A Modest Proposal for Another Phenomenological Approach to Psychopathology

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In 1912, Karl Jaspers published an article entitled “The Phenomenological Approach to Psychopathology.” This and his subsequent text, General Psychopathology, was to exert a profound influence on the development of psychiatry in general and psychiatric nosology in particular. The current Diagnostic and Statistical Manual of Mental Disorders and International Classification of Diseases both reflect, at least in part, that legacy. This article will argue that the descriptive psychopathology of Jaspers has been gradually transformed into a caricature which has substituted authority for enquiry and simplification for subtlety. We have been left with classificatory systems which impose reified categories increasingly at variance with clinical reality and increasingly divorced from the data generated by scientific enquiry. Returning to the phenomenological method, despite its contradictions, may open the way to clinical and research approaches which free us from the current straightjacket of orthodoxy which is impending our progress.

Key words: psychopathology/nosology/phenomenology

Introduction

The interest in phenomenology among mental health professionals may be undergoing one of its periodic revivals. This article contains a modest proposal to harness such interest to a critical reexamination of approaches to the descriptive psychopathology which sustains current classifications and clinical practice.

The phenomenological approach to descriptive psychopathology has in recent decades taken a back seat to the perceived need for explicit definitions of symptoms and disorders to promote reliable clinical diagnosis. Diagnostic “instruments” and the use of structured and semistructured interviews have come to be seen as the royal road to both defining research populations and reliable clinical assessment. This has bred an approach among clinicians, as well as researchers, which privileges the specific question and the proper categorization of the patient’s response.

The carefully articulated diagnostic classifications of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and International Statistical Classification of Diseases, 10th Revision (ICD 10) are generally accepted to relate meaningfully to the world of mental disorders. Nevertheless, the increasingly obvious gaps between research findings and the definitions of mental disorders in today’s diagnostic manuals is beginning to raise questions about whether validity has been sacrificed on the altar of reliability. Even the diagnostic centerpiece, schizophrenia, is starting to fragment under the impact of genetic, neuroimaging, neuropsychological, social, and other research methodologies whose findings are difficult to make sense of within anything approaching the manual’s models of schizophrenia. Bleuler’s plurality of the schizophrenias has returned, and schizophrenia is now for some once more a syndrome not a disorder. All of which reopens the question of what abnormalities of mental state and behavior best map onto the developing research database. A question which today’s self-confirming and fixed diagnostic categories with their simple symptom signposts are helpless to answer. In addition, mental health clinicians with any critical faculties cannot but notice that the better you know a patient and the more information that is available, often the more problematic becomes fitting them into any specific diagnostic category. This is the reverse of the situation in well-established medical specialities. This difficulty persists despite the rather forgiving polythetic basis of modern diagnostic classification. These research and clinical problems might be alleviated through a return to a descriptive psychopathology based on the phenomenological method.

A Problem with Contemporary Psychopathology and Nosology

Psychiatry has been preoccupied in recent decades with the Kraepelinian project of defining mental disorders in terms of symptoms and signs with the hope that a knowledge of course, prognosis, and ultimately cause would follow. The great monument to this project are today’s 2 manuals, the ICD and the DSM. The hope
was that clearly and operationally defined disorders would facilitate research, improve communication, and provide a structure to clinical practice which would improve diagnosis and treatment. This ongoing labor has reordered, solidified, and occasionally renamed the conditions inherited from past generations. More dramatically, it has generated a plethora of new disorders like posttraumatic stress disorder and panic disorder to say nothing of annexing problem behaviors like child molestation and shoplifting to their own specific mental disorders. The escalating size of the diagnostic manuals conveys an impression of progress and accumulating knowledge. But what lies behind this inflation of disorder?

The DSMs and ICDs undoubtedly began in an attempt to build diagnostic criteria out of clinical descriptions often influenced by phenomenological approaches. Today, however, they confront us not as sets of tentative hypothesis about preliminary but potentially useful ways of conceptualizing disordered states of mind and behavior. Quite the reverse, they claim to ground the subject offering the touchstone of certainty from which research and clinical practice starts and from which it derives its legitimacy. Those who create these manuals are neither fools nor rogues. They know that classificatory systems grow and develop. They welcome research, debate, and change. They are often painfully aware of the compromises and hopeful approximations which go to create the final authoritative text. But this intellectual honesty does not translate into the practices and ideologies which DSM and ICD sustain in the cities of psychiatry and psychology. In today’s field of mental health if you seek research funding or publication, you are forced into the languages of DSM or ICD. To claim rebates for clinical work or to present expert testimony to courts and tribunals, increasingly, the language of these diagnostic manuals is imposed upon you. To even contribute to the professional debates on nosology you are constrained within the premises which sustain the manuals. To be a researcher or even a mainstream clinician plunges you into the very core of the self-justifying and self-sustaining hermeneutic world of today’s manuals of mental disorders.

