Interface vol.3 no.se Botucatu 2007

Including subjectivity in the teaching of Psychopathology

Octavio Domont de Serpa Junior[I]; Erotildes Maria Leal[II]; Rita de Cássia Ramos Louzada[III]; João Ferreira da Silva Filho[IV]

[I]M.D. Doctor of Psychiatry and Mental Health (UFRJ). Associate Professor of IPUB/UFRJ; coordinator of the Laboratory of Studies and Research in Psychopathology and Subjectivity (IPUB/UFRJ); coordinator of Special Psychopathology I. Address: R. Jardim Botânico, 585/203 - Jardim Botânico - Rio de Janeiro – RJ. CEP: 22470-050 Telephone: 21 38740055 e-mail**:** domserpa@gmail.com or domserpa@ipub.ufrj.br
[II]M.D. Doctor of Psychiatry and Mental Health (UFRJ). Visiting Professor of IPUB/UFRJ; researcher for the Laboratory of Studies and Research in Psychopathology and Subjectivity (IPUB/UFRJ); professor of Special Psychopathology I. Address: Av. Venceslau Brás, 71 rear - Botafogo - Rio de Janeiro – RJ. CEP: 22290 -140. Telephone: 21 22953449 Ext. 221. E-mail: eroleal@uol.com.br
[III]Psychologist. Doctor of Psychiatry and Mental Health (UFRJ). Associate Professor of DPSO/UFES; researcher for the Mental Health and Labour Organization Program (IPUB/UFRJ), professor of Special Psychopathology I. Address: Av. Venceslau Brás, 71 rear - Botafogo - Rio de Janeiro – RJ. CEP: 22290-140. Telephone: 21 22953449 Ext. 248. E-mail: ritacrl@uol.com.br
[IV]M.D. Doctor of Psychiatry and Mental Health (UFRJ). Full Professor of the Faculty of Medicine of UFRJ; Dean of the Center for Health Sciences (CCS/UFRJ); coordinator of Special Psychopathology I. Address: Av. Brigadeiro Trompowsky, CCS building - 2nd floor - Block K - room 20 - 21941-590 - Rio de Janeiro - RJ - Brasil. Telephone: 21 25626700. E-mail: jferreira@ccsdecania.ufrj.br

ABSTRACT

Current psychopathology studies have often been presented in their descriptive dimension. This perspective is important for teaching because it helps the students to recognize and identify the symptomatology of each psychopathology case. However, subjectivity, the experience of suffering and interpersonal aspects are all lost in this perspective. Coming from another psychopathology tradition – existential anthropology – this paper presents practical psychopathology teaching experience which considers such dimensions as being relevant to the understanding of mental suffering. The features and limitations of such traditions are briefly reviewed to support this teaching experience. Two new modalities of practical teaching, used in the discipline of "Special Psychopathology I" offered by the Department of Psychiatry and Forensic Medicine at the medical school of the Federal University of Rio de Janeiro for students of psychology, will be presented according to descriptive case study methodology. With these activities we also expect to change the practice of teaching. Traditionally, interviewing of in-patients by a large group of students who observe passively what is happening is the center of this kind of education. We intend to develop a model of teaching which is closer to the proposal of the Brazilian Psychiatric Reform which views mental illness as a complex phenomenon, always involving the relationship that the subject establishes with the world.

Key-words: Psychopathology; Teaching; Subjectivity; Brazilian Psychiatric Reform; Existential Anthropology.

I) Introduction

Current study of psychopathology has often been presented in its descriptive dimension. As a foundation of psychiatric semiotics, this field of knowledge has been marked by different theoretical references and approaches in little more than 200 years of existence. Even so, this complexity has been almost unnoticeable to the inattentive eye in recent decades. Even though this perspective is relevant to teaching, by helping students recognize and identify the symptomatic dimension in psychopathology cases, it ends up leaving out the experience of illness - the subjective dimension in its relational and interpersonal aspects.

In order to extend the teaching of psychopathology in this direction, we introduced two new modalities of practical activities in the discipline *Special Psychopathology I*, offered by the *Department of Psychiatry and Forensic Medicine of the Faculty of Medicine of UFRJ*[1] for students of *Psychology of UFRJ*. This reformulation of practical teaching, traditionally centered on the model of an extensive interview of a patient, generally hospitalized, undertaken by a teacher in the presence of a large group of students who watch passively and often uncomfortably, also intends to bring the teaching and practice of psychopathology closer to the ideas that make up the set of transformations in psychiatric care taking place in Brazil, also known as *Reforma Psiquiátrica* (Psychiatric Reform). We seek not to restrict students to a psychopathology approach centered on describing the elements of mentally illness, but rather favor their understanding of psychic suffering from the point of view of the person who experiences, as well as the relational and contextual characteristics of clinical expressions of mental disorders. These initiatives aim to show the students the complexities of mental illness and the differential reach of different psychopathology approaches.

