THE PHENOMENOLOGICAL PERSPECTIVE IN THE CLINIC: FROM SYMPTOM TO PHENOMENA

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«What does phenomenology enable us to see? precisely that which does not immediately and regularly show itself... and precisely because phenomena are not immediately and regularly apparent, it is the concern of phenomenology...»
(Heidegger, "Sein und Zeit" § 7).

Tellenbach's distinction between "symptom" and "phenomena" is a good introduction for demonstrating the originality of the phenomenological approach.

This leads us to the patient and his/her history, with a beginning, an afterwards and an end. However, "clinical history" is also a task of selecting and organizing "data" obtained from clinical observation and the patient's own expression: it is the "representation" outlined by the observer from this basic material. On classifying the "facts" into categories of genus and species, types and subtypes, clinical history departs from the immediacy of the patient, his/her singularity, and tends toward a class, a *taxonomy*. The subject positively becomes an ill person inasmuch as he/she presents a set of symptoms referring to and classified into a nosological framework.

SYMPTOM AND SIGN. SIGNAL AND MEANING

It can be said, in general, that symptoms are "signs". A sign *announces something* that is not there in two ways: either by *indicating* something or by *communicating* to someone. There is always someone/something that expresses itself and someone who perceives it. When the relationship between the signal and what is signed is purely *indicative*, a pure correlate, we discover the "*signal*" (*Anzeige*) or *indicative sign* as Husserl[1] says: it designates but does not signify, it does not express *anything*. Smoke is a sign of fire.

However, it is possible that in addition to its indicative function, it may have a signifying function which arises spontaneously from conventions, experiences and other ways of transmitting knowledge. It is an agreement between various people who bestow upon the sign a meaning although not necessarily a causal relationship. Thus, a fever may be a sign of bodily disease.

In medicine, symptoms constitute signs of a disease whose nature may be *inferred* but not *perceived*. However, the function of symptoms in *somatic medicine* is different from their function in *psychiatry*. In the former, the organic behavior is foremost, while, in the second, the interest is in

[1] Husserl E.: "Logische Untersuchungen (Hua IXI/l)", Der Haag, Nijhoff, 1984. Cfr. First Research: *Expression and meaning*, chapter I.

the patient's experiences and behavior, but in both cases they refer to the ill person "as carrier of symptoms."

The *somatic symptom* is a sign of a pathological organic process of a disease linked by a causal chain (a defined or previously known disease) of which it is the final link; consequently, its function is to spring toward something different from itself . Through its *indicative* value, it immediately permits inference of the invisible causal relationships, as in most somatic diseases. Thus, incoercible vomiting in a 15-day-old child permits inference of hypertrophy of the pylorus.

This inductive methodology seeks common features in the diseased from whom it is possible, on one hand, to elaborate *types of disease*, to establish a diagnosis and to provide indications for treatment; and, on the other hand, to explain and understand the natural processes according to special methodologies. This is precisely the methodology of *natural science* medicine as well as the greater part of psychiatry.

The *psychiatric symptom* also *indicates* a *characteristic feature* (*Markmal*, Schneider) that is associated with a pathological type to which it is ascribed. It is a theoretical construction of the observer that nonetheless requires a given interaction between the therapist and the patient. Through the symptoms, the disease as alteration is announced but not shown, thus compelling *diagnostic inferences*. The symptom is the visible indicator of something inaccessible to experience, either of deep mechanisms of inferable nosological entities.

A CARTESIAN METHODOLOGY: PSYCHIATRY AND SYMPTOM

From the natural science viewpoint, we may consider either *somatic aspects* or *psychic aspects*, in general, in the *mentally ill*.

Thus in the patient's body the physician observes *deviations* from the rules regarding functions or average individual *states of being*, verified by means of experimental scientific methods, which may be communicated through *fixed concepts*. In this way clinical semiology, in the process of etiologic, physiologic and anatomic verification, will consider the sign and symptoms of mental illness as expressions of an organic-biological lesion or dysfunction and will translate it into a long and sometimes arguable enumeration of symptoms based on a descriptive operational reading[2].

