ON THE EPISTEMOLOGY OF PSYCHOPATHOLOGY: CRITICAL INSIGHTS AND METHODOLOGICAL CONCERNS

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TESIS DOCTORAL

ON THE EPISTEMOLOGY OF PSYCHOPATHOLOGY:
CRITICAL INSIGHTS AND METHODOLOGICAL CONCERNS

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ÃVÃURÃÃÃVYAÃÃRS VÃMIZ ÃÃDÃÁÃÁÃR

H AMÉA ÇÀČČ
In partibus infidelium
A mis hijos, Berta y Tomás.

Llenáis mi mundo de amor y de sentido.

Y de porquería...
Agradecimientos

A mi director de tesis, mi mentor y amigo, Pablo Ramos. Por abrirmme los ojos e indicarme el camino (eso sí, un camino largo, en ocasiones laberíntico, con frecuencia tortuoso y siempre resbaladizo). Por ayudarme a transitar este camino. Por tu apoyo y tu paciencia. Por las muchas tardes que hemos pasado juntos (ya para siempre asociadas en mi recuerdo al olor a turba y humo...). Por tu confianza y tu constante estímulo.

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Resumen

La tesis doctoral que aquí se presenta supone el compendio de tres trabajos publicados entre los años 2011 y 2016. En términos generales, estos tres trabajos abordan diversas cuestiones de carácter epistemológico y semántico que afectan al núcleo duro del trabajo psicopatológico. La línea argumental que unifica estos tres trabajos puede resumirse como constando de dos ramas fundamentales. La primera, como pars destruens, se basa en una crítica de las pretensiones de la psiquiatría de corte positivista, que entiende el fenómeno psicopatológico como un objeto determinado, reducible en última instancia a variables espacio-temporales y por tanto susceptible de análisis empírico-analítico. La segunda rama, como pars construens, se centra en una argumentación en favor del carácter hermenéutico del proceder psicopatológico.

La motivación fundamental de los diferentes artículos que aquí se exponen está basada en la incómoda aunque innegable inestabilidad (tanto teórica como práctica y conceptual) que caracteriza a la práctica psiquiátrica, una inestabilidad que pone bien a las claras la insuficiencia de todo proceder objetivante, reificador y determinista a la hora de abordar el ámbito de la patología psíquica. Así, frente a la acomodativa perspectiva que presenta a la psiquiatría como una ciencia joven, que avanza denodadamente por el camino seguro de la ciencia y que tan sólo precisa de instrumentos de medida más fiables y precisos para equiparar los logros alcanzados por el resto de especialidades médicas, estos artículos se enmarcan en una tradición de pensamiento crítico que se esfuerza por respetar la peculiar naturaleza de la experiencia subjetiva y las exigencias epistémicas que de ésta se derivan.

El primer artículo (‘Misunderstanding Psychopathology as Medical Semiology: An Epistemological Enquiry’) se centrará en la delimitación de la
psicopatología frente a semiología médica. Este análisis se basará en la identificación de algunas diferencias de carácter ontológico entre fenómenos clínicos propios de la medicina somática y fenómenos psicopatológicos, destacando la radical dependencia del sentido del síntoma mental con respecto al horizonte que representa la totalidad del individuo en quien se manifiesta (es decir, el sentido atribuido a un fenómeno psicopatológico concreto podrá fluctuar en función de quién sea el individuo en quien se identifica dicho síntoma, de su biografía, de su personalidad, de sus aspiraciones para el futuro, de sus temores, de sus relaciones sociales y familiares, etc.). Los rasgos diferenciales característicos de los síntomas mentales justificarán una serie de demandas epistémicas propias del ámbito psicopatológico, destacando un proceder hermenéutico-interpretativo que llevará a entender la psicopatología no como un compendio semiológico sino como una actividad destinada a la creación de inteligibilidad.

El segundo artículo (‘Should Definitions for Mental Disorders Include Explicit Theoretical Elements?’) se gestó inicialmente como proyecto del fin de Máster que presenté en el año 2010 (MA in Philosophy and Ethics of Mental Health, Warwick University). Este trabajo se centra en el análisis de la estructura-semántica de términos aplicados a fenómenos psicopatológicos. Así, retomando las ideas relativas al carácter interpretativo de la actividad psicopatológica con las que concluimos el primer artículo, criticamos la idea de que los fenómenos psicopatológicos puedan ser definidos en base a rasgos descriptivos de superficie (tal y como viene siendo el caso a día de hoy), como si de meros objetos se tratasen (en lugar del resultado de un proceso reconstructivo-interpretativo). Se critican además las pretensiones ateóricas de las últimas ediciones CIE y la DSM, heredadas fundamentalmente del Positivismo Lógico, y se plantean las limitaciones inherentes a una teoría descriptiva del significado. En definitiva, se plantea la necesidad de hacer explícitos, en la medida de lo posible (pues esto sólo es posible hasta cierto punto), los diferentes presupuestos teóricos que moldean nuestra
perspectiva acerca de la experiencia subjetiva y que por tanto contribuyen a
determinar tanto nuestra concepción acerca de la enfermedad mental como el
sentido global que cada uno de nosotros asocia con los diferentes términos
psicopatológicos (si bien esta conclusión implica un componente perspectivista
incompatible con las pretensiones cientificistas de una psiquiatría modelada a
imagen y semejanza del resto de especialidades médicas, es a nuestro juicio una
consecuencia inevitable derivada de la comprensión del trabajo psicopatológico
como un proceder hermenéutico-intepretativo). De esta forma, alcanzaremos a
entender el papel que dichos presupuestos teóricos juegan como guías o marcos
que orientan y sistematizan el proceder interpretativo en que consiste el juicio
psiquiátrico.

El último artículo (‘On the notion of Psychosis: Semantic and Epistemic
Concerns’) surge como un intento de comprender la arbitrariedad con la que el
término psicosis es empleado en la práctica cotidiana. Aplicando parte del
argumentario desarrollado en los dos artículos previos, se analizan las causas de la
inestabilidad del concepto de psicosis y se ejemplificará el fracaso de las
pretensiones naturalistas y positivistas en su aplicación al terreno de la
psicopatología. Retomando la necesidad de explicitar los presupuestos teóricos
desde los que analizamos la experiencia subjetiva, se hará hincapié en la necesaria
tematización de la idea de la subjetividad como ámbito en el que se desarrolla la
enfermedad mental. De este modo, el significado del término psicosis (o el de
cualquier otro término psicopatológico) será susceptible de variar, tal y como de
hecho ha sucedido a lo largo de los últimos 150 años, en función de cómo
entendamos aquello que sea la experiencia subjetiva. Del mismo modo, la
aplicabilidad del término psicosis a un caso determinado será susceptible de
variación en función de cómo entendamos aquello que sea la experiencia subjetiva
y por ende las formas en las que ésta pueda verse alterada. En último lugar, este
trabajo analiza la aspiración de todo juicio psiquiátrico a una pretensión de verdad
es decir, como psiquiatras pretendemos afirmar con un alto grado de convicción que alguien padece una afección que llamamos Psicosis). Siendo así que el trabajo psicopatológico no se aviene a la pretensión de verdad de las ciencias naturales (debido, entre otros motivos, a que el fenómeno psicopatológico no establece relaciones de causalidad ni puede ser subsumido bajo leyes deterministas y apodícticas), se exploran otras alternativas que legitimen la pretensión de verdad del juicio psiquiátrico respetando su carácter reconstructivo, teórico e interpretativo.

Podría objetarse que el objetivo al que señala el título de la presente tesis es excesivamente abarcador y que las hebras que conforman el tejido argumental que unifica los diferentes textos proceden de un campo excesivamente amplio, incluyendo la epistemología, la ontología, la filosofía del lenguaje, la semiología, la hermenéutica o la filosofía de la ciencia. En respuesta a esta objeción, cabe señalar que los diferentes trabajos aquí expuestos representan diferentes ejercicios intelectuales que a lo largo de los últimos años han tenido como principal objeto el apaciguar mi propio extrañamiento ante una inconsistencia y una arbitrariedad que siguen campanado a sus anchas en el ámbito de una psiquiatría que se resiste denodadamente a poner en cuestión aquellos fundamentos que pretenden legitimarla como una ciencia positiva. De esta manera, los trabajos aquí expuestos aspiran a contribuir al desbroce de un terreno tan confuso y complejo que en las últimas dos décadas ha motivado el desarrollo de toda una filosofía de la psiquiatría. Finalmente, las conclusiones que más adelante se exponen no deben ser interpretadas como la culminación de mi trabajo personal en este terreno. Representan, más bien, una plataforma desde la que poder seguir explorando las peculiaridades del fenómeno psicopatológico y de esta forma alcanzar una perspectiva más sólida acerca de sus exigencias epistémicas asociadas a una mejora en la práctica psiquiátrica.
Summary

This doctoral thesis represents the collection of three papers published between 2011 and 2016. Overall, these papers focus on epistemological and semantic issues pertaining to the area of psychopathology. The unifying line of argument can be described as consisting of two parts. In the first place, a pars destruens will focus on a critique against the aspirations of a positivistic psychiatry, which takes the psychopathological phenomenon as a definite object that is reducible to spatio-temporal variables and can be subsumed under deterministic and apodictic laws. Secondly, a pars construens will focus on the argument in favour of the hermeneutical nature of the psychopathological endeavour.

The main motivation underlying this doctoral thesis is based on the uncomfortable, although undeniable, instability that characterises psychiatric theory and practice. It is the author's view that this instability represents the insufficiency of all objectifying, reifying and deterministic approaches towards mental illness. Hence, against the accommodating view that represents psychiatry as a young science that walks firmly through the path of science and that only needs more sophisticated scientific devices in order to achieve similar results to those obtained by other medical disciplines, these papers pertain to a critical tradition that strives in order to respect the peculiar nature of subjective experience and the epistemic demands it imposes upon psychiatric theory and practice.

The first paper ('Misunderstanding Psychopathology as Medical Semiology') focuses on the clear delimitation between psychopathology and medical semiology. This analysis is based on the identification of ontological differences found between the object of study of bodily medicine and psychopathological phenomena, highlighting the radical dependence of the meaning of mental
symptoms (as opposed to physical symptoms) with regards to the horizon that the individual represents (i.e. the meaning attributed to a psychopathological phenomenon might differ depending on who the individual is, on his biography, his personality traits, his fears and hopes for the future, his social and family relations, etc.). These specific features pertaining to psychopathological phenomena (and subjective experience in general) will impose certain epistemic demands upon psychopathology, highlighting the need for a hermeneutic-interpretative procedure that will lead us to understanding psychopathology not as a mere semiological device, but as an activity aimed at rendering our patients' utterances and behaviour intelligible.

The second paper ('Should Definitions for Mental Disorders Include Explicit Theoretical Elements?') represents an analysis of the semantic structure of terms applied to psychopathological phenomena. Revisiting the ideas regarding the interpretative nature of the psychopathological task exposed in the first paper, we criticise the idea that psychopathological phenomena might be defined in terms of superficial descriptive criteria, as if they were mere objects that could be immediately and directly apprehended. The idea that mental symptoms can be defined in atheoretical terms, borrowed from Logical Positivism and found in the latest editions of the DSM and ICD, is critically assessed and the inherent limitations of a Descriptive Theory of Meaning are highlighted. We further argue for the need to explicitly state those theoretical assumptions that characterise our perspective on subjective experience, for they determine both the way we understand what mental illness is and the meaning that each one of us attaches to different psychopathological terms. Eventually, we will reach an understanding of the role that these theoretical assumptions play as a guiding framework for the interpretative process implied in psychiatric judgement.
The third and last article (‘On the notion of Psychosis: Semantic and Epistemic Concerns’) represents an attempt aimed at understanding the reasons underlying the arbitrariness with which the term ‘psychosis’ is deployed in clinical practice. Following the ideas developed in the previous articles, we analyse the reasons underlying the practical, semantic and theoretical instability that characterises this term, which represents in our view a perfect example of the failure of psychiatry’s naturalistic and positivistic aspirations. Revisiting the idea that theoretical assumptions regarding the nature of subjective experience should be made explicit, we will focus on the need to develop the notion of subjectivity as the realm where mental illness takes place. Following this line of argument, we will see how the meaning of the term ‘psychosis’ (or any other psychopathological term) is susceptible to variation depending on how subjective experience is conceptualised. Similarly, the possibility of applying the term ‘psychosis’ to a particular case will differ depending of how we understand what subjective experience actually is and therefore how it might become distorted. Finally, this paper examines the pretension of truth that psychiatric judgement aims for (i.e. how is it that, as psychiatrists, we can be certain that an individual is experiencing a psychosis). Since psychopathological phenomena do not stand in causal or fixed relations with other objects and cannot be subsumed under deterministic or apodictic laws, psychopathology should aim for an alternative pretension of truth (not for the one aimed at by the natural sciences) that respects its interpretative and theory-dependent character.

This doctoral thesis could be criticised for the width of its scope (after all, the issues discussed include areas related to epistemology, ontology, the philosophy of language, semiology, hermeneutics and the philosophy of science). However, the papers here compiled represent different intellectual efforts aimed at soothing the estrangement I experience when facing the inconsistencies and arbitrariness that can be found scattered all over the realm of psychiatry. In this
sense, these papers aim at shedding some light on an area of knowledge so complex and confusing that has led in the last couple of decades to the development of a new specific discipline: the philosophy of psychiatry. Finally, the conclusions reached should not be taken as my final word on the subject, but rather as a platform from which the peculiarities of psychopathological phenomena might be further explored, leading to a more solid understanding of the epistemic demands imposed by subjective experience and hopefully to an improvement in psychiatric practice.
ÍNDICE

Agradecimientos.................................................................11

Introducción........................................................................15

'Misunderstanding Psychopathology as Medical Semiology: An Epistemological Enquiry'.........................................................23

Should Definitions for Mental Disorders Include Explicit Theoretical Elements?.................................................................37

On the Notion of Psychosis: Semantic and Epistemic Concerns........49

Conclusiones.......................................................................59
INTRODUCCIÓN
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La motivación fundamental de los diferentes artículos que aquí se exponen está basada en la incómoda aunque innegable inestabilidad (tanto teórica como práctica y conceptual) que caracteriza a la práctica psiquiátrica, una inestabilidad que pone bien a las claras la insuficiencia de todo proceder objetivante, reificador y determinista a la hora de abordar el ámbito de la patología psíquica. Así, frente a la acomodaticia perspectiva que presenta a la psiquiatría como una ciencia joven, que avanza denodadamente por el camino seguro de la ciencia y que tan sólo precisa de instrumentos de medida más fiables y precisos para equiparar los logros alcanzados por el resto de especialidades médicas, estos artículos se enmarcan en una tradición de pensamiento crítico que se esfuerza por respetar la peculiar naturaleza de la experiencia subjetiva y las exigencias epistémicas que de ésta se derivan.

El primer artículo (*Misunderstanding Psychopathology as Medical Semiology: An Epistemological Enquiry*) se centrará en la delimitación de la psicopatología frente a semiología médica. Este análisis se basará en la
identificación de algunas diferencias de carácter ontológico entre fenómenos clínicos propios de la medicina somática y fenómenos psicopatológicos, destacando la radical dependencia del sentido del síntoma mental con respecto al horizonte que representa la totalidad del individuo en quien se manifiesta (es decir, el sentido atribuido a un fenómeno psicopatológico concreto podrá fluctuar en función de quién sea el individuo en quien se identifica dicho síntoma, de su biografía, de su personalidad, de sus aspiraciones para el futuro, de sus temores, de sus relaciones sociales y familiares, etc.). Los rasgos diferenciales característicos de los síntomas mentales justificarán una serie de demandas epistémicas propias del ámbito psicopatológico, destacando un proceder hermenéutico-interpretativo que llevará a entender la psicopatología no como un compendio semiológico sino como una actividad destinada a la creación de inteligibilidad.