Heidegger² writes of just this process whereby phenomena once revealed can with time be covered over and become a “dangerous” source of misleading systems. Systems can be developed from phenomenological inquiries in which the original revealed structures have been obscured by selecting some aspects and forgetting others. These ghosts of obscured phenomena can then be bound together into an authoritative structure. These systems “then present themselves as something ‘clear’ requiring no further justification and thus can serve as the point of departure for a process of deduction”.²(p60) But these degenerate systems become not a source of new knowledge but a source of error. They have become the expression of reified concepts based not on the original phenomenological explorations but on subsequent deforming simplifications. They are transformed into entities which claim to be the appearances which announce some other supposedly hidden reality, in short, they metamorphose from phenomena to symptoms. In this process, the phenomena derived as an attempt to begin the exploration of disorders of mind become the appearances of the disorders themselves. The disorder’s existence is guaranteed by these symptomatic appearances which in reality are no more than the reifications of simplified accounts of phenomena, phenomena which were, at best, intended as the starting point of an exploration of the possibility of the existence of such disorders. Such bowdlerization and concretization ends the possibility of the scientific enquiry they were intended to usher in.

This process in practice is illustrated by Ungvari and Tang³ who note Bleuler required 95 separate psychopathological phenomena to characterize the schizophrenias. Kraepelin in his final formulation used 75, but DSM-IV employs only 30.⁴,⁵ It is this truncated psychopathology which forms the basis of virtually all characterization of schizophrenia in today’s scholarly literature. In defence of the manuals, those of us whose research and clinical practice involves reviewing the case notes of colleagues would be delighted to encounter the full panoply of DSM’s phenomena noted as present or absent. At best, we tend to find 4 or 5 symptoms identified by name as present, usually without quotes or characterizations, and the absence of a phenomenon is rarely if ever recorded.

A central issue is whether the diagnostic manuals have become self-sustaining impediments to scientific progress or whether they truly remain open to refutation and productive of good practice and research. The question for this article is how a phenomenological perspective on descriptive psychopathology might progress, or confound, today’s diagnostic systems. Such a process of phenomenological enquiry might end up strengthening the rocks on which we have built the psychiatric enterprise. Conversely, it could fragment those foundations bringing down authority and reinstating science.

An equally important issue is the unforeseen effect on the practice of clinical assessment that propagating the diagnostic manuals and developing standardized instruments to identify the disorders they contain has produced. Lists of criteria and instruments made up of specific probes to elicit whether or not the criteria are met breeds an examination style based on specific questions and specific answers. The enquiry is about the presence or absence of the indicators of disorder not about an exploration of the patient’s life and state of mind.⁶ We now have generations of mental health professionals, many of whom have learned all the right questions. They may in the process, however, have lost the capacity to listen or to see what may challenge or otherwise discomfort the established diagnostic process. This would be of less importance if the disorders they seek, and
find, were firmly established clinicopathological entities with established management protocols, but they must definitely are not. The clinical bankruptcy of much of modern mental health is in part a child of that admirable project for explicit, reproducible, and shared definitions of disorders.

In the clinical situation, the “multiaxial nature” of the classificatory systems of DSM and now ICD can offer layers of complexity to the formulation of the patient’s problems. The multiaxial approach was intended to guide clinicians into taking account of the dynamic interactions in the mentally disordered between social context, personality, substance abuse, disability, and abnormalities of mental function. Though in the right hands, the multiaxial approach functions as intended, all too often, the axis are reconstructed as independent variables creating further fragmentation and simplification. This is painfully obvious in my area of forensic psychiatry where the mentally disordered offender’s personality vulnerabilities, substance abuse, and social dysfunction are often approached not just as autonomous factors but as competing explanations for the offending behavior. Particularly in those with a schizophrenic syndrome, this not only confusion for courts but leads to a failure to act effectively to recognize and reduce the risk of violence.

What Is the Phenomenological Approach and Where Did It Come From?