In the same way, when referring to the *psychic state*, it starts from *typical* psychological states, internally and externally perceived, which serve as terms of comparison. Once the whole has been characterized, especially the conscious mind, this type of scientific modality takes into account determined partial areas: attention, memory, intelligence and *norms* of comparison, acquired through experience, which are used to distinguish the deviations that will be classified as *symptoms*.

Tellenbach (1969) considers that dividing the psychic as a whole, objectifying it in recognizable and perceptible parts and proving the deviation from states and functions and physical and psychic processes with respect to the norm constitutes the fulfilment of the IInd and IVth rules of the Cartesian method (*i.e.* to divide the object of study into as many parts as possible; to enumerate in a complete way and to make a revision of the whole, until assured that nothing has been omitted).

As the symptom as "verifiable from outside" indicates that something "interior" is hidden whose causes may be rooted in different internal structures, it surpasses "the right of the phenomenal itself" and leads the psychiatrist to wonder about the conditions that determine the framework under observation in order to establish a diagnostic. In order to achieve a gradual knowledge of the

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[2] But here underlies a divided man in *res cogitans* and *res extensa*, where the thoughts of the conscious mind in reality constitute the very essence of man.
On the other hand, if the *cogito* has an absolute nature, it cannot become ill, and this could only happen to a man whose brain were affected by alterations ("Metaphysical Meditations", I, § 6). It can be deduced then that in Descartes, there can only be psychosis with an organic substratum and it is then the brain that can have influence over the spirit. On its own, delirium cannot emerge from the dimension of the psyche either. It is evident, then, that the Cartesian conception constitutes the basis for psychiatry as "technical and natural-science discipline".

increasingly clear pathogenetic factors, he tries to *deduce* the conditions of the symptoms and through them he seeks to derive a symptomatic framework, that is, to *explain* it. Thus he responds to the III[rd] Cartesian rule which takes thoughts in an ordered way from the simplest objects ascending to the most complex; also, in some way, to even put in order those which, because of their nature do not proceed from others (Tellenbach, 1969, 11).

Here, the physician finds himself moving within a subject-object, psyche-soma dualism, images of man and the world that, although they permit natural scientific knowledge and application, are insufficient for learning phenomena as the expression of modifications in humanity. Sign and symptom do not reveal anything to us of the patient, they simply refer to something hidden that produces the sign or symptom. The symptom is a sign of an "abstract nosological entity" and is understood on the natural science level.

Moreover, clinical history in its coherence depends as much on facts as narrative form depends on its exposition. As all clinical history is one possible world among many, is it not possible that one real history exists among all possible histories, the true history? But what does true history mean and what criteria are necessary to correctly achieve it? «True history constitutes, in a case, a sort of Kantian *noumena*: a sort of idea *limit* that falls beyond our cognitive possibility» (Civita, 39). In the determination of clinical "facts" there is as much constructive as narrative labor. The idea of one reality that enables confronting what must be represented in clinical history is in itself an idea limit, without substance (ibid.).

«The disease transforms the history into a "case"... The case now transforms the vital facts into medical facts... The clinical "cases" are characterized by their reference to frameworks, syndromes and forms related to representation» (Broekman, 145-6).

Immediate, direct access to experience just as it is intended here by the descriptive-observational method, ends up being an insurmountable obstacle. Firstly, because the following must be addressed: is there such thing as a simple observation? Is it possible to speak of something that has simply been observed in the psychological or psychiatric environment? It is impossible to assume the posture of an objective observer limited to recording facts. The most apparently neutral gaze commonly exercises an intrusive influence on the condition of the patient, for example inducing him to exhibit or produce in some way the symptom that the physician expects to verify and show to his colleagues; and it sometimes happens that the symptom disappears and the physician remains in the middle of the lesson as if slapped in the face. As Petrella[3] so aptly puts it, «observation is that which is accessible to the willingness of the observer». Secondly, because isolating symptoms of the whole of human existence causes them to lose the coherence they have within themselves, they become mere extrinsic aggregates, void of all dialogic value. The diseased patient is simply reduced to being the carrier of symptoms that are not confused and in whose genesis he does not participate and from which the researcher or therapist must take some distance. Moreover, when the underlying functional nexus is unknown, for example in endogenous psychosis, the symptom has what can best be described as a masking nature.

