'The Hermeneutic Problem of Psychiatry' and the Co-Production of Meaning in Psychiatric Healthcare

LUCIENNE SPENCER AND IAN JAMES KIDD

Abstract

'The co-production of meaning' is a phrase that has become entrenched in the field of public mental health, adopted almost as a slogan within the literature. But what does it actually mean? Current definitions gesture toward the very broad idea that co-production involves a collaboration between 'service users' and healthcare professionals, each contributing their knowledge to better understand and treat mental health problems. Yet, terms such as 'equal' 'reciprocal', and 'partnership' fail to clarify the nature of this 'co-production', and how it can be achieved.

To better understand the co-production of meaning, we shall attempt to develop an account of co-production through phenomenological psychopathology. Through Hans Georg Gadamer's remarks on 'the hermeneutic problem of psychiatry' two key obstacles to 'co-production' emerge: 1) contingent problems, and 2) intrinsic problems. In calling attention to these obstacles, we problematise the concept of 'co-production' in public mental health, revealing it to be more complex than originally thought. We conclude by arguing that new developments in phenomenological psychopathology can be used to overcome the limitations of 'co-production'.

1. Introduction

'The co-production of meaning' is a phrase that has become entrenched in the field of public mental health, adopted almost as a slogan within the literature. This ambiguous terminology has been inconspicuously ushered into public discourse; however, the term too often seems too narrowly or broadly defined. The Centre for Coproduction in Mental Health and Social Care at Middlesex University describes 'co-production' in terms of 'the principle that people who use services have valuable knowledge and expertise' and understands it to be a means of 'developing equal and reciprocal relationships between professionals, people using services, and communities to produce knowledge and services that are potentially more effective overall'.[1] Similarly, the

[1] Middlesex University London, *Centre for Coproduction in Mental Health and Social Care*, accessed 5 June 2023: https://www.mdx.ac.uk/our-research/centres/centre-for-coproduction-in-mental-health.

doi:10.1017/S135824612300019X

Royal College of Psychiatrists defines co-production as 'an ongoing partnership between people who design, deliver and commission services [and those] who use the services and people who need them'.[2] Moreover, the National Development Team for Inclusion claims co-production 'should seek to achieve equality and parity by bringing together people who can work as equals, to develop a shared understanding of what needs to change and a commitment to bringing that about'.[3]

Such definitions emphasise collaboration, reciprocity, parity, and similar values, all of which understand 'co-production' as a means of bringing different groups into more productive contact. Unfortunately, the definitions are often aspirational in character and fail to define their terms, some of which might be mutually inconsistent. Take the emphases on equality and parity: we assume that one main reason people need to work with and learn from others is because of differences between (or inequalities in) their skills, knowledge, and understanding. 'Co-production', more generally, is consistent with the idea of (i) equally capable people working on a common task and of (ii) unequally capable people working on a common task. The assumption is that co-producing will result in something that one single group cannot, by itself, achieve, but that could mean we have equal abilities and knowledge or unequal abilities and knowledge. But this latter option is more complex and contentious, even if it gestures to an important epistemic and moral ideal.

In this paper, we make a start on developing an account of 'co-production' that uses the resources of phenomenological psychopathology. We focus on the ideal of the co-production of meaning and start with Hans-Georg Gadamer's remarks on the 'hermeneutic problem of psychiatry'. From here, we identify two kinds of obstacles to the co-production of meaning – *contingent* and *intrinsic* – and suggest that the latter poses serious problems for the ideal of a co-production of meaning in the context of psychiatric healthcare. Fortunately, those problems could, in principle, be addressed using a phenomenological approach.

[2] National Collaborating Centre for Mental Health, *Working Well Together: Evidence and Tools to Enable Co-production in Mental Health Commissioning* (London: National Collaborating Centre for Mental Health, 2019).

[3] Sarah Carr and Meena Patel, *Progressing Transformative Co-Production in Mental Health* (National Development Team for Inclusion, 2016).

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

2. 'The Hermeneutic Problem of Psychiatry'

In his 1996 book, *The Enigma of Health*, the phenomenologist and hermeneuticist Hans-George Gadamer offered a rich account of 'the art of healing' centred on the dialogues of doctors and patients. The medical encounter, he argued, should essentially be a practice of interpretation. A doctor should 'set in motion once again the communicative flow of the patient's life experience and to re-establish that contact with others from which the person is so tragically excluded' (Gadamer, 1996, p. 138). In line with Gadamer's hermeneutically sophisticated philosophy, these dialogical medical encounters should go beyond the patient simply offering testimonies that their doctor dutifully receives and affirms. There is an ongoing exchange and exploration of the different kinds of meanings that saturate those experiences reported by the patient. Those meanings are subjected to different kinds of activities, such as interpreting, challenging, contextualising and questioning. Indeed, the richness and dynamism of our experiences should be matched by the complexity and energy of our interpretive practices. Gadamer speaks of an 'ongoing process', a 'relationship', that includes disorientation, as well as 'the experience of regaining equilibrium' (Gadamer, 1996, p. 137). In the course of these processes, there can be – to quote Gadamer's famous slogan – a 'merging of horizons', which denotes the coming together of the first-person and third-person perspective (Gadamer, 1996, p. 112). The product is a deeper and richer understanding of the patient's experiences than would be possible through mere monodirectional analysis and the static reception of the doctor.

The aspiration of *The Enigma of Health* to offer an 'art of healing' might lead one to think that this account of dialogical interpretation would apply across all forms of medicine and healthcare. In the final chapter, however, Gadamer distinguishes psychiatry and asks if his hermeneutical approach could be applied in that domain. While the psychiatrist must try to draw out the meanings of a patient's psychiatric illness[4], they will find in many cases 'an unbridgeable divide' (Gadamer, 1996, p. 171). This should worry a psychiatrist on two fronts. First, encountering that divide disrupts the dialectical activity of interpretation and, worse, the realisation of its unbridgeable character confirms the existence of permanent limitations to interpersonal

[4] We acknowledge that the term 'illness' can be controversial in this field, as it suggests that all forms of psychiatric 'difference' are necessarily pathological. We recognise the limits of this terminology, as one may be neurodiverse and not 'ill' in any way.

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

understanding. Some obstacles are temporary and removable, while others are permanent and unchangeable. A further epistemological problem is that of determining with confidence whether an obstacle is contingent or intrinsic, and whether the sense of the obstacle being resistant to removal is correct. In these cases, argues Gadamer, a psychiatrist encounters the 'hermeneutic problem of psychiatry' (Gadamer, 1996, p. 169).

We want to use Gadamer's remarks on the hermeneutic problem of psychiatry to think about the co-production of meanings within psychiatric healthcare. Gadamer offers general insights, of course, not least the complicated issues inherent in the very idea of 'producing' meanings, what it means for experiences to be meaningful, how the meanings we experience relate to one another, and so on. There are also complicated issues about different kinds of meaning and how they relate to one another, the conferral of meanings versus the identification of meanings, and the ways our practices and interests shape meaning. A crucial issue for our discussion is whether meanings *can* be 'produced' by two or more people; if not, then the idea of a 'co-production of meaning' will be a non-starter. Meanings could be *discovered* or *conferred*, but these seem quite different, and in many cases, it may be better to say that two people come to *discover* meanings: what is produced is not the *meaning* but rather its *discovery* or *articulation*. What are produced in many cases are ways of *discovering*, describing, and *appreciating* meanings: hermeneutic practice is productive if it enhances our experience of meanings. The activity is essentially an act of revelation – an activity of exploration that brings into view new kinds of meanings, previously unrealised ways that those meanings connect to one another and to one's habits, concerns, relationships, and life-projects. Of course, acts of exploration can be obstructed or disrupted by all sorts of factors. Experiencing and responding to obstacles seems integral to the activity of exploration. In what follows, we describe two general obstacles to a hermeneutically explorative kind of psychiatric healthcare practice. We start with *contingent obstacles* and then go on to *intrinsic obstacles*.

