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The grammar of psychosis

by

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“Niin monta viisasta miestä, mutta ei toisaalta yhtään
hullua puuta.”

So many wise men, but on the other hand not one
crazy tree.

(Haavikko Paavo: Puut, kaikki heidän vihreytensä, 1967)

ABSTRACT

This thesis is concerned with the philosophical grammar of certain psychiatric concepts, which play a central role in delineating the field of psychiatric work. The concepts studied are 'psychosis', 'delusion', 'person', 'understanding' and 'incomprehensibility'.

The purpose of this conceptual analysis is to provide a more perspicuous view of the logic of these concepts, how psychiatric work is constituted in relation to them, and what this tells us about the relationships between the conceptual and the empirical in psychiatric concepts.

The method used in the thesis is indebted primarily to Ludwig Wittgenstein's conception of philosophy, where we are urged to look at language uses in relation to practices in order to obtain a clearer overview of practices of interest; this will enable us to resolve the conceptual problems related to these practices.

This questioning takes as its starting point the concept of psychosis, a central psychiatric concept during the twentieth century. The conceptual analysis of 'psychosis' shows that the concept is logically dependent on the concepts of 'understanding' and 'person'. Following the lead found in this analysis, the logic of person-concepts in psychiatric discourse is analysed by a detailed textual analysis of a psychiatric journal article. The main finding is the ambiguous uses of 'person', enabling a specifically psychiatric form of concern in human affairs.

The grammar of 'understanding' is then tackled from the opposite end, by exploring the logic of the concept of 'incomprehensibility'. First, by studying the DSM-IV definition of delusion it is shown that its ambiguities boil down to the question of whether psychiatric practice is better accounted for in terms of the grammar of 'incorrectness' or 'incomprehensibility'. Second, the grammar of 'incomprehensibility' is further focused on by introducing the distinction between positive and negative conceptions of 'incomprehensibility'. The main finding is that this distinction has wide-ranging implications for our understanding of psychiatric concepts.

Finally, some of the findings gained in these studies are 'put into practice' in studying the more practical question of the conceptual and ethical problems associated with the concept of 'prodromal symptom of schizophrenia' and the agenda of early detection and intervention in schizophrenia more generally.

Keywords: conceptual analysis, definition of delusion, DSM-IV, early intervention, incomprehensibility, language use, person, philosophy of psychiatry, prodrome, psychosis, schizophrenia, sense of self, understanding, Wittgenstein.

ABSTRAKTI

Tämä väitöskirja tarkastelee eräiden keskeisesti psykiatrista toimintakenttää jäsentävien käsitteiden kuten psykoosin, harhanluulon, persoonan, ymmärtämisen ja käsittämättömyyden käsitteiden logiikkaa sekä asemaa psykiatrisessa diskurssissa.

Tämän käsiteanalyysin tavoitteena on antaa yleiskatsauksellinen kuvaus näiden käsitteiden logiikasta, siitä miten psykiatrinen työ konstituoituu näiden käsitteiden puitteissa ja mitä tämä kertoo käsitteellisten ja empiiristen elementtien suhteista psykiatrisissa käsitteissä.

Metodologisena taustana on moderni analyyttis-hermeneuttinen käsitefilosofia (Ludwig Wittgenstein), jossa käsitteelliset ilmaukset ymmärretään kielen tavallisesta käytöstä sidoksissa oleviksi, ja käsitteiden suhteita selvennetään viittaamalla kielen todellisin käyttötapoihin.

Tutkimuksen lähtökohtana on psykoosin käsite, joka oli keskeinen psykiatrinen häiriökäsite viime vuosisadalla. ”Psykoosin” käsiteanalyysi osoittaa, että se on loogisesti riippuvainen ”ymmärtämisen” ja ”persoonan käsitteistä”. Tämän analyysin antaman vihjeen perusteella persoona-käsitteiden logiikkaa psykiatrisessa kielenkäytössä tarkastellaan analysoimalla yksityiskohtaisesti yksi psykiatrinen lehtiartikkeli. Tämän analyysin keskeinen löydös on se, että persoonakäsitteiden moniselitteinen käyttö mahdollistaa tyypillisesti psykiatrisen tavan lähestyä inhimillisiä ongelmia.

”Ymmärtämisen” käsitteen kieliopin tarkastelu etenee sen vastakohdasta käsin, tutkimalla ”käsittämättömyyden” kielioppia. Ensin DSM-IV diagnostisen luokituksen käyttämän harhaluulon määritelmän tutkiminen osoittaa miten siihen liittyvät ristiriidat voidaan tiivistää kysymykseen siitä, kuvaako ”virheellisyyden” vai ”käsittämättömyyden” kielioppi paremmin psykiatrista toimintaa. Toiseksi, tutkimus tarkentaa ”käsittämättömyyden” kielioppia esittelemällä erottelun käsittämättömyyden positiivisen ja negatiivisen tulkinnan välillä. Keskeinen löydös on, että kyseisellä erottelulla on pitkällä ulottuvia seurauksia tavallemme ymmärtää psykiatrisia käsitteitä.

Lopuksi joitain esitetyistä havainnoista sovelletaan käytäntöön tutkittaessa ”skitsofrenian varhaisoireen” käsitteeseen ja laajemmin skitsofrenian varhaiseen toteamiseen ja hoitoon liittyviä käsitteellisiä ja eettisiä ongelmia.

Avainsanat: DSM-IV, harhaluulon määritelmä, kielen käyttö, käsiteanalyysi, käsittämättömyys, persoona, prodromaalioire, psykiatrian filosofia, psykoosi, skitsofrenia, varhaisinterventio, Wittgenstein, ymmärtäminen.

CONTENTS

LIST OF ORIGINAL PUBLICATIONS

I Heinimaa M. On the grammar of "psychosis". *Medicine, Health Care and Philosophy* 2000;3:39-46.

II Heinimaa M. Ambiguities in the psychiatric use of the concepts of the person: an analysis. *Philosophy, Psychiatry, Psychology* 2000;7:125-36.

III Heinimaa M. Incomprehensibility: The role of the concept in DSM-IV definition of schizophrenic delusions. *Medicine, Health Care and Philosophy* 2002;5:291-5.

IV Heinimaa M. Incomprehensibility. In: Fulford KWM Sadler JZ Stanghellini G and Morris K (eds), *Nature and narrative*. International Perspectives in Philosophy and Psychiatry Vol. 1. Oxford University Press, 2003, pp. 217-230.

V Heinimaa M. Conceptual problems of early intervention in schizophrenia. *Hong Kong Journal of Psychiatry* 1999;9:20-24.

1. INTRODUCTION

This thesis is concerned with the philosophical grammar of certain psychiatric concepts which play a central role in delineating the field of psychiatric work. Concepts receiving detailed attention are 'psychosis', 'delusion', 'person', 'understanding' and 'incomprehensibility'.

The purpose of this conceptual analysis is to give us a clearer view of the logic of these concepts, how psychiatric work is constituted in relation to them, and what this tells us about the relationship between the conceptual and the empirical in psychiatric concepts.

The method used in this thesis is mainly indebted to Ludwig Wittgenstein's conception of philosophy, where we are urged to look at language uses relevant to practices, in order to obtain a clearer overview of practices of interest; this will enable us to resolve the conceptual problems involved in these practices.

The conceptual analysis of 'psychosis' in the first paper, "On the grammar of psychosis", shows that this concept is logically dependent on the concepts of 'understanding' and 'person'. In the second paper, "Ambiguities in the psychiatric use of the concepts of the person - An analysis", I present a detailed analysis of how person-related concepts, such as 'self', 'sense of self' or 'person', are used and function in one specific psychiatric text. The grammar of 'understanding' is then tackled from the opposite end in the third paper, "Incomprehensibility: the role of the concept in DSM-IV definitions of delusion". The question of the grammar of 'incomprehensibility' is further attested more closely in the fourth paper, likewise entitled "Incomprehensibility". Finally, in the fifth paper, "Conceptual problems of early intervention in schizophrenia", the insights gained in these studies are applied to the more practical question of the conceptual and ethical problems associated with the concept 'prodromal symptom of schizophrenia' and the agenda of early detection and intervention in schizophrenia more generally.

To sum up the findings arrived at in these separate studies:

The main conclusions relating to the grammar of these psychiatric concepts were that

First, psychosis' is a psychiatric 'primitive', not amenable to an exhaustive definition in more elementary psychiatric concepts.

Second, the concept of 'psychosis' marks the very limit of a person's intelligibility to others as an understandable person, which is shown in its logical dependence on the grammar of incomprehensibility.

Due to this, uses of 'psychosis' are dependent on local conditions of understandability, and the concept is rigorously context-dependent. Attempts to decontextualize 'psychosis' from its practical uses make its content unclear.

Third, from a logical point of view this decontextualization effort adheres to a positive conception of incomprehensibility, a reading whose coherence has been contested on a logical basis (Diamond 1986, Wittgenstein 1953).

Fourth, if we adhere instead to the negative conception of incomprehensibility in the uses and explication we give to 'psychosis', the concept is contextualised as a specifically psychiatric concept, which is meaningful only in the context of clinical work.

Fifth, person-concepts provide tools for framing what takes place in this context, retaining the tension between positive and negative conceptions of incomprehensibility: this is manifest for instance in the interplay between 'self' and 'sense of self', which allows us to express psychiatric problems as involving pathological experience and at the same time to experience the possibility of overcoming the 'destiny' imposed by the pathological.

Finally, what is demonstrated throughout these studies is that discursive features play a major role in the formation of psychiatric concepts: the concepts of 'psychiatric disorder' or 'psychosis' are constituted as violations of ordinary forms of discourse, and the conception of recovery is bound up with the idea of retrieving one's role as a participant in ordinary discourse.

2. BACKGROUND AND CONTEXT OF THIS WORK

During the last two decades, the philosophy of psychiatry has emerged in the English-speaking world as a flourishing enterprise (Fulford 2003, Radden 2004). This event could also be described as a renaissance of philosophy in psychiatry; philosophical reflection in medicine has taken place since antiquity, and at the beginning of the twentieth century it was widespread in continental countries (Graham 2002, Spiegelberg 1972). A recurring question in both the historical and the recent debate is how to describe the position of psychiatry on the one hand as a scholarly discipline or field of scientific medicine, on the other as a practical professional activity (Berger 1996). The uneasiness of this issue is reflected among other things in debates on the status of the nosological concepts used by psychiatrists (Sadler, Wiggins and Schwartz 1994). This thesis will take part in this discussion at the level of basic psychiatric concepts, of which I have chosen to focus on the concept of 'psychosis' and its conceptual interconnections. The main incentive to undertake this question stems from the hope of being able to contribute to this debate by showing the implications of the philosophical grammar of the concept of psychosis.

One notion requires immediate clarification: that of 'basic psychiatric concepts'. By this term I refer to a network of concepts which mediate between the abstract conceptualisations of scientific psychiatry and real language use in therapeutic and other patient encounters. In other words, these concepts form the background from which specifically psychiatric practices may emerge. In the current historical situation, 'psychosis' is a exemplary concept of this kind, as it sustains its recalcitrant, almost two centuries old presence in everyday psychiatric vocabulary despite major attempts to reduce its role in psychiatric nosology (Fulford 1989).

The rationale of this thesis draws on the assumption that by investigating the philosophical grammar of concepts relevant for the formation and constitution of psychiatric practice, we can arrive at a more accurate conception of the senses of 'psychiatry' and the complex interrelations between psychiatry as a practical activity, as an institutionalisation of these practices, as a scientific knowledge base and as a practice producing this knowledge. This would place us in a better position to tackle questions such as the following:

1. Is psychiatry an ordinary branch of medicine or a distinct enterprise (Nys and Nys 2006)?

2. Is psychiatry an applied science or something quite distinct from science?

3. What are the relations between psychiatry, psychology and psychotherapy: Is psychotherapy a subspecies of psychiatrists' activities (Gabbard 2007), a self-standing and separate discipline (Burston and Frie 2006), or should its relation to psychiatry receive an entirely different characterization?

It is clear that recognizing the conceptual commitments implicit in psychiatric terminology ('psychiatric', 'illness', 'psychosis', 'person' or 'psychotherapy') has wide implications for all these issues.

3. PURPOSE OF THE STUDY

The concrete purpose of this conceptual analysis is to give us a clearer view of the logic of 'psychosis' in its relevant conceptual interrelations, to demonstrate how certain aspects of psychiatric work are constituted in relation to these concepts, and to make explicit what this analysis tells us about the relationship between conceptual and empirical elements in psychiatric concepts.

4. DISCUSSION OF METHODOLOGY

Reflecting on the appropriate starting point for conceptual analysis in the philosophy of psychiatry and consequently for the methodology of this work, we are led to heed Martin Heidegger's proposal in his essay on the essence of thinking, "Was heiβt denken": "Alles Bedenkliche gibt zu denken" (1992, p. 3). According to Heidegger, what gives us the possibility to think is the conspicuous, that which troubles and confuses us. This phenomenological comment on the source of philosophical questioning is in line with Ludwig Wittgenstein's conception of philosophy as an activity, whose initiative stems from perplexity about philosophical problems and which consists of various methodologically disparate attempts to extricate the philosopher from these problems (Baker and Hacker 1983, 1985; Heinimaa 1991; Kuusela 2005).

One of the characteristic and potentially also puzzling issues in the current philosophy of psychiatry is that it seems to work without worrying as to what philosophy is about. Much of the work in the field can be characterised as being based on a conception of philosophy as a general kind of science, theorizing on the basic conceptual 'furniture' of our world, with the aim of coming up with generalisations that can be applied by the specialized sciences and other human practices to the 'philosophical' problems of their respective fields. This of course does not greatly distinguish it from the bulk of current philosophical activity (Stroud 1983; Wallgren 2001).

This implies thinking of philosophy as a kind of conceptual investigation, where an attempt is made to clear up conceptual confusion by replacing troublesome generalisations with more powerful theoretical constructions.

This conception of philosophy, as giving a general account of how things – or concepts – are, is radically at odds with the conception of philosophy inherent in Wittgenstein's work (Hilmy 1987). Let us look at the following comment from the *Philosophical Investigations*, where he comments on how philosophy contrasts with scientific investigation:

> It was true to say that our considerations could not be scientific ones. –-And we may not advance any kind of theory. There must not be anything hypothetical in our considerations. We must do away with all *explanation*, and description alone must take its place. And this description gets its light, that is to say its purpose, from the philosophical problems. These are, of course, not empirical

> problems; they are solved, rather, by looking into the workings of our language, and that in such a way as to make us recognize those workings; *in despite of* an urge to misunderstand them. The problems are solved, not by giving new information, but by arranging what we have always known. Philosophy is a battle against the bewitchment of our intelligence by means of language. (Wittgenstein 1953, § 109; emphasis in original.)

Here Wittgenstein stresses 'philosophical problems' as quintessential to philosophy – this is where 'philosophising' begins. He also emphasises the distinction between philosophy and science: science is an attempt to explain things but philosophy is about giving helpful accounts of facts already well known (Hacker 2004).

For Wittgenstein philosophy is an activity working towards entangling conceptual confusions, but it should not be content with conventional attempts to solve philosophical problems by replacing old conceptions with novel ones; rather, it should bring the relevant conceptions into view with such perspicuity that these problems will no longer bother us in the same way (Hacker 2004).

This conception of Wittgenstein's philosophy is well recognised (Kuusela 2005), though also controversial (Wallgren 2001) and often hotly contested (Hilmy 1987; Hintikka and Hintikka 1986).

