Subjectivity, psychosis and the science of psychiatry

The significance for psychiatry of a patient's subjective or "lived" experience seems obvious even on casual reflection, especially in cases of severe mental illness. It is likely that curiosity and concern about what a patient is experiencing is a prerequisite for building trust or a therapeutic alliance, particularly when the experiences seem highly unsettling and unusual. Few would deny that grasping something of the patient's viewpoint should play a role both in developing and selecting therapeutic techniques.

Beyond this, it seems likely that some understanding of patients' subjective life is relevant to psychopathology as a scientific enterprise. The *explanandum* at issue in what we term "delusion", "hallucination" or "thought disorder" may, for instance, be found to involve quite different experiences across different individuals, diagnoses or subgroups, and such knowledge can improve the pathogenetic modelling of mental disorders. It is possible, in fact, that the lackluster results of neurobiological research on severe mental illness in recent decades (widely acknowledged) be in part due to neglect of this subjective dimension and the distinctions it would allow.

Given all this, it is striking to note how limited the study of patients' experiences has been in the mainstream of psychiatry and clinical psychology. One may wonder why. An obvious reason is the influence of exclusionary and reductive forms of empiricism and materialism, which have stressed the difficulty both of observing subjective life and of incorporating it into the causal order of the universe. Subjectivity can indeed seem what phenomenological philosopher M. Merleau-Ponty termed "the flaw in the great diamond of the world"[1] – a recalcitrant explanatory outlier, albeit one that is lodged at the center of each one of us (our consciousness) and is the condition for whatever knowledge we possess.

A second reason is a widespread discomfort with and incomprehension of the states of mind that characterize severe forms of mental or emotional disorder, especially psychoses. Though many scientists and scholars are fascinated by the limit-experiences that can occur in psychotic conditions, many are ready to accept what are, in scientific terms, extremely vague and potentially misleading characterizations, often involving defect and deficit assumptions that do little more than register the absence of a norm (e.g., "inappropriate affect", "false belief"). Deficit models are often criticized on ethical grounds as being condescending or even insulting to the patient's dignity, but their modes of objectification may also be *scientifically* inadequate, since they fail to register what may be qualitatively distinct about the condition being studied[2]. Conventional approaches also tend to downplay the *agentic* role of the patient – i.e., the subtle ways in which a patient's orientation or attitude, partly under his/her control, can impact the nature of delusions, hallucinations or "thought disorder"[3].

The study by Fusar-Poli and numerous co-authors published in this issue of the journal[4] is an exceptionally important contribution. There have been previous attempts, especially by phenomenologists and qualitative researchers, to collaborate intensively with patients whose experiences they study, but never on such a broad-based, quantitative scale. As the authors note, their results are in fact consistent with the rich phenomenological tradition which stemmed from K. Jaspers and the Heidelberg school and included, among the others, K. Schneider, K. Conrad, W. Blankenburg, E. Minkowski and the various contemporary experts cited in the paper.

Phenomenological psychopathology did influence mainstream British psychiatry in the 1950s through a textbook by the German-Jewish émigré W. Mayer-Gross, and penetrated North American consciousness with the anthology *Existence* in 1958[5] and Laing's *Divided Self* of 1960; but then it languished for several decades prior to its more recent renaissance beginning in the 1990s. Fusar-Poli et al's study vindicates this most venerable approach to a rigorous understanding of mental life in psychiatric illness.

The present study is mainly in the tradition of *descriptive* phenomenology, offering diverse accounts largely in the vocabulary of everyday language, eschewing attempts at explanatory synthesis[5]. Another type of phenomenology, more speculative and theoretical, does try to account for the heterogeneity of some subsets of symptoms by identifying a core or generating disorder, thereby providing models for pathogenetic research that can account for the variety and variability of certain psychotic conditions – e.g., "loss of vital contact"[6] or altered "basic-self experience"[7].

There is much to be learned from Fusar-Poli et al's report, a superb compendium of all the major experiences characteristic of psychosis, and perhaps especially of the contested category of schizophrenia. Like earlier phenomenological work, their research shows that signs and symptoms can seem very different from *within* a mental condition compared to what common sense or standard psychiatry often claims. Hallucinated voices may not exactly be "heard". What we call "delusions" may or may not be taken literally and, rather than being "erroneous beliefs", may sometimes involve withdrawal into a private or subjective world that the patient himself actually recognizes as such[8]. So-called "poverty of content of speech" – a type of "formal thought disorder" – may sometimes contain profundities.