El segundo artículo ("Should Definitions for Mental Disorders Include Explicit Theoretical Elements?") se gestó inicialmente como proyecto del fin de Máster que presenté en el año 2010 (MA in Philosophy and Ethics of Mental Health, Warwick University). Este trabajo se centra en el análisis de la estructura semántica de términos aplicados a fenómenos psicopatológicos. Así, retomando las ideas relativas al carácter interpretativo de la actividad psicopatológica con las que concluimos el primer artículo, criticamos la idea de que los fenómenos psicopatológicos puedan ser definidos en base a rasgos descriptivos de superficie (tal y como viene siendo el caso a día de hoy), como si de meros objetos se tratasen (en lugar del resultado de un proceso reconstructivo-interpretativo). Se critican además las pretensiones ateóricas de las últimas ediciones CIE y la DSM, heredadas fundamentalmente del Positivismo Lógico, y se plantean las limitaciones inherentes a una teoría descriptiva del significado. En definitiva, se plantea la necesidad de hacer explícitos, en la medida de lo posible (pues esto sólo es posible hasta cierto punto), los diferentes presupuestos teóricos que moldean nuestra perspectiva acerca de la experiencia subjetiva y que por tanto contribuyen a
determinar tanto nuestra concepción acerca de la enfermedad mental como el sentido global que cada uno de nosotros asocia con los diferentes términos psicopatológicos (si bien esta conclusión implica un componente perspectivista incompatible con las pretensiones científicas de una psiquiatría modelada a imagen y semejanza del resto de especialidades médicas, es a nuestro juicio una consecuencia inevitable derivada de la comprensión del trabajo psicopatológico como un proceder hermenéutico-intepretativo). De esta forma, alcanzaremos a entender el papel que dichos presupuestos teóricos juegan como guías o marcos que orientan y sistematizan el proceder interpretativo en que consiste el juicio psiquiátrico.

El último artículo (‘On the notion of Psychosis: Semantic and Epistemic Concerns’) surge como un intento de comprender la arbitrariedad con la que el término psicosis es empleado en la práctica cotidiana. Aplicando parte del argumentario desarrollado en los dos artículos previos, se analizan las causas de la inestabilidad del concepto de psicosis y se ejemplificará el fracaso de las pretensiones naturalistas y positivistas en su aplicación al terreno de la psicopatología. Retomando la necesidad de explicitar los presupuestos teóricos desde los que analizamos la experiencia subjetiva, se hará hincapié en la necesaria tematización de la idea de la subjetividad como ámbito en el que se desarrolla la enfermedad mental. De este modo, el significado del término psicosis (o el de cualquier otro término psicopatológico) será susceptible de variar, tal y como de hecho ha sucedido a lo largo de los últimos 150 años, en función de cómo entendamos aquello que sea la experiencia subjetiva. Del mismo modo, la aplicabilidad del término psicosis a un caso determinado será susceptible de variación en función de cómo entendamos aquello que sea la experiencia subjetiva y por ende las formas en las que ésta pueda verse alterada. En último lugar, este trabajo analiza la aspiración de todo juicio psiquiátrico a una pretensión de verdad (es decir, como psiquiatras pretendemos afirmar con un alto grado de convicción
que alguien padece una afección que llamamos Psicosis). Siendo así que el trabajo psicopatológico no se aviene a la pretensión de verdad de las ciencias naturales (debido, entre otros motivos, a que el fenómeno psicopatológico no establece relaciones de causalidad ni puede ser subsumido bajo leyes deterministas y apodícticas), se exploran otras alternativas que legitimen la pretensión de verdad del juicio psiquiátrico respetando su carácter reconstructivo, teórico e interpretativo.

Podría objetarse que el objetivo al que señala el título de la presente tesis es excesivamente abarcador y que las hebras que conforman el tejido argumental que unifica los diferentes textos proceden de un campo excesivamente amplio, incluyendo la epistemología, la ontología, la filosofía del lenguaje, la semiología, la hermenéutica o la filosofía de la ciencia. En respuesta a esta objeción, cabe señalar que los diferentes trabajos aquí expuestos representan diferentes ejercicios intelectuales que a lo largo de los últimos años han tenido como principal objeto el apaciguar mi propio extrañamiento ante una inconsistencia y una arbitrariedad que siguen camando a sus anchas en el ámbito de una psiquiatría que se resiste denodadamente a poner en cuestión aquellos fundamentos que pretenden legitimarla como una ciencia positiva. De esta manera, los trabajos aquí expuestos aspiran a contribuir al desbroce de un terreno tan confuso y complejo que en las últimas dos décadas ha motivado el desarrollo de toda una filosofía de la psiquiatría. Finalmente, las conclusiones que más adelante se exponen no deben ser interpretadas como la culminación de mi trabajo personal en este terreno. Representan, más bien, una plataforma desde la que poder seguir explorando las peculiaridades del fenómeno psicopatológico y de esta forma alcanzar una perspectiva más sólida acerca de sus exigencias epistémicas asociadas a una mejora en la práctica psiquiátrica.
Misunderstanding Psychopathology as Medical Semiology: 
An Epistemological Enquiry

Pablo Ramos Gorostiza & Jaime Adán Manes

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Misunderstanding Psychopathology as Medical Semiology: An Epistemological Enquiry

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Key Words
Psychopathology · Epistemology · Semiology

Abstract
In our everyday clinical experience we encounter significant problems directly related to the instability of psychopathological concepts. In order to trace the origin of this inconsistency, the nature of these concepts will be explored in their historical development. They will be compared to those pertaining to medical semiology, paying special attention to the specific nature of the ‘object’ each of them refers to. While concepts belonging to medical semiology refer to natural objects and retain their meaning independently of the patient’s context, psychopathological concepts refer to fragments of experience, which lose their significance if detached from their contextual horizon. The instability of psychopathological concepts is a consequence of the misunderstanding of psychopathology as medical semiology. As an alternative to this view, it will be argued that psychopathology represents an active and never-ending process aimed at the creation of intelligibility.

On the Inconsistency of Psychiatry
The history of psychiatry reveals a domain scattered with inconsistencies and heterogeneous interpretations of clinical phenomena. Lantéri-Laura [1] claimed that psychiatry’s heterogeneity was rooted in its semiologic foundations, which implied the impossibility of establishing a coherent system of psychiatric knowledge as a whole. This amounts to saying that there is a problematic internal relationship between clinical phenomena (raw psychiatric data: utterances and behavior) and psychiatric language, which we shall refer to as ‘descriptive psychopathology’. This problematic relationship is grounded on the historical development through which psychiatry became a medical discipline and inherited the epistemological structure known as medical semiology. Such a structure includes two main requirements: (1) concepts must unambiguously refer to observed clinical phenomena, and (2) symptoms, understood as conceptualized clinical data, must be stabilized by a causal account [2], so they may predict or represent their unseen cause. As we shall argue, the peculiarities of psychopathological phenomena will keep them from fulfilling either of these two criteria.

The development of pathological anatomy, physiology and experimental pathology during the 19th century...
greatly increased our understanding of pathological conditions and offered a wide range of therapeutic options; new treatments could be developed that would target any point in the pathological cascade, from the specific cause to unspecific symptoms. The increasingly established link between biological causes and effects, as well as the specific and ‘object-related’ descriptive definitions1 of physical signs and symptoms, have slowly transformed medicine into a rather stable framework of knowledge, including the definition of symptoms and their interrelation in the context of a global physiopathologic process, and its nosological structure. In spite of this, clinical experience has taught us that even though psychiatry developed as a medical specialty, therefore inheriting its epistemological structure, its framework of knowledge has remained anything but stable. This fact is exemplified by the following characteristics:

– Poor diagnostic reliability: particular patients are frequently diagnosed as suffering from different disorders by different observers at a certain given time (interobserver reliability), or by the same observer over a period of time (test-retest reliability)[3, 4]. Diagnostic reliability was significantly increased by the establishment of a nosographic consensus based on operational criteria included in the Diagnostic and Statistical Manual by the American Psychiatric Association[5] and the International Classification of Diseases and Related Health Problems by the World Health Organization[6]. In spite of this, psychiatric diagnosis remains highly inconsistent. The fact that criteriological diagnosis has been unable to further increase its reliability seems to imply that certain features of clinical judgment are not exclusively based on symptom identification, but on an interpretative faculty[7].

– Poor conceptual reliability: particular psychopathological concepts have had different meanings throughout the history of psychiatry[8]. Karl Jaspers’ descriptive approach has greatly contributed to an improved conceptual reliability by (unsuccessfully) trying to avoid theoretical assumptions. Despite this fact, core concepts such as ‘delusion’ still lack a universally accepted definition.

– Low conceptual and nosological validity[3]: in spite of being treated as natural kinds, the ontology of mental symptoms and disorders is still under debate[9]. In other words, are psychopathological symptoms discovered as natural kinds or are they theoretical constructs designed to make sense of our patients’ utterances and behavior?

– A great deal of clinical cases do not properly fit into the proposed symptomatic and diagnostic categories. In order to do away with this procrustean bed, the idea has been developed that mental disorders are not categorical, but represent a continuum[10], reconceiving current nosological models by the idea of a dimension-al architecture as opposed to a categorical view[11].

– Several mutually exclusive theories have been developed in order to offer a proper account of the same psychopathological phenomena, both from a descriptive and from a causal point of view (phenomenology, psychoanalysis, existential analysis, biological psychiatry, etc.). Despite the fact that all of them have failed to accomplish this task[12], the validity of descriptive psychopathology as psychiatric semiology has never been brought into question.

– In spite of the significant efforts applied to establishing correlations between psychopathological phenomena and neuroimaging, no specific relationship has been found. Some authors argue that this is just a matter of time and technological development. In the authors’ understanding, this failure is rooted in the fact that psychopathological phenomena and neuroimaging data are simply incommensurable.

Since the medical model succeeded in developing a stable and consistent framework, how should we understand the swampy situation psychiatry is stuck in? As a scientific discipline, psychiatry is a product of modernity[13]. As such, it is rooted in a new form of experience which, since the 16th century, has fixed the concepts of subjectivity, representation and truth and has catalyzed their ontological transformation. This inheritance, based on the idea of representation, where a symptom would stand in the place of its hidden causal lesion, endowed the epistemological framework of the first alienists with certain constrictions. As a result, and roughly described, their main task would be concerned with the following:

– raw behavioral disorders and utterances, which had not yet been conceptualized, were to be identified as symptoms via descriptive definitions;

– these symptoms would be considered as natural classes, i.e. not invented, but discovered;

– symptoms were referred, via a representational process, to a putative causal lesion or dysfunction located in the body;

1 The authors are well aware of the fact that the notion of ‘descriptive definitions’ has important implications in the philosophy of language. However, this concept is used in a broad sense, bearing no specific reference to particular semantic theories.

206 Psychopathology 2011;44:205–215

Ramos Gorostiza/Adan Manes
– some kind of therapy, either etiological or symptom-atric, could be prescribed in order to restore its natural function.

In the early 20th century, Philippe Chaslin was already well aware of the conceptual mess that was scattered all across psychiatry and of the inconsistencies it gave rise to. Under the influence of Condillac’s sensualism, Chaslin insisted that by developing a well-made language, psychiatry would get rid of its ambiguities and would develop as a proper science: ‘[i]t will only be as a result of much effort that French mental medicine will emerge from “psychiatric anarchy” and become a “well-studied science” and a “well-made language”‘ [14, 15]. The psychiatric community accepted these assumptions, as we still seem to do nowadays [16], taking for granted that properly defined concepts would refer to natural kinds of some sort. Besides the conceptual chaos described at the time by Chaslin, major problems were reported with respect to nosological inconsistency based on the lack of semiologic precision [17–19]. In the following period, authors such as Karl Jaspers and Ludwig Binswanger went deeper into understanding the lack of semiologic precision and argued that a shift from purely observational/empirical data towards the patient’s internal experience was needed [20–22]. Jaspers’ efforts, followed by the Heidelberg School, represented by himself, Gruhle, Kurt Schneider and Mayer-Gross among others [23–25], led to a more sophisticated description of clinical phenomena. In spite of this, the same semiologic structure was maintained, and hence Heidelberg’s psychopathology could not avoid following an empirical approach, reaching its height with Schneider’s first-rank symptoms [26]. Binswanger’s existential analysis, on the other hand, remained true to the interpretative openness of psychopathological phenomena.

These constraints, inherited from medicine as a modern product, would end leading psychiatry into an aporetic present. Blind to their past and still professing to emulate medical semiology, psychiatrists have long placed their hopes in the future development of new research techniques and methodological procedures that might reveal the nature of these problems and put an end to this instability [27]. Far from this, psychiatry’s failure in emulating medical semiology is rooted in specific features of mental phenomena, which demand an exhaustive enquiry into the deep grammar of clinical judgment. As we will argue, these features render it impossible to conceive descriptive psychopathology as a medical semiology.

We shall start our analysis by reviewing the historical development of clinical judgment in modern medicine, paying special attention to the specific characteristics derived from its constitution as a scientific discipline. The main feature of this analysis is its constitution as a form of semiology. In a second step, we will analyze how psychopathology unsuccessfully tried to emulate the structure of medical semiology due to a misunderstanding of its own nature. We will focus on the nature of psychopathological phenomena and on the qualities that determine their inherent instability. The conclusion will lead us to re-conceive the nature of psychopathology as an active and never-ending process aimed at the creation of intelligibility. As such, the encounter with the patient represents a permanent plea in psychopathology.

**The Development of Medical Semiology**

It is by no means our intention to offer a detailed account of the history of medicine here. Our main aim in this section is focused on explaining how medicine, as a product of modernity, became a natural scientific discipline. By ‘natural science’ we understand a discipline that can be defined by the following characteristics:

– it has a specific object of interest, grounded in the natural world;
– it unambiguously reflects a fixed and stable relationship of causality under which its objects of study must be subsumed and which can be reduced to the laws of physics; this relationship renders it possible to measure such objects, to design and reproduce experiments, to predict results and translate these into mathematical language;
– it has developed a specific language which allows us to refer to its particular objects of study and to their different components while obtaining an immediate consensus, independently of arbitrary theoretical presuppositions;
– the stability in the descriptive definition of specific concepts is determined by the deployment of descriptive criteria that are grounded on universally accepted theoretical assumptions; the universal acceptance of such assumptions is legitimized by their empirical validation and their subsumption under universal laws.

It is commonly argued that modern nosology finds its origin in the figure of Thomas Sydenham (1624–1689). By analyzing and comparing clinical and prognostic similarities, he conceived for the first time the idea that different symptoms, which were previously considered as separate diseases, were actually different manifestations of the same disorder and were associated to a particular prognosis [28]. During the 18th century, Morgagni (1682–1771),
and after him Bichat (1771–1802), developed a pathological anatomy [28]. Following their results, Virchow (1821–1902) sought to establish a correlational association between specific changes in anatomical structures and observable symptoms, hoping to make pathological anatomy the basis for the science of disease. This achievement made it possible to develop a nosological system that could be broadly stabilized by its direct and atheoretical association with a natural substrate [28, 29]; previous models, such as the galenic or hippocratic models, were mainly based on theoretical assumptions that made it impossible to establish a stable model as it could not be based on lawful, physical and determinable relationships.

The development of physiology – through the works of William Harvey (1578–1657), Albrecht von Haller (1708–1777) and François Magendie (1783–1855), among many others – took as its object of study the human body, understood as a mechanical system characterized by stable and dynamic relationships within its different elements; as Claude Bernard (1813–1878) would say: ‘[w]hat is crucial is experimentation on animals, which makes it possible to observe the mechanics of a function in a living creature...’ [30]. The turn from anatomy to physiology and the progressive development of research procedures (dying techniques, measuring procedures, imaging techniques, etc.) made it possible to transform the correlational association that had been established between detectable symptoms and lesion, observed as a specific alteration in anatomical structures, into a causal association. This achievement is best exemplified by the work of Claude Bernard on experimental physiology, an experimental science that borrowed techniques from physics and chemistry and that created the basis for the development of scientific medicine [31]. As an example of this development, diabetes mellitus passed from being defined as an association of symptoms (polydipsia, polyuria and polyphagia) to being defined by increased glycemia and, finally, as an insulin-related disorder, thus being defined by a causal process. Finally, the development of microbiology – by Koch (1843–1910) and Pasteur (1822–1895) – and of genetics played a major role in the constitution of etiology as an essential element in the natural-material (therefore causal or deterministic) pathological process. In conclusion, medicine developed as a specific form of semiology, which crystallized as the ‘School of Paris’. This amounts to saying the following:

- Medical concepts unequivocally refer to their objects. By this we understand that they possess all the sufficient and necessary conditions in order for a particular case to be subsumed under it. In the following pages we will refer to these as closed concepts. (As an example of this relation, see hyperglycemia: glycemia above the normal established values is sufficiently and necessarily defined as hyperglycemia).