2. Contingent Obstacles

Gadamer understands the hermeneutical endeavour in medicine as a complex, sustained, and necessarily interpersonal practice. We seek understanding with, and of, other people and the wider structures and concerns of our shared social world. Within psychiatric dialogue, a primary obstacle is what Gadamer calls 'the fundamentally unequal

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

relationship that prevails between doctor and patient', which dialogue and discussion can 'humanise' (Gadamer, 1996, p. 112). The immediate problem is that the kind of dialogue described by Gadamer requires resources that are usually scarce, such as time, trust, empathy, and freedom from distraction. Moreover, resources are typically conditioned by power structures, institutional barriers, negative prejudices and biases, and a wider set of epistemic and moral deficiencies. These factors, individually or collectively, can impede even sincere and well-motivated efforts to co-produce meanings. The conditions for rich interpersonal interactions aimed at mutual understanding rarely obtain in an optimal form and often we must make do; the richly authentic 'I-Thou' encounters so well described by Martin Buber are precious in part because they are rare and fragile (Buber, 2000).

The term *contingent* suggests something that was not inevitable and which could have been different. A sense of contingency sustains a sense that there are alternative possibilities, other ways that something could be, other ways that it can develop, and therefore meaningful possibilities for intentional agency. Many experiences can involve a loss of this sense of contingency. This includes many of the predicaments we typically associate with diagnoses of depression, but also includes cases in which possibilities are being blocked by material, interpersonal, social, or cultural conditions (we return to cases of psychiatric illness in the next section).

Consider some of the contingent features of psychiatric healthcare practices that can obstruct the kinds of interpersonal hermeneutical practices described by Gadamer. We have already mentioned the power imbalances latent in the psychiatric encounter, including what the feminist philosopher Miranda Fricker calls *social power*: 'a practically socially situated capacity to control others' actions, where this capacity may be exercised (actively or passively) by particular social agents, or alternatively, it may operate purely structurally' (Fricker, 2007, p. 13).

Control, here, can mean commanding or prohibiting certain actions, and determining if, how, and when another acts, which can reflect various motivations. Within psychiatry, there is usually more social power in the psychiatrist, achieved not only by their training, skills, and expertise, but also by the institutional certification of those epistemic-practical achievements (Carel and Kidd, 2014, p. 530). For instance, healthcare professionals have legal authority under the Mental Health Act to use their expert judgment to detain a person, thereby infringing on their liberty. They can define the state of mind of their patient, position them within some

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

diagnostic category, and prescribe medical treatments, including some which may transform the patient's mental state significantly. Such medico-legal systems transform epistemic status into practical and social power.

The analysis of how medico-legal structures relate to epistemic systems was famously pioneered by Michel Foucault and continued by those who adopt his genealogical exposures of the implication of psychiatric classifications into systems of power/knowledge (cf. Foucault, 1961). *Madness and Civilization*, for instance, describes a transition in the nineteenth-century asylum, whereby chains and other instruments of restraint that bound those committed were swapped for the 'abstract, faceless power' of authority (Foucault, 2001, p. 238). Kinds of physical restraint became redundant once the norms of those systems were internalised: 'the absence of constraint in the nineteenth century is not unreason liberated, but madness long since mastered' (Foucault, 2001, p. 239). Whatever the historical merits of these analyses, there is an important insight into the dynamics of epistemic and social power. Foucault describes how a patient suffers a diminution of their epistemic role: their participant role is replaced by a more limited status as 'the observed', entrapped within a systems of surveillance. Foucault also argues that psychoanalysis continues this tendency: psychoanalysis 'doubled the absolute observation of the watcher with the endless monologue of the person watched' (Foucault, 2001, p. 238). The narrative of the patient is not truly speech expression, or at least not speech expression with any power. It is, rather, 'endless monologue', functioning to elicit further behaviour which can, in turn, sustain further expert scrutiny, 'thus preserving the old asylum structure of non-reciprocal observation but balancing it, in a non-symmetrical reciprocity, by the new structure of language without response' (Foucault, 2001, p. 238).

The historical and institutional conditions may change, but the generalised tendencies to exclude an interactive dialogical model with a narrower one of monologue and scrutiny persists. Earlier forms of epistemic constraint and self-restraint have been replaced by newer and more sophisticated ones. For instance, there has been a significant shift away from sectioning under the Mental Health Act towards deinstitutionalised therapeutic practices. *Madness and Civilization* describes a certain stage in an ongoing process, inviting us to identify later developments: the earlier conceptual, administrative, and moral structuring of madness (Gutting, 1989, pp. 84ff.). Outside of sectioning, the healthcare professional no longer has the same level of control over the patient's liberty, but there are different,

subtler kinds of control now at work, including systems of epistemic control. The epistemic control involves a range of interpersonal, scientific-medical, and social components – sanist attitudes, taboos, systematic epistemic injustices, deficient economies of credibility, pharmacogenetic regimes, and the systematic stigmatisation and social and material disadvantaging of those diagnosed with psychiatric conditions (Mental Health Foundation, 2016; Kidd, Spencer, and Carel, 2023).

Let us turn back to the phenomenon of epistemic injustice. Defined broadly, these involve cases where a person is unfairly and harmfully subjected to a denial or disruption of their epistemic abilities. The paradigmatic cases are testimonial injustices and hermeneutical injustices, those being the two main kinds of epistemic injustice described by Miranda Fricker which became central to the scholarly literature (Fricker, 2007; Kidd, Medina, and Pohlhaus Jr., 2017). Fricker explains that the concept is an attempt to 'delineate a distinctive class of wrongs […] in which someone is disingenuously downgraded and/or disadvantaged in respect of their status as an epistemic subject' (Fricker, 2017, p. 53). As epistemic subjects, the activities of creating and sharing knowledge and achieving understanding of our own and others' social experiences are essential to our everyday functioning and our overall flourishing. Our epistemic capacities are interwoven with our practical interests, moral comportment, interpersonal relations, and social relations. Thus, being wronged epistemically can be seriously problematic and sometimes even fatal. When our testimonies are denied credibility, our ability to convey our goals, represent our interests, voice our concerns, and explain our preferences is impaired. If we are prevented from making ourselves intelligible to others, we lose the intelligibility which sustains meaningful interpersonal connection and engagement. Across the various forms of testimonial and hermeneutical injustice, the epistemic, moral, practical, and political harms and wrongs are made vivid.

Consider the following example of *hermeneutical marginalisation* within a university. Participants at a conference discuss what a good academic conference looks like. Those welcome to participate in the exchange may discuss the importance of inviting renowned keynote speakers, selective reviewing for submitted talks, and how best to advertise the event. Following multiple exchanges across many universities over time, an interpretive framework develops to capture 'what makes a good academic conference'. Historically, most women's inputs to academia were denied proper roles in these informational exchanges, if a woman was included at all. What

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

occurs are unjust denials of due credibility that sustain kinds of 'unequal hermeneutical participation', resulting in the construction of social-interpretive frameworks that marginalise and disadvantage certain groups (see Fricker, 2007, p. 152). Within that framework, the significance of certain actions goes unrecognised, like the importance of gender-balanced line-ups; particular needs, like offering childcare support to those who need it, go unrecognised and unmet. Important things are not understood because those who understand them are not properly included, and these hermeneutical lacunae are often difficult to close because they lack visibility or urgency (Fricker, 2007, p. 151). When these hermeneutically defective conditions persist, the experiences and testimonies of dissonant or marginalised groups will be rendered unintelligible, eccentric, or trivial.

It is worth adding that a total gap in the hermeneutical resources is a rare occurrence. Although Fricker uses terms such as 'lacuna' or 'gap', we suggest that it is better to consider the 'pool of shared ideas' (to borrow Fricker's metaphor) as being more or less depleted (and in rare cases, there may even be a complete drought). Only the hermeneutically privileged can contribute towards, alter, and remove resources from the pool of shared ideas. The hermeneutically marginalised do not have this power and are forced to contend with ill-fitting concepts (Fricker, 2017, p. 54; Medina, 2017, pp. 42–3).