II) Ethical and conceptual presuppositions

At a time in which Psychopathology has become continually shallower and ever more lacking in detail, the challenge of teaching, particularly practical teaching, is imposed upon those who wish to go beyond offering an

1 The Department of Psychiatry and Forensic Medicine is headed by Professor Alícia Navarro Dias de Souza.

objective description of signs and symptoms, undertaken by a type of "ideal" observer - universal, free from theoretical commitments and value judgements[2]. Qualified as Descriptive Psychopathology (Berrios, 1993, 1996), and often confused, abusively and totally incorrectly, with Phenomenological Psychopathology, especially in Anglo-Saxon psychiatry (Bovet & Parnas, 1993; Monti & Stanghellini, 1996), this way of understanding psychopathology is the basis of modern psychiatric classification. In attempting to be objective, atheoretical and in finding a way around its insurmountable evaluative dimension (Fulford, 1994 e 2004; Fulford *et al.*, 2005), one ends up offering lists of symptoms taken at face value, composing flat and *gestalt*-less mosaics, from which any incidence of the patient's subjectivity has been completely eradicated. The subjective experiences of those undergoing some type of moral suffering are immediately assimilated into formal categories and schemes which give them a pleasing intelligibility to the observer, confirming Foucault's analysis (1994[1961]) of the monologue on reason over madness, which comes about from a constitution of "psi" knowledge. In this scenario, how do we listen to the voices of madness and how do we make them audible to our students?

This operational focus of psychopathology unavoidably includes a concept of sickness and health, as well as an idea of what should underlie the division between normal and pathological. But none of this is explicit and these questions become naturalized and neutralized. "Naturalized" in the sense of an understanding of Nature as intrinsically opposed to Culture, and therefore not open to interpretation. The debate on "Normal and Pathological", which should come before any Psychopathology, is completely ignored and the division between the two conditions is understood as a quantitative question, subject to measurement by structured scales and instruments, made apparent by statistical procedures[3]. The field of Pathology follows, under these conditions, an intelligibility compatible to that which Canguilhem (1982[1966]) called the Ontological Theory of Disease, which understands the different types of physical and mental suffering exclusively according to objectivity, elements completely external to the subject, whether understood in its moral dimension or only as an organic totality. If such a conception of illness can give the illusory impression of satisfying the possible conditions of somatic medicine, it is not sufficient for the demands of

2 Cf. Verztman, 1996.

3 For an introduction to this discussion see Serpa Jr., 2003.

Psychopathology, which is subjective in its entirety.

The challenge of teaching Psychopathology from a different perspective becomes even more complicated when the limited availability of teaching materials is taken into account. Modern Psychopathology manuals are - in the best of hypotheses - more and more like books of semiotics, though without any questioning[4] of semiotic procedures (Serpa Jr. 1996, Silva Filho, 1996). Or glossaries - in the worst of hypotheses - more or less extensive, simply dictionaries of Diagnostic Classification Manuals. In general they are organized starting with a presentation of symptoms referring to a psychology of mental faculties from the ninth century and originally based on the examination of patients confined to the psychiatric hospitals of that time. The semiotic treasures presented by these manuals generally deal with terms coming from disparate, and not antagonistic, traditions.

We believe that a psychopathology worthy of its name should meet that which Stanghellini formulated (2004): "...primarily illuminate the quality of subjective experiences, their personal meanings and standard by which they are situated as parts of significant totalities (...) principally concerning embodiment and inter-subjectivity" (p.9). This is the aim of our proposal, be it incipient, to reformulate the practice of teaching psychopathology. We do not have the naive intention of being able to use this to find a way to suspend the implied monologue of reason over madness. We seek purely and simply to restore its *pathos*, logically and chronologically first, and even so, neglected. The *pathos*, as Canguilhem reminds us (1982 [1943]), also comes before the *logos.* A Psychopathology that is only *logos*, without *pathos*, will have no more use than an edgeless razor (Monti & Stanghellini, 1996).

We do not mean to say that a descriptive, objective approach does not have its place in the teaching of psychopathology. It certainly does, principally in dealing with practical proposals that depend on formulating a reliable diagnostic hypothesis, expressed in vocabulary common to those in the field, thereby making communication amongst them possible. Because of this, learning to competently conduct a diagnostic interview remains one of the central elements in the study of psychopathology. But not the only one. There are other practical objectives in play in mental health care and in the teaching of and research of Psychopathology. The descriptive approach soon encounters its limits

4 A notable exception to this state of affairs is the two volumes of Martins (2003, 2005).

when dealing with access to the subjective experience - to the *pathos* – of those under our care. We want to teach a Psychopathology that does not ignore subjectivity, but rather has this as its primary interest. Not in the sense of solipsistic isolation, but instead showing its indissoluble relation to the changeable and to the world in which it is rooted. This subjectivity, in turn, is not taken as an ethereal substance, immaterial, but as primordially embodied. We do not have the naive and mistaken ambition to turn Psychopathology into a general theory of subjectivity. We seek only to provide our students with an understanding of its *pathos*, of the moral pain and suffering of our patients, taking this experiential dimension in its imminently qualitative, evaluative and holistic character, in the sense of altering a life form in its totality.