After this preliminary debate on finding the appropriate approach for this study, what remains is to describe the concrete methodology used. Here I refer to Baker and Hacker's reading of Wittgenstein's 'method' (1983, 1985): according to this exegesis, in philosophy we are urged to look at the language uses relevant to practices in order to get a clearer view of practices of interest, enabling us to resolve the conceptual problems related to these practices. (Hacker 2004)

Kuusela, in his paper on Wittgenstein's 'turn' away from metaphysical philosophising to conceptual analysis, gives a lucid account of how philosophical problems may arise and how Wittgenstein's focus on the actual uses of concepts would 'dissolve' such a problem:

> For instance, I may define a unit of measurement, let us call it 'unit', by picking up a stick from the ground and saying: 'This is one unit long'. By doing so I am stating a rule that determines what it is to be one unit long, and defining this particular stick as a standard of length of one unit. However, it is important to note that with this definition I am not giving a correct/incorrect description or making a true/false

> statement about anything, for instance the length of the stick. Had I picked up another stick with a different length and defined it as 'unit', I would *not* have made a mistake or said something false, but merely defined 'unit' differently. Thus, the logical role of the definition is not that of as statement about this particular stick. Rather, my definition determines the *meaning* of 'unit' by reference to this stick. … *What might confuse us here is that exactly the same sentence 'this is one unit long' can also function as a description of or a statements about the length of a stick. Nevertheless, we must not be misled by the form of the sentence but attend to its use*. (Kuusela 2005: 108; emphasis added)

So, similarities on the surface of language (exactly similar expressions) might get us to think that their meanings are also akin. Specifically as the other use is grammatical (describing a rule of language use and consequently beyond falsity) and other use contingent (describing how things are in the world and subject to either or not being true), this might promote complex forms of metaphysical nonsense. And the cure of this embarrassing ambiguity of 'this is one unit long' is to recognise that it is used in different roles in these two situations and consequently its meaning is entirely different in these two situations.

Another example of a potential form of dissolutions that are to take place in philosophy comes from O'Drury's book, *The Danger of Words* (1973). O'Drury cites Molière's play, where a physician is asked, "how is it possible that opium is able to put people to sleep"; the physician responds with conviction, "due to its dormitive properties", a response which is laudably received. According to O'Drury, what would be relevant in this context would be to point out that the concept 'dormitive' is not doing any surplus work in this response over and above what has already been alleged by the interlocutor, and should be rejected as a pseudoexplanation.

As a third example, one could mention the critique of the 'mereological fallacy' in contemporary neuroscience by Bennett and Hacker (2003). According to them, neuroscientists confuse the logic of part/whole relations when they ascribe mental states to the brain, due to their inability to recognise that mental predicates can only be used when referring to a whole human being; applying them to a single part (such as the brain) is a misconceived and consequently meaningless way of speaking.

Another methodological point from Wittgenstein's *Investigations* relevant to this study is his use of the concepts 'language game' and 'family resemblance' to point out the ways we make use of concepts and what our immersion in the world looks like. Neither 'language game' nor 'family resemblance' avail themselves to

us as notions opting for generality, but act as pointers to make us cognizant of the kind of claims that we at least should not adhere to.

In this sense we can speak of the 'grammar' of psychosis. This use of 'grammar' is not sociolinguistic but descriptive: we look at the uses of psychiatric concepts in the context of psychiatric practice in order to recognise the connections between psychiatric concepts and their surrounding world. The aim is not principally that of giving a 'true' picture of psychiatry as a practice, but rather an illuminative one, helping us to recognise connections we are prone to disregard.

5. REVIEW OF THE LITERATURE

The concept of psychiatric disorder has been a relevant theme for philosophical reflection since antiquity. Later – in German psychiatry in the nineteenth century – the birth of a 'modern', medically oriented conception of psychiatric disorders was coupled with intensive discussion as to how psychiatric disorders should be thought of. In this overview of the literature I take this nineteenth-century debate as the starting point, since it was here that the conceptualisation of various forms of madness and insanity as 'psychoses' first took place. I first review the conceptual history of 'psychosis' and the relevant commentaries in detail. I then review recent philosophically oriented contributions to the notion of psychosis. Finally, I give briefer accounts of other concepts important for the philosophical analysis of 'psychosis' presented here, i.e. 'delusion', 'person', 'understanding' and 'prodromal symptom of psychosis'.

5.1. On the conceptual history of 'psychosis'

5.1.1. The birth of the concept in the early nineteenth century

The conceptual history of 'psychosis' starts at the beginning of the nineteenth century, when the clinical and descriptive categories relevant to modern psychiatry were first formulated (Berrios 1987; de Beer 1995a). The countries at the forefront of this development were Germany and France. From the perspective of the early twenty-first century, two themes in the development of the concept of psychosis stand apart: first of all, from an initial extension as a very general concept of mental disorder (de Beer 1995a) its extension has progressively narrowed down (Rudnick 1997), and secondly, it has been related in complex ways to the concept of schizophrenia (McGorry 1991; Berrios, Lugue and Villagrán 2003).

According to Berrios (1987), 'psychosis' was formed from the remnants of three earlier clinical categories:

First, 'Insanity' (Latin *insanus,* from *in-* 'not' + *sanus 'sane'*).[1] From the seventeenth century onwards the content of this concept was framed principally as an intellectual malady (Locke, Hobbes), where the change of personality is framed as an intellectual disorder, with delusionality as its cardinal symptomatic manifestation.

Second, 'alienation', from Latin *alienatus,* pp. of *alienare* 'to make another's, estrange,' from *alienus* 'of or belonging to another person or place', from *alius*

[1] Etymological data from Harper (2001).

'(an)other'. *Alienation* in the sense of 'loss or derangement of mental faculties, insanity' (1482) is also a term of early origin; it was particularly influential in the French language area, referring specifically to judicial aspects of madness.

The third concept was 'dementia', whose etymology stems from the Late Latin *dementare* (from the phrase *de mente*, from *de* + *mente*, abl. of *mens* 'mind'). This clinical concept prevailed in the seventeenth and eighteenth century. At the beginning of the nineteenth century it referred to various forms of psychological deterioration, but did not yet carry implications of old age, specifically cognitive impairment or irreversibility. With the emergence of neurology in the mid-nineteenth century the more obviously organic brain disorders became the neurologist's domain (irreversible 'senile dementias'), while the rest were recognised as 'vesanic dementias' (Berrios 1987), the potentially reversible late sequelæ of psychoses (Bulbena and Berrios 1986).

Berrios (1981) also describes how the evolution of the concept of delirium during the nineteenth century affected the formation of the concept of psychosis. Earlier the presence or absence of fever had played a major role in distinguishing between ordinary insanities and delirious states secondary to physical illness. During this period the concept of delirium was attached to the now explicitly recognised faculty of consciousness, and "clouding of consciousness" became the major criterion for differentiating delirium from other insanities, with hallucinatory or delusional features being relegated to the position of secondary release phenomena. According to Berrios (1981), this accelerated the formation of the concept of functional psychoses as a contrast phenomenon (where delusional features had descriptive primacy).

According to Berrios, three other processes also took place during the nineteenth century in parallel with the emergence of 'psychosis', with formative influence on advancing medical conceptions of psychiatric disorders:

1. Introduction in psychiatry of the anatomico-clinical concept of disease. In France Bayle (1822); in Germany Griesinger (1843).

2. Severance of descriptions of psychiatric symptoms from disorder concepts.

3. Simultaneous development in the discipline of psychology, i.e. the distinction made in *faculty psychology* between the intellectual, emotional, and volitional faculties, reflected in the way psychotic symptomatology was to be described (Berrios 1987; Radden 1996).

According to Berrios, the semantics of the concept of psychosis offered a reasonable way to bridge the gap between organicist thinking and experiential symptomatology, thus promoting its reception in wide psychiatric circles. The grammatical elasticity of the concept was also an asset: it was a noun, with adjectival and adverbial uses readily available.

5.1.2. Introduction of the concept: Von Feuchtersleben

The first commonly recognised use of 'psychosis' as a term occurred in German psychiatrist Ernst von Feuchtersleben´s *Lehrbuch der Ärtzlichen Seelenkunde* from 1845, which was rapidly translated into English (1847).[2] Von Feuchtersleben was a representative of the Romantic movement in early nineteenth century psychiatry, where the conception of the total personality, with vitalistic undertones, was a central theme.

> We follow practice and ordinary language and, free from all systematic prejudice, call those very complex conditions by the name of psychopathies which all physicians designate by that term. (von Feuchtersleben 1847: 245)

According to de Beer (1995a), von Feuchtersleben's definition was an attempt to deal with the concurrent *Somatiker – Psychiker* debate (de Beer 1995a; Mora 1975): the question whether mental illnesses (*Geisteskrankheiten*) are somatic or psychic affectations. He settled this issue by assuming that both the body and the psyche fall ill when the whole personality is ill (de Beer 1995a). Etymologically, 'psych-osis' is analogous to 'neur-osis': for the nineteenth-century physician the latter type of condition was conceivable as more peripheral to the personality of the patient, "in the nerves", while the former implied central or total change in the person's way of being. The extension of the concept was a broad one: initially it included such different clinical categories as *Wahnsinn* (delusionality), "monomania", *Tobsucht* (raving mania) and *Idiotie* (idiocy) (de Beer 1995a).

One peculiar aspect of conceptual development in nineteenth century psychiatry is the transformation of the concept of neurosis. According to Berrios (1987), in the early nineteenth century the concept of neurosis was very extensive, including present-day neuroses, all insanities and most neurological conditions, as well as other medical conditions. But by the early twentieth century the concept of psychosis had become more prominent and senile dementias were differentiated into individual neurological diseases (e.g. Binswagner's dementia, Pick's dementia,

[2] According to new data introduced by Bürgy (2008), Canstatt (1841) was the first writer to use the term 'psychosis' in a sense that does not exactly coincide with von Feuchtersleben's. For the purposes of this study this detail is of marginal significance and will be disregarded.

Alzheimer's dementia). By a curious conceptual inversion, and related to Charcot's and Freud's reformulation of the aetiology of 'hysterical neuroses', neuroses were now conceived of as psychogenic illnesses: in other words, a term that previously had referred distinctly to neurological illness was now used to refer to a distinctly non-neurological conditions (Bürgy 2008).

The term 'psychosis' was used in its conceptually strongest form in the concept of *Einheitspsychose* (unitary psychosis), introduced by Zeller (de Beer 1995b). According to Berrios, this concept was specifically amenable to the needs of asylum psychiatrists working in large institutional settings, who in their clinical practice found little use for the exact demarcation of individual diseases. Instead, they propounded the notion that there is only one kind of insanity, and that its different forms are caused by variations in the individual and in the environment (Berrios 1987). This conception was not far from the position of von Feuchtersleben, but it was met with some distrust in academic settings, where the main incentives were systematic taxonomy and the search for organic aetiology (de Beer 1995b).

For the purposes of the analysis developed in this thesis, it is central to recognize the holistic character of this early conceptualisation of psychosis: it implies a total morbid change in the patient's personhood.

5.1.3. Emergence of the concept of schizophrenia: Kræpelin and dementia præcox

The major events at the turn of the century in descriptive psychopathology of psychoses were the successive introductions of concepts 'dementia præcox' by Emil Kræpelin (1893) and 'group of schizophrenias' by Eugen Bleuler (1908).

Kræpelin's novel contribution to nosology was to make longitudinal course and outcome the major criteria in distinguishing psychiatric disease entities. According to Kræpelin:

> It gradually dawned on me that many patients, who initially presented a picture of mania, melancholia or amentia showed progressive dementia. In spite of individual differences they began to resemble one another. It seemed as if the earlier clinical differences had little bearing on the course of the illness. … *[W]hatever its presentation, it [the process] always led to the destruction of personality*. (Kræpelin 1983; cited by Berrios and Hauser 1988: 817. Emphasis added)

Kræpelin's orientation was a naturalist one (Shorter 1997), and to identify natural disease entities he used minute clinical descriptions based on longitudinal observation of symptoms and behaviour. Kræpelin distinguished analytically

between acute psychotic states, which led to secondary dementia, from those acute states in which a full recovery was possible. The former were to be called dementia præcox; the latter he described as manic-depressive psychoses. Kræpelin's nosological innovations soon established an unprecedented authority worldwide (Jaspers 1965).

Kræpelin's nosology structured the field of psychotic disorders and internal division of categories of psychotic condition but did not directly address the contents of concept of psychosis per se. Actually, he seldom used the word in his writing and did not make use of it as a concept (Paul Hoff, personal communication). But the concept of disease entity that he was working with clearly depended on the concept of person, as according to Kræpelin, the essential feature of the disease process, and what really made it a psychiatric disease process, was that

> [W]hatever its presentation, it always led to the destruction of personality. (From Kræpelin 1983, cited by Berrios and Hauser 1988: 817).

Consequently, Kræpelin's disease concept was intensionally identical to "psychosis" concept, as it is defined against the concept of person.

In a late publication "Patterns of Mental Disorder" (1920) Kræpelin commented approvingly on a contemporary proposal by Heinrich Schüle to distinguish between "psychoneuroses" and "cerebropsychoses", with the former as functional disturbances and the latter approaching organic diseases. In this spirit, he proposed a hierarchical distinction between three main groups of mental disorder, with differential level of seriousness and severity of organic pathology. First group comprises "delirious, paranoid, affective, hysterical and instinctual forms" and in this group the role of pathoplastic significance of individual and local characteristics is the greatest. The third group comprises diseases with clear and extensive organic pathology, like "encephalopathy, oligophrenia and paroxysmal forms". The second group is defined as lying in-between these two extremes and consists of "schizophrenic form" and "auditory-hallucinatory form".

The formulation of this model does not directly address the question of the limit of the concept of 'psychosis". The first group clearly contains both "neurotic" and "psychotic" disorders, even considering the general idioms of the day. As the term "functional" does not imply the definite absence of organic factors for Kræpelin, it would seem that the distinction between psychotic and non-psychotic disorders per se had minor significance for Kræpelin.

What is central for the purposes of this thesis is to recognise that Kræpelin's nosological conceptualisations did not directly affect the meaning of "psychosis" which retained its content as a pathology affecting a morbid change in the whole person.

5.1.4. Die Gruppe der Schizophrenien and Bleuler

As against Kræpelin's naturalistic and medically oriented influence (Shorter, 1997), the work of Eugen Bleuler took up the potential of also using psychological explanations in explaining the symptoms of 'psychoses'. His son Manfred Bleuler later noted that

> It was in Rheinau that [E. Bleuler] realised that schizophrenics could not be 'demented' since they did not lose a lively and colorful inner life (Bleuler 1991: 3).

Influenced by contemporaneous development in psychotherapy, and in direct contact with Freud and Jung (Dalzell 2007), Bleuler attempted to bridge the gap between the biological explanation inherent in Kræpelin's concept of disease and a psychological understanding by applying Semon's association psychology (Stierlin 1967) to clinical phenomena.

Bleuler criticised Kræpelin for being insufficiently explicit about the fact that dementia (Dementia Praecox) is not an autonomous phenomenon but a group of syndromes, with a potentially heterogeneous causative background. He also postulated that the central unifying characteristic of the syndrome concept is the disharmony of psychic functions:

> […]Zersplitterung und Aufspaltung des Denkens, Fühlens und Wollens und des subjektiven Gefühls der Persönlichkeit .... [Splintering and splitting of thought, emotion, will and the subjective experience of personhood]. (Bleuler 1949: 277, my translation.)

He thus focused on psychological rather than material phenomena. The central feature of psychosis for the schizophrenia group, according to Bleuler, was a weakening of associative functions (*Assoziationsspannung*) and the loss of unity of personality (Stierlin, 1967). Bleuler also strongly advocated the view that the course of schizophrenia need not always be chronic.

Bleuler himself was sharply criticised in academic psychiatry for "compromising the organic perspective and scientific validity to the psychologization of the dementia praecox concept"; Stierlin assumes that the stress Bleuler later in life placed on the possible causal role of organic factors represented a partial yielding to this criticism (Stierlin 1967).

Bleuler differentiated between so-called 'fundamental', diagnostically essential symptoms and 'accessory' symptoms. This theoretically motivated distinction clearly drew a line between the concepts of psychosis and schizophrenia: major psychotic symptoms (hallucinations and delusions) were deemed only secondary

phenomena in the disease concept. The delineation of autistic thought disorder as the core phenomenon also motivated Bleuler to extend his disease concept to include in the group of schizophrenias certain morbid states where overt psychosis was lacking but some form of thought disorder was clearly demonstrable, such as 'simple' and 'latent' forms of schizophrenia (Katanetz 1989).

This reformulation of Dementia Præcox as "group of schizophrenias" led to the following developments:

a) a change took place in the hierarchy of symptom concepts

b) the extension of the concept was broadened

c) the borderline between Dementia Præcox as against other psychiatric disorders and/or normality was obscured.

