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The role of phenomenology in psychiatric diagnosis – challenges for clinical reasoning with experiences

The complex nature of mental disorders makes the construction of diagnostic criteria in psychiatry particularly difficult. Recent editions of diagnostic manuals (e.g. APA, 2013) have focused on providing operationalized lists of diagnostic criteria necessary and sufficient for clinical categories. In reply to this operationalization approach, several authors have emphasized the importance of the phenomenology, i.e. patients' reports of experiences, in the psychiatric and psychological practice including diagnosis (e.g. Parnas & Zahavi, 2002; Ratcliffe, 2014; Kendler, 2016).

In a recent paper Kenneth Kendler (2016) provides evidence that eighteen symptoms experienced in major depression, as indicated by descriptions from psychiatry and psychology textbooks, are not included in diagnostic manuals such as DSM III or DSM V. Kendler acknowledges that diagnostic criteria should be succinct and require minimal inference. He argues that although generally effective, operationalized diagnostic criteria are often mistakenly identified with psychiatric disorders per se. The reification of criteria in clinical practice, teaching and research leads to impoverished understanding of psychiatric disorders which typically involve a variety of subtle phenomena much of which occurs in the sphere of patients' experience. This recent plea for inclusion of phenomenology is grounded in the idea that a good clinical care should aim at exploring and understanding patients' experiences (Parnas & Zahavi, 2002; Andreasen, 2007). Phenomenology is a rich reservoir of information that goes beyond operationalized criteria and that may be indispensable for successful diagnosing and understanding psychiatric disorders.

The above observations reveal an interesting tension. On the one hand, we expect psychiatrists to follow easy and effective procedures to reach a clinical diagnosis in virtue of well operationalized criteria. On the other hand, the success of psychiatric diagnosis and treatment crucially depends on whether professionals can capture and draw on the rich and complex domain of patients' experiences. It is therefore an important question whether and to what extent phenomenology can be included in the process of diagnostic reasoning in psychiatry.

In this talk I will address this question by suggesting one model that incorporates *patterns of experience* into clinical reasoning. Clinical reasoning in psychiatry is likely to be more challenging than in other domains of medicine due to its highly subjective nature and often questioned reliability (McGorry & van Oss, 2013). According to Eaton et al. (1995) psychiatric symptoms often arise from the intensification of subjective experiences or behaviours that have been present for some time. When such changes become prominent, they can be distinguished as subclinical symptoms. I will propose that one way to include the role and progressive nature of such experiences is to adopt a *clinical staging* approach to psychiatric diagnosis that captures the timing and progression of illness and can improve the timing of interventions in psychiatry (McGorry & van Oss, 2013). Clinical staging is a heuristic strategy in clinical reasoning that goes beyond static diagnostic boundaries (McGorry et al., 2006). It is due to this feature, I will argue, that the approach can capture the dynamic nature of symptoms and incorporate patterns of experiences that at an early stage may have prodromal importance and later indicate the dynamic progression of disorder. The approach helps to address the plea for phenomenology by including patients' experiences in the clinical reasoning process.

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