Descriptive Psychopathology or Symptomatological-Criteriological Psychopathology:

There is, in the field of Psychopathology, tension between two perspectives of the phenomenon of psychopathology which should be complementary, but have been established in terms of hegemony of one and near exclusion of the other. As described above, we find in *Descriptive Psychopathology* - the hegemonic tendency - a diminishment in the analysis of psychopathology, which is reduced to a *symptomatology*, in the sense of an objective description of a set of symptoms. This removes the study of psychopathology from the field of experience (subjective) and delivers it to the objectivity of the nosographic field in which the diagnostic is expressed.

Kraus (1994, 2003) calls this type of procedure Symptomatological-Criteriological Psychopathology. It can be characterized as a *representationalist* Psychopathology (Parnas & Bovet, 1995). In other words, the clinical entities/diagnostic categories with which we deal are mental representations of *natural species* objectively existent in the external world, prior to any encounter with a human consciousness to provide meaning, therefore independent of the observer. According to this understanding, a diagnostic category will be truer as it better and more accurately represents the objective world. These representations are expressed by language, taken as an epistemic intermediary between the knowing subject and the world of natural species, thus forming the vocabulary of psychopathology. The way in which language is implicitly understood here presupposes a literal, uni-vocal and context free relation to the world (Parnas & Bovet, op.cit). This approach in psychopathology is characterized by its *operationalism* (Parnas & Bovet, 1993, 1995), which refers to the organization of that vocabulary into operational rules or diagnostic criteria.

Those that seek to order signs and symptoms according to logical principles, thereby increasing diagnostic *reliability*, giving lesser importance to *validity*. Such a procedure leads to a selection of clinical manifestations in such a way that those that possess a more experiential, subjective character - like changes in self-awareness and emotional connection to surroundings - tend to be discarded, in favor of those which are more exuberant, objective and behavioral. To illustrate this procedure one need only consult the available Classification Manuals (ICD 10 and DSM-IV), as well as the majority of psychopathology manuals.

Psychopathology of first and second person perspectives:

In contrast to *Symptomatological-Criteriological Psychopathology*, Kraus (op.cit.) describes what he calls *Anthropological-Phenomenological Psychopathology*, which maintains a marginal position in current teaching of psychopathology. This, different from the former, does not deal with *symptoms*, but rather with *phenomena* (Kraus, op.cit., Tatossian, 1979). While the former are understood as referring to some type of medical dysfunction and, in objective clinical understanding, diminish the importance of the patient's subjective dimension, understood as a simple supplier of semiotic data, the *phenomena* show a global, experiential form of the patient, understood as an expression of a particular type of self relationship, with alterity and with the world. Here the subject, taken as a whole, holds a central position. The *phenomena*, therefore, necessarily refer to a *totality*, to a *structure*, to make sense, in contrast to *symptoms*, which can be taken one by one, isolated from the set or simply in juxtaposition to other symptoms. We deal with, therefore, particular ways of *being-in-the-world* as Binswanger (1970[1945]) would say, based on Heidegger. The experiential consistency of *pathos*, the lived subjectivity, are here privileged as fundamental clinical elements. In other words, *validity* is preferred to *reliability*. The *subjectivity* in question is nevertheless understood as necessarily referring to alterity - *inter-subjectivity* - to the world - *intentionality* - which neutralizes the risks of any solipsistic temptation. It is embodied in the sense of emerging from a particular type of organism interacting with the environment - human and physical - in which it lives and, in this sense, is rooted in its world, situated in context or embedded.

As indicated above, playing one model against another should not suggest a mutually exclusive alternative of one or the other. With this we can show what is gained and lost in clinical terms when each model is adopted. However, it is undeniable that Psychopathology has, in recent years, demonstrated an increasing exclusion of the model that favors subjectivity.

Taking the subjective dimension as an axis, we propose to re-describe the models proposed by Kraus (op.cit.) in other terms. We will call his *Symptomatological-Criteriological Psychopathy*, *Third-person Psychopathology* and his *Phenomenological-Anthropological Psychopathology*, *First and second-person Psychopathology*[5].

Third-person perspective:

Third-person Psychopathology adopts as an epistemological presupposition the *Third-person perspective* (Northoff & Heinzel, 2003). There is no place for experience, for the lived; there is only objectively taken behavior in this perspective. Subjectivity and inter-subjectivity are completely out of the question. Factual certainty is sought at the expense of any experiential, phenomenological certainty. In this perspective the facts can be considered atemporal and free of any context since the passing of time and historical and geographical contingencies are not considered relevant to understanding. These facts can be taken one by one, removed from their conditions of origin and set of other simultaneous facts, thus producing a fragmentation, and atomization of the object of knowledge. The type of embodiment of interest to this perspective is the objective body, that which Husserl identified as *Körper*.