Due to the fact that observable physical signs and symptoms refer to a physical substance located in the body, (1) they must obey physical laws which determine the relation of causality between themselves and their cause, and (2) they can be conceptualized by our understanding under certain categories in such a way that:

- these concepts refer very closely to their objects, so that whenever a particular symptom, for example, increased blood glucose levels, is presented, it will be directly subsumed under its corresponding concept (hyperglycemia) and no other; the close relation between these concepts and their referred objects is based on the fact that the former’s descriptive definitions include statements which are framed on a single and universally accepted theory that is subject to natural laws and is empirically verifiable; besides this, these descriptive definitions barely contain normative elements, and whenever these can be found, they tend to be accepted with a general consensus;

- these concepts (symptoms) refer through a vertical relation to their causal lesion; increased blood glucose levels refer to an insulin disturbance; the causal relation might not be directly linked to a unique and specific symptom, as is the case for pathognomonic symptoms, since most of them tend to be unspecific (fever, swelling, leukocytosis, etc.); therefore, in order to reveal their causal relation, supplementary information might be required from other accompanying symptoms. As we have seen, signs and symptoms are defined by vertical (causal) and horizontal relations, the latter being based on accompanying manifestations which reveal a common causal process [32].

2 The notion of ‘closed concepts’ seems to suggest that it is possible to offer eternal and context-independent definitions in general. Though we ultimately adhere to a contextualist perspective, in that we believe that all definitions are context dependent, and hence deny the existence of such definitions, we do believe that the natural sciences allow for a very tight relationship between descriptive definitions and the objects they refer to. In fact, this relationship is so tight that, for practical purposes, we will take them to be context independent (i.e. ‘closed’).
A singular pathognomonic symptom or a cluster of observable symptoms directly and unambiguously represent their causal lesion. (As an example, maintained hyperglycemia represents an insulin-related disorder). The certainty of the relationship between symptom and lesion is based on the empirically verified principles of physio(pathology).

These characteristics assume that the body is a system of mechanically interconnected organs [33]. An essential quality of medical semiology is that all of the patient’s utterances can be ignored except for those which relate to measurable components (duration, intensity and location) since they can be reduced to quantifiable variables related to space, time and force [13]. A fundamental quality of these utterances is that they can be detached from the holistic network of meaning instantiated in the patient/person without losing their significance; the location, intensity and duration of a particular symptom are independent from the patient’s biography, beliefs, intentions, etc. We shall now argue how psychiatry developed under the false assumption that descriptive psychopathology could emulate this model. The false assumption that psychopathology can detach utterances and behavior from their horizon of meaning is most obvious in the International Classification of Diseases (ICD-10) by the WHO and the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association (DSM-IV).

The Unstable Structure of Descriptive Psychopathology

How were psychopathological symptoms individualized and conceptualized? Once again, it is not our intention to offer a detailed historical account, but to analyze their ontological structure in order to understand why psychopathology cannot be equated to medical semiology [34].

It is often assumed that the systematic description of psychiatric symptoms, as distinct from individual diseases, first started with Jean-Etienne Dominique Esquirol (1772–1840), who was the first to distinguish hallucinations from illusions and described them as ‘perceptions without an external stimulus’ [35, 36]. Since then, numerous concepts (obsession, phobia, psychosis, neurosis, etc.) have been described by different authors. This process depended on unquestioned psychological assumptions and was based on the identification of mental symptoms as natural kinds – hence being susceptible to closed definitions – as opposed to social or moral deviance. As we shall argue, conceptual instability results from the fact that descriptive psychopathology has taken for granted the assumption that the symptoms with which it deals are in fact natural objects which represent (i.e. stand in place of) concrete biological disturbances with which they are related via a causal process [37]. As such, the putative biological signal would be susceptible to being grasped through the identification of the symptom by the psychiatrist. Unfortunately, this process seems to represent no more than a misunderstanding of the particular nature of mental phenomena [38]. The development of descriptive psychopathology based on these assumptions has had, among others, the following consequences:

- The concepts of ‘hysteria’ [39] and ‘neurosis’ [40] were abandoned due to the lack of stability in their meaning and the confusion they gave rise to.
- The most extensive definition of delusion still in use (extraordinary conviction, incorrigibility and impossibility of content), described by Karl Jaspers [20], is considered to be false (for delusions can be true after all) and has been systematically criticized [41].
- The concept of ‘psychosis’ has had several meanings throughout the last 150 years. No clear and specific definition is yet available. As a result, doubt has been cast upon its utility [42, 43].
- Several authors have highlighted the unclear limits of the concept of ‘delusion’, particularly as opposed to ‘obsession’ [44, 45].

Creating Psychopathological Concepts: Misunderstanding Psychopathology as Medical Semiology

In the next paragraphs we will try to answer the following question: how were psychopathological symptoms conceptualized? The development of psychiatry was made possible by the interaction of specific historical events that took place between the 18th and 19th centuries, including the grouping of the mad in asylums [46], the observation of patients over long periods of time, and the application of supposedly neutral (value-free) psychological theories to explain and catalogue the diverse manifestations of mental derangement such as associationism or faculty psychology [8].

During the early 19th century, the main categories applied to the insane were delusion and mania, the differences between them not being thoroughly established [47, 48]. On the other hand, symptoms had not yet been properly distinguished from general illnesses or disorders. By the observation of series of patients, alienists slowly real-
On the epistemology of psychopathology: critical insights and methodological concerns

In this sense, Esquirol defined hallucinations by identifying formal differences between these, illusions and delusions according to the unquestioned psychological theories he had inherited from his predecessors (faculty psychology). Hallucinations were therefore understood as a specific perceptual disorder as opposed to an error of judgment. Similarly, he distinguished between mental disorders that affected the mental faculties in general (mania) from those which affected only one of them (either the intellect, the emotions or the will), leaving the rest intact (monomania) [35]. This process continued throughout the 19th century with the work by authors such as George, Moreau de Tours, Morel, Baillarger and Falret, who described new symptoms and disorders (obsession, phobia, etc.) through the identification of differences and similarities between phenomena they observed in their patients and those symptoms that had already been described.

Since psychiatry was developing as a medical discipline, individual symptoms were taken to be natural kinds representing specific internal lesions. In this sense, mental symptoms had to be described through concepts whose definitions were taken to include all the necessary and sufficient elements in order to unambiguously represent the specific lesion, i.e. they had to be described through closed concepts or, in other words, as physical symptoms. In this sense, by supposing that terms related to psychopathological symptoms shared their linguistic structure with those related to physical symptoms, i.e. that they acted as closed concepts, a double advantage was acquired. Firstly, the meaning of psychopathological concepts could be described exclusively by means of formal semantics, rendering meaning apparently independent of contextual modulation and, hence, exclusively dependent on semantic saturation [49]; i.e. the complete meaning of a specific psychopathological term could be offered via a finite amount of descriptive propositions. Secondly, the psychopathological symptom referred to by the use of a closed concept was capable of standing in direct semantic relation to a physical anomaly described through another closed concept. For example, the term delusion would be unambiguously defined through a set of descriptive propositions that would stand in direct relation to a different set of propositions that would unambiguously define a specific neurological disturbance.

However, the process of symptom individuation took place via the observation of open series of patients among which similar structural mental anomalies were detected. In contrast to bodily medicine, the essential qualities that were taken to define the different psychopathological symptoms were not reducible to measurable variables that could eventually be subsumed under apodictic natural laws. In fact, these symptoms were defined according to superficial similarities found in series of patients by using one of the several psychological approaches available (e.g. general cognitive deterioration such as that found in all cases of dementia praecox). Under the superficial similarities, the deep grammar of specific symptoms suffered the risk of being neglected, for different psychological theories placed special emphasis on certain features while neglecting others, leading heterogeneous phenomena to conflation within a single concept[50]. On the other hand, if more patients had been added to that particular series, or if different patients had been a part of it, the main characteristics identified would most probably have differed. Similarly, if a different theoretical approach had been taken, different features might have been considered to constitute the core elements of a particular symptom.

As we have previously mentioned, the descriptive definition of concepts pertaining to bodily medicine was said to contain all the necessary and sufficient elements to unambiguously refer to their specific object; e.g. glycemia above the normal established value is sufficiently and necessarily defined as hyperglycemia. This was made possible by the fact that such definitions were based on theoretical assumptions that barely contained normative elements and that could be empirically verified and were therefore universally accepted, i.e. they were based on physio(patho)logy. On the other hand, the several different psycho(patho)logical theories on which the definitions of mental symptoms are based are purely abstract (i.e. not empirically verifiable), are heavily value laden (i.e. they possess significantly normative content on which there is no general consensus)[51], and are unable to offer a complete account of psychic life. This explains the need for different psycho(patho)logical theories, none of which have been universally accepted; some of them stress the importance of particular features while neglecting others and vice versa. Since a theoretical framework is needed in order to define concepts in general[52], and since psychopathology counts on several different theories regarding the nature of normal and altered psy-
Misunderstanding psychopathology as medical semiology: an epistemological enquiry

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Applying Psychopathological Concepts

By the beginning of the 20th century, descriptive psychopathology, i.e. the psychiatric database for clinical judgment, had been completely developed [55]. It was around this time that different authors realized the insufficiency of applying psychopathological concepts to utterances and behavior as if identifying natural objects (or brain dysfunctions). As a response to this, several theories were developed in order to establish the internal process through which clinical data acquired their meaning and through which symptoms could be identified and in some cases even produced. These new theories shifted the attention from a mechanistic and analytical approach towards the idea of ‘the individual as a whole’ in order to offer a framework where tacit and nonformalized information could be articulated. In other words, these theories were developed as expressions of the fundamental interpretative process demanded by the referential openness of psychopathological phenomena [56]. The main examples of this effort are Jaspers’ phenomenological approach [18, 57], Freud’s psychoanalysis [58] and Binswanger’s existential analysis [59]. Note that while these authors concurred in perceiving the need for an interpretative approach, their assumptions regarding the reasons for this were quite different. In any case, an analysis of this reaches far beyond the scope of this article.

During the second half of the 20th century, psychiatry made a new move towards positivism, catalyzed by the success of biological therapies, the need for an increase in conceptual reliability, and the ‘unscientific’ nature of the aforementioned approaches. One of the consequences, promoted by Hempel’s positivist background, was the development of operational diagnostic criteria [60]. Their insufficiency arises from the fact that the structure of formal semantics is based on a context-independent analytical process, by which the meaning of any particular statement will depend on the meaning of its constituents and the basic logical principles of identity, noncontradiction and excluded middle. Following these principles, diagnostic models such as the ICD and the DSM reflect the assumption that it is possible to carry out an immediate identification of a cluster of symptoms. As a result, the reliability of this model is based on the view that the diagnostic process consists of two independent phases, namely symptom identification and disease recognition. Conversely, Berrios and Chen [61] have shown how individual symptom identification is never an independent exercise, but is intimately entangled with the process of disease recognition. Besides their interdependence, symptom identification and disease recognition greatly depend on nonformalized contextual information.

The main route to access human experience is via utterances and behavior. In order to acquire clinical significance, these must be identified as symptoms by the often procrastinate imposition of a relevant concept belonging to our psychopathological database. As we have seen, the interpretation of raw clinical data as one particular symptom or another will depend on the diagnostic assumption and on contextual subsignificant information [62]. Due to their tacit nature or their dependence upon the context, subsignificant data have systematically defied closed definitions and definitive conceptualization.

In order to tackle this problem, in the last decades different but unsuccessful efforts have been directed towards their indirect codification, such as the development of multidimensional diagnostic procedures, the endogenomorphic axial syndromes proposed by the Vienna Group [63, 64], or the proposal of a dimensional architecture as opposed to a categorical view of mental illness [11]. Similarly, different disciplines belonging to the human sciences, such as psychology, anthropology, sociology and history, share psychopathology’s need to deal with openness of meaning. Hence, their different specific approaches have (unsuccessfully) influenced psychopathology throughout the 20th century in its search for a method of capturing the essence of mental phenomena [65].

Due to their referential openness, psychopathological data (utterances and behavior) must be interpreted with respect to their context, for the relationship between such data and the concepts used to refer to the data has an open texture, which must be respected and taken into account. In spite of this, it is the opposite view that is usually held (as when money squandering or sexual hyperactivity are immediately identified as manic symptoms without taking contextual information into account), leading to the assumption that it is possible to carry out an immediate identification between utterances or behavior and a specific mental symptom, neglecting all the problems related to structural instability inherent in all theories of reference [66]; in this sense, referential openness means that any particular utterance or behavior taken in isolation might have many different possible meanings. We hereby understand that the clinical interpretation of raw data will vary according to nonformalized contextual information that plays a tacit role in the process of clinical judgment [67]. Hence, a particular utterance can be interpreted as a delusion by a given psychiatrist, while another may identify it as an obsession by elaborating his diagnosis through the implicit use of different contextual and...
nonformalized data (e.g. information provided by the patient’s relatives, the patient’s behavior when he believes he is not being observed, etc.).

In order to understand the role that subsignificant or nonformalized data play in the symptom identification process, simple schizophrenia is particularly useful. In this sense, while no delusions or hallucinations are present and time has not yet allowed deterioration, clinical judgment must take place via present though nonformalized information. Due to its particular nature, this kind of experience seems only to be accessible through tacit knowledge; in this case, information cannot be formalized since it refers to a subjective feeling, which does not allow analytic codification. Historical examples can be found in Chaslin’s ‘discordance’ [15], Bleuler’s ‘autism’ [68], Minkowski’s ‘loss of vital contact with reality’ [69], Rümke’s ‘praecox feeling’ [54] or Blankenburg’s ‘loss of natural evidence’ [70].

Reconceiving Psychopathology

The authors do not profess that all the arguments offered so far should act as a sterile criticism of the current psychopathological approach. More than this, the ‘destructive’ process carried out so far professes nothing else than to allow us to obtain a better perspective of what, in our opinion, psychopathology is all about. Psychopathology should not be conceived as a database containing concepts used to identify mental phenomena understood as putative natural kinds, nor as an individual theory pretending to offer a complete account of altered mental life. As far as we understand, it would be better conceived as an active process, the goal of which is the creation of intelligibility or the reconstruction of fragments of experience embedded in their meaning-bearing context; i.e. subsignificant or nonformalized contextual information must be made as fully explicit as possible with the help of psychopathological theories, acknowledging the fact that these might contain mutually exclusive assumptions. Given the abstract nature of psychopathological theories and the impossibility of empirically validating them so as to subsume them under natural laws that would allow for a certain degree of precise prediction, their legitimacy will mainly depend on their internal coherence and on their capacity to explain (a posteriori) clinical phenomena. The coexistence of several psycho(patho)logical theories by which psychiatric raw data can be analyzed, and the need to interpret these data in relation to their meaning-bearing context, render psychopathological activity open to permanent reconstruction and interpretation [18, 32] (i.e. it is embedded in an endless hermeneutic task3). This idea represents a process based on the continuous application of psychopathological concepts to the intuited raw data (utterances and behavior). As we have said, this symptom identification process has been shown not to be purely observational, but intimately entangled with diagnostic assumptions and tacit, nonformalized contextual information [61]. As a result of this, and despite recently developed theories of meaning regarding operational definitions [71], psychopathological symptoms cannot be interpreted or recognized through the semantic process proposed by operational criteria.

Psychopathology, understood as a process designed to render psychiatric phenomena intelligible, stabilizes the meaning of clinical data by a hermeneutical procedure which allows nonformalized clinical data to be articulated and made explicit through clinical judgment; we must remember that psychopathological concepts, with their closed definitions, excluded contextual information from descriptive definitions.

In this sense, psychopathology is a never-ending process, from the whole to the parts and back again. This is due to the fact that it is just impossible to stretch the meaning of psychopathological concepts in order for them to become completely explicit. In this sense, we must abandon the idea that this stretching is possible at all, for it anticipates the closure of psychopathological concepts and neglects their open texture [72].

