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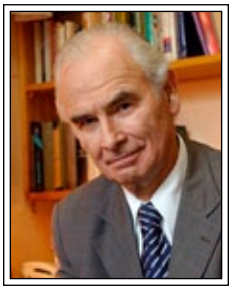
HERMENEUTICS



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HERMENEUTICS, DIALECTICS AND PSYCHIATRY

The author attempts to highlight the relationship between hermeneutics and dialectics on the one hand and psychiatry on the other, giving particular importance to the contributions of Karl Jaspers to these subjects. He first discusses the coincidences and differences between the method of understanding in the sense of Jaspers and the hermeneutic approach in the sense of Gadamer. Afterwards he describes the multiple ways in which a hermeneutic attitude can be applied in the practice of psychiatry. Thus, even before the psychiatrist try to understand a psychopathological phenomenon he finds himself needing to adopt such an attitude. The classic Rümke's description of the "Praecox-Gefühl" (feeling of what is schizophrenic) and our description of a "Melancholie-Gefühl" (feeling of what is melancholia) represent two examples of the significance of such hermeneutic attitude in the first interview and in the diagnostic process. The importance of a strict separation between the true and the false prejudgements and/or intuitions in the preverbal moment of the encounter with psychiatric patients is emphasised. The role of hermeneutics in the verbal encounter with the patient is also analyzed by describing typical language and thought disorders in schizophrenia as well as in severe depressive states. After a brief description of the transcendence of dialectics in the history of western thought, the author tries to demonstrate the advantages of a dialectic perspective in psychiatry: to see the positivity of the negative; to question the rigidity of concepts like normal-abnormal, healthy-ill, etc.; and above all, to look at the different non organic psychopathological conditions as displayed in polarities, one side being the opposite with respect to the other and vice versa and to consider the healing process

itself as movement in the opposite direction until the right balance is reached. Finally, the author attempts to show how hermeneutics and dialectics are essentially linked, because the "opening" characterizing hermeneutics is materialized in the question, whose inherent negativity is isomorph with the one of the dialectic experience. In turn, psychiatry praxis demands the ability to know how to question, how to fail and how to dialectically salvage some knowledge from this failure.

Keywords: hermeneutics, dialectics, phenomenology, psychopathology, method, understanding, schizophrenia, mania, depression, square of oppositions

Hermeneutics and psychiatry

Hermeneutics has been traditionally conceived as a method aimed at the understanding and correct interpretation of texts. But, as Gadamer [16] accurately states, the hermeneutic problem exceeds by far the area of what is "methodological", since "to understand and to interpret texts is not only a matter of science, but something evidently belonging to the human experience of the world in general" [16, p. XXVII]. When we try to understand what tradition has meant in any of the fields of human experience, we cannot avoid going beyond a mere understanding of the text we have before us, since this will transmit to us, inevitably, certain viewpoints and/or certain truths. And how to be sure of the legitimacy or "truth value" of what is understood? This is precisely the role of hermeneutics: to make the experience of truth [16] where natural science appears surpassed, as is true with history, art, law, etc., that is, in the "social sciences" (Geisteswissenschaften). Now, Gadamer himself expresses in another context: "That art of understanding we call hermeneutics has to do with what is incomprehensible and with the process of grasping the unpredictable aspects of the psycho-spiritual functioning of the human being" [16]. If we accept this definition of hermeneutics, we could ask: will the existence of a more characteristic field for its application than that of psychopathological phenomena be possible? In what other field of the human being are we going to find these two conditions more obviously united, incomprehensible and unpredictable at the same time? Every experienced psychiatrist will be able to recognize how often the psychopathological phenomenon surpasses the possibilities of natural science, e.g. by attempting to "explain" delusion with energetic theory of psychoanalysis or through measurement of neurotransmitters.

Following Dilthey, Jaspers early recognized this particularity of the psychopathological world when he separated precisely what is explainable from what is understandable [22]. With the method of "explanation" we approach the clinical reality in the way the physicist studies matter, and thus we calculate the size of cerebral ventricles, quantify intellectual capacity or measure the concentration of catabolites of neurotransmitters in urine, etc.

