



**Mental Disorder: Mind? Brain? Person!**  
**Existential Phenomenology in the Age of Neuroscience**

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**Abstract:** The essay considers the current conceptualization of mental disorder focusing on the disparity between the burgeoning of neuroscientific data and the epistemological and methodological insufficiency to interpret these data. The twenty-first century brain-centered optimism in the sciences repeats verbatim slogans of infamous mechanistic materialism and phrenology of the eighteenth century. The essay examines the epistemic trap of the brain versus mind discussion and the bio-psycho-social approaches. Mental disorder is not a disorder of the brain, it is also not a disorder of the mind but of a human being's being, which is existence. Likewise, mental disorder is neither a biological, nor a psychological or social phenomenon, it is a clinical phenomenon. Existential phenomenology opens up the way to move from reducing human experiences to explanatory constructs toward understanding these experiences in their true dynamical presence and authenticity.

**Keywords:** Jaspers, Karl; Heidegger, Martin; mental disorder; *DSM*; neuroscience; existentialism; phenomenology; brain-mind; bio-psycho-social; clinical phenomenon.

There can be no final analysis of human beings as such, since the more we reduce them to what is typical and normative the more we realize there is something hidden in every human individual which defies recognition. We have to be content with partial knowledge of an infinity which we cannot exhaust. [p. 1]  
Karl Jaspers, *General Psychopathology*

As the world renowned, contemporary physicist Max Planck said a few years ago: "Only that which can be measured is real." In contrast to this it can be argued: Why can't there be something real which is not susceptible to exact measurement? Why not sorrow, for example? [p. 7]  
Martin Heidegger, *Zollikon Seminars*

I dissected music as a cadaver. I checked harmony with algebra.  
[Antonio Salieri]  
Aleksandr Pushkin, *Mozart and Salieri*

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**Introduction**

Reflecting on mental disorder is a form of reflecting on man. Decades of practicing psychiatry and psychotherapy have demonstrated that the victorious

march of neuroscience that is mapping the *terra incognita* of mental disorder with precise facts simply reposes the old questions about brain and mind rather than resolves them. The brain does not enter a consulting room, nor does the mind enter a consulting room: a person does.

A clinician does not see a mental disorder; a clinician sees a person who might be diagnosed with having mental disorder.

A routine clinical situation raises many questions about mental disorder; questions that lead from the clinical toward the philosophical. A dark moment of despair, suffocating hopelessness, tension in the chest, anguish, spasm in the throat resolving into sobbing and bitter tears. Is this a normal human experience: a reaction to the death of a loved one or merely a sudden sadness? Or this is a mental disorder? Accordingly: Is this experience a disturbing but organic part of life, or pathological syndrome that has to be removed as a tumor or a microbe. The central question is what is being disordered when a person feels depressed, hears voices reads other people's thoughts or believes herself to be a prophet? Brain? Mind? And what about the person to whom this brain and this mind belong?

This essay reflects upon these questions focusing on the category of mental disorder, its subject matter and method of its investigation. The essay considers the role of neuroscience and existential phenomenology in understanding mental disorder and emphasizes that: (1) mental disorder is not biological or psycho-social but a clinical category, (2) the conceptualization of mental disorder is rooted in the major philosophical question about the relationship between idea and matter that is trapped in the body-mind dichotomy, (3) the current neuroscientific revolution is a phase of the historical flux and reflux between brain-centered and mind-centered conceptualizations of mental disorder, and (4) the person-centered conceptualization of mental disorder in existential phenomenology, in particular, Karl Jaspers' *General Psychopathology*<sup>1</sup> and Martin Heidegger's *Zollikon Seminars*,<sup>2</sup> opens a way for understanding mental disorders as an expression of human being's being, namely of *Existenz*.

### Mental Disorder As It Is

Mental disorder is a territory where social meets legal, brain meets mind, matter meets idea, and science meets

philosophy. Understanding mental disorder in and by itself begins from the exploring that mental that is getting disordered when mental disorder occurs.

Mental disorder is a foreigner in the medical domain. First it was treated as social aberrance, crimes, or possessions. Only about a couple of centuries ago mental disorder entered medicine as special pathology of mind (mental), different from, if not opposite to, the main corpus of medical pathology of *soma* (physical). Medical disorders are objective and material with evident malfunction of organs and systems—fever, bleeding, edema, tumor, and the like. In contrast, mental disorders are subjective, immaterial, ambiguous and frequently more similar to social inadequacy or strangeness than medical pathology: a wish to commit suicide, a belief of being the president of a state, a conviction about surveillance by neighbors, repetitive thefts from stores, feeling the need to count until 10 before pressing the elevator button, and so on.