First-person perspective and Second-person perspectives:

First-person and second-person Psychopathology adopt as an epistemological presupposition the *Perspectives of first and second-person* (Northoff & Heinzel, op.cit.). The *First-person perspective* refers to the pre-reflexive experience of one's mental and corporal states: "raw" feelings, pure experience, without recognition or reflection. These last two, as we shall see, already belong to the *second-person perspective*. We have here pure subjectivity, without either objectivity or inter-subjectivity. Something along the lines of what Nagel (1974) explored and became known as *What it is like to be...* Here, phenomenological certainty takes the place of factual certainty, differentiating immediate accessibility from incorrigibility. In contrast to the fragmenting *third-person perspective*, this perspective deals with the totality of experience. The totality of this perspective is the totality of the lived body (*Leib*), experienced in the action/perception cycle of a live organism exploring its environment. This reference to the totality of the live

5 For further details see Serpa Jr. (printing)

organism guarantees the conditions of centralizing, point of view and noetic pole of the intentional curve, which characterize this perspective. In the *Second-person perspective* (Northoff & Heinzel, op.cit.) we have the propositional recognition of experience. It is therefore necessarily reflexive and inter-subjective. Inter-subjective not only in the sense of communicating the experience to another, but also in the sense that the conceptual judgement and recognition of the experience as belonging to a specific category of psychological states is only possible by inserting the subject into a linguistic community. We no longer have here the transparency and presence of the pure experience, but instead a semi-presence and the translucency of reflexive mediation, a type of intra-subjective inter-subjectivity. The totality still predominates over fragmentation, but can be taken in its parts through the work of reflection. In this perspective, corporality is understood in a zone of mediation between the lived body (*ipseidade*) and the objective body (*alteridade*). As Zahavi (2001, 2003) and Northoff & Heinzel (2003) have pointed out, based on the concepts of Husserl and Merleau-Ponty, it is this mediation inherent to corporality itself which underlies the establishment of inter-corporality and inter-subjectivity.

Experiential Subject and Narrative Subject:

In the subjectivity in question in *First and second-person psychopathology*, we recognize, according to the indications of Zahavi (2003), two types of subject: an *experiential subject* and a *narrative subject*. The *experiential subject* presents characteristics which are similar to those of the *first-person perspective*. He is not beneath, beyond or in opposition to the experience. Instead, he is an aspect or function of his way of giving – *first-personal givenness* – to a centrality of perspective, embodied and embedded. It is a type of basic subject or self, which is neither a transcendental pre-condition nor a narrative construct, but an immediate awareness of experiential reality. In this sense, it would be more appropriate to speak of *subjectivity of the experience* in place of *subject of the experience*. This subjective and pre-reflexive modality, non-propositional, non-conceptual, non-thematic. This contrasts with a certain common understanding which considers that the subject or self can only be the result of reflection when not of the cognitive domain of concept of self or subject.[6] What we have here is a primary *presence* (Sass, 2003; Sass & Parnas, 2003), a pre-reflexive or implied self-awareness, a self-affection that simply happens, a basic feeling of existing as a

6 For further details on this discussion see Dreyfus, 1996; Gallagher, 2000; Zahavi 1999, 2002, 2003 and Zahavi & Gallagher, 2005.

vital center of the experience, and what we call *ipseidade*.

The *narrative subject*, on the other hand, is necessarily reflexive and inter-subjective since it depends completely on the insertion of the individual into a linguistic community and an adherence to values, ideals and objectives of a given cultural tradition. In this subjective modality we can speak of identity, personality, person. He is constructed in and through the narrative by an open process, constantly subject to revisions and changes of course. This process follows the life course of the subject throughout time and seeks to offer a report capable of explaining his origins, development and destiny. What we are, in this perspective, depends on the story told by us, and by others, about ourselves. We deal here with the definition Dennett (1993) gives to the notion of subject: *center of narrative gravity*.

Teaching Psychopathology and Subjectivity:

We believe that only a psychopathology which takes the experiential dimension and the different narratives that each subject is capable of producing in order to understand her psychic suffering as its central element of practice and reflection can be relevant in a setting of mental health care transformation as we have seen over the last twenty years[7]. We have witnessed in this period a progressive substitution of the hospital-centered model for substitute services, which increasingly make up the potential job market of students who intend to practice clinical mental health care after graduation. In this new model, other relational modalities are established between care-takers and those under their care: patients and family members. Relationships are established with the users that are less vertical, more regardful of the reality in which they live, in which they were born and where they express their suffering. They are expected to participate more in their treatment and therefore gain autonomy. How, then, do we continue using psychopathology tools exclusive to a body of objectifying knowledge, produced, above all, in asylums and comfortably identified with the alienating practices of the old psychiatric hospitals?