What is central for the purposes of this thesis is to appreciate that Bleuler's work retained the former meaning of 'psychosis' and elaborated on the meaningful content thereof. The following quotation is useful in illustrating how Bleuler conceptualised its meaning as relating to a wholesale transformation of the patient's personality:

> Der Schizophrene … ist nicht mehr eine kranke Persönlichkeit, weil einzelne psychische Funktionen verändert sind. Ganz in Gegenteil bemerken wir an ihm einzelne veränderte Funktionene, weil seine Persönlichkeit als Ganzes krank ist. (Bleuler 1949: 287-8)
>
> [A schizophrenic … is not a sick personality due to alterations in individual psychological functions. Quite the contrary, we observe in him individual altered functions because his personality as a whole is sick. (My translation.)]

5.1.5. Freud's conception of psychosis

The work of Sigmund Freud has also had a lasting influence on the psychiatric conception of psychoticism. One of the most important aspects of his work on these issues is Freud's persistent endeavour to find a psychological explanation of even the strangest psychiatric phenomena, rather than disregarding them as "sinnlos" and not worth further scrutiny (Spitzer 1989). On this issue Freud was heavily criticised for instance by Karl Jaspers, who thought Freud's expansion of the limits of comprehensibility went much too far, thereby compromising the meaningfulness of the concept itself. (Jaspers 1965; Phillips 1991).

Although psychosis was not an exclusive interest for Freud except in a few writings (Spitzer 1989), a theory of psychoticism nevertheless emerges (Freud 1911; Freud 1924a; Freud 1924b). Freud's explanatory attempts mostly take place in relation to delusionality (*Wahn*), and in his early works he deals with delusionality in a way not dissimilar to neuroses (Spitzer 1989). Paranoia is described as emerging from a disposition to use projective defence mechanisms. In his later writings (the case of judge Schreber) Freud identified latent homosexuality and the ego's attempts to defend itself against this as the major source of paranoid symptoms (Freud 1911; Spitzer 1989).

Thus for Freud psychosis was essentially an expression of the id and the forces of the id encroaching on the ego, to the defeat of external reality and its influence on the ego (1924a). He gives a richer account of psychotic symptoms than earlier writers, describing them not merely as anomalous incidents in psychological collapse but as reconstructive attempts at managing the demands of external reality with an ego deformed by overwhelming instinctual drives (1911, 1924b).

One important conceptual legacy of Freud's work is the concept of "reality testing". The evolution of this concept in Freud's writings has been reviewed by Hurvich (1970). The central feature for Freud is the ability of the ego to perceive external reality accurately, and he recognises motor activity and judgemental activity as quintessential for this differentiation. Later psychoanalytic literature has distinguished "sense of reality" (Federn 1952) as a contentually more adequate description of this ego function. The concept of reality testing still plays a part in the definition of psychoticism in DSM manuals, and the concept used there is closer to Freud's externalist description (Rudnick 1997).

Central for the purposes of this thesis is to appreciate that Freud's work had little direct influence on the extension of the concept of 'psychosis', but had a significant impact on its intension: the emergence of psychotic phenomena was explained in psychologically meaningful terms and its central structural features were reformulated in reference to loss of reality testing.

5.1.6. Jaspers

Karl Jaspers' major contribution to psychiatry, his *Allgemeine Psychopathologie*, was at the time of its first publication in 1913 by far most extensive and consistent attempt to give an overall view of the fields of clinical psychiatry and psychiatric research. It also represents a coherent philosophical account of psychiatry both as a practice and as a science, of the types of psychiatric disease concepts and of the psychological description of both normal and pathological functioning.

Jaspers' major philosophical contribution to psychiatry was his application of the Diltheyan contrast between *verstehen* (understanding) vs. *erklären* (explanation) as two separate modes of scientific activity: the former characteristic of the *Geisteswissenschaften* (human sciences) such as history or sociology, the latter of the natural sciences (Jenner, Monteiro and Vlissides 1986).

> Over against the psychology of theoretical explanation, Dilthey had put another, "descriptive and analytical psychology". I adopted this approach, called it "verstehende Psychologie", and worked out the already practiced procedures … by means of which, in contrast to the directly experienced phenomenon, one is able to comprehend the genetic connections within mental life, as well as meaningful relations and motives. (Jaspers 1957: 18.)

With these conceptualisations, Jaspers was able to account for both scientific and practical aspects of the psychiatrist's work. Applying this distinction to nosology, he distinguished between on the one hand incomprehensible psychiatric illnesses as 'processes', on the other understandable psychological 'reactions'. *Allgemeine Psychopathologie* was subsequently to have a major influence on early twentieth century psychiatry (Jenner, Monteiro and Vlissides 1986).

The concept of psychosis that Jaspers worked with was in accordance with contemporary diagnostic practices and was a fairly wide one: it extended from epilepsies through affect disorders to schizophrenia, for which he gave a central place in defining the essence of psychotic disorders: "…unverständlichen, im wahren Sinne verrückten, schizophrenen Seelenleben [incomprehensible, in a real sense crazy schizophrenic mental life]" (Jaspers, 1965: 483).

In Jaspers' view, the essential feature of psychoses was that in these disorders the morbid process affects the whole being of the person involved, i.e. it results in a major change in them in comparison to the pre-morbid personality. This also meant that the field of psychoses came to be structured primarily in terms of the degree to which they appeared as "un-understandable". The prime example of psychotic disorders, schizophrenias, were described as by definition incomprehensible states, and this incomprehensibility was conceived of as constitutive for these disorders:

> It is in fully developed cases of schizophrenia that Jaspers insists understanding reaches a limit and must be replaced by explanation of process. With these cases we are confronted with clinical phenomena that are simply un-understandable and with which we cannot easily feel any empathy. (Phillips 1991: 25).

Affective psychoses, on the other hand, with their more easily approachable delusional thematic, were according to Jaspers recognisable as psychoses due to the presence of "un-understandable" clinging to the delusional content, despite any disconfirmation from the outside (Oppenheimer 1974; Blankenburg, 1984).

According to Bürgy (2008), Jaspers' influence was central in cementing the distinction between "incomprehensible" psychoses and "psychologically understandable" neuroses. Jaspers himself pointed out that in neuroses patients do not understand themselves (partially incomprehensible), while in psychoses they are not comprehensible to others (incomprehensible in a general way); he also drew therapeutic implications from this distinction.

> Neurosen heiβen die seelischen Abweichungen, welche den Menschen selbst nicht ergreifen. Psychosen solche, welche den Menschen im Ganzen befallen.
>
> … Positiv gesprochen liegt der Grund der neurotischen Erkrankung in den Situationen und Konflikten, welche in der Welt dem zur Aufgabe werden, entscheidend aber erst in spezifischen Mechanismen, welche zu einer normalerweise nicht vorkommenden Umsetzung der Erlebnisse führen … *Psychosen* dagegen sind der *engere Bereich* seelischer Störungen, die für das allgemeine Bewuβtsein einen Abgrund zwischen krank und gesund aufreiβen.
>
> …Neurosen sind der Bereich der Psychotherapeuten, Psychosen der Bereich der Psychiater. (Jaspers 1965: 481-2)
>
> [Neuroses we call those psychic aberrations, which are not grasped by people themselves. Psychoses are those aberrations, which affect the whole person. … In the positive sense the source of neurotic disorder lies in the situations and conflicts, which engage the individual in his world and which only become crucial because of specific mechanisms that lead to certain transformations of experience not normally found … *Psychoses* on the other hand are *the more circumscribed* psychic disturbances which are generally thought to open up a gulf between sickness and health. … Neuroses are the field for psychotherapists, psychoses the field for psychiatrists.][3]

What is central for the purposes of this thesis is to appreciate that Jaspers' work still retained the former meaning of "psychosis", and gave it its hitherto conceptually most elaborate explication in terms of a morbid process affecting the whole personality of the patient.

[3] Translation by Jenner (1986); emphasis in original.

5.1.7. Minkowski

The French contribution to the evolution of nineteenth-century psychopathology was a central one, as described in Berrios' numerous studies in the history of psychiatry (Berrios 1981; Berrios 1987; Fuentenebro and Berrios 1995; Berrios, Luque and Villagran 2003). Yet the developments that have most powerfully influenced late twentieth century conceptions of psychosis came mostly from the German cultural area. France rather presented an unique "pocket of resistance" for mainstream nosology, and some conceptualisations relating to the concept of schizophrenia are worth recognising in the context of this thesis. For this purpose I discuss Eugene Minkowski's conceptualisation of schizophrenia as a "loss of vital contact with reality" [perte du contact vital avec la réalité] (1926).

Minkowski first notes that even though we are able to enumerate a plenitude of symptomatic features typical of schizophrenia, the essence of the malady eludes efforts at tangible description.

> Expressions such as "discordance" (Chaslin), "intrapsychical ataxia" (Stransky), "intrapsychical disharmony" (Urstein), "loss of interior unity" (Kræpelin), "dissociation" (Claude and Levy-Valensi), "schizophrenia" (Bleuler) involve the idea that it is not one or [the] other function which is damaged, but rather their cohesion, the harmonious interplay between them. (Minkowski (1926), cited in Cousin, Garrabé and Morozov (1999: 512).)

Minkowski also recognises that we are in trouble when we try to explain this loss of concordance between psychic functions, as we do not have a coherent conception of their basis in the normal psyche either. He therefore sees a useful role for metaphorical descriptions in endeavouring to identify the essential features of Dementia Præcox. The philosophical background of Minkowski's own proposal lies in Bergson's philosophy of "lived experience". He picks up the phenomenon of "autism" described by Bleuler, but criticises him for not recognising its central, "generative" role in the entire disorder (Minkowski 1926).

What is central for the purposes of this thesis is to recognise how Minkowski, in his legitimate attempt to conceptualise the essential features of Kræpelin's dementia, is led to apply a purely a and highly abstract conceptualisation that evokes the notion of "human being" at a very general level of description.

5.1.8. Schneider

Kurt Schneider's work from the 1930s has greatly influenced the conception of psychosis in the German-speaking countries, secondarily also in the anglophone

world. A self-proclaimed Kræpelinian, Schneider distinguished sharply between psychoses and "understandable abnormal reactions". According to Schneider psychoses are real disease entities, to be distinguished resolutely from other mental disorders, with no transitional forms in relation to normality. Extensionally, "psychosis" comprised the two Kræpelinian disease entities. (de Beer 1995b)

> Wir heißen eine seelische Erscheinung dann krankhaft, wenn ihr Dasein bedingt ist durch krankhafte Vorgänge des Gehirns, durch mittelbare oder durch unmittelbare Gehirnkrankheiten. …Wir beginnen mit Schizophrenien, worunter wir psychotische Prozesse verstehen, welche die Persönlichkeit in einer hier nicht näher zu schildernden Weise zerstören oder zum mindesten umbauen, Prozesse, die grundsätzlich irreparabel sind und deren Ätiologien und körperliche Grundlagen man bisher nicht kennt. (Schneider 1933: 339-41.)
>
> [We call a mental phenomenon sick, then, when its presence is dependent on sickly events in the brain, by direct or indirect brain diseases.…We begin with the schizophrenias, under which term we understand psychotic processes that destroy or at least rebuild the personality in a manner we do not describe more closely here. These processes are principally irreparable and their somatic ætiology is so far not known. (My translation.)]

Schneider dismissed the use of the concept of psychosis in the broad sense: for him it was a narrowly defined scientific concept, referring specifically to an organic illness, and did not lie on the continuum between illness and healthy personality function. According to de Beer,

> [he warned] against the terming of understandable abnormal reactions as psychoses, which occurs not only in everyday speech ('war psychoses'), but also frequently in clinical conversation. (de Beer 1995a: 319)

In Schneider's description of schizophrenia, the principal diagnostic tools are so-called "first-rank symptoms": for instance audible thoughts, commenting voices, somatic passivity experiences or thought broadcasting. According to Schneider, these first-rank symptoms differ clearly from normal experience; due to this distinctive character they can be assessed fairly reliably by different clinicians. Schneider does not claim that these symptoms are specific to schizophrenia, but that they allow reliable assessment as to their presence or absence.

What is central for the purposes of this thesis is to recognise that Schneider's work took the definition of psychosis a step further towards a less context-

bound concept, whose meaning would become more difficult to appreciate. In its intension, however, this concept was closely bound to the earlier one, implying the destruction of the personality.

5.1.9. Post-war period in the conceptualisation of psychosis

In the official classifications from the 1950s onward (ICD-8 and DSM 2), Bleuler's influence was most prominent. In the American clinical tradition in particular the extension of the concept of schizophrenia had broadened significantly. The limits of the concept of 'functional psychosis' were at this point so diffuse that any mental disorder causing considerable impairment in functioning was considered a psychosis (Rudnick 1997).

In Great Britain, on the other hand, psychiatric practice was dominated by Kræpelin's and Schneider's diagnostic approach to schizophrenia. Psychotic symptoms were primarily analysed in terms of personality changes, with particular emphasis on revealing 'first-rank' symptoms. (Katanetz 1989).

A major scientific event of this period, affecting future diagnostic practices with regard to psychotic disorders, was the UK-US diagnostic study (Gurland et al. 1970), which compared diagnostic practices in New York and London. It was found that patient characteristics played only a minor role in determining whether the diagnosis was one of schizophrenia or affective disorder, while the impact of the location was much greater. This study was one incentive leading to attempts to restrict the extension of the concept of schizophrenia, allowing more reliable diagnostics for patients from various countries and settings.

In discussing the development of 'psychosis' in this period, it is also worth noting the specific impact of the concept of 'psychogenic psychosis' in Scandinavia (Strömgren 1987, 1992; de Beer 1995b). As implied by the term, this diagnostic concept assumes that the major determinants of psychotic breakdown are psychological ones, relating to psychological structure or relevant external events. The strength of this concept in Scandinavia has probably contributed to the relatively high prestige still enjoyed in the Nordic countries by psychotherapeutic approaches to the treatment of psychosis (Opsmjorden 2001).

5.1.10. Emergence of operational nosology: DSM-III and DSM-IV

A major paradigm change in psychiatric nosology took place with the introduction of the Diagnostic and Statistical Manual of Psychiatry disorders, third edition (DSM-III) in 1980. Its approach to psychiatric diagnosis was heavily influenced by earlier work in the philosophy of science, specifically by Carl Hempel, who had been explicitly commissioned by the American Psychopathological Association to help

develop the field of psychiatric nosology (Sadler, Wiggins and Schwartz 1994). Some twenty years later, this work led up to the publication of the DSM-III.

A central feature of the DSM-III system was the application of operational diagnostic criteria to the definition of mental disorders; in other words, its goal was to define and describe these disorders in terms of simple, externally observable, often behavioural symptoms. This would ensure reliable diagnostic procedures across different settings and countries, and minimise the role of ætiological assumptions in diagnostic formulations, thus enhancing communication between professionals and the true, cumulative production of research data. The DSM-IV system published in 1994 basically continued this process, with little re-examination of the premises inherent in its predecessor.

Both publications met with extensive criticism, often based on philosophically oriented arguments as to the incongruences of their premises (Faust and Miner 1986; Stein 1991; Radden 1994; Sadler, Wiggins and Schwartz 1994; Acton 1998) and the dubious consequences of their application in either clinical (Fulford 1989; Sadler 2005) or research settings (Maj 1998; Angst 2007).

As for schizophrenia, its definition in the DSM-III (APA 1980) was a combination of the most influential contemporary sets of criteria: the course criterion came from Kræpelin, and both Bleulerian fundamental symptoms and Schneider's first-rank symptoms were included in the definition of overt psychotic state. The focus on enhancing reliability of diagnosis led to emphasising the role of productive psychotic symtoms, and mild atypical forms (simplex, latent, pseudoneurotic, borderline) were excluded from the extension of this concept.

In the meantime, the role of 'psychosis' was weakened in the DSM-III: the nosology abolished the central role of the psychosis/ neurosis distinction and avoided substantive use of the concept ('psychosis'), opting for adjectival use ('psychotic') (Bürgy 2008). Psychoticism was nevertheless still defined in the DSM-III glossary definition of 'psychotic' features in terms of Freud's notion of 'impaired reality testing':

> PSYCHOTIC. A term indicating gross impairment in reality testing. … When there is gross impairment or reality testing, the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inference about external reality, even in the face of contrary evidence. … Direct evidence of psychotic behaviour is the presence of either delusion or hallucination without insight into their pathological nature. The term psychotic is sometimes appropriate when an individual's behavior is so grossly disorganized

> that a reasonable inference can be made that reality testing is disturbed. (APA 1980: 367-8)

In practice the obvious presence of three major forms of classic symtoms (delusions, hallucinations, incoherence) were to become definitional for this concept (Fulford 1989). This event has aptly been described as moving from a conceptual definition of schizophrenia to an indexical one (Kim 1992).