SIGN, EXPRESSION AND COMPREHENSION

In psychiatry, the *symptom* not only has significance as a sign for something but also as an "*intelligible sign*" that can exercise in itself and from itself, and without commentary, a function because it communicates directly to other human beings and becomes "comprehensible" in a certain way. When a person in the street insults a passer-by in a loud voice with senseless reproaches, this constitutes a sign of mental illness. The symptom is now understood as an *expression* of the ill

[3] Petrella F.: "L'osservazione aperta alla volontà dell'osservatore". "La lezione di psichiatria: Da Emil Kraepelin a André de Lorde". *Gli Argonauti, 21*, 123-135, 1984. Cited by Civita, p. 34.

person, of a personal situation and projection. We find ourselves on the *comprehensive science level*.

The intelligible relationship between the sign and the signed presents a communicative function. Here the nexus between the sign and the signified is patent. Husserl calls it "*expression*" or *expressive sign*: the signing becomes significance.

To the *unified whole of humanity* and, therefore, to the *psychically diseased* as well, there corresponds – even on the psychic level – something that is out of reach for the natural scientist, something that rests on a totally different plane and is characterized by internal *comprehensible relationships* between *man* and his own *world*. Here, the physician discovers symptoms, signs and signifiers that are, even for the patient, interlinked in a *comprehensible* way with his world, with his relationship to others, himself and his history. However, when objective data is insufficient, we understand less and we interpret more, as Jaspers would say. *Interpretation* means satisfying the void of comprehension.

In contrast, Ricoeur emphasizes the necessity to verify the *relevance* of *comprehension* through interpretation and hermeneutics, and he denounces the dangers associated with the first level of comprehension of a text that postulates direct access to the experience of the other. One can impose on the text one's own desires, aspirations, expectations and even one's own ideological inclinations. For this reason, hermeneutics as a science of interpretation is required to enable us to pass from a *naive* comprehension to a rigorous comprehension.

"ONE MORE STEP": THE PHENOMENON

As «the phenomenon is that which – being most commonly forgotten – can be brought into the light by certain methods of approach, or it is that which more rarely emerges into the light» (Tellenbach, 1956), it is necessary here to take a further step (*Schritt zurück*) from the understanding of Jaspers, to demonstrate the pathologies as specific *modifications* of the *a priori structures* of *Dasein*.

Binswanger seeks the phenomenological genesis of this inflection of *Dasein*, previously identifying the "structural moments" (*Aufbaumomente*) in the process of *constituting* the world, that is, its *conditions of possibility*. He wonders how transcendental deficiencies affect these particular world modalities. What should become phenomenon, is in no way something exterior but, on the contrary, it is the "logos" (Blankenburg, 1991), it is not only what is perceptible to the senses, but also the *structures* observed within them and their comprehensibility. The "generality" that the singular case may demonstrate, does not correspond to a generalization of empirical cases (which would also be illegitimate as it does not rest in observation) but, rather, to the acknowledgement of the *eidos* in the Husserlian sense (Blankenburg, op. cit., 38-40).

The *phenomenon* comprehends all that is present in the subject, individual and cultural characteristics, the subject's current situation, and in general all meaning that is normally added to the *hard nucleus* of the symptom, while the symptom severs the experience so as to remain with only the pathology. Psychiatry requires that the symptom provide information regarding the illness or the hidden alteration and not regarding the patient; the phenomenon, in contrast, discards nothing and rather plays the role of *icon* for a *deficit in the way of being*, that is, for "mutations" (*Abwandlungen*) – and not for morbid alterations – in the form of existence.

While the very psychiatric descriptions by definition discard all that is "not" pathological evidence, the phenomenological attitude focuses interest on the whole of daily behavior. The facticity of daily discourse and conduct is the raw material that must be analyzed in order to achieve access to the experience of the other and to describe the particular "inflection of experience" of the majority of psychological disorders. Consequently, a downward moving framework is developed from the search for constitution to a precise description of the facticity of existence (Corin and

Lauzon)[4]. Access is sought to the basis of the patients' *Dasein*, without thereby deviating from the facticity of existence. Absolutizing aspects of the surface is not the aim, but rather a radicalization of the principle of "experience". .