We intend, with the practical psychopathology teaching modalities we present below, to transmit not only a conception of psychopathology that has its subjective and social dimensions as axis, but also to present some of the

7 For further details on this discussion see Leal (printing) and Leal *et al.* 2006.

new mental health care tools to the students[8].

III) New practices in the practical teaching of Psychopathology

Based on the above mentioned, the proposed practices for the discipline began in the first academic semester of 2005, having been offered to two undergraduate classes up to the present date. Some of the characteristics are described in the items below.

Methodology:

The methodology used was that of Case Study, accepted as empirical research methodology which investigates a phenomenon within its real life context; limits between the phenomenon and the context are clearly defined. This type of research generally deals with more variables of interest, is based on several sources of evidence and takes advantage of prior development of theoretical propositions to orient the collection and analysis of data. The unit (case) can be an individual, but it can also be a group, a company, an institution, a public policy etc. The case can be single or multiple. The *decisive case* is that which adequately serves to test a well-formulated theory (in this case, the phenomenological formulations of the first and second-person perspectives). The *revealing case* allows the possibility to observe and analyze a phenomenon generally inaccessible to scientific investigation, in this case, the subjective experience, which has been so absent in psychopathology research over the last two decades. Case studies can be descriptive, exploratory or explanatory, without any hierarchical connotation included in this distinction. The type of generalization that can come from a case study is not, evidently, a statistical generalization, typically arising out of studies which use the epidemiological method. The generalization that can be obtained from a case study is called analytical generalization, in which an already developed theory is used as a hermeneutic scale against which the study results are submitted (Yin, 2005).

In short, we can say that the methodology used in the present study is *multiple, decisive and revealing case*

[8] Data from MS/ CNSM (Health Ministry/National Mental Health Council), August 2006, show 882 Psychosocial Care Centers in Brazil. The growth of these services has been constant and regular: in 2000 there were 208 in the country. In the state of Rio de Janeiro there are 67 Psychosocial Care Centers, of which 14 are in the municipality of Rio de Janeiro (11 Psychosocial Care Centers for adults, 02 Psychosocial Care Centers for children and 01Psychosocial Care Center for alcohol and drug users).

study of exploratory nature.

The choice of user groups as a tool to obtain narratives on the experience of psychic suffering is based on the theoretical developments of Costa (1989) on the beneficial effect of the group in therapeutic practice and public ambulatory care and on the pragmatic use of groups undertaken by the Romme & Escher team(1997, 2000) in the context of people who hear voices.

1) The practical teaching group of the Day-Hospital of the Institute of Psychiatry of UFRJ: users receive the students.

The invitation to participate in the group is made by the professor responsible for the activity, who periodically visits the Day-Hospital General Assembly and the patients' therapeutic project follow-up groups to reiterate the invitation. It is relevant to mention that the professor is not part of the unit's staff. The patients are invited to make up a group to receive the students. They are asked to state that it is a Day-Hospital, what being a part of such a service and the experience of being a person in psychiatric treatment consist of, and what they expect from a psychologist in a Day-Hospital. We intend to reach certain objectives in this way:

a) introduce means of day and intensive care that are not focused on hospitalization to the students.

b) show that the treatment of severe psychiatric patients should not be focused on symptom remission, but in helping them to create new ways of living which, although different from the time before the experience of illness, allows them to continue with their own lives.

c) introduce other possibilities of practical care, besides individual care, to the students.

d) emphasize that the recovery of a standard capacity by the patients should be one of the challenges of treatment, although this does not mean a return to the state prior to illness.

e) show the students that treatment success depends largely on the ability of the professional to respect what the patient considers important for herself.

The patients who attend the activity do so voluntarily, and during the first period in which this activity was offered, some patients attended regularly. The evaluations undertaken with the patients at the end of each semester show that they attribute a therapeutic character to the activity. The fact that they recognize the activity as a space where their opinion is valued, sustains such an evaluation.

The group dynamic is unstructured. In the beginning of the group, the professor asks each to present him/herself (each group of students[9] participates in this activity two or three times during the discipline). The patients are then invited to describe what the Day-Hospital is. Next, an open dialogue is established between students and patients, taking the above-mentioned themes into consideration. The patients generally move onto life-story narratives. From their reports come the themes discussed during class such as: what it is like to live feeling threatened by persecutors, to be the victim of aggression and social discrimination, difficulties in adhering to treatment, what it means to live with a chronic illness which makes the simplest daily activities so difficult, to name only a few. The professor acts as facilitator of this dialogue. A Day-Hospital professional also participates in the group, mainly as an observer. This person usually participates when a question is directed at her. Her interventions have helped to redirect the questions under discussion to the patients.

The group lasts one hour. At the end of this period, the patients leave and the professor discusses with the students for thirty minutes. This open discussion tends to include two principal subjects: how the experience of interacting with the patients of this group was and to what degree the instrument of psychopathology could be useful in interacting with patients, their limits and their possibilities. The evaluations made by the students at the end of this discipline show the professionalizing potential of this activity. They often show surprise at discovering how these people "are strong" or how they are capable of living with and understanding their illness. In such narratives, it is evident that the students manage to articulate the symptomatic dimension of psychopathology cases to the subjective dimension of experiencing illness and its relational and interpersonal aspects.