Each particular individual is defined by a specific contextual horizon (i.e. by the specific relations it holds with its particular environment), which cannot be codified into descriptive definitions. In this sense, every single case requires a cognitive effort in order to allow taking its own horizon into account. Psychopathology, as a practical and intellectual process, is in charge of reconstructing the meaning of every particular case and of incorporating it into the body of available clinical knowledge [73]. The modus operandi of descriptive psychopathology, based on identifying symptoms as putative natural kinds, must be recused after 150 years of failing to grasp the nature of psychopathological phenomena and imposing a procrustean standard which fails to reflect the essence of the encounter between patient and psychiatrist.

3 Here we use the term ‘hermeneutics’ in a generic sense, without direct reference to Heidegger’s hermeneutics of facticity.
On the epistemology of psychopathology: critical insights and methodological concerns

Conclusion

Mental phenomena are referentially open. As such, their meaning is dependent on the patient’s context, and their individuation as psychopathological symptoms depends on tacit and explicit noncodified contextual information including the patient’s biography, beliefs, intentions, current circumstances, etc. [61]. By trying to emulate medical semiology, where concepts refer unequivocally to their objective counterpart, these features of mental phenomena have been neglected, and psychopathological symptoms have been misidentified as natural objects. To sum up, the instability of psychopathological concepts is the consequence of their attempt to grasp the essential properties of mental phenomena by means of closed descriptive definitions. In other words, the assumption that the essence of particular mental phenomena, expressed by utterances and behavior, can be captured and made explicit in closed definitions renders descriptive psychopathology logically inconsistent.

Both the inadequacy of descriptive psychopathology and the need for a better understanding of what psychopathology is have been explicitly stated by different authors [12, 56, 74, 75]. A single claim that might be inferred from these different approaches, and which has been explicitly stated elsewhere [9], is that in order to overcome psychiatric inconsistency, a deeper understanding of the peculiarities pertaining to the nature of mental phenomena is an unavoidable requirement. In response to this demand, a renewed interest in conceptual and epistemological issues has been developed throughout the last decades. Examples of this response are found in the relatively recent appearance of different institutions and associations that focus their interests on the largely unsettled philosophical underpinnings of psychiatry.

Finally, this work aims to present a plea for the need to consider psychopathology in all of its theoretical dimensions, both historical and philosophical, which must go hand in hand with psychiatric training and practice.

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The instability of psychopathological concepts is the consequence of their attempt to grasp referentially open mental phenomena. As such, their meaning is dependent on the patient's context, and the differential diagnosis between obsessive-compulsive disorder and schizophrenia is an unavoidable requirement. In response to this demand, a renewed interest in conceptual and epistemological aspects of psychiatric diagnosis; in Sadler JS, Wiggins OP, Regier DE (eds): The diagnostic criteria, Achsenkriterien zur Entwicklung der Diagnostik endogener Psychosen, in Janzarik W (ed): Psychopathologische Konzepte der Gegenwart. Stuttgart, Enke, 1982.

Misunderstanding psychopathology as medical semiology: an epistemological enquiry


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Should Definitions for Mental Disorders Include Explicit Theoretical Elements?

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Should Definitions for Mental Disorders Include Explicit Theoretical Elements?

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Key Words
Semantics · Descriptions · Theory ladenness · DSM · ICD · Classification · Psychiatric nosology · Diagnosis

Abstract
In this article we argue that mental disorders have come to be defined according to a descriptive theory of meaning. In other words, mental disorders are defined according to superficial descriptive criteria that count as necessary and sufficient criteria for the inclusion of a particular instance under its corresponding class. These descriptive criteria are allegedly theory independent, leading to the assumption that psychiatric symptoms are directly identified in an object-like fashion. Against this view, we hold that a descriptive theory of meaning is unable to offer a proper account of the meaning of mental disorders both due to its own internal limitations and to the specific nature of psychiatric phenomena. Due to the hermeneutic structure of psychiatric practice, we argue that the identification and description of mental symptoms and disorders unavoidably depends on (frequently unacknowledged) theoretical assumptions. Since there is no global consensus regarding these theoretical commitments, and due to the fact that these significantly affect the final picture we hold with respect to each mental disorder, we believe that these commitments should be explicitly stated both in diagnostic argumentation and in theoretical discussions in order to maximise self- and mutual understanding.

Introduction
It is the authors’ belief that, in spite of the efforts carried out throughout the last decades in order to increase reliability regarding psychiatric terms, the meaning that different psychiatrists hold with respect to each of these (and hence the use they make of them either in theoretical discussions, in clinical practice or in scientific research) is not as homogeneous as we tend to consider [1]. Moreover, we believe that this semantic heterogeneity underlies significant problems we encounter in daily practice, such as diagnostic instability, among others. Our first aim in this paper will be to point out what we consider to be the main reasons for this problem: psychiatry’s semantic dependence upon a descriptive theory of meaning and the long-held belief that descriptions can be theory free. Further, in the discussion, we will argue for two points. First, holding a hermeneutical standpoint, we will argue
for the need to state, more or less extensively, our theoretical convictions when defining mental disorders (i.e. we will argue that definitions cannot avoid theoretical implications and that there is no global consensus regarding these). Finally, after descriptive definitions have been ruled out as the bearers of the meaning for mental disorders, we will highlight their fundamental role as catalysing elements that help the diagnostic process in getting started.

Mental Disorders Are Defined according to a Descriptive Theory of Meaning

Mental disorders are currently classified by means of descriptive superficial\(^1\) criteria. This fact is clearly exemplified by the latest editions of the mainstream classification systems: the DSM and the ICD, which rely on the idea that mental disorders should be described according to a purely observational and theory-free approach in order to avoid a descriptive and classificatory chaos based on theoretical dissensus, as was the case during the first half of the 20th century \([2]\). Hence, it is widely taken to be the case that mental disorders are classified by means of directly observable features (if descriptions are to avoid theoretical implications, it is assumed that descriptive features are to be given through direct observation/experience) that count as necessary and sufficient criteria for the inclusion of a particular case under its corresponding class \([3–5]\).

Beside this, due to its development as a medical discipline, psychiatry incorporated the essence of modern medical semiology, developed throughout the 19th century and according to which observable manifestations of disease were causally linked to their original lesion, i.e. the internal essence of the disease (these links are established by physiopathology, pathological anatomy, microbiology and, more recently, by genetics). Hence, whenever a specific psychiatric syndrome is described and individuated it seems to be reified (here we find a realist ontological assumption at work) and granted an independent existence characterised by a putative aetiology and physiopathology yet to be discovered\(^2\) \([6–9]\) (other models for conceptualising mental disorders, such as the ‘altered function model’, the ‘biopsychosocial model’ and the ‘harmful dysfunction model’ have also been considered to carry essentialist implications \([10]\)).

Further, descriptions used to classify mental disorders (e.g. criteria A, B and C) have been equated to this putative essence (unknown aetiology X), in such a way that whenever the descriptive criteria are identified, their supposed internal cause X will be assumed to be at work \([7]\).

A similar phenomenon takes place in bodily medicine. As Malmgren and Lindqvist \([11]\) have shown, descriptive phenomena causally linked to certain disorders do no occur necessarily (they are therefore contingent) but are very likely to appear (such as a troponin increase, chest pain and certain EKG alterations as a consequence of myocardial necrosis). In this sense, myocardial necrosis is properly defined in anatomical terms, but these superficial (operational) criteria are very highly suggestive of such lesions (they act as probabilistic criteria). In the case of psychiatric disorders there is no known lesion to which the superficial features refer (as in the case of bodily disorders, these features should be considered as contingent), so the only thing that can actually define them in clinical practice is a superficial description. Hence, these descriptive criteria are not contingent but properly defining features\(^3\). In other words, descriptions for mental disorders such as those found in the DSM or the ICD transcend their original classificatory purpose and eventually adopt a defining role by standing in the place of their unknown internal cause. This, as we will try to show in the section entitled ‘Descriptions do not necessarily convey meaning’, is quite an illegitimate claim.

Beside this, the idea that superficial descriptive criteria represent a disorder’s internal cause is linked to the notion that these criteria must be directly apprehended in an object-like fashion, i.e. as objects that are causally linked to their original aetiology. In this sense, for the descriptive criteria to represent their internal cause there must be a causal, deterministic and law-abiding relation at work between both elements (the representing set of signs/symptoms and the represented internal lesion), and such deterministic relations exist only in the realm of space-time objectivity. Hence, a purely descriptive account of psychiatric disorders (seen from the perspective of medical semiology, through which signs and symp-

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\(^1\) We use the term superficial with respect to an underlying process that relates the symptom to its original internal cause. In other words, these superficial symptoms are apparently observable, as opposed to their deep internal cause.

\(^2\) This modus operandi was reinforced by the discovery of chronic arachnoiditis as the cause of general paresis \([12]\). Nowadays we see how psychiatry posits a specific (yet unknown) neurological dysfunction underlying ADHD \([13]\).

\(^3\) In this sense, through empirical research we aim to find a brain lesion that justifies the development of the defining superficial features (via DSM or ICD). Therefore, it seems that we expect the internal lesion to conform to those superficial features the appearance of which we already take for granted (hence, it seems that superficial features are taken as necessary, not contingent).
It is our opinion that this epistemic approach, which we take to be prevailing in certain environments, is severely flawed. Throughout this paper we will criticise two different aspects that we take to be fatal for this approach: the intrinsic limitations of the descriptive theory of meaning and the impossibility of developing atheoretical descriptions.

Intrinsic Limitations to a Descriptive Theory of Meaning

The ‘Open Texture’ of Descriptive Definitions

Descriptive definitions are based on the enumeration of certain features considered to be characteristic and jointly specific of a particular kind [15]. Such descriptions therefore constitute stereotypes (for example, the typical stereotype of a delusion is a false idea that is taken for true with a high degree of subjective evidence in spite of evidence against it). Stereotypes, however, are inevitably more or less weak. This idea has been thoroughly developed by Dupré [17] with respect to biological kinds, showing that no particular set of descriptive criteria can count as necessary and sufficient conditions for the inclusion of all individuals under a particular biological kind (this idea was further developed for psychiatry by Zachar [18] when he described mental disorders as practical kinds). In other words, against the rigid view that the stereotype’s descriptive definitions must include the necessary and sufficient conditions for the inclusion of a particular instance under a specific kind (including mental disorders), we see that not all individuals taken to belong to such kind conform to the stereotype’s specifications. In this sense, not all tigers conform to the typical stereotype (not all tigers are orange and some of them don’t have tails), just as not all delusions do (some delusions are not ideas but perceptions and their content is sometimes uncomfortably true). One might argue that this problem could be overcome by making descriptive definitions more precise, including more and more specifications. However, as Waismann has argued through the notion of ‘open texture’ [19], names are always defined respective to a specific context of evaluation. Hence, due to the possibility of an infinite contextual variation, there will always be certain parameters with respect to which a particular term will have not been descriptively defined (see also Searle’s [20] notion of background and Recanati’s [21] work on contextualism in the philosophy of language). This idea is in accordance with the fact that the specifications of the stereotype associated to a particular kind are determined by "open texture".

4 It is precisely because of this reason that so much money is invested into research on the genetic basis for schizophrenia and other mental disorders that is defined by the DSM (i.e. a causal link is deemed to exist between the genetic basis of schizophrenia and its superficial features).

5 The idea that a descriptive definition can give a proper account of the meaning of a sortal term was also criticised by the late Wittgenstein [22] through the notion of ‘family resemblance’. According to this idea, no descriptive definition can give a complete account of the meaning of the word ‘game’. There is no specific set of necessary and sufficient properties that all games share. However, they all share a certain resemblance, as is the case between different members of a given family.
term will vary according to the context of use. In this sense, in a particular context the stereotype of the term ‘tiger’ will include robotic or stuffed tigers, whereas in a different context it will only include the large, orange and living feline. Likewise, the stereotype of the term ‘depression’ will vary according to the context of use, as is the case between primary care and specialist care (in spite of their sharing a common descriptive definition specified in the DSM or the ICD), leading to a situation where two or more individuals engaged in a discussion regarding depression might be unable to reach a consensus because they actually mean different things by the use of this term.

The ‘Essential Incompleteness’ of Descriptive Definitions

A descriptive theory of meaning suffers from yet another problem, namely that which Michael Devitt [23] named the ‘essential incompleteness’ of descriptions. This concept highlights the fact that the meaning of some words is explained in terms of the meaning of other words, leaving the latter unexplained. Hence, if we define the term ‘anguish’ as an ‘unpleasant anxious-like emotion usually located on the chest, throat or stomach’, we are declining the responsibility of specifying the meaning of the term ‘anguish’ on the meaning of ‘emotion’, ‘anxious’ and so on [24]. Should we stick to a descriptive theory of meaning, these terms themselves would therefore have to be defined in what seems to be some sort of infinite regress.

Descriptions Do Not Necessarily Convey Meaning

Should we take mental disorders to be defined exclusively according to atheoretical descriptions based on superficial features (i.e. according to a descriptive theory of meaning), knowing what schizophrenia is would amount to being able to identify its specific set of descriptive features in a checklist fashion. Against this, we believe that the mere capacity to identify superficial clinical features says little about what a disorder actually is or about how these superficial features (symptoms) come about and are mutually articulated.

If we take mental disorders (understood from a medical perspective, according to which a symptom cluster is causally related to a specific internal lesion) to be defined according to purely descriptive criteria, two superficially identical patients will be considered as two instances of the same disorder (i.e. they have the same underlying cause). However, even if we accept that mental symptoms could be directly apprehended in an object-like fashion (such as swelling or fever), one might argue that a different internal structure (i.e. a different aetiology or physiological pathology) could underlie a common superficial appearance. In such a case, these internal differences would eventually lead them to behave differently under different circumstances (including therapeutic and prognostic implications), showing that both cases were only identical in appearance.

On the other hand, we learn from clinical practice that patients diagnosed as suffering from any particular disorder might share very few superficial features, if any at all. This might be the case when comparing two schizophrenic patients. What is this thing called ‘schizophrenia’ that they both share? Whatever it might be, it seems that it cannot be properly defined by means of superficial descriptive criteria, for we occasionally observe in clinical practice that patients sharing this diagnosis barely share any superficial features (it is a fact that we often meet patients who are catalogued as schizophrenic despite the fact that superficial clinical features do not properly meet the requirements stated by the DSM or ICD). It therefore seems that if we want to make sense of the term ‘schizophrenia’, our efforts will have to be directed elsewhere. In this sense, numerous attempts have been carried out in order to specify the internal structure or essence of schizophrenia, a primary disorder that all schizophrenic patients would allegedly share and that would articulate the manifold of superficial manifestations: Bleuler’s [28] autism, Minkowski’s [29] loss of vital contact with reality, Blankenburg’s [30] loss of natural self-evidence, Stanghellini’s [31] loss of common sense, or Sass and Parnas’ [32] disturbed ipseity, among others.

As a result, one could say that whatever it is that defines mental disorders, it should be somehow related to their internal structure or essence (i.e. their aetiology), and not to their superficial features (which could eventually prove to be unspecific). This idea goes in line with an alternative notion of meaning, generally referred to as the essentialist approach [25, 26]. In this sense, if we believe
that the essence of mental disorders is a brain lesion, then the former should be defined in terms of the latter. However, we must acknowledge the fact that the essence of mental disorders is not always conceptualised as having anything to do with the brain. In fact, there is a manifold of legitimate competing perspectives regarding the essential nature of mental disorders [33], including those that conceptualise them as brain disorders [34], as clinical syndromes (a cluster of signs and symptoms with a common prognosis), as cognitive anomalies [35, 36], as a healthy response to a pathological environment [37], as a disorder of the formal structure of consciousness [32], as a disorder of a priori existentials [38], etc.9

Hence, even though we might all share common stereotypes regarding specific mental disorders (such as those found in the DSM or the ICD), our understanding of the underlying structure that articulates the stereotype’s superficial features will determine the global picture we hold with regard to each one of these disorders. As a consequence, this picture will vary according to the notion we hold with respect to the nature of mental disorders in general [39]. Besides, each of these perspectives will condition radically different theoretical approaches that will guide the interpretative process of clinical diagnosis through diverse paths (some approaches might consider childhood trauma as essential, while others will neglect this area and highlight aspects related to neurotransmitters, genetics, the formal structure of consciousness or the alienating tendencies of modern western societies).