As Lantéri-Laura says, more than searching for «a psychiatry that would be phenomenological instead of organic or psychoanalytic, the aim is toward a psychiatric phenomenology, a description that neither creates nor criticizes its object but, rather, allows it to *appear* just as it is manifested so as to elucidate its essence»[5]. Thus the Husserlian slogan may be achieved of "returning to things themselves".

While symptomatological diagnosis is oriented toward illness, phenomenological diagnosis is directed toward the ill person himself so that he may describe in his *original manner of presentation* these peculiar modalities of experiencing and behaving with himself and with the world. Phenomenological analysis would seek to discover the possibility of an inherent "deviation" in human beings by broadening our common world so as to be able to encompass as human possibility the psychopathological world.

Illness is not reduced to the order of *having* such symptoms but rather constitutes a *way of being and perceiving the world in a peculiar way*. Psychiatric experience, on the other hand, operates a diagnostic reduction and views defective ways of existence as mere symptoms, that is, indexes of another reality where man is no longer subject but rather a clinical case.

If symptoms pertain to psychiatry in the measure to which conduct may be understood as signs of a hidden illness, for phenomenology the same conducts may be understood as *phenomena*, that is, *manifestations of a special way of presence* (Tellenbach, 1974). This involves an aperture into *what is demonstrated in and of itself, to the phenomenon*; it is not what is merely proclaimed, inasmuch as it refers to the whole of *Dasein*. The phenomenon does not shield anything behind it, no nervous apparatus, psychic apparatus or nosological entity but, rather, within it, the patient is presented in "flesh and blood", and by *showing* something there is no need for inference. The patient is a presence and not a "representation". The accent is placed on who the patient is, on who is this *who*.

The symptom then acquires the character of *phenomenon* that covers the world and itself because in the transcendence there is not only constituted a sense of toward where (the world), but also who does the transcending, the being who we are in every case. And as «transcendence is rooted in time, in the unfolding of the past into the future, vital history, biography, it acquires capital importance» (Dörr Zegers, 47). In this way, the genesis of these world projects, and their progressive limitations, may be pursued. Pathology is presented now as a unitary structure full of meaning.

Let us consider as an example a corporal or cenesthesical hallucination. As a symptom it leads us to alterations in reasoning or the so-called corporal scheme, but as *phenomenon* it leads us to perturbations of what is corporal, where the body becomes only an *object for another* (Sartre) dominating the area of interpersonal relationships, and thus limiting the structure of his *being with another*.

THE INFERENTIAL MODEL AND THE PERCEPTUAL MODEL

Symptom and *phenomenon*, then, convey two models, the *inferential* and the *perceptive* (Tatossian, 1986). For an *inferential model*, melancholia and schizophrenia are illnesses that are inaccessible to experience, and are only *inferable*. In the *perceptive model*, in contrast, the illnesses are global ways of life, attitudes with respect to the self, the body and the world.

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[4] «Understanding evolves from a back-and-forth movement between the search for constituents and a precise description of the facticity of existence».

[5] «Il s'agit moins d'une psychiatrie qui serait phénoménologique au lieu d'être organiciste ou psychanalytique, que d'une phénoménologie du psychiatrique, description qui ne crée ni critique son objet, mais le laisse apparaître tel qu'il se manifeste pour parvenir à en élucider» (Lantéri-Laura, 1986, 904) (The italics are mine).

Each of these modalities conveys a proper type of psychiatry. Experience based on the *symptom*, and the causal chains that lead to it, consider the mental problem as a *heteronomous* effect, that is, imposed on the subject by pathogenic, psychic or somatic agents. From this perspective, the objective of therapy is to put into play these mechanisms at the service of the patient, which does not, however, imply his active participation. In contrast, the *phenomenon* constitutes the *meaning* itself where the subjectivity of the patient is expressed and therapy, as it questions the other in his personalization, is a process of self-healing, even as important as the psychotherapeutic intervention may be.

