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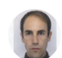
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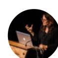
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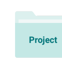

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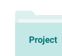

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Disturbances of Embodiment as Core Phenomena of Depression in Clinical Practice

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Keywords
Phenomenology · Standardized diagnosis · Major depressive disorder · Embodiment · Core depression

Abstract
This paper proposes a phenomenological approach to the diagnosis of depression, with the aim of overcoming the broadness and nonspecificity of the concept of major depressive disorder (MDD) in current systems of diagnostic classification of mental disorders. Firstly, we outline the methodological limitations of the current classification systems for the diagnosis of MDD. Secondly, we offer a conceptual differentiation between a "symptomatological" versus a "phenomenological" diagnosis of depression. Thirdly, we propose characteristic "disturbances of embodiment" as the fundamental phenomena of "core depression", which manifest themselves in 3 dimensions: embodied self, embodied intentionality, and embodied time. A more useful diagnosis of depression may be achieved by describing the phenomena that constitute a core depression, in order to avoid the overdiagnosis of MDD and its negative consequences in clinical practice.
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Introduction

According to a recent report from the World Health Organization, depression is the leading cause of disability worldwide and a major contributor to the global burden of disease [1]. In Chile, the burden of disease of unipolar depression represents the second cause of years of work lost in the general population, and the first cause among women 20–44 years old [2]. The lifetime prevalence of depression (major depression plus dysthymia) in men is 9.9% and in 23.4% in women, thus constituting one of the most important public health problems in the nation [3].

Since the middle of the 20th century, several authors have outlined the imprecision of the concept of depression, and consequently stated doubts about the high reported rates of prevalence of this mental disorder [4–7] which may be a consequence of a broad definition of major depression. In fact, major depression is commonly conceived as a heterogeneous condition, and, although classifications differ widely in the number and description of subtypes [8], evidence for a group of an endogenous or "melancholic" depression has been supported [9–14].

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Several authors have directly questioned the concept of major depressive disorder (MDD) [15, 16] in both the Diagnostic and Statistical Manual of Mental Disorders (DSM) [17] and the International Classification of Mental and Behavioural Disorders (ICD) [1]. In recent years, the existence of different forms of depression has been suggested according to the response to antidepressant treatment: (1) "biological disease of depression," responsive to antidepressants, (2) neurotic depression, nonresponsive to antidepressants, and (3) mixed depression (with manic elements), which is nonresponsive to antidepressants and responsive to antipsychotics [18, 19].

When the diagnosis is made at the primary health care level, the general practitioner usually prescribes an antidepressant. However, antidepressants can have important side effects, including drowsiness, weight gain, tremor, constipation, sexual dysfunction, etc. They may even increase the risk of breast cancer [20] and have been found to be carcinogenic in animal studies [21]. Therefore, a wide concept of depression does not only mean unnecessary costs for the health care systems, but also iatrogenic morbidity and possibly mortality, so a narrower, more valid concept could imply substantial public health gains.

In this paper, we present the hypothesis that the concept of MDD [1, 17] is unspecific because the lists of symptoms that compose the diagnostic criteria in the current classifications fail to grasp the "core phenomenon" of depression [5]. We propose that the latter implies "disturbances of embodiment," which could serve as a more valid basis for the diagnosis of a "core depression," in order to distinguish it from other forms of depression, as seen in other pathological entities – such as depression in personality disorders or schizophrenic or epileptic depression – or in normal mood variations. This argument derives from empirical studies, clinical experience, and the phenomenological approach to the diagnosis [7, 5, 22–30].

The classical authors from the continental European tradition in psychopathology, such as Kraepelin [31] and Bleuler [32], the very founders of scientific psychiatry, already considered the disturbances of corporeality as fundamental phenomena of depression. Kurt Schneider's [33] description of the disturbance of "vital feelings" as the core phenomenon of depression is another example of the importance of bodily experience in this illness. Other authors who have approached the subject from a more empirical perspective have also found disturbances of corporeality to be a key feature of depression. In the mid-1960s, Pfeiffer [4] carried out a long-term, transcultural study, in which he compared depression in patients from Germany and Indonesia. He found that there were only 3 main symptoms of the disorder which are always present and independent of the type of civilization or culture: (1) the shift of mood "toward the depressive pole" ("hard to define"), (2) the presence of abnormal bodily sensations, and (3) the alteration of vegetative functions, such as sleep and appetite. This implies that all the fundamental manifestations of depression are closely related to corporeality. In the last decades, phenomenological psychiatrists have pointed to disturbances of embodiment in depression [34–43]. Recently, mainstream psychiatry has also paid more attention to the strong link between major depression and somatic symptoms [44–46], and especially between major depression and physical pain like stomach pains and headache [47, 48].

Regardless of the research and clinical evidence, the importance of changes in the experience of corporeality in depression has not yet been appropriately recognized by the current classification and diagnostic systems. The fifth edition of the DSM [17] makes only an indirect reference to bodily experience in 2 of its 9 diagnostic criteria: the 1st "depressive mood" and the 6th "fatigue or energy loss." We find a more direct reference to the body in the category "weight increase or decrease" (the 3rd criterion), but in a rather unspecific way. The ICD-10 [1] does not sufficiently acknowledge the importance of the experience of corporeality in depression either, and its description of depression outlines symptoms belonging rather to the cognitive sphere, such as a lack of concentration and self-esteem, notions of guilt, and a pessimistic vision of the future.