Descriptions Cannot Be Purely Descriptive nor Theory Free

It was Sir Aubrey Lewis, drawing on Hempel’s general insights into the nature and purposes of scientific classification, who introduced the idea that a purely descriptive language (as opposed to a theoretical language) was needed in order to clarify the chaotic situation in which psychiatric classification found itself during the mid-20th century [40]. In Lewis’ words, ‘for the purpose of public classification we should eschew categories based on theoretical concepts and restrict ourselves to the operationalized, descriptive type of classification...’ [40]. Hence, it has been taken to be the case that a descriptive language must set aside all theoretical assumptions and limit itself to the accurate description of observable phenomena10. However, the mere possibility of such a language has nowadays been rejected. In this sense, it is considered that all observation is inevitably biased by theoretical commitments. Throughout the second half of the 20th century, different authors such as Quine [41], Putnam [42] and Hesse [43] raised different claims towards the rejection of the logical positivist’s assumption that observation was theory independent. However, the most important critiques against the possibility of a theory-free observation are Norwood Hanson’s ‘Patterns of Discovery’ [44] and Thomas Kuhn’s ‘The Structure of Scientific Revolutions’ [45]. In this line, authors such as Spitzer [46], Parnas and Bovet [47] or Faust and Miner [48] have identified unacknowledged theoretical commitments in the allegedly atheoretical latest editions of the DSM.

But the theory dependence of observation does not only affect our present clinical practice. Going back in time to the period in which a particular psychiatric disorder was described, the set of individuals based on whom the stereotype would be established expressed raw data that required interpretation in order to be described as clinical symptoms. This interpretation was dependent on the theoretical assumptions held at the time as well as on practical interests. In this sense, Esquirol’s [49] identification and definition of hallucinations was dependent on faculty psychology, just like Bleuler’s [28] notion of schizophrenia was based on associationism and Freud’s psychoanalytic theory. The essential idea at this point is that, depending on the theoretical framework deployed in the interpretative process, raw data may be interpreted in different ways, so the resulting superficial image of the stereotype (i.e. the object-like representation that gives rise to the descriptive definition) may differ according to the theory at use, in such a way that a single term might eventually be described with different descriptive definitions, leading to a highly confusing polysemy [50, 51].

However, the theory dependence of observation is not the only problem regarding the idea of a purely descriptive language for defining psychiatric disorders. As we be-

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9 One could aim at constructing a global theory that would include all these different perspectives. However, simply combining all these perspectives would not yield a total view, because each would be in conflict with many others with regard to prominent presuppositions, methods, aims and conclusions.

10 It must be acknowledged that a purely descriptive and atheoretical approach was precisely what Karl Jaspers was intending to achieve through his understanding of Husserl’s phenomenology as a descriptive psychology [52]. However, Jaspers’ perspective, far from being theory independent, depends greatly on neo-Kantian arguments [53].

11 Kuhn’s insights have been highly contested and he has frequently been criticised for taking a relativistic approach [5]. In spite of its interest, a thorough analysis of this topic is far from the scope of this article. For the present case, we’ll just admit to share a Kuhnian perspective.
On the epistemology of psychopathology: critical insights and methodological concerns

believing, the very nature of psychiatric disorders could never allow for factual descriptions. The point here is that psychiatric phenomena are not just observed as mere objects that stand in front of us, waiting to be described. They are not directly perceived by our senses, but the product of the psychiatrist’s reconstruction or interpretation. Moreover, they cannot be reduced to space-time variables nor can they be described in isolation, i.e. detached from their context of appearance (who the person is, her biography, her beliefs, intentions, emotions, etc.). Psychiatric raw data are not just seen or observed. In order to be understood as psychiatric phenomena (i.e. in order to acquire meaning from a clinical perspective) utterances and behaviour must be interpreted or seen ‘as’ psychiatric phenomena. In other words, these raw phenomena can only be understood as psychopathological symptoms when embedded in the patient’s contextual horizon (i.e. information obtained from our patients is meaningless and has no psychiatric value if it is detached from who they are, their biography, their totalitu)[51]. The problem here is that contextual information is way too extensive to be completely accounted for. In this sense, it is our theoretical assumptions, among other factors, that determine which pieces of contextual information are relevant for the interpretative process of diagnosis [24, 54].

Discussion

As far as we have argued, it seems that a descriptive theory of meaning cannot give a proper account of the meaning of mental disorders. This liability gets only worse if we expect these descriptions to remain theory independent. Throughout the next paragraphs we will present two ideas that will try to offer an alternative solution for the above-mentioned problems: (1) the need for reintroducing theoretical elements when defining mental disorders and (2) the understanding of descriptive definitions (as those included in the DSM and ICD) as catalysing elements that help the diagnostic process in getting started.

Reintroducing Theory into Definitions

As we have seen, the deployment of a theoretical framework is both essential as well as inevitable in the identification and description of mental disorders. Hermeneutic processes such as psychiatric diagnosis must be guided and constrained in order to prevent interpretative anarchy and extreme relativism. An internally consistent and globally coherent theoretical framework offers a guideline for reconstruction and avoids extreme relativism by limiting interpretative possibilities[13].

We have also seen that the particular theory at use will highlight or downplay certain phenomena, so that the superficial image will vary significantly with respect to the theoretical framework at use (see for example the superficial differences between Kraepelin’s dementia praecox and Bleuler’s schizophrenia). Hence, since a theoretical commitment is both essential and inevitable, we believe it would be useful to state this commitment explicitly in order to: (1) be aware of how and why we are reconstructing raw data in a particular way (i.e. we would be in possession of our theoretical commitments instead them owning us) and (2) clarify what it is that we exactly mean when we use a term such as ‘depression’ or ‘schizophrenia’.

In this sense, if we all shared a common theoretical framework, it would play an identical effect on all of us and it could therefore be allegedly ignored. However, it is not at all the case that we all share a common theoretical perspective. Since this perspective articulates our understanding of both the general idea of what a mental disorder is and the meaning of specific mental disorders (not just their superficial image but their internal structure too), it should be explicitly stated in order to grant terms such as ‘schizophrenia’, ‘depression’ or ‘bipolar disorder’ (among many others) a definition that would allow not just the specification of their superficial features but an understanding of their internal structure (and therefore a specification of the process that guides interpretative reconstruction and diagnosis). This idea seems to reintroduce a great deal of instability that was apparently overcome by the establishment of descriptive criteria via DSM and ICD (schizophrenia, for example, will have several possible definitions, including different superficial criteria, which will vary according to the clinician’s theoretical commitments). However, as we have explained elsewhere [55], we believe this instability to be inherent to psycho-

Theoretical Elements in Definitions for Mental Disorders

As opposed to this, bodily symptoms can be detached from the patient’s biography without them losing clinical value (Blumberg’s sign represents a peritoneal irritation irrespective of the patient’s beliefs, hopes and desires) [55]. All hermeneutic processes are by nature perspectivistic. Interpretation is open to infinite possibilities, since there are infinite standpoints from which the phenomena to be interpreted are peer upon. However, we believe some interpretations to be better than others. Those guided by globally coherent and comprehensive theories, those which take more information into account, in a more systematic fashion, those with a higher predictive power and which offer a finer and more comprehensible global picture, are considered better interpretations for our purposes. This is what we call a moderate relativism, which we advocate for. Extreme relativism, on the other hand, would include spurious and loose interpretations, which we take to be unacceptable for clinical practice.

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pathology (it was never fully overcome by the deployment of operational criteria at all) and so it must be acknowledged and accounted for\textsuperscript{14}. In this sense, diagnosis should be based not just on the supposed ‘observation’ and identification of independent symptoms in a checklist fashion, but should be argued according to the particular theoretical perspective at use (which, by the way, should be explicitly stated). This idea implies that a particular case could be consistent with different diagnoses depending on the underlying theoretical assumptions (nonrepresentational, tacit and contextual information will be articulated differently through the deployment of different theoretical perspectives, leading to different superficial reconstructions)\textsuperscript{[54, 56, 66]. Of course, one might choose the reconstruction based on the theoretical perspective one believes to be better or stronger (psychoanalysis, cognitive psychology, biological psychiatry, phenomenology, systemic psychology, etc.) or the one that has a greater explanatory power, i.e. which gives a better account of the global picture. Lacking scientific strength, as it might seem, this instability is something we possibly simply have to accept, acknowledge and learn to live with. On the other hand, this idea is consistent with the understanding of psychopathology, not as a specific theory, but as a practical effort aimed at the creation of intelligibility [57].

The Catalysing Role of Descriptive Definitions

So, if descriptive definitions are unable to offer a proper account of the meaning of mental disorders, what role should they play? First of all, we must admit that, whatever the theoretical perspective at use, the superficial features associated with any particular mental disorder tend to be quite representative of the kind (though, once again, not properly defining). Hence, through the encounter with the patient we sooner or later identify certain superficial features that more or less fit into a specific disorder. However, this tends to be no more than a first impression that will catalyse the diagnostic and theory-guided interpretative process (what at first might seem a delusion, a hallucination or a depressed mood might be further reconstructed in a different way)\textsuperscript{[24]. If, for example, we recognise the standardised superficial features of ‘major depression’ when confronted with a particular patient, we should then aim at reconstructing the whole picture according to the theoretical assumptions we hold with respect to our understanding of what major depression is (its internal structure, its relation to contextual variables and to personality traits, the understanding of what it is that is affected – the brain [58], the cognitive processes [59], the Endon [60], etc.). So, even if the expressed superficial features are compatible with a particular stereotype, it might be the case that the theory-dependent reconstruction of the deep structure renders such diagnosis inappropriate. In the same way, it might be the case that a certain reconstruction strongly suggests a particular diagnosis even though the superficial features are not consistent with the stereotype.

Beside this, it has been argued that the initially identified symptoms will lead to a diagnostic assumption that will bias the reconstruction of raw data and will tend to highlight phenomena compatible with this assumption, while minimising other aspects that would contribute to its refutation [61]. Once again, by being as aware as possible of the more or less implicit elements that guide the diagnostic process (theoretical framework, ontological assumptions, contextual information, diagnostic prejudices, etc.)\textsuperscript{15}, while keeping in mind that these can never be fully apprehended, we might be able to minimise such biases and offer a better explanation of the global picture and hence a stronger diagnostic argument [62].

Finally, it is true that the descriptive definitions offered in the DSM and the ICD promoted a great increase in reliability (i.e. we all apparently agree on what we are talking about). However, whenever we engage in a discussion regarding a particular psychiatric disorder, our understanding of what this disorder consists of is far more complex than a simple description of its superficial features, for it implies theoretical aspects related to the internal structure of the disorder in question and to tacit implications derived from clinical practice (including, for example, contextually variable ostensive definitions through which we learn to identify specific disorders during our training period)\textsuperscript{[24, 56, 63]. In this sense, our understanding of what the term ‘depression’ actually means will tend to vary across different contexts, such as primary and specialist care (even though a superficial descriptive definition is shared). Therefore, unless an attempt is made in order to explicitly clarify implicit theoretical assumptions (as well as other tacit elements that might play a relevant role in our understanding of mental disorders), we have reasons to believe that mutual understanding might be at stake [39].

\textsuperscript{14} This instability affects not only general descriptive and classification processes, but individual reconstruction/diagnosis too. However, this instability tends to be locally minimised by the deployment of shared theoretical assumptions and a common background of tacit knowledge (such as shared ostensive definitions throughout the training period).

\textsuperscript{15} We must keep in mind that these background assumptions are way too extensive to be fully apprehended in an explicit fashion. Beside this, trying to articulate all this information explicitly would render practical tasks impossible.
On the epistemology of psychopathology: critical insights and methodological concerns

Conclusions

The latest editions of the DSM and ICD were developed in order to offer a stable and widely accepted classification for mental disorders based on purely descriptive criteria. However, these descriptions have nowadays acquired a defining role, surpassing their original classificatory purpose, leading mental disorders to be defined according to a descriptive theory of meaning. As we have argued, this model is unable to offer a proper account of the meaning of mental disorders because, inter alia, psychiatric raw data is not directly observed and described, but necessarily reconstructed and interpreted according to (frequently unacknowledged) theoretical commitments. Hence, our understanding of what a particular mental disorder is (and of what mental disorders are in general) will depend on such theoretical commitments. This idea implies that a single term, as well as the general notion of ‘mental disorder’, might acquire different meanings depending on the theoretical perspective at play. Though this argument threatens psychiatry’s empirical aspirations, we believe it states the nature of the problem in a more realistic fashion, and actually accounts for the theoretical, conceptual and practical instability that characterise the realm of mental health. Superficial descriptions play an important role, although they should not be taken to define mental disorders. Theoretical elements guide the interpretative process and account for what kind of information participates in it (they articulate the use of explicit, nonrepresentational, tacit and contextual information), determining the superficial features ultimately identified. Hence, theoretical commitments play a decisive role in establishing the meaning of mental disorders. The lack of consensus regarding the manifold of psychological and psychopathological theories, therefore, accounts partly for psychiatry’s internal inconsistency. However, uncomfortable as it might feel, this instability seems to be inherent to psychiatry and must therefore be acknowledged and not simply neglected (as would be the case were we to insist on the atheoretical and purely descriptive nature of DSM- and ICD-like psychopathological descriptions).

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On the Notion of Psychosis: Semantic and Epistemic Concerns

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In spite of its frequent and apparently unproblematic use, the meaning of the term 'psychosis' remains largely unclear. Throughout this paper we will analyse some of the reasons underlying psychiatry's failure to define the notion of psychosis in a clear and unambiguous fashion, highlighting the inadequacy of a natural-scientific framework (inherited by psychiatry through its development as a medical discipline) when dealing with subjective experience. Following a longstanding trend in psychopathology, we will argue for the need to follow a hermeneutical approach, which is both perspectival and theory-laden. In order to prevent arbitrariness or a crude relativism, we will describe the notion of 'hermeneutic objectivity' as an epistemic construct aimed at legitimising psychiatric judgement and its pretension of truth.

Key word

On the notion of psychosis: semantic and epistemic concerns

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Introduction

As psychiatrists, we are expected to identify individuals who are experiencing a psychosis and clearly differentiate them from those who are not. This is no trivial task, since identifying someone as psychotic might have consequences for their health and well-being. The prescription of antipsychotic medication and the risk of experiencing significant negative side effects. A clear and precise differentiation between psychosis vs. no-psychosis has become particularly relevant in early intervention services working with individuals who are at high risk of transition to psychosis.

At the time that he committed an offence could act as an exculpatory circumstance. Also, labelling someone as psychotic can legitimise having him sectioned in an inpatient unit. Discrimination linked to the notion of psychosis demands that this diagnosis is not established arbitrarily. Moreover, labelling someone as psychotic might have a negative impact on self-image and lead to disempowerment.

In consequence, labelling a patient as psychotic should not be done arbitrarily but with a high degree of certainty. In the modern era, it is scientific knowledge that has achieved the status of knowledge proper and as such it represents the path towards truth and certainty. In fact, it is psychiatry's adoption of a natural-scientific methodology, inherited through its development as a medical discipline, that legitimises the practice of treating millions of kids with amphetamines worldwide, depriving patients from their freedom or deciding that an individual was unaware of what he was doing when he committed an offence. As such, psychiatry aims towards a pretension of truth that is characteristic of the natural sciences, a deterministic and law-abiding truth that is universally accepted.

So that the term 'psychosis' is applied rigorously in clinical practice, two different though interrelated questions should be answered. There is a semantic question – how can I define the term psychosis in clear and unambiguous terms? and an epistemic question – how can I rightly include a particular individual under the kind psychosis?