Up to now, psychiatry has provided us with the history of the illness but not of the man. Phenomenological analysis does not aspire to proposing diverse "models" of noso-graphic articulation but, rather, to explore in depth with inexorable radicalism the essence of some fundamental psychopathological experiences and to recover them in terms of their meaning for human ways of being; it leaves to the side all naturalistic utopianism in order to indicate in the psychopathological condition the radical connotation of a human experience. This does not imply, in any way, dedication to the study of singular cases but, rather, describing them as examples inasmuch as their particularity reaches at the same time to the essence of this deficit in the way of being, that is, its general meaning. It is not a question of transforming classical semiology, as if it were necessary to renounce at all costs the already acknowledged signs in order to invent others, but, rather, to clarify the meaning itself of the notion of signs and its antepredicative basis. Phenomenological psychiatry «does not alter classical semiology but, rather, describes its metamorphosis in an *anthropological symptomatology*... considering the studied cases as examples, seeking to understand acute problems as the transformations in world experience and chronic illnesses as destinies» (Lantéri-Laura, 1957, 670).

Nor is it a question of rejecting a symptomatological-criteriological diagnosis by denouncing it for its thing-ism in order to present a new "phenomenological" reformulation, inasmuch as the procedures of operational symptomatological diagnosis have improved the trustworthiness of diagnosis, further promoting empirical research.

«... the labor of psychiatry requires two methods, one, natural-scientific, that operates in part mathematically and inductively, and another, psychological-phenomenological. Both methods are mutually limiting, but there exists a "symmetrical equivalence" between the two, according to what Becker sustains. Only in this way can the person be approached as well as the mentally ill as an indivisible whole» (Kuhn, 1998, 333-334).

In order to speak in terms of Habermas, inasmuch as the psychiatric perspective is associated with natural science epistemology, *instrumental interest* is characteristic: its objective is to identify signs in the mechanisms that affect conduct, in order to be able to modify them. In contrast, the human sciences are characterized by *communicative interest*[6]: conducts are understood as penetrating the very meanings, which are revealed through an attentive examination or, as Blankenburg says (1986), by a "contemplative immersion." In fact, the majority of the decisions made by the psychiatrist are not founded in traditional semiology and a descriptive psychopathology but, rather, in the degree of freedom relative to his own behavior and his own experience. Blankenburg bases psychic pathology in a psychopathology and a semiology of human freedom and this permits appreciation of the equilibrium between the autonomy and the heteronomy of the subject, with the objective of taking a series of banal and daily decisions that the habitual nosological and semiological balance cannot quite orient.

Indeed, medical knowledge is, in some way, anthropologic knowledge, of man as subject to illness, of *homo patiens*. «Pain and suffering are not only "pathos" but also "logos"», says Lopez

[6] This springs from Jaspers's differentiation between "comprehensive relations of comprehensive psychology" and "causal relations of explicative psychology", a distinction that derives from Dilthey, in "Ideas on a Descriptive and Analytical Psychology".

Ibor, they don't only produce knowledge in those who suffer but also in those who wish to accompany man in his suffering. The understanding of the ill and the understanding of psychiatry are thus one and the same understanding. The *phenomenon* in this circumstance that is manifest in itself is the expression of this understanding, that is, how and why the physician and patient *should meet just now*.

But there is also the acceptance that, in spite of this "interlocutory" dimension, human life is not transparent to knowledge and forever guards a mysterious and non-theorizable element. Nothing in existence is fully a possession of itself and nothing is totally strange to itself, thus...

«... I could never grasp the present that I am living with absolute certainty, given that what is lived is never absolutely comprehensible, that which I comprehend never exactly grasps my life, hence I never form a single thing with myself. Such is the fate of a being once born, that is, of one being, that, once and far all, has been given to himself as something to comprehend» (Merleau-Ponty, 1945, 399)[7].

BIBLIOGRAPHY

Azorin J. M., Tatossian A.: "Signification de la phénoménologie en psychiatrie". *Psychologie Médicale, XX, 12*, 1723-1727, 1988.

Berquez G.: "L'illusion phénoménologique et le réel biologique. Essai de Psychiatrie théorique". *L'Evolution Psychiatrique*, Tome *51*, l, 87-99, 1986.

Binswanger L.: "Ausgewählte Werke (Band IV) Der Mensch in der Psychiatrie". Heidelberg, Asanger, 1994; "Ausgewahlte Werke (Band I). Drei Formen Missglückten Daseins". Heidelberg, Asanger, 2, 1992.