Fricker further develops the concept of hermeneutical injustice by stipulating that a group can be limited not only by *what* they can express but also *how* they can express it: 'the characteristic expressive style of a given social group may be rendered just as much of an unfair hindrance to their communicative efforts as an interpretive absence can be' (Fricker, 2007, p. 160). In this context, a speech expression may be disregarded as unreliable or unintelligible due to the subject's style of speech. Rebecca Tsosie provides a useful example of such hermeneutical injustice inflicted upon Indigenous groups in Northern California. In *Lying vs Northwestern Indian Cemetery Protective Association,* the court permitted the extension of a logging road through a site that the Indigenous groups of Northern California called 'sacred'. The court ruled that the government was not harming the Indigenous groups as they did not 'coerce the Indigenous peoples into giving up their "belief" that the land was "sacred"' (Tsosie, 2017, p. 361). The word 'sacred' was not seen to hold any legal weight, evaluated to be a concept held 'in the mind' at an individual level (*ibid*.). Therefore, although the Indigenous groups had the means to articulate the harm they encountered, such spiritual language is structurally barred by the legal system. As such, the Indigenous interpretation of the events was rejected.

Unlike testimonial injustice, Fricker understands hermeneutical injustice as a 'somewhat indirect' discrimination because 'the injustice will tend to persist regardless of individual efforts' (Fricker, 2017, p. 54). In other words, it is grounded in *structural* hermeneutical marginalisation. The injustice lies in the wider social structure, as certain groups are excluded from contributing to a shared interpretative framework. Accordingly, hermeneutical injustice typically endures despite the hearers' attempts to understand the speaker, as the interpretive framework renders the marginalised speaker almost unintelligible. The marginalisation of the victims is built into the very structure of the interaction and has a scope that extends beyond the given interaction. Nevertheless, Medina clarifies that the agent's responsibility is not diminished in a case of hermeneutical injustice. As Medina points out, there is collective culpability for hermeneutical injustice as 'an entire culture can be held responsible for not trying to understand a particular kind of experience or a particular kind of subjectivity' (Medina, 2017, p. 42). For this reason, Medina claims 'we can identify degrees of complicity in how individuals respond to lacunas and limitations in the hermeneutical resources they have inherited and in how they participate (or fail to participate) in expressive and interpretive dynamics' (Medina, 2017, p. 42–3).

Testimonial and hermeneutical injustices relate to psychiatric healthcare practice, particularly encounters between patients and psychiatrists. Testifying and interpreting are integral to all interpersonal interactions but have a special significance within contexts where interpersonal understanding is especially difficult and complex. 'Co-producing meaning' depends on our ability to initiate and sustain richer testimonial interactions and to engage in complex reciprocal hermeneutical practices. If so, epistemic injustice is a powerful obstacle. Consider a specific harm of hermeneutical injustice – *cognitive disablement* – which Fricker defines as follows:

> [A] cognitive disablement prevents her from understanding a significant patch of her own experience: that is, a patch of experience which it is strongly in her interests to understand, for without that understanding she is left deeply troubled, confused, and isolated, not to mention vulnerable to continued harassment. (Fricker, 2007, p. 51)

Cognitive disablement means our epistemic energies cannot be directed effectively since we remain, to some degree, obscure to ourselves; our goals, reasons for action, preferences and sense of the world cannot be understood in ways that provide confidence and

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

satisfaction, a state often correlated with anxiety, fear, self-estrangement, and uncertainty. Moreover, if an individual is cognitively disabled, they may misidentify the source of it as some failure of their own. In this case, our understanding of our relationship to the social world is distorted. A whole dense structure of social-epistemic norms, prejudices, constraints, and practices goes unrealised as a person lacks the vital ability to perceive and understand oppressive structural realities. Under these conditions, the co-production of meaning would inevitably fail since it is blocked by individual, interpersonal, and institutional conditions.

To develop this claim, consider the inequalities inherent in forming, legitimating, and maintaining socially and epistemically authoritative interpretive frameworks. It is insufficient for a patient to simply *talk* to the healthcare professional. Interactions always take place in some framework, however tacit and unsystematic, that sustains our sense of relevance, credibility, and plausibility, and supplies some sense of typical interactive styles and possibilities. A patient must understand the framework, if they are really to authentically and successfully communicate their experiences, and that understanding will be more likely if they were involved in the construction of the framework. The key interpretive framework found in psychiatry is that of diagnostic manuals such as the DSM (Diagnostic and Statistical Manual of Mental Disorders) and a main criticism has been their failure to properly include the perspectives of patients (Cooper, 2005; Pickersgill, 2014; Schaffner and Tabb, 2015; Tabb, 2015). Indeed, patient input into the DSM seems to have been deprioritised from the outset. Robert Spitzer, chair of the task force behind the DSM-3, once argued that it is 'politically correct nonsense' to suggest that psychiatric patients and their family members could provide any valuable insight into diagnostic criteria, which he felt should be developed only by 'committees of mental health professionals who are chosen because of their expertise in some aspect of psychiatric diagnosis' (Sadler and Fullford, 2004).

Such blunt assertions of hermeneutical exclusion are apparent, but many other sources will be less obvious or, at least, better concealed. Moreover, claims about contributions which patients can make must always be cashed out and justified, and how easy this will be depends on the nature of the contribution. Tasia Scrutton, for instance, notes that many persons who experience auditory hallucinations as positive and important life events do so by appealing to spiritual interpretations; interpretations that conflict with the medical interpretations urged by, and much more intelligible to, their doctors (Scrutton, 2017). However, spiritual understandings of auditory hallucinations

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

are not included in the DSM, meaning that this kind of perspective – which is common and often deeply culturally-sustained – will be excluded (Scrutton, 2017, p. 350). In this case, unequal hermeneutical participation denies certain people and communities from a practice that would have value for them and one that would, in some sense, enable richer meaning-making (Fricker, 2007, p. 153). Moreover, the inclusion of religious interpretations of auditory hallucinations might strain the more general metaphysical frameworks that shape scientific epistemic practices. These frameworks perpetuate an implicit scientific naturalist conception of the world which denies the existence of gods and other supernatural beings and acts at a profound level as an economy of credibility. Such frameworks make it hard to find credible accounts of auditory hallucinations as, for instance, aural encounters with God (cf. Kidd, 2017). In these cases, a Gadamerian 'merging of horizons' could be impossible, because the horizons are too different in their basic ontological presuppositions to be merged.

We have described some individual, interpersonal, and structural obstacles that might generate and sustain testimonial and hermeneutical injustices in ways that will tend to block the sorts of collaborative practices involved in the 'co-production of meaning'. We think they are contingent in the sense that they (a) are products of historical events, decisions, and developments that could have been different and which (b) in principle could be different in the future because (c) workable alternatives to them either exist, even if in underdeveloped forms, or could be developed. The study of these contingent obstacles is a multidisciplinary project – encompassing philosophy, sociology, history, and other disciplines – and identifying and developing alternatives to our current practices is a task for all those concerned with our psychiatric healthcare systems. Nevertheless, sensitivity to contingent factors comes with the risk of undue optimism. Contingent obstacles can still be deeply entrenched, and many people will resist their removal, not least because principled cases can be made for retaining current arrangements and rejecting proposed alternatives. A further risk is that our focus on contingent obstacles occludes the possibility that some obstacles are *intrinsic* – ones which would emerge and persist even if all the social and epistemic challenges were eliminated or had never existed in the first place.

In the following sections, we develop the idea that some real obstacles to 'co-producing meaning' in psychiatric healthcare may reside in the predicaments experienced by patients, rather than more

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

contingent interpersonal or structural realities. To do this, we will appeal to phenomenological psychopathology.