Throughout the next paragraphs we will attempt to understand how psychiatry has approached these questions from within the framework of medical semiology. We will then proceed to exemplify the failure of psychiatry's attempt to define one of its core notions, that of psychosis, in clear and unambiguous terms. In a next step we will argue for the reasons underlying this failure (namely the illegitimacy of some of psychiatry's epistemic assumptions), and we will conclude by offering an alternative approach for psychiatry's quest for knowledge.
On the notion of psychosis: semantic and epistemic concerns

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Summary

In spite of its frequent and apparently unproblematic use, the meaning of the term ‘psychosis’ remains largely unclear. Throughout this paper we will analyse some of the reasons underlying psychiatry’s failure to define the notion of psychosis in a clear and unambiguous fashion, highlighting the inadequacy of a natural-scientific framework (inherited by psychiatry through its development as a medical discipline) when dealing with subjective experience. Following a longstanding trend in psychopathology, we will argue for the need to follow a hermeneutical approach, which is both perspectival and theory-laden. In order to prevent arbitrariness or a crude relativism, we will describe the notion of ‘hermeneutic objectivity’ as an epistemic construct aimed at legitimising psychiatric judgement and its pretension of truth.

Key word

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Introduction

As psychiatrists, we are expected to identify individuals who are experiencing a psychosis and clearly differentiate them from those who are not. This is no trivial task, since identifying someone as psychotic might have extremely serious consequences:

a) Clinical: those who are included under the category ‘psychosis’ will often be prescribed antipsychotic medication and will hence be at risk of experiencing significant side-effects, just like failing to identify a patient as psychotic might prevent him from receiving more adequate treatment. A clear and precise differentiation between psychosis vs. no-psychosis has become particularly relevant in early intervention services working with individuals who are at high risk of transition to psychosis.

b) Legal: the identification of an individual as psychotic at the time that he committed an offence could act as an exculpatory circumstance. Also, labelling someone as psychotic can legitimise having him sectioned in an inpatient unit.

c) Social: the stigma and the risk of social exclusion and discrimination linked to the notion of psychosis demands that this diagnosis is not established arbitrarily. Moreover, labelling someone as psychotic might have a negative impact on self-image and lead to disempowerment. In consequence, labelling a patient as psychotic should not be done arbitrarily but with a high degree of certainty. In the modern era, it is scientific knowledge that has achieved the status of knowledge proper and as such it represents the path towards truth and certainty. In fact, it is psychiatry’s adoption of a natural-scientific methodology, inherited through its development as a medical discipline, that legitimises the practice of treating millions of kids with amphetamines worldwide, depriving patients from their freedom or deciding that an individual was unaware of what he was doing when he committed an offence. As such, psychiatry aims towards a pretension of truth that is characteristic of the natural sciences, a deterministic and law-abiding truth that is universally accepted.

So that the term ‘psychosis’ is applied rigorously in clinical practice, two different though interrelated questions should be answered. There is a semantic question – how can I define the term psychosis in clear and unambiguous terms? and an epistemic question – how can I rightly include a particular individual under the kind psychosis? Throughout the next paragraphs we will attempt to understand how psychiatry has approached these questions from within the framework of medical semiology. We will then proceed to exemplify the failure of psychiatry’s attempt to define one of its core notions, that of psychosis, in clear and unambiguous terms. In a next step we will argue for the reasons underlying this failure (namely the illegitimacy of some of psychiatry’s epistemic assumptions), and we will conclude by offering an alternative approach for psychiatry’s quest for knowledge.
On the epistemology of psychopathology: critical insights and methodological concerns

How does psychiatry traditionally address semantic and epistemic questions?

Before addressing these questions, we must consider where psychiatry, taken as a medical/natural-scientific discipline, stands.

In the first place, psychiatry inherited a set of ontological assumptions and a specific epistemological framework through its development as a medical discipline. In short, this framework (namely, medical semiology) states that a specific set of symptoms represents an unseen internal lesion (i.e. etiology), whether structural or functional, with which it is linked through a causal and deterministic relation (this causal relation can be traced back through biochemical, anatomical, physiological, microbiological, or genetic processes). Since this specific set of symptoms univocally represents (i.e. stand in the place of) its unseen internal lesion, they may both be equated. Hence, disease X may be defined either by the specific set of observable and objective symptoms (a descriptive definition) or by its etiology (an essential definition).

By adopting this epistemological framework, psychiatry assumed that mental symptoms were causally linked to their unseen internal cause (i.e. putative neurological dysfunction, whether anatomical, physiological or functional). Since this relation was deemed to be causal and deterministic, an objective nature was necessarily assumed for mental symptoms, for deterministic relations exist only in the realm of space-time objectivity. Further, it is commonly accepted that mental disorders have come to be defined according to descriptive criteria such as those found in the DSM and the ICD. These classificatory systems rely on the idea (borrowed from Logical Positivism) that mental disorders should be described according to a purely descriptive and theory-free approach. This widely accepted idea reinforces the above-mentioned assumption that mental symptoms are objective entities, for if they are to be defined by means of atheoretical and purely descriptive terms they must be apprehended through observation (i.e. in an object-like fashion).

So, turning back to the semantic question, what is psychiatry’s answer? As we have already mentioned, psychiatry’s answer (taken as a medical discipline and hence deploying medical semiology as its epistemological framework) is that psychosis should be defined through the description of a set of objective features that are causally linked to a yet unknown internal lesion and that can be identified as being either present or absent. For over a hundred years the term ‘psychosis’ has been linked to the notions of irrationality, incomprehensibility or loss of touch with reality. Since these notions lack the kind of objectivity expected from descriptive definitions and are very likely to be either theory or value-laden, psychosis eventually came to be defined by those allegedly objective features that typically occurred in patients considered as irrational, as incomprehensible or as having lost touch with reality: delusions, hallucinations, disorganised speech, or catatonic behaviour (i.e. psychotic symptoms). Following this line of argument, the term ‘psychosis’ will refer to a yet unknown neurological dysfunction that is common to all psychotic symptoms.

Let’s move on to the epistemic question (how can I rightly include a particular individual under the kind ‘psychosis’?). Clinical judgement has been argued to follow an abductive logic (in short, it follows a ‘known-effect-to-putative-cause’ reasoning direction, with different possibilities of interpretation of the empirical fact). In this sense, clinical judgement always implies a sign-token (any particular item that belongs to a specific type) and a sign-type (a universal or category, whether a symptom or a disease, which is synonymous with the descriptive definition of a sign) under which the token must be included. Following the principles of medical semiology, the descriptive definition for a sign-type includes all the necessary and sufficient features required for the complete characterisation of sign-token. Hence, the identification of the allegedly objective features that characterise psychosis (i.e. the descriptive criteria characterising delusions, hallucinations, disorganised speech, or catatonic behaviour) allows for the immediate inclusion of the individual under the kind ‘psychosis’, which in turn refers to the existence of an underlying (yet unknown)
neurological dysfunction that is common to all psychotic symptoms.

**Some problems related to the concept of psychosis**

Unfortunately, and in spite of psychiatry's natural-scientific aspirations, both the meaning of the term ‘psychosis’ and the path for its indubitable application in clinical practice are far from clear. Let’s have a quick look at some of the problems that the notion of psychosis faces:

a) The notion of psychosis is very often equated or reduced to schizophrenia. In this sense, a vast amount of papers that include the term ‘psychosis’ in their title actually focus on schizophrenia. Whereas this condition represents a paradigmatic type of psychotic disorder, the term ‘psychosis’ seems to be equally applicable to a wide range of non-schizophrenic disorders (e.g. chronic delusional disorder, acute psychotic episode, affective psychoses etc.).

b) A direct consequence of defining psychosis by the presence of delusions, hallucinations, disorganised speech, or catatonic behaviour is the fact that non-productive psychoses become highly problematic or even contradictory (in this sense, what is psychotic about Simple Schizophrenia?)\(^1\). In a similar fashion, the ascertainment of attenuated or transient delusions and hallucinations (as the Comprehensive Assessment of At-Risk Mental States does) often fails to identify the prodromal phases of schizophrenia, where such symptoms are most often not even present. Further, equating psychosis to the presence of delusions or hallucinations neglects a longstanding psychopathological tradition according to which these symptoms are secondary or even contingent\(^2\).

c) A widely heterogeneous clinical sample might report phenomena that satisfy the commonly accepted descriptive criteria for delusions (i.e. high subjective evidence and incorrigibility). These could allegedly include paranoid delusions in schizophrenic patients, delusions in the context of affective disorders, overvalued ideas, fanatic religious beliefs, obsessive-like phenomena, rigid cognitive patterns found in autistic spectrum disorders or an exaggerated mistrust found in paranoid personality disorders. In spite of their complying with superficial descriptive criteria, their deep structure and the relation they hold with co-presenting phenomena varies to such a degree that assuming the existence of a common (anatomical, psychological, functional, computational, or neurocognitive) path or an identical psychological structure would lead to a rough conflation and a complete lack of specificity, eventually rendering the concept of psychosis meaningless. In a similar fashion, labelling as psychotic all patients who satisfy the descriptive criteria for auditory hallucinations (these have been described in a wide variety of disorders, ranging from schizophrenia to affective disorders, personality disorders\(^3\), conver- sive disorders\(^4\), sensory deprivation\(^5\), or anxiety dis- orders\(^6\)) would arguably render the extension of the term ‘psychosis’ extremely heterogeneous and hence of little use for both research and clinical practice;

d) A descriptive definition of psychosis doesn’t really say much about what psychosis actually is (all it offers are the descriptive features that an individual must allegedly satisfy in order to be identified under the kind ‘psychosis’). So, what is it that psychotic symptoms have in common? In short, most mental health professionals would answer to this question by saying that they all somehow imply losing touch with reality or, more technically speaking, a failure in reality testing or reality monitoring. However, no matter how often we talk about reality, little thought is actually given to what reality actually is or to how we get to know things about the world. In fact, a number of tacit and unacknowledged ontological and epistemological assumptions are held, most of which are still subject to vivid debates (e.g. ontological realism, a correspondence theory of truth, a representational theory of mind, an ontic independence between man and world, the existence of a clear and unambiguous matching between world and language etc.).

e) There is little agreement as to whether this term should be applied in certain cases (e.g. emotionally unstable patients who report hearing voices that encourage them to self-harm, anxiety-related overvalued paranoid thoughts, mood-congruent ideas in affective disorders, body-image distortion in anorexia nervosa etc.) and clinicians often disagree as to whether a particular token represents an instance of a specific kind of psychotic symptom. These facts point toward the idea that the allegedly descriptive features that characterise psychosis are not as objective as we wish they were. Probably the simplest illustration of this idea is the fact that a patient presenting with all the allegedly objective and descriptive features for any psychotic symptom might be after all malingering...

**What’s the reason underlying these problems?**

In our view, the main reasons underlying psychiatry’s failure to achieve the conceptual and epistemic consistency it aims for (clearly exemplified by the history of psychosis) is the fact that psychopathological phenomena are not objective entities, they do not stand in causal relations with regards to co-existing objects, their eliciting...
requires the use of non-representational information and, most important, utterances and behaviour, understood as psychopathological phenomena, only acquire meaning when interpreted from within their horizon of meaning (i.e. the individual understood as a meaning-bestowing totality).

Psychopathological phenomena are not mere objects standing in the realm of space and time. They are not directly apprehended, but are the product of an interpretative endeavour: no one can actually see a delusion or a hallucination. An utterance only acquires meaning when analysed within its specific context, i.e. the individual understood as a horizon of meaning 21. Only then, when we take into account the patient's biography, his personality traits, his hopes for the future, his fears, his traumas, his world etc., can we really understand the meaning of an utterance and hence label it as a delusion with a certain degree of certainty. Depending on this horizon, the interpretation of the utterance will have one meaning or another: he might be malingering, his paranoid traits might be due to past traumatic events, his high degree of conviction might be due to rigid cognitive patterns, the incorrigibility might be due to his reluctance to accept evidence that would shatter his world, etc. Similarly, no fragment of behaviour carries meaning in itself. It is only when we reach an understanding of the individual that we can ascribe meaning to his behaviour. Since psychotic symptoms are always identified as such through an interpretative process that requires taking into account the individual's idiosyncrasy, they may never be directly apprehended as physical things (i.e. in an object-like fashion). Furthermore, since the individual (understood as the horizon of meaning upon which interpretations take place) can never be fully or exhaustively apprehended, the result of the reconstructive process will remain inevitably open and unfinished (new information can always be obtained that might lead to an alternative reconstruction). Trying to establish a deterministic (fixed, causal and law-abiding) relation between psychotic symptoms (the reconstruction of which is always open, as the result of an interpretative process) and a specific internal lesion (anatomical, functional, physiological etc.), the meaning of which is closed or fixed, therefore seems rather illegitimate. We will probably all agree that there are certain clinical cases where we all believe a patient to be psychotic (let's say, the very typical schizophrenic patient who experiences paranoid delusions, passivity phenomena and commenting auditory hallucinations, a severely depressed patient who assures that he's already dead, a jealous husband who knows that his wife is cheating on him without any evidence etc.). This intersubjective consensus might lead us into believing that there is something characteristic and specific about psychosis that we are all apprehending and that this feature could also be objectively identified in all other psychotic patients (after all, it might make sense to believe that we're apprehending an objective, descriptive and representational feature of psychosis if we're all agreeing on the conclusion). However, the fact remains (as the history of psychiatry has shown) that the meaning of psychosis cannot be codified in analytical terms and there is no set of specific features that are identified in all psychotic patients. One of the main reasons for this has been argued to lie in the role of present, although non-representational information that modulates the meaning of apprehended phenomena (following Rejon’s example, the difference between schizophrenic and melancholic delusions may be observed and pointed out – it may receive an ostensive definition – but it cannot be found in the descriptive definition of delusion 10). This is clearly seen in clinical practice, where we continuously face atypical cases (that don’t comply with commonly accepted descriptive features) in which diagnostic dissensus is the rule. It is in this sense that the role of non-representational information (how it is articulated, taken into account or simply neglected) helps in understanding some of the reasons why some psychiatrists might conclude that a particular patient is psychotic whereas others won’t 1.

**Introducing an alternative approach**

According to the previous line of argument, we conclude that the natural-scientific pretension of truth that psychiatry aims for (i.e. based on certainty and law-abiding determinism) rests on illegitimate assumptions (based on the naturalisation or objectification of psychopathological phenomena). In spite of this, we are still committed to a pretension of truth that allows for valid and reliable judgements that underpin and justify our clinical deci-
On the notion of psychosis: semantic and epistemic concerns

Hermeneutic objectivity: psychopathology’s quest for certainty

Hermeneutic reconstructions must respect certain constraints in order to avoid spurious interpretations and arbitrariness. In order for a community of psychiatrists to be able to make sense of the notion of psychosis (i.e. share a common understanding regarding its meaning and the way it is applied in clinical practice), they must be able to share a set of theoretical, pragmatic and common sense assumptions that might guide the reconstructive process through a common path, allowing for a common diagnostic conclusion (or at least for the establishment of a dialogical interaction focused on the interpretative process leading to a diagnostic rationale). In this sense, the result of an interpretative activity (such as psychiatric diagnosis) might achieve a varying degree of hermeneutic objectivity, the value of which will depend on features such as its plausibility, its global coherence, its capacity to articulate contextual and non-representational information, its capacity to justify the relation between symptoms present and absent, its acknowledgement of underlying theoretical implications, its predictive power or its capacity to offer effective paths for intervention.

As an oxymoron, the notion of ‘hermeneutic objectivity’ must be understood in a metaphorical sense. As we already mentioned, hermeneutical endeavours never disclose natural objects that could ultimately be subsumed under universal laws (as a natural-scientific approach would pretend). This metaphorical notion of objectivity makes reference to fallible constructs that can never fully account for the totality of the reconstructed individual. Further, such constructs can never be directly grasped or intuited, but only apprehended through a narrative (reconstructive) and intellectual effort. However, the better a reconstruction complies with the abovementioned features (those that determine the value of ‘hermeneutic objectivity’) the more it will resemble an ideal of objectivity (i.e. in the sense of achieving a greater level of intersubjective validity, global coherence and plausibility) b.

In essence, the semantic and epistemic value of psychopathological terms (i.e. the way they are defined and how they are applied in clinical practice) does not rely on objective measures, nor does it abide by deterministic laws. On the contrary, this value relies on the strength of the context-dependent and theory-laden reconstructive consensus reached by the community of those who struggle to make sense of altered subjective experience through clinical practice.