Phenomenological approaches share a project to systematically consider and study human experience and behavior in a manner which does not start from prior theories and assumptions. The slogan of “to the things themselves” evokes the active attempt to set aside the prejudices about what should be and start trying to grasp how something actually is. In psychopathology, it is about the struggle to grasp the nature of experiences prior to their being lost in futile debates about the meanings and definitions of the words used by others to describe those experiences. One of the few things, however, modern philosophers of science seem agreed upon is the impossibility of simply gathering the type of facts which form the scientific discourse without prior assumptions and theories expressed within an agreed language. Whether the phenomenological enterprise can in fact provide a method for a direct confrontation with the objects of the world in general, and human experience in particular, must remain questionable. What is, however, important and potentially liberating for the psychopathologist is that this approach leaves a place for subjective experience and attempts to circumvent, if not overcome, the imposed technologies of examination and classification which weigh down our subject. As a minimum, the phenomenological approach allows a place for genuine curiosity and wonder when confronting the mental experience of our patients.

The term phenomenology is used frequently enough in the current psychiatric literature, but the meanings attached to the term are many and various, including in the area of psychopathology.

1. Phenomenology as the precise definition of psychiatric symptoms. This merges into an operational technology, which lies at the heart of such classifications as the DSM, in which authority constructs and imposes definitions in the name of consistency, reproducibility, and ease of communication. Though, currently, this is probably the commonest usage of the term phenomenology, it is really phenomenology with no connection to phenomenology as a methodology or system of ideas.

2. Phenomenology as a way of describing the experiences and actions of patients. A description in which an attempt is made to approach the accounts given by others, and the observations of them, without imposing preexisting assumptions about significance. The intention is to describe both the subjective world and behavior of the patient in and for themselves. The method is linked to Husserl’s transcendental reduction which in simplistic terms means assuming, for the moment, what is to be described exists in isolation from the rest of the world freed of questions of context, significance, and type. This can then be used in exercises of classification or understanding. It is first and foremost a methodology.

3. Phenomenology which attempts not just to grasp descriptively and empathically the experience of the other but to derive their essential meaning in a process Husserl called eidetic analysis. An analysis that aims to be always rooted in the actual experience of the concrete lived world. This phenomenology is linked to Minkowski’s structural analysis. Here an attempt is made to delineate a generating or basic disturbance of consciousness from which the rest of the abnormalities in the patient’s state derive. A recent example is provided by Stanghellini’s analysis of the lack of commonsense as a basic relational deficit in the schizophrenias.

4. Phenomenology in which the inner world of the other is grasped through an analysis of categories of experience such as of time, space, the materiality of the world, and causality. This Ellenberger termed categorical phenomenology. It is an approach permeated with the arcane language, concepts, and occasional brilliant insights of Heidegger. It does not usually confines itself to descriptions on the way to scientific or clinical understanding but metamorphoses into a joint project between patient and clinician to make meaningful, and transcend, the distress and disorder of their existence.
Thus, phenomenology covers a spectrum from technology, via a methodology, to systems of understanding which merge into psychotherapeutic practices. Phenomenology has even been invoked in the journey to the infernal region of antipsychiatry with its rejection of all categories of madness and notions of diseases of mind. All except the phenomenalist technology make some appeal to the ideas developed within the phenomenological movement in philosophy. The manner in which the ideas and practices of philosophers and psychiatrists interact in the field of phenomenology is, however, far from clear, even in the case of Karl Jaspers who had a foot in both camps.

The Phenomenological Movement

Edmund Husserl (1859–1938) stands at the base of the phenomenological movement which arguably begins with the publication of Logical Investigations. Husserl’s phenomenology is indebted to Brentano (1838–1917), but like most continental philosophers of the period, there are obvious influences from Descartes, Kant, and Hegel. Husserl’s most famous pupil, and his eventual personal nemesis, was Martin Heidegger (1889–1976). Heidegger remains contentious and contaminated because of his active involvement in National Socialism. Whether his Nazi enthusiasm stemmed from the temptations of power, anti-Semitism, or from his philosophical position does not effect this judgement. Through Husserl’s teachings, books, and the editorship of the Jahrbuch für Philosophie und phänomenologische Forschung from 1913, he influenced a whole generation of philosophers. These included Max Scheler (1880–1937), Jean-Paul Sartre (1905–1980), Maurice Merleau Ponty (1908–1961), as well as psychiatrists including Erwin Straus (1891–1954), Kurt Schneider (1887–1967), LudwigBinswanger (1881–1966), and even Jacques Lacan (1901–1981). An excellent introduction to contemporary thought on Husserl is presented by Smith and Smith though sadly psychiatry and psychology attract some appeal to the ideas developed within the phenomenological movement in philosophy. The manner in which the ideas and practices of philosophers and psychiatrists interact in the field of phenomenology is, however, far from clear, even in the case of Karl Jaspers who had a foot in both camps.