Methodological Limitations of the Classification Systems in the Diagnosis of MDD

Current systems of classification and diagnosis, such as DSM-5 [17] and ICD-10 [1] follow a categorical model. They confirm or reject the presence of a mental disorder based on a number of signs and/or symptoms previously defined by consensus. DSM-5 requires the fulfilment of 3 general criteria: (1) the presence of ≥5 of a series of 9 symptoms for a period of at least 2 weeks; (2) that these symptoms cause a certain degree of impairment in social, occupational, or other important areas of functioning, and (3) that they are not attributable to the effects of a substance or medical condition. The 9 symptoms are: depressed mood, markedly diminished interest or pleasure in almost all activities, weight loss/gain or decrease/

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increase in appetite, insomnia or hypersomnia, retardation or psychomotor agitation, fatigue or loss of energy, feelings of worthlessness or guilt, a diminished ability to think or concentrate and indecisiveness, and, finally, suicidal ideation with/without a specific plan. One of the first 2 symptoms, i.e., depressed mood or inability to experience pleasure, should always be present. In the ICD-10, a distinction is made between 3 core symptoms, at least 2 of which have to be present for a period of at least 2 weeks (depressive mood, loss of interest and enjoyment, and reduced energy and diminished activity), and 7 associated symptoms, that are not necessarily present, such as diminished capacities of attention and concentration, diminished self-esteem, ideas of guilt or worthlessness, pessimism with respect to the future, suicidal ideas or acts, sleep alteration, and loss of appetite. In addition, ICD-10 distinguishes 3 degrees of major depressive episode: mild, moderate, and severe.

DSM and ICD diagnostic and classification systems have methodological limitations and differ from approaches used in classical psychopathology:

1. They suggest that psychiatric symptoms are "objective" and measurable as in somatic medicine, but most of them are subjective manifestations expressed in very different forms depending on the idiosyncrasy of the patient. The expressions "I feel depressed" or "I feel anxious" can mean many different things. In the patient-clinician relationship, the encounter of subjectivities, the symptoms acquire their real semiological value.
2. Categorical systems assume that mental disorders are entities in themselves, and are consequently verifiable (as in somatic medicine). They try to be more "scientific" and attempt to overcome the lack of substrate with "strict" definitions as to the number of symptoms required. In contrast, the phenomenological approach conceives mental disorders as "ideal types," which was originally postulated by Jaspers [49], and updated in the last decades by Schwartz et al. [50–52], assuming that psychopathological syndromes generally do not have a biological substrate on which the diagnosis is based.
3. Operational systems try to minimize the subjectivity of the observer. They are based on a philosophy of science that aims at objective knowledge, in the sense of being intersubjectively certifiable independently of individual opinion or preference, on the basis of data obtainable via suitable experiments or observations [53]. In contrast, phenomenological approaches make use of the subjectivity of the observer. For example, clinicians frequently make the diagnosis of mental disorders within the first 5 min of interviewing a patient [54, 55], which shows the importance of the clinician's intuition. In 1942, Rümke [56] described the "praecox feeling" in schizophrenia, and in 1980, Doerr-Zegers and Tellenbach [30] the "melancholy feeling" in depression.
4. The diagnostic and classification systems reduce the description of a clinical picture to a number of manifestations that generally oscillates between 7 and 10. This arbitrary definition causes the list of diagnostic criteria to always be incomplete. For example, the Hamilton Scale [57] has 21 symptoms or "criteria," but there could also be more if the clinician registers all the symptomatology referred by a large number of patients [7]. On the other hand, DSM and ICD do not mention anxiety as a symptom of depression whereas clinical experience and empirical studies [4, 58–60] show that anxiety is almost always present.
5. Among the 9 criteria listed in DSM-5, some may be infrequent in non-Western cultures [4, 7, 61]. Although the DSM-5 has improved its international compatibility compared to previous versions and aims for cultural sensitivity [62], transcultural manifestations of depression are still insufficiently acknowledged. Infrequency or absence of symptoms in certain cultures may cause a shifting of the threshold to diagnose depression in those cultures.
6. Finally, the relationship between the listed criteria is only one of contiguity: they are put beside each other without any form of ranking between, as if all 9 are equally important and frequent. If one were to acknowledge the different frequency and importance of the symptoms for diagnosing depression, then a hierarchy and weights of symptoms for the diagnostic process should exist.

Symptomatological versus Phenomenological Diagnosis of Depression

We suggest that the current symptomatological diagnostic criteria of MDD could become more valid by incorporating a phenomenological approach to the diagnosis of depression. By phenomenology, we do not refer to the behaviorist approach of consciousness in the third-person perspective (known as heterophenomenology [63]) according to the amalgam as used in DSM, where phenomenology functions as a synonym of symptomatology [17]. We rather refer to the concept of phenom-

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enology as a descriptive science of embodied consciousness in the first-person perspective and, more specifically, to the Husserlian concept of phenomenology [49, 64–69].