3. Intrinsic Obstacles

There has been a particular focus in the literature on the inherent link between psychiatric illness and communication difficulties. For instance, a person with a psychiatric disorder may be wilfully silent due to a newfound apathy towards the hearer and towards communication itself, or even a desire to keep one's audience at a distance. In the case of schizophrenia: 'the interviewee may be much less aware of or concerned with the needs of the interviewer, potentially due to the intensity of other symptoms or a significant lack of connection with conventional reality, including conventional uses of language (Pienkos *et al.*, 2021, p. 61; see also Sass, 2017, p. 53). Indifference towards language and communication has also been found to be a core theme in depression (Kendler, 2016). Indeed, this indifference toward communication may result from the overall distraction of this illness itself. In the words of Styron: 'the ferocious inwardness of the pain produced an immense distraction that prevented my articulating words beyond a hoarse murmur; I sensed myself turning wall-eyed, monosyllabic […]' (Styron, 2010, p. 17).

Language difficulties may also be a product of 'an unfocused or vacillating cognitive style that prevents topics from being carried through to closure' (Sass, 2017, p. 53). For example, patients with psychosis have described a state of chaotic thinking: 'My head is "swarming" with thoughts or "flooding". I become overwhelmed by all the thinking going on inside my head. It sometimes manifests itself as incredible noise' (Fusar-Poli *et al.*, 2022, p. 176). This, too, has been found in cases of anxiety, whereby 'the mind jumps from one random thought to another, resulting in speech patterns that are sped up, disorganized, and incoherent' (Aho, 2018, p. 262).

Some studies suggest that deficiencies in the 'theory of mind' (briefly, the capacity to recognise distinct mental states in other people) may also lead to communication impairment. Such difficulties are common in ADHD (Çiray *et al.*, 2022) and ASD (Andreou and Skrimpa, 2020). Finally, a further cause of communication breakdown, commonly found in schizophrenia, 'can be the sense or belief that words and language are absurd or arbitrary' (Pienkos *et al.*, 2021, p. 58).

To further understand language impairment in psychiatric illness, we may turn to phenomenology, which characterises psychiatric

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

illness as a profound alteration of the lived world. Most people move through the world with what R.D. Laing calls an 'ontological security':

> […] he can live out into the world and meet others: a world and others experienced as equally real, alive, whole, and continuous. Such a basically ontologically secure person will encounter all the hazards of life, social, ethical, spiritual, biological, from a centrally firm sense of his own and other people's reality and identity. (Laing, 1964, p. 33)

This is to say that the ontologically secure person is irrevocably intertwined with the world and has confidence in the predictable way it is presented. Due to this confidence and predictability, the manner in which the ontologically secure moves through the world does not even come to their attention. They perceive the world pre-reflectively as 'perception […] is the background against which all acts stand out and is thus presupposed by them' (Merleau-Ponty, 2012, p. lxxiv). The philosophy of psychiatry, however, identifies a breakdown in the subject-world synthesis in the case of psychiatric illness. R.D. Laing refers to this as an 'ontological *insecurity*', although it has also been dubbed a 'death of possibilities' (Ratcliffe and Broome, 2012), an 'anomalous world' (Madeira *et al*., 2019) and 'unworlding' (Sass, 1990).

An ontological breakdown may disrupt a number of phenomenological factors. First, there may be a disruption in one's sense of Self. This is a common report for people with psychosis: 'I thought I was dissolving into the world; my core self was perforated and unstable, accepting all the information permeating from the external world without filtering anything out' (Fusar-Poli, *et al*., 2022, p. 172). This is a particular focus of Laing, who states that '[the ontologically insecure person] may not possess an over-riding sense of personal consistency or cohesiveness […]. It is, of course, inevitable that an individual whose experience of himself is of this order can no more live in a "secure" world than he can be secure in himself' (Laing, 1964, p. 37).

Second, there may be a disruption in one's experience of space. The lived space is the space in which a person pre-reflexively orientates themselves and moves through. In cases of agoraphobia, the illness imposes upon the person an inability to leave the realm of 'home' or the familiar: 'the centrality of the physical home, with its borders and boundaries, marks a threshold from agoraphobic embodiment to non-agoraphobic embodiment' (Trigg, 2013, p. 418). This too has been identified as a feature of depression: 'distancing

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

is experienced as loss of spatial depth and things become dull and flat as in everything is out of reach, living as static objects; not integrated into a landscape, occupying places and not regions' (Tatossian, 2019, p. 87)

Third, there may be a disruption in one's experience of time. The embodied being is necessarily positioned in 'time', and every experience receives its meaning against the background of its temporal profile. The experience of a slowing down of time has been identified as a core feature of depression (Minkowski, 1933; Binswanger, 1960; Fuchs, 2013; Gallagher, 2012; Vogel *et al.*, 2018). People with depression may report that '[time] goes very, very slowly. Like I remember lying awake at about 4am in my […] room and it was going so slowly, all I had to do was get through to the morning so I could get some help and it seemed almost impossible just to get through those few hours because it was taking so long' (Ratcliffe, 2015, p. 175). In contrast, anxiety is typically experienced as an acceleration of time: 'Sufferers experience this temporal quickening through a number of bodily sensations including "palpitations", "accelerated heart rate", "sweating", "trembling or shaking", and "shortness of breath"' (Aho, 2018, p. 262).

Fourth, there may be a disruption in one's relation to one's body. By this we do not refer to the physical, objective body ('I have a body') but the lived body ('I *am* a body'). This refers to the body as experienced from within, in the first-person perspective. The lived body is at the centre of all experience, yet a breakdown in one's relation to one's body is characteristic of a number of psychiatric illnesses. This is particularly common in Anorexia Nervosa. Drawing upon Sartre, Svenaeus argues that those with anorexia adopt the objectifying gaze of the Other, thus causing them to experience their body as uncanny (Svenaeus, 2018, 44–50). Abnormal body experiences may also be reported in schizophrenia: 'I didn't feel [my body]. I didn't feel alive. It didn't feel mine […]. I never felt a feeling of fusion or harmony between "me" and "my" body: it always felt like a vehicle, something I had to drive like a car' (Fusar-Poli, *et al.*, 2022, p. 171).

Fifth, there may be a breakdown in one's perceived possibilities to interact with the world. The objects in the world that motor intentionality is directed toward appear to the embodied subject as offering certain opportunities for interaction, known as 'affordances' (Gibson, 1968). People with depression, however, report that objects in the world no longer offer possibilities for interaction in the way they once did. While a kettle once offered the affordance of making a cup of tea, that object no longer appears to offer possibilities for

engagement: 'it takes an enormous amount of effort to engage with the world and your own life' (cited by Ratcliffe, 2015, p. 33) So too, in schizophrenia:

> People and things are no longer encountered as 'ready-to-hand'[5]—as affording a range of immediately perceived interactive possibilities (the way a friendly smile affords conversation or a chair sitting) specified by the norms and conventions tacitly governing the context in which they're encountered. Instead, everyday encounters and projects are experienced as puzzling or devoid of meaning. (Krueger, 2020, p. 602)

Finally, there may be a breakdown in one's intersubjective capacities. Phenomenology recognises that a fundamental aspect of our experience of the world is that we find ourselves in a shared world. One's experience of the Other is thus necessary for one's sense of a meaningful world. Objects in the world only make sense in relation to a shared world; for example, my understanding of a telephone only has meaning in a world of Others. However, the manner in which one relates to the Other has been found to be transformed in some forms of psychiatric illness. This breakdown of intersubjectivity is a symptom of PTSD: 'the traumatized individual is unable to perceive the affordances the other offers because their ability to empathize is impacted: the girl in the café might be perceived as a potential threat, as someone who could hurt me' (Wilde, 2019, p. 144). Wilde identifies that this difficulty to engage with the Other drives 'a sense of alienation, of being cut off, and not being at home in the world' (*ibid.*). A disruption of intersubjectivity has also been found in depression (Ratcliffe, 2018), schizophrenia (Laing, 1964), and agoraphobia (Trigg, 2013).