Among the many insights to be gleaned is the prominence (at least for *some* patients *some* of the time) of the experience of insight and illumination. Confronted with "madness", the academic observer or man-on-the-street stresses metaphors of darkness, confusion, and subterranean journeys, and this sometimes accords with the patient's viewpoint. But, as Fusar-Poli et al[4] report, patients may describe some "psychotic" states as shot through with a sense of almost blinding clarity and revelation. We must beware of projecting our own yearnings and value judgments onto the patients. They, at least, can sometimes feel not beneath, but far above the quotidian realities of "normal" people, who

neglect more encompassing and foundational though ineffable truths – truths perhaps accessible only to forms of self-conscious or hyperreflexive awareness unavailable to most of us[3].

In closing, one must acknowledge some gaps in our grasp of subjectivity and its significance for psychiatry. It may be obvious to common sense that the exercise of free will, together with a person's experience of meaning or significance, do play a role in human behavior and thereby affect the material plane of brain functioning (if I choose to close my eyes, in prayer, patterns in visual cortex are altered). But it is also true that we have difficulty incorporating the domains of conscious life and its physical substrate within a single explanatory account (the mind/body problem). In particular, we have difficulty integrating "act" with "affliction" aspects of psychological existence[3] – that is, appreciating the subtle but decisive ways in which defensive or other goal-directed forms of thought or behavior can interact with aspects of mental life over which the person has little or no control.

Even more basic is the challenge of observing and describing consciousness itself, whose ever-changing, all-encompassing flow we, as human beings and language speakers, are constantly tempted to misperceive or misdescribe. We succumb to this temptation by using words that stress the substantive over the transitory aspects of experience, or by focusing on particular objects of awareness while ignoring subtle alterations in, for example, the experience of space, time, or the overall atmosphere of reality. In fact, no approach can be fully "bottom-up" in the sense of being purely empirical or a-theoretical: when it comes to describing experience, patients as well as professionals are burdened (though also blessed) with the objectifying prejudices of their language and their worldview. The study of "lived experience" may then be impossible as a foolproof, quasi-empiricist venture. It is, however, also indispensable – and to both the ethical and the scientific enterprise of psychiatry[9].

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What is good acute psychiatric care (and how would you know)?

There is an old joke told of a tourist asking for directions, only to be advised by a local: "Well, I would not start from here". We have the acute mental health services we have inherited. Asylums closed during the great era of deinstitutionalization, clunkily evolving into our current inpatient estates. Crisis teams were established (without any real evidence) to provide choice and less coercive treatment, but often seem to function solely for – in dreadful contemporary management-speak – "admission avoidance".

As a thought experiment, if you were to start afresh, setting up services without the baggage of existing buildings and services, what would you create? And dream some more: your budget is limitless, and recruitment and retention of staff is not a problem. You would not build what we have now – but why not, and what would you replace it with? Would you have inpatient wards? Sure – better equipped, with finer facilities and more staff; but how many, and why, and what exactly would happen on them? Home treatment teams: not everyone wishes to be in hospital in a crisis, but which interventions should they provide? How creative might you get with new models of treatment, engaging social care, the third sector, and local communities?

So, first we hit a wall of reality as we are reminded that we have budgets, staff shortages, and buildings in various levels of disrepair. We enter a world of opportunity costs: maintaining a ward might mean reducing a community service or hiring fewer occupational therapists. And then we hit an evidence wall. What are wards for, what do they do? Containment, safety, care? All of these surely, but perhaps the emphasis has been on the first two (and many people are unaware that much of the initial "locking of wards" was with intent to stop the public walking into space containing people at their most vulnerable, not the other way around). But does "containment" work? German data suggest that locked units do worse than open ones in terms of suicide[1]. Parallel challenges can be thrown at home treatment teams. The evidence supports them saving money (not a bad thing of itself) and reducing hospital admissions[2], but their impact on safety and reducing coercive care is limited, and data on patient experience are modest[3].

One can ask what "effectiveness" means: are "preventing harm" and "avoiding admission" the limits of our vision and ambition for acute care? Evaluations have often emphasized these, as they are easier to measure. What might you alternatively explore (and how would you weigh that sunlight)? More short-term crisis-focused psychological interventions (which ones?); a more trauma-focused service philosophy; better working with housing and domestic violence teams? As a follow-on, we bet your answers will be very different depending upon whether you use, work in, manage, or commission services.

In this issue of the journal, Johnson et al[4] provide a comprehensive overview of the existing evidence in acute mental health care, and the gaps and opportunities for innovation. They argue convincingly that key steps are reducing coercion, addressing