Despite the short period of time this activity has been practiced, some observations can be made. This instrument has shown itself to be potent in illustrating the complexity of the field of psychopathology. It has become easier, through this instrument, to show that how we perceive the patients comes also from the lens we use for their interaction. The force attributed to nosological categories as instruments capable of informing about the subject were relativized. The patients reports on the experience of being a psychiatric patient was always richer than the purely symptomatic description. The themes of these reports show all the complexity of mental health care. To finish this

[9] The class is divided into six groups of eight students each

presentation, I will describe two situations which illustrate this particularly well.

In the first of these the patients discuss how it is often difficult to adhere to treatment because, contrary to what we usually think, the symptoms - such as delusions and hallucinations - may, besides causing problems in their relationship with the world, also produce a type of subjective comfort. In this specific case a rich debate ensued regarding what could be done to help them adhere to treatment, especially when an element of suffering and loss is present. In the other situation, a relevant debate took place on revealing the diagnosis. This allowed for a discussion considering legal perspectives from the patients point of view, showing that this theme involves much more than simply knowing what the law recommends, what our obligations are, and what the patients rights are. Questions such as: who would give the diagnosis? What consequences could there be for the patient in receiving the diagnosis from a person recognized as being responsible for his treatment and from a person not recognized as such? How should this be stated and discussed? What fantasies appear when a diagnosis is either not explained or given without further details? All of these points were discussed from the point of view of the opinion of the patients. Since we started from the lived experience of these patients, which brought forth the different life stories of the relationship between the illness and the treatments undergone, the complexity involved was pointed out - a rarely perceivable aspect when we suppress the dimension of experiencing suffering and reduce it to a simple list of symptoms to be recognized and specified.

2) Talking with users about therapeutic workshops

The second activity proposed in the discipline was closer contact with patients who use the therapeutic workshops of the Day-Hospital. In this activity, contrary to the previous one, a group of students meets with a single patient and she is invited to talk about her participation in a specific workshop.

As in the above-described activity, the professor is not part of the Day-Hospital staff. The workshop coordinator is responsible for recommending patients to be invited to the interviews.

During the initial contact the patient is told the type of group that will meet (Psychology students) and its purpose (to discuss the place of the workshop in treatment). After agreeing, the patient is taken to meet the group, which meets in a meeting room. The group of students receives the patient, who is called upon to speak principally about the activity developed in the workshop, the moment in which she was directed to this activity, the importance of

the workshop in her treatment, and the relationship established with colleagues and the activity coordinator. During this characterization, each patient in her own way inserts the workshop into the treatment context and, little by little, talks about how she became ill and how this is experienced.

The encounters were all quite unique. The connection between them was the fact that the patients participated in the same workshop - *plastic arts*. The way in which each one participated in the workshop also varied greatly. To exemplify we cite three reports.

One of the patients, who had lived on the street, spoke of the workshop as something so important that it marked two totally different moments of his life: before he lived in chaos (mental, financial, etc.); after the workshop he could better express himself and better direct his sketching and painting abilities: through the sale of his paintings he rented a hotel room where he lived at the time of the interview.

A second patient, on the contrary, was not very interested in working with paints or any of the other workshop activities. He was, however, always present, was especially fond of the coffee served there and of performing tasks to help the coordinator: caring for materials, stock management etc. He said he was used to following "the coordinator's orders", felt good in the workshop and believed he had friends there. His treatment experience was strongly connected to that institution and to the workshop since he had not previously received any type of treatment. He had spent years simply "walking around the city, from Pavuna to Barra, walking, only walking", "I was crazy at that time", he said.

A third patient who also felt good in the workshop, confirmed its importance, but confessed to only going to the activity due to insistent invitations from the coordinator. His arrival at the institution was always followed by a stroll around the grounds. He only went to the workshop if called.

Reports such as these allowed us to debate the questions that came up, during a period of time reserved for this purpose, after the patient had left. We generally returned to the patient's characterization of the workshop, her experiences there. We also discussed how the interview was conducted and what had called the attention of each student in that encounter, etc. The students are then invited to visit the workshop, if they wish to, on a day that can be booked with the coordinator of the activity[10].

10 Optional attendance of the workshop takes place at a time different from that of the practical teaching activity due to the fact that the practical class begins near the time the workshop activities finish. Furthermore, although the group is relatively small (up to eight students), the

Final Considerations

We confirmed that over-estimating the importance of the observation of the phenomenon of psychopathology, third-person perspective, contributes to the students objectifying the patients and their experiences. This way of understanding mental disorders does not harm only the practice of teaching. Far from being a mere artifact, this point of view influences the interventions the students will later develop as professionals. This view will be a powerful instrument in defining clinical work where (1) the idea of mental illness discounts how the subject operates in the world; (2) evaluation in psychopathology is limited to indicating the presence or absence of symptoms; (3) the observation of the presence/absence of alterations such as delusions and hallucinations holds a privileged position in indicating mental illness.