The progressive narrowing of the scope of psychoticism was even more explicit in DSM-IV (APA 1994), which mentions five and practically applies four different definitions of psychoticism, each of different conceptual strength. Rudnick (1997) here recognises two major types of definitions of psychoticism: a narrow one (comprising only delusions and prominent hallucinations, without insight into their pathological nature) and a broad one (comprising delusions, hallucinations and/or disorganization). The former definition manifests a clearly higher threshold for a diagnosis of a psychotic disorder.

It is interesting to observe how the demonstration of a clear organic ætiology for psychopathological phenomena tightens the requirements for considering them psychotic: only when prominent hallucinations are present without insight into their pathological nature is a diagnosis of (organic) psychosis justified. This is summarised in Table 1 below.

Table 1. Presence and absence of insight in psychotic disorders according to DSM-IV (APA 1994).

	with insight	without insight
Delusions		Delusional disorder, Organic psychosis, Schizophrenia
Hallucination	Schizophrenia	Organic psychosis
Incoherence	Schizophrenia	Schizophrenia

Thus, when we have an understandable explanation of psychotic symptoms (such as an organic ætiology), and the patient shares our view of their pathological nature, we are forbidden by the grammar to consider them as psychotic. Here

the close connection between incomprehensibility and psychosis is strikingly manifest.

In addition, a number of authors have pointed out problems related to the predominant tendency in the DSMs to conceptualise delusionality as a disorder of inferential thinking, a misinference (Fulford 1989, Spitzer 1990, Rudnick 1997). They propose that identifying psychotic symptoms as simple misinferences or misperceptions does not pay due attention to the fact that psychoticism usually involves disordered evaluation of background assumptions. Thus modern nosological conceptualisations of 'psychosis' are bound to present a contentually impoverished version of the concept: operationalisation, the focus on reliability and the consequent decontextualisation make it increasingly difficult to appreciate meaningful aspects of the 'psychosis' concept, i.e. what is really wrong in 'psychotic' symptoms (Fulford 1989; Rudnick 1997; Parnas 1999).

What is central for the purposes of this thesis is to recognise the progressive narrowing of the extension of "psychosis" and how attempts to decontextualise the concept by using explicit criteria are thwarted by the necessity to appeal to "incomprehensible" features or "lack of insight".

5.2. Significant philosophical accounts of 'psychosis'

5.2.1. Finnish literature

There is only little Finnish literature addressing issues in the philosophy of psychiatry and specifically intended as independent contributions to the field. There are, however, some authors in whose writings the concepts of 'mental disorder', 'psychosis' or 'schizophrenia' have received specific focus, and who deserve mention in this context.

In the twentieth century there are three names which deserve mention: the psychiatrist Martti Siirala, the psychologist Lauri Rauhala and the philosopher Oiva Ketonen. The work of both Siirala and Rauhala manifests an active attempt to reconceptualise mental illness, in the former case as a transformation of 'social pathologies' insidiously present in societal life (Siirala and Benedetti 1961; Siirala 1983), in the latter by means of a personalist reading of Heidegger's *Sein und Zeit*, as forms of maladaptation or response to maladaptive psychological environment (Rauhala 1987). Both authors argue against a one-sidedly medical concept of mental illness (Siirala 1961, Rauhala 1990). Ketonen too has addressed the issues of psychiatric diagnosis (1987, 1992) and treatment (1978) in brief essays of considerable logical clarity and conceptual force. For instance in his essay "Mielisairauden käsite – filosofin näkemys" [The concept of mental illness:

a philosopher's view] he gives an illuminating description of what it means to "understand reality", that is, for psychiatric purposes, to have intact reality testing:

> Todellisuuden ymmärtäminen ei ole vain kokemuksen todellisuuden käsittämistä, vaan pikemminkin yleisesti ottaen, mikä on todellisuuden rakenne, kuinka se 'toimii' ja mikä on mahdollista. … Se on myös intuitio siitä, mitä me odotamme kuuluvan siihen maailmaan, jota emme ole vielä kohdanneet. (Ketonen 1992: 11.)
>
> [Understanding reality is not merely grasping the reality of an experience, but rather grasping the structure of reality more generally, how it 'functions' and what is possible. … It is also an intuition of what we can expect to belong to that world which we have not yet encountered. (My translation.)]

Among the younger generation, Jorma Laitinen has investigated psychiatric diagnosis (1977) and schizophrenia (1994) from a philosophical perspective. The philosopher Jyri Puhakainen recently stirred some public debate with his affirmation of the person (1998); yet this volume mainly drew on Rauhala's work and the existing international debate on the legitimacy of scientific medicine, and had little original to contribute beyond its polemical merits.

5.2.2. International literature

The picture of the conceptual history of 'psychosis' drawn in 4.1 describes by and large the evolution of conceptualisations acceptable to the psychiatric establishment of their time. Contemporary philosophically oriented accounts are nevertheless often radically divergent in the claims they make. Particularly conspicuous among these are the writings of Thomas Szasz and Michel Foucault; Szasz attacks the concept of mental illness as a whole, 'psychosis' included, while Foucault focuses specifically on the transformation of 'madness' to a medical disease entity.

As examples of these critical accounts, the following are worth describing in some detail:

a. Szasz's 'physicalist' rejection of the concept of mental illness as being medically relevant only by way of metaphor, as there are no physical findings essential for calling a phenomenon a 'disease' (Szasz 1972, 1982; Fulford 1989).

b. Foucault – a philosopher and ardent investigator of structural forms of societal power – has been a seminal figure in sociologically

oriented accounts of 'madness'. In his writings (1987, 1967), he describes psychiatric concepts such as 'schizophrenia' as a form of societal power that tames the societally disruptive and threatening voice of 'madness' into an organic defect state.

c. Ronald Laing, a clinical psychiatrist, in his early work (1960) made room for the patient's subjectivity in understanding mental illness. In his later work (1967) Laing espoused a radical reformulation of mental illness as a veritable form of individual mutiny against oppressive societal conditions, and as a 'breakthrough' to novel forms of existence.

These critiques received their most active socio-political expression in the so-called 'anti-psychiatric' movement of the 1960s and 1970s, with overtones of leftwing radicalism and consumerism. The practical consequences of this movement were most concrete in Italy, where legislative measures led to the actual closing down of mental hospitals.

The work of these writers, and the political visibility of the antipsychiatric movement, gave rise to an extensive debate on the legitimacy of psychiatric concepts, echoes of which still emerge occasionally in the psychiatric literature. The spirit of this discourse has often been the clash between on the one hand writers keen to challenge the legitimacy of the psychiatric 'reduction' of madness (Lanteri-Laura 1999), on the other proponents of the status quo attempting to invalidate this criticism (Vatz and Weinberg 1994; Gutting 1994). Yet beyond the writings of these initial epigones, whose works are still of interest in the philosophy of psychiatry (Vice 1992), relatively little constructive writing has emerged from this often highly adversarial and impassioned discussion, and by 1980 the momentum of the antipsychiatry movement had shifted from an intellectual discursive activity to a consumerist movement (Rissmiller and Rissmiller 2006).

A few later writers are also worth mentioning:

The work by the sociologist Jeff Coulter, *Approaches to Insanity* (1973) was an important early discussion of the concept of mental disorder and its conceptual commitments. Likewise his later paper on the "grammar of schizophrenia" (1991) is a thought-provoking, subtle essay, delving into the conceptual commitments of this concept in a pragmatic manner. Coulter's main focus in social science, however, has been elsewhere, and his contributions to the field thus remain marginal.

The psychologist Peter Sedgwick (1982) emphasized the role of political commitments in medicine and psychiatry (Vice 1992); he proposed that all illnesses

are in the first instance deviances, which receive a characteristic response from patients' families, peers and society at large. Unlike Szasz, Sedgwick does not see any fundamental difference between physical and mental illnesses, but he is critical of the estrangement from societal activities that is likely to be created by poorly administered and financed psychiatric care facilities (Vice 1982). Sedgwick's activities in this field were thwarted by his early death.

Other writers focusing their critical accounts specifically on conceptual aspects of schizophrenia are Hunt (1990), Margolis (1991), Boyle (1990) and Bentall and Slade (1992).

Paper I will contribute directly to this discussion by elucidating the conceptual moorings of 'psychosis'.

5.3. The concept of delusion

As already pointed out in 4.1, from a historical perspective delusionality has been a central focus both in the evolution of the nosology of psychosis and in the debate over the philosophical ramifications of this nosology. Jaspers mentions delusionality (*Wahn*) as the central defining feature of schizophrenic symptomatology (Jaspers 1965), while Freud's conception of defective reality testing focuses primarily on explaining delusionality as a phenomenon.

In the post-war literature too delusions occupy a central position, and the bulk of this literature focuses directly or indirectly on explaining delusions. Schneider's distinction between 'one-linked' and 'two-linked' delusional phenomena (delusional idea vs. delusional perception; Schneider 1949) was assimilated by British psychopathology and critically evaluated by Spitzer (1990). A conceptual history of this controversy is provided by Berrios (1991).

The central theme within contemporary writing on delusion is the following: is delusionality explicable, perhaps simplistically, as a form of misinference (Rust 1990, Stone and Young 1997), as a higher level loss of rationality (Davies 2001, Campbell 2001, Hohwy 2004), or are other conceptual frameworks necessary to account for it (Fulford 1993, Gillett 1994, Sass 1995, Jones 1999, Gerrans 1999, Parnas and Sass 2001, Kapur 2003)? The contrast is typically between medicalist attempts to describe delusions as (simple) neurological symptoms and critical accounts that assume that this reduction is not a viable programme.

Fine, Craigie and Gold (2005), in their recent review of research, propose a two-by-two model of the basic assumptions underlying the relevant studies. They distinguish on the one hand between explanatory vs. expressive approaches

(delusion as an explanation of anomalous experience vs. as a direct expression of an anomaly), on the other hand between the presence or absence of a "belief acceptance anomaly", i.e. the proneness to take for granted notions most of us would disregard as being out of question. They conclude that none of the four possible combinations of these basic assumptions can withstand scrutiny in the face of the available empirical data. Yet they fails to explore critically the validity of the basic assumptions of research tackling this issue.

Campbell's (2001) article is an interesting comment within this debate, and he is able to provide suggestions as to how to make the basic assumptions in the field more valid. In the following, I discuss this article at some length in order to make Campbell's ideas more accessible.

Campbell formulates the question as pertaining to the content of the basic delusional belief. He points out that

> The basic philosophical problem raised by delusions is … since we have to ascribe meaning in such a ways as to make the subject rational, we end up having no way in which to formulate the content of subject's delusion. (Campbell 2001: 91.)

That is, due to our characteristic way of reading rationality into persons, the question is how we can frame the content of their irrationality in the first place.

Campbell describes the divergences in the models available in this field as between empiricist and rationalistic accounts of delusionality. The former are 'bottom-up' theories, which describe delusions as rational responses to abnormal experience. The latter, on the other hand, assume a 'top-down' disturbance of belief formation.

Campbell first discusses two articles (Ellis and Young 1990; Stone and Young 1997) as examples of empiricist accounts. They develop explanations of the Capgras' delusion (a delusion whereby individuals typically experience people close to them as being replaced by impostors) as originating from a mismatch between a lacking normal emotional response to close people (supposedly due to neurological dysfunction) and the recognition of their numerical identity, and reacting to this odd situation by forming a belief like Capgras' delusion. Campbell puzzles over how rational it really is to respond in this exceedingly far-fetched manner. He points out that

> … the key question is whether the deluded subject can really be said to be holding on to the ordinary meanings of the terms [he seems to be using]. (Campbell 2001: 95).

According to Campbell, empirical accounts are unable to tackle this question in the first place, due to the commitments they have to make to frame the subject of their account. Thus some top-down disturbance in a belief system has to be assumed when the concept of 'delusion' is applied.

Second, Campbell offers an alternative rational description, drawing on Wittgenstein's late work in "Über Gewissheit" and in terms of deviant 'framework propositions' – referring to the kinds of basic assumptions we have to have in the first place, to be able take part in any discursive activity. Citing Wittgenstein:

> All testing, all confirmation and disconfirmation of a hypothesis takes place already within a system. And this system is not a more or less arbitrary and doubtful point of departure for all our arguments: no, it belongs to the essence of what we call an argument. The system is not so much the point of departure, as an element in which arguments have their life [Lebenselement der Argumente]. (Wittgenstein 1969, §105)

Likewise, Campbell points out that only when we have our 'framework propositions' correctly in place does it make any sense to try to establish the content or correctness of our beliefs. Thus Campbell proceeds to ask whether delusional beliefs have the same epistemological status as 'framework propositions'.

This attempt to describe the failing rationality in delusionality comes close to that given in Paper III, and Campbell draws a parallel conclusion as to the definite inadequacy of dealing with delusions as a form of misunderstanding.

Another point of interest is the "explanatory plus presence of belief acceptance anomaly" (Coltheart 2005) model of the Capgras' delusion proposed by Langdon and Coltheart (2000), in which they appeal to a "bias to favour personal rather than subpersonal causal explanations" as a partial explanation of the "belief acceptance anomaly". In effect, this means that in order to account accurately for anomalous rationality in delusions, we have to appeal to person-level concepts; this implicitly means that delusions as phenomena cannot be understood without recognising their contextualisation as anomalies of personal existence.

Paper III will contribute directly to this discussion, by showing that some aspects of the grammar of delusion in principle resist being framed as forms of misinference (misunderstanding).

5.4. On the conceptual history of 'understanding' and 'incomprehensibility' in psychiatry

The principal locus of the discussion of our understanding of psychotic phenomena and its limits is Jaspers' widely read account of schizophrenia as an incomprehensible disorder proper (Jaspers 1965, Hoenig 1965). Most of the subsequent discussion, until quite recently, has taken this controversial concept as its point of departure, either directly (Jenner, Monteiro and Vlissides 1986, Walker 1995, Hoerl 2001) or indirectly (Stotz-Ingenlath 2000). Read's professedly 'Wittgensteinian' account of the limits of understanding in psychiatric disorders has conferred a new philosophical credibility on the old distinction between 'understandable' and 'incomprehensible' elements in psychiatric disorders, and has spurred a series of responses (Read 2003; Sass 2003).

Another work on a related theme is Freud's (1919) essay *Unheimlichkeit* [the Uncanny], where he relates the source of horror experience to the return of the familiar in covert form. Fredrick Svenaeus has developed this idea towards a conception of illness as a rupture in "homelike Being-in-the-World", with Heidegger's phenomenological ontology as the major philosophical stimulus (Svenaeus 1999, 2000).

Another form of questioning of 'understandability' or its absence has lately taken place in the form of questioning of the narrative self and its coherence (Silvern 1990, Phillips 2003), echoing recent developments in the conceptualisation of the human sciences (Phillips 1991). In this context, mental illness is conceived of as manifesting a contingent limit on the possible coherence of self-narrative (Phillips 1991, Silvern 1990). Some writers, however, assume that a certain incoherence is constitutional to human beings (Lacan 1980). This 'narrative turn' has also been influential in conceptualising therapeutics, specifically in the family therapy movement (White and Epston 1990; Holma 1999; Seikkula 2003)). Gallagher (2004), writing on the application of 'interaction theory' in describing and accounting for autism, is an example of research that couples conceptual analysis with a neuroscientific research agenda.

A novel way to frame issues relating to understanding others in the context of psychiatric work is raised by the metaphor of 'world-travelling' by Potter (2003). Despite its practical merits, Potter's paper is reluctant to engage with the deeper conceptual levels of this issue. Misak's paper (2005) is an instructive account of the limits of autonomy in the face of severe mental illness; the writer succeeds in articulating the significance of the logical features of the concept of psychosis for the concrete illness experience and for how one copes with it.