The subject matter of physical disorders is matter, body in particular. The subject matter of mental disorders is mind, a sort of unknown, invisible entity, not a material substrate, but an ideal construct. No clear definitions exist of mind. Even the mere reality and occurrence of mind remained a perplexing question. Correspondingly, the etiology and pathogenesis of mental disorder was unknown. Now, two centuries later, with major advancements in brain science and great variety of theories of mind, the newest *DSM-5* still states that the causes of mental disorders are mainly unknown.<sup>3</sup> When and if the etiopathogenesis of a mental disorder becomes known, it would consider a material process, not a mental construction. Consequently, the disorder would be moved from an obscure—ideated—province of the mental to the main—materialistic—domain of medicine.

The first case in point was neurosyphilis. Special clinical forms of mania with delusions of grandeur, depression, *tabes dorsales* or *dementia paralytica*, that were clinically different from other types of mania; depression and dementia were considered mental disorders. Then, their material etiopathogenesis was found: discovery of *spirocheta*, a microorganism that causes syphilis, and then confirmation of its presence in the brain lesions of the patients with such disorders.

<sup>1</sup> Karl Jaspers, *General Psychopathology*, trans. J. Hoening and Marian W. Hamilton, Baltimore, MD: Johns Hopkins University Press, 1997. [Henceforth cited as *GP*]

<sup>2</sup> Martin Heidegger, *Zollikon Seminars: Protocols-Conversations-Letters*, ed. Medard Boss, trans. Franz Mayr and Richard Askay, Evanston, IL: Northwestern University Press 1987. [Henceforth cited as *ZS*]

<sup>3</sup> DSM-5 Task Force, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5*, Washington, DC: American Psychiatric Association 2013. [Henceforth cited as *DSM-5*]

Consequently, these special clinical forms were moved from the class of mental disorders to the class of physical disorders, namely, sexually transmitted infectious diseases. The same happens with mental presentations of *myxedema*, multiple sclerosis, brain tumor, and other organic physical disorders: their material substratum was found and they became considered mental syndromes of physical illnesses.

This residual principle of categorization of a disorder as mental only if there is no evidence that it is physical, could be seen in daily practice, for example in the emergency room. An athletic man of 26, is pale, tense, and panicky. His girlfriend has just left him for his friend. The man complains of feeling faint, intolerable pain in his chest, difficulties breathing, and fear of dying. The clinical picture suggests acute somatised anxiety or panic attack, possibly associated with a psychological trauma. However, this diagnosis is not the chief to be considered. First of all, complex analyses will be done (blood work, MRI, Ultrasound, EKG, etc.) to confirm or reject myocardial infarction and other forms of physical pathology. Only if these objective data are uneventful and thus a diagnosis of physical pathology can be excluded, then the diagnosis of mental pathology (panic attack) will be made. The point here is not that a panic attack is less real than a heart attack. The point is that the reality of a panic attack is fundamentally different from the reality of a heart attack. There are no objective, measurable evidences to explain a panic attack. For example, while a heart attack designates damages of the heart, no equivalent carrier of damages is found to designate a panic attack.

### Matter and Mind: Materialism and Idealism

This uncertainty of the subject matter of mental disorder engenders a plentitude of theories. In sum, they fall into two lines. The first line is materialism – mental disorder is a disorder of the brain. The second line is idealism – mental disorder is a disorder of the mind.

Emerging from Aristotelian and Platonic constructs and masterfully elaborated by René Descartes, the Western thinking tradition rests upon two ultimate concepts of the world – matter and idea. The materialistic conceptualization of mental disorder is rooted in matter, its idealistic counterpart is rooted in the mind.

Materialism considers the mental as an expression of the physical. The subject matter of mental disorder is the brain, where mentality is reduced to materiality. For

example neurosyphilis: here, specific delusions, mania, depression are seen as results of pathological activity of spirochete in the brain. Scientific knowledge is just not deep enough to prove this completely at this time. Sooner or later a microbe, a neuromediator, a lesion in some hidden corner of the brain, a genetic deviation – something substantial and objective will be discovered. Hence mental disorder does not carry any special quality but is the same as physical disorder, an object to be investigated by rational natural-scientific methods, based on the explanatory paradigm, the objectivity of measurement and the power of experimentation.