Blankenburg W.: "Le perte de l'évidence naturelle". Paris, P.U.F., 1991; "Sur le rapport entre Pratique Psychiatrique et Phénoménologie". In: P. Fédida (ed.): "Phénoménologie, Psychiatrie, Psychanalyse". Paris, GREUP, Echo-Centurion, pp. 133-140, 1986; "Nomothetische und idiographische Methodik in der Psychiatrie", S*chweizer Archiv für Neurologie, Neurochirurgie und Psychiatrie*, Band 128, Heft l, pp.13-20, 1981; "Phenomenology and Psychopathology", *Journal of Phenomenological Psychology*, *11*, pp. 50-78, 1980; "Toward a more man-centred psychiatry". In: K. E. Schafer, U. Stave & W. Blankenburg (ed.): "Individuation Process and Biographical Aspects of Disease", (A new Image of Man in Medicine, vol. III), New York, Futura, pp. 139-220, 1979.

Borgna E.: "I conflitti del conoscere; strutture del sapere ed esperienze della follia". Milano, Feltrinelli Editori, 1988; "Fenomenologia applicata in psichiatria". In: C. L. Cazzullo, e C. Sini (ed.): "Fenomenologia: Filosofia e Psichiatria". Milano, Masson, pp. 71-82, 1984.

Broekman J. M. : "El tiempo en los cuadros clinicos de Merleau-Ponty". In: M. L. Rovaletti (ed.): "Temporalidad; El problema del tiempo en el pensamiento actual". Buenos Aires, Lugar Editorial, 1998; "Phänomenologisches Denken in Philosophie und Psychiatrie". *Confinia Psychiat*., 8, pp. 165-188, 1965.

Calvi L.: "Prospettive antropofenomenologiche". In: G. B. Cassano e altri (a cura di): "Trattato Italiano di Psichiatria", l[a] ediz. 1993, 2[a] ediz., 1999, Masson Italia, Milano.

Cargnello D.: "Ambiguità della Psichiatria". In: AA.VV.: "Scienza, Linguaggio e Metafilosofia". Napoli, Guida Editori, pp. 317-361, 1980. Ora anche in: *Comprendre*, *9*, 1999.

Carvalho Teixeira J. A.: "Fenomenologia, Existencialismo e Psicopatologia". In: "Fenomenologia e Psicologia". Lisboa, Instituto Superior de Psicología aplicada, pp. 47-54, 1994 (Actas de las I[a]s Jornadas de Psicologia e Psicopatologia Fenomenológicas e Existenciais, Lisboa, 23-24 Novembro 1990).

Cazzullo C. L.: "La fenomenologia: terreno d'incontro fra filosofia e psichiatria". In: C. L. Cazzullo, C. Sini: "Fenomenologia: filosofia e psichiatria". Milano, Masson Italia Editori, pp. 5-8, 1984.

Civita A.: "Ricerche Filosofiche sulla Psichiatria". Milano, Guerini, 1990.

[7] «... je ne pourrais jamais saisir le présent que je vis avec une certitude apodictique, qu'ainsi le vécu n'est jamais tout a fait compréhensible, ce que je comprends en rejoint jamais exactement ma vie, et qu'en fin je ne fais jamais une avec moi-même. Tel est le sort d'un être qui est né, c'est-à-dire qui, une fois et pour toujours, a été donné à lui même comme quelque chose à comprendre" (Merleau-Ponty, 1945, 399).