Both papers III and IV will contribute to this discussion directly. They add to the existing literature by emphasising the distinction between empirical debate (reading Jaspers' thesis as an empirical one) and conceptual analysis (where Jaspers' thesis is understood as symptomatic of the proper logic psychiatric concepts) and by showing that the radical failure of understanding or narrative coherence is a central logical characteristic of the concept of psychosis.

5.5. On the conceptual history of 'person' in psychiatry

The concept of 'person' has an extensive historical presence in the philosophy of psychiatry. One of the main themes in the theoretical discussion concerning psychiatric diagnostics and therapeutics has in fact been the clash between personalist and organicist forms of explanation. In early nineteenth century Germany this clash took the form of the opposition between *Somatiker* and *Psychiker* (de Beer 1995a); in the early twentieth century, Binswanger's and Gebsattel's 'anthropological' (Spiegelberg 1972) approaches to relations between the human being and illness were influential in the field. Another strand of the same issue is the conceptual history of the 'self' in psychoanalytic and post-psychoanalytic psychotherapeutics (existential psychiatry, self-psychology etc.) (Mann 1991, Sass 1992a, Sass 1992b).

In the recent philosophy of psychiatry this questioning has been present from the beginning, with the central theme of how to account for the intuitive freedom of personal being (Gawin 1969, Richardson 1979, Schneider 1973, Barnes 1981, Gillett 1990, Mann 1991, Binns 1994, Harré 1997, van Staden 2002, Thornton 2003, Miron 2004). A somewhat narrower thematisation has focused on the concept of 'personal identity' (Hope 1994, Hinshelwood 1995); this has spurred a specifically extensive debate with the presence of the nosological concept of 'identity disorders' in current psychiatric classifications (Apter 1991, Clark 1996, Gillett 1997, Matthews 2003).

Another strand in this discourse is found in writings that emphasise the significance of 'subjective experience' and the necessity of taking this into account in psychiatric practice and nosology (Estroff 1989; Liebermann 1989; Strauss 1989, 1991, 1996; Davidson and Strauss 1992). Likewise Strauss (1992) connects this concern with that for the role of the 'person' in psychiatric discourse.

Recently, Parnas (Parnas and Sass 2001, Parnas and Handest 2003) has dealt extensively with the phenomenology of person-related features (*Ich-Störungen*) in classic conceptions of schizophrenia. Fuchs (2002), in a short review of the

relations between 'person' and psychosis, points out the centrality of this concept for understanding 'psychosis' as well as mental disorders more generally.

Paper II adds directly this discussion by providing a detailed analytical account of the uses of 'person' concepts in the context of clinical psychiatry.

5.6. Prodromal symptoms of psychosis

One recent development in the field of psychosis research is the increasing focus on the early stages of psychosis, with the aim of developing early identification and treatment options. Since in this context the limits of this already controversial concept are stretched even further, this has given rise to a philosophically informed debate on the conceptual and ethical vagaries inherent in this endeavour.

Bleuler already explicitly recognized the presence of an often extended prodromal period in schizophrenic psychoses, but he considered its clinical picture to be too variable and unstable to be of diagnostic use (Bleuler 1908). Parnas and Handest (2003) recognise Joseph Berze's work (1914) as a sophisticated description of the early stages of schizophrenia. Meyer-Gross (Huber 1995) was one of the first psychopathologists to draw attention to their potential utility in preventive work. Conrad's monograph (Conrad 1958) was the first systematic exposition of the symptomatological features of the early stages of schizophrenia (although published only in 1958, the empirical material for this study was collected during 1940-41).

Another empirical line of research comes from Schneider's disciple Gerd Huber, who applied a strong concept of schizophrenia, implying homogeneity in the evolution of the disease process. On the basis of longitudinal data he proposed the concept of 'basic symptoms' (*der Basis Symptom*), which are described as subtle, mostly subjectively experienced mild disorders in perception, cognition, information processing, speech or action, and which are prevalent in the pre-psychotic or residual stages of schizophrenic psychoses (Huber 1995). According to Huber, these symptoms are specific expressions of schizophrenic vulnerability; they are described as preceding psychotic decompensation and as being sometimes the only clinical manifestation of a proneness to schizophrenic psychoticism. There are some research data to support these claims (Klosterkötter et al. 2001; Schultze-Lutter et al. 2007).

Recent research in this field has emerged primarily from a clinical perspective, following Falloon's seminal study (Falloon 1992) and McGorry's Australian group's systematic conceptual and practical innovations (McGorry 1991; Yung and McGorry 1996; Yung et al. 1996; McGorry, Yung and Phillips 2001; McGorry, Yung

and Phillips 2003; McGorry et al. 2006). The central features of this agenda are a broad preventive clinical focus, the use of mild symptomatic features as proxies for targeting psychosis risk, the active development of treatment and educational strategies, and the simultaneous development of service provision and research studies.

Conceptual questions have also had a recognizable though not prominent presence during this expansive phase of development, and both conceptual and ethical issues are dealt with in occasional papers (Larsen and Opjordmoen 1996; Parnas 1999; Heinimaa and Larsen 2002; McGorry, Yung and Phillips 2003; Jackson 2003; Yung 2003; Corcoran, Malaspina and Hercher 2005; Nelson et al. 2008). Earlier papers focused prominently on the conceptual unclarities related to early stage concepts (Larsen and Opjordmoen 1996; Parnas 1999), while more recent writings have mostly been fairly uncritical with regard to nosological issues and have rather focused on ethically precarious issues relating to early detection and intervention agendas (Corcoran, Malaspina and Hercher 2005).

Paper V will contribute directly to this discussion by focusing on a description of the conceptual problems related to the concept of 'prodromal symptom of schizophrenia', and by applying insights gained in the other studies (Papers I, II and III) in this context.

6. DETAILED PRESENTATION OF ARTICLES AND THEIR CONCLUSIONS

The overall line of reasoning in the five publications is as follows:

The conceptual analysis of 'psychosis' in the first[4] article, "On the grammar of psychosis", shows that this concept is logically dependent on concepts 'understanding' and 'person'. In the second article, "Ambiguities in the psychiatric use of the concepts of the person - An analysis", I present a detailed analysis of the use and functioning of such person concepts as 'self', 'sense of self' and 'person' in one particular psychiatric text. The grammar of 'understanding' is next tackled in the third article, "Incomprehensibility: the role of the concept in DSM-IV definitions of delusion", from the opposite end, by studying the role of 'incomprehensibility' in definitions of schizophrenic delusions. This question is examined more closely in the fourth article (actually a chapter in an edited volume) entitled "Incomprehensibility". Finally, the fifth article, "Conceptual problems of early intervention in schizophrenia", applies the insights gained in these studies to the more practical question of the conceptual and ethical problems associated with the concept of 'prodromal symptom of schizophrenia' and the agenda of early detection and intervention in schizophrenia more generally.

6.1. *On the grammar of psychosis*

The concrete aim of this article is to examine the use of the concept of 'psychosis' in ordinary clinical encounters and settings. The choice of this concept for detailed scrutiny was motivated by the central place occupied by major psychoses in the focus of psychiatric work and research since the mid-eighteenth century. The concept itself is an important one in the process of formation of modern psychiatry, and despite the considerable vacillation in its role in recent psychiatric nosology, in clinical practice it remains a major distinction made by psychiatrists in assessing and treating psychiatric patients and in making individual clinical decisions.

The concrete analytical move is to examine the philosophical grammar of 'madness'. In this analysis, a clear asymmetry emerges between first-person expressions (e.g. "I am mad") and third-person expressions ("He is mad"). This is further analysed in relation to "understanding" and "person" – two concepts which are powerfully

[4] This refers to logical order and to the order of conceiving these separate studies, not to the chronology of their publication.

interconnected. Saying that someone is 'mad' appears in this analysis tantamount to him/her being in principle incomprehensible. The relevance of these findings for understanding the uses of 'psychosis' is made clear in the discussion. The findings of the paper boil down to the following theses:

1. 'Psychosis' is a primitive term of psychiatric discourse, not amenable to an exhaustive definition in terms of more elementary psychiatric concepts.

2. The concept of 'psychosis' marks the extreme limit of a person's intelligibility to others as an understandable person, as shown by its logical dependence on the grammar of incomprehensibility.

3. Consequently, the uses of 'psychosis' are dependent on local conditions of understandability, and the concept is rigorously context-dependent. Attempts to decontextualize 'psychosis' from its practical uses make its content unclear.

This study gave rise to two questions for further scrutiny: 1) how to characterise the meaning of 'not-understanding' or incomprehensibility and what are its implications, 2) what is the meaning of 'person' as used in contexts relevant to clinical psychiatry.

6.2. *Ambiguities in the psychiatric use of the concepts of the person - An analysis*

Following the lead found in the analysis presented in 5.1, the logic of the uses of person-concepts in psychiatric discourse was explored by means of a detailed textual analysis of one particular psychiatric text (Davidson and Strauss 1992), recently published in a psychiatric journal. Dealing extensively with an original psychiatric article was justified by the methodological notion that the task of philosophical clarification is to stay as close as possible to the concrete contexts of language use, not in an attempt to set normative standards for language use but rather in order to make the relevant language uses more perspicuous, more readily accessible in the whole of their connections and implications.

The main questions this article set out to investigate were

1. What are the uses to which concepts of the person, such as 'self', 'sense of self' or 'person', are put in psychiatric discourse?

2. Does the description of their use clarify the significance of conceptual and empirical elements in conceptions of mental illness?

The concrete analysis of Davidson and Strauss' article was carried out by first collecting and grouping all expressions using one or more of the relevant concepts ('self', 'sense of self', 'agent', 'person', 'subject', 'one' and 'people'), and then dividing these groups into subgroups according to the similarity or dissimilarity of the uses to which the relevant concept was put (the analytical procedure).

Thereafter, representative examples of the subgroups found were taken as typical instances of the type of use in question and were analysed further in terms of their interrelations and mutual substitutability, to give a clearer picture of the distinctions made between these usages (the synthetic procedure).

The 'Discussion' section fell into two parts. First, the functioning of self-concepts in two-person psychiatric discourse (limited to first- and second-person expressions) was analysed to determine their role in constituting specifically psychiatric kinds of phenomena. Second, the grammar of person was studied with a focus on third-person expressions in psychiatric speech.

The main findings of this analysis were as follows:

1. With regard to the uses of person-concepts in psychiatric discourse, the study showed that the concept of 'self' stands for the objects of psychiatry in the various ways they are conceived (as facts, resources, tools or agents); the use of 'sense' together with 'self' gives expression to the potentiality of an individual (a patient) to overcome the determinacy of 'selfhood', while the use of 'person' manifests an attempt to address patients as active participants in psychiatric discourse..

2. Concepts of psychiatric disorders are closely bound and logically dependent on the concept of personhood: not only is the concept of 'psychiatric disorder' constituted in violation of ordinary forms of discourse, but the conception of recovery also seems to be bound up with the idea of retrieving one's role as a participant in ordinary discourse.

3. The ambiguity of 'person' in psychiatric texts stems from an attempt to describe clinical situations without undermining the radical 'openness' of being human (Taylor 1985).

4. The interplay between 'self' and 'sense of self' allows us to express psychiatric problems as involving pathological experience and at the same time to experience the possibility of overcoming the 'destiny' imposed by the 'flawed self'.

The main finding of this study is the central role played by the ambiguous uses of 'person' in enabling a specifically psychiatric kind of concern in human affairs. Harré (2000) was an invited commentary on this article while Heinimaa (2000) represents my response to Harré's commentary.

6.3. *Incomprehensibility: the role of the concept in DSM-IV definitions of delusion*

The grammar of 'understanding' was tackled from the opposite end, by studying the logic of the concept of 'incomprehensibility'. This methodology was chosen due to the following considerations:

1. Early attempts (Heinimaa, 1992) at analysing the concept of 'understanding persons' by contrasting it with the concept of 'knowing persons' failed to address the specific concerns in the context of psychiatric discourse, and were bound to divert attention from concrete psychiatric language use (Peter Winch, personal communication).

2. There are indications in the literature that studying the positive concept as such is not a primary promoter of conceptual understanding: as Heidegger points out, our material or conceptual tools show their "Vor-Handen-Sein" only where this accessibility is compromised (Mulhall 1990). Foucault (1987) claims as a general thesis that psychological conceptualisations need failures of psychological coping to become manifest, while Gadamer (1993), in "Verborgenheit des Gesundheits", demonstrates that health is what is hidden and is only manifested in illness.

First, in paper III**,** the role of the concept of 'incomprehensibility' was studied in the context of the definitions of delusions given by the DSM-IV classification in describing schizophrenic delusions.

The contents of paper III fall into two parts, the first concentrating on bizarre delusions, the second on the DSM-IV definition of delusion in its entirety. In the first part, components of the DSM-IV characterisations of a bizarre delusion ("clearly implausible content", "non understandable", "do not derive from ordinary life experiences") are analysed with the help of examples of imaginary language use. In the second part, the analysis deals with the framing of delusions as "misinterpretation[s] of perceptions or experiences", and the inconsistencies of this conceptualization.

The main findings of this paper were a follows:

1. The definition of bizarre delusion is internally contradictory, based on mutually exclusive criteria of implausibility and incomprehensibility in conjunction.

2. The organising concept in the definition of delusion is 'misinterpretation'; this interpretation leads to impoverishment of the content of the concept of delusion.

3. Uses of 'delusion' are better accounted for in terms of the grammar of 'incomprehensibility' than of that of 'misinterpretation'.

All in all, this analysis illuminates how ambiguities in the DSM-IV definition of delusion boil down to the question whether psychiatric practice is better accounted for in terms of the grammar of 'misinterpretation' or of 'incomprehensibility'.

6.4. *Incomprehensibility*

The grammar of "incomprehensibility" was further focused on by drawing on the distinction between positive and negative conceptions of 'incomprehensibility', based on Cora Diamond's discussion of "positive and negative conceptions of nonsense" in Wittgenstein's philosophy (Diamond 1986, Wittgenstein 1953). The main finding of my study was that the distinction has wide-ranging implications for our understanding of psychiatric concepts.

At the beginning of the article, instances are cited from the psychiatric literature of encountering the question of how to understand 'not understanding'. Diamond's distinction between positive and negative conceptions of nonsense is then applied in this setting. The meaning of this distinction is further characterised by appealing to examples from the writings of Wittgenstein and Peter Winch. The article concludes with a discussion of some of the implications of this analysis.

The main finding of this paper can be summed up as follows: saying that something is incomprehensible is not after all an explanation but rather an expression of despair, where our ordinary ways of comprehending people and situations elude us. In other words, 'incomprehensibility' is not a form of understanding at all, but marks the limits of understanding in human life.

6.5. *Conceptual problems of early intervention in schizophrenia*

Some of the findings obtained in these studies were "put into practice" by exploring the more practical question of the conceptual and ethical problems associated with the concept of 'prodromal symptom of schizophrenia', and the agenda of early detection and intervention in schizophrenia more generally. The main finding of this study was that given the current state of affairs, the legitimacy of applying this concept in clinical work is institutional rather than scientific in character.

7. DISCUSSION

A clearer view of psychiatric conceptualisations and their rootedness in concrete linguistic and extra-linguistic practices enables us to recognise the highly unstable status of psychiatric concepts as cultural constructs. This observation in no way undermines the significance of scientific data relevant to psychiatric practice; but it shows that scientific data are subordinate to the whole of the practical institution of psychiatry.

Effectively, this means conceiving psychiatry as an independent system of practices and corpus of knowledge, whose basic concepts are constitutive and also symptomatic of the field of events with which it confronts itself. In this sense, 'psychosis' is a psychiatric 'primitive'; it is a conceptualisation of the events that have relative primacy in delimiting this field from other professional and human activities.

The following question is likely to be raised: If defining psychoticism is dependent on a concept that ultimately has no substantial (empirical) reference, what are we doing when we assert psychosis as a nosological concept or as a determination of a nosological concept (as in 'psychotic')? Isn't 'psychosis' left hanging in the air, and don't its users fall victim to nonsense metaphysics, if the concept is not explicable in other terms, grounded ultimately in the empirical world of medicine?