The second line asserts sovereignty of the mental, its independence from the material. The mental represents its own world of psychological and social forces, that cannot be reduced to the material. The subject matter of mental disorder is a special entity. In contrast to certainty of the materialistic line, the idealistic never knew what exactly this special entity is. The principal point is that it is subjective and thus cannot be objectified and define with the precision of natural science. The subject matter of mental disorder has been conceptualized as *pneuma*, spirit, soul, or *Geist*. Following the dominating Anglo-American tradition of the last hundred years it is typically referred to as mind. Mental disorder carries its own special quality and requires its own methods of investigation. The mental refers to a microcosm – an internal world of its own presentations – thoughts, feelings, dreams, wishes, volitions, intentions, and the like. The life of the mental is not merely evident and familiar, but central for a human being: it is the *sine qua non* and makes humans different from everything else in the world. The mental penetrates a human being's existence at every given moment: feeling one's presence in the world, capable to reflect upon pain or happiness.

However, the mainstream of Western tradition favors objective materialistic reality, and tends to leave subjective idealistic reality for poets and philosophers. Many physicians as well as patients frequently are eager to convert the elusiveness of the subjective reality of psychic experiences to the hard currency of the objective reality of brain pathology. Psycho-social as well as epitemic factors contribute to such situation. Psychologically and morally, neurochemical imbalance sounds better than depression, reducing the stigmatization of the discriminative mad/bad dictum that stemmed from the old but still strong equation of mental disorder and social aberrance. Epistemically, materialistic reduction keeps the conceptualization of mental disorder in the frame of deterministic and explanatory paradigm, providing

the comfort of predictability and subordination. Running from the subjective reality of person's internal world toward its objectification in impersonal things feels like running from the freedom and infinitude of persona toward the cage of comfortable rationality and "numerical values" (ZS 78).

Though historically the mental sometimes was anchor to the heart and other organs, the majority of materialistic theories connected it to brain. Epistemologically and methodologically there is not too much to add to the thousand-plus years Hippocrates' formula:

Men ought to know that from the brain and from the brain only arrives our pleasures, joys, laughter and jests, as well as our sorrows, pains, griefs, and tears.<sup>4</sup>

The later developments incorporated new data regarding brain structure, functions, and the processes of the transformation of brain activity into mental activity. Progress in explaining brain-mind connections was seen as progress in medicine, and was guided by the most accelerating natural sciences at that moment—physics, chemistry, and biology.

By the end of the nineteenth century the brain-theory of mind was blossoming. The brilliant German physician Wilhelm Griesinger, the founder of modern biological psychiatry, set the stage: "Patients with so-called 'mental illness' are really individuals with illnesses of nerves and brain."<sup>5</sup> A hundred years later, at the end of the twentieth century, avalanching advances in cognitive neuroscience, brain imaging, genetics, and molecular neurochemistry have equipped this materialistic view with new powerful, exciting, and promising data. However, at the end of the day, even the *DSM-5*, a major proponent of the "mental is brain" dictum, affirms that "a complete description of the underlying pathological process is not possible for most mental disorders" (*DSM-5* xii). There is a good deal of evidence that mental process are related to brain activity but there is no definite understanding of whether and how a particular mental disorder of a particular person is caused by a particular process in this person's brain.

<sup>4</sup> Cited in Franz Alexander and Sheldon T. Selesnick, *The History of Psychiatry: An Evaluation of Psychiatric Thought and Practice From Prehistoric Times to the Present*, New York, NY: Harper & Row 1966, p. 31.

<sup>5</sup> Cited in Edward, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, New York, NY: John Wiley & Sons 1997, p. 76. [Henceforth cited as *HP*]

The history of the idealistic line—mental disorders are disorders of the mind—includes social and psychological approaches. The social approach, treating the mentally sick as criminals or animals is evidently the oldest approach. Even today media outlets keep attention focused on such cases in which mental disorders are presented as instances of cultural deviations, moral aberrations, social abnormality, religious eccentricity, or criminal actions.