With the method of "understanding" in the way Jaspers [22] means it, on the other hand, we have access to phenomena which completely escape the very eagerness to quantify, like feelings and emotions, the world of interpersonal atmospheres, the experience of art or, in general, the world of meaning. How one psychic phenomenon arises from another is something very different from the lineal causality of the physical world, and the method of understanding intends to do justice to that difference. To be able to understand the biographical sense of a given illness, or to interpret a delusion within itself and not from supposed underlying extraconscious causalities are two typical tasks where the psychiatrist has to employ the method of understanding and where he is performing hermeneutics in its purest form.

But even when the psychiatrist tries to understand a delusion or a behavior, he finds himself in the first encounter with the patient faced with the need to adopt something like a "hermeneutic attitude". Let us just think of that classic description given by Rümke of the "Praecox-Gefühl" (feeling of what is schizophrenic) and which he considers the central element in the diagnosis of schizophrenia, and how this precisely matches the important concept of "prejudgment" in Gadamer, "that judgement expressed before the definite proof of all the determinant objective moments" [16, p. 255]. We described something similar with respect to depressive illness [8; 9]. There also exists here something like a "feeling of what is melancholic", which is more intense, the nearer the condition is to stupor, whose objective side is the phenomenon we called "cadaverization" ("Leiche-werden" in German or "chrema" in Greek) or process of "Verdinglichung" (transforming into a thing) of the depressive's body. Just as the strict separation of true from false prejudgments is seen as one of the major tasks of hermeneutics in the interpretation of both art and history, so in psychiatry it will be an important task that the teacher has to perform for his disciple, teaching him to grasp these atmospheric emanations coming from the patient and to distinguish true from false impressions at the time he makes a diagnosis. This atmospheric moment of the encounter with the patient acquires particular importance in the field of psychosis. First, it will have to begin in that moment, apparently more superficial, which is the atmospheric emanation. Gadamer himself opened the possibility of incorporating the pre-verbal world to the hermeneutic task through the importance he attached to the concept of "taste" or rather "good taste" [16, p. 40]. For him, taste "...in its most characteristic essence, is not a private thing, but a social phenomenon of first order" [16, p. 41]. What is normally called "lack of contact", "flat affectivity" or "distance" in the encounter with the schizophrenic patient corresponds to a pre-verbal originary phenomenon as precise as taste ("Good taste is always sure of its judgements", Gadamer tells us [16, p. 41]). In the encounter with the schizophrenic we lack a certain feeling of community, which the Japanese have called "ki" [10]. Our respective emanations do not harmonize, they do not have the same tonal quality. The difficulty in verbal communication is then almost always preceded by this failed pre-verbal communion.

In the case of the depressive patient it is not harmony that is missing, but the sensation that he or she is not completely a subject in his own right. This peculiar feature of the interpersonal encounter, so well described by Sartre in "Being and Nothingness" [29], of being not a mere object for the other in the manner of things, but a subject with a given life history, more or less disappears when one faces the depressive person. The fundamental element of this "prémiere relation", where the other appears directly to me as a subject is, according to Sartre, the look of the other, the fact of being seen by him, of being objectified by him. Now then, that look which allows me to perceive the other as a subject and as a thing, is weakened in the depressive patient. One could say, the look on the face of the depressive person "has sunk behind the eyes", as we have described it in previous papers [8; 9]. To know how to correctly interpret the shades of the interpersonal encounter with our mental patients in the pre-verbal stage is also a hermeneutic task of great importance, both for the development of a good doctor-patient relationship as well as making a correct diagnosis.

Now, where hermeneutics reaches its greatest importance for psychiatry is naturally in the verbal moment of the relation with the patient. We will not refer now to its transcendent role in psychotherapy. We will limit ourselves to the role of hermeneutics in the diagnostic interview. Above all, we must remember that language is for Gadamer not only the medium, but also the horizon of every hermeneutic experience. In a passage of his book "Truth and Method", he writes: "Language is not only one of the abilities of the human being insofar as he is in the world, but in it is base and is represented the fact that humans simply have world. For the human the world is there in a form under which it has no existence for any other living being. And this existence of the world is linguistically constituted." [16, p. 419].