Because of this criticism, we have proposed the two above-mentioned activities which, though still recent and demanding evaluations appropriate for each proposal, as well as occasional adjustments, have already shown, in the words of one student, "something more humane" in contact with the patient. In other words, the subjectivity recuperated through the practical classes, through first-person reports, clearly brings to teaching our belief in non-reductionist clinical care, clinical care which recovers and respects singularities and which should be sustained in Psychology courses.

Acknowledgements

We would like to thank all the patients who participated in the proposed activities for their collaboration. We would also like to thank Madalena Pizzaia, Coordinator of the IPUB/UFRJ Day-Hospital, Eliane Santos, Coordinator of the "Life Workshop" and Nuria Malajovich Muñoz, for Laboratory discussions and for the translation of the abstract into Spanish.

physical space of the workshop would be tight if this entire group along with the regular uses were present.

Bibliography

BERRIOS, G. E. **The History of Mental Symptoms.** Descriptive Psychopathology since the nineteenth century. Cambridge: Cambridge University Press, 1996.

BINSWANGER, L. Sur la direction de recherche analytico-existentielle en psychiatrie [1945]. In Binswanger, L. **Analyse Existentielle ey Psychanalyse Freudienne.** Discours, Parcours, et Freud. Paris: Gallimard, 1970, p.51-84.

BOVET, P. & PARNAS, J. Schizophrenic Delusions: A Phenomenological Approach. **Schizophrenia Bulletin**, vol.19, n.3, p.579-597, 1993.

CANGUILHEM, G. **O Normal e o Patológico.** Rio de Janeiro: Forense Universitária, 1982 [1966].

COSTA, J.F. **Psicanálise e Contexto Cultural: imaginário psicanalítico, grupos e psicoterapias**. Rio de Janeiro: Ed. Campus, 1989.

DENNETT, D. C. **La conscience expliquée**. Paris: Odile Jacob, 1993.

DREYFUS, H. L. The Current Relevance of Merleau-Ponty´s Phenomenology of Embodiment. **The Electronic Journal of Analytic Philosophy**, vol. 4 (Spring 1996).

FOUCAULT, M. Préface. In Foucault, M., **Dits et Écrits**, vol.I. Paris: Gallimard, 1994 [1961], p.159-167.

FULFORD, K.W.M. Closet Logics: Hidden Conceptual Elements in the DSM and ICD Classification of Mental Disorders. In SADLER, J.Z., WIGGINS, O.P. & SCHWARTZ, M.A. (org.) **Philosophical Perspectives on Psychiatric Diagnostic Classification**. Baltimore: The Johns Hopkins University Press, 1994, p. 211-232.

FULFORD, K.W.M. Facts/Values: Ten Principles of Value-Based Medicine. In RADDEN, J. (org.) **The Philosophy of Psychiatry**. A Companion. Oxford: Oxford University Press, 2004, p.205-234.

FULFORD, K.W.M., BROOME, M., STANGHELLINI, G. & THORTON, T. Looking with both eyes open: fact and value in psychiatric diagnosis? **World Psychiatry**, vol.4, n.2, p.78-86, 2005.

GALLAGHER, S. Philosophical conceptions of the self: implications for cognitive science. **Trends in Cognitive Science**, vol.4, n.1, p.14-21, 2000.

KRAUS, A. Phenomenological and Criteriological Diagnosis: Different or Complementary? In SADLER, J.Z., WIGGINS, O.P. & SCHWARTZ, M.A. (org.) **Philosophical Perspectives on Psychiatric Diagnostic Classification**. Baltimore: The Johns Hopkins University Press, 1994, p. 148-160.

KRAUS, A. How can the phenomenological-anthropological approach contribute to diagnosis and classification in psychiatry? In FULFORD, B., MORRIS, K., SADLER, J. & STANGHELLINI, G. (org.) **Nature and Narrative**. An introduction to the new philosophy of psychiatry. Oxford: Oxford University Press, 2003, p.1999-216.

LEAL, E. M. Psicopatologia do *Senso Comum* : uma psicopatologia do ser social. In SILVA Fº, J.F. (org.) **Psicopatologia Hoje**. Rio de Janeiro: UFRJ (printing).

LEAL, E. M., SERPA JR., O. D., MUÑOZ, N. M; GOLDENSTEIN, N.DELGADO, P. G.. Psicopatologia da autonomia: a importância do conhecimento psicopatológico nos novos dispositivos de assistência psiquiátrica .In: Revista Latinoamericana de Psicopatologia Fundamental. Vol. IX. No. 3 September 2006, p. 433-446..

MARTINS, F.. **Psicopathologia II**. Semiologia Clínica. Brasília: Universidade de Brasilia, 2003.