Phenomenological psychiatrists have referred to the relevance of the distinction between symptom and phenomenon [5, 30, 70–72], especially since this may serve as the basis for the elaboration of the so-called phenomenological diagnosis [73, 74]. This distinction between symptom and phenomenon traces back to Heidegger's [75] transcendental ontology, but it is already implicitly present in the Husserlian delimitation of the phenomenological conception of phenomenon, in contrast to the positivistic concept of sense data. Moreover, our phenomenological approach to diagnosis is framed in Husserl's mereological method. Husserl's basic idea is that the phenomenon is both a holistic structure and a co-constituted reality [76].

While the current symptomatological diagnosis begins with a checklist of atomistic symptoms, the phenomenological diagnosis takes the phenomenon as the starting point, which appears from the beginning as a holistic structure, a sort of gestalt. Thus, the phenomenological diagnosis takes the exact opposite direction as the standardized one: it does not develop from elementary entities (symptoms) towards a nosological configuration or syndrome, but rather starts from a complex structure (phenomenon), from which the single symptoms may be unfolded. In this way, the symptoms can only be described through the analysis or decomposition of the holistic phenomenon, as parts of the same whole. Thus, among the advantages of the phenomenological diagnosis is that it takes into account, on the one hand, both the inner relation between the phenomenon and the symptoms, and the immanent interconnection between the symptoms, on the other.

The relationship of contiguity between isolated symptoms was identified as a methodological limitation in the current diagnostic manuals of MDD. By building on the terminological resources of the mereological theory of whole and parts [76–78], single symptoms, which we can access through the phenomenological diagnosis, are the abstract result of the analysis of a whole phenomenon. They are not "independent parts" or "pieces," which are isolated and contiguous, as in the symptomatological diagnosis. They are rather "dependent parts" or "moments" structurally interconnected within a whole phenomenon. In contrast to the concept of symptom, which designates a neutral and objective measure, the phenomenological concept takes into account the intersubjective dimension in the diagnostic process. The phenomenon is, by definition, experienced/co-constituted by the patient and clinician; it corresponds to the patient's self-experience and includes the way the patient's experience is lived by the clinician [79, 80].

The phenomenological diagnosis of depression proposed in this paper is based on the notion of "ideal type," which forms a comprehensive system with interrelated aspects. This offers an effective way to unify various forms of diagnostic classification, useful in clinical treatment and empirical research [49–52]. Mental disorders without an organic basis are not entities per se, but configurations or forms of psychopathological "reality" which the clinician cannot sufficiently access by either quantitative methods or consensus, only with phenomenological "intuition" [30, 54–56].

"Disturbances of Embodiment" as Fundamental Phenomena of Depression

Embodiment is a key paradigm of recent interdisciplinary approaches in the areas of philosophy, psychology, psychiatry, and neuroscience. It is primarily departing from the phenomenological distinction between the "lived-body" and the physical or corporeal body, or body subject and body object. The lived-body is the body experienced "from within," the own experience of one's body tacitly given in the first-person perspective. The physical body corresponds to the body thematically investigated "from without," or from a third-person perspective, e.g., by natural sciences such as anatomy and physiology [66]. The lived-body is the body that one "is" while the physical body is the body that one "has" [81]. Thus, disturbances of embodiment in MDD do not refer to impairment on an organic or biological level, but rather to the alteration in the experience of one's own body and how this experience affects the other through the "expressive body." [82]

Within the phenomenological paradigm, disturbances of embodiment have been described in depression and schizophrenia; in both cases, there is an "objectification" of the bodily experience. In these conditions, rather than being tacit and transparent, the body takes on layers of opacity, and no longer serves as a medium of one's involvement in the world [38]. In schizophrenia, patients lose the sense of "personally belonging" [49] to their embodied experiences and do not experience their body as their own, rather experiencing it from without, as an object, losing its first-person mode of presentation [83, 84]. The characteristic of disturbances of embodiment in schizophrenia has been called "disembodiment" [38, 79,

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85]. In contrast, in depression, patients conserve the sense of their body as their own. They also experience their body as an object, but from within, as their own objectified body. The characteristic of disturbances of embodiment in depression has previously been called "chrematization" [30] and "corporealization" [86, 87]. "Chrematization" is derived from the Greek chrema, which denotes "thing" (or in German "das Ding" [Latin, *res*], meaning reification or objectification). This phenomenon in depression corresponds to the "bodily devitalization," i.e., the diminishment of the body's feeling of being alive or being able, which manifest to different degrees, culminating in melancholic stupor and nihilistic delusions, as in cases of Cotard's syndrome.

We propose characteristic disturbances of embodiment as the fundamental phenomena of core depression, which manifests in 3 fundamental dimensions: embodied self, embodied intentionality, and embodied time. This hypothesis is based on the empirical studies on depression carried out at the beginning of the 1970s in Chile [7], which were later elaborated on [22–30]. Following up on this previous research, we suggest that depression, including the symptoms listed in the DSM, ICD, and Hamilton Scale as well as many others symptoms observed in clinical practice, is composed of 5 fundamental phenomena. Three correspond to disturbances of embodiment, all present in what we would call core depression. The other 2 dimensions imply cognitive phenomena which are not always present, with variations depending on cultural factors [4, 7, 61].