Only on few occasions do we have the opportunity of proving with greater certainty this assertion of Gadamer than when we face a schizophrenic patient. Since the first descriptions of this illness, primordial importance was given to thought/language disturbances. The so called "loosening of associations" of Bleuler [7], the classic incoherence or the neologisms, have always been considered among the basic symptoms of schizophrenia. In previous papers [10; 13; 14] we have tried to demonstrate that the disturbance of language was the only specific symptom of this illness. We also stated then, that perhaps the loss of the "dialogic" character of the word is its most substantive phenomenon. And how does this alteration appear in the encounter with the patient? Perhaps the most characteristic feature of the verbal encounter with the schizophrenic patient is the sensation the explorer constantly has of not being able to really understand what the patient is saying. It deals with an experience similar to that of being in a country whose language we don't master as well as we'd like. Let's omit the most severe disturbances of language like incoherence or neologisms, and focus our attention only on the "loosening of associations". Here too, there are no failures in the grammatical structure. Although there

are no flagrantly absurd or bizarre contents of the thought process we cannot truly understand what the patient says. Gadamer highlights this phenomenon when he states: "World is world no only when it accedes to language, but language has a true existence only in the measure that the world is represented in it" [16, p. 531]. In other words, if the world changes, language changes, if the perception of world is altered, its expression will necessarily be altered. Now then, in the failed dialogue with the schizophrenic patient the distance of his world from ours is manifested to us, but at the same time we perceive that the dialogue itself turns schematic and progressively more difficult. What Gadamer underlines as the essential element of a conversation does not occur here: the fact that we can not command it as we wish, but, on the contrary, the conversation leads us in unsuspected directions. "In fact, true conversation is never that which we would have liked to hold. On the other hand, in general it would be more correct to say that we "enter" into a conversation, if not that we "get involved and mixed" in it." [16, p. 361]. The conversation with schizophrenic patients occurs, inversely, in a tiring way, it is interrupted at every moment, the explorer feels empty, without ideas, and has to make an effort to pose new questions, being more directive, to avoid the disappearance of the dialogue in an uncomfortable silence. In other words, what Gadamer described as the central element of the true conversation, of the hermeneutic dialogue, is missing here.

In the depressive patient the moment of verbal communication has also quite specific peculiarities. The most extreme form of his disturbance is certainly found in conditions related to stupor. There is no reply there, the other is absent. We are faced with something like a lifeless body. The process of transforming into a thing ("Verdinglichung") is almost complete [8; 9]. In the moderate depressions of daily clinical practice the communicative disturbance is, naturally, much less, but it maintains, however, that seal of lifelessness we have referred to before. Every clinical psychiatrist will be able to remember the slow and forced nature which characterizes the dialogue with the depressive patient. Unlike what occurs in the encounter with the schizophrenic, there is nothing incomprehensible here, at no time are we perplexed, because his world is not distant from ours; we are only annoyed by how slow he is and the narrowing of his interests, which are limited to his own body or to the other classic themes of ruin, poverty and guilt. Even when the depressive episode has been resolved, the communication is not very easy. These patients are too laconic to describe their improvement and the doctor feels, after the dialogue has begun, that there is nothing else to talk about. A marked contrast is frequently observed between the numerous complaints and the accompanying expression of suffering during the depressive state and the almost total oblivion of the illness once the episode is past. These patients give the impression of an "irritating" normality and it is difficult for the therapist to relate that person with the one he saw suffering so intensely only weeks or months before.

The same analysis could be attempted with respect to other psychopathological conditions, such as obsessive-compulsive disorder or hysteria. In each of these disorders a particular style of communication can be found, for whose description and interpretation the psychiatrist must develop an appropriate hermeneutic attitude.

In summary, hermeneutics and psychiatry appear interrelated even before all theory about the psychopathological phenomena and any therapeutic process have taken place. In addition to its obvious importance in psychotherapy, hermeneutics plays a basic role in the first interview (and thus in the diagnostic processes), and not only as it relates to verbal communication with the patient, but also in that previous wordless moment where the grasping of atmospheric emanations from the other as well as the creation of a concordant and consequently common atmosphere occur.

