The Breivik case and "conditio psychiatrica"

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In Denmark, a Scandinavian country linguistically proximate to Norway, the Breivik case (BC) stirred a similar, media-based, diagnostic debate, involving lay public, psychiatrists, and other professionals. The BC merits a commentary, not related to the judicial/forensic specifics, but concerning the current status and problems of psychiatric diagnosis and profession that the account of this case (1) so emphatically brings forth.

More than 30 years ago, psychiatry, attempting to match somatic medicine in its scientific aspirations, underwent an "operational revolution", introducing criteria-based diagnoses and "operational definitions" of such criteria. The BC shows, quite dramatically, that such criteria are not, in fact, *operational* in the original sense of specifying *action rules* (2), intended to link the psychiatric concepts with their counterparts in reality (*operations*, as in: X is *harder* than Y because X *can make a scratch* on Y, but not vice versa). None of the divisive issues in the BC was disambiguated through an appeal to operational action rules. What "operational" criteria actually amount to is no more than simple, lay-language descriptions of symptoms and signs. Moreover, the operational project came at a price. It radically abridged, simplified and compressed the then existing corpus of clinical knowledge into diagnostic manuals accessible to *grand publique*, because written in lay-language and stripped of theoretical and psychopathological reflection. These manuals have been for long the main source of clinical knowledge for psychiatrists in training (3) and it is mistakenly assumed (4,5) that a structured interview, asking preformulated questions in a fixed sequence, is an adequate methodology for obtaining psychodiagnostic information, even in sensitive situations, where the patient can be expected to dissimulate (1). This "death" of psychopathology (3) has created an intellectual hypodensity that blurs the professional borders of psychiatry, thereby welcoming any opinion as a voice *a priori* worthy of attention, equal, and legitimate. Unfortunately, operational revolution also failed to fulfil its motivating promise of a breakthrough to actionable etiological knowledge. "A gaping disconnect" is now widely recognized between the impressive progress in genetics and neurosciences and "its almost complete failure" to elucidate the causes and guide the diagnosis and treatment of psychiatric disorders (6,7).

As the BC illustrates, psychiatry will continue to crucially depend on the distinctions in the phenomenal realm, that is, domains of experience, expression, behaviour, rationality, and so forth. However, at the same time, the BC reveals important problems there. The discussion of Breivik's potential psychosis/delusions appears to have revolved around apparently mutually independent issues (e.g., are his views really shared; how to consider his affect and isolation; how to view his peculiar linguistic expressions; is surveillance of behaviour an adequate substitute for the knowledge of his inner world; etc.). It seems forgotten that falsity of a thought content is *not* a definitive feature of delusion. Jaspers emphasized that his triad of falsity, conviction, and incorrigibility (imported into the current diagnostic criteria) was not *defining* but *merely suggestive* of delusion (8). Delusion usually involves alterations in the patient's subjective framework with its interconnecting perspectives on himself, world, and others (8,9). Delusion is, therefore, typically identified in a larger temporal, situational, and experiential context. The collateral information feeds into that context, which also entails considerations of "double book-keeping", ability to dissimulate, and (ir)rationality of the transition between belief and action.

The BC discussion reveals an implicit epistemological tension in the very conception of psychiatric diagnosis, a tension apparently only vaguely perceived by the discussing parties and rarely explicitly addressed in the literature. It is a tension between an operational, cross-sectional approach of "symptom counting", without a guiding hierarchy and intelligibility principle (10), and a more prototypical perspective, which articulates a psychopathological Gestalt, emerging from the interactions between the whole and its reciprocally implicative aspects (11,12). The BC also illustrates a universal interpersonal human attitude, often interfering with clinical tasks, the so-called "principle of charity" (13). This is a subconscious, automatic, compensating tendency to make one's interlocutor appear as more rational than he actually is, for example, by smoothening out the bumps of his reasoning, filling up the gaps of his logic, and normalizing the instances of his flagrant irrationality.

It is worthwhile to recall that the BC-type debate is not unique to our times. Foucault devoted a seminar to a quite similar public diagnostic discussion in 1835 (14). It concerned a suspected insanity of Pierre Rivière, a just literate peasant, who murdered his mother, sister, and brother and was able to present in his defence a 100-page account of his life and motivations.

Psychiatry was, is, and will continue to be an object of intense societal attention and extra-scientific pressures. Only rigorous psychopathological standards can empower psychiatry to fulfill its clinical obligations and resist or modify the external pressures.

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