The 1st fundamental phenomenon constituting a disturbance of embodiment is the alteration of the subject's relationship with his own body. It is a disturbance of the sensitivity (the way of finding or feeling oneself in one's own body), "die Befindlichkeit" in German, as used in classical psychopathology [88] and anthropological medicine [89]. The symptoms belonging to this dimension, together with the alteration of the biological rhythms (the 3rd phenomenon), have been considered by the classical and the contemporary authors as the essential disturbances of the illness [4, 7, 22, 25, 26, 30, 88]. From the patient's perspective, the change in the experience of their own body is shown in multiple forms, among which depressed mood (the 1st DSM criterion) and energy loss (the 6th DSM criterion) represent only part of the complex phenomenon. Patients complain of many of these symptoms, which are all interconnected since they are all manifestations of the alteration of "Befindlichkeit": anxiety, heaviness of limbs, pain in several parts of the body, precordial oppression, the classic globus melancholicus, feeling cold or nauseous, etc. Alterations of self-embodiment can also be observed by the clinician: paleness, an opaque gaze, expressions of anxiety and helplessness, omega melancholium forehead wrinkles, eyelids with Veraguth folds, the slumping of the body as a whole, etc.

The 2nd phenomenon corresponds to the alteration of the relationship of the subject with the world, which can be described as a disturbance of the patient's embodied affective intentionality. This is usually characterized as an inhibition, which is subjectively lived by the patient as a generalized inability, the incapacity to feel pleasure and/or any feelings at all. Binswanger [90] considered this phenomenon as the essence of depression and called it "not-being-able to" ("das Nicht-Können" in German) and Bleuler [32] called it an "alteration of the centrifugal functions" (i.e., the functions that connect us with the environment). Patients complain of not being able to pay attention during conversations or to concentrate when reading, that they forget things, find it difficult to decide and begin things, and that even the simplest things seem difficult for them, etc. Such manifestations were labeled by Mayer-Gross et al. [91] as "generalized insufficiency of all mental activities." This phenomenon of embodied intentionality can be objectively observed by the clinician as a general slowdown, which presents with diminished facial expression, a slowing of body movements, a tendency to remain static, latency of responses, lowering of the tone of voice, etc. It is important to note that inhibition does not only refer to an inability to act, but also to feel pleasure, pain, or any emotion at all. So inhibition is not only a pragmatic "I cannot," but at the same time an affective "I cannot," and finally a more fundamental embodied "I cannot," since one acts and feels through one's body. Thus, depressive inhibition does not primarily concern the cognitive level or the psychomotor system (which is also present in Parkinson disease and in paralysis, for instance), but rather the lived-body. From the clinician's perspective, this disturbance of embodied intentionality may appear through a specific missing of the patient's bodily resonance in the context of an intercorporeal and interaffective dialogue during the diagnostic process [39].

The 3rd phenomenon corresponds to alterations of embodied time, and it manifests as disturbances of biological rhythms. These are altered, inverted, or suspended. The sleep-wake rhythm is altered (insomnia and, less frequently, hypersomnia), appetite (loss, and occasionally excess), digestion (often constipation, sometimes diarrhea) and libido (generally diminuition, but, infrequently, an increase is observed). An example of an inversion of a biological rhythm occurs with circadian rhythms:

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energy loss or fatigue is more intense in the morning than in the evening, i.e., the opposite of in healthy people. Another example of inversion may be seen in patients who are still able to work and feel worse on weekends. Examples of suspension of rhythmicity are amenorrhea, and, above all, the disappearance of the rhythmic character of emotions. Human emotions are transitory and do not depend on the will. In depression, emotions (generally those of a negative tonality) persist for hours, days, and weeks. This is most pronounced in agitated depression. This third phenomenon can only be partially observed by the clinician, e.g., in the persistence of anxiety and agitation.

The 4th fundamental phenomenon of depression is constituted by delusional ideas, with the classic themes of being guilty, poor and ill. They are not reducible to the previous 3 fundamental phenomena, because they imply a cognitive and not a bodily level. Their frequency varies across different cultures. The same occurs with the 5th and last fundamental phenomenon, suicidal ideation and/or suicidal attempts. These are not necessarily present in core depression.

Therefore, we propose basing the diagnosis of core depression on the first 3 fundamental dimensions of embodiment, all of which must always be present, although the various symptoms associated with each may not all be present. Thus, it is not a matter of adding and subtracting supposedly "objective" symptoms or criteria, such as insomnia, an incapacity to experience pleasure or fatigue, but to grasp the phenomena that are behind the symptoms and which, in turn, contain them.

Discussion

In this paper, we propose a phenomenological approach to the diagnosis of depression which may serve to reduce the broadness and nonspecificity of the construct of MDD in the current diagnostic classifications [1, 17]. Depression may be described and diagnosed using core phenomena. This could contribute to reducing the frequency of the diagnosis in clinical practice, relate to savings in health service systems, and avoid adverse drug reactions due to the overuse of antidepressant drugs. This approach could be useful to delineate a more valid construct for clinical practice and research.