However, it is worth noting that these profound alterations in one's sense of Self, space, time, body, and possibilities for action naturally lead to a difficulty in engaging with the Other. In the words of Laing, for the ontologically insecure person:

> The whole 'physiognomy' of his world will be correspondingly different from that of the individual whose sense of self is securely established in its health and validity. Relatedness to other persons will be seen to have a radically different significance and function. (Laing, 1964, p. 37)

[5] 'Ready-to-hand' is a term coined by Heidegger to capture the way in which objects in the world offer themselves for practical use, e.g. the cup of tea is 'ready-to-hand' as it calls to be drunk.

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

In other words, the breakdown in relationship with the Other is because the person with psychiatric illness has a radically different lifeworld. These breakdowns in intersubjectivity make for further disruptions in co-production. Co-producing meaning presupposes an ability to engage in certain kinds of interpersonal practices, such as discussing, trusting, and empathising. Through psychiatric illness, there is a loss (or at least a barrier to) interpersonal abilities, without which co-production cannot be achieved.

A further interruption of co-production comes with the inexpressibility of one's lived experience while in a position of ontological insecurity. As one patient with psychosis describes: 'There are things that happen to me that I have never found words for, some lost now, some which I still search desperately to explain, as if time is running out and what I see and feel will be lost to the depths of chaos forever' (Fusar-Poli, 2022, p. 168). In *Darkness Visible*, William Styron describes depression as 'so mysteriously painful and elusive in the way it becomes known to the self […] as to verge close to being beyond description. It thus remains nearly incomprehensible to those who have not experienced it in its extreme mode' (Styron, 2010, p. 5). So too, in describing her experience of bipolar disorder, Nancy Tracey claims emotional pain is even harder to express than physical pain:

> Language is insufficient to express emotional pain and turmoil. We have good words for describing physical pain: radiating, hot, throbbing, sharp, achy and so on. But when it comes to emotional pain we're "sad." […] It's not surprising that people don't get what we're talking about. (Tracey, 2016, p. 74)

Indeed, the ineffable nature of psychiatric illness motivates Gadamer's pessimism for a hermeneutic approach to psychiatric healthcare. He states that 'the patient's insight into their own illness is disturbed' (Gadamer, 1996, p. 168). A (perhaps) uncharitable reading of Gadamer may dismiss this claim as more epistemic injustice, as Gadamer underestimates the patient's ability to understand their own illness experience. However, it seems that Gadamer is instead attempting to touch upon a profound disturbance in the patient's lifeworld, leading to a struggle to make sense of one's experience.

Therefore, even if hermeneutical injustice were eliminated from the psychiatric encounter, entrenched communication problems are an aspect of the illness itself. This infringes upon the co-production of meaning, as the illness itself inhibits the patient's capacity to discuss their lived experience. In what follows, we argue that in

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

order to overcome Gadamer's 'Hermeneutical Problem' and achieve co-production in meaning we need to turn to phenomenological psychopathology.

4. Co-Production through Phenomenological Psychopathology

In the search for alternative approaches to psychiatry, there has been a reignited interest in phenomenological psychopathology: an approach that uses the phenomenological method to highlight the lived experience of the person with mental ill-health and invites a person-centred approach to diagnosis and treatment. Advocates of the phenomenological method recognise that it is impossible to conduct an isolated investigation on the 'mind' or 'brain' of a psychiatric patient because embodied subjectivity is irreducible to a mere mind, and that we need a rich account of experience to understand what we are seeking to explain scientifically.

At the heart of phenomenological psychopathology is the work of Karl Jaspers. Jaspers marries the phenomenological tradition of early Husserl with the psychology of his contemporaries, such as Wilhelm Dilthey, Max Weber, and Georg Simmel, to form a revolutionary approach to psychiatric practice. As Zahavi and Loidolt observe, Jaspers' goal was to transform psychiatry with the insights of philosophy: 'Jaspers passionately defended the need for methodological pluralism, emphasizing the extent to which methods and viewpoints from philosophy had a special value for psychiatry' (Zahavi and Loidolt, 2022, p. 58).

Jaspers begins by distinguishing between the objective and the subjective symptoms one can examine in a psychiatric patient. Objective symptoms can be observed on the surface and deduced through sense perception and 'rational thought' (Jaspers, 1968, p. 1314). Objective symptoms include 1) 'concrete events that can be perceived by the senses' (e.g., physical gestures and speech expression), 2) 'all measurable performances' (e.g., whether the patient can work, or learn, or retain memory), 3) 'the rational content of what the patient tells us' (e.g., reports of delusion) (*ibid*.). These objective symptoms were the main focus of the psychotherapists in Jaspers' day (and arguably continue to dominate modern psychiatry).

In contrast, Jaspers recognises that the psychiatric patient also has subjective symptoms, which are not as easily assessed. Drawing on Husserl's phenomenological tradition, Jaspers understands subjective symptoms as the elusive inner life of the psychiatric patient.

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

This can be understood as the emotional, temporal, spatial, and intentional style of one's embodied experience in the world. In the context of psychiatry, Jaspers applies the phenomenological method to examine the patient's lifeworld in a state of psychiatric illness. This is at the centre of phenomenological psychopathology – understanding psychiatric illness through the lifeworld of the patient.

5. Overcoming the Contingent Obstacles

Phenomenological psychopathology challenges the contingent obstacles of communication in psychiatric practice, first and foremost by redressing the unequal power structures in psychiatric healthcare and developing a patient-centred approach. By inviting the patient into an informational exchange that prioritises their own expression of their lived experience, the clinician is no longer the arbiter of meaning-making. This shift in epistemic authority is one of the key benefits of a phenomenological approach to psychopathology: meaning-making is centred not around the clinician but the patient.

As we have seen, in a clinical exchange, the meaning the psychiatric patient places on aspects of the world may not be taken seriously and may be dismissed as irrational or a product of illness itself. This can be understood as a form of testimonial injustice. Through phenomenological psychopathology, on the other hand, the patient's interpretation is placed at the centre of the therapeutic process. Phenomenological psychopathology can be understood as the development of 'a framework for approaching mental illness in which theoretical assumptions are minimized, and the forms and contents of the patient's subjective experience are prioritized' (Stanghellini *et al.*, 2019, p. 3). Phenomenological psychopathology surpasses the limited scope of pre-structured interviews and diagnostic criteria by examining the patient's lifeworld. After all, in the words of Stanghellini *et al.*: 'we, as clinical psychiatrists, do not usually sit in front of a broken brain – we sit in front of a suffering person' (Stanghellini *et al.*, 2019, p. 4). This shift in epistemic authority is one of the key benefits of a phenomenological approach to psychopathology: meaning-making is centred not around the clinician but the patient.

Moreover, as a 'quest for meaning', phenomenological psychopathology strives to overcome the hermeneutical inequality perpetrated by traditional interpretive frameworks. By casting aside the often ill-suited hermeneutical resources of the diagnostic manual,

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

phenomenological psychopathology seeks to articulate the world as it appears to the person with psychiatric illness, 'including all those details that resist standard semiological classification' (Stanghellini *et al.*, 2019, p. 959).

Indeed, the rejection of pre-given interpretive frameworks is at the heart of phenomenological psychopathology, as it plays a key role in Jaspers' 'General Psychopathology'. Jaspers identifies 'theoretical prejudice' in the work of his predecessors, whereby clinical examination was skewed in order to fit within a dominant theoretical framework: 'anything that supports it or seems relevant is found interesting; anything that has no relevance is ignored; anything that contradicts the theory is blanketed or misinterpreted' (Jaspers, 1997, p. 17). As such, Jaspers calls for a suspension of 'all outmoded theories, psychological constructs or materialist mythologies of cerebral processes' and 'basic constructs or frames of reference' (Jaspers, 1968, pp. 1315–6). This bracketing includes the taxonomy and classification pre-established in psychiatry, as well as all inherited, obsolete psychological theories that may unduly influence the psychiatrist.

