and Norko insofar as it aims to clarify the *essential* features that must hold for a condition to count as belonging to the category question.

³ Some of these constitutive features are listed and briefly defined in a chapter on phenomenology and psychiatric classification by Parnas and Zahavi (2002). However, while they do distinguish some of these basic features of subjectivity, they do not propose anything akin to a dimensional approach.

⁴ Genetic phenomenology, introduced by Husserl, is the phenomenological study of the temporal genesis and unfolding. It investigates necessary laws of temporality as well as contingent development (e.g. in cases of psychopathology). For a more detailed account of genetic phenomenology’s role in psychopathology, see Sass (2010).