Corin E., Lauzon G.: “From symptoms to phenomena: the articulation of experience in schizophrenia”. 25 (l), 3-50, Spring 1994.
Daumézon G., Lantéri-Laura G.: “Signification d’une sémiologie phénoménologique”. *L’Encéphale*, vol. *50*, n. *5*, pp. 478-51, 1961.
Derrida J.: “Genèse et structure de la phénoménologie”. In: Derrida J.: “L’écriture et la différence”. Paris, Du Seuil, pp. 229-251, 1976a; “La structure, le signe et le jeu dans le discours des sciences humaines”. In: J. Derrida: “L’écriture et la différence”. Paris, Du Seuil, pp. 409-428, 1976b.
Döerr Zegers O.: “Psiquiatría Antropológica; contribuciones a una Psiquiatría de orientación fenomenológica-antropológica”. Chile, Editorial Universitaria, 1995.
Fédida P. (ed.): “Phénoménologie, Psychiatrie, Psychanalyse”. Paris, GREUP, Acte du Colloque, Echo-Centurion, 1986.
Fédida P., Schotte J.: “Psychiatrie et Existence”. Grenoble, Jérôme Millon, 1991.
Francioni M.: “La portata dell’istanza fenomenologica in psichiatria”. *Ricerche di Psicologia*, *V, 18*, 77-87, 1981.
Galimberti D.: “Psichiatria e Fenomenologia”. Milano, Feltrinelli, 1987; saggio introduttivo di E. Borgna.
Habermas J.: “Theorie und Praxis; Sozial philosophische Studien”. Frankfurt, Suhrkamp, 1978.
Halling S., Goldfarb M.: “The new generation of Diagnostic Manuals (DSM-III, DSM-III-R, and DSM-IV-R): an overview and a Phenomenologically based critique”. *Journal of Phenomenological Psychology*, *XXVII*, *1*, 49-71, Spring 1996.
Heaton J. M.: “A discussion on Phenomenology, Psychiatry and Psychotherapy”. In: A.J.J. Koning, F.A. Jenner: “Phenomenology and Psychiatry”, London. Toronto-Sydney, New York-San Francisco, Academic Press-Grune, Stratton, pp. 11-34, 1982.
Heidegger M.: “Sein und Zeit”. Tübingen, Max Niemeyer, 1963.
Hoeller K.: “An introduction to Existential Psychology and Psychiatry”. In: K. Hoeller (ed.): “Readings in Existential Psychology & Psychiatry”. *Seattle Review of Existential Psychology & Psychiatry*, 3-20, 1990.
Hoff P.: “Relevance of Transcendental Philosophy to the Foundations of Psychopathology”. In: M. Spitzer, B.A. Maher: “Philosophy and Psychopathology”. New-York, Springer Verlag, pp. 211-220, 1990.
Husserl E.: “Logische Untersuchungen (Hua IXI/l)”, Der Haag, Nijhoff, 1984; “Phänomenologische Psychologie”, *Huss. IX*, 1962; “Philosophie als strenge Wissenschaft”, Frankfurt, Klostermann, 1965.
Karlsson G.: “Psychological Qualitative Research from a Phenomenological Perspective”, Stockholm, Almqvist, Wiskell International, 1993; “Facts and meaning: An examination of their role in psychological research from a phenomenological perspective”. *Scandinavian Journal of Psychology*, *31*, 248-258, 1990.
Kuhn R., Maldiney H.: “Préface” à L. Binswanger: “Introduction à l’analyse existentielle”. Paris, Minuit, 1971.
Kuhn R: “Daseinsanalyse: phénoménologie de l’existant”. In: P. Fédida: “Phénoménologie, Psychiatrie, Psychanalyse”, Paris, G.R.E.U.P., Echo-Centurion, pp. 9-26, 1986; “El síntoma corno hecho a ser comprendido; En torno a la frase ‘en la psiquiatría los síntomas son ellos mismos hechos a ser comprendidos’”. In: M.L. Rovaletti “Corporeidad: La problemática del cuerpo en el pensamiento actual”, Bs. As. Lugar Editorial, 1998.
Koning A. de, Jenner F. A.: “Phenomenology and Psychiatry”. London, Toronto-Sydney, New York-San Francisco, Academic Press-Grune, Stratton, 1982.
Kraus A.: “La significación de la fenomenología para el diagnóstico psiquiátrico”. *Escritos de Filosofía*, XIV, *27-28*, 213-229, Enero-Diciembre 1995.
Lantéri-Laura G.: “Philosophie phénoménologique et Psychiatrie”. *L’Evolution Psychiatrique*, 4, 653-675, Anné 1957, Octobre-Decembre; “Phénoménologie et critique des fondements de la psychiatrie”, *L’Evolution Psychiatrique*, *51*, *4*, 895-906, 1986 ; “Sémiologie et critique de la connaissance”, *L’Evolution Psychiatrique*, *51*, *4*, 825-833, 1986.
Lopez Ibor J.J.: “Enfermedad, dolor y sufrimiento”. Noticias Médicas, 1970.
Maldiney H.: “Regard, Parole, Espace”. Lausanne, L’âge de l’homme, 1973. It is included: “Comprendre” (pp. 27-86); “Le dévoilement des concepts fondamentaux de la psychologie à travers la Daseinanalyse de L. Binswanger” (pp. 87-101); “Daseinanalyse: phénoménologie de l’existant?”. In: P. Fédida: “Phénoménologie, Psychiatrie, Psychanalyse”, Paris, G.R.E.U.P., Echo-Centurion, pp. 9-27, 1986; “L’existant”. In: P. Fédida, J. Schotte: “Psychiatrie et Existence”, Grenoble, Jérôme Millon, pp. 23-46, 1991.