Karl Jaspers

Arguably, it was Karl Jaspers of all those influenced by the phenomenological movement who had the greatest influence on psychiatry or at least mainstream psychiatry in the English-speaking world. Jaspers as a philosopher sits more comfortably within the existential tradition than the strictly phenomenological. Nietzsche and Kierkegaard are his most obvious influences, and it is in his exegesis of Nietzsche that one of his most impressive essays in psychopathology is to be found as he struggles to relate the philosopher’s genius to his neurotic and eventually psychotic states.

Jaspers, who began as a law student before qualifying in medicine, presented his dissertation on crime and nostalgia in 1908. This owes its most obvious debt to Max Weber. In 1910, Jaspers’ classic study of morbid jealousy appeared. This illustrates his approach based upon extremely detailed case histories which focus on both the patient’s actions and their inner experiences, drawing together the commonalities between the cases to provide a vivid picture of the phenomena which make up morbid jealousy. The next year saw an article on the psychopathology of schizophrenia. Jaspers then published what amounts to a manifesto for a phenomenological psychopathology, rapidly followed by the first edition of the General Psychopathology.

Jaspers in later life acknowledged the influence of Husserl writing “as a method I adopted Husserl’s phenomenology...although I rejected its further development to insight into essences. [This made it possible] to describe the inner experiences of patients as phenomena of consciousness...so clearly that they became recognizable with certainty in other cases.” Despite such clear acknowledgments of his debt to phenomenological thought, others have found fit to question Husserl’s influence on Jaspers. The General Psychopathology is clearly not simply an exposition of Husserlian ideas and, for better or for worse, Jaspers dissociated himself from the directions phenomenology took in the later
work of Husserl and from most of Heidegger’s ideas.\textsuperscript{39,43} The \textit{General Psychopathology} remains, however, indebted to the phenomenological approach, and parts can only adequately be understood within that philosophical context.\textsuperscript{44,45} Jaspers\textsuperscript{39} linked the phenomenological method to eclecticism in theory and research with an open-minded attempt to “survey all possible pictures without lapsing into any,” (p19) Jaspers invokes a caution verging on scepticism to any systems based on psychopathology alone “as all concepts of this kind are always merely provisional, always “wrong” [but] if they stimulate analysis and lead to finer distinctions they served their purpose” (Quoted in Kolle\textsuperscript{46}). Jaspers seems to envisage a psychopathology and a nosology which is open ended, ever changing, never authoritative, always conscious of its limitations, provisional, and refutable. A psychopathology and a nosology which if it ever is to rest and become a fixed point of reference can only do so when externally validated clinicopathological entities set its boundaries. Even then because these clinicopathological entities manifest through the consciousness of a living person, the complexity of the experience of mental disorder will always escape, to some extent, the psychopathologists attempts to describe and define.\textsuperscript{38} No wonder some of Jaspers colleagues accused him of being a nihilist.\textsuperscript{39}

\textbf{Phenomenological Psychopathology}

Phenomenological psychopathology as a method can be regarded as having 4 distinct, albeit overlapping, stages:

1. Engaging repeatedly with others who share some assumed psychological or behavioral dysfunction (eg, extraordinary beliefs, hearing voices, stalking others, intense jealousy, profound unremitting hopelessness, the label of schizophrenia, etc). Exploring using spontaneous accounts and responses to direct enquiries, their experiences and actions which could be related to their dysfunction either directly, indirectly, or even conceivably. Some favor a structured enquiry as part of the engagement which explores areas of experience which might otherwise pass unregarded or shamefully hidden (eg, related experience of time, distance and direction, reality (materiality), ideas about what causes what, sense of control and agency, evoked fantasy and images, etc).