MARTINS, F. **Psicopathologia I**. Prolegômenos. Belo Horizonte: Ed. PUCMINAS, 2005.

MINISTÉRIO DA SAÚDE/Coordenação Nacional de Saúde Mental (2006). Saúde Mental em Dados Ano I, n. 2, Jan. to July, 2006. www.saude.gov.br/sas/mental .

MONTI, M. R. & STANGHELLINI, G. Psychopathology: An Edgeless Razor? **Comprehensive Psychiatry**, vol.37, n.3, p.196-204, 1996.

NAGEL, T. What is it like to a bat? In BLOCK, N., FLANAGAN, O. & GÜZELDERE, G. (org.) **The Nature of Consciousness**. Philosophical Debates. Cambridge(Mass.): MIT Press, 1997, p.519-527.

NORTHOFF, G. & HEINZEL, A. The self in philosophy, neuroscience and psychiatry: an epistemic approach. In KIRCHER, T. & DAVID, A.S. (org.) **The Self in Neuroscience and Psychiatry**. Cambridge: Cambridge University Press, 2003, p.40-55.

PARNAS, J. & BOVET, P. Research in Psychopathology: Epistemological Issues. **Comprehensive Psychiatry**, vol.36, n.3, p.167-181, 1995.

ROMME, M., ESCHER, S. (org.). **Na Companhia das Vozes. Para uma análise da experiência de ouvir vozes.** Lisboa: Ed. Estampa, 1997.

ROMME, M., ESCHER, S.. **Making Sense of Voices; A guide for mental health professionals working with voice-**

hearers. London: Mind Association, 2000.
SASS, L. A.. Self-disturbance in schizophrenia: hyperreflexivity and diminished self-affection. In KIRCHER, T. & DAVID, A.S. (org.) **The Self in Neuroscience and Psychiatry**. Cambridge: Cambridge University Press, 2003, p.242-271.
SASS, L. A. & PARNAS, J. Schizophrenia, Consciousness and the Self. **Schizophrenia Bulletin**, vol.29, n.3, p.427-444, 2003.
SERPA JR., O. D.. Para uma semiologia do mental. **Cadernos IPUB**, vol.5, p.149-153, 1997.
SERPA JR., O. D.. Indivíduo, Organismo e Doença. A atualidade de *O Normal e o Patológico* de Georges Canguilhem. **Psicologia Clínica**, vol.15, n.1, p.121-135, 2003.
SERPA JR., O. D. Subjetividade, Valor e Corporeidade: os desafios da psicopatologia. In SILVA FILHO, J.F. (org.) **Psicopatologia Hoje**. Rio de Janeiro: Ed.UFRJ (printing).
SILVA FILHO, J. F.. A semiologia, seu saber e a psiquiatria. **Cadernos IPUB**, vol.5, p.155-163, 1997.
STANGHELLINI, G. **Disembodied spirits and deanimated bodies**. The psychopathology of common sense. Oxford: Oxford University Press, 2004.
TATOSSIAN, A. **Comptes rendus du Congrès de Psychiatrie et de Neurologie de langue française**. Tome I. Phénoménologie des Psychoses. Paris: Masson, 1979.
VERZTMAN, J. S. Será possível transformer a prática do ensino prático? In FIGUEIREDO, A.C. & SILVA FILHO, J.F. (org.) *Ética e Saúde Mental*. Rio de Janeiro: Topbooks, 1996, p.115-122.
YIN, R.K. – *Estudo de Caso. Planejamento e métodos.* Porto Alegre: Bookman, 2005 (3rd edition).
ZAHAVI, D.. Michel Henry and the phenomenology of the invisible. **Continental Philosophy Review**, vol.32, p.223-240, 1999.
ZAHAVI, D.. Beyond Empathy: Phenomenological Approaches to Intersubjectivity. In Thompson, E. (org.) **Between Ourselves**. Second-person issues in the study of consciousness. Thorverton: Imprint Academic, 2001, p.151-167.
ZAHAVI, D. First-person thoughts and embodied self-awareness: Some reflections on the relation between recent analytical philosophy and phenomenology. **Phenomenology and Cognitive Sciences**, vol.1, p.7-26, 2002.
ZAHAVI, D. Phenomenology of self. In KIRCHER, T. & DAVID, A.S. (org.) **The Self in Neuroscience and Psychiatry**. Cambridge: Cambridge University Press, 2003, p.56-75.
ZAHAVI, D. & GALLAGHER, S. Phenomenological Approaches to Self-Consciousness. In ZALTA, E. N. (org.) ***The Stanford Encyclopedia of Philosophy (Spring 2005 Edition).*** Available for *download at* http://plato.stanford.edu/archives/spr2005/entries/self-consciousness-phenomenological/ .

Translated by Geoffrey Corley
Translation from **Interface - Comunicação, Saúde, Educação**, Botucatu, v.11, n.22, p. 207-222, May/Aug. 2007.