Even though Plato's ship of fools departed several centuries ago, the idea to see mental disorder as a social construct, a form of social suppression of those who are different, has never completely left the psychiatric horizon.<sup>6</sup> The colorful and influential anti-psychiatric movement, including scholarly views of Michel Foucault and Thomas Szasz;<sup>7</sup> the *DSM-I* with Adolf Meyer's ideas that mental disorder is caused not by the pathology of brain, but by a negative environment;<sup>8</sup> and Silvano Arieti's multi-volume set of the *American Handbook of Psychiatry*<sup>9</sup> attested to the limitations of the emerging reductionist interpretation of mental disorder. It is difficult to deny that social factors impacted the design of some disorders: the Vietnam War and

<sup>6</sup> In *Book VI* of Plato's *Republic*, Socrates describes to Ademantes a ship of fools as allegory for a vessel without a pilot, populated by deranged lunatics. Later, this allegory has been widely used in a psychiatric context, in particular as an allusion to the medieval practice of isolating, incarcerating, or punishing people with mental disorders. Two works to depict the medieval understanding of this allusion are the 1494 text by Sebastian Brant, *Ship of Fools*, trans. Alexander Barclay, Edinburgh, 1874 [accessible as eBook # 20179 at the Project Gutenberg Library, <http://www.gutenberg.org/files/20179/20179-h/20179-h.htm>], and the painting by Hieronymus Bosch, *Ship of Fools*, c. 1490-1500). A twentieth century interpretation of this analogy is Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard, New York, NY: Random House, 1965.

<sup>7</sup> Thomas S. Szasz, *The Myth of Mental Illness: Foundations of Theory of Personal Conduct*, New York, NY: Harper & Row, 1974.

<sup>8</sup> American Psychiatric Association, Committee on Nomenclature and Statistics, *Diagnostic and Statistical Manual: Mental Disorders*, Washington DC: American Psychiatric Association, 1952.

<sup>9</sup> Silvano Arieti, ed, *American Handbook of Psychiatry*, 8 Volumes, New York, NY: Basic Books, 1974-1986.

Posttraumatic Stress Disorder or the Soviet dissident movement and Sluggish Schizophrenia. If the story of masturbation as mental disorder feels like a historical anecdote, the story of the establishment and then the abolishment of homosexuality demonstrates the actuality of social constructing of mental disorder. In the case of homosexuality, it became a disorder to suit Victorian morals. The change of social politics during activism and the human rights movements lead to the removal of homosexuality from the official list of mental disorders. Ironically, the procedure again was not medical but political: anonymous voting.

The social plays a principal role in the theoretical categorization of mental disorder and its practical application as involuntary hospitalization. The official definition of mental disorder in the *DSM* includes social signs, "significant distress or disability in social, occupational or other important activities" (*DSM-5* 20). At the same time, the definition states that socially deviant behavior that does not result from a "dysfunction in an individual" is not mental disorder. In sum it remains unclear how to determine such dysfunction and its connection to deviant behavior? There are no objective tests to prove or deny this connection. However, it directly impacts the decision-making regarding involuntary hospitalization, a procedure that is as routine for psychiatry, as unimaginable to the rest of medicine. Three indications for involuntary hospitalization—a threat of a person with mental disorder to others, a threat to oneself, and inability to provide oneself with vital basics—belong to the social realm. So, the social domain is indeed an important dimension of mental disorders.

The psychological approach of the idealistic line of the conceptualization of mental disorder focuses on a person, her internal experiences, thoughts, feelings, wishes, phantasies, and dreams. Instead of the materialistic measurement of objects, psychological methods pay great respect to subjectivity as a special instrument of understanding. Autobiographies, journals, diaries, and introspection are considered among the powerful vehicles for explorations of a person's inner world of subjective reality that is seen as most important for psychological development. Mental disorder of depersonalization, for example, entered psychiatry right from the diaries of the Swiss philosopher, Henri Frédéric Amiel.

The psychological approach originates in the philosophical tradition, including the classical self-reflections of Saint Augustine's *Confessions* or Søren

Kierkegaard's writings. If the materialistic line of the conceptualization of mental disorder is practically merging with bio-medical science, the idealistic line of the conceptualization of mental disorder grew out of philosophical reflection.

Along with the body-centered and mind-centered conceptualizations there always have been a third venue of integrative or eclectic theories that take into account different aspects of mental disorder, such as cultural, social, psychological, biological, physiological, and other approaches. Many researchers as well as practitioners find them useful for particular pragmatic purposes. However, from an ontological and epistemological perspective, such approaches do not appear independent. They confuse factors contributing to the development of mental disorder with the subject matter of this disorder. Any theoretical conceptualization of mental disorder is based epistemologically on one of the two primaries—matter or mind. Some integrative approaches recognize their original theoretical take on mind or matter as primary. Others declare some form of atheoretical eclecticism. Nonetheless, such declarations do not free the thinking process itself from its fundamentals. For European rational thinking, these fundamentals are found in the Cartesian *res extensa—res cogitans* paradigm. In the case of mental disorder, matter and mind are not merely theoretical epistemic primers, but also material domains related to brain and mind.