This enquiry and witnessing attempts to progress without assumptions about whether the accounts reflect pathology, are reasonable, are symptomatic, are accurate or even plausible, reflect unconscious mechanisms, or are useful and relevant. Jaspers attempts a distinction between the form of a psychopathological phenomena which is shared by all like experiences and therefore generalizable and the content which is individual, specific, and productive of theories of meaning but not categories. This distinction is a helpful fiction directing attention to the form of experiences which are indeed critical to any process of recognition and categorization. It remains a fiction, however, given that firstly experience is always about something and their form is only manifest in their content, and secondly, some experiences are pathological because of their content not just their form (eg, Jaspers criteria for the ununderstandability of delusions).

2. Augmenting what emerges from the self-accounts of those with the supposed dysfunction with potentially relevant material from artistic, philosophical, and other cultural sources in an attempt to provide as “rounded” a description as possible. The material “borrowed” in this manner is strictly about the nature of the experiences not their understanding in some intellectual or cultural context. For example, in attempting to grasp the nature of vexatious and querulous litigation, it is revealing and relevant to use Dickens’ descriptions in Bleak House of the experience of being caught up in an unremitting and futile pursuit of justice through the endless Courts of Chancery. What would not be relevant is Dickens’ understanding that what drives the plaintives to madness is a complex legal system designed to enrich lawyers and entrap suitors. This latter theory of causation, however, attractive and personally satisfying, remains strictly outside of phenomenology’s world. Phenomenologists may use not only descriptions of potentially similar phenomena from artistic and biographic material but also conceptual structures deriving from philosophical speculations, psychological studies, and even neurobiological observations.\textsuperscript{47–49}

3. Bringing to the material a degree of imaginative empathy sufficient to grasp potential connections and articulate partially inchoate experience. Empathy is, as Jaspers\textsuperscript{35} warned, only of use if it remains modest and constrained to the task of clarifying. Empathy easily becomes a serious danger to the task of descriptive psychopathology when it moves to understand and make meaningful, thus potentially slipping through the backdoor all the preconceptions, dynamic assumptions, essentialism, and models that were so carefully excluded at the outset.

4. Deriving from the totality of the material a provisional description of all those aspects of experience and behavior which make up a description of the phenomenon. That is, a description of those elements necessary to make this phenomenon what it is and all those elements whose absence is critical to it remaining what it is and not becoming some other.

This stage may not emerge obviously from the material but may require the use of imaginative variation. This involves varying the elements in the description taking them away one by one until the description collapses as an account of the phenomenon or
alternatively adding elements until it metamorphoses into what you believe to be another phenomenon. Clearly, this organization of the data cannot remain entirely innocent. This all too easily becomes an exercise of imposing preexisting assumptions. Thus, bringing the whole exercise down at the final hurdle.

Without such a process of ordering the experiences and behaviour, however, any particular psychopathological phenomenon in a particular person must remain forever unique and incomparable. We as clinicians would be reduced to speaking only of this patient, paralyzed and incapable of generalization or applying external knowledge. The project to describe, classify, and to systematically investigate mental disorder would collapse. Not a few phenomenologically influenced psychiatrists have progressed down exactly this path, declaring madness dead, and psychopathology to exist only in the eye of the beholder.50

5. The final stage is to employ the phenomenological descriptions to inform and direct subsequent examinations and to lay the basis for a provisional classification which then seeks its refutation in the science of systematic enquiry.

It might be objected that when this account is stripped of good intentions and caveats, all that remains is exactly the approaches to clinical examination and psychiatric nosology that this phenomenological method was supposed to counter and improve. Is it differentiated only by the dubious claim to be constantly and self-consciously provisional and tentative? Or worse still, is it only distinguished by the politically correct embracing of refutability? The answer to such objections lies perhaps in the modesty of the phenomenological method which strives to clarify and explore not to create authoritative systems. Unlike today’s operational definitions, phenomenology as a method does not attempt to short cut and substitute for the fruits of genuine scientific enquiry.

Descriptive psychopathology, whether it uses a phenomenological method or not, inevitably involves the imposition of artificial divisions onto what is continuous lived experience. We do not perceive, evaluate, intend, and act, we simply pick out our favorite chocolate from the box. The separations inflicted on experiential reality reflect our prior assumptions about the nature and basis of mental function, eg, that perception, preference, and movement are mediated by distinct, albeit inked, neural process.