We propose 3 fundamental phenomena involving "embodiment"; all 3 have to always be present for a diagnosis of core depression. This does not suggest that the criteria of DSM-5 and ICD-10 are not reliable or not useful. The approach that we propose can be complementary and add validity to the construct. The symptoms listed in the classifications and scales correspond to manifestations of depression, and consequently belong to 1 of the 5 fundamental phenomena. The phenomenological approach to depression does not limit us to a determined number of symptoms; it rather embraces all the possible manifestations of the disorder. For example, criterion 1 (depressed mood) and criterion 6 (energy loss) correspond to the relationship of the subject to his own body. Criteria 2, 5, and 8 (incapacity to experience pleasure, retardation, and diminished ability to concentrate) correspond to the altered body-world relationship. Criterion 3 (loss of appetite) and criterion 4 (insomnia) correspond to the alteration of the relationship between the body and time. We propose that criteria 7 and 9 of DSM-5 (i.e., feelings of guilt and suicidal ideas), which are not directly related with disturbances of embodiment, are not fundamental for diagnosis because they may not always be present in core depression.

Our proposed approach also has limitations and weaknesses. The diagnosis of depression may depend on the experience and type of training of the clinician. It may thus be less reliable than counting symptoms, but it can add validity to the construct. The line between depression and nondepression remains difficult. We assume that our approach leads to a narrower construct of depression, but further empirical study will have to show this. The differentiation between depression and nondepression has also proved to be an important fault of current classifications that cannot be corrected by symptom counts and functional criteria. The description of typical bodily experiences in depression listed as possible alterations of "Befindlichkeit" in the first fundamental phenomenon may appear vague. However, the vagueness in this description corresponds to the vagueness and variability of the bodily experiences of the patients themselves.

The phenomenological approach to depression is not categorical [1, 17], dimensional [92–94], or a combination of the two [16]. Rather, it is based on the notion of "ideal types" [49–52]. We have indirectly opposed the view that depression is a continuous nosological category, i.e., a quantitative deviation from "normal" affective experience. Our approach supports the position of the current diagnostic systems that depression is a qualitatively distinct disorder. However, depression may not be a discrete category [95]. We argue that core depression is not a mere "subtype" of MDD, but a holistic construct or "ideal type" [49–52] that may be useful for clinical practice and research.

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Positivistic paradigms in psychiatry and the subsequent establishment of classification systems aim to be more "scientific." They have excluded subjectivity, with serious consequences for the validity of psychiatric diagnoses, empirical research, and psychotherapeutic interventions [96]. In this context, we show the importance of reincorporating the patient's subjective experiences as well as the viewpoint of the clinician who observes the phenomenon and establishes the diagnosis [22, 39, 55, 79, 80]. Nevertheless, whereas most psychiatrists implicitly include such phenomenological data in clinical diagnosis and decision-making, it cannot be assumed that all clinicians have this intuitive skill to recognize and typify their patients in the proposed way to a similar degree. Thus, this diagnostic approach will require further conceptualization, standardization, and clinical guidance. We consider that the phenomenological experience of the clinician has a diagnostic value, e.g., symptoms like "fatigue or loss of energy nearly every day," "feelings of worthlessness or excessive or inappropriate guilt," are not symptoms of MDD per se, but they have diagnostic relevance if, and only if, they appear in the more holistic context of the clinician's intuition of a disturbance of embodiment. Otherwise, these symptoms are not meaningful for the diagnosis. They may also manifest in other disorders or may be found in normal mood variations. For instance, the clinician could observe, in the opaque gaze of his patient, a characteristic disturbance of embodiment, common in patients suffering from depression. Such phenomena, which are not objectively given like symptoms, but only appear through the experience of the psychiatrist, are excluded from a manualized diagnosis, but they have a fundamental diagnostic value, as pointed out by phenomenological psychiatrists [5, 30] and empirical research [54, 80]. Further conceptualization and clinical research are needed in order to test the reliability and validity of our proposed phenomenological approach. Evaluating the subjective experiences of clinicians during the diagnostic process could be included in future clinical research paradigms, addressing not only the experiences of patients but also with a novel intent to describe this phenomenon from the perspective of the clinicians.

Finally, phenomenological psychopathology usually describes general structures of experience such as temporality, spatiality, corporeality, and intersubjectivity, and their disturbances in mental disorders [69]. For instance, Viktor von Gebsattel [97], in 1928 (reedited in 1954), was the first author to describe the structural dimension of temporality in depression. Only a few classical and modern authors have made contributions to this subject; among them are Erwin Straus [98] and, recently, Kevin Aho [99]. These authors more or less coincide in considering the standstill of the internal time ("the immanent time of becoming" [97] in von Gebsattel's words) as the essential phenomenon of depression, with the consequent disappearance of the future. We are aware that the 3 basic phenomena described as core depression, although manifesting on a clinical level, derive from this specific disturbance of temporality. However, it was not the intention of this paper to expand descriptions of general structures of experience, but rather to contribute to the development of specific diagnostic tools for improving clinical practice.

Disclosure Statement

There are no conflicts of interest.

References

1 World Health Organization: The ICD-10 Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva, World Health Organization, 2012.

2 Ministerio de Salud (Minsal): Informe final estudio de carga de enfermedad y carga atribuible. Santiago, Minsal, 2007.

3 Vicente PB, Rioseco SP, Saldivia BS, Kohn R, Torres PS: Estudio chileno de prevalencia de patología psiquiátrica (DSM-III-R/CIDI) (ECPP). Rev Med Chile 2002;130:527–536.