Although some advocates of the method have attempted to devise a psychiatric classification that is rooted in a phenomenological approach (see Fernandez, 2019), the most common view held amongst phenomenological psychotherapists is that, given the world-disrupting nature of psychiatric illness, there is no straightforward, universal translation for any psychiatric experience. Rather than a one-size-fits-all approach, phenomenological psychopathology strives to facilitate reflective awareness and communicability of the patient's first-person account through doctor-patient dialogue.

Therefore, the phenomenological psychopathologist is sensitive to the communicative hurdles the patient faces and demonstrates a reflexive awareness that the language of the diagnostic manual may be an ill-fitting hermeneutical resource for the patient's lived experience. Through phenomenological psychopathology, the clinician not only exercises a hermeneutical openness to the patient's interpretation but rejects the dominant interpretive framework in order to foster the patient's alternative understanding of their illness experience.

While such an emphasis on the first-person perspective may tackle the contingent communication problems in psychiatric practice, what is less evident, is how phenomenological psychopathology can help us tackle the intrinsic obstacles. These problems are far more challenging to overcome, as they are part of the very nature of the illness itself. In what follows, we consider how useful phenomenological

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

psychopathology can be for overcoming inherent communication problems in co-production.

6. Overcoming Intrinsic Obstacles

Phenomenological psychopathology goes beyond a mere description of 'what it is like' to have a certain psychiatric illness; phenomenological psychopathology concerns an in-depth examination of the interpersonal, intentional, temporal, spatial, and affective structure of the patient's lifeworld. In collating these valuable first-person descriptions, the clinician and patient can, over time, paint a picture of the lifeworld of a given psychiatric illness by drawing out the prevalent core structures in each account. Consequently, phenomenological psychopathology 'provides tools that can facilitate successful clinical diagnosis as well as the revision of our diagnostic categories' (Stanghellini *et al*., 2019, p. 4).

However, how does the phenomenologist initially attain meaningful first-person descriptions when faced with intrinsic obstacles to expression? Many of the burgeoning resources in phenomenological psychopathology focus on developing new interview techniques to extract the first-person narrative from the patient. The most popular include the PHD method of interview (Stanghellini *et al*., 2019), The Examination of Anomalous World Experience (EAWE) (Pienkos, Silverstein, and Sass, 2017) and the Examination of Anomalous Self Experience (EASE) (Parnas *et al*., 2005). These interview techniques acknowledge the inherent problems in conveying complex illness experiences. For example, Parnas *et al*. observe:

> The experiences may be *fleeting*, perhaps even verging on something *ineffable*. They are *not* like material objects that one can 'take out of one's head' and describe them as if they were *things* with certain properties, or redescribe the experience at different occasions in exactly the same terms. The patient may be short of words to express his own experience. (Parnas *et al*., 2005, p. 237).

Advocates of phenomenological psychopathology go on to recommend techniques for the clinician to employ in order to encourage meaningful dialogue. These include taking metaphorical language seriously, establishing a good rapport with the patient, and 'a patient-doctor mutually interactive reflection' (Parnas *et al*., 2005). The latter involves a back-and-forth between patient and clinician, where the clinician reformulates the question, provides examples, and slowly extracts the meaning from the patient in the style of a

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

semi-structured interview (*ibid*.). An account of how best to extract a meaningful account of the patient's lived experience can also be found in Stanghellini and Mancini's 'toolbox': 'the family of tools in use during the interview' (Stanghellini and Mancini, 2017, p. 3). This includes 1) phenomenological unfolding, 2) hermeneutic analysis, and 3) dynamics analysis (Stanghellini, 2016).

A further technique is that of guiding a self-narrative from the patient. Anna Bortolan emphasises that the narrative aspect of phenomenological psychopathology offers the patient not only epistemic insight but is also part of the recovery process. She argues that, by putting one's phenomenological experience into words, the patient has command over the ambiguous and overwhelming change in her lifeworld: 'This increased sense of control, in turn, inclines us to be more proactive in regulating our feelings, which results in less overwhelming emotions and an increased sense of empowerment' (Bortolan, 2019, p. 1059). In some cases, however, the collapse of the possibility of meaningful narration may be integral to the experience. Certain experiences of grief and depression, for instance, may involve the loss of an orientation towards the future that narrative practice presupposes (Ratcliffe and Broome, 2012).

Nevertheless, phenomenological psychopathology in its current form only offers resources for the *clinician* to mediate successful meaning-making. It does not currently offer resources for those with lived experiences to tackle the intrinsic obstacles to communication. For this reason, we turn to the phenomenology of illness more broadly and to Havi Carel's 'phenomenological toolkit' (Carel, 2012, 2016). Stanghellini's phenomenological 'toolbox' shares many similarities with Carel's 'phenomenological toolkit': both advocate employing the epoche, drawing out the meaning structures of illness and examining the patient's being-in-the-world. However, Carel's phenomenological toolkit is first and foremost 'a patient resource' and only secondly 'aimed at training clinicians' (Carel, 2016, p. 199).

Carel argues that a phenomenological method is an essential tool for the expression of illness, and for the develop of a rich (or 'thick') account of the illness experience: 'a philosophical framework that views cognition as embodied, focuses on subjective experience, and provides a robust existential account of selfhood is well suited to understanding the experience of illness' (Carel, 2012, p. 100). While phenomenological psychopathology advocates for phenomenology as an ideal resource for clinicians, Carel recognises that it is also an ideal tool for patients to communicate their experiences. Carel's opts for a 'flexible individual tool which patients can use to develop

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

their understanding of their illness', instead of focusing on the clinician's understanding (Carel, 2012, pp. 106–7).

Indeed, Carel even extends the process beyond the bounds of the patient-clinician dialogue, and transforms the hermeneutical process into a collaborative effort between patients, clinicians, and family members in a workshop setting:

> The small-group structure of the workshop and the fact that participants all suffer from an illness, or aim to care for ill persons, provide a safe environment that will allow participants to share the idiosyncrasies of their experiences with no pressure for these to fit into a pre-given mould. (Carel, 2016, p. 202)

Given the ineffability of illness, a collective attempt at expression may be more effective with more participants contributing their knowledge. This is reminiscent of Fricker's account of Wendy Sanford, who is introduced to the term 'postpartum depression' after participating in a university-based workshop. In a 'life-changing forty-five minutes', she can make sense of her own experience of postpartum depression. Consequently, a 'hermeneutical darkness' is 'suddenly lifted from Wendy Sandford's mind' (Fricker, 2007, p. 149).

Moreover, Carel's phenomenological toolkit attempts to provoke meaningful reflection, not merely through language and text, but through 'visual and sensual samples' (Carel, 2012, p. 109). In the words of Carel, 'The evocative force of images and sounds will enable participants to explore possibly unnamed emotions and experiences. The phenomenological dimension of the workshop is amplified by this use of varied media, which will appeal to the experiential and perceptual, rather than restrict exploration to already formulated ideas' (*ibid.*). As the ineffable experiences of illness seem to defy everyday language, it may indeed be more promising to appeal to expression beyond language.

It is worth qualifying here that such phenomenological approaches are by no means simple and fail-safe methods for tackling intrinsic communication problems. Overcoming intrinsic obstacles to communication is no mean feat. However, we propose that through a phenomenological toolkit, we can go some way towards finding new ways of expressing the near inexpressible.

7. Conclusion

This chapter began with Gadamer's 'hermeneutic problem of psychiatry', which identifies an 'unbridgeable divide' between clinician

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

and patient in the psychiatric encounter (Gadamer, 1996, p. 171). This poses a problem for the co-production of meaning in mental health research, as a collaborative effort in meaning-making is an essential aspect of co-production. In considering Gadamer's 'hermeneutic problem of psychiatry', two key obstacles to successful co-production emerge, the first being contingent barriers to communication. The genuine dialogue described by Gadamer requires scarce resources – time, trust, empathy – and runs up against power structures, institutional barriers, negative biases, and general deficiencies in shared moral energies. These contingent factors result from historical events, decisions, and developments that could have been different. One key contingent factor is hermeneutical marginalisation, whereby communication is inhibited due to gaps in the interpretive framework, caused by a lack of inclusion of marginalised voices in the meaning-making process. Contingent factors such as these inhibit the co-production of meaning.