Dialectics and psychiatry

Dialectics dates back to the beginning of philosophical thinking, appearing in different forms in the two great pre-Socratic philosophers: Parmenides of Elea and Heraclitus of Ephesus. For Parmenides dialectics is a method which allows one to prove the falsehood of appearances that the senses give us and in this way, to purify the thinking of irrationalities. For Heraclitus, on the other hand, dialectics represents the basic principle which structures and directs all that exists, since reality is ordered in polarities which need one another [21]:

"Should there be no injustice, even the name of justice would be ignored". (Fragment No. 23)

"Good and evil are one. The physicians cut, burn and torture... making the patients a good that seems an evil". (Fragment No. 58)

"It is sickness that makes health pleasant ; evil, good ; hunger, plenty ; weariness, rest." (Fragment No. 111)

Plato [27] uses dialectics as a method to get to the truth through dialogue and by proving the contradictions inherent in nature as well as in thinking. In Hegel the concept of dialectics reaches its greatest universality: dialectics would be, to a certain extent, identical to the perhaps most universal feature of reality, which is its "restlessness". According to Gadamer [17] this concept is similar to that of "energeia" in Aristotle [2]. "Energeia" is present in daily life in the form of movement, but is also the motor of history and of all that exists in time. Both reality and knowledge would be one and the same process, but the truth of a process is only reached at the end of it, since every cross section will show its internal contradiction: the contradiction between the bud and the blossom that refutes it will be resolved in the fruit; this is the so called dialectic moment, when the synthesis overcomes the contradiction between the thesis and its denial, the antithesis [19].

Now then, we find dialectic thinking and /or dialectic interpretation of reality not only among philosophers. The religious historian Mircea Eliade [15] has demonstrated how dialectic thinking is at the foundation of every religion and particularly of the Asian ones. The Christian dogma itself of the "Incarnation of the Word" is a good example of a *coincidentia oppositorum,* of a dialectical synthesis of what is radically sacred and what is radically profane. But the dialectic moment also appears repeatedly in the great poets. Thus, we read in Goethe, in the Book of Aphorisms:

"We and objects
light and darkness,
body and soul,
spirit and matter,
God and the universe,
the idea and the extension,
what is ideal and what is real,
sensuality and reason,
fantasy and understanding,
being and nostalgia" [18, p. 707].

The application of dialectic thinking to psychiatry was first proposed by Wolfgang Blankenburg [3; 4; 5; 6]. His starting point is the hypothesis that certain positivity can be enclosed in what **is negative** (the abnormality or the illness). The question of the positivity of what is negative was systematically developed by Hegel [20], but it is found in many forms in daily life and also in the religious world. Blankenburg points out, as an example, the case of Christianity, where this type of thinking repeatedly appears: the last will be the first, it is necessary to die in order to resurrect, etc. Now then, this statement is relevant not only theoretically, but also practically; when the psychiatrist does not take what is negative simply as such, he will be obliged to enlarge his horizon of understanding, to change his frame of reference and to question the traditional concept of illness. And thus, Blankenburg underlines the positive aspects of schizophrenia, like the depth of its perception of the world, its nearness to genius, etc. [4], and later the positive aspects of hysteria, as could be its lack of rigidity, its easy adaptability, its capacity for entertaining, etc. [5].

Following this line suggested by Blankenburg, we tried to advance in the dialectic perspective of the great psychopathological syndromes [11]. As the initial model we took the manic-depressive diad, where it is easy to recognize the polar and dialectical character: mania is the reverse of depression and vice versa, but at the same time they need one another so much that in some way one is contained in the other and vice versa. How frequently we perceive, behind the joy and hyperactivity of the manic, infinite sorrow and, inversely, behind the sorrow and inactivity of the depressive patient, feelings of envy and aggressiveness which are almost impossible to emanate from his weakened

and harmless appearance. On the other hand, what draws one's attention is the fact that the situations triggering the two illnesses would seem to be inclined to produce the opposite effect: what would result in joy for any normal person (move to a better house, happy marriage of a daughter, birth of a child who is wanted, a promotion at work, trip abroad, etc.) would cause depression, while those triggering mania generally represent intolerable setbacks (death of a very loved one, financial bankruptcy, diagnosis of a serious or mortal illness, situations of great pressure, etc.). In other words, the manic makes his mania **against** depression, while the depressive patient makes his depression **against** the mania. And following in the dialectic perspective, what is manic could be seen as **what is positive** about the depression, as a defense against that inability, that congealed anguish, that stopping of time. And conversely, what is depressive could be conceived as **what is positive** with respect to mania, as being saved from frivolity, from exhausting hyperactivity, from continuous disrespect for others or from inability to maintain both thinking and behavior within rational and socially acceptable limits.