To take an example, in exploring and describing an experience, such as the passion of jealousy, it is inadequate to remain at the sufferer’s account of imposed ungovernable reactions, however evocative it may be of that nasty state of mind. Bringing to the descriptive process, the fruits of prior phenomenological explorations may allow a finer elucidation of this individual’s concrete experience. One hypothesis about jealousy suggests that it involves an intentional attitude to another person believed to owe the jealous fealty, who is judged to be, or about to be, unfaithful. The reaction to that apprehended loss involves desires, painful feelings, fantasies, and predispositions to behave. The drama is played out within a cultural and interpersonal context which sets the parameters of all of the separate elements.51,52

Using this model allows an exploration which is finer grained, more likely to evoke a sense in the sufferer of being understood, and potentially links to later therapeutic intervention. It remains, however, just a hypothesis, useful or otherwise. The correspondence of the model to the reported experiences of patient groups and community samples can be systematically evaluated and the model reviewed in the light of such studies.53 What cannot happen as long as one remains true to the phenomenological method is the creation of a category which then defines for all time the experience of jealousy.

A Practical Example

An example of this phenomenological approach enabling our contemporary science to progress where conventional diagnostics had failed would be ideal. In the continuing absence of such an exemplar, an account is provided from our current work with unreasonably persistent complainants.

Our clinic receives referrals from the courts of persistent complainers who, in pursuit of their notions of justice, resorted to threats, stalking, or other forms of violence. The traditional approach centers on evaluating whether or not they have a major mental disorder such as delusional disorder. The difficulties fitting such people into existing definitions of mental disorders are one of the reasons for the clinical disinterest and almost total disappearance of any systematic studies in this area.54 The phenomenological approach ignores diagnostics and focuses on attempting to grasp and describe in each individual what initiated and sustained the problem behavior. The days when journal editors and readers would tolerate detailed clinical case histories are gone, so in its stead a schema of a suitable anonymized case analysis is presented in figures 1 and 2. This man believed the health professionals had abrogated their obligations to him. Obligations constructed from a traditional view of doctors as dedicated agents of the patients interests combined with an exaggerated view of their therapeutic powers. There is in such querulous complainants a remarkable overlap in terms of personality, worldview, self-image, and even personal histories. Most share a zealous commitment to their quest which endows them with an enviable energy marked by elation, enthusiasm, and loquaciousness. The pursuit of justice becomes the core of their being. All combine the expected desire for reparation and/or compensation, with a desire for personal vindication.
Conclusion

The phenomenological approach to psychopathology is riddled with contradictions. To stand in wonder before the world does not obviously relate to programme of establishing generalizable descriptions. Attempting to grasp in a totalizing movement fits ill with projects of separation and organization which in effect produce the reified mental disorders of today’s diagnostic manuals. Husserl’s grandiose project to ground all human sciences in Jaspers’ hands becomes a method to serve the needs of a developing scientific psychiatry. Yesterday’s phenomenological psychopathology is in no small part responsible for the phenomenalism of today’s diagnostic practices. Establishing a basis for generalization and a common language to progress research and clinical practice inevitably struggles to remain self-consciously tentative and provisional in the face of a human need for authority. In practice, there is always a dialectic between the observational/experiential data and the search for, and imposition of, structure and order on that data.

The resolution of the tensions inherent in today’s phenomenological psychopathology in its application to classification can only be resolved externally by establishing clinicopathological entities which will allow transformations of phenomena into simplified symptom signposts. The current dialectic will then be replaced by a new set of contradictions between the presence of the clinicopathological entity and the experience of that disorder in the sufferer. For example the fully characterized variants of today’s major depressions, will continue to manifest through the depressed person who will never be reducible to the disorder which influences and perverts their experience of the world. But this would have become a problem for philosophers, not health professionals. For medicine, it is sufficient to know enough to treat pathology for the benefit of the patient. Reduction is the essence of all science. Defining and classifying allows generalization and systematic study which produces knowledge, which in turn leads to the reductions which allow diagnosis, prognosis, and treatment. For the health professional, phenomenology is a methodological stepping-stone. The problem is that most of today’s psychopathological stepping-stones seem to lead nowhere particularly useful for either medical science or clinical practice. It is psychopathology’s task to seek new paths in the hope not of establishing a new orthodoxy but of making itself irrelevant.

Fig. 1. The Problem Behavior. This unfolded over 5 years. At the time of referral, he was involved in 5 separate legal actions (all self-represented), was picketing 3 establishments, wrote almost daily to newspapers, his M.P. and the Queen, and was attempting to set up a Web site.
Fig. 2. The Unfolding of Querulousness.

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