I would respond to this query along the following lines:

Besides being conventionally understood as a referential expression (identifying a clinical syndrome or state), uses of the concept of psychosis also mark the very limits of a person's intelligibility to others. As I see it, this dual structure or inherent ambiguity of 'psychosis' can be described in terms of the positive and negative conceptions of 'incomprehensibility'.

Immersed in the natural-scientific endeavour of psychiatric research, we need to be able to demonstrate a certain degree of stability in our use of diagnostic concepts. For this purpose, we use explicit and tangible operationalisations of phenomena typically present in diagnosed patients. With regard to psychoses, one consequence of this situation is the recent focus on ensuring the reliability of its diagnostic definitions, another the general trend of attempting to minimise the role of the concept of 'psychosis' in classification. For these purposes we have to rely on a positive conception of incomprehensibility: we deal with 'psychosis' or 'psychotic symptoms' as empirical facts. This has led to increasingly narrow

definitions with seemingly self-evident symptom concepts, such as the presence of delusions defined as 'wrong beliefs' or as 'misinterpretations', hallucinations or 'grossly incoherent' thinking or speech. "Seemingly", as even now, the use of any of these concepts and consequently the diagnosis of their presence "in a patient" entails an appeal to incomprehensible features in the way the patient presents to us (See article I).

Thus the price we pay for these referentially more stable and (to the scientific community) more palatable definitions has been that we are forced to propose exceedingly narrow explications of psychosis, creating a gap between official definitions and concrete clinical uses, as with the DSM-III system (APA 1980). Even further, the DSM-IV (APA 1994) has been forced to use five different syndrome-dependent definitions of psychotic symptoms, thus implicitly acknowledging the inherent disunity of modern explications of this concept, which nevertheless is central to our conceptions of major psychiatric disorders. Thus it is clear that we have a problem here, nor have we come that far from the situation described by Erik Strömgren in 1969:

> It is quite striking that although most contemporary psychiatrists seem to use the term "psychosis" in roughly the same sense, very few make attempts to define it. … Whenever the concept is the subject of discussion among psychiatrists, somebody will say it is impossible to define it, that there is perhaps no content behind the word, and that, therefore, it is useless or may be even harmful. (Strömgren 1969 p. 786.)

From a logical point of view, the decontextualization effort taking place in defining 'psychosis' as the presence of "delusions, hallucinations or incoherence" adheres to a positive conception of incomprehensibility, and is thus inherently compromised (see article IV). 'Incomprehensibility', and consequently 'psychosis', are relational concepts, and any attempt to read these relational events into individuals is doomed to fail. The resulting definitions do not quite achieve their aim. In some situations, as clinicians we may be recommended – against our better knowledge – to withdraw treatment incentives: psychiatric emergencies often miss predefined diagnostic criteria sets, yet give rise to an urge to "do something". In other situations, we may be forced to focus on individuals who from our practice-based experience do not really belong to the proper focus of psychiatric attention: in preventive treatment settings this is a potential source of confusion.

To mention an example of a comparable 'nemesis' of a clinical concept, Parnas and Bovet (1991) have described the 'disintegration' of the concept of 'schizophrenic

autism', when subjected to conceptualization according to the practices of "standard objectivistic descriptive model of medicine".

On the other hand, if we take seriously the hint provided by the discussion of the "negative conception of nonsense" and its implications for the concept of psychosis (see article IV), we are forced to conclude that the concept of 'psychosis' cannot in principle be severed from the clinical contexts of its use.

In this sense, one can maintain (as I have pointed out as a conclusion in article I) that the uses of 'psychosis' are dependent on local conditions of understandability, and that the concept is rigorously context-dependent. Its proper context of application is within professional psychiatric practice, where it serves to discriminate situations where people are more or less incapable of maintaining their integrity vis-à-vis their surroundings and their life histories. This uprootedness is a serious threat for both the individual and the local community, and 'psychosis' is a way to locate the sources of this threat to the individual. This conclusion come very close to Sedgwick's (1982) position, according to which all illnesses (not only psychoses) are primarily social maladies and their medical explanations invariably play a secondary role.

Thus it is something incomprehensible, something the local community is unable to share with the patient, that psychiatrists are confronted with; and it is against this incomprehensibility that psychiatrists as practicing clinicians attempt to provide novel understandings, in some cases working things out practically and in some cases by appealing specifically to psychiatric terminolology, framing what takes place in terms of 'psychotic symptoms'. But the frame of reference within which these psychiatric understandings occur is delimited by situational features, by the fact that posing the question of the presence or absence of psychoticism only arises when we are confronted with the 'incomprehensible'.

What are the concrete implications of what I am suggesting here? Do these considerations somehow do away with the concept of psychosis? That is not my reading of it. Rather, they put the concept into context as a specifically psychiatric one: one which is meaningful only in environments where psychiatric clinicians do their work. Clinically significant psychological and behavioral dysfuntion would then mean discontinuities in the life stories of our patients so severe that we cannot account for them in ordinary psychosocial terms. Thus they force us to look for alternative explanations, at other levels of description (Fabrega 1991).

In a nutshell, saying that something is 'incomprehensible' is not giving an explanation, the reference of which would be the inconceivable state of affairs depicted. Consequently, the concept of 'incomprehensibility' does not imply

anything specific or generally conceivable about the conditions of its occurrence. It merely shows us that whatever understanding we have pursued is not available, and that we have to attempt to understand what is presented to us in a novel way.

It is good to realise that statements to the effect to what I have said have formely been made by experienced clinicians. I might refer for instance to the article by Erik Strömgren (1969), where he concludes that no satisfactory definition of psychosis is available and that this state of affairs should be accepted at face value.

> On the other hand, there is no doubt that there is a practical need for the concept [of psychosis]. Everybody uses it and, in spite of all critical evaluations, it seems to fulfil an important purpose. It must cover something that is an important reality for everyone who has been working practically in clinical psychiatry. … The different definitions [of psychosis] can thus be accepted only with qualification. Their existence may imply a warning that sometimes we should be careful not to define too much, and especially not too clearly. There are concepts, like psychosis, that are of such practical importance as to make them indispensable, even if, at the present moment, nobody can define them in a way that will satisfy anybody. Until we are much wiser that we are now, a certain amount of obscurity is much wiser than brilliant pseudo-clarity. (Strömgren 1969 p. 786.)

The view Strömgren presents us with effectively boils down to the institutional character of the validation available for a concept like psychosis. Since the institution of psychiatric practice could not function as it does without appealing to this obscure concept, we should recognise this need as a real one and be satisfied to work with the concept, without requiring definitive external substantiation of its validity. A similar justification for legitimising early detection and intervention in psychosis is presented in paper V.

Josef Parnas, in his review of recent conceptualizations of the early stages of psychosis, also finds that current notions of psychiatry are conspicuously insufficient for conceptualising schizophrenic change processes:

> From a phenomenological point of view, a fully developed psychotic syndrome signifies the emergence of a new organisational unity where a new order of meaningfulness (a new coherence) has replaced the old one. This new coherence arrests further and complete self-dissolution. … The notion of the 'schizophrenic world' raises some

> limitations of the applicability of the medical model in psychiatric research. If the embodied brain with its consciousness is viewed as incessantly constructing meaning, then psychiatric symptoms are not disconnected and independent form each other. Symptoms cannot therefore be regarded atomistically, either in their definitions or in the search for their causes. Such a possibility offers a serious epistemological challenge to the objectivistic-operational framework of contemporary psychiatry. (Parnas 1999: 27.)

There is presumably also another objection. What about the following facts: 1) psychotic states are readily recognised across cultures; 2) in clinical cases there is a well-demonstrated pathology present, which can be independently identified for instance by neurobiological and epidemiological indices; 3) a psychopharmacologically fairly coherent group of medications ('antipsychotics', all sharing a dopamine D2 receptor blocking effect) have an well documented treatment effect in these states (Kapur and Lecrubier 2003)? Do not all these findings speak for the reality of the clinical concept?

Yet it is important to remember that the recognition, delineation and diagnosis of psychosis are not exercises in neurobiology. In the context of clinical work it is a practical response to a local upset; in research settings it is a more or less practice-based application of inclusion criteria for a group of subjects, whether chosen according to clinical or epidemiological criteria.

Here we are presented with the basic disjunction in using 'psychosis': which is the 'true' reference of the concept of psychosis the clinical or the 'scientific' one? Is it the one applied by practical clinicians in treatment settings or the one that is formed by applying operational research criteria? The groups that get identified as 'psychotic' in these two essentially different settings are probably not comparable. This, however, is too easy to interpret as implicating inaccuracy of clinical diagnosis – "it was false in x % of cases". Such a potential argument is not a 'scientific fact', and – to cite Maj's (1998) astute remarks on clinical versus DSM-IV definitions of schizophrenia – it is difficult to say whether this means that the operational approach discloses the weakness of the concept of psychosis or vice versa.

The above questioning actually re-enacts the "Einheitspsychose" debate (see 4.2). If we accept that psychosis is a clinical concept in the first place, we are prone to see the clinical usage as primary one; what externalist research is able to tell us influences the distinctions we make in practice, but does not underlie them.

So am I claiming that there are no somatic correlates to psychosis? Not at all, rather the reverse. In practice there is a multitude of somatic counterparts to

psychosis – but none of them need be specific to the clinical concept. It is likely that some psychoses are direct consequences of brain disease (think of General Paralysis of the Insane – the most prevalent psychosis of the nineteenth century), while other cases are 'functional' disorders, with brain function clearly implicated but not describable without going into purely hypothetical constructions. And some cases of 'psychosis' would seem to be primarily interpersonal maladies – situations where local belief systems and interpersonal relations malfunction in some idiosyncratic manner.

I would like to underline that these are all 'psychoses', and that the heterogeneity of the phenomena covered by the concept is definitional. Furthermore, it would be misleading to try to distinguish between 'real' and 'pseudo' psychosis in this group of clinical events: the concept simply does not stretch that far without losing its point.

In this light, one could maintain that the DSM-IV, in dispersing 'psychosis' across a spectrum of disorders and giving disorder-dependent definitions of what is required in order to call a disorder 'psychotic', is taking a step towards a more realistic and contextually relevant use of 'psychosis'. The authors of the DSM, however, tend to see this event as lessening the significance of the concept, and with this notion one could disagree.

As a practical conclusion, these logical considerations imply that as both researchers and clinicians we have to remain acutely aware of the differential and radically distinct perspectives we are involved in when doing clinical work. This particular feature of our work has been acutely described by Heinz Lehmann, an eminent Canadian psychiatrist and a firsthand witness of the radically novel perspective on mental illness created by the introduction of chlorpromazine into clinical practice (Healy 2001):

> I think what [we psychiatrists] do is, anyway what I do, is to oscillate, and you have to learn to do that very quickly. I look at somebody completely biologically and a fraction of a second later completely psychologically and a fraction of a second later I look at his social environment and so on. And that keeps going like in a film, until it seems to become a continuum – but is isn't really a continuum, at least, I don't think of it as such. (H. Lehmann in Healy 2001.)

In a way, the incomprehensible discontinuities of the kind of activity we adopt in treating our patients can be described as a mirror image of the incomprehensible discontinuities we are faced with in the lives of our patients in the first place.

It is also of considerable interest to notice that Jaspers himself acknowledged that the recognition of schizophrenic 'incomprehensibility' requires concrete contact with the patient.

> Wir haben die Intuition von einem Ganzen, dass schizophren heißt, aber wir fassen es nicht, sondern zählen eine Unmenge von Einzelheiten auf oder sagen "unverständlich", und jeder begreift dies Ganze nur in eigener neuer Erfahrung in Berührung mit solchen Kranken. (Jaspers, 1965: 486-7.)

> We have the intuition of a whole which we call schizophrenia, but we do not grasp it; instead we enumerate a vast number of particulars or simply say 'ununderstandable', while each of us only 'comprehends' the whole from his own new experience of actual contact with such patients. (Jaspers, 1962: 582)

This implies that something like "tacit clinical knowledge" is of central importance for psychiatric practice, and that the challenge that our patients present us with is not the correct application of general knowledge but our commitment to react to and recognise what takes place in our patients' lives, whatever the level of description required to grasp this event. Recognition of the requirements placed on the psychiatrist by his or her situation naturally implies that the necessary encounter take place within a professional setting, not in a 'medical factory' producing technological solutions alien to this situational encounter.

One can also point out how the contention of the concept of "mental disorder" running the empirical of "mental disorder" and not the other way round (Paper II) is expressed in the account of psychosis given here: the fact that we are able to conceive the "incomprehensible" encountered in psychoses as signifying a mental disorder is a phenomenon that can only take place against the background of discursive comprehensibility in which we live in. And the relevance of this finding does not concern only psychoses but runs through the entire field of "mental disorders" (Fuchs 2002). It is worth noting that for Jaspers not only psychoses were "incomprehensible" but neuroses, too, though in a narrower sense (see section 4.1.6). And Singh's recent paper shows how similar conceptual commitments (anchored in the notion of "authenticity" and its contradiction, "inauthenticity") also run through lay thinking in conceiving therapeutics of ADHD (Appelbaum 2005; Singh 2005).

It can also be noted that the development of atomistic definitions for delusions and hallucinations, structured assessment methods for the evaluation of their presence (such as the SCID-I)[5] and simplified assessment descriptions for epidemiological use (such as the CIDI)[6] has led to a recognition of psychoticism in the form of 'psychotic symptoms' to an extent that surpasses earlier conceptions (van Os et al. 2000). Researchers obviously see this as a potential screening method for psychotic disorders (Hanssen et al. 2003). Clinicians may also be inclined to interpret this as 'hidden morbidity', and a focus of further research and potentially novel goals for professional intervention. Despite an impressive level of sophistication in the methodology of this area of epidemiological research, such studies are a potential target of methodological distrust, as it is difficult to know what the positive response of a research subject really amounts to. An accurate description of raw data like this would be to say that they tell us about the subject's "proneness to respond affirmatively to CIDI psychosis section items".

In any case, the main conclusion drawn by Van Os et al. from this research data is that psychotic symptoms such as delusions and hallucinations are expressed on a continuum in the population, and they postulate that it is often causes extraneous to these symptoms themselves that bring about a shift to a clinical expression of psychosis (Hanssen et al. 2005). From the conceptual point of view this can be interpreted as a dissolution of 'psychosis' as a factual state of affairs, as its determinants do not manifest "zones of rarity" (Kendell and Jablensky 2003) between their presence and absence; their significance is decided in terms of practical clinical considerations, such as a perceived need of care (Bak et al. 2003; Hanssen et al. 2005).

Another conclusion to be drawn on basis of the studies forming this thesis (specifically article II), but merely alluded to here, is how misleading it is to see psychotherapy as intrinsically separate from psychiatrists' work (either as a different discipline or as a tool in the psychiatrist's tool-box): on the contrary, as far as I can see, the professional encounter - which is often but by no means always referred to as 'psychotherapy' - is at the very core of psychiatry as a profession. The concepts 'psychiatric disorder' or 'psychosis' are constituted in violation of ordinary forms of discourse, and the conception of recovery is bound up with the idea of retrieving one's role as a participant in ordinary discourse. A similar contention was made by Heidegger in his conversations with Dr. Boss:

> Bei ärtzlichem Helfen-Wollen: Zu beachten, dass es immer um das Existieren geht och nicht um das Funktionieren von etwas. Wenn man

[5] Structured Clinical Interview for DSM-IV Disorders (First 1996).

[6] Composite International Diagnostic Interview (WHO 1993), a diagnostic system for the use of lay interviewers in epidemiological research.

> nur das Letztere beabsichtigt, hilft man gar nicht zum Dasein. Dies gehört zum Ziel. (Heidegger 1987 p. 202.)
>
> As to the physician's desire to help [his patient]: One must pay attention to the fact that it always concerns the existence and not the functioning of something. If one only aims at the latter, then one does not help the at all to *Da-sein [to exist]*. But this is the goal. (My translation)

In other words, an illness always appears against the background of our discursive way of being, and all medical help has to occur within this perspective to be truly helpful for the patients affected.

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9. REFERENCES

Acton GS. 1998. Classification of psychopathology: The nature of language. *Journal of Mind and Behavior* 19: 243-255.

American Psychiatric Association. 1980. *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition (DSM-III). Washington DC: American Psychiatric Association.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV). Washington DC: American Psychiatric Association.

Angst J. 2007. Psychiatric diagnoses: The weak component of modern research. *World Psychiatry* 6: 94-95.