### **The Flux and Reflux of Brain-Centered and Mind-Centered Conceptualizations of Mental Disorder**

The materialistic and idealistic theories sometimes would move closer together, forming hybrids, sometimes radically diverge from one another, but most often they would clash. A period dominating by a brain-centered theory would follow by a rise of a mind-centered theory. Then, the polarity would change again. One of latest representatives of the idealistic romantic school of psychiatry (the *Psychiker* as they called themselves), Karl Wilhelm Ideler believed that mental disorder is independent from the body. He emphasized the role of passions and introduced the method of pathography, the connections between biography, mental disorder, and creativity. Ideler's young deputy was Carl F. O. Westphal, one of the most famous European psychiatrists and most ardent proponent of the brain-centered materialism. Westphal hardly

tolerated his chief's position and propagated shifting the focus from an interview room to the autopsy table and the microscope.

Psychoanalysis demonstrates the flux and reflux of materialistic brain-centered and idealistic mind-centered conceptualizations of mental disorder. Sigmund Freud was an assistant of Theodor Meynert, a giant of the brain-centered position, who discovered the neurosyphilitic lesions in the brain. Meynert sarcastically disregarded therapy, saying that treatment of untreatable mental diseases is useless. Instead, he appraised "scientific basis in a deep and finely grained understanding of the [brain's] anatomical structure" (HP 77). Freud's initial research was quite materialistic and neurohistological. His first psychoanalytic ideas appealed to Hermann von Helmholtz's materialistic theories of electricity and magnetism. Even though psychoanalysis—with its primary focus on mental forces and their unconscious dynamics—was often considered the most complete mind-centered conceptualization of mental disorder, Freud himself never departed from his original vision of libido as a physical discharge at the ends of nerves, and also not from his appeal that, eventually, psychology will be replaced by chemistry.

The psychoanalytic triumph of a mind-centered conception of mental disorder was long, but not everlasting. As in the beginning of the twentieth century, Freudian psychoanalysis defeated Meynert's neuroanatomy, half a century later psychoanalysis was conquered by revolutionary advances in neuroscience. Thomas Insel, the Freud of contemporary neuroscience, calls this "a tectonic shift."<sup>10</sup> Nowadays the decade of the brain follows the decade of mind as it continues the brain mapping project. Next advances might very well include a MyBrainMap app, next to a GoogleMap app, and some MyNeuralCircuitry button for GoogleGlasses.

The findings of neuroscience are powerful and promising. The psychological effect of brain imagery is impressive. Scholarly interpretations of these findings indicate hope for future theories in their ability to connect brain functions with mental dispositions. However, what we can expect from such tectonic shift and what cannot be expected, remains still open to interpretation.

## The Neuroscientific Revolution and Mental Disorder

Current interventions by neuroscience into the theory of mental disorder present another chapter in the materialistic tradition. Following the advances of eighteenth century neuroanatomy, nineteenth century neuroscience, cerebral localization, and phrenology, and twentieth century neurophysiology, twenty-first century neuroscience aspires to translate the elusive subjectivity of mind into the factual objectivity of brain. The plenitude of amazing scientific discoveries expose significant limitations in their interpretation. Contemporary neuroscience relies on the same mixture of epistemological naiveté and aggressive positivism, as did mechanistic materialism of the seventeenth to nineteenth centuries. Consider the following, "An extremely small chemical and physical change in the brain...will suffice to bring out a mental disorder" (HP 626). A line from a popular lecture on the latest achievements of the neuroscientific revolution? Yes, but of 1852, not of 2015! The twenty-first century neuroscience dictum,

all the richness of our mental life—all our feelings, our emotions, our thoughts, our ambitions, our love lives, our religious sentiments and even what each of us regards as his or her own intimate private self—is simply the activity of these little specks of jelly in our heads, in our brains. There is nothing else.<sup>11</sup>

This resembles so closely the seventeenth century assertion,

"to have an accurate idea of the operations from which thought results, it is necessary to consider the brain as a special organ designed especially to produce it, as the stomach and the intestines are designed to operate the digestion, the liver to filter bile, the parotids and the maxillary and sublingual glands to prepare the salivary juices."<sup>12</sup>

Between these two excerpts is a huge distance in terms of scientific knowledge about how the brain works, but almost no distance in terms of theoretical interpretation

<sup>11</sup> Vilayanur S. Ramachandran, *A Brief Tour of Human Consciousness: From Impostor Poodles to Purple Numbers*, New York, PI Press 2004, p. 3.