These structural issues must be redressed to ensure a reciprocal dialogue between clinician and patient, whereby both parties can participate in meaning-making. The study of these contingent factors is ever-growing in the philosophy of psychiatry. Nevertheless, sensitivity to contingent factors should not occlude the possibility that some obstacles are intrinsic. In other words, even if all the social and epistemic challenges were eliminated, or had never existed in the first place, some intrinsic factors would persist no matter what the social world or the psychiatric care system is like. Difficulties in co-producing meaning in psychiatric healthcare may result from the illness itself. We refer to these as the intrinsic obstacles to communication. Communication difficulties may arise due to a newfound chaotic way of thinking or indifference towards the clinician. However, in turning to phenomenology, it becomes apparent that communication difficulties can arise from a profound alteration in one's lifeworld. A transformation of the way one experiences their body, their sense of self, time, space, objects in the world and others can lead to ineffability. Thus, even if a hermeneutically just psychiatric context could be constructed, the illness itself may inhibit successful meaning-making in co-production.

In calling attention to the contingent and intrinsic obstacles to communication, we problematise the concept of 'co-production', revealing it to be more complex than originally thought. We conclude by arguing that new developments in phenomenological psychopathology can be used to overcome the contingent obstacles to co-production and can go some way towards ameliorating the intrinsic obstacles too. Phenomenological psychopathology redresses the uneven power

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

structures in psychiatry by prioritising the patient's experience. Moreover, it rejects the interpretive frameworks traditional to psychiatric healthcare, and attempts to develop a new framework from the expressions of the patients themselves. As such, phenomenological psychopathology is hermeneutically just, as the patient plays a central role in the meaning-making process.

When tackling the intrinsic problems of co-production, we found that phenomenological psychopathology fell short. While it provides clinicians with resources for extracting the narratives of lived experience from the patient, the method fails to provide resources for the patient to better express the inexpressible. Thus, we turn to Havi Carel's 'phenomenological toolkit', which helps patients voice their illness experience in phenomenological terms. The phenomenological toolkit also attempts to provoke expression through visual and sensual stimulations, as Carel recognises that our day-to-day language is ill-equipped for transformative experiences. While intrinsic problems still obstruct successful co-production, we believe Carel's phenomenological toolkit lends itself towards the expression of ineffable experiences.

Gadamer's hermeneutic problem of psychiatry should trouble those who propose to co-produce meaning in psychiatric healthcare. By highlighting the contingent and intrinsic obstacles of expressing the lived experience of psychiatric illness, we hope that those intending to co-produce meaning may reflect upon ways of overcoming these hurdles. We suggest the phenomenological method as a promising approach for ameliorating these communication difficulties. Ultimately, we hope to find new ways of bridging the so-called 'unbridgeable divide' in psychiatric healthcare.

References

Kevin Aho, 'Temporal Experience in Anxiety: Embodiment, Selfhood, and the Collapse of Meaning', *Phenomenology and the Cognitive Sci*ences, 19 (2020), 259–70.

Maria Andreou and Vasileia Skrimpa, 'Theory of Mind Deficits and Neurophysiological Operations in Autism Spectrum Disorders: A Review', *Brain Sciences*, 10:6 (2020), 393.

Ludwig Binswanger, *Mélancolie et Manie: Études Phénoménologiques*, Jean-Michel Azorin and Yves Pélicier (trans.), (Paris: Presses Universitaires de France, 2011 [1960]).

Anna Bortolan, 'Phenomenological Psychopathology and Autobiography', in Giovanni Stanghellini, Matthew Broome,

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press

Anthony Vincent Fernandez, Paolo Fusar-Poli, Andrea Raballo, and René Rosfort (eds.), *The Oxford Handbook of Phenomenological Psychopathology* (Oxford: Oxford University Press, 2019), 1053–64.
Martin Buber, *I and Thou*, Ronald Gregor Smith (trans.), (New York: Scribner Classics, 2000).
Havi Carel, 'Phenomenology as a Resource for Patients', *The Journal of Medicine and Philosophy*, 37:2 (2012), 96–113.
Havi Carel, *Phenomenology of Illness* (Oxford: Oxford University Press, 2016).
Havi Carel and Ian James Kidd, 'Epistemic Injustice in Healthcare: A Philosophical Analysis', *Medicine, Health Care and Philosophy*, 17 (2014), 529–40.
Sarah Carr and Meena Patel, *Progressing Transformative Co-Production in Mental Health* (National Development Team for Inclusion, 2016).
Remzi Oğulcan Çiray, Gonca Özyurt, Serkan Turan, Ezgi Karagöz, Çağatay Ermiş, Yusuf Öztürk & Aynur Akay, 'The Association Between Pragmatic Language Impairment, Social Cognition and Emotion Regulation Skills in Adolescents with ADHD', *Nordic Journal of Psychiatry*, 76:2 (2022), 89–95.
Rachel Cooper, *Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders,* (New York: Springer, 2005).
Anthony Vincent Fernandez, 'Phenomenological Psychopathology and Psychiatric Classification', in Giovanni Stanghellini, Matthew Broome, Anthony Vincent Fernandez, Paolo Fusar-Poli, Andrea Raballo, and René Rosfort (eds.), *The Oxford Handbook of Phenomenological Psychopathology* (Oxford: Oxford University Press, 2019), 1016–30.
Michel Foucault, *Madness and Civilization*, 2nd edition, (Abingdon: Routledge, 2001 [1961]).
Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (Oxford: Oxford University Press, 2007).
Miranda Fricker, 'Evolving Concepts of Epistemic Injustice', in Ian James Kidd, José Medina, and Gaile Pohlhaus Jr (eds.), *The Routledge Handbook of Epistemic Injustice* (London: Routledge, 2017), 53–60.
Thomas Fuchs, 'Depression, Intercorporeality, and Interaffectivity', *Journal of Consciousness Studies*, 20 (2013), 219–38.
Paolo Fusar-Poli, Andrés Estradé, Giovanni Stanghellini, Jemma Venables, Juliana Onwumere, Guilherme Messas, Lorenzo Gilardi, Barnaby Nelson, Vikram Patel, Ilaria Bonoldi,

Massimiliano Aragona, Ana Cabrera, Joseba Rico, Arif Hoque, Jummy Otaiku, Nicholas Hunter, Melissa G Tamelini, Luca F. Maschião, Mariana Cardoso Puchivailo, Valter L. Piedade, Péter Kéri, Lily Kpodo, Charlene Sunkel, Jianan Bao, David Shiers, Elizabeth Kuipers, Celso Arango, and Mario Maj, 'The Lived Experience of Psychosis: A Bottom-Up Review Co-Written by Experts by Experience and Academics', *World Psychiatry*, 21:2 (2022), 168–88.

Hans-Georg Gadamer, *The Enigma of Health: The Art of Healing in a Scientific Age* (Stanford: Stanford University Press, 1996).

Shaun Gallagher, 'Time, Emotion, and Depression', *Emotion Review*, 4:2 (2012), 127–32.

J.J. Gibson, *The Senses Considered as Perceptual Systems* (London: Allen & Unwin, 1968).

Gary Gutting, *Michel Foucault's Archaeology of Scientific Reason: Science and the History of Reason* (Cambridge: Cambridge University Press, 1989).

Karl Jaspers, *General Psychopathology*, Julius Hoenig and Marian W. Hamilton (trans.), (Baltimore, MD: Johns Hopkins University Press, 1997 [1913]).

Karl Jaspers, 'The Phenomenological Approach in Psychopathology', *The British Journal of Psychiatry*, 114:516 (1968), 1313–23.