Appelbaum P. 2005. Psychopharmacology and the power of narrative. *American Journal of Bioethics* 5: 48-49.

Apter A. 1991. The problem of who: Multiple personality, personal identity and the double brain. *Philosophical Psychology* 4: 219-248.

Bak M Myin-Germeys I Hanssen M Bijl R Vollebergh W Delespaul P van Os J. 2003. When does experience of psychosis result in a need for care? A prospective general population study. *Schizophrenia Bulletin* 29: 349-58.

Baker GP Hacker PMS. 1983. *An analytical Commentary on Wittgenstein's Philosophical Investigations. Vol. 1.* Oxford: Basil Blackwell.

Baker GP Hacker PMS. 1985. *Wittgenstein: Rules, Grammar, and Necessity. An Analytical Commentary on Wittgenstein's Philosophical Investigations, Vol. 2.* Oxford: Basil Blackwell.

Barnes H. 1981. Sartre's concept of the self. *Review of Existential Psychology and Psychiatry* 17: 41-66.

Bayle ALJ. 1822. Traité des maladies du cerveau et des membranes. Cited in: Pichot: 234.

Beer MD. 1995a. Psychosis: From mental disorder to disease concept. *History of Psychiatry* 6: 177-200.

Beer MD. 1995b. The importance of the social and intellectual contexts in a discussion of the history of the concept of psychosis. *Psychological Medicine* 25: 317-321.

Bennett MR Hacker PMS. 2003. *Philosophical Foundation of Neuroscience.* Oxford: Blackwell.

Bentall RP Slade PD (eds). 1992. *Reconstructing Schizophrenia*. London: Routledge.

Berger LS. 1996. Toward a non-Cartesian psychotherapeutic framework: Radical pragmatism as an alternative. *Philosophy, Psychiatry, Psychology* 3: 169-184.

Berrios GE. 1981. Delirium and confusion in the 19th century: A conceptual history. *British Journal of Psychiatry* 139: 439-449.

Berrios GE. 1987. Historical aspects of psychoses: 19th century issues. *British Medical Bulletin* 43: 484-498.

Berrios GE Hauser R. 1988. The early development of Kraepelin's ideas on classification: A conceptual history. *Psychological Medicine* 18: 813-21.

Berrios GE. 1991. Delusions as "wrong beliefs": A conceptual history. *British Journal of Psychiatry* 159 (Suppl 14): 6-13.

Berrios GE Lugue R Villagrán JM. 2003. Schizophrenia: A conceptual history. *International Journal of Psychology and Psychological Therapy* 3: 111-140.

Binns P. 1994. Affect, agency and engagement: Conceptions of the person in philosophy, neuropsychiatry and psychotherapy. *Philosophy, Psychiatry, Psychology* 1: 13-23.

Blankenburg W. 1984 Unausgeschöpftes in der Psychopathologie von Karl Jaspers. *Nervenartz* 55: 447-460.

Bleuler E. 1908. *Dementia praecox oder Gruppe der Schizophrenien*. Leipzig: Deuticke.

Bleuler E. 1949. *Lehrbuch der Psychiatrie.* 8th edition revised by M. Bleuler. Berlin: Springer Verlag.

Bleuler M. 1991. The concept of schizophrenia in Europe during the past one hundred years. In: Flack, Miller and Wiener (eds.): 1-16.

Boyle M. 1990. *Schizophrenia: A Scientific Delusion?* London: Routledge.

Bulbena A Berrios G. 1986. Pseudodementia: facts and figures. *British Journal of Psychiatry* 148: 87-94.

Burston D Frie R. 2006. *Psychotherapy as a Human Science.* Pittsburgh PA: Duquesne University Press.

Bürgy M. 2008. The concept of psychosis: historical and phenomenological aspects. *Schizophrenia Bulletin Advance Access* doi:10.1093/schbul/sbml36.

Campbell J. 2001. Rationality, meaning and the analysis of delusion. *Philosophy, Psychiatry, Psychology* 8: 89-100.

Canstatt C. 1841. *Handbuch der medizinischen Klinik*. Stuttgart: Enke.

Cantell K Koivusalo E Pelkonen R Raivio K (eds). 1987. *Terveyttä etsimässä: Lauri Saxenin juhlakirja*. [In search of Health: In Honour of Professor Lauri Saxen] Helsinki: Otava.

Clark SRL. 1996. Mind, memes and multiplex. *Philosophy, Psychiatry, Psychology* 3: 21-28.

Coltheart M. 2005. Conscious experience and delusional belief. *Philosophy, Psychiatry, Psychology* 12: 153-157.

Conrad K. 1958. *Die beginnende Schizophrenie: Versuch einer Gestaltanalyse des Wahns*. Stuttgart: G. Thieme.

Corcoran C Malaspina D Hercher L. 2005. Prodromal interventions for schizophrenia vulnerability: the risks of being "at risk". *Schizophrenia Research* 73: 173-84.

Coulter J. 1973. *Approaches to Insanity*. London: Martin Robertson.

Coulter J. 1991. The grammar of schizophrenia. In: Flack, Miller and Wiener (eds.): 161-172.

Cousin FR Garrabé J Morozov D. (eds.) 1999. *Anthology of French Language Psychiatric Texts*. Institut d'Edition Sanofi-Synthelabo.

Dalzell TG. 2007. Bleuler's reception of Freud. *History of psychiatry* 18: 471-482.

Davidson L. Strauss JS. 1992. Sense of self in recovery form severe mental illness. *British Journal of Medical Psychology* 65: 131-145.

Davies M. 2001, Monothematic delusions: towards a two-factor account. *Philosophy, Psychiatry, Psychology* 8: 133-158.

Diamond C. 1986. What nonsense might be? In: Shanker (ed.): 125-141.

Drury MO'C. 1973. *The Danger of Words*. London: Routledge & Kegan Paul.

Ellis AW Young AW. 1990. Accounting for delusional misidentifications. *British Journal of Psychiatry* 157: 239-248.

Estroff SE. 1989. Self, identity and subjective experiences of schizophrenia: In search of the subject. *Schizophrenia Bulletin* 15: 189-196.

Fabrega H. 1991. Conceptualizations of human behavioral breakdowns: An analysis using the doctrine of cultural relativism. In: Flack, Miller and Wiener (eds.): 110-143.

Falloon IRH. 1992. Early intervention for first episodes of schizophrenia: A preliminary exploration. *Psychiatry* 44: 4-15.

Faust D Miner RA. 1986. The empiricist and his new clothes: DSM-III in perspective. *American Journal of Psychiatry* 143: 962-7.

Federn P. 1952. Narcissism in the structure of the ego. In: *Ego Psychology and the Psychoses*. New York: Basic Books.

Feuchtersleben E von. 1845. *Lehrbuch der Ärtzlichen Seelenkunde. Vienna: Carl Gerols*. English translation by Lloyd HE (1847): *The Principles of Medical Psychology*. London: New Sydenham Society.

Fine C Craigie J Gold I. 2005. Damned if you do, damned if you don't: the impasse in cognitive accounts of the Capgras delusion. *Philosophy, Psychiatry, Psychology* 12: 143-151.

First MB Spitzer RL Gibbon M Williams JBW. 1996. *Structured Clinical Interview for DSM-IV Axis I Disorders Research Version* (SCID-I). New York: New York State Psychiatric Institute.

Flack WF Jr Miller DR Wiener M. (eds.) 1991. *What Is Schizophrenia?* New York: Springer.

Foucault M. 1967. *Madness and Civilization: A History of Insanity in the Age of Reason*. London: Tavistock.

Foucault M. 1987. *Mental Illness and Psychology*. Berkeley: University of California Press.

Freud S. 1911. Psycho-Analytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia Paranoides). Standard Edition 12: 3-82. Strachey J et al. (eds.) London: Hogarth Press and Institute of Psychoanalysis, 1953-74.

Freud S. 1919. "Das Unheimliche". In: *Gesammelte Werke* Vol. XII: 227-278. London: Imago, 1942.

Freud S. 1924a. Neurosis and psychosis. Standard Edition 19: 147-153. (cf. Freud 1911,)

Freud S. 1924b. Loss of reality in neurosis and psychosis, Standard Edition 19: 181-187. (cf. Freud 1911.)

Fuchs T. 2002. Der Begriff der Person in der Psychiatrie [Concept of the person in psychiatry]. *Nervenarzt* 73: 239-46.

Fuentenebro F Berrios GE. 1995. The predelusional state: a conceptual history. *Comprehensive Psychiatry* 36: 251-59.

Fulford KWM. 1989. *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press.

Fulford KWM. 1993. Values, illness and failure of action. In Graham G (ed.): *Philosophical Psychopathology*. Cambridge MA: MIT Press.

Fulford KWM Sadler JZ Stanghellini G Morris K (eds). 2003. *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry*. Oxford: Oxford University Press.

Gabbard G. 2007. Psychotherapy in psychiatry. *International Review of Psychiatry* 19: 5-12.

Gadamer HG. 1993. *Über die Verborgenheit der Gesundheit*. Frankfurt am Main: Suhrkamp.

Gallagher S. 2004. Understanding interpersonal problems in autism: Interaction theory as an altenative to theory of mind. *Philosophy, Psychiatry, Psychology* 11: 199-217.

Gavin WJ. 1969. The meaning of a person. *Journal of Existential Psychiatry* 7: 33-35.

Gerrans P. 1999. Delusional misidentification as subpersonal disintegration. *Monist* 82: 590-608.

Gillett G. 1990. Neuropsychology and meaning in psychiatry. *Journal of Medicine and Philosophy* 15: 21-39.

Gillett, G.: 1994, Insight, delusion and belief. *Philosophy, Psychiatry, Psychology* 1: 227-236.

Gillett G. 1997. A discursive account of multiple personality disorder. *Philosophy, Psychiatry, Psychology* 4: 213-222.

Graham G 2002. Recent work in philosophical psychopathology. *American Philosophical Quarterly* 39: 109-134.

Griesinger W. 1843. Über psychische Reflexaktionen: Mit einen Blick auf das Wesen der psychischen Krankheiten. *Archiv für physiologische Heilkunde* 2: 76-113.

Gruzalski B. (ed.) 1982.*Value Conflicts in Health Care Delivery*. Cambridge MA: Ballinger.

Gurland BJ Fleiss JL Cooper JE Sharpe L Kendell RE Roberts P. 1970. Cross-national study of diagnosis of mental disorders: Hospital diagnoses and hospital patients in New York and London. *Comprehensive Psychiatry* 11: 18-25.

Gutting G. 1994. Michel Foucault's Phänomenologie des Krankengeistes. In: Micale and Porter (eds.): 331-347.

Guttorm F. (ed.) 1983. *Contemporary Philosophy: A New Survey*. Vol. 4. The Hague: Martinus Nijhoff.

Hacker PMS. 2004. Übersichtlichkeit und übersichtliche Darstellungen. *Deutsche Zeitschrift für Philosophie* 52: 405-420.

Hanssen MS Bijl RV Vollebergh W van Os J. 2003. Self-reported psychotic experiences in the general population: a valid screening tool for DSM-III-R psychotic disorders? *Acta Psychiatrica Scandinavica* 107: 369-377.

Hanssen M Bak M Bijl R Vollebergh W van Os J. 2005. The incidence and outcome of subclinical psychotic experiences in the general population. *British Journal of Clinical Psychology* 44: 181-91.

Harper D. 2001. Online Etymological Dictionary. http://www.etymonline.com/

Harré R. 1997. Pathological autobiographies. *Philosophy, Psychiatry, and Psychology* 4: 99-109.

Harré R. 2000. Verbal games: The redundancy of "self" in psychiatric talk. *Philosophy, Psychiatry, Psychology* 7:137-138.

Healy D. 2001. Psychopharmacologists I. New York: Hodder Arnold.

Heidegger M. 1987. *Zollikoner Seminare, Protokolle-Gespräche-Briefe*. Boss M (ed.). Frankfurt am Main: Vittorio Klosterman.

Heidegger M. 1992. Was heisst Denken? Stuttgart: Philipp Reclam.

Heinimaa M. 1991. "Filosofia terapiana" -metafora Wittgensteinin filosofiassa. [The "philosophy as therapy" metaphor in Wittgenstein's philosophy.] *Ajatus* 48: 152-181.

Heinimaa M. 1992. On understanding and knowing persons. Unpublished paper given 30.11.1992 at Research Seminar of Department of Philosophy, Åbo Akademi, Turku, Finland.

Heinimaa M. 2000. Broken language and broken lives: A response to commentary. *Philosophy, Psychiatry, Psychology* 7: 139-140.

Hilmy SS. 1987. *The Later Wittgenstein: The emergence of a New Philosophical Method*. Oxford: Basil Blackwell.

Hinshelwood RD. 1995. The social relocation of personal identity as shown by psychoanalytic observations of splitting, projection, and introjection. *Philosophy, Psychiatry, and Psychology* 2: 185-204.

Hintikka MB Hintikka J. 1986. *Investigating Wittgenstein*. Oxford: Basil Blackwell.

Hirsch SR Shephard M. (eds.) 1974. *Themes and Variations in European Psychiatry*. Bristol: John Wright & Sons.

Hoenig J. 1965. Karl Jaspers and psychopathology. *Philosophy and Phenomenological Research* 26: 216-229.

Hoerl C. 2001. Introduction: Understanding, explaining and intersubjectivity in schizophrenia. *Philosophy, Psychiatry, Psychology* 8: 83-88.

Hohwy J. 2004. Top-down and bottom-up in delusion formation. *Philosophy, Psychiatry, Psychology* 11: 65-70.

Holma Juha. 1999. *The Search for a Narrative: Investigating Acute Psychosis and the Need-Adapted Treatment Model from the Narrative Viewpoint*. Jyväskylä: University of Jyväskylä.

Hope T. 1994. Personal Identity and Psychiatric Illness. *Philosophy: Journal of the Royal Institute of Philosophy* 37 Suppl: 131-143.

Huber G. 1995. Prodrome der Schizophrenie. *Fortschritte der Neurologie und Psychiatrie* 63: 131-138.

Hunt G. 1990. Schizophrenia and Indeterminacy, *Theoretical Medicine* 11: 61-78.

Hurvich M. 1970. On the concept of reality testing. *International Journal of Psycho-Analysis.* 51: 299-312.

Jackson GE. 2003. The dilemma of early intervention: Some problems in mental health screening and labeling. *Ethical Human Sciences and Services* 5: 35-40.

Jaspers K. 1957. Philosophical autobiography. In: Schlipp (ed.): 5-94.

Jaspers K. 1965. *Allgemeine Psychopathologie*. 8th edition. Berlin: Springer Verlag.

Jaspers K. 1962. *General Psychopathology*. Translated by Hoening J Hamilton MW. Manchester: Manchester University Press.

Jenner FA Monteiro AC Vlissides D. 1986. The negative effects on psychiatry of Karl Jaspers' development of Verstehen. *Journal of the British Society for Phenomenology* 17: 52-71.

Jones E. 1999. The phenomenology of abnormal belief: A philosophical and psychiatric inquiry. *Philosophy, Psychiatry, Psychology* 6: 1-16.

Kaplan HI Sadock BJ Freedman AM. (eds.) 1975. *Comprehensive Textbook of Psychiatry II* (2nd Edition), Volume 1. Baltimore: Williams & Wilkins.

Kapur S. 2003. Psychosis as a state of aberrant salience: A framework linking biology, phenomenology and pharmacology in schizophrenia. *American Journal of Psychiatry* 160: 13-23.

Kapur S Lecrubier Y. (eds.) 2003. *Dopamine in Pathophysiology and Treatment of Schizophrenia*. London: Martin Dunitz.Katanetz EP. 1989. The delineation of schizophrenia from other psychiatric illnesses. *British Journal of Psychiatry* 155: 160-165.

Kendell RE Jablensky A. 2003. Distinguishing between validity and utility of psychiatric diagnoses. *American Journal of Psychiatry* 160: 4-12.

Ketonen O. 1978. Selittämisen, ymmärtämisen ja tulkinnan ongelma inhimillisen kokemuksen tarkastelussa. [The problem of explaining, understanding and interpretation in studying human expericence.] In: Laitinen, Lehtonen and Achté (eds.): 11-35.