In a later paper [12] we tried to apply this model of analysis to all the non organic psychopathological syndromes, with the result that when ordering these in polarities they naturally adopted a structure similar to the one that has the square of oppositions in the Aristotelian logic, with contrary (polar), subcontrary, contradictory (mutually exclusive) and subaltern forms of judgement. It would be a curious case of isomorphism (**fig. 1**). In the upper line we see displayed the whole range of psychopathological syndromes called "psychotic" and ordered according to greater or lesser structural proximity with the schizoid of the depressive pole. Paranoid schizophrenia would be very close to the nucleus itself of the schizoid structure, the catatonic form would be found already on the way towards the depressive pole, consistent with Kraepelin, who struggled to decide whether to include catatonia as part of dementia praecox or as part of manic-depressive psychosis [23]. The schizo-affective psychoses would be halfway between the two poles and the manic and/or depressive psychoses with delusions and the classical bipolar forms would be grouped between these and the depressive pole. Unipolar depressions, on the other hand, would certainly be very close to the depressive nucleus, but on the vertical line, on the way to the obsessive pole, where most of the so-called psychosomatic conditions are also found, whose links both with the obsession's and with the depression's world have been repeatedly outlined [25; 31]. In the vertical line on the left side, between the schizoid and the hysterical pole, there are ordered those juvenile forms of schizophrenia which the classic authors called hebephrenia and the different borderline personalities, up to their most structured forms which end up coinciding with the classical hysterical and histrionic personality. In the lower horizontal line, the different forms of neurosis are ordered according to the closeness to the hysterical at one extreme and the obsessive structure at the other. Near the former are found the ancient hysterical neuroses,

which in DSM IV are part of dissociative disorders (1, No. 300.12-15), then anxiety neurosis, in DSM IV generalized anxiety disorder (300.02). Panic disorders (300.01) would be equally far from the two opposite poles, and agoraphobia (300.22) already on the way to the obsessive pole, and finally obsessive-compulsive disorder (300.30).

This perspective is more consistent with the clinical observation of multiple transitions between different psychiatric illnesses. To give only one example: the polarity schizoid-depressive –which leaves in between the whole range of the psychotic syndromes classically called "endogenous"- allows us to resolve the old dispute between the theory of the "unique psychosis" and the one which postulates the existence of perfectly different nosological entities. The distinction between opposite and contradictory structures also seems to be important, since between these named last structures no transitions would be possible. About the "contradictory" and excluding character of hysteria and depression I refer to the interesting findings of Alfred Kraus [24; 25]. Hermann Lang [26] has in turn described something similar for the opposition between schizophrenia and obsessive-compulsive neurosis. We must also remember that the classification of these four structures is not arbitrary. There is on the one hand the classical distinction of two great psychoses (schizophrenia and manic-depressive psychosis) and of two great neuroses (hysterical and obsessive-compulsive). But it is also possible to see their existence without having to appeal to their respective relationship with the most common psychiatric illnesses. Thus, in a previous paper we have tried to define these four structures according to the form in which temporality, spatiality, the experience of body and interpersonality is given in each of them [11].