4 Pfeiffer WM: Die Symptomatik der Depression in transkultureller Sicht; in Hippius H, Selbach H (eds): Das depressive Syndrom. München/Berlin/Wien, Urban & Schwarzenberg, 1968, pp 151–167.

5 Tellenbach H: Melancholie, ed 4. Berlin/Heidelberg/New York, Springer, 1983.

6 Lehmann HE: Epidemiology of depressive disorders; in Revie (ed): Depression in the 70s: Modern Theory and Research. Princeton, Excerpta Medica, 1971, pp 21–31.

7 Doerr-Zegers O, Enríquez G, Jara C: Del análisis clínico-estadístico del síndrome depressivo a una comprensión del fenómeno de la depressividad en su contexto etiopatogénico. Rev Chil Neuro-Psiquiat 1971;10:17–39.

8 Haslam N, Beck AT: Subtyping major depression: a taxometric analysis. J Abnorm Psychol 1994;103:686–692.

9 Ambrosini P, Bennett D, Cleland CM, Haslam N: Taxonicity of adolescent melancholia: a categorical or dimensional construct? J Psychiatr Res 2002;36:247–256.

10 Grove WM, Andreasen NC, Young M, Endicott J, Keller MB, Hirschfeld RMA, Reich T: Isolation and characterization of a nuclear depressive syndrome. Psychol Med 1987;17:471–484.

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200.89.68.20 - 8/16/2017 3:50:26 PM