Ketonen O. 1987. Todellisuuden taju [Sense of reality] In: Cantell, Koivusalo, Pelkonen and Raivio (eds): 29-37.

Ketonen O. 1992. Mielisairauden käsite: filosofin näkemys. [The concept of mental illness: a philosopher's view]. *Helsingin lääkärilehti* 39; nro 7: 9-13.

Kim Y. 1992. Conceptual vs. indexical symptomatologies of schizophrenia. *Seishin Shinkeigaku Zasshi* [Psychiatria et Neurologia Japonica]. 94: 711-37.

Klosterkötter J Hellmich M Steinmeyer EM Schultze-Lutter F. 2001. Diagnosing schizophrenia in the initial prodromal phase. *Archives of General Psychiatry* 58: 158-64.

Kraepelin E. 1920. Patterns of mental disorder. In: Hirsch Shephard (eds.): 7-30.

Kraepelin E. 1983. *Lebenserinnerungen*. Springer: Berlin.

Kuusela Oskari. 2005. From metaphysics and philosophical theses to grammar: Wittgenstein's turn. *Philosophical Investigations* 28: 95-133.

Lacan J. 1988. *Book II: The Ego in Freud's Theory and in the Technique of Psychoanalysis*. Miller J-A (ed.): New York: Norton.

Laing RD. 1960. *The Divided Self: An Existential Study in Sanity and Madness*. Harmondsworth: Penguin.

Laing RD. 1967. *The Politics of Experience and the Bird of Paradise*. Harmondsworth: Penguin.

Laitinen J. 1977. *Diagnoosilauseiden filosofisesta statuksesta*. [On the philosophical status of diagnostic statements.] Helsinki: Psychiatria Fennica.

Laitinen J. 1994. *Lääketieteen mallit psykiatriassa: skitsofrenia tieteenfilosofisessa katsannossa*. [Medical models in psychiatry: schizophrenia from the perspective or the philosophy of science.] Turku: University of Turku.

Laitinen J Lehtonen J Achté K. (eds.) 1978. *Psykiatrian ja filosofian rajamailla* [At the boundary between psychiatry and philosophy]. Helsinki: Psychiatria Fennica.

Langdon R Coltheart M. 2000. The cognitive neuropsychology of delusions. *Mind and language* 15: 184-218.

Lantéri-Laura G. 1999. Une approche historique et critique des problèmes épistémologiques en psychiatrie. *Annales médicopsychologiques* 157: 74-83.

Larsen TK Opjordmoen S. 1996. Early identification and treatment of schizophrenia: Conceptual and ethical considerations. *Psychiatry* 4: 371-80.

Lieberman PB. 1989. "Objective" methods and "subjective" experiences. *Schizophrenia Bulletin* 15: 267-275.

Maj M. 1998. Critique of the DSM-IV operational diagnostic criteria for schizophrenia. *British Journal of Psychiatry* 172: 458-460.

Mann DW. 1991. Some philosophical directions towards a simple theory of the self. *Theoretical Medicine* 12: 53-68.

Margolis J. 1991. The trouble with schizophrenia. In: Flack, Miller and Wiener (eds.): 97-110.

Matthew S. 2003. Blaming agents and excusing persons: The case of DID. *Philosophy, Psychiatry, Psychology* 10: 169-174.

McGorry PD. 1991. Paradigm failure in functional psychosis: Review and implications. *Australian and New Zealand Journal of Psychiatry* 25: 43-55.

McGorry PD Yung AR Phillips LJ. 2001. Ethics and early intervention in psychosis: Keeping up the pace and staying in step. *Schizophrenia Research* 51: 17-29.

McGorry PD Yung AR Phillips LJ. 2003. The "close-in" or ultra high-risk model: A safe and effective strategy for research and clinical intervention in prepsychotic mental disorder. *Schizophrenia Bulletin* 29: 771-90.

McGorry PD Hickie IB Yung AR Pantelis C Jackson HJ. 2006. Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier, safer and more effective interventions. *Australian and New Zealand Journal of Psychiatry* 8:616-22.

Micale MS Porter R. (eds.) 1994. *Discovering the History of Psychiatry*. New York: Oxford University Press.

Minkowski E. 1926. The notion of loss of vital contact with reality and its aplications in psychopathology. In: Cousin Garrabé and Morozov (eds.): 507-30.

Miron R. 2004. From psychiatry to philosophy: The concept of self in Karl Jaspers. Lyyun: *Jerusalem Philosophical Quarterly* 53: 123-150.

Misak C. 2005. ICU Psychosis and Patient Autonomy: Some Thoughts from the Inside. *Journal of Medicine and Philosophy* 30:411-430.

Mora G. 1975. Historical and theoretical trends in psychiatry. In: Kaplan Sadock and Freedman (eds.): 1-75.

Mulhall S. 1990. *On Being in the World: Wittgenstein and Heidegger on Seeing Aspects*. London: Routledge.

Nelson B Yung AR Bechdolf A McGorry PD. 2008. The phenomenological critique and self-disturbance: Implications for ultra-high risk ("prodrome") research. *Schizophrenia Bulletin* 34: 381-92.

Nys TRV Nys MG. 2006. Psychiatry under pressure: Reflections on psychiatry's drift towards a reductionist biomedical conception of mental illness. *Medicine, Health Care and Philosophy* 9: 107-115.

Oppenheimer Hans. 1974. Comprehensible and incomprehensible phenomena in psychopathology: A comparison of the psychology of Sigmund Freud and Karl Jaspers. *Comprehensive. Psychiatry* 15: 503-10.

Opjordsmoen S. 2001. Reactive psychosis and other brief psychotic episodes. *Current Psychiatry Reports* 3: 338-341.

Parnas J Bovet P. 1991. Autism revisited. *Comprehensive Psychiatry* 32: 7-21.

Parnas J. 1999. From predisposition to psychosis: Progression of symptoms in schizophrenia. *Acta Psychiatrica Scandinavica* Suppl. 395: 20-29.

Parnas J Sass LA. 2001. Self, solipsism, and schizophrenic delusions. *Philosophy, Psychiatry, Psychology* 8: 101-120.

Parnas J Handest P. 2003. Phenomenology of anomalous self-experience in early schizophrenia. *Comprehensive psychiatry* 44: 121-34.

Phillips James. 1991. *Narrative structures in psychopathology*. Unpublished paper given at the Joint Conference of the European Society for Philosophy of Medicine and Health Care and the Philosophy Group of the Royal College of Psychiatrists, "Philosophy and Mental Health", in St. Catherine's College, Oxford, U.K., 28.6.-30.6.1991.

Phillips J. 2003. Psychopathology and the narrative self. *Philosophy, Psychiatry, Psychology* 10: 313-328.

Pichot P. 1994. Nosological models in psychiatry. *British Journal of Psychiatry* 164: 232-240. Potter Nancy. 2003. Moral tourists and world travellers: Some epistemological issues in

understanding patients' worlds. *Philosophy, Psychiatry, Psychology* 10: 209-223.

Puhakainen J. 1998. *Persoonan kieltäjät: Ihmisen vapaus ja vastuu aivotutkimuksen ja lääketieteen puristuksessa* [The deniers of the person: Human freedom and responsibility in the clutches of brain research and medicine]. Helsinki: Like.

Radden J. 1994. Recent criticism of psychiatric nosology. *Philosophy, Psychiatry, Psychology* 1: 193-200.

Radden J. 1996. Lumps and bumps: Kantian faculty psychology, phrenology, and twentieth-century psychiatric classification. *Philosophy, Psychiatry, Psychology* 3: 1-14.

Radden J. (ed.) 2004. *The Philosophy of Psychiatry: A Companion*. Oxford: Oxford University Press.

Rauhala L. 1987. Psyykkisesti häiriintyneen maailmankuvan konstituution analyysi. [Analysing the structure of the world view of a mentally disturbed person.] *Ajatus* 44: 129-146.

Rauhala L. 1990. *Humanistinen psykologia* [A humanist psychology.] Helsinki: Yliopistopaino.

Read R. 2003. Literature as philosophy of psychopathology: William Faulkner as Wittgenstein. *Philosophy, Psychiatry, Psychology* 10: 115-124.

Richardson WJ. 1979. The mirror inside: The problem of the self. *Review of Existential Psychology and Psychiatry* 16: 95-112.

Rissmiller DJ Rissmiller JH. 2006. Evolution of the antipsychiatry movement into mental health consumerism. *Psychiatric Services* 57: 863-6.

Rudnick A. 1997. On the notion of psychosis: The DSM-IV in perspective. *Psychopathology* 30: 298-302.

Rust J. 1990. Delusions, irrationality and cognitive science. *Philosophical Psychology* 3: 123-138.

Ryan JK. (ed.) 1973. *Studies in Philosophy and the History of Philosophy* Vol. 6. Washington DC: Catholic University of America Press.

Sadler JZ Wiggins OP Schwartz MA. 1994. *Philosophical Perspectives on Psychiatric Diagnostic classification*. Baltimore: Johns Hopkins University Press.

Sadler JZ. 2005. *Values and Psychiatric Diagnosis*. Oxford: Oxford University Press.

Sass L.A. 1992a. Das Selbst und seine Schicksale: Eine "archäologische" Untersuchung der psychoanalytischen Avantgarde I. *Psyche* 46: 52-90.

Sass L.A. 1992b. Das Selbst und seine Schicksale: Eine "archäologische" Untersuchung der psychoanalytischen Avantgarde II. *Psyche* 46: 626-641.

Sass LA. 1995 *The Paradoxes of Delusion*. Ithaca: Cornell University Press.

Sass LA. 2003. Incomprehensibility and understanding: On the interpretation of severe mental illness. *Philosophy, Psychiatry, Psychology* 10: 125-132.

Schneider K. 1933. Psychopathie und Psychose. *Nervenartz* 6: 337-344.

Schneider K. 1949. The concept of delusion. In: Hirsch Shephard (eds.): 33-39. Translated by H. Marshall.

Schneider MG. 1973. The existentialistic concept of the human person in Viktor E Frankl's logotherapy. In: Ryan (ed.): 39-64.

Schultze-Lutter F Klosterkötter J Picker H Steinmeyer E Ruhrmann S. 2007. Predicting first-episode psychosis by basic symptom criteria. *Clinical Neuropsychiatry* 4: 11-22.

Schlipp PA. (ed.) 1957. *The Philosophy of Karl Jaspers*. New York: Tudor.

Sedgwick P. 1982. *Psychopolitics*. New York: Harper & Row.

Seikkula J. 2003. The open dialogue approach to acute psychosis: Its poetics and micropolitics. *Family process* 42: 403-418.

Shanker S. (ed.) 1986. *Ludwig Wittgenstein: Critical Assessments*. Volume 2: *From Philosophical Investigations to On Certainty: Wittgenstein's later philosophy*. London: Croom Helm.

Shorter E. 1997. *History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York: John Wiley.

Siirala M Benedetti G. 1961. *Die Schizophrenie des Einzelnen und der Allgemeinheit*. Göttingen: Vandenhoeck & Ruprecht.

Siirala M. 1983. *From Transfer to Transference: Seven Essays on the Human Predicament*. Helsinki: Helsinki University Press.

Silvern LE. 1990. A hermeneutic account of clinical psychology: Strengths and limits. *Philosophical Psychology* 3: 5-27.

Singh I. 2005. Will the "real boy" please behave: Dosing dilemmas for parents of boys with ADHD. *American Journal of Bioethics* 5: 34-47.

Spiegelberg H. 1972. *Phenomenology in Psychology and Psychiatry: A Historical Introduction*. Evanston IL: Northwestern University Press.

Spitzer M. 1989. *Was ist Wahn? Untersuchungen zum Wahnproblem*. Berlin: Springer.

Spitzer M. 1990. On defining delusions. *Comprehensive Psychiatry* 31: 377-397.

Staden CWV. 2002. Linguistic markers of recovery: Theoretical underpinnings of first person pronoun usage and semantic positions of patients. *Philosophy, Psychiatry, Psychology* 8: 105-121.

Stein D. 1991. Philosophy and the DSM-III. *Comprehensive Psychiatry* 32: 404-415.

Stierlin H. 1967. Bleuler's concept of schizophrenia. *American Journal of Psychiatry* 123: 996-1001.

Stone T Young AW. 1997. Delusions and brain injury: The philosophy and psychology of belief. *Mind and Language* 12: 327-365.

Stotz-Ingenlath G. 2000. Epistemological aspects of Eugen Bleuler's conception of schizophrenia in 1911. *Medicine, Health Care and Philosophy* 3: 153-159.

Strauss JS. 1989. Subjective experiences of schizophrenia: Toward a new dynamic psychiatry II. *Schizophrenia Bulletin* 15: 179-187.

Strauss JS. 1991. The Meaning of schizophrenia: Compared to what? In: Flack, Miller and Wiener (eds.): 81-90.

Strauss JS. 1992. The person – key to understanding mental illness: Towards a new dynamic psychiatry, III. *British Journal of Psychiatry* Suppl 18: 19-26.

Strauss JS. 1996. Subjectivity. *Journal of Nervous and Mental Disease* 184: 205-12.

Stroud B. 1983. Winttgenstein's philosophy of mind. In: Guttorm (ed.): 319-341.

Strömgren E. 1969. Uses and abuses of concepts in psychiatry. *American Journal of Psychiatry* 126: 777-788.

Strömgren E. 1987. The development of the concept of reactive psychoses. *Psychopathology* 20: 62-67.

Strömgren E. 1992. The concept of schizophrenia: The conflict between nosological and symptomatological aspects. *Journal of Psychiatric Research* 26: 237-246.

Svenaeus F. 1999. *The Hermeneutics of Medicine and the Phenomenology of Health*. Motala, Sweden: Linköping Studies in Arts and Science.

Svenaeus F. 2000. Das unheimliche: Towards a phenomenology of illness. *Medicine, Health Care and Philosophy* 3: 3-16.

Szasz TS. 1972. *The Myth of Mental Illness*. London: Paladin books.

Szasz TS. 1982. The concept of psychosis: A cause and a consequence of certain medical-ethical dilemmas. In: Gruzalski (ed.): 7-20.

Taylor C. 1985. *Human Agency and Language. Philosophical Papers 1*. Cambridge: Cambridge University Press.

Thornton T. 2003. Psychopathology and two kind of narrative account of the self. *Philosophy, Psychiatry, Psychology* 10: 361-367.

Van Os J Hanssen M Bijl RV Ravelli A. 2000. Strauss (1969) revisited: A psychosis continuum in the general population? *Schizophrenia Research* 45: 11-20.

Vatz RE Weinberg LS. 1994. The rhetorical paradigm in psychiatric history: Thomas Szasz and the myth of mental illness. In:Micale and Porter (eds.): 311-330.

Vice J. 1992. *From Patients to Persons: The Psychiatric Critiques of Thomas Szasz, Peter Sedgwick and R.D. Laing*. New York: Peter Lang.

Walker C. 1995 Karl Jaspers and Edmund Husserl IV: Phenomenology as empathic Understanding. *Philosophy, Psychiatry, Psychology* 2: 247-266.

Wallgren T. 2001. Hintikka's later Wittgenstein: Some problems. *SATS: Nordic Journal of Philosophy* 2: 98-119.

White M Epston D. 1990. *Narrative means to Therapeutic Ends*. New York: W.W. Norton.

World Health Organization (WHO). 1993. *Composite International Diagnostic Interview: Version 1.1*. Geneva: WHO.

Wittgenstein L. 1953. *Philosophical Investigations*. Oxford: Basil Blackwell.

Wittgenstein L. 1969. *On Certainty*. Oxford: Basil Blackwell.

Woods SW Miller TJ McGlashan TH. 2001. The "prodromal" patient: Both symptomatic and at-risk. *CNS Spectrums* 6: 223-32.

Yung AR McGorry PD. 1996a. The prodromal phase of first-episode psychosis: Past and current conceptualizations. *Schizophrenia Bulletin* 22: 353-370.

Yung AR McGorry PD McFarlane CA et al. 1996b. Monitoring and care of young people at incipient risk of psychosis. *Schizophrenia Bulletin* 22: 283-303.

Yung AR. 2003. The schizophrenia prodrome: A high-risk concept. *Schizophrenia Bulletin* 29: 859-865.