How, then, can we define the term ‘psychosis’ and apply it in clinical practice? 1

The first point we need to make clear is that psychosis is not a thing, a definite and objective entity that can be fully defined in descriptive terms. We can argue that there is something that most patients who have been labelled as psychotic throughout the last century seem to share. In this sense, Heinimaa finds in the notion of ‘un-understandability’ the core semantic trend followed by the notion of psychosis throughout the 20th century (following Bleuler, Jaspers, Schneider, Spitzer and eventually the DSM) c. In our opinion, un-understandability could be argued to represent a disadjustment between

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a. Most important, these theoretical assumptions must include an understanding regarding the nature of subjectivity and reality (after all, psychosis is understood as a disorder of subjective experience or as a disturbance in the way in which individuals apprehend reality).

b. Consensual Qualitative Research, a methodological approach for subjective experience deployed in phenomenological investigations, represents a practical endeavour that is based on a very similar line of thought “.

c. It must be kept in mind that this paper has merely semantic and epistemic purposes. We are hence trying to understand the conditions of possibility for defining psychosis and not trying to achieve such a definition.
man and world that is experienced by an observer as an irreducible estrangement. However, not all forms of understandability can be considered as abnormal, pathological, or psychotic (see for example the eccentric or the genius who is ahead of his time). In this sense, we must keep in mind that what we aim at understanding is a fellow human being in his relation towards the world (it is a person that we fail to understand, and hence a person who is psychotic – not a symptom). We therefore identify a need to articulate the relationship between man and world, between subjectivity and reality, so that we may determine which forms of incomprehensibility should count as psychotic (hence psychosis becomes a theoretical construct that tries to account for certain forms of incomprehensibility). Unfortunately, an understanding of the relationship between man and world is the very task that philosophy has struggled with for over 2500 years and no definitive answers have become available. Hence, a theoretical commitment with the most appealing theoretical assumption regarding the nature of the relationship between man and world (or subjectivity and reality) seems to represent an indispensable requirement in order to reach a definition for the term ‘psychosis’. Once the structure of this relationship has been disclosed, an account of how it might break down will come to define the deep structure of psychosis (or several accounts might come to define different possible ways of becoming psychotic).

In this sense, we identify a trend (focused mainly on schizophrenia) that expanded throughout the 20th century and that realised that reconstructing an individual for diagnostic purposes demands the previous articulation of the relationship between man and world (Minkowski’s loss of vital contact with reality, Binswanger’s Transcendence, Blankenburg’s loss of natural self-evidence, Stanghellini’s loss of common sense, Sass and Parnas’ ipseity disturbances etc.). In fact, the notion of incomprehensibility as a core element pertaining to the notion of psychosis seems to have drawn back in the last decades, allowing for a growing focus on the ontological status of man and on the idea of a disadjustment between man and world.

However, these ideas imply a risk that should not be neglected. The underlying theoretical assumptions implied in the notion of psychosis cannot say in definitive terms what man or world are, for they only represent one approach among many (the history of philosophy is clear proof of this point). This should preclude descriptive definitions aimed at saying what psychosis is, for 1) they falsely imply knowing what man and world are, and 2) they neglect the fact that psychosis is a theoretical construct (whose meaning is also modulated by legal and social dimensions) and the product of a hermeneutic reconstruction. In spite of its perspectivistic flavour, a definition of the kind ‘taking into account this theory about man, world and reality, the term psychosis could be understood as…’ would seem, in our opinion, more epistemologically sound.

As we already mentioned, not all definitions (understood as theoretical constructs) should be granted the same value. The better a definition complies with the values ascribed to hermeneutic objectivity (in the sense of plausibility, global coherence, appropriation of theoretical assumptions, articulation of contextual information etc.) the better it will be, the closer it will stand to our aspired value of truth and the more it will resemble an ideal of objectivity.

According to the proposed view, the methodological framework that underlies the use of the term psychosis in clinical practice is a theory-guided hermeneutical process. The fact is then that a single patient might be interpreted or reconstructed according to different alternative theories or perspectives that offer different value to contextual and non-representational information. His utterances, his behaviour, other accompanying phenomena, his expression, his biography, his personality traits, his hopes and desires, his life-world as a meaning-bestowing totality, they all have semantic value, the relevance of which will be determined by different factors (one of which, as we have already mentioned, is the theoretical model in place). Hence, a patient can be considered both as psychotic and as non-psychotic at the same time (it is not at all strange that we find this happening in clinical practice). There is thus no certainty, at least not in the causal-deterministic terms implied by the pretension of truth of the natural sciences. Once again, however, not all interpretations should be granted the same value. The greater the value of hermeneutic objectivity, the better the individual reconstruction will be and hence the more the clinical judgement will approach a value of truth.

A final remark regarding psychotic symptoms. Although these can no longer be considered to bear the meaning of the term psychosis, they still play a central role in clinical practice. They represent the most frequent and charac-
teristic forms through which an observer may conceptualise or categorise the experience of estrangement that interaction with a fellow human being might arouse. The fact that we might be able to reconstruct an utterance or a fragment of behaviour as a psychotic symptom does not allow for identifying the individual under the kind ‘psychosis’. However, the initial identification of an utterance or a fragment of behaviour as an instance that satisfies the descriptive features of a specific type of psychotic symptom can be taken to represent an initial (and essential) step that catalyses the interpretative diagnostic process 33 34.

Conclusions

A pretension of truth based on causal relations and deterministic laws requires an epistemic framework that does not legitimately apply to psychiatry, for psychopathological symptoms are not directly apprehended as spatio-temporal physical objects nor do they stand in causal relations with surrounding objects. Given the nature of psychiatry’s object of study (i.e. subjective experience), psychopathological raw data (i.e. uninterpreted utterances and behaviour) must be rendered meaningful through an interpretative process. The hermeneutic nature of this endeavour precludes both a single and universally accepted definition for psychosis and a uniquely valid diagnostic conclusion for any particular individual. It is hence due to the very nature of psychopathological phenomena as belonging to the realm of subjective experience that the semantic and epistemic questions defy an answer in the kind of terms expected by the natural sciences. However, neither all definitions nor all individual diagnostic reconstructions can be granted the same value. According to the above-mentioned view, the better they comply with certain features (such as global coherence, plausibility, acknowledgement of theoretical and philosophical assumptions, the capacity to articulate contextual information, predictive power or the capacity to open paths for intervention), the better the interpretation will be and the more it will resemble an ideal of objectivity.

Finally, we observe that the notion of incomprehensibility, a core element in the history of the notion of psychosis, seems to have drawn back in the last decades allowing for a growing focus on the ontological status of man and on the idea of a disadjustment between man and world 29 32. In this sense, we believe that further theoretical and philosophical input on the relational structure between man and world will allow for better and more solid conceptualisations of psychosis.

References


1 Interestingly, these accounts tend to consider delusions or hallucinations as contingent phenomena and, most important, allow for an understanding of the internal structure that interweaves the different clinical manifestations (namely what Minkowski called trouble génératrice 15).

20 In fact, the notion of incomprehensibility as a core feature of psychosis has been repeatedly contested throughout the last decades: a) a lack of understanding might be due to my own incapacity to understand a patient, b) the act of understanding is context-dependent (someone might be considered as incomprehensible in a particular context and understandable in a different setting), c) a particular theory regarding a breakdown in the relationship between man and world might render certain phenomena (previously considered as incomprehensible) understandable...
On the epistemology of psychopathology: critical insights and methodological concerns

26 Minkowski E. La notion de la perte de contact vital avec la réalité et ses applications en psychopathologie. Paris: Faculté de Médecine de Paris 1926.
CONCLUSIONES
1. **Through its development as a medical discipline, psychiatry inherited medicine’s epistemic framework: medical semiology.**

   a) According to this framework, *observable signs and symptoms stand in causal relations with their unseen internal cause.* These causal relations can be determined by means of empirical methods and subsumed under deterministic laws. Examples of such determinations include physio(path)ology, pathological anatomy, microbiology or genetics.

   b) The inheritance of medical semiology as its epistemic framework implied the assumption that *psychiatry’s object of study is ontologically equivalent to that of somatic medicine.*

2. **Psychiatry’s adoption of somatic medicine’s epistemic framework** (i.e. medical semiology) is *illegitimate*, since:

   a) Psychiatry’s object of study is **subjective experience**.

   b) Ontological differences can be identified between psychiatry’s object of study and that of somatic medicine. As opposed to physical signs or symptoms, *subjective experience does not belong to a field where events necessarily follow deterministic and apodictic rules and where features and events can be predicted.* Subjective experience, including mental symptoms, lacks material qualities and does not stand in causal relations with co-existing objects. *All relationships within subjective experience are based on meaning, which is inherently open* (a single event or experience is susceptible of having alternative meanings for different people).

   c) *Ontological properties of subjective experience defy empirical analysis and subsumption under deterministic laws.*

3. **Psychopathological phenomena only acquire meaning when analysed from within their horizon of meaning** (i.e. the individual from whom they emerge).

   a) *Any utterance or fragment of behaviour,* taken as an expression that stems from an individual, *cannot be considered in itself as symptomatic* (or pathological). Before they can be labelled as pathological they must be granted a
meaning and this requires a certain degree of knowledge regarding the individual from whom they emerge (i.e. their horizon of meaning).¹

b) **Understanding an individual is an inexhaustible task.** In other words, we never reach a complete understanding of a fellow human being (no matter how well we might know someone, they might always surprise us...). Hence, *since the meaning of any particular expression* (utterance or fragment of behaviour) *depends on how the individual from whom it emerges has been understood* (i.e. on how the horizon of meaning is reconstructed), *the meaning assigned to the expression will remain always and inevitably open.*

4. Psychopathology is neither a closed set of rules nor a glossary of terms whose meaning has been definitively fixed. **We understand psychopathology as an active process aimed at creating intelligibility** by rendering our patient’s utterances and behaviour meaningful. Psychopathology is an interpretative endeavour, running back and forth from the expression to the individual and back to the expression.

   a) Patients are reconstructed in clinical practice through our encounter with them by means of a *hermeneutic/interpretative procedure.*

   b) As in all hermeneutic processes, *different reconstructive alternatives are viable.* Just like any particular scenery can be depicted following different artistic styles, a particular individual might be reconstructed or interpreted from different perspectives that prioritise different aspects human existence (see Conclusions, section 7). However, *not all reconstructions possess the same value.*

5. **The interpretative process requires a guiding framework.** This framework is composed by different (and frequently unacknowledged) prejudices² regarding the nature of *man, subjectivity, the world, reality,* illness, etc.

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¹ The sentence “I am going to kill myself” might have a very different meaning when uttered by a young and emotionally unstable woman who has just been broken up with and when uttered by an 80-year-old individual who is physically impaired, who has recently become a widower and who is experiencing serious economic difficulties.
a) The validity of these prejudices (or theoretical assumptions) is subject to vivid debates (e.g. a Representational Theory of Mind, a Correspondence Theory of Truth, the idea of a direct and unequivocal correspondence between world and language, an ontological independence between man and world, etc.).

b) Theoretical assumptions determine what kind of information is relevant for the reconstruction of a particular individual and how this information should be articulated.

6. There are different (and frequently incompatible) theoretical frameworks regarding the ideas of subjectivity, man, world and reality (all of which are indispensable for psychiatry).

   a) There is no single set of theoretical assumptions regarding the notions of subjectivity, man, world or reality that can be universally accepted and considered as definitively valid. After all, an understanding of the relationship between man and world is the very task that philosophy has struggled with for over 2500 years and no definitive answers have become available.

   b) We must make an effort in order to acknowledge and make explicit our theoretical prejudices. This way we will gain control over them, instead of being controlled by them.

7. Different diagnostic conclusions might be arrived at, depending on the theoretical assumptions in place.

   a) As long as diagnostic judgement in psychiatry is based on a hermeneutic procedure, a particular case will be susceptible of being legitimately reconstructed or interpreted in different ways, hence reaching different diagnostic conclusions. This, however, does not imply that all reconstructions or interpretations are equally valid.

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2 We leave out here those negative implications usually linked to the term ‘prejudice’. We want to focus on its meaning as theoretical assumptions, as preconceived understanding, as a background against which all of our interpretations stand.
8. Psychiatry's adoption of medical semiology (taken as an empirical method aimed at establishing causal, deterministic or law-abiding relations between observable symptoms and internal lesions) as its epistemic framework laid the foundations for the development of a **semantic model based on a descriptive theory of meaning**. However, this model **fails to account for the meaning of psychopathological terms**.

   a) According to a descriptive theory of meaning, psychopathological terms are defined by means of **descriptions of directly observable features**. These descriptions should **remain theory-free**.

   b) However, psychopathological phenomena are the result of an interpretative endeavour. **They are not directly observable for they are not objects** (in other words, they are characterised by their meaning and not by the causal or deterministic relations they establish with co-existing objects).

   c) **There is no atheoretical perspective**. Grasping any phenomenon requires a previous background against which it acquires a particular meaning. In the case of psychopathological phenomena, this background should include theoretical elements relative to man, subjectivity and the world.

9. In spite of psychiatry's aspiration to reach unambiguous and universally accepted definitions for psychopathological terms (such as 'psychosis'), their meaning will remain inevitably open to variation depending on the theoretical assumptions in place.

   a) **Our theoretical prejudices or assumptions help determine the meaning that each one of us grants to different psychopathological terms**, irrespective of the descriptive definitions we might link to these terms (e.g. those found in the DSM or ICD)\(^3\). In this sense, even in spite of sharing the same descriptive definition for a psychopathological term (for example, high subjective evidence and incorrigibility in the case of delusion), the different members of any given community will assign

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\(^3\) In this sense, the meaning I assign to the term 'delusion' will vary depending on my understanding of the notions of subjectivity, world or reality, irrespective of the descriptive definition assigned to this term by classification systems such as the DSM or the ICD.
it a different meaning depending on those theoretical assumptions or prejudices they hold.

b) As long as the definitions for psychopathological phenomena rely on a range of alternative (and often incompatible) theoretical assumptions, TISIMASEY DEHYNISUE AND TNIUERPAIX ACCEPSED DEHNISNOR V HILAQTABIX QEMAINAN TNACHIEELABIE GOAL. This idea can help us understand why the meanings linked to notions such as 'psychosis', 'neurosis', 'Melancholia', 'Schizophrenia' or 'hysteria' have been so unstable.

c) X SQING SO MAKE OTQ SHEOESICAL AHTMPSIONREMPUCIS (for this is only possible to a certain extent) VE RHED ROME LIGHS ON SHE PASH FOLLOWED DTIQING SHE QEONROQIEUS. PQOERRS HAS CTIMINASE IN SHE DIAGNOSIC JTDGEMENS AND VE RESSIE SHE PAINS OF DEPAQSTQE IQAANX SHEOESICALDIRECTRION. This idea bears significant IMPLICATIONR VISH QEGACOR SO HOV SQAINEE AND RSTDENSR AQE CTQEN SIX SATGHS.

10. A hermeneutical framework, such as the one we argue for, does not imply arbitrariness or relativism.

a) HEQEAR DIHEQENS CONCITHONR MIGHTS BE QEACHED SHOOTGH AN INSEQQIESUS POCERRT RICH AR PRIXHIAS STJDGEMENSAS. ALL INSEQQIESASIONRAVE SHE RAME UALTIE.

b) Psychopathology aims towards a POSENATION OF SQISH though this one is DIHEQENS QOM. SHE ONE AIMED AS EX SHE NASTQALCIENCER.

c) We introduce the notion of AHEQENETIC OBJECTUIXY as a measure of the VALIDIF OF AN INSEQQIESASUE QEONROQISON. This notion is applicable both for the reconstruction of a particular individual (leading to a diagnostic judgement) and for the development of psychopathological concepts (for example, a definition for the term 'psychosis' that goes beyond the mere enumeration of allegedly

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4 If a psychoanalyst, a CBT trained psychologist, a hard-core biological psychiatrist and a phenomenologically oriented philosopher were to discuss the meaning of the term 'delusion', they should make a prior effort aimed at clarifying exactly where each one of them is standing if they are really interested in achieving mutual understanding (and this is so in spite of their sharing the same descriptive definition offered by the DSM or the ICD).
Hermeneutic objectivity is a construct that weighs elements such as the plausibility of a given interpretation, its global coherence, its capacity to articulate contextual and non-representational information, its capacity to justify the relation between symptoms present and absent, its acknowledgement of underlying theoretical implications, its predictive power or its capacity to offer effective paths for intervention.
Anexo I

Introduction

This doctoral thesis represents the collection of three papers published between 2011 and 2016. Overall, these papers focus on epistemological and semantic issues pertaining to the area of psychopathology. The unifying line of argument can be described as consisting of two parts. In the first place, a pars destruens will focus on a critique against the aspirations of a positivistic psychiatry, which takes the psychopathological phenomenon as a definite object that is reducible to spatio-temporal variables and can be subsumed under deterministic and apodictic laws. Secondly, a pars construens will focus on the argument in favour of the hermeneutical nature of the psychopathological endeavour.