11 Harris M, Farquhar F, Healy D, LeNoury J, Baker D, Whitaker C, Linden S, Green P, Roberts AP: The incidence and prevalence of admissions for melancholia in two cohorts (1875–1924 and 1995–2005). J Affect Disord 2011;134:45–51.
12 Parker G: A case for reprising and redefining melancholia. Can J Psychiatry 2013;58:183–189.
13 Healy D: Melancholia: past and present. Can J Psychiatry 2013;58:190–194.
14 Parker G, McCraw S, Blanch B, Hadzi-Pavlovic D, Synnott H, Rees AM: Discriminating melancholic and non-melancholic depression by prototypic clinical features. J Affect Disord 2013;144:199–207.
15 Parker G: Through a glass darkly: the disutility of the DSM nosology of depressive disorders. Can J Psychiatry 2006;51:879–886.
16 Cole J, Mcguffin P, Farmer AE: The classification of depression: are we still confused? Br J Psychiatry 2008;192:83–85.
17 American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, ed 5: DSM-5. Washington, American Psychiatric Publishing, 2013.
18 Ghaemi SN, Voehringer P: The heterogeneity of depression: an old debate renewed. Acta Psychiatr Scand 2011;124:497.
19 Ghaemi SN, Voehringer P, Whitham EA: Antidepressants from a public health perspective: re-examining effectiveness, suicide, and carcinogenicity. Acta Psychiatr Scand 2013;127:89–93.
20 Cosgrove L, Shi L, Creasey DE, Anaya-McKivergan M, Myers JA, Huybrechts KF: Antidepressants and breast and ovarian cancer risk: a review of the literature and researchers' financial associations with industry. PLoS One 2011;6:e18210.
21 Sternbach H: Are antidepressants carcinogenic? A review of preclinical and clinical studies. J Clin Psychiatry 2003;64:1153–1162.
22 Doerr-Zegers O: Análisis fenomenológico de la depresividad en la melancolía y en la epilepsia. Actas Luso Esp Neurol Psiquiatr Cienc Afines 1979;7:291–304.
23 Doerr-Zegers O: Über melancholische und epileptische Depressivität; in Tellenbach H (ed): Psychiatrie als geistige Medizin. München, Verlag für Angewandte Wissenschaften, 1987, pp 90–96.
24 Doerr-Zegers O: Depresión, endogenidad y corporalidad. Rev Neuro-Psiquiatría 1992;55:237–253.
25 Doerr-Zegers O: Fenomenología de la corporalidad depresiva. Salud Ment 1993;16:22–30.
26 Doerr-Zegers O: El cambio de la corporalidad y su importancia para la determinación de un síndrome depresivo fundamental o nuclear. Rev Psiquiatría Fac Med Barna 1993;20:202–212.
27 Doerr-Zegers O: Psiquiatría antropológica: Contribuciones a una psiquiatría de orientación fenomenológico-antropológica. Santiago de Chile, Editorial Universitaria, 1995.
28 Doerr-Zegers O: Fenomenología de la corporalidad en las grandes psicosis; in Rovaletti LM (ed): La problemática del tiempo en el pensamiento actual Buenos Aires. Buenos Aires, Oficina de Publicaciones Universidad de Buenos Aires, 1996, pp 303–314.
29 Doerr-Zegers O: Fenomenología de la corporalidad en la depresión delirante. Salud Men 2002;25:1–9.
30 Doerr-Zegers O, Tellenbach H: Differentialphänomenologie des depressiven Syndroms. Nervenarzt 1980;51:113–118.
31 Kraepelin E: Einführung in die Psychiatrische Klinik. Leipzig, Johann Ambrosius Barth, 1916, p 359.
32 Bleuler E: Lehrbuch der Psychiatrie (umgearbeitet von Manfred Bleuler), ed 13. Berlin/Göttingen/Heidelberg, Springer, 1975.
33 Schneider K: Psychopathic personalities, ed 9 (transl. by Hamilton MW). London, Cassel, 1958.
34 Fuchs T: Leibliche Kommunikation und ihre Störungen. Z Klin Psychol Psych 1996;44:415–428.
35 Fuchs T: Das Gedächtnis des Leibes. Phänomenologische Forschungen 2000;5:71–89.
36 Fuchs T: Melancholia as a desynchronization. Towards a psychopathology of interpersonal time. Psychopathology 2001,34:179–186.
37 Fuchs T: The challenge of neuroscience: psychiatry and phenomenology today. Psychopathology 2002;35:319–326.
38 Fuchs T: Corporealized and disembodied minds. A phenomenological view of the body in melancholia and schizophrenia. Philos Psychiatry Psychol 2005;12:95–107.
39 Fuchs T: Depression, intercorporeality and interaffectivity. J Conscious Stud 2013;20:219–238.
40 Fuchs T: Psychopathology of depression and mania: symptoms, phenomena and syndromes. J Psychopathol 2014;20:404–413.
41 Fuchs T, Schlimme JA: Embodiment and psychopathology: a phenomenological perspective. Curr Opin Psychiatry 2009;22:570–575.
42 Stanghellini G: Disembodied spirits and deanimated bodies: the psychopathology of common sense. Oxford, Oxford University Press, 2004.
43 Ratcliffe M: Feelings of being. Phenomenology, psychiatry and the sense of reality. Oxford, Oxford University Press, 2008.
44 Simon GE, VonKorff M, Piccinelli M, Fullerton C, Ormel J: An international study of the relation between somatic symptoms and depression. N Engl J Med 1999;341:658–659.
45 Denninger JW, Papakostas GI, Mahal Y, Merens W, Alpert JE, Nierenberg AA, Yeung A, Fava M: Somatic symptoms in outpatients with major depressive disorder treated with fluoxetine. Psychosomatics 2006;47:348–352.
46 Trivedi MH: The link between depression and physical symptoms. Prim Care Companion J Clin Psychiatry 2004;6:12–16.
47 Lépine JP, Briley M: The epidemiology of pain in depression. Hum Psychopharmacol 2004;19:3–7.
48 Beverly K, Shailesh J, Trivedi MH: Depression and pain. Implications for symptomatic presentation and pharmacological treatments. Psychiatry (Edgmont) 2005;2:12–18.
49 Jaspers K: General Psychopathology (transl. by Hoenig J, Hamilton MW). London, Johns Hopkins University Press, 1997.
50 Schwartz MA, Wiggins OP: Diagnosis and ideal types: a contribution to psychiatric classification. Compr Psychiatry 1987;28:277–291.
51 Schwartz MA, Wiggins OP, Norko M: Prototypes, ideal types, and personality disorders: the return to classical psychiatry. J Pers Disord 1989;3:1–9.
52 Schwartz MA, Wiggins OP, Norko M: Prototypes, ideal types, and personality disorders: the return to classical phenomenology; in Livesley WJ (ed): The DSM-IV Personality Disorders. New York, Guilford Press, 1995, pp 417–432.
53 Hempel CG: Aspects of scientific explanation and other essays in the philosophy of science. New York, Free Press, 1965.
54 Gauron EF, Dickinson JK: The influence of seeing the patient first on diagnostic decision making in psychiatry. Am J Psychiatry 1969;126:199–205.
55 Kendell RE: The role of diagnosis in psychiatry. Oxford, Blackwell, 1975.
56 Rümke HC: Das Kernsymptom der Schizophrenie und das "Praecox Gefühl." Zentralbl Gesamte Neurol Psychiatr 1942;102:168–175.
57 Hamilton M: Rating depressive patients. J Clin Psychiatry 1980;41:21–24.
58 Merikangas KR, Angst J, Eaton W, Canino G, Rubio-Stipec M, Wacker H, Wittchen HU, Andrade L, Essau C, Whitaker A, Kraemer H, Robins LN, Kupfer DJ: Comorbidity and boundaries of affective disorders with anxiety disorders and substance misuse: results of an international task force. Br J Psychiatry 1996;168:58–67.
59 Kessler RC: The prevalence of psychiatric comorbidity; in Wetzler S, Sanderson WC (eds): Treatment Strategies for Patients with Psychiatric Comorbidity. New York, John Wiley & Sons, 1997.
60 Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS: The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA 2003;289:3095–3105.
61 Heerlein A, Doerr-Zegers O: Transkulturelle Aspekte der depressiven Erkrankungen; in Holm-Hadulla RM, Draguhn A (eds): Die vielen Gesichter der Depression. Heidelberg, Universitätsverlag, 2015.
62 Regier DA, Kuhl EA, Kupfer DJ: The DSM-5: classification and criteria changes. World Psychiatry 2013;12:92–98.
63 Dennett D: Consciousness Explained. London, Penguin, 1991.
64 Husserl E: Erfahrung und Urteil. Hamburg, Meiner, 1939.