<sup>12</sup> Pierre J. G. Cabanis, *On the Relations Between the Physical and Moral Aspects of Man*, trans. Margaret Duggan Saidi, Baltimore: Johns Hopkins University Press 1981, p. 116.

<sup>10</sup> Thomas R. Insel and Bruce N. Cuthbert, "Brain Disorders? Precisely," *Science* 348/6234 (1 May 2015) 499-500, here p. 499. [Henceforth cited as *BD*]

of this knowledge.

Neuroscience clearly takes the most extreme materialistic position: mind is brain. Insel and Cuthbert introduce "precision psychiatry" that instead of the old-fashion mud of subjective mental disorders deals with precise, measurable, objective brain disorders (*BD* 499-500). There are two epistemic positions to consider. First, the category of the subject matter of mental disorder, and second, the category of being real.

The brain is not the subject matter of mental disorder, since brain disorder is not equal to mental disorder. Both are ontologically different domains. Material regularities do not provide insights to understanding ideas. The processes of a brain producing thoughts are certainly not parallel to the processes of a liver producing bile. Liver and bile belong to the same continuum of matter. As liver is part of matter, so also is bile. The cells of the liver produce bile – one piece of matter generates another piece of matter. Brain-thought relationships are different. While liver and bile belong to the material aspect of the same reality, brain and thoughts are aspects of two principally different sorts of reality, namely matter and idea. The assumptions that matter produces ideas or vice versa are just assumptions, hypotheses that have been developed for centuries, while still remaining far from being conclusive. At this moment, whether matter and mind meet is merely a highly heated theme of speculation.

The second epistemic position regarding the ontological vulnerability of mind is brain reductionism is in the category of being real. Reality can be material and reality can be ideal. Material reality can be, so to speak, touched or seen – objectively registered, fixated in its space-temporal configuration. Ideal reality cannot be directly seen or touched; cannot be objectively registered. Mind is not material, it is ideal. Although brain imaging does not picture the mind, nonetheless, mind is real. My sadness is real, though I have never seen it. My thoughts are real, even though neither you nor I can see or hear them. It feels evident and familiar that the material is real and objective. It often feels somewhat uncomfortable to accept that the subjective could be real. The ideal is real and subjective. Even after a century of quantum revolution in physics, subjectivity is still a foreign category for natural science. The reality of the material and the reality of the ideal are different types of reality and this difference could be epistemological confusing and methodologically misleading. Natural science strives to be precise and tends to eliminate subjectivity as something troubling

and unsuitable. Such dead end in the epistemological and methodological assessment of mental disorder is rooted in the categorical dichotomy of mind and brain; it cannot be resolved within the Cartesian paradigm.

### **Mental Disorder: Clinical, Phenomenological, and Existential**

Given the complexity of understanding mental processes, each research domain supplies only one aspect of the phenomenon. One group of researches deals with biological side of mental disorder and receives a data that the mental disorder is of materialistic biological nature. Another group of researches deals with psycho-social side of mental disorder and receives data that the mental disorder is of idealistic psychosocial nature. Integrative, multifactorial theories are methodologically the same, they rely upon metadata and assume that these data proved a complete picture. Using a Heideggerian metaphor, these biological, psychological, and social data are ultimately "blind to the phenomenon."

This certainly does not mean that biological, psychological, or social data about mental disorder are not important. They can be very valuable and helpful for many purposes. Again, using the Heideggerian metaphor, they are blind nonetheless to the essence of the phenomenon of mental disorder.

Mental disorders are seen not as biological, spiritual, social, or any other category. No one sees mental disorders. A physician sees people with mental disorders. This is a clinical category. The clinical ramification is through person-to-person communication. The subject matter of the clinical approach is a person, a human being. The diagnosis is not reducible to biochemical, electrophysiological, or neurocognitive findings. Any such methods are considered adjunct, additional to the central clinical method. A disorder is a clinical phenomenon that presents life distorted by a pathological process. From Hippocrates' precept to treat a person, not a disease, to Karl Marx's vision of disease as life limited in its freedom, the clinical approach addresses the human being as a whole. A bioscientist (a medical technician), being the subject of an investigation, focuses on a diseased organ or symptom as an object of investigation. A person with a disorder is reduced to some presentations of such disorder. In other words, the person is objectified. This subject-object dichotomy rules and restricts the process of their communication. The clinician as subject of co-

experience interacts with a patient who is likewise subject of co-experience. A holistic human-beings-togetherness allows for overcoming such subject-object dichotomy. An integrative clinical approach leaves the cage of subject-object polarization and moves toward the openness, freedom, and responsibility of a person-person relationship.