The main motivation underlying this doctoral thesis is based on the uncomfortable, although undeniable, instability that characterises psychiatric theory and practice. It is the author’s view that this instability represents the insufficiency of all objectifying, reifying and deterministic approaches towards mental illness. Hence, against the accommodating view that represents psychiatry as a young science that walks firmly through the path of science and that only needs more sophisticated scientific devices in order to achieve similar results to those obtained by other medical disciplines, these papers pertain to a critical tradition that strives in order to respect the peculiar nature of subjective experience and the epistemic demands it imposes upon psychiatric theory and practice.

The first paper ('Misunderstanding Psychopathology as Medical Semiology') focuses on the clear delimitation between psychopathology and medical
On the Epistemology of Psychopathology: Critical Insights and Methodological Concerns
Tesis Doctoral escrita por Jaime Adán Manes y dirigida por el Dr. Pablo Ramos Gorostiza
Facultad de Medicina. Universidad Autónoma de Madrid.
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This analysis is based on the identification of ontological differences found between the object of study of bodily medicine and psychopathological phenomena, highlighting the radical dependence of the meaning of mental symptoms (as opposed to physical symptoms) with regards to the horizon that the individual represents (i.e. the meaning attributed to a psychopathological phenomenon might differ depending on who the individual is, on his biography, his personality traits, his fears and hopes for the future, his social and family relations, etc.). These specific features pertaining to psychopathological phenomena (and subjective experience in general) will impose certain epistemic demands upon psychopathology, highlighting the need for a hermeneutic-interpretative procedure that will lead us to understanding psychopathology not as a mere semiological device, but as an activity aimed at rendering our patients' utterances and behaviour intelligible.

The second paper ('Should Definitions for Mental Disorders Include Explicit Theoretical Elements?') represents an analysis of the semantic structure of terms applied to psychopathological phenomena. Revisiting the ideas regarding the interpretative nature of the psychopathological task exposed in the first paper, we criticise the idea that psychopathological phenomena might be defined in terms of superficial descriptive criteria, as if they were mere objects that could be immediately and directly apprehended. The idea that mental symptoms can be defined in atheoretical terms, borrowed from Logical Positivism and found in the latest editions of the DSM and ICD, is critically assessed and the inherent limitations of a Descriptive Theory of Meaning are highlighted. We further argue for the need to explicitly state those theoretical assumptions that characterise our perspective on subjective experience, for they determine both the way we understand what mental illness is and the meaning that each one of us attaches to different psychopathological terms. Eventually, we will reach an understanding of

Anexo I (Introduction) 2
the role that these theoretical assumptions play as a guiding framework for the interpretative process implied in psychiatric judgement.

The third and last article (‘On the notion of Psychosis: Semantic and Epistemic Concerns’) represents an attempt aimed at understanding the reasons underlying the arbitrariness with which the term ‘psychosis’ is deployed in clinical practice. Following the ideas developed in the previous articles, we analyse the reasons underlying the practical, semantic and theoretical instability that characterises this term, which represents in our view a perfect example of the failure of psychiatry’s naturalistic and positivistic aspirations. Revisiting the idea that theoretical assumptions regarding the nature of subjective experience should be made explicit, we will focus on the need to develop the notion of subjectivity as the realm where mental illness takes place. Following this line of argument, we will see how the meaning of the term ‘psychosis’ (or any other psychopathological term) is susceptible to variation depending on how subjective experience is conceptualised. Similarly, the possibility of applying the term ‘psychosis’ to a particular case will differ depending of how we understand what subjective experience actually is and therefore how it might become distorted. Finally, this paper examines the pretension of truth that psychiatric judgement aims for (i.e. how is it that, as psychiatrists, we can be certain that an individual is experiencing a psychosis). Since psychopathological phenomena do not stand in causal or fixed relations with other objects and cannot be subsumed under deterministic or apodictic laws, psychopathology should aim for an alternative pretension of truth (not for the one aimed at by the natural sciences) that respects its interpretative and theory-dependent character.

This doctoral thesis could be criticised for the width of its scope (after all, the issues discussed include areas related to epistemology, ontology, the philosophy of
On the Epistemology of Psychopathology: Critical Insights and Methodological Concerns

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language, semiology, hermeneutics and the philosophy of science). However, the papers here compiled represent different intellectual efforts aimed at soothing the estrangement I experience when facing the inconsistencies and arbitrariness that can be found scattered all over the realm of psychiatry. In this sense, these papers aim at shedding some light on an area of knowledge so complex and confusing that has led in the last couple of decades to the development of a new specific discipline: the philosophy of psychiatry. Finally, the conclusions reached should not be taken as my final word on the subject, but rather as a platform from which the peculiarities of psychopathological phenomena might be further explored, leading to a more solid understanding of the epistemic demands imposed by subjective experience and hopefully to an improvement in psychiatric practice.

Anexo I (Introduction) 4
Anexo II

Conclusiones

1. A través de su desarrollo histórico la psiquiatría hereda el marco epistémico propio de las ciencias médicas: la semiología médica.
   a) Según este modelo, los síntomas y signos observables se encuentra en una relación de causalidad con una lesión interna inaccesible al ojo desnudo. Dicha relación es susceptible de ser trazada mediante determinaciones causales basadas en el modelo empírico-analítico, propio de las ciencias naturales. Ejemplos de dichas determinaciones incluyen la fisio(pato)logía, la anatomía patológica, la microbiología o la genética.
   b) La adopción de la semiología médica como marco epistémico implica la asunción por parte de la psiquiatría de que su objeto de estudio es equivalente al objeto de estudio de las demás ramas de la medicina.

2. La adopción del modelo epistémico propio de las ciencias médicas (la semiología médica) por parte de la psiquiatría es ilegítima, pues:
   a) El objeto de estudio de la psiquiatría es la experiencia subjetiva.
   b) Existen diferencias de carácter ontológico entre el objeto de estudio de la psiquiatría y el objeto de estudio de la medicina somática: La experiencia subjetiva, en oposición a los síntomas somáticos, no se enmarca en un ámbito regido por leyes deterministas y apodicticas que permitan una predicción certera. La experiencia subjetiva, incluyendo los fenómenos psicopatológicos, carece de propiedades materiales y no establece relaciones de causalidad con objetos co-existentes. La relaciones que establecen los fenómenos subjetivos están mediadas por su sentido, que permanece siempre e inevitablemente abierto.
c) Las características ontológicas de la experiencia subjetiva excluyen la posibilidad de su sometimiento a un análisis empírico-analítico y a su subsunción bajo leyes deterministas.

3. El fenómeno psicopatológico únicamente adquiere sentido cuando se analiza y se comprende desde su horizonte de sentido, entendiendo como tal la totalidad del individuo en quien se manifiesta.

   a) Cualquier verbalización o fragmento de conducta, entendida como manifestación de un individuo, no puede ser sintomática (o patológica) en sí misma. Es necesario previamente dotar de sentido a estas manifestaciones y esto exige un saber acerca del individuo en cuestión.

   b) Comprender al individuo es una tarea inagotable. En otras palabras, nunca es posible conocer a un individuo en su totalidad (por muy bien que conozcamos a un individuo, siempre nos puede sorprender...). En consecuencia, dado que el sentido atribuido a una manifestación depende del modo en que el individuo del cual emerge ha sido reconstruido, el sentido atribuido a cualquier manifestación será siempre e inevitablemente abierto.

4. La psicopatología no es un compendio de reglas cerradas ni un glosario de términos cuyo significado esté definitivamente fijado. Entendemos la psicopatología como una técnica de creación de inteligibilidad que pretende dotar de sentido a las manifestaciones de nuestros pacientes. La psicopatología se entiende pues como un proceso activo, de carácter interpretativo, que va desde la manifestación al individuo y de vuelta a la manifestación en un circuito incesante.

   a) A través del encuentro con el paciente, éste ha de ser reconstruido mediante un proceder hermenéutico/interpretativo.

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1 La verbalización “Voy a quitarme la vida” es susceptible de tener un sentido muy diferente en una mujer joven y emocionalmente inestable al ser abandonada por su pareja y en un paciente de 80 años, dependiente, recientemente enviudado y con serias dificultades económicas.
b) Como en todo proceso hermenéutico, existen diferentes alternativas reconstructivas. Al igual que un mismo escenario puede ser representado desde diferentes estilos artísticos, un mismo individuo puede ser reconstruido desde diferentes perspectivas que priorizan determinados aspectos del individuo (véase el apartado 7 de las conclusiones). Sin embargo, no todas las reconstrucciones poseen el mismo valor.

5. El proceso interpretativo requiere un marco que guíe la reconstrucción.
Este marco está determinado por diferentes prejuicios2 (acerca de la naturaleza del hombre, de la subjetividad, del mundo, de la realidad, de la enfermedad, etc.), que con frecuencia tienden a pasar desapercibidos.

   a) La validez de estos prejuicios (o presupuestos teóricos), con frecuencia implantados acríticamente en nuestro pensamiento, está frecuentemente sujeta a intensos debates (teoría representacional de la mente, teoría de la verdad por correspondencia, la idea de una correspondencia inequívoca entre mundo y lenguaje, independencia ontológica entre hombre y mundo, etc.).

   b) Dada la sobrereabundancia de información que puede pasar a formar parte de la reconstrucción del caso concreto, los presupuestos teóricos contribuyen a determinar qué información es más relevante y cómo debe articularse.

6. Los diferentes modelos teóricos relativos a la subjetividad, a la naturaleza del hombre, del mundo y de la realidad (aquellos que conforman nuestros prejuicios o presupuestos teóricos y que resultan imprescindibles para la psiquiatría) son múltiples y pueden resultar incompatibles entre sí.

   a) No podemos concluir que exista un único subconjunto de presupuestos que sea universalmente aceptado y definitivamente válido. Al fin y al cabo, la

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2 Obviamos aquí las connotaciones negativas habitualmente asociadas a término ‘prejuicio’. Queremos centrarnos en su significado como presupuestos teóricos subyacentes, como comprensión preconcebida, como estrato o trasfondo sobre el que necesariamente descansan nuestras interpretaciones.
historia de la filosofía es el vivo ejemplo de la multiplicidad de aproximaciones hacia la idea del hombre, del mundo, de la verdad, etc.

b) Debemos hacer un esfuerzo por ser conscientes de nuestros prejuicios teóricos. De esta forma somos nosotros quienes los poseemos, en lugar de que sean ellos quienes nos posean a nosotros.

7. **En función de los presupuestos teóricos subyacentes podremos alcanzar diferentes conclusiones diagnósticas.**

   a) Puede resultar legítimo que un mismo caso sea reconstruido de formas alternativas, de modo que se alcancen diferentes conclusiones diagnósticas. En otras palabras, mientras que el juicio diagnóstico en psiquiatría esté basado en un proceder hermenéutico, no puede decirse que exista una única conclusión diagnóstica válida. Esto, sin embargo, no implica que toda interpretación sea igualmente válida.

8. **La adopción de la semiología médica** (entendida como un modelo empírico-analítico basado en el establecimiento de relaciones de causalidad entre síntoma y lesión) **como marco epistémico por parte de la psiquiatría ha condicionado el desarrollo de un modelo semántico basado en una teoría descriptiva del significado.** Sin embargo, **este modelo fracasa** al intentar dar cuenta del significado de los términos psicopatológicos.

   a) Los términos psicopatológicos se definen, de acuerdo con este modelo, en base a criterios descriptivos de rasgos *directamente observables y libres de carga teórica*.

   b) Sin embargo, los fenómenos psicopatológicos son productos de una actividad interpretativa-reconstructiva. No son objetos enmarcados en una dimensión espacio-temporal. En consecuencia, **no son directamente observables.**
c) No existe una perspectiva atórica. La aprehensión de cualquier fenómeno requiere de un prejuicio o posicionamiento previo. En el caso de la psicopatología, dichos presupuestos deben incluir elementos relativos a la comprensión de la subjetividad y del mundo.

9. A pesar de la aspiración de toda ciencia a alcanzar definiciones claras, inequívocas y universalmente aceptadas, el sentido de los términos psicopatológicos (por ejemplo, el de psicosis) permanece abierto y es susceptible de variar en función de los presupuestos teóricos en juego.

   a) Nuestros prejuicios o presupuestos teóricos contribuyen a determinar el sentido que cada uno de nosotros otorga a los diferentes términos psicopatológicos, con independencia de las definiciones descriptivas que vinculemos a dichos términos⁴. Así, a pesar de que diferentes miembros de una comunidad compartan los criterios descriptivos vinculados a un término psicopatológico (por ejemplo, la alta evidencia intersubjetiva y la incorregibilidad en el caso del delirio), cada uno de ellos asociará un sentido diferente a este término en función de los presupuestos teóricos que maneje.

   b) Mientras la definición de los términos psicopatológicos dependa de presupuestos teóricos variables (como son aquellos relativos a la subjetividad, al mundo y a la realidad), no podremos alcanzar definiciones últimas y definitivas. Esta idea nos ayuda a comprender los motivos subyacentes a la inestabilidad semántica que caracteriza a términos tales como 'psicosis', 'neurosis', 'esquizofrenia' o 'histeria'.

   c) La explicitación de nuestros presupuestos teóricos aclara el proceso reconstructivo que culmina con el juicio diagnóstico y determina el punto de

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⁴ Así, el sentido que otorgo al término delirio variará en función de cómo comprenda las nociones de subjetividad, mundo y realidad, independientemente de que asocie a este término una definición descriptiva al estilo de la DSM.
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partida para cualquier discusión teórica. Esta idea acarrea importantes implicaciones relativas al modelo formativo aplicado a estudiantes de medicina y residentes de psiquiatría.

10. **Un marco hermenéutico no implica una visión relativista ni aboga por la arbitrariedad.**

   a) Si bien un proceso interpretativo, como es el juicio psiquiátrico, permite alcanzar conclusiones alternativas, no todas las interpretaciones tienen el mismo valor.

   b) La psicopatología aspira a una _pretensión de verdad_, si bien ésta no es la de las ciencias naturales.

   c) Se presenta la noción de _'objetividad hermenéutica'_ como una medida de la validez interpretativa. Es aplicable tanto a la reconstrucción del caso concreto (juicio diagnóstico) como a la creación de conceptos psicopatológicos (por ejemplo, una definición del concepto de psicosis que no se limite a la enumeración de rasgos descriptivos y que incluya elementos teóricos que permitan una aproximación a su estructura profunda).

   c) La objetividad hermenéutica es un constructo que tiene en cuenta factores tales como la _plausibilidad global de la reconstrucción, su coherencia, la aprehensión de presupuestos teóricos que guían el proceso reconstructivo y determinan nuestra comprensión de los conceptos empleados, su capacidad para articular material contextual y no representacional, su capacidad para justificar la relación entre síntomas presentes y ausentes, su capacidad predictiva y su capacidad para abrir vías para intervenciones efectivas._

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4 En este sentido, si un psicoanalista, un psicólogo de formación cognitivo-conductual, un psiquiatra de formación biologista y un filósofo de formación fenomenológica van a discutir acerca del delirio, deberán realizar un ejercicio previo destinado a explicitar sus presupuestos teóricos si es que realmente desean poder comprenderse los unos a los otros (y esto es así a pesar de que todos compartan la definición descriptiva ofrecida por la DSM o la CIE).

Anexo II (Conclusiones) 6