To show what is depressive as polar with respect to what is schizophrenic or what is obsessive with respect to what is hysterical is more than a semantic game or a mere theoretical digression. By seeing one as the positive side of the other and vice versa, our capacity for understanding is widened and prejudices are eliminated with respect to the supposed negativity of one or other condition and a privileged way of therapeutic action is opened to us: to avoid a mere adaptation to that nonexistent "average" by attempting to make the patient aware of the positivity of his supposedly abnormal features or symptoms, but in such a way that he begins a journey in the opposite direction, towards its opposite pole, which is not so far away from him, in fact he is still in it, and so he can approach the measure or Greek "metron", because, as the old wisdom of Heraclitus [21] says:

"Cold things become warm, and what is warm cools; what is wet dries, and the parched is moistened." (Fragment 126)

Hermeneutics, dialectics and psychiatry

We have outlined some aspects of the relationship between hermeneutics and psychiatry and also between psychiatry and dialectics. We pointed out that hermeneutics already appears essential in the first encounter with the patient, both in its pre-verbal moment and in the verbal one. We also pointed out the advantages that the dialectic perspective offers in psychiatry and how it is better adapted to the richness and complexity of psychopathological phenomena than other ways of thinking, like causal and linear ones.

Now the question is: which relationship exists between hermeneutics and dialectics and then between both and psychiatry?

Wiehl [32] states that the relationships between phenomenology, dialectics and hermeneutics can be better understood if one starts with the concepts of theory and method. Thus, phenomenology is undoubtedly more a method than a theory, while dialectics is perhaps both things at the same time. It demands, even more, a certain dynamic (dialectic) unity between theory and method. Both have to be virtually at the same level. Hermeneutics, in turn, is neither a theory nor a method, but something like an original understanding, which will even allow distinguishing, and following to establish the dialectic relationship between theory and method. The world as a whole is opened to a certain extent to the hermeneutical understanding and we could say that one of the first perceptions resulting from this attitude is the dialectic structuring of reality. The distinction between theory and method appears as one of these dialectic structures. Phenomenology, hermeneutics and dialectics have in common the fact that no one of them is able to function separately from the method as it occurs in many other theories. They can also be distinguished from any other form of theory because of their absolute reference to what is originary and primordial.

What has been developed up to now would be enough to understand why phenomenology, dialectics and hermeneutics are so important to psychiatry. The object of our work as psychiatrists is the mentally ill human being, that is to say, the most complex reality of the universe, since what gets ill is precisely what makes knowledge, culture and finally the human world possible: the mind or spirit. Therefore, it is a great temptation to fall into reductionist interpretations of the human phenomena, whether these are of a psychological or a biological type. The complexity of the object of our science and the fact that we must finally objectify ourselves, force us to try to maintain as open an attitude as possible; and nothing better to achieve this goal than adopting a hermeneutic attitude through which we can discover the dialectic structures of the human being. The phenomenological method will serve us, on the other hand, to deeply explore some particular aspects of this reality, last but not least, for the right application of the derivate and quantizers methods of natural sciences, which in turn will enable us to manage this same reality.

Plato was the first to see the essential relationship between hermeneutics and dialectics. The "opening" characterizing hermeneutics is materialized in the question, "It is not possible to make the experience when the previous questioning fails", says Gadamer [16, p. 439]. But certain negativity is inherent in the question. Socrates brought this negativity to the most radical dimension in his famous sentence: "I only know that I know nothing". And this negativity of the hermeneutic question is isomorphic with the negativity of dialectic experience. Each experience must go through the failure for reaching its real dimension. To question starting from an attitude of the widest "opening" and to make the experience of negativity are both substantive elements of everyday practice of psychiatry. It is not possible to exercise the vocation of psychiatry without knowing how to question, how to fail and how to dialectically rescue some knowledge from this failure.

Fig. 1. Fundamental psychopathological structures and their relation with common non organic syndromes in psychiatry (Doerr-Zegers, 1972, 1987)*

Schizoid depressive structure	Paranoid schizophrenia	Catatonic schizophrenia	Schizo-affective psychoses	Delusional manias or depression	Bipolar depression	Depressive structure
A			Contraries			E
Hebephrenic schizophrenia	Subalterns				Subalterns	Unipolar depression
Schizotypal personality						Somatoform disorders
Borderline personality			Contradictories			Avoidant personality
Narcissistic personality						Obsessive personality
I			Sub-contraries			D
Hysterical structure	Conversion disorder	Generalized anxiety disorder	Panic disorder	Agoraphobia	Obsessive-compulsive disorder	Obsessive structure

* *Note:* This diagram was outlined in a paper from 1972, being presented now in actualized form. It is based on the "square of oppositions" used by classic logic for classifying different types of judgements.

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