In modern times the clinical approach was most consistently developed in German psychiatry that always respects its philosophical foundations. The connection between the clinical method and philosophy, especially between existentialism and philosophy, is not only epistemologically transparent, but also touchingly personal. Two major figures in phenomenology and existentialism—Karl Jaspers and Martin Heidegger—worked in the area that overlaps psychopathology and philosophy. Jaspers' way to philosophy led through psychopathology. Heidegger's way was of an opposite direction—from philosophy to psychopathology.

Jaspers' *GP* becomes an opening chapter of his significant philosophical investigations, as his existential phenomenology emerges from descriptive psychopathology. Jaspers begins as a psychiatrist searching for an accurate systematization of mental disorders, not merely formulating some scientific regularity, but to discover its origin, not merely to know about mental disorder, but to know mental disorder as such. Behind academic curiosity and the ambitious goal to succeed, Jaspers had intimately personal motivation—mental disorder was reality living in his life. His wife was familiar with depression; her sister died from a mental disorder and her brother suffered from it. In addition, Jaspers' own brother suffered from mental disorder and eventually committed suicide. Jaspers himself was prone to deep psychological introspection, one of the major themes of which was personal reflection on health, illness, and death.

Jaspers' quest could not be satisfied by reducing mental disorder to brain functions, or by limiting it to the uncertainty of an elusive *Geist*. This quest was about mental disorder in its totality, in its human truth. His quest for an ultimate understanding of mental disorder ends in the necessity to understand a person with mental disorder as a whole in the totality of his position in the world. To know a disorder one needs to know a human being with this disorder. To know a human being as existing one needs to know *Existenz*. Jaspers demonstrates the birth of the existential from the clinical and the closeness of the clinical descriptive method to phenomenological methodology. His existentialism

was instigated by reflection on mental disorder.

A clinical principle of attending to clinical phenomena stands close to phenomenology. Mastery of clinical observation is the ability to learn from clinical observation. Instead of imposing some external scientific regularities to measure separate presentations, a clinician grasps a clinical picture—the way different symptoms come together into a clinical unity of diagnosis.

Heidegger's study of mental disorder come as a closing chapter of his long and productive way as a co-founder of phenomenology and one of the most prominent existentialists. His turn to mental disorder happened in a traumatic and painful period in his personal life. His son, who served in German Army during the WWII, was in captivity far in Russia. He himself faced distressing restrictions related to his position in Nazi Germany. Heidegger himself sought mental help. About this time Medard Boss, a psychiatrist interested in his philosophy suggested seminars on phenomenology, existentialism, and psychopathology. They began at the Burghölzli clinic where the history of psychiatry was created—Eugen Bleuler describing autism and schizophrenia, Carl Gustav Jung carrying out his associative experiments and sharing his thoughts with Freud in almost daily correspondence, as well other well-established figures in the field. Heidegger's seminars for doctors and psychologists continued for ten years. The result is the *Zollikon Seminars*, comprised of existential phenomenological meditations on mental disorder.

Heidegger brilliantly and aggressively dismissed "the dictatorship of scientific thinking" (ZS 274), instead developing a humanistic approach to understanding mental disorder. Heidegger was talking to psychiatrists, who often were very critical and negative to his ideas and whose thinking was mainly Cartesian and not responsive to existential and phenomenological conceptions. In the polemical atmosphere of the seminars, Heidegger presented lucid argumentation regarding the subject matter of mental disorder and ways to know it. His discussion of sadness and tears reveals the differences between the scientific method and the phenomenological methodology.

Heidegger discussed the work of the prominent psychiatrist Robert Hegglin who applied the scientific method. The psychiatrist proposed the ways to objectify sadness. Sadness itself cannot be measured, but its expressions—tears—"can be investigated quantitatively in various directions" (ZS 78). Heidegger

argues: "You can never actually measure tears.... Where do tears belong? Are they something somatic or psychical? They are neither the one, nor the other" (ZS 81). This is a phenomenological consideration—tears are a phenomenon that is. The essence of the phenomenon of tears is not about whether they are material or ideal. The essence of tears is that they are tears, and this essence can be grasped in the immediacy of experience. Heidegger calls it, "seen directly" (ZS 81), as opposite to "blindness to phenomena" (ZS 75).