Kenneth S. Kendler, 'The Phenomenology of Major Depression and the Representativeness and Nature of DSM Criteria', *The American Journal of Psychiatry*, 173:8 (2016), 771–80.

Ian James Kidd, *Epistemic Injustice, Healthcare, and Illness: A Bibliography*, (2017), accessed 6 June 2023: https://ianjameskidd.weebly.com/epistemic-injustice-healthcare-and-illness-a-bibliography.html.

Ian James Kidd, José Medina, and Gaile Pohlhaus Jr (eds.), *The Routledge Handbook of Epistemic Injustice* (London: Routledge, 2017).

Ian James Kidd, Lucienne Spencer, and Havi Carel, 'Epistemic Injustice in Psychiatric Research and Practice', *Philosophical Psychology*, ahead-of-print (2023), 1–29.

Joel Krueger, 'Schizophrenia and the Scaffolded Self', *Topoi*, 39 (2020), 597–609.

Ronald David Laing, *The Divided Self: An Existential Study in Sanity and Madness* (London: Penguin Books, 1964).

Luis Madeira, Elizabeth Pienkos, Teresa Filipe, Mariana Melo, Guilherme Queiroz, João Eira, Cristina Costa, Maria Luísa Figueira, and Louis Sass, 'Self and World Experience in Non-Affective First Episode of Psychosis', *Schizophrenia Research*, 211 (2019), 69–78.

José Medina, 'Varieties of Hermeneutical Injustice', in Ian James Kidd, José Medina, and Gaile Pohlhaus Jr (eds.), *The Routledge Handbook of Epistemic Injustice* (London: Routledge, 2017), 41–52.

Mental Health Foundation, *Stigma and Discrimination*, (2016), accessed 6 June 2023: https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination.

Maurice Merleau-Ponty, *Phenomenology of Perception*, Donald A. Landes (trans.), (Abingdon: Routledge, 2012).

Middlesex University London, Centre for Coproduction in Mental Health and Social Care, accessed 5 June 2023: https://www.mdx.ac.uk/our-research/centres/centre-for-coproduction-in-mental-health.

Eugene Minkowski, *Le Temps Vécu: Études Phénoménologiques et Psychopathologiques*, Yves Pelicier (ed.), (Paris: Presses Universitaires de France, 2013 [1933]).

National Collaborating Centre for Mental Health, *Working Well Together: Evidence and Tools to Enable Co-Production in Mental Health Commissioning* (London: National Collaborating Centre for Mental Health, 2019).

Josef Parnas, Paul Møller, Tilo Kircher, Jørgen Thalbitzer, Lennart Jansson, Peter Handest, and Dan Zahavi, 'EASE: Examination of Anomalous Self-Experience', *Psychopathology*, 38:5 (2005), 236–58.

Martyn D. Pickersgill, 'Debating DSM-5: Diagnosis and the Sociology of Critique', *Journal of Medical Ethics*, 40:8 (2014), 521–5.

Elizabeth Pienkos, Steven Silverstein, and Louis Sass, 'The Phenomenology of Anomalous World Experience in Schizophrenia: A Qualitative Study', *Journal of Phenomenological Psychology*, 48:2 (2017), 188–213.

Elizabeth Pienkos, Borut Škodlar, and Louis Sass, 'Expressing Experience: The Promise and Perils of the Phenomenological Interview', *Phenomenology and the Cognitive Sciences*, 21:1 (2021), 53–71.

Matthew Ratcliffe, *Experiences of Depression: A Study in Phenomenology*, (Oxford: Oxford University Press, 2015).

Matthew Ratcliffe, 'The Interpersonal Structure of Depression', *Psychoanalytic Psychotherapy*, 32:2 (2018), 122–39.

Matthew Ratcliffe and Matthew Broome, 'Existential Phenomenology, Psychiatric Illness, and the Death of Possibilities', in Steven Galt Cowell (ed.), *The Cambridge Companion to Existentialism* (Cambridge: Cambridge University Press, 2012), 361–82.

John Z. Sadler and Bill Fulford, 'Should Patients and Their Families Contribute to the DSM Process?', *Psychiatric Services*, 55:2 (2004), 133–8.

Louis Sass, 'The Truth-Taking-Stare: A Heideggerian Interpretation of a Schizophrenic World', *Journal of Phenomenological Psychology*, 21:2 (1990), 121–49.

Louis Sass, *Madness and Modernism: Insanity in the Light of Modern Art, Literature, and Thought* (Oxford: Oxford University Press, 2017).

Kenneth F. Schaffner and Kathryn Tabb, 'Varieties of Social Constructionism and the Problem of Progress in Psychiatry', in Kenneth S. Kendler and Josef Parnas (eds.), *Philosophical Issues in Psychiatry III: The Nature and Sources of Historical Change* (Oxford: Oxford University Press, 2015), 85–106.

Anastasia Philippa Scrutton, 'Epistemic Injustice and Mental Illness', in Ian James Kidd, José Medina, and Gaile Pohlhaus Jr (eds.), *The Routledge Handbook of Epistemic Injustice* (London: Routledge, 2017), 347–55.

Fredrik Svenaeus, *Phenomenological Bioethics: Medical Technologies, Human Suffering, and the Meaning of Being Alive* (London: Routledge, 2018).

Giovanni Stanghellini, 'Phenomenological Psychopathology and Care. From Person-Centered Dialectical Psychopathology to the PHD Method for Psychotherapy', in Giovanni Stanghellini and Massimiliano Aragona (eds.), *An Experiential Approach to Psychopathology*: *What is it Like to Suffer from Mental Disorders?* (Berlin: Springer, 2016), 361–78.

Giovanni Stanghellini, 'Phenomenological Psychopathology and Psychotherapy', in Giovanni Stanghellini, Matthew Broome, Anthony Vincent Fernandez, Paolo Fusar-Poli, Andrea Raballo, and René Rosfort (eds.), *The Oxford Handbook of Phenomenological Psychopathology* (Oxford: Oxford University Press, 2019), 952–71.

Giovanni Stanghellini and Milena Mancini, *The Therapeutic Interview in Mental Health: A Values-Based and Person-Centered Approach* (Cambridge: Cambridge University Press, 2017).

William Styron, *Darkness Visible: A Memoir of Madness* (New York: Open Road Integrated Media, 2010 [1990]).

Kathryn Tabb, 'Psychiatric Progress and the Assumption of Diagnostic Discrimination', *Philosophy of Science*, 82:5 (2015), 1047–58.

Arthur Tatossian, *La Fenomenologia delle Psicosi*, Riccardo Dalle Luche and Giampaolo Di Piazza (eds.), (Roma: G. Fioriti, 2019 [1979]).

Nancy Tracey, *Lost Marbles: Insights into My Life with Depression and Bipolar* (2016).
Dylan Trigg, 'The Body of The Other: Intercorporeality and the Phenomenology of Agoraphobia', *Continental Philosophy Review*, 46:3 (2013), 413–29.
Rebecca Tsosie, 'Indigenous Peoples, Anthropology, and the Legacy of Epistemic Injustice', in Ian James Kidd, José Medina, and Gaile Pohlhaus Jr (eds.), *The Routledge Handbook of Epistemic Injustice* (London: Routledge, 2017), 356–69.
David H. Vogel, Katharina Krämer, Theresa Schoofs, Christian Kupke, and Kai Vogeley, 'Disturbed Experience of Time in Depression – Evidence from Content Analysis', *Frontiers in Human Neuroscience*, 12 (2018), np.
Lilian Wilde, 'Trauma and Intersubjectivity: The Phenomenology of Empathy in PTSD', *Medicine, Health Care and Philosophy*, 22 (2019), 141–5.
Dan Zahavi and Sophie Loidolt, 'Critical Phenomenology and Psychiatry', *Continental Philosophy Review*, 55:1 (2022), 55–75.

https://doi.org/10.1017/S135824612300019X Published online by Cambridge University Press