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65 Husserl E: Ideen zu einer reinen Phänomenologie und phänomenologischen Philosophie. 1. Den Haag, Martinus Nijhoff, 1950.
66 Husserl E: Ideen zur einer reinen Phänomenologie und phänomenologischen Philosophie. 2. Den Haag, Martinus Nijhoff, 1952.
67 Husserl E: Logische Untersuchungen, Den Haag, Martinus Nijhoff, 1975.
68 Merleau-Ponty M: Phénoménologie de la perception. Paris, Gallimard, 1945.
69 Gallagher S, Zahavi D: The phenomenological mind, ed 2. New York, Routledge, 2012.
70 Hofer G: Phänomen und Symptom. Nervenarzt 1954;25:342–344.
71 Haefner H: Symptom und Diagnose; in Stolze H (ed): Arzt im Raum des Erlebens. München, Lehmann, 1959, pp 29–39.
72 Blankenburg W: Aus dem phänomenologischen Erkrankungsfeld innerhalb der Psychiatrie (unter Berücksichtigung methodologischer Fragen). Schweizer Archiv Neurol Psychiatrie 1962;90:412–421.
73 Tatossian A: Symptômes cliniques et structures phénoménologiques. Psychiatries 1978; 35:45–52.
74 Kraus A: How can the phenomenological-anthropological approach contribute to diagnosis and classification in psychiatry?; in Fulford B, Morris K, Sadler JZ, Stanghellini G (eds): Nature and Narrative: An Introduction to the New Philosophy of Psychiatry. Oxford, Oxford University Press, 2003, pp 199–216.
75 Heidegger M: Sein und Zeit. Tübingen, Max Niemeyer, 1927.
76 Palette V: Evidence as norm of normativity in perception; in Doyon M, Breyer T (eds): Normativity in Perception, New Directions in Philosophy and Cognitive Science. New York, Palgrave Macmillan, 2015, pp 196–208.
77 Stumpf C: Über den psychologischen Ursprung der Raumvorstellung. Leipzig, Hirzel, 1873.
78 Brentano F: Deskriptive Psychologie. Hamburg, Meiner, 1882.
79 Fuchs T: Phenomenology and psychopathology; in Gallagher S, Schmicking D (eds): Handbook of Phenomenology and the Cognitive Sciences. Dordrecht, Springer, 2010, pp 547–573.
80 Pallagrosi M, Fonzi L, Picardo A, Biondi M: Assessing clinician's subjective experience during the interaction with patients. Psychopathology 2014;47:111–118.
81 Marcel G: Etre et Avoir. Paris, Montaigne, 1955.
82 Zutt J: Aus dem Weg zu einer anthropologischen Psychiatrie. Berlin/Göttingen/Heidelberg, Springer, 1963.
83 Parnas J, Moeller P, Kircher T, Thalbitzer J, Jannson L, Handest P, Zahavi D: EASE: Examination of anomalous self-experience. Psychopathology 2005;38:236–258.
84 Irarrázaval L: The lived body in schizophrenia: transition from basic self-disorders to full-blown psychosis. Front Psychiatry 2015; 6:9.
85 Stanghellini G: Embodiment and schizophrenia. World Psychiatry 2009;8:56–59.
86 Fuchs T: Psychopathologie von Leib und Raum. Phänomenologisch-empirische Untersuchungen zu depressiven und paranoiden Erkrankungen. Darmstadt, Steinkopff, 2000.
87 Fuchs T: The phenomenology of shame, guilt and the body in body dysmorphic disorder and depression. J Phenomenol Psychol 2002; 33:223–243.
88 Berner P, Gabriel E, Katschnig H, Kieffer W, Koehler K, Lenz G, Simhandl C: Diagnosekriterien für Schizophrene und Affektive Psychosen. Genf, Weltverband für Psychiatrie, 1983.
89 Plügge H: Wohlbefinden und Missbefinden. Beiträge zu einer Medizinischen Anthropologie. Tübingen, Max Niemayer, 1972.
90 Binswanger L: Melancholie und Manie. Pfullingen, Neske, 1960.
91 Mayer-Gross W, Slater E, Roth M: Clinical Psychiatry. London, Baillière, Tindall & Cassell, 1974.
92 Solomon A, Haaga DA, Arnow BA: Is clinical depression distinct from subthreshold depressive symptoms? A review of the continuity issue in depression research. J Nerv Ment Dis 2001;189:498–506.
93 Hankin BL, Fraley RC, Lahey BB, Waldman ID: Is depression best viewed as a continuum or discrete category? A taxometric analysis of childhood and adolescent depression in a population-based sample. J Abnorm Psychol 2005;114:96–110.
94 Bowins B, Depression: discrete or continuous? Psychopathology 2015;48:69–78.
95 Benazzi F: Various forms of depression. Dial Clin Neurosci 2006;8:151–161.
96 Fuchs T: Subjectivity and intersubjectivity in psychiatric diagnosis. Psychopathology 2010; 43:268–274.
97 von Gebsattel VEF: Prolegomena einer Medizinischen Anthropologie. Berlin/Göttingen/Heidelberg, Springer, 1954.
98 Straus E: Das Zeiterlebnis in der endogenen Depression und in der psychopatischen Verstimmung. Monatsschr Psychiatrie Neurol 1928;LXVIII:640–656.
99 Aho K: Depression and embodiment: phenomenological reflections on motility, affectivity, and transcendence. Med Health Care Philos 2014;16:751–759.

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