Here again, the phenomenological principle of the attunement to the phenomenon comes very close to the clinical principal of attending to a patient, not just measuring a single sign. Heidegger explores blushing, physiologically related to vessel tension and blood circulation. "Can the blushing be measured? Blushing with shame cannot be measured. Only the redness can be measured, for instance by measuring the circulation of blood" (ZS 81). Then follows the differential diagnosis of redness—Heidegger's phenomenology speaks as the clinical mastery, that stands as the goal of true medical proficiency—the ability to see the clinical picture with its inner sense and meaning.

Phenomenologically speaking we can easily distinguish between a face blushing with shame and for instance, a face, flushed with fever or as a result of going inside a warm hut after a cold mountain night outside. All three kinds of blushing appear on the face, but they are very different from each other and are immediately distinguished in our everyday being-with and being-for each other. We can "see" from respective situations whether someone is embarrassed, for instance, or flushed for some other reason. [ZS 81]

The type of seeing Heidegger refers to is exactly the type of seeing of the true clinician. In its essence a clinical method is professional mastery to relate to a patient and to observe his condition and to see a clinical phenomenon that in medicine is called the clinical picture. The similarity between the clinical and the phenomenological relies upon the importance of direct experience, an appeal to a whole-person-living-his-life aspiration for truth, and a search not just for the answer, but for understanding.

Both Jaspers and Heidegger radically departed from Cartesian dichotomy. The styles of their departures were congruent to their backgrounds. Jaspers was a physician, a representative of the famous Heidelberg school of psychiatry with its strong natural science methodology and with its motto: Mental disorder is a disorder of brain. Throughout his medical training,

psychiatric practice and research he was governed by the Cartesian maxim that there is need for a method in finding truth. He appreciates great psychological and psychopathological findings and the theory that was built upon the foundation of Cartesian subject-object polarization, body-mind dichotomy and explanatory time-spatial determinism. Jaspers' *GP* shows how a natural scientist steered by a drive to clinical truth has to break the spell of the Cartesian paradigm and be open to the actuality of world.

Jaspers accepts that this paradigm provides psychopathology and medicine with major facts. But then, following his high purpose to understand a human being as a whole, Jaspers realizes that these facts are not complete. The facts are correct, but they miss the complexity of mind. "Descartes' division... will yield us facts, though the sphere of application is limited and disappears altogether when we reach the encompassing nature of life itself" (*GP* 224). Jaspers developed an epistemic idea of a total relational context of the phenomena that paves the ground to see "reality in its abundance" as "essentially neither a psychic inner experience nor a physical process in space, but it is something occurring in the medium of both" (*GP* 224). In contrast, Heidegger comes from pure ontology, assertively rejecting any Cartesian dichotomy, revealing the limitations of natural science and showing the ability of humanistic approach to the truth to which a scientific approach remains blind.

The following expresses the passion of Heidegger's position:

He [the physicist] believes that conceptual precision is a requirement which must be fulfilled by every science. But this belief is justified only if one believes in the dogma that [everything in] the world is completely calculable and that the calculable world is the [only] true reality. This conception is pushing us toward uncanny developments—already looming now—in which one no longer asks who and how the human being is. Instead he [the human being] is conceived of beforehand from the background of the technical manipulatability of the world. [ZS 141]

### Beings versus Brains

Returning back to my consultation room, I see patients here, not brains. The gap between the avalanche of breath-taking findings in neuroscience excites researchers, gives powerful language to pharmaceutical companies, insurance giants and other major players of

the mental health industry. The neuroscience also brings a sort of satisfaction that everything is explainable by some clear-cut regularities that rule our feelings, thoughts, wishes and dreams in accordance with reliable laws of chemistry and physics. Some patients find it reassuring to know that their anxieties or fears are merely a disbalance of neuromediators. However, later on, many patients realize that the way they live their lives cannot be reduced to metabolic processes of chemical mediators.

This brings to memory the fear of losing freedom and independence, and our unconscious search for

authority: "The authority of science replaces the loss of all other authorities" (*GP* 808). Jaspers teaches to be comfortable with the reality that our knowledge about mental disorder will never be conclusive because our knowledge about human being can never be conclusive. Human being does not have limits; his development is open and everlasting. The more data neuroscience brings, the more important are physicians who listen with an ear of love," physicians who fit Heidegger's call: "There is the highest need for doctors who think and who do not wish to leave the field entirely to scientific technicians" (*ZS* 103).