Marchais P.: “Le nombre, les échelles et les critères diagnostiques; problématiques actuelle”. *Annales Médico-Psychologiques*, vol. 153, *l0*, 716-720, 1995.
Merleau-Ponty M.: “Phénoménologie de la perception”. Paris, Gallimard, 1945.
Mishara A. L. “A Phenomenological Critique of Commonsensical Assumptions in DSM-III-R: The Avoidance of the Patient’s Subjectivity”. In: Sadler, Wiggins Schwartz (ed.), op. c., pp. 129-147.
Ramos Gorostiza P., Gonzalez Calvo J. M.: “El sentido de la Psicopatología y el papel de la fenomenología. Contribución a una controversia”. *Actas Luso-españolas de Neurología y Psiquiatría*, *23*, *5*, 281-286, 1995.
Rapisarda V., Liberti C.: “Aspetti teoretici e pratici del rapporto fenomenologia-psichiatria”. In: C. L. Cazzullo, C. Sini (ed.): “Fenomenologia: filosofia e psichiatria”. Milano, Masson Italia Editori, pp. 175-184, 1984.
Ricci Sindoni P.: “I confini del conoscere. Jaspers dalla psichiatria alla filosofia”. Napoli, Giannini Editore, 1980.
Ricœur P.: “Du texte à l’action”. *Essais d’herméneutique*, *II*, Paris, Seuil, 1986.
Rovaletti M. L.: “Alienación y Libertad”, Investigaciones en Psicología (Revista del Instituto de Investigaciones en Psicología de la UBA), 1996, Año 1, *1*, 119-135; “La psiquiatría una ciencia de la persona”, Vertex (Bs. As.), n. 28, pp. 85-91, 1997; “A significao da Fenomenología na Psiquiatría”, Temas: Teoria e pratica do Psiquiatria, vol. 26, n. 52, pp. 150-163, Sao Paulo, 1996.
Sadler J., Wiggins O. P., Schwartz M. A. (eds.): “Philosophical perspectives on Psychiatric classification”. Baltimore, John Hopkins University Press, 1994.
Saurí J.: “Significación de la nomenclatura psiquiátrica”. *Revista de Neuropsiquiatría*, XLIV, *2*, 69-76, (Perú) Junio 1981; “Qué es diagnosticar en psiquiatría”, Bs. As., Bonum, 1994.
Spitzer M., Maher B.A.: “Philosophy and Psychopathology”. New York, Springer Verlag, 1990.
Tatossian A.: “Pratique Psychiatrique et Phénoménologie”. In: P. Fédida, (ed.): “Phénoménologie, Psychiatrie, Psychanalyse”. Paris, G.R.E.U.P., Echo-Centurion, pp.123-l32, 1986.
Tellenbach H.: “Die Räumlichkeit der Melancholischen (II); Analyse der Räumlichkeit melancholischen Daseins”, *Nervenartz*, 27, 289-29, 1956; “La melancolía”, Madrid, Ediciones Morata, 1974; Estudios sobre la Patogénensis de las perturbaciones Psíquicas, México, F.C.E., 1969.
Wiggins O.P., Schwartz M.A., Spitzer M.: “Phenomenological/descriptive Psychiatry: The Methods of Edmund Husserl and Karl Jaspers”. In: M. Spitzer *et al.*: “Phenomenology, Language and Schizophrenia”, New York, Springer Verlag, pp. 46-69, 1992.

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